COLORADO DOMESTIC VIOLENCE OFFENDER MANAGEMENT BOARD

STANDARDS AND GUIDELINES FOR THE ASSESSMENT, EVALUATION, TREATMENT, AND BEHAVIORAL MONITORING OF DOMESTIC VIOLENCE OFFENDERS

Colorado Department of Public Safety
Division of Criminal Justice
Office of Domestic Violence and Sex Offender Management

700 Kipling Street, Suite 3000
Lakewood, CO 80215
(303) 239-4442
1 (800) 201-1325 in Colorado only

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1.0 Domestic Violence Offender Management Board

Introduction to the Domestic Violence Offender Management Board

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

The Board is committed to carrying out its legislative mandate to enhance public safety and the protection of victims and potential victims through the development and maintenance of comprehensive, consistent and effective standards for the evaluation, assessment, treatment and behavioral monitoring of adult domestic violence offenders. The Board will continue to explore the developing literature and research on the most effective methods for intervening with domestic violence offenders and to identify best practices in the field.[2]

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.). These standards govern the practice of mental health professionals who meet the qualification requirements and are approved by the DVOMB.

[1] Although the term assessment does not appear in § 16-11.8-101, the DVOMB has included this term as part of the treatment process defined by the DVOMB Standards and Guidelines pursuant to § 16-11.8-102(4).
[2] For more information about the Board, membership, and mandates, please see the DVOMB By-laws.

1.01 Purview of the DVOMB

I. Pursuant to statutory purview of § 16-11.8-103(4)(a)(ii) C.R.S.[3], the DVOMB has purview over ~~a~~ guilty pleas, pleas of nolo contendere, convictions after criminal trials, deferred sentences, and stipulation/finding of a domestic violence factual basis. These standards and guidelines are required 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[4], or private probation
- Ordered by the parole board per the parole agreement
- Ordered as part of the community corrections sentence (i.e. doc inmates occupying state funded community correction beds)
- Ordered to complete as part of a pre-sentence offender evaluation[5]

***Discussion point**: in cases where the domestic violence offender enhancer/tag has been removed, the court may still order a defendant to domestic violence offender treatment when the court makes a finding for the requirement to undergo treatment as being reasonably related to the defendant's rehabilitation, community safety, or the goals of probation[6]. Defendants who are ordered to undergo domestic violence offender treatment shall meet the requirements of the DVOMB standards and guidelines which includes addressing responsibility for the domestic violence related behaviors in the index offense.*

II. There may be other individuals in need of evaluation, assessment, treatment, and supervision who do not meet the statutory definition of a domestic violence offender or are not under the jurisdiction of the Colorado criminal justice system. Approved Providers should consider the use of the DVOMB Standards as a best practice guideline and at their discretion for cases that do not fall under the purview of the DVOMB. The board provides the following guidance regarding use of the standards for adults who are not under the statutory purview of the DVOMB. These standards and guidelines may be utilized as best practice in the following situations where there are concerns of abusive, harmful, or domestic violence behavior for:

- Adults placed on diversion, without a deferred sentence
- Adults requesting a pre-plea evaluation[7]
- Adults requesting a domestic violence evaluation as part of a domestic relations or civil protection order case pursuant to § 14-10-124, C.R.S.

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[3] Pursuant to § 16-11.8-103(4)(a)(II) C.R.S., the DVOMB Standards apply to adult domestic violence 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.

[4] C.R.S.13-10-104.5(a)(V)(e), Municipalities shall adopt an ordinance establishing Guidelines and Standards that are consistent with the Guidelines and Standards adopted by the DVOMB pursuant to Section 16-11.8.103(4).

[5] C.R.S.18-6-801(1)(b), Partners in Change v. Domestic Violence Offender Management Board, within the Division of Criminal Justice of the Department of Public Safety of the State of Colorado, Case Number 06cv10083.

[6] C.R.S.18-1.3-204(2)(a)(15), Courts possess probationary powers to stipulate conditions.

[7] Pre-plea matters are not subject to the purview of the DVOMB Standards.

- Where a party is receiving services for domestic abuse behavior provided by a county department of human services/social services (DHS/DSS) without a legal requirement
- A person who voluntarily enters into treatment due to self-disclosed behaviors related to domestic violence behaviors

III. Youth who engage in relationship abuse: it is not the intention of the legislation, or the DVOMB, that these standards and guidelines be applied to the treatment of juveniles who have engaged in teen dating violence or relationship abuse. Despite many similarities in the behavior and treatment of juveniles and adults, important differences exist in their developmental stages, the process of their offending behaviors, and the context for juveniles who must be addressed differently in their diagnosis and treatment. Please see the current publication of the best practice guidelines for working with youth who engage in relationship abuse.

1.02 Terms of reference

I. The DVOMB *Standards* use a variety of terms referencing persons who are subject to these *Standards*. The terms that are frequently used in the *Standards* include domestic violence offender, offender, and client. These terms of reference are used in different sections of the Standards based on the focus of a given section (e.g., treatment, supervision, etc.), as well as the preferred language of professional stakeholders who frequently reference that section. The DVOMB notes that the use of the term 'domestic violence offender' is consistent with the statutory definition identifying a person who 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. However, the DVOMB recognizes that the use of the term domestic violence offender is in no way intended to label individuals by their behavior, or suggest that those who undergo treatment cannot live a violence and abuse free life-style.

II. Adherence to the standards by Approved Providers is monitored through the application, complaint, and standards compliance review processes. Standards are mandatory and designated by "shall" or "must", while guidelines are distinguished by the use of the term "should." Although the DVOMB does not have purview over other stakeholders involved in the supervision of defendants convicted of a domestic violence offense (for example, probation, parole, and the judiciary), it offers these guidelines as a tool to assist in the management of offenders and to enhance collaboration among stakeholders and to provide guidance on best practices.

1.03 Legal Definition of Domestic Violence

Pursuant to Section § 18-6-800.3(1), C.R.S., the criminal definition of "domestic violence" means an act or threatened act of violence upon a person with whom the actor is or has been involved in an intimate relationship. "Domestic violence also includes any other crime against a person, or against property, including an animal,

or any municipal ordinance violation against a person, or against property, including an animal, when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship." The criminal definition for domestic violence serves as the legal basis upon which a court determines if an underlying factual basis of domestic violence exists.

1.04 Clinical Features of Domestic Violence and Abusive Behaviors

The following definition of domestic violence is a more comprehensive definition of domestic violence that shall be used for the purposes of evaluation, assessment and treatment of domestic violence offenders under these Standards and Guidelines. Caution should be exercised when applying this definition and list of abuse types in circumstances that have not been identified through the legal system. Not all domestic violence behaviors are illegal, but they may be abusive or harmful to the person who has experienced the behavior. This definition and list of abuse types serve a framework to broadly define domestic violence behaviors in a clinical context that can be used to holistically address all forms of abuse with an offender who has been referred for services.

Domestic violence is an emerging, cyclical, or established pattern of attitudes and/or behaviors that are abusive, controlling, harmful or predatory against a person. Such domestic violence behaviors are choices that attempt to cause a specific outcome rooted in power and control and often intersect with multiple forms of abuse. Domestic violence offenders can present with multiple areas of risk to reoffend (i.e., domestic violence reoffending, lethality, non-domestic violence reoffending). A domestic violence offender is a person who engages in a pattern of one or more of the following abuse categories: dominance, dependence, dissonance, vengeance, surveillance, and violence. This list is not an exhaustive list regarding the forms of abuse related to domestic violence and should be considered and used for clinical purposes.

Dominance	Coercive Control - engaging in a pattern of behaviors to gain control and power by eroding a victim's autonomy, self-efficacy, and self-esteem, marked by domination and entrapment that extends across the spectrum of violent tactics.[8] Cultural Abuse - using culture as a means to excuse, minimize, or otherwise justify their abusive behavior. This may include disparaging the victim's culture, forcing a victim to embrace the offender's culture, isolating a victim from mainstream culture, using culture to silence a victim, using language barrier to isolate a victim, using other language to shut a victim out, etc. Emotional Abuse - using non-physical behaviors that may be subtle or more obvious which are meant to control, isolate, or frighten the victim. This type of abuse may present as threats, insults, yelling, constant monitoring, excessive jealousy, manipulation, humiliation, intimidation, or dismissiveness. While these emotionally abusive behaviors do not leave physical marks, they do cause harm, disempower, and traumatize the victim who is experiencing the abuse. Financial Abuse – controlling, exploiting, limiting, or withholding access to economic assets, employment or resources to negatively impact the financial capacity of the victim. Psychological Abuse - An intense or repeated pattern of confusing or doubt inducing behavior that creates psychological stress, confusion or doubt in the victim. This may include threats or acts of self-harm or homicide, denial of abuse, gaslighting, or stalking. Verbal Abuse - Using words or verbal iterations to as a means to control, coerce, manipulate, intimidate, ridicule, or degrade the victim and negatively impact their psychological health or otherwise cause harm. Collateral harm or abuse - causing harm to secondary victims whether directly or indirectly to harm, manipulate, intimidate or coerce in an abusive or controlling manner. Reproductive Abuse – using coercion, control, deceit, manipulation or threats to impact pregnancy, sabotage of contraceptives, use of contraceptives, access to contraceptives, and unilaterally decides reproductive choices as a method to gain power and control over another person(s).
Dependence	Immigration or Legal Status Abuse - Using or exploiting a victim or their family's lack of documentation, legal or illegal status, or citizenship as a means to threaten, control or, coerce the victim. Isolation and Social Abuse - attempting to foster conditions that aim to isolate a victim from their friends, family or community. These behaviors cause harm by cutting off healthy relationships, limiting social engagement, interfering with social networks, disrupting social interactions, or attempting to cause reputational harm.
Dissonance	Substance Abuse – using mood altering substances as a tool to perpetuate coercive control against the victim, including but not limited to sabotaging sobriety or limiting resources. The use of mood-altering substances by an offender does not cause domestic violence nor is it an excuse for abuse.[9] Intellectual Abuse - disrespecting another's learning style, ability, ways of thinking or intellectual interests. This can involve ridiculing a victim's ideas, devaluing a victim's opinions, or controlling the victim's access to educational or other learning opportunities. Gaslighting - attempting to create self-doubt and confusion in the victim's mind, by distorting reality and forcing the victim to question their own judgment and intuition. Spiritual Abuse - using faith, spirituality, religion, or the lack thereof as a means to intimidate, hurt, or control the victim.

[8] Dutton, M. A., Goodman, L., James, R. J. (2006). Development and Validation of a Coercive Control Measure for Intimate Partner Violence: Final Technical Report.
[9] Rivera, E. A., Phillips, H., Warshaw, C., Lyon, E., Bland, P. J., Kaewken, O. (2015). An applied research paper on the relationship between intimate partner violence and substance use. Chicago, IL: National Center on Domestic Violence, Trauma & Mental Health.

Vengeance	Animal abuse - mistreating, threatening, or killing any pet or animal, such as torturing, tormenting, mutilating, maiming, poisoning, or abandoning to emotionally manipulate or coerce the victim.[10] Administrative Abuse through Systems - utilizing systems intended to provide safety to a victim to harass, threaten, intimidate and/or control the victim instead. Using children - using or manipulating children as a means to control, coerce, manipulate, or otherwise cause harm to a victim. Destruction of Property - damaging, destroying, devaluing or taking possession of the tangible property of the victim as an act to harm, retaliate or intimidate the victim.
Surveillance	Monitoring Abuse - using or manipulating the environment physically or virtually to gain access and gather information about a victim regarding their schedule, activities, whereabouts, and interactions. These behaviors are a violation of the victim's expectation of and right to privacy regardless of consent, awareness or knowledge. These behaviors can undermine a victim's sense of safety, sanity, and security. This definition may include unwanted advances by the domestic violence offender in the pursuit of the identified victim. Stalking - engaging in a pattern of behavior directed at a specific person that attempts to develop, expand or maintain a relationship with the victim. These behaviors can cause substantial emotional distress or fear for the victim's safety or the safety of others. Victims may or may not be aware of these behaviors.[11] Technology-Facilitated Abuse - using technologies to bully, harass, stalk or intimidate. These behaviors may include non-consensual image sharing.
Violence	Physical abuse - using any physical act or object (including weapons) with the potential for causing harm, injury, disability, or death to exert power and control over the victim. Such physical acts can include targeting anyone or anything the victim may have an attachment to. Physical abuse can include coercing other people to commit any physical acts against the victim. Strangulation[12] - impeding or restricting the airway or circulation of the blood of a victim by applying pressure to the neck or chest, or by blocking the nose or mouth.[13] Sexual abuse[14] - using any physical act, behavior, or exploitation that is sexual in nature and causes harm to the victim without consent.

[10] Fabres et al., (2014). Adulthood Animal Abuse Among Men Arrested for Domestic Violence. Violence Against Women, 20(9) 1059–1077.
[11] Woodlock, W. (2017). The Abuse of Technology in Domestic Violence and Stalking, Violence Against Women, 23(5) 584–602; Senkans et al. (2017). Assessing the Link Between Intimate Partner Violence and Postrelationship Stalking: A Gender-Inclusive Study, Journal of Interpersonal Violence, 1–31.
[12] § 18-3-202(1)(g), C.R.S.: "With the intent to cause serious bodily injury, he or she applies sufficient pressure to impede or restrict the breathing or circulation of the blood of another person by applying such pressure to the neck or by blocking the nose or mouth of the other person and thereby causes serious bodily injury." § 18-3-203(1)(h)(i), C.R.S.: "With the intent to cause bodily injury, he or she applies sufficient pressure to impede or restrict the breathing or circulation of the blood of another person by applying such pressure to the neck or by blocking the nose or mouth of the other person and thereby causes serious bodily injury."
[13] Mcquown et al. (2016). Prevalence of strangulation in survivors of sexual assault and domestic violence. American Journal of Emergency Medicine, 34, 1281–1285; Thomas et al. (2014). "Do You Know What It Feels Like to Drown?": Strangulation as Coercive Control in Intimate Relationships, Psychology of Women Quarterly, Vol. 38(1) 124-137; Zilkens et al. (2016). Nonfatal strangulation in sexual assault: a study of clinical and assault characteristics highlighting the role of intimate partner violence, Journal of Forensic and Legal Medicine, 43, 1-7.
[14] §16-11.7-102(3), C.R.S.

1.05 General Overview of the Evaluation and Treatment Process

I. Upon order by the Court or Parole Board, an offender is required by statute to receive an evaluation and attend treatment as recommended.15 The offender evaluation will result in treatment recommendations that assess the offender's need for treatment, determine what type of treatment is needed, and identify the initial risk level and any additional needs the offender may have related to containment, stabilization and safety (Section 4.0).

II. Treatment is the comprehensive set of planned therapeutic experiences and interventions designed to assist the offender in changing any power and control dynamics, abusive thoughts, and behaviors (Section 5.01). Treatment requires the offender to attend in-person group or individual sessions at a minimum of once a week or more depending on the offender's treatment level (Section 5.03). Treatment is individualized and progress is assessed during a Treatment Plan Review (TPR), which occurs every two to three months (Section 5.07). The degree to which an offender progresses in treatment and remains compliant is based on meeting goals associated with the core competencies rather than the passage of a specific amount of time or sessions (Section 5.03).

III. Progress through treatment and victim safety is monitored by the Multi-Disciplinary Treatment Team (MTT) consisting of the Approved Provider, the supervising officer, a Treatment Victim Advocate (Section 7.0), and any other adjunct member of the MTT (Section 5.02). The MTT communicates regularly and shares information about the offender during the course of treatment in order to mitigate risks, support accountability, and improve victim safety. At the conclusion of treatment and as required by the Standards, an offender can be discharged as complete, unsuccessful, or administratively (Section 5.09).

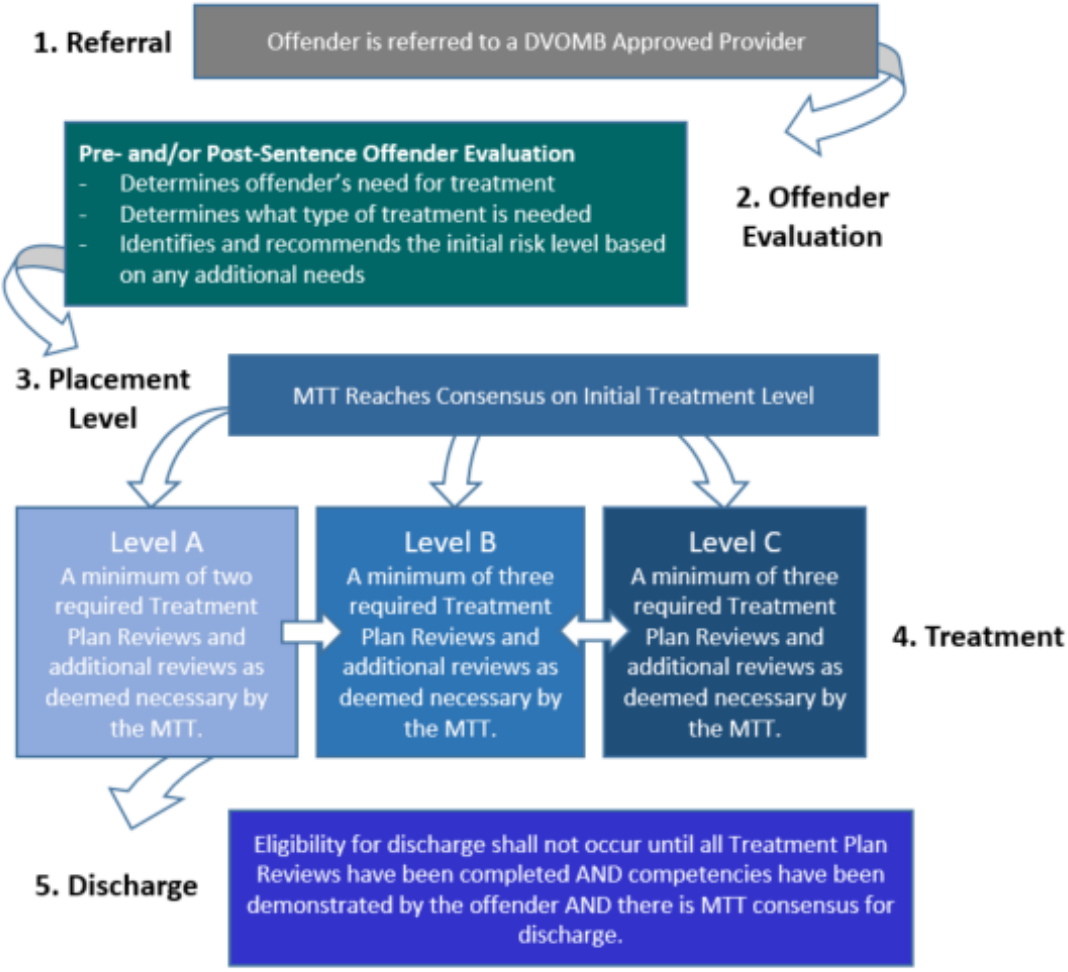
IV. Treatment is the comprehensive set of planned therapeutic experiences and interventions designed to assist the offender in changing any power and control dynamics, abusive thoughts, and behaviors (Section 5.0). Treatment requires the offender to attend in-person group or individual sessions at a minimum of once a week or more depending on the offender's treatment level (Section 5.05). Treatment is individualized and progress is assessed during a Treatment Plan Review (TPR), which occurs every two to three months (Section 5.06). The degree to which an offender progresses in treatment and remains compliant is based on meeting goals associated with the core competencies rather than the passage of a specific amount of time or sessions (Section 5.07).

V. Progress through treatment and victim safety is monitored by the Multi-Disciplinary Treatment Team (MTT) consisting of the Approved Provider, the supervising officer, a Treatment Victim Advocate (Section 7.0), and any other adjunct member of the MTT (Section 5.02). The MTT communicates regularly and shares information about the offender during the course of treatment in order to mitigate risks, support accountability, and improve victim safety. At the conclusion of treatment and as required by the Standards, an offender can be discharged as complete, unsuccessful, or

[15] §18-6-801(1)(a), C.R.S.

administratively (Section 5.08). Please refer to the Figure 1 below for a visual depiction of this process.

Figure 1. Overview of Offender Treatment



Acknowledgement and Dedication, February 7, 2008

The Domestic Violence Offender Management Board and the Division of Criminal Justice hereby acknowledges Gary Burgin, probation supervisor for the 18th Judicial District State Probation Office, for his dedication and continual commitment to ending domestic violence. Gary worked on various projects with the DVOMB for many years. Most recently, he participated on the DV Treatment Review Committee. Gary's leadership on this committee promoted professional collaboration. Gary's refusal to minimize abuse in any context and his expertise regarding the management and containment of offenders has been invaluable. He quickly became known as the "gold standard" for probation goals and ideals. He unified and inspired the committee with his endless perseverance to create a new, more effective treatment model for domestic violence offenders. Gary's contributions have--and will continue to have--impact on the *Standards and Guidelines for Domestic Violence Offenders.*

2.0 Historical Perspective

Domestic violence offenders were treated on a voluntary basis prior to 1979, as no formal court referral system existed. In 1979, the Jefferson County District Attorney's Office in conjunction with Women in Crisis began a domestic violence program for individuals criminally charged. The following year, Alternatives to Family Violence, an Adams County treatment program, assisted in the development of a referral system for offenders from municipal court; however, there were no formal standards governing the treatment of those who were referred.

In 1984, the Denver Consortium helped institute a mandatory arrest policy in Denver. As a result of increased arrests, additional offenders were referred for treatment increasing the need for providers to work with domestic violence offenders. Community members, including representatives of victim services, treatment agencies, and the criminal justice system, became concerned that the treatment provided to these offenders was inconsistent.

As a result of these concerns, a statewide committee on intra-agency standards was formed that included both urban and rural groups. Experts in the field of domestic violence contributed information to the committee. In 1986, written treatment standards were completed and approved by the Service Provider's Task Force, a subcommittee of the Colorado Coalition Against Domestic Violence, formerly the Colorado Domestic Violence Coalition.

In 1987, Representative John Irwin, with support of the domestic violence community, successfully proposed a law mandating treatment for all people convicted of a crime with an underlying factual basis of domestic violence (§18-6-803, C.R.S.). In addition to mandated treatment, the new law established the State Commission, appointed by the Chief Justice of the Colorado Supreme Court to create standards for treatment, and provide for appointment of certification boards in each judicial district. These local boards were charged with certifying and monitoring approved providers' compliance with the *Standards and Guidelines*.

The new law had two major shortcomings, creating tensions that ultimately led to the dismantling of the law. First, no funds were allocated to support the effort of the State Commission and the local certification boards. Secondly, some licensed mental health professionals objected to the local certification board process, believing that it created a "double jeopardy" situation. Both the local certification boards and the Colorado State Department of Regulatory Agencies regulated the professionals. In response to these concerns, Representative Steve Toole proposed HB 1263 in the 2000 legislative session. Effective July 1, 2000, Section 16-11.8-101, et. seq., C.R.S. established the Domestic Violence Offender Management Board that is responsible for promulgating standards for

treatment and establishing an application process for treatment providers. Section 16-11.8-101, et. seq., C.R.S. authorizes the Colorado mental health licensing boards and the Department of Regulatory Agencies to approve treatment providers in conjunction with the Domestic Violence Offender Management Board. The Board commends the General Assembly for recognizing domestic violence, a long-standing social problem as a crime, and enacting proactive legislation.

3.0 Guiding Principles

The treatment of offenders in the State of Colorado employs a variety of theories, modalities, and techniques. Domestic violence offenders are a separate category of violent offenders requiring a specialized approach. The primary goals are cessation of abusive behaviors and victim safety.

It is the philosophy of the Domestic Violence Offender Management Board that setting standards for domestic violence offender approved providers alone will not significantly improve public safety. In addition, the *process* by which domestic violence offenders are assessed, treated, and managed by the criminal justice system and social services systems should be coordinated and improved.

Domestic violence offender treatment is a developing field. The Board will remain current on the emerging research and literature and will modify these *Standards and Guidelines* based on an improved understanding of the issues. The Board must also make decisions and recommendations in the absence of clear research findings. Therefore, such decisions will be directed by the Guiding Principles, with the governing mandate being the priority of public safety and attention to commonly accepted standards of care. Additionally, the Board will endeavor to create state standards that reflect that Colorado communities have unique geographic features, challenges, and resources.

These Guiding Principles are designed to assist and guide the work of those involved in the management and containment of domestic violence offenders.

Management: The management of domestic violence offenders involves the knowledgeable, accountable participation of law enforcement, victim services, advocates, the DVOMB and all systems involved such as mental health, substance abuse services, and child protection services. In order to manage domestic violence offenders and to reduce and ultimately eliminate domestic violence, a coordinated community response is required, thus offender containment is one element of offender management.

Containment: The preferred approach in managing offenders is to utilize a containment process. Those involved in the containment process are directly responsible for holding offenders accountable while under supervision of the court. This includes, but is not limited to: the courts, the supervising agents of the court, such as probation, and the approved providers. While these *Standards and Guidelines* require approved providers to communicate, collaborate, and consult with the rest of this containment group, this concept of containment and communication should be strived for by the courts and supervising agents of the courts as well.

3.01 Victim and community safety are paramount.

Victim and community safety are the highest priorities of the *Standards and Guidelines*. This should guide the system responses of the criminal justice system, victim advocacy, human services and domestic violence offender treatment. Whenever the needs of domestic violence offenders in treatment conflict with community (including victim) safety, community safety takes precedence.

3.02 Domestic violence is criminal behavior.

3.03 The management and containment of domestic violence offenders requires a coordinated community response.

The Board encourages the development of local coalitions/task forces to enhance inter-agency communication and to strengthen program development.

All participants in offender management are responsible for being knowledgeable about domestic violence and these *Standards and Guidelines*. Open professional communication confronts offenders' tendencies to exhibit secretive, manipulative, and denying behaviors. Only in our aggregate efforts, applying the same principles and working together, can domestic violence offender management be successful.

Other involved professionals such as mental health providers, substance abuse counselors and health care professionals bring specialized knowledge and expertise.

Information provided by each participant in the management of an offender contributes to a more thorough understanding of the offender's risk factors and needs, and to the development of a comprehensive approach to treating and containing the offender.

Decisions regarding the treatment of domestic violence offenders shall be made by the containment group.

3.04 Successful management and containment of domestic violence offenders are enhanced by increased public awareness of domestic violence issues.

The complexity and dynamics of domestic violence are not yet fully understood and many myths prevail. These myths inhibit proactive community responses to domestic violence.

Knowledgeable professionals have a responsibility to increase public awareness and understanding by disseminating accurate information about domestic violence. This may facilitate communities to mobilize resources and to effectively respond to domestic violence.

3.05 There is no singular profile of a person who commits acts of domestic violence.

People who commit acts of domestic violence vary in many ways such as age, race and ethnicity, sexual orientations, gender identities, gender, mental health condition, profession, financial status, cultural background, religious beliefs, strengths and vulnerabilities, and levels of risk and treatment needs. People who commit abusive offenses may engage in more than one pattern of offending and may have multiple victims.

3.06 Cultural competencies and factors.

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

3.07 It is the nature of domestic violence offenders that their behaviors tend to be covert, deceptive, and secretive.

These behaviors are often present long before they are recognized publicly.

3.08 Domestic violence behavior is dangerous.

When domestic violence occurs, there is always a victim. Both literature and clinical experience suggest that this violence and/or abuse can have devastating physical, emotional, psychological, financial and spiritual effects on the lives of victims and their families. Offenders may deny and minimize the facts, severity, and/or frequency of their offenses. Domestic violence offenders often maintain a socially-acceptable facade to hide their abusive behaviors. At its extreme, domestic violence behavior can result in the death of the victim, offender, family members, and others.

3.09 Domestic violence behavior is costly to society.

Domestic violence has significant economic impact on various individuals and groups, including but not limited to, the victim, family and offender, schools, business and property owners, faith communities, health and human services, law enforcement and the criminal justice system.

3.10 All domestic violence behavior is the sole responsibility of the offender.

3.11 Offenders are capable of change.

Responsibility for change rests with the offender. Individuals are responsible for their attitudes and behaviors and are capable of eliminating or modifying abusive behavior through personal ownership of a change process. Ideally, this includes cognition, affect, and behavior. Treatment enhances the opportunity for offender change. Change is based on the offender's motivational levels and acceptance of responsibility. Motivation for change can be strengthened by effective treatment and community containment.

3.12 Assessment and evaluation of domestic violence offenders is an on-going process.

Because of the cyclical nature of offense patterns and fluctuating life stresses, domestic violence offenders' levels of risk are constantly in flux. Changes that occur as a result of the supervision or treatment of offenders cannot be assumed to be permanent. For these reasons, continuous monitoring of risk is the joint responsibility of the responsible criminal justice agency and the approved provider. The end of the period of supervision should not necessarily be seen as the end of dangerousness.

3.13 Domestic violence offender treatment differs from traditional psychotherapy.

In traditional psychotherapy, the client engages in a voluntary therapeutic relationship with a therapist of his/her choice, based largely on goals and purposes decided by the client. Court ordered offender treatment differs from traditional therapy in the following ways:

- Treatment is not voluntary. A therapeutic alliance is not a prerequisite for treatment.
- The offender enrolls in treatment at the court's direction, and sanctions are applied for failure to participate.
- The offender must receive treatment only from providers approved by the state to provide the treatment.
- Individual treatment goals are determined by the therapist to reduce recidivism and increase victim and community safety.
- Decisions regarding treatment and containment are made jointly between approved providers and criminal justice agencies.
- Approved providers are required to consult and communicate with the victim advocate and other involved agencies.
- Confidentiality is limited by the requirements of the criminal justice system and the needs of victim safety.
- Victim advocacy is an essential component of offender treatment.
- Minimization and denial of the need for treatment is expected, and therefore, treatment involves the challenging of the offender's perceptions and beliefs.

3.14 The preferred treatment modality is group therapy.

3.15 Victims have a right to safety and self-determination.

Victims of domestic violence undergo tremendous turmoil and fear as a result of the violence inflicted. Their feelings and their potential for further harm should always be afforded the utmost consideration.

Victims have the right to determine the extent to which they will be informed of an offender's status in the treatment process and the extent to which they will provide input through appropriate channels to the offender management and treatment process.

3.16 Offender treatment must address the full spectrum of abusive and controlling behaviors associated with domestic violence, and not just the legally defined criminal behavior(s).

3.17 Domestic violence offender assessment, evaluation, treatment and behavioral monitoring should be non-discriminatory and humane, and bound by the rules of ethics and law.

Individuals and agencies carrying out the assessment, evaluation, treatment and behavioral monitoring of domestic violence offenders should not discriminate based on race, religion, gender, gender identity, sexual orientation, disability, national origin or socioeconomic status. Domestic violence offenders must be treated with dignity and respect by all members of the team who are managing and treating the offender regardless of the nature of the offender's crimes or conduct. Individual differences should be recognized, respected and addressed in treatment.

3.18 Treatment programs shall strive to have staff composition reflect the diversity of the community they serve.

4.0 Offender Evaluation

The purpose of a domestic violence offender evaluation (hereafter offender evaluation) is to assess the offender's need for treatment, determine what type of treatment is needed, and identify the risk level and any additional needs the offender may have related to containment, stabilization and safety. While the evaluation provides valuable information and recommendations, and as new information emerges, or risk level changes within the course of treatment, an offender's treatment should be tailored to address those changes.[16] Each offender shall receive a thorough assessment and evaluation[17] that examines the interaction between the offender's mental health, social/systemic functioning, family and environmental functioning, and offending behaviors. Evaluators have an ethical responsibility to conduct evaluations in a comprehensive and factual manner, regardless of the offender's status within the criminal justice system. Consequently, evaluators will prioritize the physical and psychological safety of victims and potential victims in making recommendations that are appropriate to the assessed risk and needs of each offender.

4.01 Referral for Offender Evaluation Services:

I. If a criminal justice agency[18] makes a referral to an Approved Provider, that Approved Provider shall notify the criminal justice agency if the offender does not make contact within the time frame indicated. If no time frame was included with the referral, the Approved Provider shall notify the criminal justice agency within one week if the offender does not contact the Approved Provider.

   Discussion Point: *It is considered a best practice for the criminal justice supervising officer (or agent) to provide as much information as possible to the Approved Provider when the referral is made. Collateral information such as the police report, prior evaluations, the results to the Domestic Violence Screening Instrument (DVSI) and/or the Level of Service Inventory, a summary of the offender's criminal history, and any other documentation should be provided when available and applicable. The availability of collateral documentation helps Approved Providers start the evaluation process.*

II. At the time of the referral and before conducting the offender evaluation, Approved Providers shall assess the need for interpretation services including foreign languages, specific dialects, and sign language. An Approved Provider should communicate in the client's preferred language to the extent that it supports and improves the client-provider relationship.

   The client or the Approved Provider may request an interpreter at any time. If such

[16] Bonta, J., & Wormith, J. S. (2013). Applying the risk-need-responsivity principles to offender assessment. In L.A. Craig, L. Gannon, L., & T. A. Dixon (Eds.), What works in offender rehabilitation: An evidence-based approach to assessment and treatment (pp. 71–93). Hoboken, NJ: Wiley-Blackwell.
[17] Each evaluation shall be sensitive to the functioning, skills, and mental and physical capabilities of each offender.
[18] Probation, private probation, parole, community corrections, or diversion.

a request is made, the Approved Provider shall:

- Inform the client of the request and the potential impacts of an interpreter;
- Document the request or recommendation for a language interpreter, by the client, referral source, or Court, and if the client accepts or rejects interpreter services;
- Notify and coordinate with the referral source and allow for an interpreter to be present;
- The Approved Provider should use an approved court or certified interpreter when possible; and
- Assess if an interpreter is appropriate for maintaining client confidentiality and able to support the domestic violence offender evaluation and treatment process. Interpreters are encouraged to take the DV100 training course to learn more about the DVOMB Standards and requirement.

***Discussion Point**: Approved Providers who speak languages other than English are identified on the DVOMB Approved Provider list. The referral source should review the Approved Provider List prior to making a referral when the client's preferred language is other than English. Such clients may benefit from teletherapy in their preferred language or teletherapy in combination with other appropriate modalities.*

In the event that neither an Approved Provider or an interpreter are available to accommodate the client's preferred language, the client may continue to participate if they can speak English sufficiently to engage in the treatment process. If not, the client may also be referred back to the presiding court or parole board with a recommendation for an alternative disposition that is reasonably related to the rehabilitation of the offender and protection of the victim.

III. Initial Appointmen: After the offender has made contact with the Approved Provider, the Approved Provider should make all reasonable attempts to schedule the initial appointment with the offender within one week of being contacted by the offender. If the Approved Provider is not able to schedule an initial appointment within a reasonable time, the Approved Provider shall communicate with the supervising officer or agent for next steps.

IV. Interstate Compact Requirements: Pursuant to § 17-27.1-101, C.R.S, Approved Providers shall notify the Colorado Interstate Compact Office whenever an out-of-state offender enrolls in a domestic violence offender treatment program. This applies to all offenders who have been convicted of or have agreed to a deferred judgment, deferred sentence, or deferred prosecution for a crime in another state. The Approved Provider may complete the offender evaluation, but may not start domestic violence offender treatment until approval has been granted by the Colorado Interstate Compact Office.

V. Refusal to Admit: Approved Providers shall provide written documentation with reasons for refusal to admit to treatment to the responsible criminal justice agency within one week.

VI. Offenses Involving Unlawful Sexual Behavior: When there is a conviction for an offense for which the underlying factual basis has been found by the court on the record to include an act of domestic violence, and the conviction includes a sex

offense as defined in Section 16-11.7- 102 (3), C.R.S. or an offense which the court finds on the record to include an underlying factual basis of a sex offense, then that offender shall be evaluated and treated according to the Colorado Sex Offender Management Board Standards and Guidelines For The Assessment, Evaluation, Treatment And Behavioral Monitoring Of Adult Sex Offenders.

4.02 Parameters of the Offender Evaluation

I. The offender evaluation shall not be used to determine guilt or innocence, or whether or not an act of domestic violence has occurred as the offender has already pled guilty to, or has been convicted of a domestic violence offense.

***Discussion Point**: The criminal justice system, not the Approved Provider, is responsible for making legal decisions regarding guilt or innocence, pleas, convictions, and sentencing. When a pre- or post-sentence evaluation is conducted, the presumption is that the offender is guilty and will complete domestic violence offender treatment per the Standards and Guidelines. Evaluations performed prior to a finding of guilt (e.g., pre-plea, conviction, etc.) may not meet the requirements of these Standards and Guidelines. As such, Approved Providers may need to create an updated evaluation as an addendum to any previously performed evaluation that does not meet the DVOMB Standards and Guidelines.*

II. The offender evaluation shall be used to develop baseline measures in order to assess offender gain, lack of progress, or regression with regard to criminogenic need and risk of re-offense.

III. Evaluation(s) shall direct initial placement of the offender into the appropriate level and intensity of treatment as identified in *Standard* 5.06.

IV. Approved Providers shall not represent or imply that an offender evaluation meets the criteria for a domestic violence offender evaluation if it does not comply with the DVOMB *Standards and Guidelines*. Approved Providers shall include a statement in each completed evaluation as to whether the evaluation is fully compliant with the DVOMB *Standards and Guidelines* or not.

V. Specific goals of the evaluation shall assess and determine the following:

- Level and nature of risk, including possible lethality for future domestic violence[19] (Reference Appendix E, Section VII);
- Individual criminogenic needs[20], domestic violence, and issues related to power and control (Reference Appendix E, Section IV);
- Strategies for managing criminogenic needs and the presence of any domestic violence and issues related to power and control;

[19] Campbell, J. C. (2005). Assessing dangerousness in domestic violence cases: history, challenges, and opportunities. Criminology and Public Policy, 4, 653–672.
[20] Hilton, Z. & Dana L. Radatz, D. (2018). The Criminogenic and Noncriminogenic Treatment Needs of Intimate Partner Violence Offenders International Journal of Offender Therapy and Comparative Criminology, 62(11) 3247–3259.

- Offender strengths (e.g., pro-social support factors, employment, education);
- Any potential destabilizing factors (e.g., job loss, homelessness, bankruptcy);
- Offender responsivity factors (Reference Appendix E, Section VI);
- Level of offender accountability (Reference Appendix E, Section I);
- Assessment of amenability[21] for treatment is defined as:
    - The ability to comprehend treatment concepts
    - The physical and mental ability to function in a treatment setting
    - The presence of potential language barriers (see Standard 5.03 for more information).
- Considerations and clinical factors unique to a Specific Offending Population (e.g., female offenders, LGBQIA+ offenders) using the guidelines from Appendix B;
- Relevant diagnostic considerations regarding the treatment of co-existing conditions, the need for medical or pharmacological treatment (if indicated), and further assessments needed to address areas of concern;
- Overall clinical issues and criminogenic needs in the form of a case conceptualization and make recommendations for the Offender Treatment Plan;
- Recommendations of initial strategies for monitoring related to community and victim safety.

Discussion Point: *The Standards and Guidelines do not preclude an Approved Provider from performing an evaluation as well as the treatment for the same offender.*

4.03 Pre-Sentence Offender Evaluation (PSE)

The purpose of a presentence evaluation (PSE) is to provide the court with relevant information upon which to base sentencing decisions. The domestic violence offender evaluation establishes a baseline of information about the offender's risk and protective factors, treatment needs and recommendations, and amenability to treatment. The PSE may include recommendations about an offenders' suitability for community supervision.

I. A PSE shall only be conducted by an DVOMB Approved Pre-Sentence Evaluator.

II. The PSE is not a required evaluation for offenders. A Pre-Sentence Evaluator may perform a PSE to obtain information that will provide treatment recommendations related to domestic violence and dynamics of power and control, results of any

[21] Amenability to domestic violence treatment refers to the offender's capacity to effectively participate, function, and understand treatment concepts. Significant cognitive (e.g., thinking) impairments can preclude an individual's ability to sufficiently pay attention during treatment sessions, learn new information, and/or self-reflect. Similarly, some cases of acute mental illness may interfere with participation due to the presence of impaired reality testing (e.g., delusions or hallucinations).

additional psychological testing, strategies for offender containment, monitoring, and supervision requirements based on assessments of an offender's risk, needs, and responsivity.[22] The PSE shall comply fully with the *Standards and Guidelines*, specifically 4.02, 4.05, 4.06, 4.07 and Appendix E of which results in a comprehensive and in-depth offender evaluation (e.g., personality, intelligence, psychopathy, developmental disabilities, etc.).

III. If a pre-plea evaluation has been performed, once there is a finding of guilt, an offender evaluation that complies with the *Standards and Guidelines* shall be utilized to determine treatment needs.

IV. Evaluations conducted for the purposes of pre-trial diversion that meet criteria set forth per § 18-1.3-101(5), C.R.S.[23], shall conform to these *Standards and Guidelines* and be conducted by a Pre-Sentence Evaluator. Pre-Sentence Evaluators may make recommendations for treatment based on the results of an evaluation for consideration by the prosecuting agency.

***Discussion Point**: Approved Providers are sometimes referred clients whom have neither been charged or convicted of domestic violence in a criminal court, but are subject to court orders from a civil court. Pursuant to § 14-10-124(4)(IV)(f), C.R.S.[24], if a finding of domestic violence is made, the offending party may be ordered to participate in a domestic violence offender evaluation and treatment as recommended. Civil orders for evaluations and treatment are not subject to the DVOMB Standards and Guidelines. Approved Providers may choose if and how they are to perform evaluations referred by civil court order and treatment to the participating party. The DVOMB encourages Approved Providers to use the DVOMB Standards and Guidelines as a best-practice guide in conjunction with their professional and ethical judgment appropriately.*

[22] Bonta, J., & Wormith, J. S. (2013). Applying the risk-need-responsivity principles to offender assessment. In L.A. Craig, L. Gannon, L., & T. A. Dixon (Eds.), What works in offender rehabilitation: An evidence-based approach to assessment and treatment (pp. 71–93). Hoboken, NJ: Wiley-Blackwell; Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., . . . Solano, I. (2016). Domestic Violence Perpetrator Programs: A Proposal for Evidence-Based Standards in the United States. Partner Abuse, 7(4), 355-460. doi:10.1891/1946-6560.7.4.355; Radatz, D. L., & Wright, E. M. (2016). Integrating the principles of effective intervention into Batterer Intervention Programming: The case for moving toward more evidence-based programming. Trauma, Violence, & Abuse, 17, 72–87. http://dx.doi.org/10.1177/1524838014566695.

[23] 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 approved provider 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, that the individual is appropriate for the program.

[24] § 14-10-124(4)(IV)(f), C.R.S. When a civil court finds by a preponderance of the evidence that one of the parties has committed domestic violence, the court may order the party to submit to a domestic violence evaluation. If the court determines, based upon the results of the evaluation, that treatment is appropriate, the court may order the party to participate in domestic violence treatment. At any time, the court may require a subsequent evaluation to determine whether additional treatment is necessary. If the court awards parenting time to a party who has been ordered to participate in domestic violence treatment, the court may order the party to obtain a report from the treatment provider concerning the party's progress in treatment and addressing any ongoing safety concerns regarding the party's parenting time. The court may order the party who has committed domestic violence to pay the costs of the domestic violence evaluations and treatment.

4.04 Post-Sentence Offender Evaluation

I. The post-sentence offender evaluation is a required component of the offender's intake process and shall be conducted with each offender by an Approved Provider. In cases in which a PSE has been completed and a copy has been obtained by the Approved Provider, the post-sentence offender evaluation shall expand upon the PSE as necessary and applicable (Reference "Required Minimum Sources of Information" Section 4.05). If there is a conflict between the pre- and post-sentence offender evaluation findings, the Approved Provider may consult with their Domestic Violence Clinical Supervisor (DVCS) or peer-consultant for resolution if needed.

II. When the substance abuse screening and/or clinical judgment indicate the need for further assessment, the offender shall be referred to a CAS or LAC for a substance abuse assessment.

III. When further offender mental health assessment is indicated and the Approved Provider is not a licensed mental health professional, the Approved Provider shall refer the offender to a licensed mental health professional for further assessment.

4.05 Required Minimum Sources of Information

To determine the most accurate prediction of risk, as well as offender treatment planning that comports with research and best practice, evaluations shall include sources of information, which include integration of criminal justice information, victim input, other collateral information, previously performed offender evaluations, information obtained from a clinical interview of the offender, and the use of assessment instruments. Approved Providers shall comply with all mental health listing, licensure, or certification requirements regarding client confidentiality and privacy.

I. Approve Providers shall obtain the following required sources of information:

   A. Criminal justice and/or court documents including but not limited to the following:

      1. Law enforcement reports including the index offense report, affidavit or summary, and where available, the victim statements, other witness statements, and photos from current and prior incidents;

      2. Criminal history

         Approved Providers shall attempt to obtain criminal justice and/or court documents first from the supervising officer (or agent). If this information is not provided by the supervising officer (or agent), then the Approved Provider may seek the information from the offender's legal representation (if available and at the discretion of counsel) or through the court, law enforcement, or prosecuting agency directly. Under no circumstances shall an Approved Provider request an offender to obtain the police report or victim statements.

B. Victim input, including but not limited to victim impact statement (if available), written reports, direct victim contact, and information via a victim advocate or victim therapist. The MTT shall make victim safety and victim confidentiality its highest priority. Please refer to Section 7.05 for more information on victim information and confidentiality.

***Discussion Point**: Women's perceptions of safety are substantial predictors of reassault.*[25]

C. Any relevant and previously completed evaluations, treatment, and/or medical records. These may include, but are not limited to, offense-specific, psychological, psychiatric, substance abuse, or medical evaluations and records. If the Approved Provider is unable to obtain these records, the attempts made shall be documented.

D. Available collateral contacts directly related to the current offense (e.g., medical and mental health practitioners, Departments of Human Services)

E. Other collateral contacts as relevant and appropriate (e.g., family members)

II. Required Assessment Instruments

To provide the most accurate prediction of risk for domestic violence offenders, the offender evaluation shall include at a minimum, the use of instruments that have specific relevance to assessing domestic violence offenders. Assessment instruments used for the purpose of conducting an offender evaluation shall defer to the most current version and have demonstrated reliability and validity based on published research.

A. Domestic Violence Risk Assessment Instruments[26]

1. Domestic Violence Risk and Needs Assessment Instrument (DVRNA) (Reference *Standard,* 4.06 and the DVRNA Training Manual). This research-informed instrument is designed to assist in the classification of offenders based on risk and need to determine the appropriate intensity of treatment.

2. At least one additional domestic violence risk assessment instrument.

B. At least one substance abuse screening instrument[27]

C. least one mental health screening instrument

D. At least one cognitive screening instrument.

[25] Edward W. Gondolf, Batterer Intervention Systems: Issues, Outcomes, and Recommendations. (Thousand Oaks, CA: Sage Publications, 2001) 201.
[26] Nicholls et al., (2013). Risk Assessment in Intimate Partner Violence: A Systematic Review of Contemporary Approaches, Partner Abuse, 4(1), 76-168.
[27] Bruijn, D. & Graaf, I. (2016). The role of substance use in same-day intimate partner violence - A review of the literature, Aggression and Violent Behavior 27, 142–151.

III. Required Minimum Content of Offender Clinical Interview

The offender evaluation shall include a structured clinical interview[28] with the offender and address the following evaluation areas as referenced in Appendix E:

A. Psychosocial history

B. Mental health history

C. Substance use history

D. Relationship history with attention to domestic violence dynamics and any issues related to power and control

E. Prior history of trauma or adverse experiences

F. Family history of sections B, C, D, and E above

G. Criminogenic needs

H. Offender accountability

I. Motivation for and amenability to treatment

J. Responsivity factors

4.06 Domestic Violence Risk and Needs Assessment Instrument (DVRNA)

Placement in treatment shall be determined by the pre-sentence or post-sentence offender evaluation in conjunction with the Domestic Violence Risk and Needs Assessment Instrument (DVRNA). For any required form relating to the DVRNA, please refer to the DVRNA Scoring Manual.

I. Introduction

The literature demonstrates that there are significant risk factors that should be considered in working with domestic violence offenders. In the absence of a researched instrument that clearly identifies the ongoing risk of offenders during treatment; the following are some of the risk factors identified in the literature that shall be considered in treatment planning and ongoing Treatment Plan Review. These risk factors may not be present at the initial evaluation, but may become evident during treatment resulting in a need for a change in treatment planning and intensity of treatment. Additionally, mitigation of these risk factors may indicate a need for reduction in intensity of treatment. Once the offender has been evaluated according to Standard 4.0 Offender Evaluation, the Approved Provider will complete the DVRNA. When identifying a risk factor for an offender, the Approved Provider is required to identify the source from which the information is

[28] R. Borum, "Improving the Clinical Practice of Violence Risk Assessment: Technology Guidelines and Training, American Psychologists 51:9 1996, 945-956.

drawn. This will help ensure that the information and risk determination is defensible. Examples of required sources include criminal history, law enforcement report, publicly released victim report/ impact statement, Office of Behavioral Health approved substance abuse screening instrument, offender clinical interview, mental health screen, and other information as required in Offender Evaluation Standard 4.05.

DVRNA was developed from several research studies that identify risk factors for future abuse or re-offense by known domestic violence offenders. The majority of this research was conducted on male offenders. Because there are some contextual differences between patterns of male and female offending, the MTT shall consider the relevance of these risk factors for females on a case-by-case basis.

II. Victim Information:

A. The ultimate goal in reviewing and utilizing victim information is to protect the victim.

1. Information on confidential victim statements shall be kept in a file separate from the offender file.

2. When a victim states that his/her information cannot be revealed beyond the Approved Provider, the Approved Provider and the victim advocate, without compromising victim confidentiality, may consult with probation and shall ascertain other potential ways to document or address victim concerns.

Example: If the victim reports substance abuse by the offender, the Approved Provider may require random urinalysis, thus obtaining information without revealing victim information.

III. Scoring Method Used in Determining Intensity of Treatment:

A. Some risk factors on the DVRNA are identified as Critical or Significant and result in minimum placement for initial treatment. The actual placement level may be higher depending on the total number of domains in which there are risk factors.

B. Offenders who do not have more than one risk factor as identified in the DVRNA may be considered for the Level A intensity of treatment. This one risk factor cannot be identified as Critical or Significant.

C. The domains on the DVRNA are identified by letter (A-N). The risk factors listed under the domains are numbered. When scoring the DVRNA the maximum score for a domain is one. The maximum score on the DVRNA is therefore fourteen (14). Specific risk factors listed under the DVRNA do not each count for one point.

D. Offenders who have two to four domains in which risk factors are present or any Significant Risk Factor as identified in the DVRNA, shall be placed in Level B intensity of treatment.

E. Offenders who have five or more domains in which risk factors are present or any risk factor as identified as a Critical Risk Factor in the DVRNA shall be placed in Level C intensity of treatment.
F. If the clinical and professional judgment of the MTT indicates a need to override the criteria listed above in A through D, there shall be consensus of the MTT and the written justification shall be placed in the offender's file.

IV. DVRNA Risk Factors

Risk factors are used as one measure to guide:

- Initial treatment planning including the design of offender competencies that must be demonstrated by the offender.

- Ongoing Treatment Plan Reviews that determine any or all of the following:

    - Changes during treatment in regards to treatment planning,
    - Justification for changes to the Treatment Plan, such as required additional treatment or reduction in the intensity of treatment
    - Risk increase or mitigation

The following DVRNA domains of risk factors (A-N) shall be taken into consideration throughout an offender's treatment. Significant and Critical Risk Factors that warrant initial Level B or Level C placement are listed first for ease of use with this instrument. Please refer to the DVRNA Scoring Manual for information regarding these individual risk factors.

4.07 Formulation of Treatment Recommendations, Alternative Options, and Considerations

I. Formulations of Treatment Recommendations

A. The Approved Provider shall design an individualized treatment plan for the offender through conducting and completing the offender evaluation.

B. The recommendations from the offender evaluation shall be based upon a formulation of all pertinent data collected in the evaluation process. Each recommendation shall be clear, and concise with a supporting explanation. Treatment considerations should be based on the conclusions and recommendations of the offender evaluation.

C. Evaluation(s) shall result in an initial Offender Treatment Plan with the understanding that assessment is an ongoing process, which may necessitate changes to the plan through each transition of treatment and supervision process by the MTT.

***Discussion Point**: As a best practice, Approved Providers should complete the offender evaluation in no more than 30 days following the initial appointment and clinical interview. If the Approved Provider is unable to complete the offender evaluation within 30 days, the Approved Provider shall document the reasons why*

and communicate to the MTT.

D. Each individual treatment plan shall include at a minimum the recommended:

   a. Initial level for placement in treatment based on the DVRNA (Reference *Standard* 4.06 for Levels of Treatment);[29]
   b. Treatment goals specific and measurable objectives to target criminogenic needs including, domestic violence and issues related to power and control;[30]
   c. Methods for enhancing positive and pro-social factors;
   d. Second contact interventions or treatment options that are the most clinically relevant to addressing the most significant criminogenic need for Level B and C offenders (not applicable for Level A offenders);
   e. Supervision or monitoring recommendations needed to enhance the safety of the victim and offender containment;[31]
   f. Considerations for Specific Offender Population (as defined in *Standard* 9.0), Approved Providers shall utilize all applicable assessment criteria (Reference Appendix B).

E. Approved Providers shall not recommend alternative therapies such as couples counseling, anger management or stress management in lieu of domestic violence offender treatment. Approved Providers shall not render legal opinions or recommendations. If a pre-plea evaluation has been performed, once there is a finding of guilt, an evaluation that complies with the *Standards and Guidelines* shall be utilized to determine treatment needs.

F. The Approved Provider shall review the initial offender treatment plan with the MTT and accept input from the MTT. A treatment plan, with measurable goals, objectives, outcomes, and timeframes, shall be implemented after the completion of the offender evaluation process.

***Discussion Point**: The Approved Provider is a MTT member who is the subject matter expert regarding the treatment needs of the offender and who is responsible for providing services in accordance with DVOMB Standards and Guidelines. If the MTT has questions or concerns related to the offender's treatment plan, they should be addressed with the Approved Provider along with the other members of the MTT. The Approved Provider shall be the ultimate authority related to the treatment of the offender. The MTT should model pro-social, collaborative, and co-operative behavior for offenders when committed to the MTT model. This includes communicating clearly and effectively with each member of the MTT and with the offender.*

II. Considerations for the Assessment of Offenders when Domestic Violence Offender

[29] Coulter, M., & VandeWeerd, C. (2009). Reducing domestic violence and other criminal recidivism: Effectiveness of a multilevel batterers intervention program. *Violence and Victims*, *24*(2), 139–152.

[30] Radatz, D. L., & Wright, E. M. (2016). Integrating the principles of effective intervention into Batterer Intervention Programming: The case for moving toward more evidence-based programming. Trauma, Violence, & Abuse, 17, 72–87. http://dx.doi.org/10.1177/1524838014566695.

[31] Webster, M. and K. Bechtel (2012). *Evidence-Based Practices for Assessing, Supervising and Treating Domestic Violence Offenders*. Crime and Justice Institute at Community Resources for Justice: Boston, MA.

Treatment Is Contraindicated

Through the process of conducting and completing the offender evaluation, if indicators suggest that the offender's risk and criminogenic needs related to domestic violence and issues of power and control are not supported, the Approved Provider shall consider alternative treatment or intervention options. In such circumstances, the offender evaluation may recommend alternative interventions and treatment options. The offender evaluation shall include compelling clinical evidence that is well documented and using assessment instruments and collateral information when considering alternative interventions and possible treatment options.

***Discussion Point**: Should an Approved Provider determine that an offender is not amenable to domestic violence offender treatment under any of the following areas as prescribed by the Standards and Guidelines, the Approved Provider may request a variance from the Board for a modified domestic violence offender treatment plan in lieu of a recommendation for no domestic violence offender treatment.*

A. *Considerations for Assessing Self-Defending Victims when Domestic Violence Offender Treatment is Contraindicated*[32]

If at any stage of the process (e.g. pre-sentence, post-sentence, or during treatment), the Approved Provider has clinical information (e.g., characteristics, context, and motivating factors) suggesting that the individual may be a self-defending victim, the following criteria, at a minimum, shall be considered to determine if domestic violence offender treatment per the *Standards* is contra-indicated:

a. The individual acted out of fear, self-defense, and self-preservation in the current incident; OR
b. The individual's behavior was situational and not used as a method of coercion, control, punishment, intimidation or revenge; OR
c. The individual has suffered a pattern of domestic violence by their partner; OR
d. The act or behavior was pre-emptively used to escape or to stop future abuse; OR
e. The individual's criminal history did not involve threats to person(s), animal(s), or property.

If the Approved Provider recommends against domestic violence offender treatment, the MTT shall then be notified and consulted of the recommendation(s) to obtain consensus. The MTT will determine next steps. In such cases, the Approved Provider shall include in the offender evaluation a summary of supporting clinical documentation. The MTT may recommend alternatives for consideration by the presiding court or the Parole Board for possible modification to the sentencing order and requirements.

[32] Larance et al., (2019). Understanding and Addressing Women's Use of Force in Intimate Relationships: A Retrospective. Violence Against Women, 25(1) 56–80.

***Discussion Point**: Individuals who have been identified as self-defending victims have a right to safety and self-determination. Until the MTT reaches consensus, it is important for the MTT to consider all available options to minimize the risk of re-traumatizing the individual. These options include placing the individual on an administrative hold, conducting individual sessions, and gathering more clinical information for purposes of ongoing assessment. Approved Providers should practice within their clinical expertise and scope. Refer to Section 7.04(I) regarding guidance for TVAs on how to handle these types of situations.*

B. *Considerations for Offenders Assessed as Having No Domestic Violence Offender Treatment Needs Based on the Absence of Risk and Criminogenic Needs*[33]

1. Through the process of conducting the offender evaluation, if clinical indicators suggest that the offender does not present domestic violence and power and control dynamics related to domestic violence, then the Approved Provider shall consider alternative interventions and treatment options. When considering whether an offender has no domestic violence offender treatment need under the DVOMB *Standards and Guidelines*, the Approved Provider shall consider the following criteria using best clinical judgment:

    a. The offender has been identified initially as requiring Level A treatment in addition to any other risk assessment instruments and collateral information indicating an absence of a criminogenic need for domestic violence offender treatment.
    b. The offender does not have a history of engaging in coercion, threat, intimidation, revenge, retaliation, control, or punishment toward the victim in this case or in any other current or former relationships.
    c. The offender has little or no prior documented history of criminality or delinquency, excluding minor violations or violations posing no substantial threat to persons, animals or property. Consideration of the age of the offender at time of any identified prior offense, the circumstances of the offense, and whether there is a documented history of similar behavior may be considered.

    ***Discussion Point**: It is important to note that these cases arise in rare circumstances.*

2. The Approved Provider shall consult with the MTT and obtain consensus when making a recommendation for an alternative intervention or treatment option. If there is a lack of conclusive clinical evidence in support of these criteria, the MTT may initially approve domestic violence offender treatment and reassess these considerations during the first Treatment Plan Review period to determine if domestic violence offender treatment is no longer needed or harmful.
3. At any stage of the process (e.g. pre-sentence, post-sentence, or at a

[33] Radatz, D. L., & Wright, E. M. (2016). Integrating the principles of effective intervention into Batterer Intervention Programming: The case for moving toward more evidence-based programming. Trauma, Violence, & Abuse, 17, 72–87. http://dx.doi.org/10.1177/1524838014566695.

treatment plan review), if an offender does not present with any domestic violence treatment needs nor any other general treatment needs, the Approved Provider may recommend that the offender should not be required to undergo any treatment based on the clinical judgement of the Approved Provider. In such cases, the Approved Provider shall consult with the MTT, obtain consensus, and may refer the case back to the presiding court or the Parole Board, according to local policy and procedure.

***Discussion Point**: In cases where the offender does not agree with the alternative treatment plan presented by the Approved Provider, the offender evaluation will be reviewed, modified as needed and finalized by consensus of the MTT. The finalized evaluation will include at minimum all the required elements as indicated in 4.03 and 4.04. According to local policy and procedure, a special report may be submitted to the court, the Parole Board, and/or a summons served upon the offender for hearing, for judicial consideration.*

C. *Considerations for Assessing When a Significant Mental Health Disorder or Cognitive Impairment Contraindicates Domestic Violence Offender Treatment*

A domestic violence offender's amenability to engage in and benefit from domestic violence offender treatment may be impacted by the presence of a mental health disorder or cognitive impairment. It is critical for the Approved Provider to assess the extent to which an offender's mental health disorder or cognitive impairment and/or pervasive power and control dynamic are interrelated when making recommendations in the offender evaluation. As a result, the Approved Provider shall evaluate the offender to identify if and how the presence of any mental health disorders or cognitive impairment may impact the offender's amenability to successfully participate in domestic violence offender treatment and include diagnoses where appropriate and applicable.

If the Approved Provider does not have the appropriate expertise and credentials to diagnose, then the provider shall consult with a qualified mental health care provider or refer the offender to another provider who can make such a diagnosis.

1. If the Approved Provider determines that the offender is not amenable for domestic violence offender treatment due to a lack of stabilization of symptoms related to a mental health disorder, the Provider shall then identify what steps could be taken, if any, to assist the offender in being able to participate in domestic violence offender treatment.

2. If the Approved Provider determines that the offender is not amenable for domestic violence offender treatment due to a cognitive impairment that is beyond the capability of the therapeutic milieu to manage, the Approved Provider shall then identify what steps could be taken, if any, to assist the offender in being able to participate in domestic violence offender treatment.

3. For offenders whose mental health disorder or cognitive impairment is

concurrent to a pathological power and control dynamic, adjunct mental health treatment may be conducted in conjunction with domestic violence offender treatment. Adjunct mental health treatment may be necessary to assist the offender in domestic violence offender treatment. In some cases, a referral to an adjunct mental health treatment or a health care provider may be prioritized prior to domestic violence offender treatment. This is done with MTT consensus in the interest of stabilizing the offender's needs.

4. If the Approved Provider recommends against domestic violence offender treatment, the supervising officer (or agent) and Treatment Victim Advocate shall then be notified of the recommendation(s). The MTT will determine next steps. In such cases, the Approved Provider shall include in the offender evaluation a summary of supporting clinical documentation. The MTT may recommend alternatives for consideration by the presiding court or the Parole Board for possible modification to the sentencing order and requirements.

D. *Considerations for Assessing Psychopathy[34] when Domestic Violence Offender Treatment is Contraindicated*

Domestic violence offenders who present with psychopathy may exhibit patterns of generalized violence and antisociality. An offender who is evaluated as psychopathic or as having significant psychopathic tendencies may be unmanageable in the community[35] and could present greater risk to victim(s) and the community at large (Refer to Appendix E).

***Discussion Point**: When possible, offenders whom present with characteristics that may be indicative of psychopathy should receive a PSE in order to allow for sentencing recommendations to be made to the presiding court.*

1. An Approved Provider should use screening or assessment tools designed to identify psychopathy (e.g., PCL-R, PCL-SV, P-SCAN, MCMI-IV). These tools help determine if and how the offender can benefit from domestic violence offender treatment and their amenability to supervision in the community.

2. If the Approved Provider does not have the appropriate expertise and training to administer tools for identifying psychopathy, then the Approved Provider shall consult with a qualified mental health care provider or refer the offender to another provider who can perform the required testing to make a proper assessment.

3. At any stage of the process (e.g. pre-sentence, post-sentence, or during treatment), the Approved Provider may terminate services in the interest of

[34] Huss et al. (2006). Clinical Implications for the Assessment and Treatment of Antisocial and Psychopathic Domestic Violence, Journal of Aggression, Maltreatment & Trauma, Vol. 13(1), 59-85; Huss, M. & Langhinrichsen-Rohling, J., (2006). Assessing the Generalization of Psychopathy in a Clinical Sample of Domestic Violence Perpetrators. Law of Human Behavior, 30:571–586, DOI 10.1007/s10979-006-9052-x; Juodis et al., (2014). What Can be Done About High-Risk Perpetrators of Domestic Violence? Journal of Family Violence, 29:381–390, DOI 10.1007/s10896-014-9597-2.

[35] Unmanageable in the community can be evidenced by a history of repeated failures while under supervision by the criminal justice system.

victim and community safety, and make an alternative recommendation for needed intervention, if:

(1) The Approved Provider makes a determination that domestic violence offender treatment is not appropriate due to clinical reasons related to the presence of psychopathy or significant psychopathic tendencies;

OR

(2) The MTT makes a determination that the offender cannot be supervised adequately in the community under the current terms and conditions of supervision.

If a case meets the requirements of (1) or (2) above, the Approved Provider shall notify and carefully plan with members of the MTT for discharging the offender from domestic violence offender treatment (if applicable). The Approved Provider shall include in the offender evaluation a summary of supporting clinical documentation. In such cases, the domestic violence offender may be referred back to the presiding court or the Parole Board, according to local policy and procedure.

4.08 Required Minimum Reporting Elements for Submittal to the Multi-Disciplinary Treatment Team (MTT)

I. Offender Evaluation Summary

The purpose of the required written report to the supervising criminal justice agency (or agent) is to provide a summary of information obtained, assessed, and recommended from the offender evaluation. The report is intended to be brief and concise and to include, at a minimum, the following elements:

A. Identify Sources of Information

The written evaluation shall verify that all required sources of information were included. While victim input needs to be factored into the evaluation, no reference regarding victim contact or lack of contact shall be made in the report. The written evaluation shall not reveal specifics of how the victim input criteria was obtained or attribute victim input to a specific non-public record source. If the victim requests to have their input included in the written evaluation, written permission from the victim shall be obtained prior to any victim information being included in the evaluation summary and report. The evaluator has the discretion to omit victim statements if it endangers victim safety and/or compromises treatment goals.

A written release of information is not required for victim statements obtained from public records (e.g. police records). If victim statements are identified Approved Providers are required to specify that information came from a public record.

***Discussion Point**: While the expectation and intent is that all required information will be obtained, in the rare circumstance when a source of information could not be obtained, the Approved Provider shall document why that information could not be obtained, what efforts were made to obtain the information, and the*

resulting limitations of the evaluation and conclusions.

B. Identify assessment instruments utilized such as assessment instruments, screening instruments, mental health, and/or substance abuse evaluation instruments

C. Provide overview of the findings based at a minimum of the following areas:

1. Domestic violence and issues of power and control

2. Review of the DVRNA (Reference Standard 5.04) and one other domestic violence risk assessment instrument.

3. Level and nature of domestic violence risk as described in terms of scenario development (e.g., likelihood, imminence, frequency, severity, victims, and context).[36]

4. Offender accountability (Reference Appendix E Section I)

5. Offender motivation and prognosis (Reference Appendix E Section II)

6. Criminogenic needs (Reference Appendix E Section IV)

7. Offender responsivity (Reference Appendix E Section VI)

8. Considerations and clinical factors unique to a Specific Offending Population (e.g., female offenders, LGBTQIA+ offenders) using the guidelines from Appendix B.

9. Specific victim safety issues.

D. Provide the initial treatment plan as required by Standard 4.07.

4.09 Ongoing Assessments and Updating Offender Evaluations

I. Approved Providers shall conduct ongoing assessments of the offender's compliance with, and progress in treatment. These assessments and Treatment Plan Reviews shall be performed at a minimum according to the *Standards* identified in Section 5.07 and when any potentially destabilizing change occurs in the offender's life (e.g., job loss, divorce, or medical health crisis), or when any clinically relevant issues are uncovered (e.g., childhood trauma, prior relationship abuse, or re-emergence of mental health problems). The assessments may require the Approved Provider to modify the treatment plan and how the offender is being monitored in consultation with the MTT. The results of each assessment shall be added to the offender's treatment plan and contract.

[36] J. Reid Meloy and Thomas Schroder, Violence Risk and Threat Assessment: A Practical Guide for Mental Health and Criminal Justice Professionals (San Diego, CA: Specialized Training Services, 2000). Belfrage, H., & Strand, S. (2008). Structured spousal violence risk assessment: Combining risk factors and victim vulnerability factors. International Journal of Forensic Mental Health, 7(1), 39–46; Echeburúa, E., Fernández-Montalvo, J., de Corral, P., & López-Goñi, J. J. (2009). Assessing risk markers in intimate partner femicide and severe violence: A new assessment instrument. Journal of Interpersonal Violence, 24(6), 925–939.

II. When an offender transfers to a new Approved Provider or returns to treatment after an extended period of time, the Approved Provider shall attempt to obtain any previously completed pre- or post-sentence offender evaluations, treatment plan reviews, or discharge summaries. The prior offender evaluation may be amended for the purpose of updating assessment instruments and any clinically relevant findings. Considerations for when a prior offender evaluation is no longer valid and should be updated includes, but is not limited to, the following criteria:

    1. The prior offender evaluation was completed more than 60 days past the time of discharge;
    2. The offender committed a new offense while in treatment that suggests an increase in dynamic risk and poses a risk to the victim or community safety;
    3. The offender was discharged either administratively or unsuccessfully from domestic violence offender treatment.

    If the Approved Provider is unable to obtain these records, the attempts made shall be documented. If an Approved Provider updates an offender evaluation, the results of the updated evaluation shall formulate new treatment goals as appropriate.

    ***Discussion Point**: The decision to update or conduct a new offender evaluation should be based on factors regarding the recency of the prior offender evaluation, significance of the changes in the offender's life, and the emergence of new clinical information related to static and/or dynamic factors. Approved Providers are encouraged to consider these factors in conjunction with their overall clinical judgement of the individual offender and the potential victim and community safety concerns that may be present.*

III. For offenders whom have previously attended domestic violence offender treatment, Approved Providers may assess the degree to which an offender comprehends and demonstrates the Core Competencies during the ongoing evaluation and treatment process. Approved Providers should exercise caution when assessing the extent to which an offender has met the Core Competencies when relying solely on offender self-report.

5.0 Offender Treatment

Domestic violence offender treatment is defined as therapy, monitoring, and supervision of a person who committed a domestic violence offense (hereafter client), which conforms to the Standards and Guidelines created by the DVOMB. Consistent with current research and professional practices, domestic violence offender treatment is the comprehensive set of planned therapeutic experiences and interventions designed to uniquely change the power and control dynamics, abusive thoughts, and behaviors. Such treatment specifically addresses the occurrence and dynamics of domestic violence and utilizes differential strategies to promote client change. Much more importance is given to the meeting of all treatment goals than the passage of a specific amount of time, since clients make progress in treatment at different rates. Treatment is more successful when it is delivered consistently and with fidelity to the individual needs of the offender (hereafter client). For the statutory definition of treatment, see Section 16-11.8.102, C.R.S.

In the interest of victim and community safety, the purpose of treatment is to foster conditions that allow the client to:

(a) Manage effectively the individual factors that contribute to abusive behaviors;

(b) Develop strengths and competencies to address criminogenic needs;

(c) Identify and change thoughts, feelings and actions that may contribute to offending, and;

(d) Establish and maintain stable, meaningful, and pro-social lives.

Treatment provides client containment through collaboration with the Multi-Disciplinary Treatment Team (MTT). Treatment must be tailored to each client's responsivity factors[37] based on the diversity of the population. In particular, providers are required to be approved by the DVOMB in order to work with female and LGBT+ clients.

The DVOMB Standards employ different levels of treatment based on general criminology research that supports a differential treatment model determined by client risk, criminogenic needs, and responsivity (Andrews & Bonta, 1994). The length of treatment is determined by MTT consensus, based on individual risk and needs of the client, and progress in treatment measured by a minimum number of treatment plan reviews (Refer to Overview Chart on page 10).

[37] Effective service delivery of treatment and supervision requires individualization that matches the clients' 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 a client's attitudes, thoughts, and behaviors.

5.01 Principles of Effective Intervention for Domestic Violence Offender

I. ***Victim Safety:*** Victim safety shall be a priority of treatment. Treatment approaches and practices shall always support victim safety and promote client accountability through the core competencies. The participation of the Treatment Victim Advocate (TVA) is an integral part of the MTT and assists in promoting victim safety. Treatment shall not blame or intimidate the victim or place the victim in a position of danger.

II. ***Client Diversity:*** Clients represent a diverse population requiring holistic and individualized approaches to treatment. Clients may present with more than one area of risk and treatment need. Treatment shall be based on the offender evaluation and ongoing assessment of the client to include any co-occurring clinical concerns (e.g., mental health, substance abuse, prior trauma, family dysfunction, etc.). The Approved Provider shall deliver treatment that addresses risk and protective factors, focuses on criminogenic needs, and incorporates the client's responsivity to treatment.

III. ***Individualized Treatment:*** Individualized treatment shall be based on the initial treatment plan and subsequent treatment plan reviews that determine the levels, frequency, and duration of domestic violence offender treatment. Levels and frequency of treatment include Level A (low intensity), Level B (moderate intensity), and Level C (high intensity). Duration of treatment varies based on individual client progress and the minimum number of treatment plan reviews.

IV. ***Environmental and Cultural Influences:*** Interventions are informed by environmental and cultural influences including the client's age, family unit (e.g. intergenerational cycle of abuse), peer influences, community, media, and societal messages on attitudes and behaviors related to domestic violence. It is important to view these influences through the framework of pro-social, resilience to trauma, and risk factors to each client. Services should be provided in a manner sensitive to cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues, or disabilities that are or become known.

V. ***Fidelity of Practice:*** The degree to which program follows a particular intervention model or theory refers to the fidelity of practice. This principle focuses on how services are delivered by treatment staff who are qualified, properly trained, and receive adequate supervision in accordance to the *Standards and Guidelines*. Adhering to the fidelity of practice principle is important for treatment success and integrity to the Standards.[38]

[38] Radatz, D. L., & Wright, E. M. (2016). Integrating the principles of effective intervention into batterer intervention programming: The case for moving toward more evidence-based programming. Trauma, Violence, & Abuse, 17(1), 72–87.

5.02 Who Can Provide Treatment

I. Domestic Violence Offender Treatment Services

Pursuant to C.R.S. 16-11.8-104, domestic violence offender treatment and ongoing assessment shall be provided by an Approved Provider throughout the treatment process. Approved Providers must have met the qualifications described in Section 9.0 of these Standards and their name must appear on the Approved Provider List.

***Discussion Point**: A provider who chooses to begin treating a client during the pre-conviction stage should provide treatment in compliance with these Standards and Guidelines to the extent possible.*

II. Second Contact Services

A. An Approved Provider who treats domestic violence offenders under the jurisdiction of the criminal justice system must use domestic violence offender treatment as defined by this Section of the Standards (see Definition Section). This does not preclude the client from receiving adjunctive treatment as clinically indicated based on the risk level and needs of the client. Adjunct treatment and interventions are referred to as Second Contacts. In consultation with the MTT, the Approved Providers shall:

- Use their clinical judgment to prioritize treatment needs and develop a treatment plan that responds to any additional treatment needs;
- Serve as the default member of the MTT to facilitate the collaboration and coordination with the Second Contact in the event that no other member is able and willing to serve in that role;
- Assess the appropriateness of any professional providing a second contact service including those who have an established therapeutic relationship with the client (e.g., mental health provider);
- Determine if a Second Contact qualifies as required by these Standards and is clinically relevant to the client's overall treatment goals and safety to the victim.
- Include and collaborate with the Second Contact as an adjunct member of the MTT.

B. The Second Contact shall be administered by a clinician or another professional who understands and supports the overall goals of offender treatment. The following exclusionary criteria shall be grounds for the MTT to identify an alternative second contact to meet second contact requirements:

- The professional undermines or fails to contribute to the individual client's treatment goals;
- The professional is unwilling or unable to coordinate and collaborate with

the MTT;

- The professional does not provide a service found by the offender evaluation and treatment plan to be a necessary second contact;
- There is no professional available to observe and verify the client engaging in such an activity to fulfill a second contact (e.g., anonymous groups, volunteering)

In such cases where a second contact professional meets this criteria, an alternative second contact shall be identified by the Approved Provider and agreed upon by the MTT.

***Discussion Point**: Professionals identified to provide a second contact may have limited professional experience or training in domestic violence dynamics. In some cases, it may become necessary for the MTT to offer education regarding the client's individual treatment plan, requirements of offender treatment, and the role of the MTT. Additionally, it is beneficial for Second Contact Providers to agree to work as a united team for the success of the client and the protection of the victim in order to avoid triangulation and collusion. Refer these professionals to the DV100 training if necessary.*

III. Options for Domestic Violence Group and Individual Treatment Coverage

Based on the Principles of Risk, Needs, and Responsivity, continuity of care is important to promote the client's amenability in treatment within the context of the dosage, consistency, structure, and containment in order for treatment to be effective with clients. This section outlines the options available to Approved Providers when an Approved Provider is not available to provide treatment.

A. Emergencies and Cancellations

When an Approved Provider is not able to facilitate a group or individual session due to unforeseen circumstances, the Approved Provider may:

- Cancel a session when necessary (e.g., holidays, inclement weather, medical emergency, etc). In the event a session is cancelled, the Approved Provider shall notify the client(s) of the cancellation. To the extent possible, the Approved Provider should attempt to reschedule any cancellations in order to promote stability and consistency in the context of the treatment.

  OR

- Make arrangements for coverage of the group session. Once arrangements have been made, the Approved Provider shall subsequently notify the MTT during regular MTT communication about the coverage implemented for the session. If the need for coverage persists, the Approved Providers shall coordinate for ongoing coverage and shall provide subsequent notification to the MTT.

***Discussion Point**: It is a best practice for an Approved Provider to communicate cancellations or coverage arrangements to the MTT as soon as possible. Communicating cancellations in a timely manner gives MTT members awareness and the ability to plan for any potential safety considerations or containment issues that may be prompted by such cancellation.*

B. Coverage for Planned Absences

When an Approved Provider plans in advance for an absence (e.g. vacation, medical procedure), the Approved Provider shall make arrangements for coverage of the group session, and notify the MTT in advance through a regular communication method such as a monthly report or email.

Requirements for Group Coverage

Anytime an Approved Provider is not able to facilitate a group or individual sessions, Approved Providers shall first seek coverage by another DVOMB Approved Provider. In the event that another DVOMB Approved Provider cannot provide treatment coverage, the Approved Provider shall utilize one of the following individuals for group coverage:

- An experienced DVOMB Associate Level Candidate who demonstrates competency in facilitating the group as determined by the DVOMB Provider (refer to Section 9.0(V) of the Standards and Appendix D - Administrative Policies (I)(A);

  OR

- Another mental health provider who has a mental health listing in Colorado with the Department of Regulatory Agencies, and who has group facilitation skills and the ability to implement the lesson plan.

The provider shall supply a session plan to the identified individual who will cover the treatment session and/or address generalized psycho-educational treatment competencies.

***Discussion Point**: The individual providing coverage should be aware that doing domestic violence specific treatment can only be done by an Approved Provider and domestic violence specific issues should be deferred to the Approved Provider upon their return. Clinicians should work within their range of experience, skill, knowledge or expertise.*

C. Indefinite Coverage or Client Transfer (More Than One Month)

If the provider absence lasts longer than one month and becomes indefinite, or if the provider is planning to no longer provide treatment services for an extended period of time or close their practice, the provider shall obtain a DVOMB Approved Provider to provide treatment services, and/or accept a client transfer, during the absence period.

D. Abuse of Coverage

Approved Providers who rely on the coverage options in a manner that would hinder progress or extend the amount of time a client is required to be in treatment may be subject to formal complaints and administrative actions.

5.03 Multi-disciplinary Treatment Team (MTT)

I. MTT Membership: The MTT consists of Approved Provider, responsible referring criminal justice agency, and Treatment Victim Advocate at a minimum. Other professionals relevant to a particular case may also be a part of the MTT such as human services, child welfare, and child protection services.

Discussion Point: *Offenders who are sentenced to receive a domestic violence offender evaluation and treatment services are sometimes placed in the community without supervision (e.g., state probation, private probation, parole, or community corrections). Circumstances for unsupervised court orders vary, but these cases should be rare due to the possible risks posed to victim and community safety. The lack of a supervision officer can compromise the effectiveness of the MTT, offender containment, and accountability; can undermine efforts toward creating safe case management strategies; and may create ethical challenges for approved Domestic Violence Treatment Providers. Providers are encouraged to work with community stakeholders to address the lack of a supervising officer for domestic violence offenders when it occurs. This includes identifying strategies for how these offenders will be managed in such situations to enhance public safety. Domestic Violence Treatment Providers may accept such a client into treatment if, in their clinical judgment, it is in the best interests of the client, victim, and community safety to do so.*

II. MTT Purpose: The MTT is designed to collaborate and coordinate offender treatment. Therefore, the work of the MTT needs to include staffing cases; sharing information; and making informed decisions related to risk assessment, treatment, behavioral monitoring, and management of offenders. The MTT by design may prevent offender triangulation and promote containment.

III. MTT Training: In the best interest of having an effective MTT, team members should successfully complete training specific to domestic violence in each of the following areas:

- Dynamics of domestic violence
- Dynamics of domestic violence victims
- Domestic violence risk assessment
- Offender treatment

The MTT may also want to consider cross training to further develop team competency.

IV. ***MTT Communication:*** The MTT will determine the most effective methods and frequency of communication, which can include face to face and/or non-face to face contact. Information regarding frequency can be reviewed in the Treatment Plan Review Intervals in Standard 5.07.

V. ***Offender Containment:*** This is one of the goals of the MTT. The MTT will collaborate to establish consequences for offender noncompliance.

VI. ***Victim Confidentiality:*** The MTT shall make victim safety and victim confidentiality its highest priority. However, when the Treatment Victim Advocate makes contact with the victim, the victim shall be informed regarding the limits of confidentiality. The MTT has the responsibility to protect confidential information that cannot be discussed during the MTT process. Specific victim information may be shared with the MTT only after written consent has been given by the victim (Refer to *Standard* 7.04g). Therefore, the Treatment Victim Advocate will not be expected to violate victim confidentiality. In cases where there is not written consent or where the advocate has not had contact with the victim, the Treatment Victim Advocate provides perspectives and insights regarding victim issues in general, not regarding a specific victim. (Please note: Some information is not confidential such as homicidal, suicidal ideation/intent, and child abuse or neglect) Refer to *Standard* 7.0 in its entirety.

Discussion Point*: Protection of the victim is priority, therefore, if the only information available that would prevent offender discharge is victim information, and the MTT has determined that victim information cannot be revealed in order to protect the victim, and there are no other ways to validate or confirm, then the MTT may determine that discharge is appropriate*.

VII. ***MTT Consensus:*** Consensus is defined as the agreement among the team members. The MTT shall have consensus as its goal in managing offenders. The MTT shall reach consensus for the following phases of treatment, at a minimum: initial placement in treatment, when treatment planning indicates a change in level of offender treatment, and discharge. While there is acknowledgment that there is a supervising agent for the court, the intent and goal are to work collaboratively.

A. MTT members are encouraged to discuss and attempt to resolve differences in order to achieve consensus. An effort should be made by MTT members to meet in person to work toward resolution.

B. Potential conflict within the MTT: MTT members have the goal of settling conflicts and differences of opinion among themselves, which assists in presenting a unified response.

The MTT is encouraged to review the Guiding Principles when resolving conflicts (Refer to Standard 3.0 in its entirety). MTT members may choose to justify in writing, utilizing offender competencies and risk factors for the court, the reason for their recommendations for treatment.

C. If there is lack of consensus, each MTT member has the option of documenting his/her position and reasons for that recommendation.

D. The MTT may request a meeting with the probation supervisor and/or Domestic Violence Clinical Supervisor if they believe it may help reach consensus, or

E. In the rare event that there continues to be a lack of consensus, MTT members may document their recommendation and submit it to the court for ultimate decision. While the MTT is waiting for the decision of the court, all conditions of probation and treatment continue until a decision is made.

Discussion Point: *The Approved Provider has the authority to discharge an offender from treatment. Probation has the authority to refer the offender to another Approved Provider or return the offender to court for further disposition.*

VIII. Treatment Report: At a minimum of once a month, the Approved Provider shall submit a written report to the supervising criminal justice agency to include:

A. Results from most recent required Treatment Plan Review

B. Offender progress regarding competencies

C. Any recommendation related to discharge planning

D. Offender's level of treatment

E. Evidence of new risk factors

F. Offender degree of compliance such as fees, attendance, and level of participation

5.04 Domestic Violence Offender Treatment

I. Group Therapy: In-person group therapy is the preferred and expected modality in which domestic violence offender treatment should occur. Group therapy promotes development of pro-social skills, provides positive peer support and is used for group process. Other treatment modalities such as individual, psycho-educational, and other adjunct options may be appropriate for goal-oriented purposes. The specific client needs and the purpose of alternative modalities shall be determined by the Approved Provider. Changes in modality shall be documented in the client's

treatment plan and reviewed during each Treatment Plan Review.

A. In-person group sessions shall:

i. Be facilitated by a DVOMB Approved Provider at the rate of time and ratio of clients listed in the table below:

Group Size	Number of Clients	Group Duration	Number of Providers
Small	1-2	1 Hour	1
Medium	3-12	1.5 Hours	1-2
Large	13-16	2 Hours	2

Large group sessions shall be co-facilitated by one Approved Provider and one co-facilitator who is another individual listed on the DVOMB Approved Provider List or a Mental health professional listed with the Colorado Department of Regulatory Agencies (DORA) *who understands and supports the overall goals of offender treatment*. Co-facilitation can be done by interns who are listed as an Associate Level Candiate. The Approved Provider shall document any co-facilitators during Group Sessions. Approved Providers shall not exceed group size maximums without the prior approval from the Application Review Committee through a variance request.

***Discussion Point**: The preferred group size generally ranges from 8 to 12 clients. In addition to these Standards and Guidelines, it is the responsibility and expectation that Approved Providers set group size based on their experience, training, facilitation skills, and requirements from DORA.*

ii. Prioritize in-person services prior to the use of teletherapy in accordance with Standard 5.05 (IV) and Appendix I.

iii. Differ based on function such as educationally focused or a combination of education and therapy, or skills-based group. Approved Providers are not required to create three distinctly different groups but may create a combination of modalities.

iv. Be separated by specific offending populations (e.g., female and and LGBTQ+ offending populations) and should continuously assess the need for the appropriate placement in treatment.

v. Be content and gender specific.

vi. Be specific to sexual orientation and gender identity (Refer to Appendix B).

***Discussion Point**: For many individuals, gender identity and gender expression are non-binary and can lie on a spectrum. Allowing transgender individuals to participate in a group with peers that identify as the same sex as they do may have a greater potential for the successful completion of treatment. Placement of individuals that do not fall within the binary model of gender should be based on the best environment for the client and that which has all clients' best interests in mind.*

B. Approved Providers should:

i. Monitor and control groups to minimize exposure to negative peer modeling and harmful behaviors and to provide for the safety of all group members. Not only are the dynamics multifaceted in group therapy, the safety of group members is of concern.

***Discussion Point**: Attempt to provide treatment with co-facilitators of diverse sexual orientation, gender expression, and culture to the best of their abilities. The intensity of these groups requires a strong team approach to model healthy interpersonal relationship dynamics and communication.*

ii. When determining group size, an Approved Provider should continually assess individual client needs and group dynamics to ensure the best size for healthy group functioning. The therapeutic benefit and group cohesion decrease substantially when the group size becomes large enough for clients to disengage. People with additional needs, may need a smaller group to effectively progress through treatment. Approved providers should consider client needs in determining the gender of the providers who are co-facilitating group sessions.

II. ***Individual Treatment:*** Individual treatment (50-minute minimum) may be utilized on a case-by-case basis appropriate for treatment, such as crisis intervention, initial stabilization, or to address severe denial. If individual treatment is the only form of treatment, it shall be for specific and documented reasons by the Approved Provider and in consultation with the MTT consultation notes in the offender's case file.

III. ***Teletherapy:*** In some cases, teletherapy may be an appropriate modality to meet the needs of the client. The provision of services via teletherapy is considered to be a privilege that is intended to promote risk-reduction strategies, engagement in the therapeutic process for the client, and the promotes the best interest of victim safety.

A. The provision of teletherapy services to individuals subject to the DVOMB

Standards and Guidelines shall only be conducted by a DVOMB Approved Provider who has met the criteria established by Section 9.08 and who is listed as being Telehealth Approved. Online programs or individuals who are not listed on the DVOMB Approved Provider List do not meet the requirements set forth in 16-11.8-104, C.R.S.

B. Approved Providers who are listed as Teletherapy Approved shall:

i. Follow all DVOMB Standards and Guidelines and ethical codes of conduct in the same manner as is expected during face-to-face or in-person sessions.

ii. Establish policies that ensure that teletherapy is driven by the individual risk, need, and responsivity factors of the client, victim safety considerations, and continuity of care allowing for both teletherapy and in-person services.

iii. Have a dedicated workspace that is free from distractions and ensures confidentiality.

iv. Facilitate virtual group sessions at the rate of time and ratio of clients listed in the table below:

Group Size	Number of Clients	Group Duration	Number of Providers
Small	1-2	1 Hour	1
Medium	3-10	1.5 Hours	1-2
Large	13-16	2 Hours	2

The Approved Provider shall document any co-facilitators for Group Sessions. Approved Providers shall not exceed virtual group size of more than 12 clients per group.

Discussion Point: *When facilitating large group sessions via teletherapy, careful consideration should be given to the level of risk, group composition, client dynamics, and the abilities of the provider. Providers should be mindful of the challenges that come with a large group format, including maintaining engagement, managing risk factors, monitoring body language, and ensuring that administrative tasks do not interfere with effective facilitation. Large group Sessions regularly should be co-facilitation by another individual listed on the DVOMB Approved Provider List or a mental health professional listed with the Colorado Department of Regulatory Agencies (DORA) who understands and supports the overall goals of offender treatment. Co-facilitation can be done by interns who*

are listed as an Associate Level Candidate. Proper documentation of co-facilitators is necessary to ensure accountability and oversight.

v. Have the HIPAA required equipment, hardware (e.g., monitors, camera, microphone, etc.), software and knowledge to facilitate services.

Discussion Point: Approved Providers must implement best practices to ensure secure, effective, and seamless service delivery. This includes using HIPAA-compliant platforms, maintaining updated computer systems and software, and safeguarding client confidentiality through encrypted communications and secure data storage. Regular system updates, strong password management, and reliable backup procedures are essential to prevent technical disruptions and protect sensitive information. Additionally, practitioners should establish clear protocols for addressing connectivity issues, emergency situations, and client accessibility concerns. Providers are recommended to arrange their workstation that allows for all clients to be visible (i.e., gallery view) which may require more than one monitor.

vi. Maintain an option for in-person services for the clients because some clients may transition from teletherapy to in-person services or vice versa. Teletherapy may be an option after the client establishes a therapeutic relationship in treatment, has stable mental health, and shows progress toward treatment goals.

vii. Provide in-person services to clients who work or reside with accessibility to their program, unless the Provider is unable to provide services based on a language barrier or the appropriateness criteria listed in Appendix I.

Discussion Point: Referring agents and supervising officers should avoid circumstances where clients are receiving services from Approved Providers outside of the jurisdiction in which the client is being supervised. Outsourcing referrals can negatively impact clients who require in-person services at some point in treatment. This practice of outsourcing referrals can effectively undermine the viability of local programs, pose risks to victim safety, and restrict continuity of care.

viii. Not engage in non-session related tasks or activities while conducting teletherapy sessions (e.g. driving, recreation activities, tending to others, tending to non-session related work, etc.).

ix. Not include other individuals, other than co-therapists or approved MTT members, during teletherapy sessions.

x. Ensure the use of multi-media (e.g. pre-recorded videos, audio, etc.) is relevant, appropriate, and supportive of the topics, curriculum, and/or application of the Core Competencies. Multi-media shall not replace treatment nor be used in a manner inconsistent with general mental health ethics and best practices.

***Discussion Point**: At times, a video or audio clip (e.g., 10 to 15 minutes) can aid in teaching and demonstrating different Core Competencies with clients. The use of these types of multi-media should be carefully and intentionally integrated as part of lesson planning.*

C. Clients referred for domestic violence offender treatment shall not be not eligible for teletherapy during their first Treatment Plan Review if they present with any TWO of the following risk factors identified on the DVRNA:

i. Prior conviction of domestic violence (A1).

ii. Substance abuse/dependence (B1) or illegal drug use (B3)

iii. In need of a mental health evaluation (C7)

iv. Offender was on community supervision at the time of the offense (F1)

v. Explicit domestic violence attitudes (J1)

vi. Any prior domestic violence offender treatment (K)

The MTT may deviate from these exclusionary criteria in Standard 5.04 (III)(C) if an Approved Provider recommends a clinical override for a client and there is MTT consensus. The MTT shall not recommend the use of teletherapy solely as a result of convenience or preference of the Approved Provider or the client. The MTT consensus shall document agreement that:

i. The clinical rationale for attending teletherapy exceeds or outweighs the benefits of in-person services;

AND

ii. The clients' ability to attend in-person services is not viable;

AND

iii. The client's individual risk factors and the victim's safety are not compromised through teletherapy modalities.

D. Any client who is sentenced to unsupervised probation or court monitoring shall not be eligible for teletherapy services for during the duration of their treatment. Please reference Section 5.02 regarding the Multi-Disciplinary Treatment Team (MTT).

E. The Approved Provider in consultation with the MTT, shall determine if and when the client is appropriate for in-person or teletherapy services using the appropriateness criteria outlined in Appendix I. A mixture of in-person group therapy and teletherapy can enhance client engagement in treatment. If considering the use of teletherapy the provider shall:
   i. Assess the appropriateness and readiness of a client for teletherapy services and determine if there are any concerns that would impact the client's level of engagement or ability to attend teletherapy sessions (e.g. compliance concerns, specific responsivity issues, ongoing substance misuse, or any victim safety concerns etc.).
   ii. Have an established therapeutic relationship with the client, or clients for group therapy, prior to considering the use of teletherapy.
   iii. Determine if the client's progress in treatment can appropriately be assessed via teletherapy (e.g., body language, etc.).
   iv. DOCUMENT The reason teletherapy is being utilized (e.g., distance of client to services, medical risks or conditions, lack of resources to support in person therapy, community risk, etc.)
   v. Collaborate and consult with the MTT regarding the clinician's recommendation/decision for teletherapy.
   vi. Document the clinical rationale of the supporting reasons why a client should receive in-person, teletherapy, or a combination of both modalities.

F. For clients who are eligible and determined to be appropriate for teletherapy, Approved Provider shall:
   i. Notify the MTT when there is a violation of the treatment contract and to consider the severity of the violation, victim safety, the client's progress toward the Core Competencies, and general risk-related behavior in determining if the client needs to attend in-person sessions.
   ii. Establish a safety plan or process for identifying client location in the event of an emergency (e.g. asking client for their location in the group chat, etc).
   iii. Check in with the client at each treatment plan review to determine if teletherapy is a suitable approach for the client to meet the goals identified in their treatment plan and if any adjustments are needed. This can be adjusted anytime based on clinical indicators that suggest teletherapy is contra-indicated.
   iv. Notify the MTT if there are issues regarding participation, limitations, and how the rationale for teletherapy services may impact other activities of

the client (e.g. if teletherapy is being provided due to a community safety risk such as a pandemic, other community access/activities should be reviewed by the team).

v. Require any additional monitoring of the client based on the Provider's ability to assess the client's individual risk factors and victim safety concerns.

vi. Transition the client from teletherapy if they are no longer appropriate, in violation of the treatment contract, failing to progress, or disengaging from treatment. In such cases, the client shall either return to in-person services or be discharged in accordance with Section 5.09.

***Discussion Point**: Approved Providers may offer an initial orientation for the client to understand and become familiarized with using a virtual platform. When using a hybrid approach with clients attending both face-to-face and virtually, it is considered a best practice for the Approved Provider to use technology that provides for the monitoring of participants in both formats.*

5.05 Implementation of Individualized Treatment Plan

A provider who treats domestic violence offenders under the jurisdiction of the criminal legal system must use domestic violence offender treatment (see Definition Section). Providers shall develop an individualized treatment plan that is formulated based on the client risk and needs, evaluation recommendations, and the core treatment competencies. The individualized treatment plan may incorporate adjunct services that address ongoing or emerging co-occurring issues. The individualized treatment plan shall identify treatment goals for the client in order to promote victim and community safety.

I. Individualized Treatment Plan: Upon a client entering treatment, a provider shall develop a written treatment plan based on the relevant risks and needs identified in current and past assessments/evaluations of the client. The process shall be guided by the treatment provider and developed through collaboration with the client. The Treatment Plan shall:

- Promote victim and community safety.[39]
- Promote client engagement through motivational enhancement strategies.[40]
- Identify the behaviors mandating treatment and specifically address all clinical issues outlined in the intake evaluation and via validated risk assessment.[41]

[39] § 16-11.8-101 C.R.S. includes reference to enhancing the protection of current victims and potential victims.
[40] Santirso, F. A., Gilchrist, G., Lila, M., & Gracia, E. (2020). Motivational strategies in interventions for intimate partner violence offenders: A systematic review and meta-analysis of randomized controlled trials. Psychosocial Intervention, 29(3), 175-190.
[41] Friedman, B. D., Yorke, N. J., Compian, K., & Arner Lazaro, D. (2022). A multimodal approach to reduce attrition, recidivism, and denial in abuser intervention programs. Journal of Offender Rehabilitation, 61(8), 426–441; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. Psychological Services, 18(4), 566–573; Radatz, D. L., Richards, T. N., Murphy, C. M., Nitsch, L. J., Green-Manning, A., Brokmeier, A. M., & Holliday, C. N. (2021). Integrating 'principles of effective intervention' into domestic violence intervention programs: New opportunities for change and collaboration. American Journal of Criminal Justice, 46, 609-625.

- Include measurable treatment goals that address protective and risk factors consistent with the client's treatment needs, competency and ability.[42]
- Include planning for and referral to adjunct treatment as indicated.[43]
- Be written in a way that is understandable to the client in consideration of the client's responsivity factors.[44]
- Be reviewed with the client and the MTT at a minimum of every 2-3 months, referred to as Treatment Plan Reviews.[45]

II. Core Treatment Competencies

Domestic violence offender treatment shall help clients develop competencies (that is, knowledge, skills, and attitudes) to effectively address their risk-related problems, develop protective factors, establish non-abusive relationships, and lead non-offending lives. The required competencies shall be facilitated for all clients. The potential competencies may be included for clients when clinically indicated. The required and potential competencies are not an exhaustive list of all potential competencies needing to be addressed in treatment. As such, Approved Providers may include additional competencies to address risk factors and individual treatment needs, where needed and indicated in the treatment plan. The list of competencies is not set forth in a linear curriculum order nor as a prioritized list of behavioral goals. Instead, the competencies may be addressed in an order consistent with the treatment plan, the needs of the client, the order of group treatment sessions, or across multiple aspects of treatment. Assisting clients to achieve the competencies in their treatment plan shall be the basis for prioritizing ongoing and subsequent second contact requirements in accordance with the treatment level of the client.

Domestic Violence and General Criminality

Clients shall meet the following required competencies related to Domestic Violence and General Criminality:

1. Define all types of domestic violence and abusive behavior (reference working clinical definition of domestic violence) and demonstrates acceptance of accountability and responsibility for offending and abusive behaviors.[46]

[42] Burghart, M., de Ruiter, C., Hynes, S. E., Krishnan, N., Levtova, Y., & Uyar, A. (2023). The Structured Assessment of Protective Factors for violence risk (SAPROF): A meta-analysis of its predictive and incremental validity. Psychological Assessment, 35(1), 56–67; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. Psychological Services, 18(4), 566–573; Radatz, D. L., Richards, T. N., Murphy, C. M., Nitsch, L. J., Green-Manning, A., Brokmeier, A. M., & Holliday, C. N. (2021). Integrating 'principles of effective intervention' into domestic violence intervention programs: New opportunities for change and collaboration. American Journal of Criminal Justice, 46, 609-625.

[43] Radatz, D. L., Richards, T. N., Murphy, C. M., Nitsch, L. J., Green-Manning, A., Brokmeier, A. M., & Holliday, C. N. (2021). Integrating 'principles of effective intervention' into domestic violence intervention programs: New opportunities for change and collaboration. American Journal of Criminal Justice, 46, 609-625.

[44] Radatz, D. L., Richards, T. N., Murphy, C. M., Nitsch, L. J., Green-Manning, A., Brokmeier, A. M., & Holliday, C. N. (2021). Integrating 'principles of effective intervention' into domestic violence intervention programs: New opportunities for change and collaboration. American Journal of Criminal Justice, 46, 609-625.

[45] § 16-11.8-101 C.R.S. includes reference to monitoring of offenders.

[46] Gannon, T. A., Olver, M. A., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review, 73*; Hilton, N. Z., Eke, A. W., Kim, S., & Ham, E. (2023). Coercive control in police reports of intimate partner violence:

2. Identify the history of current and former patterns of domestic violence behaviors and thoughts regarding onset, frequency, and persistence. This includes awareness and discuss the intent of previous grooming tactics.[47]

   ***Discussion Point**: Clients may invoke their 5th Amendment right for current or pending cases. While Approved Providers shall not unsuccessfully discharge an offender from treatment solely for refusing to answer incriminating questions, a treatment provider may opt to discharge a client from treatment or not accept a client into treatment if the provider determines a factor(s) exists that compromises the therapeutic process.*

3. Identify and challenge cognitive distortions and belief systems that plays a negative or unhealthy role in the client's thoughts, emotions, and behaviors.[48]

   ***Discussion Point**: The research on the intrinsic factors that motivate a client's offending behaviors and attitudes is still emerging. Approved Providers are encouraged to explore the underlying sources of offending. This May include specific personality traits or disorders, certain types of cognitive schemas, and other considerations.*

4. Recognize and manage dynamic risk factors and adaptive skills to mitigate those risk factors.[49]

Potential Competencies – The following potential competencies may be required when clinically indicated for General criminality:[50]

Conceptual definition and association with recidivism. *Psychology of Violence, 13*(4), 277–285; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence*, *29*, 151-164.

[47] Gannon, T. A., Olver, M. A., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review, 73*; Hilton, N. Z., Eke, A. W., Kim, S., & Ham, E. (2023). Coercive control in police reports of intimate partner violence: Conceptual definition and association with recidivism. *Psychology of Violence, 13*(4), 277–285; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence*, *29*, 151-164.

[48] Hilton, N. Z., Eke, A. W., Kim, S., & Ham, E. (2023). Coercive control in police reports of intimate partner violence: Conceptual definition and association with recidivism. *Psychology of Violence, 13*(4), 277–285; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573; Pornari, C. D., Dixon, L., & Humphreys, G. W. (2021). A preliminary investigation into a range of implicit and explicit offense supportive cognitions in perpetrators of physical intimate partner violence. *Journal of Interpersonal Violence, 36* (3-4), NP2079-2111; Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence*, *29*, 151-164.

[49] Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence*, *29*, 151-164.

[50] Okano, M., Langille, J., & Walsh, Z. (2016). Psychopathy, alcohol use, intimate partner violence: Evidence from two samples. *Law & Human Behavior, 40*(5), 517-523; Peters, J. R., Nunes, K. L., Ennis, L., Hilton, N. Z., Pham, A., & Jung, S. (2022). Latent class analysis of the heterogeneity of intimate partner violent men: Implications for research and practice. *Journal of Threat*

- Recognize and manage current procriminal attitudes and behaviors.
- Identify, acknowledge, and manage use of mood-altering substances.
- Identify the history of current and former pro-criminal behaviors, thoughts, and associates

Self-Regulation and Self-Care

Clients shall meet the following required competencies related to Self-Regulation and Self-Care:

5. Demonstrate and implement self-regulation skills to include but not limited to emotional regulation, stress management, communication skills, anger management, conflict resolution, problem solving, delayed gratification, parental and financial responsibility, etc.[51]

6. Demonstrate the ability to discuss past experiences and how any unresolved trauma may impact offending behavior as a way to adopt effective coping strategies.[52]

***Discussion Point**: The goal of this competency is to understand how past experiences have impacted the client and what ways they can deal with these issues differently in non-abusive ways.*

7. Develop and maintain prosocial activities and networks to include but not limited to completing education, maintaining employment, obtaining stable housing, life skills, recreational and social activities, etc.[53]

Assessment & Management, Online Advance Publication, October 13, 2022; Robertson, E. L., Walker, T. M., & Frick, P. J. (2020). Intimate partner violence perpetration and psychopathy: A comprehensive review. *European Psychologist, 25*(2), 134-145.

[51] Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of the risk factors for intimate partner violence. *Partner Abuse, 3(3*), 231-280; Farzan-Kashani, J., & Murphy, C. M. (2017). Anger problems predict long-term criminal recidivism in partner violent men. *Journal of Interpersonal Violence, 32*(3), 3541-3555; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573; Rolle, L., Giardina, G., Caldarera, A., & Brustia, P. (2018). When intimate partner violence meets same sex couples: A review of same sex intimate partner violence. *Frontiers in Psychology, 9*(1506), 1-13; Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence*, *29*, 151-164.

[52] Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of the risk factors for intimate partner violence. *Partner Abuse, 3(3*), 231-280; Lee, K. A., Bright, C. L., & Betz, G. (2022). Adverse childhood experiences (ACEs), alcohol use in adulthood, and intimate partner violence (IPV) perpetration by black men: A systematic review. *Trauma, Violence, & Abuse*, *23*(3), 372-389; Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51.

[53] Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of the risk factors for intimate partner violence. *Partner Abuse, 3(3*), 231-280; Gerstenberger, C., Stansfield, R., & Williams, K. R. (2019). Intimate partner violence in same-sex relationships. *Criminal Justice & Behavior, 46*(11), 1515-1527; Grace, F. X., McNary, S. B., & Murphy, C. M. (2022). Employment status and recidivism after relationship violence intervention. *Psychology of Violence*, 13(2), 127-135; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for

Potential Competencies - The following potential competencies may be required when clinically indicated for the client to meet:

- Identify, acknowledge, and manage mental health needs and the development of supports.[54]

- Identify, acknowledge, and manage the need for crisis management and stabilization (i.e. suicidal or homicidal ideation, housing insecurity, client decompensation).[55]

- Identify, acknowledge, and manage their own reintegration into the community.[56]

- Identify, acknowledge, and manage boundaries.

- Identify and promote healthy sexual behavior, intimacy, and relationship skills.[57]

- Increase ability to recognize attachment issues.[58]

Survivor Impact and Community Safety

Clients shall meet the following required competencies related to Survivor Impact and Community Safety:

8. Demonstrate insight about the impact of their domestic violence offense on all individuals and promote victim empathy when clinically indicated.[59]

treatment. *Psychological Services, 18*(4), 566-573; Spencer, C. M., & Stith, S. M. (2020). Risk factors for male perpetration and female victimization of intimate partner homicide: A meta-analysis. *Trauma, Violence, & Abuse, 21*(3) 527-540.

[54] Callan, A., Corbally, M., & McElvaney, R. (2021). A scoping review of intimate partner violence as it relates to the experiences of gay and bisexual men. *Trauma, Violence, & Abuse, 22*(2), 233-248; Capaldi, D. M., Knoble, N. B., Shortt, J. W., & Kim, H. K. (2012). A systematic review of the risk factors for intimate partner violence. *Partner Abuse, 3(3)*, 231-280; Dawson, M., & Piscitelli, A. (2021). Risk factors in domestic homicide: Identifying common clusters in the Canadian context. *Journal of Interpersonal Violence, 36*(1-2), 781-792; Morgan, et al. (2012). Treating offenders with mental illness: A research synthesis. *Law & Human Behavior, 36*(1), 37-50; Rolle, L., Giardina, G., Caldarera, A., & Brustia, P. (2018). When intimate partner violence meets same sex couples: A review of same sex intimate partner violence. *Frontiers in Psychology, 9*(1506), 1-13; Spencer, C. M., & Stith, S. M. (2020). Risk factors for male perpetration and female victimization of intimate partner homicide: A meta-analysis. *Trauma, Violence, & Abuse, 21*(3) 527-540; Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51.

[55] Dawson, M., & Piscitelli, A. (2021). Risk factors in domestic homicide: Identifying common clusters in the Canadian context. *Journal of Interpersonal Violence, 36*(1-2), 781-792; Scott, K., Heslop, L., Kelly, T., & Wiggins, K. (2015). Intervening to prevent repeat offending among moderate-to-high risk domestic violence offenders: A second-responder program for men. *International Journal of Offender Therapy & Comparative Criminology, 59*(3), 273-294.

[56] Stansfiled, R., Semenza, D., Napolitano, L., Gatson, M., Coleman, M., & Diaz, M. (2022). The risk of family violence after incarceration: An integrative review. *Trauma, Violence, & Abuse, 23*(2), 476-489.

[57] Spencer, C. M., Toews, M. L., Anders, K. M., & Emanuels, S. K. (2021). Risk markers for physical teen dating violence perpetration: A meta-analysis. *Trauma, Violence, & Abuse, 22*(3), 619-631; Sparks, B., Wielinga, F., Jung, S., & Olver, M. E. (2020). Recidivism risk and criminogenic needs of individuals who perpetrated intimate partner sexual violence offenses. *Sexual Offending: Theory, Research, and Prevention, 15*(1), Article e3713.

[58] Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51.

[59] Bichard, H., Byrne, C., Saville, C. W. N., & Coetzer, R. (2022). The neuropsychological outcomes of non-fatal strangulation in domestic and sexual violence: A systematic review. *Neuropsychological Rehabilitation, 32*(6), 1164–1192; Godfrey, D. A., Kehoe,

***Discussion Point**: Demonstration of this competency regarding the impact of a domestic violence offense can include, but is not limited to accountability letters, victim empathy panels, and surrogate offender and victim dialogue. Opportunities for any therapeutic work between the client and the identified victim or secondary victims may be done after the client has completed domestic violence offender treatment during aftercare.*

9. Increase understanding of how intergenerational patterns of family, peer group, community, and culture can normalize domestic violence and foster attitudes and responses that condone and tolerate domestic violence.[60]

10. Develop and implement safety plans to address risk factors and potentially high-risk situations.[61]

11. Cooperate with supervision requirements, court orders, and the terms and conditions.[62]

Potential Competencies - The following potential competencies may be required when clinically indicated for the client to:

- Increase understanding and demonstration of parental responsibility to enhance and ensure the wellbeing of the children.[63]

C. M., Bastardas-Albero, A., & Babcock, J. C. (2020). Empathy mediates the relations between working memory and perpetration of intimate partner violence and aggression. *Behavioral Sciences, 10*(3), 63; Hamel, J., Cannon, C. E. B., & Graham-Kevan, N. (2023, April 6). The consequences of psychological abuse and control in intimate partner relationships. *Traumatology*. Advance online publication; Holmes, M. R., Berg, K. A., Bender, A. E., Evans, K. E., O'Donnell, K., & Miller, E. K. (2022). Nearly 50 years of child exposure to intimate partner violence empirical research: Evidence mapping, overarching themes, and future directions. *Journal of Family Violence, 37*, 1207-1219; Lafontaine, M. F., Guzmán-González, M., Péloquin, K., & Levesque, C. (2018). I am not in your shoes: Low perspective taking mediating the relation among attachment insecurities and physical intimate partner violence in Chilean university students. *Journal of Interpersonal Violence, 33(*22), 3439–3458; Spencer, C. M., Stith, S. M., & Cafferky, B. (2022). What puts individuals at risk for physical intimate partner violence perpetration? A meta-analysis examining risk markers for men and women. *Trauma, Violence, & Abuse, 23*(1), 36-51.

[60] Copp, J. E., Giordano, P. C., Longmore, M. A., and Manning, W. D. (2019). The development of attitudes towards intimate partner violence: an examination of key correlates among a sample of young adults. *Journal of Interpersonal Violence, 34*, 1357–1387; Herrero, J., Rodríguez, F. J., and Torres, A. (2017). Acceptability of partner violence in 51 societies: The role of sexism and attitudes toward violence in social relationships. *Violence Against Women, 23*, 351–367; Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573.

[61] Spencer, C. M., & Stith, S. M. (2020). Risk factors for male perpetration and female victimization of intimate partner homicide: A meta-analysis. *Trauma, Violence, & Abuse, 21*(3) 527-540; Stewart, L. A., Gabora, N., Kropp, P. R., & Lee, Z. (2014). Effectiveness of Risk-Needs-Responsivity-based family violence programs with male offenders. *Journal of Family Violence*, *29*, 151-164.

[62] Hilton, N. Z., & Radatz, D. L. (2021). Criminogenic needs and intimate partner violence: Association with recidivism and implications for treatment. *Psychological Services, 18*(4), 566-573.

[63] Hine, L., Meyer, S., McDermott, L., & Eggins, E. (2022). Intervention programme for fathers who use domestic and family violence: Results from an evaluation of Caring Dads. *Child & Family Social Work, 27*, 711-724; Labarre, M., Bourassa, C., Holden, G. W., Turcotte, P., & Letourneau, N. (2016). Intervening with fathers in the context of intimate partner violence: An analysis of ten programs and suggestions for a research agenda. *Journal of Child Custody, 13*(1), 1–29; Meyer, S. (2017). Motivating perpetrators of domestic and family violence to engage in behavior change: The role of fatherhood. *Child & Family Social Work, 23*(1), 97–104; Stover, C. S., Clough, B., Clough, M., DiVertro, S., Madigan, L., & Grasso, D. J. (2022). Evaluation of a statewide implementation of Fathers for Change: A fathering intervention for families impacted by partner violence. *Journal of Family Violence, 37*, 449-459.

***Discussion Point**: If the offender has abused any pregnant partner, this may need to be addressed as an additional competency. In such cases, the client should demonstrate an understanding and insight that abuse during pregnancy may present a higher risk to the victim and unborn child.*

5.06 Levels of Treatment

I. ***There are three levels of treatment*** that include Level A (low intensity), Level B (moderate intensity), and Level C (high intensity). Offenders are placed in a level of treatment based on the findings from the intake evaluation, offender treatment needs, and level of risk as identified by the DVRNA. Research demonstrates that matching offender risk to intensity of treatment reduces recidivism (Andrews & Bonta, 1994). Intensity of treatment is differentiated by frequency of clinical contact and content of treatment.

II. ***Initial Determination of Treatment Level*** is recommended by the Approved Provider after the Offender Intake Evaluation has been completed and approved by the MTT. While some offenders may remain in the same level throughout treatment, there is also the ability to move offenders to a different level of treatment as needed. This is based on new information such as change in risk factors, mitigation of risk, continuing abuse, or denial.

A. Only offenders in Level C may be considered for a decrease in treatment level and then only to Level B.

B. No offenders in Level B or C are eligible for a decrease in treatment to Level A.

C. Decreasing an offender's level of intensity of treatment shall only occur at scheduled Treatment Plan Review intervals and shall be approved by consensus of the MTT. This change in treatment level shall include written justification placed in the offender's file describing the need for change in treatment.

D. Increasing an offender's level of treatment to a higher intensity of treatment may occur at any time and shall be approved by consensus of the MTT. This change in treatment level shall include written justification placed in the offender's file describing the need for change in treatment.

III. ***If any Information is Missing*** from the Offender Intake Evaluation and the DVRNA, an offender shall not be placed in Level A. A Temporary Placement to treatment Level B may be indicated. Because the missing information may be related to risk factors, there is a need for safety considerations, resulting in a minimum Temporary Placement to Level B. Even though there is information missing, there may be sufficient information obtained from the DVRNA to justify the offender's placement in Level C.

A. Of the missing information, the MTT will identify that which is unobtainable and document why. However, if the missing information is a result of lack of offender cooperation, the MTT shall take this into account in its determination of level of treatment. Offender resistance or noncompliance (e.g. release of information) shall result in ineligibility for placement in Level A.

   Once missing information has been received, the MTT shall determine the appropriate level of treatment, which may be Level A, B, or C. If the Temporary Placement was to Level B, and after reviewing additional information, the MTT determines treatment shall be Level A, it is not considered a decrease in treatment intensity.

B. The MTT shall make a determination within 30 days of the offender intake evaluation.

IV. *Parameters for Treatment Levels*

A. When an offender is in severe denial (Refer to Glossary), the MTT shall consider individual sessions or a group format to address the denial.

   ***Discussion point**: Placing an offender with severe denial in group with offenders who are not exhibiting severe denial may not be appropriate for the offender or the group.*

B. Groups shall differ based on function; such as educationally focused or a combination of education and therapy, or skills based group. Approved Providers are not required to create three distinctly different groups but may create a combination of modalities.

C. The first principle for differentiating treatment, repeatedly found to be valid in criminal justice interventions, is that higher and lower risk offenders shall not be treated together (Lowencamp & Latessa, 2004). Therefore, Level A and C shall not be together for therapeutic sessions.

D. Offenders in all levels of treatment may be together for some educational non-therapeutic classes.

E. Some offenders in Level C treatment who exhibit features of psychopathy may not be appropriate for empathy based treatment (Hare, 1993; Hare, 1998).

V. *Safeguards*

Certain safeguards have been created to ensure that offenders are monitored and that victim safety is the highest priority. These safeguards include the following:

A. Victim information shall be protected and victim confidentiality maintained at all times.

B. All offenders shall have at least the minimum number of required Treatment Plan Reviews at identified intervals based on level of treatment and individual Treatment Plan(s).

C. Prior to the first required Treatment Plan Review, the Approved Provider shall have obtained and reviewed offender criminal history and available victim contact information.

D. Core competencies shall be demonstrated by offenders prior to discharge (Refer to
Standard 5.05).

E. Offender risk factors shall be addressed by offender competencies. Some offenders will have additional risk factors that require demonstration of additional competencies and additional Treatment Plan Reviews.

F. Offender risk is dynamic and may increase during treatment resulting in the need for additional offender competencies being added to the Treatment Plan.

G. If the offender is deemed to be a risk to the community, an alternative disposition shall be discussed with the MTT and subsequently recommended to probation.

VI. *Level A (Low Intensity)*

The offender population that is identified for Level A at the initial placement in treatment does not have an identified pattern of ongoing abusive behaviors. They have a pro-social support system, may have some established core competencies, minimal criminal history, and no evidence at the beginning of treatment of substance abuse or mental health instability.

A. Placement Criteria for Level A
   1. MTT consensus
   2. Offenders are not appropriate for Level A if there is still missing information from the intake evaluation or the Domestic Violence Risk and Needs Assessment instrument (DVRNA). The responsibility to obtain information may rest with the MTT or the offender.
   3. If one or no risk factors are identified from the implementation of the DVRNA and the pre or post-sentence intake evaluation (Refer to *Standard* 4.0 in its entirety), there is a need for low intensity treatment.
   4. Offenders who are placed in Level B or C are never eligible to be moved to Level A.

***Discussion Point**: The MTT should take into consideration victim safety concerns before placing an offender into Level A. Because this level of treatment for an offender is low intensity and potentially a shorter period of time, victim safety must continue to be monitored where possible and*

appropriate. Some victims may be reluctant to provide information regarding the offender at the point of initial evaluation or early in treatment and more information may become available as treatment continues.

B. Intensity of Treatment
   1. Content and Contact
      a. Group clinical sessions that address psycho-educational content, core competencies, criminogenic needs, and Treatment Plan issues.
      b. Clinical sessions shall be held once a week

C. Transition

If new disclosure/information is obtained and risk factors increase, offender shall be moved to Level B or Level C.

VII. *Level B (Moderate Intensity)*

The offender population that is identified for Level B treatment has moderate risk factors. At the initial placement of treatment, they have an identified pattern of ongoing abusive behaviors. There may also be some denial of the abuse and some moderate resistance to treatment. They may or may not have a pro-social support system and may have some criminal history. There may be some evidence at the beginning of treatment of moderate substance abuse or mental health issues. Therefore, the following is identified as the most appropriate intensity of treatment for this population.

A. Placement Criteria for Level B

1. MTT consensus
2. Two to four risk factors identified in the DVRNA or one Significant Risk Factor identified in the DVRNA that indicates initial placement in Level B. Additionally, the pre- or post-sentence intake evaluation (Refer to Standard 4.0 in its entirety) identifies a need for moderate intensity of treatment.
3. Additional risk factors identified by the MTT for an offender in Level A justify a placement in Level B.
4. If risk factors are mitigated for an offender in Level C, the offender may be moved to Level B if there is MTT consensus.

B. Intensity of Treatment

1. Content and Contact: Weekly group clinical sessions that address core competencies, criminogenic needs, and Treatment Plan issues using cognitive behavioral treatment plus at least one additional monthly clinical intervention from the following list:
   a. An individual session to address denial or resistance
   b. A clinical contact to further evaluate and/or monitor issues such as

mental health

c. Additional treatment such as substance abuse treatment or mental health treatment

2. Substance abuse treatment: Violence cannot be successfully treated without treating substance abuse problems. All offenders evaluated as needing substance abuse treatment shall complete such treatment. Such treatment shall be provided by a CAS or higher. If the Approved Provider does not provide a substance abuse treatment program, the Provider shall conduct shared case supervision and treatment planning with the counselor providing the substance abuse treatment at a minimum of once per month or more frequently as the case dictates.

C. Transition

If new disclosure/information is obtained and risk factors increase, offender shall be moved to Level C. Offenders at this level are never eligible to move to Level A.

VIII. *Level C (High Intensity)*

The offender population that is identified for Level C treatment has multiple risk factors. These individuals will most likely require cognitive skills-based program. There may be significant denial and high resistance to treatment. These individuals often have employment and/or financial instability. In general, they do not have a pro-social support system. They are likely to have a criminal history and substance abuse and/or mental health issues. Therefore, stabilization of the offender and crisis management may be needed at the beginning of treatment.

A. Placement Criteria for Level C

1. MTT consensus
2. Five or more risk factors identified in the DVRNA or one Critical Risk Factor identified in the DVRNA that indicate initial placement in Level C Additionally, the pre- or post- sentence intake evaluation (Refer to Standard 4.0 in its entirety) identifies a need for a high intensity treatment.
3. Additional risk factors are identified by the MTT for an offender in Level A that justifies a placement in Level C.
4. Additional risk factors are identified by the MTT for an offender in Level B that justifies a placement in Level C.

B. Intensity of Treatment

1. Content and Contact: Minimum of two contacts per week. One contact to address core competencies and one treatment session such as cognitive

skills group, substance abuse, or mental health issues group.

a. A clinical contact involves therapeutic intervention specifically related to the offender's criminogenic needs and risk factors. Therefore, the two contacts cannot be on the same day.
b. The intent of this level of treatment is to disrupt patterns of abuse.
c. Face to face contact is required so the Approved Provider can assess the offender's attention level responsiveness, appearance, possible substance abuse, and mental health status. This contact will also assess and promote victim safety.

2. Substance abuse treatment: Violence cannot be successfully treated without treating substance abuse problems. All offenders evaluated as needing substance abuse treatment shall complete such treatment. Such treatment shall be provided by a CAS or higher. If the Approved Provider does not provide a substance abuse treatment program, the Approved Provider shall conduct shared case supervision (treatment planning) with the Approved Provider providing substance abuse treatment at a minimum of once per month or more frequently as the case dictates.

C. Transition

If the offender progresses in treatment and if risk factors are mitigated, the MTT may reduce the offender intensity of treatment to Level B. Offenders in Level C are never eligible to move to Level A.

5.07 Required Treatment Plan Review Intervals For All Levels

The purpose of the Treatment Plan Review is to re-assess offender degree of progress and risk, and to make any necessary modifications to the Treatment Plan and goals. The intensity of treatment may need to be modified based on the findings of the Treatment Plan Review.

I. The Approved Provider shall review the Treatment Plan and the offender's progress toward meeting treatment goals. The Approved Provider shall consult with members of the MTT at all Treatment Plan Review intervals and shall provide feedback to the MTT regarding the outcome. The Approved Provider shall review the offender's Treatment Plan with the offender. At the conclusion of each Treatment Plan Review, the next Treatment Plan Review will be scheduled and noted in the Treatment Plan. The offender shall sign the Treatment Plan to acknowledge the review.

***Discussion Point**: The Treatment Plan Review may be done in lieu of, or in addition to, the regularly scheduled monthly Treatment Report.*

II. Treatment Plan Review shall include at a minimum:

A. Input from probation, such as compliance with probation terms and conditions, and new criminal history

B. Discussion Point: If there is no probation supervision, use Colorado Bureau of Investigation's website or contact the judge if appropriate.

C. Input from Treatment Victim Advocate, even if victim contact in a given case is unavailable

D. Review of offender progress in accordance with the Treatment Plan, offender competencies, and risk factors.

E. MTT verification that no additional risk factors have been identified or reported through other sources outside of offender contact as relevant (e.g. social services, psychiatrist, new partner, parents, or clergy)

F. Discussion Point: This list of suggested contacts is intended to be a guideline regarding who to contact. The MTT can determine who is appropriate or relevant to contact on a case-by-case basis throughout treatment as well as prior to discharge.

III. Approved Providers shall complete the first Treatment Plan Review after the completion of two to three months of treatment. This first Treatment Plan Review shall be scheduled and identified in the offender's initial Treatment Plan.

A. Purpose of this Treatment Plan Review is to reevaluate whether the offender is in the appropriate level of treatment, refine the Treatment Plan in accordance with the next Treatment Plan Review period, and to measure progress. Offenders are not eligible for discharge at the first Treatment Plan Review period. The Treatment Plan Review shall include a review of the offender's understanding and application of competencies. Any missing information from the DVRNA or offender intake evaluation shall be obtained, reviewed, and incorporated into treatment planning. If the information was the offender's responsibility to obtain, the Approved Provider shall consult with the MTT and determine how to proceed regarding the missing information and the of-fender's lack of compliance.

IV. The Second required Treatment Plan Review shall occur two to three months after the completion of the first Treatment Plan Review.

A. Purpose of this Treatment Plan Review is to measure offender progress and motivation, and to determine whether there are additional clinical needs necessary to achieve treatment goals and to determine whether additional Treatment Plan Reviews are needed.

B. The MTT shall determine whether additional treatment plan reviews are needed based on the offender's progress toward meeting treatment goals and offender competencies. If the offender has not met all treatment goals nor met all discharge criteria, then additional Treatment Plan Reviews shall be scheduled. The offender shall be informed of the goals for the next Treatment

Plan Review and the goals shall be identified in writing.

C. Treatment Discharge planning may begin for Level A offenders at this Treatment Plan Review only if offenders can complete all required Treatment Completion Discharge criteria prior to the next Treatment Plan Review (Refer to Standard 5.08 I). Once the discharge criteria have been met, the MTT may determine the discharge date. Treatment Discharge is based on an offender demonstrating and understanding of all required competencies, completion of treatment goals, mitigation of risk, and other factors as identified in the Treatment Plan.

V. Additional or subsequent Treatment Plan Reviews shall be performed as determined by the MTT and shall be done at intervals of two to three months.

A. Offenders placed in Levels B and C shall have at least one additional Treatment Plan Review. The purpose of the Treatment Plan Review is to measure offender progress and motivation, and to determine whether there are additional clinical needs to achieve treatment goals and to determine whether additional Treatment Plan Reviews are needed.

B. The MTT shall determine whether additional treatment plan reviews are needed based on the offender's progress toward meeting treatment goals and offender competencies. If the offender has not met all treatment goals nor met all discharge criteria, then additional Treatment Plan Reviews shall be scheduled. The offender shall be informed of the goals for the next Treatment Plan Review and the goals shall be identified in writing.

C. Treatment discharge planning may begin for Level B and C offenders at this Treatment Plan Review only if all treatment goals and 5.08 I Offender Discharge Treatment Completion criteria have been met or can be met prior to the next Treatment Plan Review. Treatment Discharge is based on an offender demonstrating an understanding and application of all required competencies, completion of treatment goals, mitigation of risk, and other factors as identified in the Treatment Plan (Refer to Standard 5.08 I). Once the discharge criteria have been met, the MTT may determine the discharge date.

VI. A Treatment Plan Review may need to be performed at any time as justified by such factors as a crisis situation for the offender, discovery of new risk factors, new arrest, etc. This Treatment Plan Review would be in addition to the required Treatment Plan Reviews.

VII. Options for offenders in Level A and B Treatment after Treatment Plan Review is performed:

A. Continue the offender's Treatment Plan as designed and review progress, stagnation, or regression with offender, including scheduling additional Treatment Plan Reviews as needed. (Refer to Standard 5.07 V B). Completion of a Treatment Plan Review does not require conducting an individual counseling session with the offender.

B. Increase intensity of the offender's current level of treatment, or increase the level of treatment based on lack of offender progress demonstrated by using offender competencies, identification of additional risk factors, or input from any MTT member.

VIII. Options for offenders in Level C Treatment after Treatment Plan Review is performed:

A. Continue the offender's Treatment Plan as designed and review progress, stagnation, or regression with offender, including scheduling additional Treatment Plan Reviews as needed (Refer to Section 5.07 V B). Completion of a Treatment Plan Review does not require conducting an individual counseling session with the offender.

B. Increase intensity of Level C treatment based on lack of offender progress demonstrated by using offender competencies, identification of additional risk factors, or input from any MTT member.

C. Decrease level of treatment based on offender progress demonstrated by using offender competencies, reducing or mitigating risk, or reviewing reports from probation or the Treatment Victim Advocate. (Shall have consensus of the MTT.)

5.08 Offender Discharge

There are three types of discharge:

- Treatment Completion
- Unsuccessful Discharge from Treatment
- Administrative Discharge from Treatment

For each type of discharge, responsibilities of the offender, MTT, and Approved Provider are identified. MTT consensus is required for discharge. In the event there is a lack of consensus, refer to *Standard* 5.02 VII C.

***Discussion Point**: Protection of the victim is priority. Therefore, if the only information that is available that would prevent offender discharge is victim information and the MTT has determined that victim information cannot be revealed in order to protect the victim and there are no other ways to validate or confirm, then the MTT may determine that discharge is appropriate.*

I. Treatment Completion

A. Offender Responsibilities, Progress in Treatment

The offender has demonstrated adherence to all of the following:

1. All required competencies
2. Conditions of the Treatment Plan

3. Conditions of the Offender Contract

B. MTT Responsibilities

The MTT has verified all of the following:

1. The offender has demonstrated all required competencies, Offender Contract requirements, and other conditions of his/her Treatment Plan;
2. The offender has completed all required Treatment Plan Reviews (not to include the intake evaluation);
3. The required consultation has occurred at each stage of treatment;
4. No additional risk factors have been identified or been reported through other sources outside of offender contact as relevant (e.g. social services, psychiatrist, new partner, parents, or clergy).

   ***Discussion Point**: The MTT may determine who is appropriate or relevant to contact on a case by case basis throughout treatment as well as prior to discharge.*
5. Reduction of risk as reported by Approved Provider, using information from other MTT members, and
6. MTT consensus regarding discharge. The definition of consensus is that members are in agreement.

C. Approved Provider Responsibilities
The Approved Provider shall create a discharge summary to be provided to probation and/or the court. This summary shall document findings from Standard 5.08 I A & B and include at a minimum the following:

1. Type of discharge
2. Information regarding the level(s) of treatment
   a. Initial level of treatment
   b. Any changes to level of treatment
   c. Level of treatment upon completion
3. Information regarding risk factors
   a. Initial risk factors
   b. Any changes to risk factors during treatment, increase or decrease
   c. Identification of current risk factors
4. Verification that the offender Treatment Plan components, offender competencies, and criteria for treatment completion have been demonstrated
5. Duration of offender treatment
6. Summary of verification of MTT responsibilities for discharge (Refer to *Standard* 5.08 I B)
7. Any current or ongoing concerns identified by the MTT.

II. Unsuccessful Discharge from Treatment

A. Offender Responsibilities, Progress in Treatment

Offender has not met responsibilities and requirements related to one or more of the following:

1. All required competencies
2. Conditions of the Treatment Plan
3. Conditions of the Offender Contract

B. MTT Responsibilities

The MTT has verified all of the following:

1. The offender's lack of progress related to offender demonstrating required competencies, compliance with Offender Contract requirements, and other conditions of the Treatment Plan.
2. Completion of any required offender Treatment Plan Reviews (not to include the intake evaluation).
3. Required consultation has occurred at each stage of treatment.
4. Any additional risk factors that have been identified or been reported through other sources outside of offender contact as relevant (e.g. social services, psychiatrist, new partner, parents, or clergy).

   ***Discussion Point**: The above list of other sources is intended to be a guideline regarding whom to contact. The MTT may determine who is appropriate or relevant to contact on a case-by-case basis throughout treatment as well as prior to discharge.*

5. Any increase in level of risk as reported by Approved Provider, using information from other MTT members.
6. MTT consensus regarding unsuccessful discharge. The definition of consensus is defined as the agreement among the MTT members.

C. Approved Provider Responsibilities

The Approved Provider shall create a Discharge Summary to be provided to probation and/ or the court. This summary shall document findings from Standard 5.08 II. A and B and include at a minimum the following:

1. Type of discharge

   Identify offender deficiencies and resistance related to:

   a. Required offender competencies
   b. Treatment Plan
   c. Offender Contract

   Approved Provider has clinically documented the offender's noncompletion of Treatment Plan requirements, including, but not limited to, unwillingness to master all required core and additional competencies as identified in the offender's Treatment Plan and Offender Contract requirements.

2. Information regarding the level(s) of treatment
   a. Initial level of treatment
   b. Any changes to level of treatment
   c. Level of treatment at discharge

3. Information regarding risk factors
   a. Initial risk factors
   b. Any changes to risk factors during treatment
   c. Identification of current risk factors

4. Approved Provider has documented the offender is inappropriate for continued treatment due to the presence of Significant Risk Factors, offender denial, and/or offender lack of progress in treatment.

5. Duration of offender treatment

6. Summary of verifications of MTT responsibilities for discharge (Refer to *Standard* 5.08, B)
7. Any current or ongoing concerns identified by the MTT.

8. MTT consensus for this discharge status and reasoning is documented.

9. Identification of whether the court supervision period has ended and offender has refused to continue in treatment.

III. Administrative Discharge from Treatment

A. Offender Responsibilities

Offender shall provide verification of the need for an administrative discharge as requested by the MTT.

B. MTT Responsibilities

MTT shall verify the reason for administrative discharge.

1. Reasons may include, but are not limited to, circumstances such as the offender is on medical leave, the offender's employment has transferred the offender to a new location, military deployment, or there is a clinical reason for a transfer.
2. MTT consensus for this discharge status and reasoning is documented.

C. Approved Provider Responsibilities

The Approved Provider shall create a Discharge Summary to be provided to probation and/ or the court. This summary shall document findings from Standard 5.08 III A and B and include at a minimum the following:

1. Type of discharge

2. Information regarding the level(s) of treatment

a. Initial level of treatment
b. Any changes to level of treatment
c. Level of treatment at discharge

3. Information regarding risk factors
   a. Initial risk factors
   b. Any changes to risk factors during treatment. Identification of current risk factors

4. Degree to which the offender Treatment Plan components, offender competencies,
   and criteria for treatment completion have been demonstrated

5. Duration of offender treatment

6. Summary of verifications of MTT responsibilities for discharge (Refer to *Standard* 5.08 III B)

7. Any current or ongoing concerns identified by the MTT

8. MTT consensus for this discharge status and reasoning is documented.

IV. Transferring Programs

Approved Providers shall not accept an offender transferring into their program without the responsible referring criminal justice agency's written approval. The receiving Approved Provider, the previous Approved Provider, and the MTT shall perform case coordination, including discussion of any additional treatment that may be required. The final recommendation for treatment shall be determined by the new MTT. The receiving Approved Provider shall require the offender to sign a release of information, allowing the previous Approved Provider to submit a copy of the discharge summary. The previous Approved Provider is required to provide a copy of the discharge summary immediately upon receipt of the release to the receiving Provider.

The Approved Provider shall create a Discharge Summary to be provided to probation and/or the court. This summary shall document findings from Standard 5.08 III. A and B and include at a minimum the following:

A. Type of discharge

B. Information regarding the level(s) of treatment
   1. Initial level of treatment
   2. Any changes to level of treatment
   3. Level of treatment at discharge

C. Information regarding risk factors
   1. Initial risk factors

2. Any changes to risk factors during treatment
3. Identification of current risk factors

D. Degree to which the offender Treatment Plan components, offender competencies, and criteria for treatment completion have been demonstrated

E. Duration of offender treatment

F. Summary of verifications of the MTT responsibilities for discharge (Refer to *Standard* 5.08 III B)

G. Any current or ongoing concerns identified by the MTT

H. Consensus for this discharge status and reasoning is documented.

V. Re-admission into treatment with the same Approved Provider:

Prerequisites for offenders re-entering treatment with an Approved Provider:

a. Consensus of the MTT to re-admit the offender into treatment.

b. Consensus of MTT regarding placement in treatment, including updated evaluation and DVRNA if appropriate.

c. The Approved Provider shall review and update the Offender Contract and Treatment Plan with the offender.

5.09 Couple's Counseling

I. Couple's counseling is not a component of domestic violence treatment. The offender is the client in offender treatment, not the couple, and not the relationship. Therefore, couple's counseling is not permitted during domestic violence offender treatment.

II. The offender is prohibited from participating in any couples counseling while in offender treatment. This includes any joint counseling that involves the offender and the victim.

Because of the potential therapeutic challenges of concurrent treatment along with dangers and risk to victim safety, this standard further clarifies that offenders will not participate in marriage or couple's counseling of any kind with anyone with the victim outside of offender treatment.

6.0 Treatment Contract and Confidentiality

Effective supervision and treatment of offenders is dependent upon open communication among the Multi-Disciplinary Treatment Team (MTT) members. Communication and collaboration among MTT members are required as part of domestic violence offender treatment. Confidentiality in domestic violence offender treatment differs from traditional therapy settings due to the justice involvement and supervision setting.[64] For purposes of evaluation, treatment, supervision and case management, individuals who have committed domestic violence related offenses must agree to the terms of the treatment contract and releases of confidentiality in order to participate in treatment. For information regarding victim confidentiality refer to *Standard* 7.05.

6.01 An Approved Provider shall notify clients of the limits of confidentiality imposed on mental health professionals by mandatory reporting law § 19-3-304, C.R.S. and § 13-21-117, C.R.S. as well as any necessary disclosures related to Extreme Risk Protection Orders (ERPO) pursuant to § Section 13-14.5-104, C.R.S.

6.02 Treatment Contract Requirements

I. The Treatment Contract is the signed treatment agreement between the Approved Provider and the client that specifies the responsibilities and expectations of the client AND the Approved Provider.

II. The provider shall have a written and signed contract with each client prior to the commencement of treatment. The contract shall define the specific responsibilities of both the provider and the client. A client's failure to comply with the terms of the contract may result in discharge from treatment. The provider's responsibility is to practice within their professional standards as defined in the Colorado Mental Health Practice Act and in the Standards and Guidelines established by the DVOMB. A provider's failure to comply with the terms of the contract may result in a complaint with the Colorado Department of regulatory agencies or the DVOMB.

A. The contract shall explain the responsibility of the provider to:

1. provide the costs of assessment, evaluation, treatment, and a sliding scale based on eligibility;
2. notify the client in writing of the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304, C.R.S. and

[64] In accordance with the §12-43-218, C.R.S., Approved Providers shall safeguard the confidentiality of offender information from those for whom waivers of confidentiality have not been obtained.

to Section 1243-219, C.R.S.;

3. Describe the Releases of information required to share and receive information about the client as part of the treatment process pursuant to THIS SECTION of these Standards and Guidelines;
4. Describe the client's right to refuse treatment, release of information, or any other treatment related document. refusal can result in failure to be admitted into treatment which could be a violation of the sentencing requirement or parole agreement;
5. Describe how progress in treatment is measured regarding the duration, intensity, and methods;
6. Describe the importance of how following any required orders of the court or parole board, or conditions of any community corrections placement is a requirement of treatment;
7. Establish expectations for the client to meet the requirements of the treatment contract, the potential outcomes to the client for failing to comply with the treatment contract, and possible reasons why a client can be terminated from treatment;
8. provide information on crisis response and 24-hour emergency services;
9. provide the procedures for how to file a complaint should the client have concerns regarding the approved provider or their services;
10. inform the client of the parameters of teletherapy and have a signed agreement by the client in accordance with standard 5.04 and appendix I, if applicable;
11. request any prior treatment or medical records as needed and relevant to assessing the client for treatment purposes.
12. Notify the MTT of violations or noncompliance by the client and provide notice to law enforcement and/or courts, when appropriate.

B. It is considered to be best practice for the Approved Provider to explain:

1. Potential costs associated with any recommended adjunct services as needed, including but not limited to medical, behavioral health, psychological tests, and other consultations;
2. The steps and potential consequences for individuals who are removed from group or individual services;
3. The process for how violations of the Treatment Contract or noncompliance with the Treatment Plan are addressed and may lead to termination from treatment.

C. The contract shall explain the responsibility of the client to:

1. Meet financial responsibilties and Pay for the costs of current and prior assessment and treatment and include potential outcomes for any failure to pay. The client may also be required to pay for the costs of treatment for the victim(s) of the client's abusive behavior, as well as secondary

victims such as family members;

2. Sign releases of information as required by these standards Including but not limited to: Supervising officer/referring agent, treatment victim advocate, and any other release of information requested by DVOMB Treatment Provider or Evaluator.
3. Disclose any prior treatment including domestic violence offender treatment and agree to a release of information to obtain prior evaluation and treatment records;
4. Not use any substance illegally or in a way that impedes with treatment goals or interferes with the client's motivation, engagement, or compliance with supervision or treatment requirements;

   ***Discussion Point**: Approved Providers are encouraged to follow the ethical code for mental health and substance use professionals when assessing for issues. If there are clinical indicators that a client's active use or misuse of any substance, including a medical use of thc, is interferring with treatment, the mtt should document those concerns and notify the presiding court. approved providers may recommend substance use treatment at any time during the course of treatment and ultimatley may choose to not offer treatment due to a client's active use or misuse of any substance regardless if there is a court order allowing for the client to use.*

5. Attend and participate in Domestic Violence offender treatment, including cooperating with monitored sobriety and attendance requirements as directed in the *Standards and Guidelines*;
6. Follow the established group norms and understand that you can be required to leave the group if asked to do so by the approved provider.
7. Never record any information before, during, or after the session. This is considered a violation of client and other client confidentiality. Clients shall not document any information about other clients or other information that is not relevant to their progress in treatment.
8. Never copy, plagiarize, or use artificial intelligence for any aspect related to evaluation or treatment.
9. Comply with the limitations and restrictions as described in the terms and conditions of probation, parole, and/or community corrections;
10. Comply with ANY existing criminal or civil court orders and to notify the Provider and the supervising officer of any changes with any existing court orders;
11. Not violate criminal statutes or ordinances (city, county, state, or federal);
12. Not purchase or possess firearms or ammunition unless there is a specific court order expressly allowing the offender to possess firearms and ammunition.

***Discussion Point**: In these cases, it is incumbent upon the client to provide a copy of the court order to the Approved Provider to qualify for this modification of the Treatment Contract. The MTT should collaboratively design a safety plan to address factors related to client risk and victim safety. An approved provider has the choice to refuse a client into treatment or continue with a client in treatment, regardless if there is a court order allowing the client to have access to a firearm.*

13. Not participate in any couple's counseling or family counseling while in domestic violence offender treatment. This includes any joint counseling that involves the offender and the victim or secondary victims to the index offense;
14. Not threaten, harass, intimidate, monitor, or stalk any individuals, including members of the MTT;
15. Not reoffend, avoid high-risk situations, choose to be free from violence and abusive behaviors, and report any such behavior to the provider and the supervising officer as soon as possible;
16. Not have unsafe or unwanted contact with any past or potential victims;
17. Understand the potential consequences of violations of the treatment contract.

D. If the client is eligible for Teletherapy, the contract shall also explain the responsibility of the client to:

1. Adhere to the offender treatment contract and adhere to all in-person rules regarding group norms and behaviors.
2. Use a webcam or smartphone during the session that allows for the client and their surroundings to be seen by the Approved Provider.
3. Access a reliable and secure internet connection in a private, quiet, confidential, well-lit space free from distractions.
4. Understand the steps to access the session via phone in the event of technical problems.
5. Notify their DVOMB Approved Provider if they are having trouble comprehending the material or content.
6. Agreement by the client to not have anyone else in the session unless approved by the MTT.
7. Agree to additional behavioral monitoring and monitored sobriety testing to the frequency determined by the Approved Provider.
8. Consequences of not complying or participating in domestic violence treatment.

E. Client Absences from Treatment

All client absences shall be reported within 24 hours of the absence to the

MTT. The Treatment Victim Advocate will determine if the victim shall be notified according to the agreement with the victim (Refer to Standard 7.0 in its entirety). The referring agency may request a modification of the notification criteria.

Clients are responsible for participating in treatment. When a client has two absences within a Treatment Plan Review period, the Approved Provider shall consult with the MTT to determine what actions or modifications to the Treatment Plan may be needed, if any, to improve the client's amenability and readiness to participate in treatment. These efforts should consider circumstantial events within the client's life and aim toward preventing the client from further absences from treatment. The consequence of two or more absences does not automatically result in a discharge of a client, but rather the initiation of case planning by the MTT. However, failure to attend or continued patterns of absences can be grounds for unsuccessful discharge. The MTT may require the offender to provide documentation of reasons for absences.

6.03 Releases of Information

I. When enrolling a client in treatment, a provider shall obtain certain signed releases of information based on the informed consent of the client in accordance with all applicable statutes and regulations including but not limited to the mental health practice act[65] and Health Insurance Portability and Accountability Act (HIPAA). The information shall be provided in a manner that is easily understood, verbally and in writing. The information shall be in the client's primary language, a secondary language in which they are fluent, or through other modes of communication as may be necessary to enhance understanding. The Approved Provider shall present the following releases, which should each be completed as a separate document with its own signature from the client:

A. Required Treatment Release of Information for the Multi-Disciplinary Treatment Team: Releases of information are a requirement of participation in Domestic Violence Offender Treatment as a condition of probation, parole, and community corrections. The Approved Provider shall:

1. Obtain a release of information for all members of the MTT as well as the victim(s) of record and may include but is not limited to the current or former partner(s) of the client, any current or past therapist or Approved Provider, any guardian ad litem, or other professionals working on behalf of the adult and child victims of the offender. E
2. Ensure the release is documented and explains that written and verbal information will be shared between all members of the MTT in the interest of continuity of care, case planning, and victim safety.

***Discussion Point**: Members of the MTT should use discretion in disseminating information to current or former partners. Consideration for victim safety shall guide the decisions.*

[65] Mental Health Practices Act, Title 12, Article 245.

B. Release of Information for Research Purposes: For research or data collection purposes, a provider shall present a release for voluntary informed consent by the client. The client may agree to a release of confidentiality for information to be shared with the Board for the purpose of research related to the evaluation or implementation of the Standards and Guidelines for domestic violence offender management in Colorado, in compliance with 45 CFR § 164.508 and pursuant to 16-11.8-103(5.5)(a), C.R.S.

Discussion Point: *The research release is voluntary and should be presented for the client's review and determination for voluntary informed consent. All other releases are required for domestic violence offender treatment.*

C. Required Release for the Domestic Violence Offender Management Board: A provider shall present a release for voluntary informed consent by the client and that their records may be reviewed as part of any application, complaint, standards compliance review, or technical assistance request.

6.04 An Approved Provider may obtain a release of information for communication with other parties in addition to those described and required in Section 6.0 as clinically necessary.

7.0 Victim Advocacy

Victim advocacy in offender treatment is critical in order to continually address victim safety issues. Victim safety and offender risk are fluid and dynamic. Shared information among professionals involved in the case and shared decision making are vital in this work. These are necessary, critical, and interdependent parts of treatment.[66] In the interest of victim and community safety, the purpose of treatment is to foster conditions that allow the offender to:

(a) Manage effectively the individual factors that contribute to abusive behaviors;
(b) Develop strengths and competencies to address criminogenic needs;
(c) Identify and change thoughts, feelings and actions that may contribute to offending, and;
(d) Establish and maintain stable, meaningful, and pro-social lives.

Victim and community safety are the highest priorities of the Standards and Guidelines. This should guide the responses of the criminal justice system, victim advocacy, human services, and domestic violence offender treatment. Whenever the needs of domestic violence offenders in treatment conflict with the needs of community (including victim) safety, community safety takes precedence.[67]

Treatment Victim Advocates (TVA) serve in a capacity to provide community-based victim advocacy services that are enumerated in 13-90-107, C.R.S. and possess the mandated privileges and confidentiality protections defined in statute for the purpose of these Standards and Guidelines. For more information regarding the statute, see 13-90-107 C.R.S.

The following section outlines the requirements necessary to become a Treatment Victim Advocate (TVA), the role of the TVA, and what initial and ongoing victim advocacy services require. It is the expectation of the DVOMB that individuals also governed under the Mental Health Practice act (Title 12, Article 43 of the Colorado Revised Statutes) will also comply with the statutes, rules, and policies of their Governing Board. Resources and forms for victim advocacy are available on the DVOMB website.[68]

[66] DVOMB Standards and Guidelines, Section 3.0: Guiding Principles.
[67] DVOMB Standards and Guidelines Section 3.01: Guiding Principles.
[68] https://dcj.colorado.gov/boards-commissions/domestic-violence-offender-management-board

7.01 Treatment Victim Advocate Responsibilities

I. Treatment Victim Advocate

All Approved Providers shall have a qualified, designated professional in the role of Treatment Victim Advocate.

II. Dual Roles

Approved Providers shall not have a dual role with her/his advocate as defined in DVOMB Standards Section 7.03 VIII. Dual Roles.

III. Treatment Victim Advocate Qualifications

See DVOMB Standards Section 7.03 Qualifications of Treatment Victim Advocate.

IV. Notification to the DVOMB Office

A. Approved Providers shall update the name of their Treatment Victim Advocate (TVA) in the Provider Data Management System, including the TVA's current contact information, and verification of the TVA's qualifications.
B. Additionally, a confirmation letter from the TVA verifying that advocacy is being provided per the DVOMB Standards and Guideline shall be provided to DVOMB staff.

V. Cooperative Relationships

Approved Providers, in conjunction with their TVA, shall be knowledgeable about victim resources. Providers shall also maintain cooperative working relationships with both community-based and system-based allied professionals for the purpose of enhancing comprehensive safety and support for domestic violence victims.

VI. Provider Responsibilities when Utilizing a New Treatment Victim Advocate

When a TVA ends service with a Provider or treatment agency, the Provider is responsible for ensuring continuity of care for victim advocacy services between the outgoing TVA and the new TVA. The Provider shall provide necessary information regarding the offender and victim contact information for the new TVA to maintain ongoing contact with the victim as requested.

7.02 Role of Treatment Victim Advocates

Victim advocates are highly trained, experienced, knowledgeable, and skilled professionals. The victims of these complex and dangerous crimes require a specialized victim advocacy approach with training in intimate partner violence. The TVA provides an opportunity for victims to participate in the multidisciplinary treatment team (MTT) process. If the victim is provided the opportunity and elects to participate, the TVA will represent the victim within the MTT. The TVA also represents experiences and perspectives of victims in general within the MTT, regardless of whether the specific victim engages in services or not.

I. TVAs are an integral member of the MTT, and work with the MTT and the Approved Provider to:

   A. Function as a liaison, and will represent the victim and/or general victim considerations within the MTT.

   B. Participate in MTT problem solving during case management and staffings.

      ***Discussion Point**: The role of the TVA on the MTT includes identifying erroneous beliefs or attitudes that, if present, may be harmful to victims.* The TVA promotes more comprehensive case conceptualization for the MTT to understand the meaning and impact of victim and offender behaviors, even when the members of the MTT have conflicting (different) information.

   C. Collaborate with the MTT to engage in an in-depth conversation around domestic violence dynamics.

      1. Provide trauma-informed education and perspectives related to victim experiences.

      2. Provide knowledge concerning victim safety. For example:
         - Criminal/civil protection orders
         - Safety planning
         - Potential for future harm

   D. Provide outreach to the offender's current or past non- victim partner, as appropriate and determined by the TVA, the approved provider, and the MTT based on specific identified concerns (see standard 6.03 for information about requirements for waivers of confidentiality).

      ***Discussion Point**: While it may be appropriate for a TVA to reach out to a current or past non-victim partner, this is not required and should only be done based upon MTT consensus.*

7.03 General Requirements for Treatment Victim Advocates

I. TVAs shall:

A. Be familiar and comply with these DVOMB Standards and Guidelines.

B. Be Violence Free and not engaged in any acts of domestic violence, including physical or verbal abuse, threats, coercion, or intimidation of others.

C. Not have a conviction of, or a deferred judgement (other than a traffic violation of 7 points or less) for a municipal ordinance violation, misdemeanor, felony, or have accepted by a court a plea of guilty or nolo contendre to a municipal ordinance violation, misdemeanor, or felony if the municipal ordinance violation, misdemeanor, or felony is related to the ability to be an effective advocate under these Standards and Guidelines, as demonstrated at a minimum by a Colorado bureau of investigation criminal background check.

D. Not have any civil dispute that is related to the ability to Practice as an effective advocate under these standards and guidelines.

E. Be aware that any history of victimization and trauma may impact their work with victims and limit their ability to be an effective advocate.

F. Maintain victim confidentiality and not disclose confidential communications in accordance with these standards and 13-90-107, C.R.S.

G. Not have a dual role with their Approved Provider, the offender or the victim.

***Discussion Point**: It is the expectation of the DVOMB that individuals also governed under the Mental Health Practice act (Title 12, Article 43 of the Colorado Revised Statutes) will also comply with the statutes, rules, and policies of their Governing Board.*

A dual role can include, but is not limited to:

1. A relationship with the Provider that is likely to impair the TVA's professional judgement (e.g., spouse, relative, etc.).

2. A relationship in another therapeutic or case management capacity with the **same** domestic violence offenders or victims **for whom they are providing TVA services**.

3. A relationship with more than one person in an intimate partner relationship within the same treatment agency or across multiple treatment agencies.

   Discussion point: if TVAs receive a referral for both partners of an intimate relationship, they should discuss the potential for a dual role with the providers and identify alternatives for one of the partners.

4. Any other relationship with the victim or the offender. This will impair the TVA's judgement or increase the risk of client exploitation.

   ***Discussion Point**: dual relationships can create barriers to an open and honest dialogue. The advocate may be concerned about raising issues that may potentially impact the personal or other relationship with the provider. Dual roles may be confusing to a victim and impact their ability to trust the advocate. If TVAs have a concern for a potential dual role, they should contact the DVOMB or their licensing authority.*

7.04 Qualifications for Treatment Victim Advocates Status

There are two practice levels for TVAs: provisional and certified.

I. Provisional Treatment Victim Advocate Requirements

Provisional level is for individuals who want to start the process of becoming a certified TVA. Provisional TVAs may begin accumulating the required experiential and training hours for certification through Colorado organization for victim assistance (COVA) or national organization for victim assistance (nova) the COVA domestic violence treatment victim advocate certification or nova basic advocate credential with domestic violence specialty shall be applied for within two years of working as a provisional domestic violence treatment victim advocate.

A. Experiential Criteria:

   Provisional TVAs shall:

   1. Possess a minimum of 70 hours of experience working with domestic violence victims. These hours may be achieved through any combination of employment, volunteer work, or internships.

   2. Obtain the additional 70 experiential hours within two years as required for certification as a TVA.

B. Training Criteria:

Provisional TVAs shall:

1. Possess a minimum of 30 initial hours of training in domestic violence to include: victim advocacy, domestic violence dynamics, victimization, safety planning, confidentiality, and mandatory reporting.

2. Obtain the additional 30 hours of training within the two years required for certification as a TVA.

   ***Discussion Point**: training is a helpful component for the work of a provisional TVA, and obtaining as much training as possible within the first year of work is beneficial.*

C. Peer Consultation is strongly encouraged with other Certified Domestic Violence TVAs, or with local victim services. Peer Consultation may include:

1. Sharing information about training opportunities

2. Sharing information regarding resources

3. Confidentiality issues
4. Advocacy on behalf of a specific population

5. Technical assistance, safety planning, and brainstorming difficult cases

II. Certified Treatment Victim Advocate

Certification through either the Colorado organization for victim assistance (COVA) or the national organization for victim assistance (NOVA) national advocate credentialing program is required. These programs are administered through COVA and nova.

- COVA certification as a treatment victim advocate

- NOVA certification as a basic victim advocate with domestic violence specialty

  Discussion point: the NOVA certification is not specifically designed for treatment victim advocates. However, those who have a nova certification as a basic victim advocate with domestic violence specialty should meet the requirements of the COVA certification. The trainings identified below may not correspond with the nova training requirement categories of the application.

A. Experiential Criteria

COVA certification requires verification (e.g., letter from approved provider to verify hours, documentation of work as an advocate, or hours log of TVA work) of a minimum of 2 years (full or part-time) of active status or volunteer work experience in the field, or a minimum of 140 service hours. Service hours must include direct service to victims (phone or in person) but may also include case review meetings (including MTT meetings), shadowing, case management, and staff supervision.

B. Training Criteria

Certified domestic violence TVAs are required to have a minimum of 60 total hours of initial training, which includes the electives, and then 32 additional hours of continuing education every 2 years.

Training hours per the COVA program for certified domestic violence treatment victim advocate with focus on the following:

1. Victimology topics (15 hours)
2. Advocate skills (15 hours)
3. System agency response (15 hours), and
4. Electives specific to domestic violence treatment advocacy (15 hours), including but not limited to:

   DVOMB CORE trainings and domestic violence offender issues such as:

   - The Domestic Violence Risk and Needs Assessment (DVRNA)
   - DVOMB Standards and Guidelines
   - Multi-disciplinary treatment team
   - Domestic violence offender treatment competencies.
   - Domestic violence characteristics and dynamics
   - Risk/lethality assessment
   - Confidentiality
   - Safety planning
   - Co-occurrence of domestic violence and child abuse

- Topics could include, but are not limited to, intimate partner violence and the impact on the child
- Elder abuse
- Special victim and offender populations
- Client/TVA boundaries

Discussion Point: The DVOMB recognizes that there are many diverse trainings available for TVAs that will support them in their certification training requirements, and encourages TVAs to seek out additional quality training options as well as share them with other TVAs. The trainings identified above should correspond with the COVA training requirement categories of the application.

C. Peer consultation is strongly encouraged with other Certified Domestic Violence TVAs, or consultation with local victim services. Peer consultation may include:

1. Sharing information about training opportunities
2. Sharing information regarding resources
3. Confidentiality issues
4. Advocacy on behalf of a specific population
5. Technical assistance, safety planning, and brainstorming difficult cases

D. Specific Offender Populations

Specific offender populations are defined as a group of individuals that share one or more common characteristics such as race, religion, ethnicity, language, gender, age, culture, sexual orientation, and/or gender identity that would allow for the group to be considered homogenous.[69]

If Approved Providers are specializing in a specific population of offenders, the Domestic Violence TVA shall have a minimum of seven (7) hours of training on each specific offender and victim population.

E. Continuing Education and Renewal of Advocacy Certification

1. Renewal of COVA or NOVA certification is required every 2 years.
2. TVAs shall submit proof of recertification to the Approved Provider.

[69] DVOMB Standards Appendix C - Glossary of Terms and Section 9.07.

7.05 Initial and Ongoing Advocacy

TVAs shall provide initial and ongoing advocacy with the victim contingent on the victim's willingness to participate. Whether the victim opts to participate in TVA services, or not, should not impact the offender's status in treatment. The offender shall be required to provide a release of information for the victim including any available contact information. The release of information shall also include the current partner for more information about when to contact the current partner, see section 7.02 i. D. Above.

I. TVA's Initial Contact with the Victim

A. The TVA shall make initial contact to each victim once the offender begins treatment and signs the release of information. The approved provider shall share victim contact information, if available.

B. The TVA may also reach out to the victim at additional times during the offender's treatment, based on the victim's willingness to participate with the TVA. If there is a victim safety issue, the TVA shall contact the victim to provide this information to the victim.

C. The TVA may need to find recent contact information for victims through the probation VSO, the supervision officer, a law enforcement agency, or the district attorney's office. The TVA should not attempt to locate or contact victims using social media and the internet unless confidentiality and safety are addressed.

***Discussion Point**: TVAs are responsible for receiving training on the safe use of technology if they are going to contact the victim through social media or the internet.*

D. The TVA shall inform the victim of the extent of the information that will be provided regarding the offender's treatment during TVA victim contacts. Information to be shared may include, but not be limited to, enrollment, attendance, discharge, and victim safety concerns.

E. During the initial contact, the TVA shall also explain the limits of confidentiality regarding the information that is shared during the TVA victim contact, including any mandatory reporting obligations of suspected abuse or neglect of children.[70]

1. All TVAs have a responsibility to report suspected abuse or neglect of

[70] See Section 7.05 regarding Confidentiality for more information.

children and shall report as required by community-based victim advocacy requirements.[71]

2. Advocates shall inform victims of this upon initial contact and as appropriate during victim contacts.

3. Advocates may inform the Approved Provider when a report has been made with the victim's permission.

F. The TVA contact(s) shall address the following:

1. A brief explanation of the role of the TVA

2. Explanation of confidentiality requirements for community-based victim advocates and how TVAs follow these requirements whether or not the victim wishes to be contacted including preferred and most secure method of contact.

3. General overview of the domestic violence offender treatment process.

4. General domestic violence dynamics and information, as appropriate.

5. Address safety concerns with the victim and safety planning as needed.

6. Provide referrals and resources, including information about protection orders, as appropriate.

***Discussion Point**: the TVA may share other information, such as specific offender treatment information, based on the circumstances of the case. However, TVAs should consult with the MTT and use caution when considering whether to share additional information, in order to not compromise victim safety.*

71 The privilege established by C.R.S. 13-90-107: Who may not testify without consent states:
(k) (I) A victim's advocate shall not be examined as to any communication made to such victim's advocate by a victim of domestic violence, as defined in section 18-6-800.3 (1), C.R.S., or a victim of sexual assault, as described in sections 18-3-401 to 18-3-405.5, 18-6-301, and 18-6-302, C.R.S., in person or through the media of written records or reports without the consent of the victim. (II) For purposes of this paragraph (k), a "victim's advocate" means a person at a battered women's shelter or rape crisis organization or a comparable community-based advocacy program for victims of domestic violence or sexual assault and does not include an advocate employed by any law enforcement agency: (A) Whose primary function is to render advice, counsel, or assist victims of domestic or family violence or sexual assault; and (B) Who has undergone not less than fifteen hours of training as a victim's advocate or, with respect to an advocate who assists victims of sexual assault, not less than thirty hours of training as a sexual assault victim's advocate; and (C) Who supervises employees of the program, administers the program, or works under the direction of a supervisor of the program.

G. TVA Records and Retention

The TVA shall document any victim contact, or attempted contact, in a file separate from the offender's treatment file. No one, including the Approved Provider, shall have access to the TVA's records. Records retention should follow the requirements of community-based advocates. The TVA notes may be brief and general in nature regarding the victim contact.

7.06 Privilege of Confidential Victim Advocates

For the purpose of these standards and guidelines, treatment victim advocates (TVA) serve in a capacity to provide community- based victim advocacy services that are enumerated in 13-90-107, C.R.S. and possess the mandated privileges and confidentiality protections defined in statute. For more information regarding the statute, see 13-90-107 C.R.S.

The community-based victim advocacy statute states, in part, that "a victim's advocate shall not be examined as to any communication made to such victim's advocate by a victim of domestic violence, as defined in section 18-6-800.3(1), C.R.S. in person or through the media of written records or reports without the consent of the victim."

I. Importance of Victim Confidentiality

The ability to have confidential communications with and confidential assistance from domestic violence treatment advocates is critical for victims of domestic violence, both for their safety and for their ability to reach out to and to trust advocates.

***Discussion Point**: It is the treatment victim advocate's responsibility to know the different types and roles of other advocates and victim assistants in community-based organizations or in the criminal justice system. Other advocates have different duties and requirements in regard to confidentiality of victim information. (reference DVOMB website MTT resources document: explanations of the different advocate roles in Colorado).*

II. It is important for advocates to explain the benefits and limitations of confidentiality to the victims they assist. When **a victim chooses** not to provide information, the approved provider, the MTT and the treatment victim advocate shall honor the victim's decision and right to control their own information.

III. Consultation with the Provider

A. If the victim does give verbal or written permission, the TVA can discuss offender behavior or victim concerns with the Provider. The TVA and Provider will discuss ways the offender behaviors can be addressed in treatment, without the offender knowing the information was provided by the victim. The offender shall not be given any indication that the victim provided information, as protecting information shared by the victim is critical.

B. If the victim does not give permission for the TVA to discuss specific information with the Provider, the TVA shall respect the victim's wishes. The advocate can discuss general victim considerations but shall not discuss specific victim information.
C. TVAs shall know the Approved Provider's or agency's confidentiality policies and procedures, as they may be different from the TVA's confidentiality requirements.

IV. Exceptions to victim confidentiality

A. When reporting suspected abuse or neglect of children, TVAs shall:

1. Inform victims of this upon initial contact and as appropriate during victim contacts.
2. Notify the victim when a report is made for suspected child abuse or neglect, or when their information is shared under a court order
3. Advocates may inform the Approved Provider when a report has been made with the victim's permission.

B. Informed consent for releases of information

1. The TVA shall explain options to victims regarding providing consent before their information is shared by the TVA with anyone else, including other members of the MTT.

2. TVAs shall document the victim's verbal consent and all conditions that apply, and then written consent should be obtained as soon as possible. Victim consent should be informed, written, and reasonably time-limited. Victim consent may be obtained ***verbally*** for information being shared ***only*** with the Approved Provider.

3. Treatment Victim Advocates shall honor victims' rights and choices regarding what, if any, victim information will be shared, and with whom including:
   - What specific victim information the advocate will be sharing

- Who the information is to be shared with
- How that information may be utilized
- When that information will be shared
- The time period for the release

C. TVA Role in Facilitating Releases of Information

1. A release of information from the victim is not required for advocacy to be provided by a TVA. A sample release form is available on the DVOMB website.

2. When a victim requests that information be shared with the offender or the MTT, the TVA is responsible for:
   - Exploring with the victim the possible range of consequences of sharing the information.
   - Obtaining a written release from the victim is required to share the information with the MTT and the offender. Ensuring that the Approved Provider and MTT consider how to effectively address the victim's concerns in order to consider the impact to the victim and victim safety. The information might not be directly shared with the offender, but rather the offender's treatment plan may be modified to address the issues of concern. The TVA should release the minimum information necessary to support the victim interests.
   - Informing the victim of the MTT plan for addressing the victim's concerns and modify the safety plan accordingly.

3. TVAs shall accept a victim's verbal request to withdraw a release of information. The advocate shall obtain verification in writing from the victim as soon as possible.

4. TVAs shall not accept a release of information form from another agency in lieu of a release of information from their own Approved Provider or agency.

7.07 Domestic Violence Treatment Victim Advocates Resources

Domestic violence TVAs shall be, at a minimum, knowledgeable about the following victim resources in the communities that domestic violence TVAs and/or the approved providers for whom they work serves:

- Community-based victim advocacy services, including shelter services[72],

[72] https://dcj.colorado.gov/boards-commissions/domestic-violence-offender-management-board

- The role of the probation victim service officer (VSO) and how to collaborate/coordinate victim services,
- The role of the parole victim services unit and how to collaborate/coordinate victim services,
- Address program confidentiality,
- Behavioral health services,
- Sexual assault support services,
- Culturally and linguistically appropriate services, and
- How to locate similar resources in other areas that may be of interest to victims.

8.0 Coordination With The Criminal Justice System

8.01 Community Relationships

Approved Providers shall not practice in isolation. Approved Providers have a responsibility for developing a community approach to the provision of treatment. They shall maintain cooperative working relationships with domestic violence victim services, other Approved Providers and criminal justice programs, as well as alcohol/drug abuse programs and social services. In order to increase networking opportunities, it is recommended that Approved Providers attend community-based task force meetings.

8.02 Initial Contact

If a criminal justice agency makes a referral to an Approved Provider, that Approved Provider shall notify the criminal justice agency if the offender does not make contact within the time frame indicated. If no time frame was included with the referral, the Approved Provider shall notify the criminal justice agency within one week if the offender does not contact the Approved Provider.

8.03 Initial Appointment

Approved Providers shall make all reasonable attempts to provide an initial intake appointment within one week of contact by the offender.

8.04 Refusal to Admit

Approved Providers shall provide written documentation with reasons for refusal to admit to treatment to the responsible criminal justice agency within one week.

8.05 Transferring Programs

Approved Providers shall not accept an offender transferring into their program without the responsible criminal justice agency's written approval. The receiving Approved Provider, the previous Approved Provider, and the MTT will do case coordination, including discussion of any additional treatment that may be required. The final recommendation for treatment will be determined by the receiving Approved Provider.

8.06 Reporting

A monthly written summary report shall be sent to the offender's responsible criminal justice agency and shall include information on attendance, payment of fees, participation, offender progress, and any violations of the offender contract. The responsible criminal justice agency may request additional information regarding level of participation in treatment.

8.07 Absences

An offender may not be successfully discharged unless the offender has completed all the required Treatment Plan goals and met all discharge criteria. The responsibilities of the offender contract shall include the following agreements by the offender:

I. Offenders are responsible for attending treatment.
II. If an offender has more than three absences, the MTT shall consult to determine any needed consequences or modifications to the Treatment Plan. The MTT may require the offender to provide documentation of reasons for absences.
III. All offender absences shall be reported within 24 hours of the absence to the Treatment Victim Advocate and the referring agency. The Treatment Victim Advocate will determine if the victim shall be notified according to the advocacy agreement with the victim (Refer to Standard Section 7.0 in its entirety). The referring agency may request a modification of the notification criteria.

8.08 Individual Treatment

Individual treatment (50 minute minimum) may be utilized on a case by case basis if the Approved Provider can demonstrate to the MTT an appropriate need for this treatment, such as crisis intervention, initial stabilization, or to address severe denial at the beginning of treatment. If individual treatment is the only form of treatment, it shall be for special circumstances. The Approved Provider shall document these special circumstances and the MTT consultation notes in the offender's case file.

8.09 Length of Treatment

These Standards incorporate different levels of treatment and focus on offender risk. The length of treatment is determined by individual offender risk and progress in treatment (Refer to Overview Chart on page 5-38).

8.10 Intensity of Treatment

The MTT shall have consensus when modifying the level of treatment for an offender and agree to related changes in the treatment plan.

I. ***There are three levels of treatment*** that include Level A (low intensity), Level B (moderate intensity), and Level C (high intensity). Offenders are placed in a level of treatment based on the findings from the intake evaluation, offender treatment needs, and level of risk as identified by the DVRNA. Research demonstrates that matching offender risk to intensity of treatment reduces recidivism (Andrews & Bonta, 1994). Intensity of treatment is differentiated by frequency of clinical contact and content of treatment.

II. ***Initial Determination of Treatment Level*** is recommended by the Approved Provider after the Offender Intake Evaluation has been completed and approved by

the MTT. While some offenders may remain in the same level throughout treatment, there is also the ability to move offenders to a different level of treatment as needed. This is based on new information such as change in risk factors, mitigation of risk, continuing abuse, or denial.

A. Only offenders in Level C may be considered for a decrease in treatment level and then only to Level B.

B. No offenders in Level B or C are eligible for a decrease in treatment to Level A.

C. Decreasing an offender's level of intensity of treatment shall only occur at scheduled Treatment Plan Review intervals and shall be approved by consensus of the MTT. This change in treatment level shall include written justification placed in the offender's file describing the need for change in treatment.

D. Increasing an offender's level of treatment to a higher intensity of treatment may occur at any time and shall be approved by consensus of the MTT. This change in treatment level shall include written justification placed in the offender's file describing the need for change in treatment.

8.11 Violations of Offender Contract

Violations of Offender Contract or noncompliance with the Treatment Plan may lead to termination from the program. At a minimum, written or verbal notification of the violations shall be provided to the MTT. Notification of the violations on noncompliance will be provided to law enforcement and/or courts, when appropriate. Violations of the Offender Contract may include exhibiting signs of imminent danger to others or escalating behaviors that may lead to violence.

8.12 Treatment Discharge

Refer to *Standard* Section 5.08 – Offender Discharge

8.13 Out-of-State Court Orders

Approved Providers will comply with Section 17-27.1-101 et. seq., C.R.S. Failure to comply may result in legal and monetary penalties pursuant to Section 17-27.1-101(9)(a), C.R.S.

9.0 Provider Qualifications

Due to the nature and seriousness of domestic violence, professionals who work with domestic violence offenders require training, competencies, and expertise in domestic violence offender dynamics and victim safety.[73] The following section outlines the requirements necessary to become a DVOMB Approved Provider, and to continue practicing as a DVOMB Approved Provider (hereafter Approved Provider). Nothing within this section alleviates an Approved Provider from their duty to adhere to their ethical code of conduct of their credential, pertaining to supervision and consultation.

I. Pursuant to Section 16-11.8-104, C.R.S., domestic violence offender services shall only be provided by a DVOMB Approved Provider. Providers not on the DVOMB Approved Provider List, including any provider who is denied placement or removed from the Provider List, shall not provide any treatment, evaluation, or assessment services pursuant to statute in Colorado to domestic violence offenders. No referral source shall use any provider not on the Provider List, denied placement or removed from the Approved Provider List per Section 16-11.8-104, C.R.S.[74]

II. Listing as an Approved Provider

There are three practice levels and three specific listing categories available on the DVOMB Approved List.

- Associate Level Provider Candidate – Section 9.01
- Associate Level Provider – Section 9.02
- Full Operating Level Provider – Section 9.03
- Domestic Violence Clinical Supervisor (DVCS) – Section 9.04
- Specialized Pre-Sentence Evaluator Listing – 9.05
- Specific Offender Population Listing – 9.06

[73] Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., . . . Solano, I. (2016). Domestic Violence Perpetrator Programs: A Proposal for Evidence-Based Standards in the United States. Partner Abuse, 7(4), 355-460. doi:10.1891/1946-6560.7.4.355. Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. International Journal of Mental Health Nursing, 17, 57-64.; Roth, A. D., Pilling, S., & Turner, J. (2010). Therapists training and supervision for clinical practice. Behavioural and Cognitive Psychotherapy, 38, 291-302.

[74] Pursuant to 16-11.8-104(1) C.R.S, On and after January 1, 2001, the department of corrections, the judicial department, the division of criminal justice within the department of public safety, or the department of human services shall not employ or contract with and shall not allow a domestic violence offender to employ or contract with any individual or entity to provide domestic violence offender treatment evaluation or treatment services pursuant to this article unless the individual or entity appears on the approved list developed pursuant to section 16-11.8-103 (4).

Specific Offender Population (SOP) is a listing category for either female and/or LGBTQIA+ offenders. Once approved by the DVOMB, these individuals may provide domestic violence services to that population.

- Teletherapy Listing – 9.07

  Teletherapy means to deliver services through a secured telecommunications system that facilitates the synchronous, real-time, video-based assessment, treatment, and behavioral management of a domestic violence offenders in locations different from the Approved Provider. Only those Approved Providers who have applied and been approved by the ARC shall be able to provide domestic violence offenders services via teletherapy.

III. Out-of-State Equivalency Applications: Individuals who hold professional licensure, domestic violence offender (intimate partner) or batterer intervention licensure, certification or approval, and reside outside Colorado may seek Associate or Full Operating Level status if they meet all of the qualifications listed in the *Standards and Guidelines*. Required supervision hours must have been provided by an individual whose qualifications substantially match those of a DVOMB DVCS as defined in these Standards. Out-of-state applications will be reviewed on a case-by-case basis.

IV. Required Minimum Content of a Domestic Violence Clinical Supervision Contract

The Domestic Violence Clinical Supervision Contract is the signed supervision agreement between a supervisee and a Domestic Violence Clinical Supervisor (DVCS). Clinical supervision as part of Section 9.0 of the Standards refers to the supervision of a supervisee regarding domestic violence offender services that fall under the purview of the DVOMB. A supervisee is anyone under these Standards and Guidelines who requires supervision as part of an application (e.g., Associate Level Provider Candidate or Associate Level Provider) or as part of a Compliance Action Plan (CAP). A DVCS shall recommend to the supervisee for completion of an application or CAP, only when the supervisee demonstrates qualification for such endorsement. DVCS shall not endorse any supervisees who they believe are unfit or who demonstrates they are unable to provide appropriate services under these *Standards and Guidelines*. A DVCS may withdrawal support for a supervisee for such reasons or for violations of the supervision contract.

A. As part of the contract, the supervisor shall agree to:

1. Review supervisee's work with of clients through their verbal reports and written case records.
2. Assist supervisee with questions of ethics and law, transference, counter transference, critical situations including suicidality and homicidally, and self-care, amongst other topics.

3. Review all application documents and will assist supervisee with the application process.
4. Identify areas of improvement of the supervisee, and will refer to appropriate training.
5. Be available during business hours to schedule consultation or client-based emergency questions.
6. Review, critique, provide guidance and sign all documentation produced by the supervisee. This includes verifying documentation produced by the applicant through co-facilitation is signed by a Full-Operating Level Provider, if applicable.
7. Assist supervisee throughout the application process.
8. Document and provide all completed hours to the supervisee, regardless of final outcome of supervision.
9. Maintain professional license, certification and/or approvals and liability insurance, and to promptly inform the supervisee of any development that could disqualify the DVCS from carrying out their professional role as a supervisor.
10. Inform supervisee of any legal or legislative matters that become known that may affect the supervision or the supervisee's progress towards DVOMB approval.
11. Maintain information provided by applicant as confidential. With exception to agencies listed in this contract, DVCS will not disclose any identifying information of the applicant discussed in sessions, or with the DVCS's peer consultant. Standard exceptions to confidentiality apply, such as when child abuse, threat to self or others is suspected.
12. Address any practice found to be outside of the *Standards and Guidelines* with the supervisee and immediately correct.
13. Notify the DVOMB of termination of supervision agreement within one calendar week.
14. Provide the appropriate supervision regarding the coverage, including the population being covered.

B. As part of the contract, the supervisee shall agree to:

1. Review and follow all *Standards and Guidelines*, including the Administrative Policies.
2. Disclose to the supervisor of any criminal or civil legal history that may impact the supervisee's ability to practice under these *Standards and Guidelines*.
3. Notify the supervisor if they obtain legal charges of any kind within a 24-hour period.
4. Acknowledge that they can only provide co-facilitated domestic violence offender services (evaluation, individual and group education and treatment) with a Full-Operating Level Provider or a DVCS. At no time prior to DVOMB approval, will the supervisee provide ANY domestic violence

related services independently.

5. Provide documentation of listings with DORA or unofficial transcripts for individuals seeking Associate Level Provider Candidacy status.
6. Maintain compliance with current mental health or substance use listing with DORA along with any other licensing and approval agency (e.g., Behavioral Health Administration, DVOMB, SOMB, etc.), and agree to inform the DVCS within 24 hours of any complaint, lawsuit, or sanction against the supervisee in Colorado or any other state/jurisdiction. If an Associate Level Provider Candidate does not have a current mental health or substance use listing, it is understood that this will be followed by the supervisee once such a listing is obtained.
7. Enroll and participate in any training recommended by the DVCS.
8. Understanding that supervision is NOT psychotherapy. If personal issues arise during clinical supervision, supervisee agrees to seek their own psychotherapy in order to resolve issues.
9. Providing consent for the DVCS to communicate with the:
    i. Staff of the DVOMB
    ii. Agency(ies)
    iii. Identified Treatment Victim Advocate (TVA)
    iv. Full-Operating Level Provider, if co-facilitation is taking place with a Full-Operating Level Provider
    v. And any other relevant members of the MTT

9.01 Requirements for All New Applicants Seeking Associate Level Candidacy[75]

Associate Level Provider Candidacy is for individuals who want to become a DVOMB Approved Provider. Associate Level Provider Candidates, regardless of their credentials, must receive approval from the Application Review Committee (ARC) prior to beginning to provide any services to domestic violence offenders.

Individuals who have never applied to become listed on the DVOMB Approved Provider List must first start the process by applying for Associate Level Provider Candidacy using the required application (Application 1 – Associate Level Provider Candidate Application). Initial listing as an Associate Level Provider Candidate is valid for one year from the date of approval in order to allow the applicant time to develop competency in the required areas. Associate Level Provider Candidates may begin accumulating the required hours once approved by the ARC. Associate Level Provider Candidates shall not provide any domestic violence offender services without co-facilitation until their DVCS has determined they are able to facilitate independently and on their own.

I. Prior to beginning work with domestic violence offenders, applicants must

[75] Spence, C., Cantrell, J., Christie, I., & Samet, W. (2002). A collaborative approach to the implementation of clinical supervision. Journal of Nursing Management, 10, 65-74.; 16-11.8-104(2)(a) C.R.S. The board shall require any person who applies for placement, including any person who applies for continued placement, on the approved provider list developed pursuant to section 16-11.8-103 (4) to submit to a current background investigation that goes beyond the scope of the criminal history record check described in section 16-11.8-103 (4) (a) (III) (A). In conducting the current background investigation, the board shall obtain reference and criminal history information and recommendations that may be relevant to the applicant's fitness to provide domestic violence offender treatment evaluation or treatment services pursuant to this article.

apply and be approved by the ARC as an Associate Level Candidate. Approval is based on the applicant meeting all of the following criteria and the discretion of the ARC. The applicant shall:

A. Not have any conviction for any municipal ordinance violation, misdemeanor, felony, or court-martial conviction if the municipal ordinance violation, misdemeanor, or felony or court-martial conviction is related to the ability of the approved applicant to practice under these Standards as reviewed and determined by the Application Review Committee. The term "conviction," as it is used in Section 9.0 of these Standards & Guidelines, is defined in Appendix D ("Domestic Violence Offender Management Board Administrative Policies"). A certified copy of the judgment from a court of competent jurisdiction of such conviction, shall be conclusive evidence of such a record.

B. Not be party to any civil dispute that is related to the ability of the applicant or provider to practice under these *Standards and Guidelines* as reviewed and determined by the ARC. The consequence of any circumstance impacting a Provider's ability to practice under these Standards and Guidelines could result the removal from the Approved Provider List.

C. Not abuse drugs or alcohol, nor shall an applicant or provider use drugs and/or alcohol in a way that compromises their ability to practice under these *Standards and Guidelines*, as determined by the ARC. Such drug/alcohol use or abuse may result in the denial of an applicant's application, or in the removal of a provider from the Approved Provider List.

II. Supervision Requirements for **Associate Level Provider Candidates**

A. The supervision of an Associate Level Provider Candidate shall be done by a DVCS who is registered and in good standing with the Colorado Department of Regulatory Agencies (DORA). A supervision agreement signed by the Associate Level Provider Candidate and by the DVCS shall be submitted with the application.
B. Associate Level Provider Candidates must co-facilitate all face-to-face sessions with offenders with a Full-Operating Level Provider or a DVCS, present either physically or virtually throughout the application process until the DVCS has determined the Associate Level Provider Candidate can facilitate independently. This includes all domestic violence services, including but not limited to individual sessions, group sessions, evaluations and any other domestic violence related services governed by these *Standards and Guidelines*.

C. Associate Level Provider Candidates may identify Specific Offender Populations (SOP) in their application. The DVCS selected shall be approved with the identified SOPs.

D. The DVCS shall review and co-sign and all domestic violence session notes, treatment plans, treatment plan review reports, evaluations, and all other reports and documentation by the applicant. The DVCS is responsible for all domestic violence clinical work performed by the Associate Level Provider Candidate. In the event that co-facilitation is obtained with a Full-Operating Level Provider, session notes must be co-signed by the Full-Operating Level Provider doing the co-facilitation.

E. The DVCS shall employ supervision methods aimed at assessing and developing required competencies. This includes seeking ongoing input from a Full-Operating Level Provider for any co-facilitation hours accumulated (if applicable). It is incumbent upon the supervisor to determine the need for additional training and supervision hours based upon that individual's progress in attaining competency to perform such treatment.[76]

F. The frequency of face-to-face supervision hours specific to domestic violence specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

G. The appropriate modality for supervision shall be determined by the DVCS based upon the competencies, training, education, and experience of the supervisee, as well as the treatment setting. Factors that shall be considered are community safety and offender needs, urban versus rural setting, and the availability of resources.

H. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, audio, teleconferencing, and Internet). Face-to-face supervision may be completed through video conferencing. All communication shall be synchronous.

[76] Fairburn, C. G. & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. Behaviour Research and Therapy, 49, 373-378.; Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. International Journal of Mental Health Nursing, 17, 57-64.

I. The DVCS shall seek feedback from at a minimum the core MTT members (i.e. treatment provider, supervising officer, treatment victim advocate) in order to assist in the assessment of applicant competencies.

J. The DVCS shall assess and attest to a minimum level of competency to perform DVOMB related services, of the Associate Level Provider Candidate prior to submitting this application.

9.02 Associate Level Provider Requirements

The Associate Level is an introductory level for those who meet the minimum requirements of the Standards and requires ongoing supervision by a Domestic Violence Clinical Supervisor (DVCS). All applicants shall apply for, and be approved at, the Associate Level status prior to applying for Full-Operating Level.

Associate Level Provider Candidates seeking the Associate Level shall apply using the required application (Application 2 – Practice Level Application) and be approved by the ARC. Approval is based on the Associate Level Provider Candidate meeting all of the following criteria and the discretion of the ARC.

I. Educational and Experiential Criteria

The Associate Level Provider Candidates shall:

A. Hold a professional mental health license, CAS, listing as a candidate for a mental health license, or Unlicensed Psychotherapist with the Colorado Department of Regulatory Agencies (DORA), and not be under current disciplinary action that the Application Review Committee (hereafter ARC) determines would impede the Associate Level Provider Candidate's ability to continue practicing as a DVOMB Approved Provider.

B. Possess 300 general experiential counseling hours. These hours shall be face-to-face client contact hours providing evaluations and/or individual and/or group counseling sessions. The Associate Level Provider Candidate must have received a minimum of **15** hours of one-to-one supervision while accruing the **300** hours.

***Discussion Point**: Associate Level Provider Candidates with a CAS or higher or a masters in counseling may demonstrate this with transcripts, licensure or certification.*

C. Have accrued **54 face-to-face domestic violence offender contact hours working with domestic violence offenders** within the past five years for those who hold a master's degree in counseling or higher. These contact hours may not be solely accrued via teletherapy and are in addition to the 300 general experiential hours and shall include the co-facilitation of offender evaluations, group sessions, and may include individual treatment. These contact hours shall

not be obtained in less than a four-month period.

OR

Have accrued **108 face-to-face domestic violence offender contact hours working with domestic violence offenders** within the past five years for those who hold a Baccalaureate degree. These contact hours are in addition to the 300 general experiential hours and shall include the co-facilitation of offender evaluations, group sessions, and may include individual treatment. These contact hours shall not be obtained in less than a four- month period.

D. Submit documentation of co-facilitation hours from a Full-Operating Level Provider or a DVCS through a letter of support verifying the face-to-face client contact hours working with domestic violence offenders.

E. Possess a minimum of 25 face-to-face client contact hours providing clinical substance abuse treatment at a Behavioral Health Administration (BHA) licensed facility or co-facilitated by a CAS or higher, and supervised by an LAC.

II. Training Criteria

The Associate Level Provider Candidate shall:

A. Have obtained the following DVOMB CORE trainings:
- DV100 – DVOMB and Standards Training (Required)
- DV101 – Domestic Violence Risk and Needs Assessment (DVRNA) Training (Required)
- DV102 – Offender Evaluation Training (Required)
- DV103 – Offender Treatment Training (Required)

B. Possess a minimum of **14 hours** of documented training within the past five years regarding victim safety and dynamic subject areas.[77]

Domestic Violence Victim Safety and Dynamics – 14 Hours
- Role of victim advocate in domestic violence offender treatment
- Offender containment and working with a victim advocate
- Crisis intervention
- Legal issues including confidentiality, duty to warn, and orders of protection
- Impact of domestic violence on victims
- Victim dynamics to include obstacles and barriers to leaving abusive relationships

C. Complete any training recommended by the DVCS in order to meet or improve

[77] Cannon, C., Hamel, J., Buttell, F., & Ferreira, R. J. (2016). A survey of domestic violence perpetrator programs in the United States and Canada: Findings and implications for policy intervention. Partner Abuse, 7(3), 226–276.

applicant competencies.

III. The Associate Level Provider Candidate shall complete all application requirements which includes submitting:

A. Offender services work product (e.g. offender evaluations, treatment plans, and contracts) that demonstrates compliance with the DVOMB *Standards and Guidelines*

B. Reference letters demonstrating MTT coordination

C. DVCS competency assessment of the applicant indicating they meet the minimum proficiency in each category.[78]

IV. Supervision Requirements for Continued Placement of **Associate Level Providers**.

A. Once approved by the ARC, all Associate Level Approved Providers (both licensed and unlicensed) shall receive ongoing supervision for a minimum of two hours per month or more as determined appropriate by a DVCS. One hour shall be individual and one hour may be group supervision. Task force meetings are not an acceptable modality for supervision of Associate Level Providers.

B. The appropriate modality for supervision shall be determined by the DVCS based upon the training, workload, education, experience, and the professional judgement of the DVCS. Factors that shall be considered are community safety, and offender needs, urban versus rural setting, and the availability of resources. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, teleconferencing, and Internet). Face-to-face supervision may be completed through video conferencing. All communication shall be synchronous.

C. The DVCS shall employ supervision methods aimed at assessing and further developing required competencies of the Associate Level Provider. This may include seeking ongoing input from at a minimum the core MTT members (i.e. treatment provider, supervising officer, treatment victim advocate).[797]

V. Continued Placement for **Approved Associate Level Providers**.

Associate Level Providers shall reapply for continued placement every two years or

[78] Fairburn, C. G. & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. Behaviour Research and Therapy, 49, 373-378.; Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. International Journal of Mental Health Nursing, 17, 57-64.

[79] Fairburn, C. G. & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. Behaviour Research and Therapy, 49, 373-378.; Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. International Journal of Mental Health Nursing, 17, 57-64.

as determined by the DVOMB using the required application (Application 3 - Biennial Renewal Application). Approval for continued listing is based on the Associate Level Provider meeting all of the following criteria and the discretion of the ARC:

A. Continuing education shall consist of the completion of a minimum of 28 clock hours over a two-year period that are evenly split in the years between renewal periods (e.g., August 1st, 2025 through July 31st, 2027 the Provider does 14 hours of continuing education). These trainings shall be in areas relevant to improve Provider competencies in delivering services, and working with domestic violence offenders. The 28 hours shall:
   - Comprise of trainings recommended by the DVCS to enhance the Associate Level Provider's competencies.
   - Include diversity, equity, and inclusion training, and victim safety and dynamics training.
   - Include the completion of a DVOMB Standards Booster and Policy Update training, along with a DVRNA Booster training.

B. Submit reference letters demonstrating MTT coordination.

C. Acknowledge compliance with any updates made to the DVOMB *Standards and Guidelines* since their initial approval.

D. Comply with all other requirements as outlined in the application and DVOMB Administrative Policies.

9.03 Full Operating Level Provider Requirements

The Full-Operating Level is an advanced level for those who exceed the minimum requirements of the Standards and demonstrate mastery of the competencies greater than that of an Associate Level Provider. Full-Operating Level Providers are expected to be competent and capable of providing both domestic violence post-sentence offender evaluation and offender treatment services. Full-Operating Level Providers do not require ongoing supervision by a Domestic Violence Clinical Supervisor (DVCS), but must have ongoing peer consultation. Full-Operating Level Providers may co-facilitate with Associate Level Provider Candidates, but may not provide supervision to Associate Level Provider Candidates or Associate Level Providers.

Associate Level Providers seeking the Full-Operating Level listing shall apply using the required application (Application 2 – Practice Level Application). Approval is based on the Associate Level Provider meeting all of the following criteria and the discretion of the ARC:

I. Educational and Experiential Criteria

The Associate Level Provider shall:

A. Hold a professional mental health license, CAS, or Unlicensed Psychotherapist with the Colorado Department of Regulatory Agencies (DORA), and not be under current disciplinary action that the Application Review Committee (hereafter ARC) determines would impede their ability to practice as a DVOMB Approved Provider.

B. Possess a minimum of 600 general experiential counseling hours. These hours shall be face-to-face client contact hours providing evaluations and/or individual and/or group counseling sessions. The applicant must have received 50 hours of one-to-one supervision for the 600 hours.

***Discussion Point**: Applicants with a CAS or higher or a masters in counseling may demonstrate this requirement of 600 general counseling hours with transcripts, licensure or certification.*

C. Have a minimum of 500 hours of face-to-face client contact hours working with domestic violence offenders within the past five years. The required hours may include domestic violence related co-facilitation of offender evaluations, group sessions, or individual treatment sessions. These contact hours shall not be obtained in less than a six-month period in order to allow for the DVCS to assess competencies and the Associate Level Provider's ability to co-facilitate with Associate Level Provider Candidates.

D. Have 50 face-to-face client contact hours providing clinical substance abuse treatment at an Behavioral Health Administration (BHA) licensed facility or co-facilitated by a CAS or higher, and supervised by a LAC.

II. Training Criteria

The Associate Level Provider shall:

A. Demonstrate a balanced training history to work towards competencies, as designed and directed by the DVCS.

B. Have a minimum of 50 hours of documented training within the past five years that is specifically related to domestic violence evaluation and treatment methods for those who hold a master's degree.

OR

C. Have a minimum of 100 hours of documented training within the past five years that is specifically related to domestic violence evaluation and treatment methods for those who hold a Baccalaureate degree.

D. Have obtained training in the following topics areas:

Legal Issues

- Colorado domestic violence and family violence related laws
- Orders of Protection
- Forensic therapy
- Confidentiality and duty to warn in domestic violence cases
- Treatment within the criminal justice system

Domestic Violence Victim Safety and Dynamics

- Role of victim advocate in domestic violence offender treatment
- Offender containment and working with a victim advocate
- Crisis intervention
- Legal issues including confidentiality, duty to warn, and orders of protection
- Impact of domestic violence on victims
- Victim dynamics to include obstacles and barriers to leaving abusive relationships

Offender Evaluation and Assessment Specific to Domestic Violence

- Clinical interviewing skills
- Domestic violence risk assessment
- Lethality risk assessment
- Substance abuse screening
- The use of collateral sources of information
- Types of abuse
- Domestic violence offender typologies
- Cognitive distortions
- Criminal thinking errors
- Criminogenic needs

Treatment Facilitation and Treatment Planning

- Substance abuse and domestic violence
- Offender self-management
- Motivational interviewing
- Provider role in offender containment
- Forensic psychotherapy
- Coordination with criminal justice system
- Offender accountability
- Recognizing and overcoming offender resistance
- Offender contracts
- Ongoing domestic violence offender assessment: skills and tools
- Offender responsivity to treatment

- Learning Styles
- Personality Disorders
- Risk, Needs and Responsivity
- Motivational Interviewing
- Limitations of offender confidentiality

III. Associate Level Providers shall demonstrate compliance with the DVOMB *Standards and Guidelines* by completing all application requirements which include, but are not limited to submitting:

A. Offender services work product (e.g. offender evaluations, treatment plans, and contracts) that exceeds the minimum requirements of the DVOMB *Standards and Guidelines* that represents work that is indicative of their abilities to develop and train others through co-facilitation of others.

B. Reference letters demonstrating MTT coordination.

C. DVCS competency assessment of the Associate Level Provider indicates they exceed the minimum proficiency in each category and demonstrate mastery of the competencies greater than that of an Associate Level Provider.

***Discussion Point**: It is important to note that in order to be approved as a Full-Operating Level Provider, Associate Level Providers must demonstrate a higher level of proficiency in each competency in order to ensure that they are ready to operate without supervision as well as teach others through co-facilitation.*

IV. Peer Consultation requirements for **Full-Operating Level Providers** Following Approval by the ARC

Once approved by the ARC, all Approved Full-Operating Level Providers (both licensed and unlicensed) are required to have peer consultation with another approved Full-Operating Level Provider, or a DVCS for a minimum of one hour per month. The peer consultant must also be approved in all specific populations that the Full-Operating Level Provider is approved. Local task force meetings may count toward the monthly peer consultation requirement.

Full-Operating Level Providers shall co-sign any documentation of co-facilitation done for the purpose of an application to the DVOMB for placement on the Approved Provider List.

V. Continued Placement for Full-Operating Level Providers

Full-Operating Level Providers shall reapply for continued placement every two years or as determined by the DVOMB using the required application (Application 3 - Biennial Renewal Application). Approval for continued listing is based on the Full-Operating Level Provider meeting all of the following criteria and is subject to the

discretion of the ARC:

A. Continuing Education for Full-Operating Level Providers shall consist of the completion of 20 clock hours every two years in areas relevant to improve Provider competencies in delivering treatment and evaluation services with domestic violence offenders. As an option for accumulating continuing education hours, no more than half of the required continuing education hours may be demonstrated through documented community education and training on issues related to domestic violence. Of the 20 hours, the Provider shall:
   - Include trainings that aid in the development of the Full-Operating Level Provider in their delivery of offender treatment services.
   - Include diversity, equity, and inclusion training, and victim safety and dynamics training.
   - Include the completion of a DVOMB Standards Booster and Policy Update training, along with a DVRNA Booster training. The Associate Level Provider may apply DVOMB Standards Booster and Policy Update, in addition to the DVRNA Booster training hours towards total CEU hours for renewal.

B. Submit reference letters demonstrating MTT coordination.

C. Acknowledge compliance with any updates made to the DVOMB *Standards and Guidelines* since their initial approval.

D. Comply with all other requirements as outlined in the application and DVOMB Administrative Policies.

9.04 Domestic Violence Clinical Supervisor Requirements

Domestic Violence Clinical Supervisor (DVCS) is for licensed Full-Operating Level Providers and represents the highest status of those who have obtained the additional training, education, and experiential requirements to be supervisors. Once approved, these individuals may provide supervision to Associate Level Provider Candidates, Associate Level Providers, and DVCS apprentices in accordance with the *Standards and Guidelines*. Initial listing as a DVCS Apprentice is valid for one year from the date of approval in order to allow the applicant time to develop competency in the required areas.

Full-Operating Level Providers seeking approval as a Domestic Violence Clinical Supervisor (DVCS) shall apply using the required two-step application process application (Application 4 - Domestic Violence Clinical Supervisor Application). Approval is based on the Full-Operating Level Provider meeting all of the following criteria and the discretion of the ARC.

I. Part 1 - Intent to Apply for DVCS

Individuals seeking to be listed as a DVCS shall meet the following criteria:

A. Be currently listed as a Full-Operating Level Provider for a minimum of two years and possess a minimum of 1,000 hours of face-to-face client contact working with domestic violence offenders.

B. Hold licensure or certification as Licensed Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, or Licensed Addiction Counselor, and not be under current disciplinary action that the ARC determines would impede the applicant's ability to practice as a DVCS.

C. Possess a minimum of 49 hours of training specific to substance abuse and addiction.

D. Possess a minimum of 21 hours of training in clinical supervision.

E. Possess a minimum of 100 hours providing general clinical supervision during the past five (5) years.

F. Attest to having knowledge of the DVOMB application requirements pertaining to responsibilities of DVCSs. DVOMB Approved Provider or applicant shall not represent themselves as a DVCS until approval by the ARC has been granted.

G. Receive an initial assessment by an Approved DVCS to determine if the supervisee meets the minimum requirements and competencies of Section 9.04, prior to the commencement of supervision. Those who are assessed by the Approved DVCS as competent shall submit an Intent to Apply application.

II. Part 2 - Domestic Violence Clinical Supervision Apprenticeship

A. Once a Full-Operating Level Provider has received approval by the ARC for their Intent to Apply, the Full- Operating Level Provider is referred to as an apprentice. An apprentice may provide supervision to DVOMB applicants with the oversight of an Approved DVCS. The DVCS shall review and is charged with the responsibility of all clinical supervision work performed by the apprentice.

B. The DVCS shall employ supervision methods aimed at assessing and developing required competencies of the apprentice. It is incumbent upon the supervisor to determine the need for additional training and supervision hours, based upon

that apprentice's progress in attaining competency in the required areas.[80]

***Discussion Point**: Best practice supervision methods should be used when possible and appropriate to maximize the learning and development of an apprentice's supervision skills.*

C. The frequency of face-to-face supervision hours specific to the supervision of domestic violence services will be determined by the DVCS.

D. The appropriate modality for supervision shall be determined by the DVCS based upon the competencies, training, education, and experience of the supervisee, as well as the treatment setting. Factors that shall be considered are community safety and offender needs, urban versus rural setting, and the availability of resources.

E. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, teleconferencing, and Internet). Face-to-face supervision may be completed through video conferencing. All communication shall be synchronous.

F. The DVCS shall seek feedback from at a minimum the core MTT members (i.e. treatment provider, supervising officer, treatment victim advocate) in order to assist in the assessment of apprentice's competencies.

G. The apprentice shall submit competency ratings from the DVCS using the "Competency Based Assessment for Approval as a DVOMB Clinical Supervisor", including a letter of recommendation and narrative that addresses the following how the apprentice has stayed current on the literature/research in the field (e.g. attend conferences, trainings, journals, books, etc.).

H. The apprentice must maintain listing in the areas they are providing supervision and must maintain compliance with the Standards.

III. Apprentice Work Product and Supervision Competencies

The Apprentice shall demonstrate compliance with the DVOMB *Standards and Guidelines* by completing all application requirements which include, but are not limited to submitting:

A. Offender services work product (e.g. offender evaluations, treatment plans, and contracts). Work product must demonstrate the highest level of

[80] Fairburn, C. G. & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. Behaviour Research and Therapy, 49, 373-378.; Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. International Journal of Mental Health Nursing, 17, 57-64.

comprehension, implementation, and compliance with the *Standards and Guidelines*. The apprentice must demonstrate the ability to develop highly sophisticated written work product that is indicative of their abilities to effectively teach others as a supervisor.

B. DVCS competency assessment of the apprentice indicates they exceed the minimum proficiency in each category and demonstrate mastery of the competencies suggesting they are ready to supervise others.

***Discussion Point**: It is important to note that in order to be approved as an DVCS, an Apprentice must demonstrate proficiency in the DVCS competency assessment in order to ensure that they are ready to mentor and supervise.*

IV. Peer Consultation requirements for **Domestic Violence Clinical Supervisors** Following Approval by the ARC.

A. DVCS shall have a minimum of one hour of peer consultation per month with other Approved Provider who are also licensed, and at minimum, Full-Operating Level. This peer consultation shall be documented as to time, date, and who attended. Group supervision and formal one-on-one supervision hours may also apply toward this requirement. Local task force meetings shall not count toward the monthly peer consultation requirement.

B. Face-to-face peer consultation may be completed through video conferencing (such as telephone, teleconferencing, and Internet). All communication shall be synchronous.

VI. Continued Placement for Domestic Violence Clinical Supervisors

DVCS shall reapply for continued placement every two years or as determined by the DVOMB using the required application (Application 3 - Biennial Renewal Application). Approval for continued listing is based on the DVCS meeting all of the following criteria and is subject to the discretion of the ARC:

A. Continuing Education for DVCS shall consist of the completion of 20 hours every two (2) years in topic areas relevant to improved treatment with domestic violence offenders, and improved supervision with supervisees. As an option for accumulating continuing education hours, no more than half of the required continuing education hours may be demonstrated through documented community education and training on issues related to domestic violence. Of the 20 hours, diversity, equity, and inclusion training, victim safety and dynamics training shall be included. In addition, the DVCS shall complete the *DVOMB Standards Booster and Policy Update* training and *a DVRNA Booster*

training every two years.

B. Submit reference letters demonstrating MTT coordination.

C. Acknowledge compliance with any updates made to the DVOMB *Standards and Guidelines* since their initial approval.

D. Comply with all other requirements as outlined in the application and DVOMB Administrative Policies.

9.05 Specialized Pre-Sentence Evaluator Application Requirements for Approval Status

Full-Operating Level (FOL) Providers or Associate Level Providers who are applying for FOL, and are seeking an additional listing as a Specialized Pre-Sentence Evaluator shall apply using the required application (Pre-Sentence Evaluation Listing Application). Approval is based on the Full-Operating Level Provider or Associate Level Providers applying for FOL meeting all of the following criteria and the discretion of the ARC:

I. Educational and Experiential Criteria

A Full-Operating Level Provider or An Associate Level Provider who are applying for FOL shall:

A. Hold a professional mental health license from the Colorado Department of Regulatory Agencies (DORA), and not be under current disciplinary action that the ARC determines would impede the applicant's ability to practice as a DVOMB Approved Provider. Certifications and candidacies do not meet this requirement.

B. Possess a minimum of 21 hours of training specific to advanced evaluation strategies, techniques, procedures for conducting forensic evaluations obtained within the past five (5) calendar years.

C. Possess a minimum of 50 experiential hours conducting domestic violence pre-sentence offender evaluations.

D. Demonstrate competency according to the applicant's respective professional standards and ethics consistent with the accepted standards of practice of domestic violence offender evaluations.

E. Assessed as competent of the DVOMB Evaluator Competencies by a DVCS who is also approved as a Specialized Pre- Sentence Evaluator.

II. Supervision requirements for those seeking the Pre-Sentence Evaluator listing:

A. The DVCS shall review and co-sign all pre-sentence evaluations performed by the Full-Operating Provider or Associate Level Providers who are applying for

FOL.

B. For Associate Level Providers concurrently applying to become Full-Operating Level Providers, the DVCS is responsible for all clinical work performed by the applicant and pre-sentence evaluations shall be co- facilitated.

C. The DVCS shall employ supervision methods aimed at assessing and developing required competencies. It is incumbent upon the supervisor to determine the need for additional training and supervision hours, based upon that individual's progress in attaining competency to perform such treatment.[81] Face-to-face supervision may be completed through video conferencing. All communication shall be synchronous.

D. The frequency of face-to-face supervision hours specific to domestic violence pre-sentence evaluations calculated as follows:

Direct Clinical Contact Hours per Month	**Minimum Supervision Hours per Month**
0-59	2
60-79	3
80 or more	4

III. Associate Level Providers shall demonstrate compliance with the DVOMB *Standards and Guidelines* by completing all application requirements which include, but are not limited to submitting:

A. Offender services work product (e.g. offender evaluations, treatment plans, and contracts) that meets or exceeds the minimum requirements of the DVOMB *Standards and Guidelines* that represents work that is indicative of their abilities to develop and train others through co-facilitation of others.

B. Reference letters demonstrating MTT coordination.

C. DVCS competency assessment of the Associate Level Provider indicates they exceed the minimum proficiency in each category and demonstrate mastery of the competencies.

[81] Fairburn, C. G. & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behaviour Research and Therapy, 49,* 373-378.; Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. *International Journal of Mental Health Nursing, 17,* 57-64.

9.06 Specific Offender Populations[82]

Specific Offender Population (SOP) is a listing category for either female and/or LGBTQIA+ offenders. Once approved by the DVOMB, these individuals may provide domestic violence services to those designated populations.

In order to provide services to Specific Offender Populations (SOP) identified by the DVOMB, the Associate Level Candidate or Approved Provider shall obtain the corresponding specific approval status to provide domestic violence services to that population. There are currently two specific offender populations that require approval by the DVOMB before domestic violence offender services (e.g., evaluation, treatment, advocacy) can be provided: female offenders and LGBTQIA+ offenders.

Associate Level Candidates or Approved Providers seeking an additional listing as with either female offenders, LGBTQIA+ offenders, or both, shall apply using the required application (SOP Listing Application). Approval is based on the Associate Level Candidate or Approved Provider meeting all of the following criteria and the discretion of the ARC:

I. Experiential and Training Criteria

The Associate Level Candidate or Approved Provider shall:

A. Have 50 face-to-face general client contact hours with that specific population. Based on the assessment of competencies by the SOP DVCS of the applicant, these hours can be demonstrated with services to justice involved and non-justice involved domestic violence populations including other mental health or substance abuse services obtained under a valid DORA registration. All face-to-face hours acquired with domestic violence offenders shall be obtained by co-facilitating with an Approved Provider who is approved with that specific population, who is Full-Operating Level or a DVCS.

B. Have a minimum of 14 hours of SOP domestic violence offender training. In order to meet all required competencies, the DVCS may require additional training in areas where the applicant may need growth and improvement. SOP training hours may also be utilized in new or additional applications, in the appropriate training categories.

II. Supervision requirements for those seeking an **SOP listing**:

A. The Associate Level Candidate or Approved Provider must work under a DVCS who is approved to work with the corresponding Specific Offender Population

[82] A Specific Offender Population is defined as a group of individuals that share one or more common characteristics such as race, religion, ethnicity, language, gender, age, culture, sexual orientation and/or gender identity that would allow for the group to be considered culturally sensitive to the offender.

(referred to as the SOP DVCS) while completing the application process.

B. The DVCS shall seek feedback from at a minimum the core MTT members (i.e. treatment provider, criminal justice supervising officer, treatment victim advocate) in order to assist in the assessment of applicant SOP competencies.

C. The appropriate modality for supervision shall be determined by the DVCS based upon the competencies, training, education, and experience of the supervisee, as well as the treatment setting. Factors that shall be considered are community safety and offender needs, urban versus rural setting, and the availability of resources.

D. Specific Offender Population Domestic Violence Clinical Supervision hours may be in conjunction with supervision hour requirements of the supervisee's required supervision hours.

E. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, teleconferencing, and Internet). Face-to-face supervision may be completed through video conferencing. All communication shall be synchronous. Task force meetings are not an acceptable modality for supervision for SOP supervision or peer consultation.

III. The Associate Level Candidate or Approved Provider shall demonstrate compliance with the DVOMB *Standards and Guidelines* by completing all application requirements which include, but are not limited to submitting:

A. Offender services work product (e.g. offender evaluations, treatment plans, and contracts) that meets or exceeds the minimum requirements of the DVOMB *Standards and Guidelines*.

B. Reference letters demonstrating MTT coordination.

C. DVCS assessment of the SOP competencies for the Associate Level Candidate or Approved Provider indicating they meet or exceed the minimum proficiency in each category and demonstrate mastery of the competencies.

IV. Requirements for Approved Providers with an SOP Listing:

A. Continued Supervision Requirements for **SOP Approved Providers**:
   1. Based on the level of approval, licensed and unlicensed Approved SOP Provider are required to have:
      a. DV Clinical Supervision commensurate to the requirements for current Level of Approval (e.g. Associate Level). The DV Clinical Supervisor must also hold the same SOP approval.

b. Peer Consultation commensurate to the requirements for current Level of Approval, (e.g. FOL, DVCS). The Peer Consultant must also hold the same SOP approval.

2. SOP supervision or peer consultation, shall be conducted following Standards in this Section 9.06, II.

B. Continued Placement for Approved Specific Offender Population Approved Providers:

1. All Approved Providers shall reapply for continued placement every two years or as determined by the Board.
2. SOP approved Providers must complete a portion of their continuing education to include topics on the SOP approved in.

Note: Research cited in this document speaks to the benefits of clinical supervision, therapist training, and therapist competencies but does not specifically dictate the necessity of these.

9.07 Teletherapy Provider

I. The Associate Level Candidate or Approved Provider shall apply using the required application (Teletherapy Application). Approval is based on the Associate Level Candidate or the Approved Provider meeting all of the following criteria and is subject to the discretion of the ARC. The Associate Level Candidate or Approved Provider shall:

C. Possess 25 general experiential counseling hours of conducting telehealth services.

OR

Possess a certification in teletherapy (e.g., PESI, Inc.)

A. Demonstrate competency with the use of teletherapy and application of teletherapy under the DVOMB Standards and Guidelines.

B. Use a HIPAA approved platform and possess a valid Business Associates Agreement (BAA).

C. Receive the necessary amount of supervision in order to become competent in the provision of telehealth services to offenders.

D. Complete all application requirements associated for this listing status.

II. Supervision requirements for those working towards Teletherapy Approval:

A. The DVCS shall review and co-sign and all domestic violence session notes, treatment plans, treatment plan review reports, evaluations, and all other reports and documentation by the applicant. The DVCS is responsible for all domestic violence clinical work performed by the applicant.

B. The DVCS shall employ supervision methods aimed at assessing and developing required competencies. It is incumbent upon the supervisor to determine the need for additional training and supervision hours, based upon that individual's progress in attaining competency to perform such treatment.[83]

C. The frequency of face-to-face supervision hours specific to domestic violence specific treatment and/or evaluation calculated as follows:

Direct Clinical Contact Hours per Month	Minimum Supervision Hours per Month
0-59	2
60-79	3
80 or more	4

D. The appropriate modality for supervision shall be determined by the Domestic Violence Clinical Supervisor based upon the training, workload, education, experience of the supervisee, work towards provider competencies, and the professional judgement of the DVCS. Factors that shall be considered are community safety, and offender needs, urban versus rural setting, and the availability of resources.

E. Modes of supervision may include individual or group supervision, direct observation and electronic (such as telephone, teleconferencing, and Internet). Face-to-face supervision may be completed through video conferencing. All communication shall be synchronous.

F. The DVCS shall assess the applicant on the Teletherapy Competencies and shall seek feedback from at a minimum the core MTT members (i.e. treatment, supervising officer, treatment victim advocate) in order to assist in the assessment of applicant competencies.

III. Continued Supervision and Peer Consultation Requirements for Teletherapy Approved Providers:

A. Through the course of required supervision, Associate Level Approved Providers shall address teletherapy to the extent necessary with a DVCS who is

[83] Fairburn, C. G. & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. Behaviour Research and Therapy, 49, 373- 378.; Lynch, L. & Happell, B. (2008). Implementing clinical supervision: Part I: Laying the groundwork. International Journal of Mental Health Nursing, 17, 57-64.

Teletherapy Approved.

B. Through the course of required peer consultation, Full Operating Level and DVCS Approved Providers shall address teletherapy to the extent necessary with a peer consultant. The peer consultant must also be Teletherapy Approved.

IV. Continued Placement for Teletherapy Status

A. Continuing Education for Approved Providers with the Teletherapy listing shall consist of the completion of a minimum of 1 clock hour every two years in areas relevant to improve provider competencies in delivering treatment and evaluation services with court ordered domestic violence offenders.

Reference Guide for Applicants

Requirements	Degree and DORA Credentials (One of the Following Options)	Administrative Requirements	Clinical Supervision	Approval
Associate Level Candidacy	• Hold a baccalaureate degree or above in a behavioral science field with training and experience as a counselor or psychotherapist • Hold a baccalaureate degree in any field with a minimum of a Certified Addiction Specialist credential • Hold a baccalaureate degree in any field with a minimum of a Certified Addiction Technician (CAT) credential • Be a Masters level student participating in a formal clinical internship or field placement during the final portion of their degree leading to matriculation in order to be eligible to be listed with DORA	• Clinical Supervision Agreement • State and Federal Criminal Background Check • Civil Background Check	• Minimum of 2 to 4 hours per month based on the number of direct clinical contact hours	Upon approval, applicant is listed as an Associate Level Candidate on the Approved Provider List and has 12 months to submit a Practice Level Application for the Associate Level. Ongoing clinical supervision required after approval.

Requirements	Degree and DORA Credentials	Experiential Hours			Training Hours	Clinical Supervision & Peer Consultation	Approval
		General Counseling*	Domestic Violence Treatment & Evaluation	Substance Abuse Treatment			
Associate Level*	Hold a professional mental health license, substance use certification, or be listed as a candidate for a mental health license or substance use certification, or Unlicensed Psychotherapist listing with DORA.	300 Hours a minimum of 15 hours of one-to-one supervision**	54 hours for Master's Degree Applicants 108 Hours for Baccalaureate Degree Applicants	25 Hours	DV100 – 1.5 Hours DV101 – 7 Hours DV102 – 7 Hours DV103 – 7 Hours 14 Hours of victim safety & dynamics Total: 36.5 Hours	Minimum of 2 to 4 hours of domestic violence clinical supervision per month based on the number of direct clinical contact hours.	Upon approval, applicant is listed as an Associate Level on the Approved Provider List. Ongoing clinical supervision required.
Full-Operating Level*	Hold a professional mental health license, substance use certification, or Unlicensed Psychotherapist listing with DORA.	600 Hours a minimum of 50 hours of one-to-one supervision**	500 Hours	50 Hours	50 Hours for Master's Degree Applicants 100 Hours for Bachelor's Degree Applicants	Minimum of 1 hour of peer consultation per month	Upon approval, applicant is listed as Full Operating Level on the Approved Provider List. There is no clinical supervision required.
Domestic Violence Clinical Supervisor (DVCS)* Apprentice	Hold licensure or certification listing with DORA as a: • Licensed Psychologist • Licensed Clinical Social Worker • Licensed Professional Counselor • Licensed Marriage and Family Therapist • Licensed Addiction Counselor	A minimum of 100 hours providing general clinical supervision during the past 5 years.	1,000 Hours	N/A	21 Hours of Clinical Supervision Training 49 Hours of training specific to substance abuse and addiction.	Minimum of 2 to 4 hours of domestic violence clinical supervision per month based on the number of direct clinical contact hours needed during apprenticeship.	Upon approval, applicant is listed as a DVCS Apprentice on the Approved Provider List. The apprentice can apply to be a DVCS and if approved, would be listed as DVCS on the Approved Provider List

* There are continuing education requirements for each practice level. Please see Section 9.0 for more information.
** Associate Level Candidates with a CAS or higher or a masters in counseling may demonstrate general counseling hours with transcripts, licensure or certification.

Appendices

Appendix A – Administrative Policies

This Appendix is designed for listed Domestic Violence Offender Management Board (DVOMB) Approved Providers (hereafter referred to as Providers) pursuant to Section 16-11.8-103, C.R.S., as well as those who have filed a Associate Level Candidate Application for listing status with the Domestic Violence Offender Management Board (DVOMB). The DVOMB does not have professional licensing authority, but rather statutory authority to develop an application and review process for Approved Providers and to add or remove Approved Providers from its Approved Provider List pursuant to section 16-11.8-101, et. seq. The provisions of this Appendix constitute the processes of the DVOMB related to applications, listing, denial of placement, Standards Compliance Reviews complaints, appeals and other administrative actions.

The Director of the Colorado Department of Public Safety (CDPS) may suspend or modify any of these procedures in the interest of justice to avoid irreparable harm to crime victims or to the citizens of Colorado. If the situation warrants, the DVOMB may exercise the option of seeking guidance from the Office of the Attorney General for possible legal action.

I. LISTING STATUS AS A PROVIDER

A. This Appendix applies to individuals who are listed in the following categories:
   1. Practicing Status
   2. Not Currently Practicing Status
   3. Inactive Status

B. Requirements for Practice (Active) Status

   1. Individuals must apply and be approved to be listed with the DVOMB pursuant to section 16-11.8-103 (4), C.R.S. Active status refers to an Approved Provider working in a capacity under the Standards and Guidelines. Approved Providers may maintain an active listing status regardless if the Approved Provider chooses to provide direct services to clients or services under the Standards and Guidelines.

   2. Providers not listed on the DVOMB Approved Provider List (hereafter Provider List) including any provider who is denied placement or removed from the Provider List, shall not provide any treatment, evaluation, or assessment services pursuant to Section 16-11.8-104, C.R.S. in Colorado to domestic violence offenders. Per Section 16-11.8-104, C.R.S., referral sources "shall not employ or contract with and shall not allow a domestic violence offender to employ or contract with any individual or entity to provide domestic violence offender treatment evaluation or treatment services pursuant to this article unless the individual or entity appears on the approved list developed pursuant to section 16-11.8-103 (4)."

C. Requirements for Not Currently Practicing Status

   1. Not Currently Practicing – If a Provider wishes to retain their listing status but is not providing any evaluation, treatment, coverage, peer

consultation or clinical supervision services for domestic violence offenders, the Provider may request to be placed on Not Currently Practicing Status. During this time, a Provider will retain their status on the Provider List, but shall not provide any domestic violence offender services including treatment, evaluations, coverage, and peer consultation or clinical supervision. The Not Currently Practicing status may be requested by the Provider at any time.

2. The Provider may not remain under Not Currently Practicing status longer than two renewal cycles (4 years). Following completion and approval of the second renewal application, the Provider must either relinquish listing status completely or move to a practicing status.

3. Before a Provider who is under Not Currently Practicing Status may resume providing evaluation, treatment, coverage, peer consultation or clinical supervision, the Provider shall notify the DVOMB in writing of the intention to resume providing such services (including the name of a supervisor for those who are Associate or Provisional Level providers, or a required peer consultant for those who were Full Operating Level Providers) and receive written verification from the DVOMB of the submission.

4. If necessary, the ARC may request the Provider to submit documentation of their compliance with the *Standards* prior to or within six months of resuming a practicing status. The listed provider shall meet the minimum qualifications (e.g. training, clinical experience, competency, staying active in the field, etc.) to maintain prior listing status and practice level (Provisional Level, Associate Level, or Full Operating Level).

D. Requirements for Inactive Status

Individuals who are no longer providing any domestic violence services under these Standards and Guidelines may have their status approval removed voluntarily or involuntarily. An Approved Provider may be temporarily moved to an Inactive Status if the Approved Provider fails to respond within 30 days to program staff of the DVOMB. It is the responsibility of the Provider to maintain updated mailing information in their PDMS profile.

E. Maintenance of the DVOMB Approved Provider List

1. DVOMB staff shall maintain the Provider List on the DCJ website. Paper copies will be provided and distributed upon request.

2. The DVOMB will update and publish any changes to a Provider's status on the Provider List in accordance with Section 16-11.8-103(4)(c), C.R.S.

3. Referral sources will be notified and the Approved Provider will be taken off the Provider List either 31 days from the date of issue of the Letter of Removal OR following the completion of the DVOMB's appeal process should either party appeal the decision. If the situation warrants, the DVOMB may exercise the option of seeking guidance from

the Office of the Attorney General for possible legal action.

II. APPLICATIONS FOR LISTING STATUS

The purpose of the application process is to allow for applicants to demonstrate their individual competencies, qualifications, and abilities toward working with domestic violence offenders. Applicants must demonstrate compliance with the Standards through any application. There is an application associated with each listing status that must be submitted to the ARC prior to approval being granted.

A. There are four types of active practice levels as defined in Section 9.0:
   1. Associate Level Candidate
   2. Associate Level
   3. Full Operating Level
   4. Domestic Violence Clinical Supervisor

B. Types of Applications

   1. Associate Level Candidate - This application is for individuals who want to begin the process of becoming a DVOMB Approved Provider. Applicants regardless of their credentials must complete the application and receive approval from the Application Review Committee (ARC) prior to beginning any co-facilitated services to domestic violence offenders. Upon approval, applicants will be listed as Associate Level Candidates.

   2. Practice Level Application for Status – This application is for individuals seeking placement on the Provider List at the Provisional Level, Associate Level or currently Approved Providers seeking to move-up in practice level. Applicants must demonstrate that they meet the qualifications of, and compliance with the Standards for Treatment with Court Ordered Domestic Violence Offenders published by the Domestic Violence Offender Management Board (hereafter referred to as the Standards).

   3. Additional Applications - These applications are for individuals who have received approval or are in the process of applying for placement on the Provider List and who are seeking placement as a Domestic Violence Clinical Supervisor (DVCS), a Pre-Sentence Evaluator, or who are seeking approval to work with a Specific Offender Population (SOP).

   4. Renewal Application for Continued Placement – Applicants who are currently on the Provider List and are seeking to remain as on the Provider List.

C. General Requirements for Applications

   1. Provision of Services: Applicants intending to work toward becoming an Approved Provider shall submit an Associate Level Candidacy Application. The application must be approved by the ARC.

   2. Professional Standards and Ethics: Applicants shall demonstrate competency according to the individual's respective professional

standards and ethics consistent with the accepted standards of practice of domestic violence offender services.

3. Documentation: All information requested in the application shall be submitted. Failure to comply with the application requirements may result in the denial of the application and/or continued placement for a specific listing status on the Provider List.

4. Time Limits: With exception to renewal applications, all pending applications automatically expire after eight months from the date of the ARC initial review. If the ARC is experiencing a delay in processing an application, an extension may be granted to the applicant on a case-by-case basis.

5. Requests for Extensions – Applicants may request an extension prior to the expiration of an application or before the due date of an application. Requests for an extension by an applicant shall demonstrate in writing the need for an extension. For renewal applications, the required fee must be submitted with a request for extension.

6. Application Fees – The DVOMB assesses fees to cover the costs of processing applications. Refer to *"The Application Fee Schedule"* for the fee schedule for each listing status. Application fees may not be transferred to another individual, but may be used as payment for other DVOMB functions on a case-by-case basis.

D. Continued Placement Requirements

1. Renewal Application – All Providers who are currently on the Provider List, including Not Currently Practicing Status, shall submit a renewal application every two years in order to maintain placement on the Provider List.

2. Grace Period for Renewal – Providers who do not submit an application for renewal of their status by the expiration date will have a 30-day grace period in order to submit their application materials. Failure to submit application materials within 30 days after the date of expiration for approved provider status will require providers to have to begin the application process by submitting a Associate Level Candidate Application.

3. Eligibility for Future Renewal Once Provider Approval Has Expired

   If someone was voluntarily removed from the Approved Provider List within the last two calendar years, the individual may retain their approval by submitting a Associate Level Candidate Application and a Practice Level Application that excludes the following requirements: co-facilitation hours, work product, CEU hours outside of what is required for practice level CEU's for renewal.

   ***Discussion Point**: If a person is reapplying after a voluntary removal that*

was preceded by a period of not currently practicing status, the ARC will consider such applications on a case-by-case basis and determine requirements.

If someone was voluntarily removed from the Approved Provider List for more than two calendar years, the individual must complete the normal application process required by Section 9.0.

III. ADMINISTRATIVE REQUIREMENTS FOR APPROVED PROVIDERS

A. Respect and Non-discrimination: An Approved Provider shall model behavior and conduct in a manner that is humane, non-discriminatory and consistent with their professional ethics and rules. Additionally, Approved Providers shall not allow personal feelings regarding a client's crime(s) or behavior to interfere with professional judgment and objectivity. When an Approved Provider cannot deliver the highest quality of service for any reason, the Approved Provider shall refer the client elsewhere.

B. For the purposes of the Administrative Policies and Section 9.0 and of these *Standards and Guidelines*, "conviction" means a conviction by a jury or by a court and shall also include a deferred judgment and sentence agreement, a deferred prosecution agreement, a deferred adjudication agreement, an adjudication, and a plea of guilty or nolo contendere (sometimes referred to as an "Alford" plea). For the purposes of the Administrative Policies and Section 9.0 of these Standards and Guidelines, "conviction" also includes any criminal record which has since been expunged and/or sealed except that "conviction" does not include any juvenile record which has been expunged pursuant to 19-1-306 or another state's equivalent.

C. Failure to disclose a criminal conviction, as "conviction" is defined in these Standards and Administrative Policies, may result in the denial of an individual's application to the DVOMB Approved Provider List. Should such a failure to disclose be discovered after an applicant's approval to the Approved Provider List, such a failure may be used by the DVOMB in its decision making related to whether an individual should continue to be listed with the DVOMB.

D. Approved Providers shall not engage in any abusive, violent, or criminal behavior in their own lives that would impede, interfere, or negatively impact their ability to practice under these Standards and Guidelines as reviewed and determined by the ARC. Approved Providers shall:

    1. Not have any conviction for any municipal ordinance violation, misdemeanor, felony or court-martial conviction if the municipal ordinance violation, misdemeanor, felony or court-martial conviction is related to the ability of the applicant to practice under these Standards, as reviewed and determined by the Application Review Committee. A certified copy of the judgment from a court of competent jurisdiction of such conviction, as "conviction" is defined in Section III(C) above, shall be conclusive evidence of such a record.

2. Not be party to any civil dispute that is related to the ability of the applicant or provider to practice under these Standards and Guidelines as reviewed and determined by the ARC. The consequence of any circumstance impacting a Provider's ability to practice under these Standards and Guidelines could result the removal from the Approved Provider List.

3. Not abuse drugs or alcohol, nor shall an applicant or provider use drugs and/or alcohol in a way that compromises their ability to practice under these Standards and Guidelines, as determined by the ARC. Such drug/alcohol use or abuse may result in the denial of an applicant's application, or in the removal of a provider from the Approved Provider List.

4. Notify the DVOMB in writing within 10 days upon the issuance of any summons and within 10 days of any arrest. Providers must also notify the DVOMB in writing within 10 days upon sustaining any, conviction, entering a nolo contender plea, or entering into any deferred judgement or deferred prosecution agreement for a municipal ordinance violation, misdemeanor, or felony; however, no such notification needs to be made if the underlying offense (or alleged offense) is for a traffic violation involving 7 points or less. Finally, the DVOMB must be notified in writing within 10 days of a provider becoming the restrained party in either a criminal or a civil order of protection. The DVOMB will be updated by the Colorado Bureau of Investigation of any of the above, and will consider such information, including proper and timely notification of the DVOMB, in its decision making related to whether an individual should continue to be listed with the DVOMB.

E. Offender Fees: The offender paying for their evaluation and treatment is an indicator of responsibility and shall be incorporated in the treatment plan. All Approved Providers shall offer domestic violence offender evaluation and treatment services based on a sliding scale fee. (See Glossary of Terms – Appendix C)

F. Offender Records: All Approved Providers shall have written documentation of the offender evaluation information, treatment plan, treatment plan reviews, offender contract, case notes, offender's observed progress, attendance, payment of fees, collateral contacts and records, record of referrals, violations of offender contract, monthly reports to the supervising agent, and discharge summary. In addition, Approved Providers working with domestic violence offenders shall meet record keeping standards outlined by their professional groups. Questions regarding professional record retention shall be directed to the Colorado Department of Regulatory Agencies.

G. Confidentiality: An Approved Provider shall not disclose confidential communications as described in section 12-245-220, C.R.S.

H. Data Collection: Providers shall submit data consistent with the DVOMB's data collection plan and participate in, and cooperate with, DVOMB research projects related to evaluation or implementation of the Standards or domestic violence

offender management in Colorado in accordance with sections C.R.S. 16-11.8-103(4)(a)(IV).

I. Duty to Warn:

1. Approved Providers have the duty to warn as defined in Section 13-21-117, C.R.S. If the offender shows signs of imminent danger or escalated behaviors that may lead to violence, the Approved Provider shall:
    a) Contact the victim or person to whom the threat is directed and victim services, if appropriate;
    b) Notify law enforcement when appropriate;
    c) Contact the responsible criminal justice agency to discuss appropriate responses. The response shall include, but is not limited to, an assessment by the MTT of the current treatment and a decision whether the changes to treatment are appropriate based on the increased containment needs of the offender.

2. Approved Providers are required by law to report child abuse and/or neglect according to statute Section 19-3-304, C.R.S.

J. Release of Information: When enrolling a client in treatment, a provider shall obtain certain signed releases of confidentiality based on the informed consent of the client. The information shall be provided in a manner that is easily understood, verbally and in writing, in the native language of the person, or through other modes of communication as may be necessary to enhance understanding. A provider shall obtain the following releases, which should each be completed as a separate document with its own signature from the client:

1. Required Treatment Release: This release shall explain that written and verbal information will be shared between the following individuals: victim(s) of record, all members of the MTT and shall, if applicable, extend to the Department of Human Services, or other individuals or agencies responsible for the supervision of the client. Other releases of confidentiality may include the offender's former partner(s), current and/or past therapist or Approved Provider, and where warranted, any guardian ad litem, or other professionals working on behalf of the adult and child victims of the offender. The provider shall document any exceptions to this Standard.

2. Required Adjunct Treatment or Intervention Release: For clients recommended and planned to undergo a required adjunct treatment or intervention to address a co-occurring issue as a second contact in addition to domestic violence offender treatment, this release shall comply with all state and federal regulations.

3. Required Substance Use Disorder Treatment Release: For clients undergoing substance use disorder treatment co-occurring with domestic violence offender treatment, this release shall comply with the provisions of 42 C.F.R. § 2.31.

4. Research Release: A provider shall present this release for voluntary

informed consent by the client. The client may agree to a release of confidentiality for information to be shared with the Board for the purpose of research related to the evaluation or implementation of the Standards and Guidelines for domestic violence offender management in Colorado, in compliance with 45 CFR § 164.508.

Discussion Point: The research release is voluntary and should be presented for the client's review and determination for voluntary informed consent. All other releases are required for domestic violence offender treatment.

K. Confidentiality of DVOMB Files: Information contained in the DVOMB files, including application materials for applicants, Providers, and those who have filed an application are considered confidential and are not available to the public. This includes background investigations, criminal history checks, unfounded complaints, certain types of Standards Compliance Reviews, school transcripts, letters of recommendation, trade secrets, confidential commercial data including applicant forms created for business use, curriculum developed for the business and clinical evaluations. Any information that, if disclosed, would interfere with the deliberation process of the Application Review Committee (ARC) of the DVOMB is also subject to this policy. The Colorado Open Records Act applies to other materials (Section 24-72-201, C.R.S.).

L. Approved Provider Contact Information: Approved Providers are responsible for notifying the DVOMB in writing of any changes in provider name, address, phone number, program name, Treatment Victim Advocate, Domestic Violence Clinical Supervisor or Peer Consultant and any additional Treatment locations, no later than 2 weeks after any change.

M. Complaints: Any victim, offender or community member that has concerns or questions regarding an Approved Provider or their treatment practices may contact the DVOMB. Complaints must be submitted in writing to the Board or the Department of Regulatory Agencies (DORA). All complaints received by the Board will be forwarded to DORA and handled by the appropriate DORA board.

N. Violations of Standards: Violations of these Standards and Guidelines may be grounds for action by the DVOMB pursuant to Section 16-11.8-103, C.R.S. in accordance with these Administrative Policies.

IV. TYPES OF ACTIONS RELATED TO APPROVAL RELATED TO LISTING STATUS

A. Approval – The ARC has determined that the applicant or Provider has met the minimum requirements to provide services to domestic violence offenders in Colorado and will be eligible to receive referrals by appearing on the Provider List.

B. Modified Approval – The ARC has determined that the applicant or Provider has met a portion of the minimum requirements to provide services to domestic violence offenders. In such cases, the ARC can grant modified approval for offender services with restrictions and set conditions for that approval.

C. Reduction in Level – Based on the determination of the ARC, a Provider's status is reduced (e.g., Domestic Violence Clinical Supervisor reduced to a Full Operating Provider) for a period of time and subject to the requirements of that approval level upon the effective date of the reduction.

D. Denial – The ARC has determined that the applicant has NOT met the minimum requirements to provide services to court ordered domestic violence offenders in Colorado. The applicant is denied placement on the Provider List and shall not provide services in Colorado to domestic violence offenders.

E. Change in Status

1. Voluntary Removal: The Provider has requested to be removed from the Provider List without duress of a pending complaint or Standards Compliance Review (SCR). Upon removal, services shall not be provided to domestic violence offenders in Colorado by the requesting individual.

2. Involuntary Removal: Based on the determination of the ARC, an Approved Provider is denied placement on the Approved Provider List and shall not provide any services in Colorado to domestic violence offenders upon the effective date of removal. This includes Approved Providers who are removed as a result of not being able to demonstrate compliance with the Standards following a denial, a Standards Compliance Review (see Section V), or a founded complaint (see Section VI).

3. Process for Re-placement on the Approved Provider List After Involuntary Removal: Providers involuntarily removed from the Provider List are required to submit a Associate Level Candidate Application prior to submitting a Practice Level Application for Status. When submitting a Associate Level Candidate Application, Providers involuntarily removed must address the concerns and/or compliance issues to the satisfaction of the ARC. Providers involuntarily removed shall apply at the Associate Level first prior to becoming eligible to apply for Full Operating Level, unless otherwise stipulated by the ARC. This provision does not apply to Providers who were involuntarily removed from the Provider List solely as a result of the expiration of a DORA license, registration, or certification, so long as the provider applies for replacement when current with DVOMB renewal.

V. BASIS FOR ARC ADMINISTRATIVE ACTION REGARDING DENIAL, REDUCTION, OR REMOVAL FROM THE PROVIDER LIST

The DVOMB can deny, reduce, or remove placement on the Provider List for any specific listing status to any applicant or Provider under these Standards. Those applicants or Providers who are denied, reduced, or removed from a specific listing status on the list will be provided with a copy of the DVOMB Administrative Policies. Administrative actions taken by the ARC regarding the listing status of a DVOMB Approved Provider does not constitute an action taken against the provider's registration, licensure, or certification by the Department of Regulatory Agencies. Reasons for denial, reduction, or removal include, but are not limited to the following:

A. The ARC determines that the applicant or Provider does not demonstrate the qualifications required by these Standards;

B. The ARC determines that the applicant or Provider is not in compliance with the Standards of practice outlined in these Standards;

C. The applicant or Provider fails to provide the necessary materials for application as outlined in the application materials and the administrative policies and procedures;

D. The ARC determines that the applicant or Provider exhibits factors (e.g., boundaries, impairments, etc.) which renders the individual unable to provide services to offenders;

E. The ARC determines that the results of the background investigation, the references provided or any other aspect of the application process are unsatisfactory.

F. The ARC determines that the overall work product submitted does not adequately demonstrate skills or competencies for the status being sought for by an applicant.

Those applicants or Providers who are denied, reduced, or removed from a specific listing status on the list will be provided with a copy of the DVOMB Administrative Policies. Administrative actions taken by the ARC regarding the listing status of a DVOMB Approved Provider does not constitute an action taken against the registration, licensure, or certification by the Department of Regulatory Agencies.

VI. APPROACHES TO PROMOTING AND SUPPORTING COMPLIANCE WITH THE STANDARDS

Implementation of the Standards and Guidelines is an important part to work of the DVOMB. Mechanisms to verify compliance with the Standards and Guidelines serve as a way of promoting victim safety and the successful assessment, evaluation, and treatment of domestic violence offenders.

***Discussion Point**: Inquiries about the Standards and Guidelines may be screened by program staff using the Standards Compliance Review Criteria (per Application Review Committee Standard Operating Procedure) when providing training and technical assistance (TTA) to Approved Providers.*

The purpose of Standard Compliance Reviews (SCR) is to ensure that Providers are adhering to all applicable *Standards for Treatment with Court Ordered Domestic Violence Offenders* and to identify innovative and exceptional practices in areas related to domestic violence offender evaluation, assessment, and treatment. The ARC may conduct SCRs at any time. Once a Provider has successfully completed an SCR, he or she will be exempt from random selection for six years.

A. Technical Assistance

Questions pertaining to the application and interpretation of the Standards can be directed toward the DVOMB staff who are available to provide clarification and support as needed and applicable on a case by case basis. DVOMB Approved Providers and other individuals who use the Standards are encouraged to contact DVOMB staff with questions when technical issues arise.

B. Standard Compliance Reviews

The Application Review Committee (ARC) can initiate a Standards Compliance Review (SCR) for an Approved Provider either Voluntarily, Randomly or For Cause per the authority of the DVOMB. SCR is a process wherein the ARC conducts a review of a provider's compliance with the Standards and Guidelines. This process may reveal innovative approaches and best practices in areas related to client evaluation, assessment, and treatment. Pursuant to C.R.S. 16-11.8-103(4)(a)(III)(D) the ARC must perform compliance reviews on at least ten percent of treatment providers on the Approved Provider List every two years. 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. Approved Provider will be given the opportunity to demonstrate compliance with the *Standards and Guidelines* by submitting documentation to the ARC during the SCR process.

1. Types of Standards Compliance Reviews:

    a) *Voluntary* - An individual Approved Provider can contact program staff and volunteer for a Standard Compliance Review (SCR). Self-selection for an SCR may offer the Approved Provider an opportunity to review aspects of their practice to determine if there are any areas that need to be updated to be complaint with the Standards.

    b) *Random* – The ARC may conduct periodic SCRs of treatment providers on the Approved Provider List on a randomized basis to determine if a Provider is following the requirements of the Standards. Selection of Approved Providers subject to a random SCR will be based on the Provider Identification Number in the Provider Data Management System (PDMS). The DVOMB will direct the ARC as to what services, documentation, or aspects of the Standards need to be reviewed as part of randomized SCRs.

    c) *For Cause* – The ARC may vote to initiate an SCR for cause when information is obtained or an anonymous complaint sufficiently alleges an Approved Provider is not complying with the *Standards and Guidelines*. The ARC, in conjunction with the program staff, will evaluate the information received to determine the scope, credibility, and severity of the alleged circumstances. Program staff and the ARC Chair shall determine the most appropriate method for investigating and resolving compliance issues or

concerns.

2. The ARC may select one of the following Levels based on the information available concerning the Standards Compliance Review:
    a) Level 1 – Implementation Verification

        A Level 1 SCR evaluates and determines whether an Approved Provider has implemented requirements of the Standards and Guidelines related to administrative, training, or MTT consultation actions.

    b) Level 2 – Work Product Review

        In addition to the requirements of Level 1, a Level 2 SCR evaluates and determines whether an Approved Provider is adhering to the requirements of the Standards and Guidelines related to written work product (e.g., offender evaluation summary report, treatment plans, treatment plan reviews monthly progress reports, MTT communications, contracts, discharge summaries, etc.).

    c) Level 3 – Site Visit & File Review

        In addition to the requirements of Level 2, a Level 3 SCR is a comprehensive audit to determine if whether an Approved Provider is adhering to the requirements of the Standards and Guidelines. This includes a review of client files, attendance of group sessions, evaluations, or other services provided under the Standards and Guidelines.

3. Provider Notification – Providers will receive a notification letter when they have been selected for an SCR and the type of SCR being administered. The notification letter will also include instructions regarding how to respond to the ARC. The Provider must submit all requested materials, by the deadline identified in the notification letter. If multiple Providers are subject to an SCR who are under a single organization or agency, the ARC may initiate one SCR process that incorporates the investigation of all Providers within the organization or agency.

4. SCR Review – Once information has been received, the ARC will review the Approved Provider's response to the SCR and any other relevant information concerning the Approved Provider in order to identify any Standard violations, innovations, or best practices. Information related to the type of SCR, documentation request, and the response from the Approved Provider remain confidential to the public prior to the ARC determining if any violations are found.

5. ARC Determination – The ARC will notify the Approved Provider who is the subject of the SCR in writing of the SCR outcome within 21 days of the ARC review. The SCR will identify at least one or more of the following

outcomes:

a) The Approved Provider is approved for continued placement, and no further action is required at that time.

   Outcome: The Approved Provider retains their level and status is maintained. The ARC may provide general feedback for the Approved Provider for their consideration.

b) An innovative practice is identified as a best practice.

   Outcome: The Approved Provider retains their level and status is maintained. If an Approved Provider demonstrates skills, competencies, and abilities of a higher practice level, the ARC has the discretion of awarding an increase in practice level.

c) Standards violations are founded.

   Outcome: The Approved Provider may be offered a Compliance Action Plan (CAP) to resolve the founded violations from an SCR. The ARC will determine whether the Approved Provider may retain their practice level or whether the practice level will be reduced while the CAP is in effect. The CAP will specify the timeframes, actions, and documentation needed by the Approved Provider to demonstrate any founded violations have been resolved. The Approved Provider must demonstrate to the ARC that the founded violations have been resolved systemically. Once the Approved Provider has completed the CAP to the satisfaction of the ARC, the Approved Provider will retain their practice level. For Voluntary and Random SCRs, information related to resolved violations, the supplemental documentation and the outcome of the SCR remains part of the Approved Provider's confidential file and not available to the public. The information related to violations, the supplemental documentation and the outcome of a For Cause SCR are part of the Approved Provider's file and can be made available to member of the public upon request.

   The ARC has the discretion to administer any action listed in Section IV of these Administrative Policies if:

   i. The Approved Provider subject to a CAP declines, refuses, or fails to participate in the CAP required to resolve the founded violations.

   ii. The Approved Provider subject to a CAP cannot resolve the founded violations or the Approved Provider is unable to demonstrate skills, competencies, and abilities consistent with the Provider's practice level.

d) A formal complaint will be opened by the DVOMB and also forwarded to the Department of Regulatory Agencies (DORA), on behalf of the ARC.

C. COMPLAINTS

In the provision of services to domestic violence offenders, actions by an individual that violate the Standards or any general practice requirements of their certification, license, or registration, can be reported as a formal complaint to the DVOMB. Formal complaints (hereafter referred to as complaint) received by the DVOMB are reviewed by the ARC and shall be forwarded to the Department of Regulatory Agencies (DORA) for processing.

A. When a complaint is made to the DVOMB about an Approved Provider on the Provider List, the complaint shall be made in writing to the DVOMB and submitted. The appropriate complaint form is available on the DVOMB website. All complaints against Approved Providers on the Provider List will be forwarded for investigation and review to DORA pursuant to section 16-11.8-103(4)(a)(III)(D) C.R.S.. Concurrently, the DVOMB will review and investigate the complaint for potential action pursuant to section 16-11.8-103(4)(a)(III)(D) C.R.S..

B. Upon receipt of a Formal Complaint, DVOMB staff will notify the complainant in writing of the receipt of the complaint.

Complaints regarding individuals who have never been listed or who were not listed on the Provider List at the time of the complaint, are not appropriate for DVOMB intervention. The DVOMB will inform complainants that it does not have the authority to intervene in these cases but may refer complaints against such individuals to DORA for further action. Complaints appropriate for DVOMB intervention are those complaints against DVOMB Approved Providers, who are on the Provider List, or who were on the Provider List at the time of the alleged violation. Complaints against an Approved Provider regarding actions of unlisted persons under the supervision of that the Approved Provider, are also appropriate for DVOMB intervention.

Per 16-11.8-103(4)(a)(III)(D) C.R.S., complaints will be reviewed and investigated in the following manner:

1. All complaints will be subject to an initial administrative review by the staff of the DVOMB. This review will determine if the complaint process has been followed using the proper forms available on the DVOMB website. Insufficient or improper filings may not be accepted for review and the DVOMB staff will provide written notice of the deficiencies to the complainant.

2. DVOMB staff will forward complaints to the ARC for review and will notify the complainant in writing of the receipt of the complaint.

    a. If the complaint fails to allege a Standards violation sufficiently, the ARC will notify the complainant in writing.
    b. Determinations under section 2.a. above are final and not subject to appeal.

3. If a complaint sufficiently alleges a Standards violation, ARC's review of the complaint (a process separate from any review contemplated or completed by

DORA) may take any of the following actions. Actions taken by the ARC may be independent from any action taken by DORA. Findings, conclusions or results from the ARC's review may be different from those reached by DORA):

a. Determine complaint unfounded, and notify complainant and identified Approved Provider in writing.

   OUTCOME: No formal actions will appear on file for this identified Approved Provider regarding this complaint.

b. Request clarifying information from the complainant and/or the identified Approved Provider.

c. Contact the identified Approved Provider and complainant to determine if the complaint can be resolved informally through mutual agreement between the Approved Provider and complainant. The decision to resolve a complaint by using mutual agreement will be made on a case-by-case basis. If mutual agreement can be reached as agreed upon by the complainant and Approved Provider, the complaint will be determined to be unfounded. The complainant will be notified in writing of the mutual agreement and the complaint will be unfounded.

   OUTCOME: No founded complaint will appear on file for this identified provider regarding this complaint. The information that a mutual agreement or the letter containing the terms of the mutual agreement will be available upon request.

d. Request both parties appear before the ARC. Either party may request alternate electronic means with the ARC in lieu of appearing in person. The request to appear electronically must be made at the time of the request by the ARC to appear. Any decision to conduct a meeting is made at the sole discretion of the ARC. If the ARC holds a meeting regarding the complaint, the following procedures apply:

   1. Both the complainant and Approved Provider will be notified in writing of the date, time and place for the meeting.

   2. If mutual agreement resolving the complaint can be reached, the complaint will be determined to be unfounded. The complainant and Approved Provider will be notified in writing that the complaint will be unfounded.

      OUTCOME: No founded complaint will appear on file for this identified provider regarding this complaint. The information that a mutual agreement or the letter containing the terms of the mutual agreement will be available upon request.

e. Request Program staff to further investigate the information contained in the complaint either directly or through investigators or consultants.

   1. Conclude that a complaint is unfounded and the identified provider is notified of the results of the complaint

OUTCOME: No formal actions will appear on file for this identified provider regarding this complaint. As an unfounded complaint, the details of the complaint remain confidential.

2. Conclude that a complaint is founded, and the Approved Provider is notified of the outcome of the complaint, which may include any action listed in Section IV of these Administrative Policies. Any founded complaint in one approval category shall result in a review of the individual's other approval categories, and may impact these other approval categories as well (e.g., a founded complaint against an Approved Provider who is approved to work with female offenders may impact the individual's status to work with LGBTQ+ offenders as well).

   OUTCOME: A formal action and the Standards that were identified to have been violated regarding this complaint will be recorded in the file for the Approved Provider. As a founded complaint, the details of the complaint will be available to the public upon request.

   If the decision is made to remove the Provider from the Approved Provider list, referral sources will be notified and the identified provider will be taken off the list either 31 days from the date of issue of the Letter of Removal *OR* following the completion of the appeal process should either party appeal the decision. If the situation warrants, the DVOMB may exercise the option of seeking guidance from the Office of the Attorney General for possible legal action.

VII. REQUEST FOR RECONSIDERATION AND APPEAL PROCESS

Any applicant or DVOMB Approved Provider under these Standards who disagrees with a decision made by the ARC regarding denial, reduction, or removal from the Provider List related to a particular status or approval may exercise two administrative options in the following order:

1. Request for reconsideration by the ARC; and

2. Appeal any final decision made by the ARC to the DVOMB following a request for reconsideration.

Requests for reconsideration and appeals are limited to complaints, denial for placement on the Provider List for a specific listing status, the involuntary removal from the Approved Provider List, or for a reduction in approval status.

A. Request for Reconsideration by the ARC

   1. Submitting A Request - Applicants or Providers must submit a request for reconsideration in writing to the DVOMB within 30 days from the date of issuance of the notification letter to the applicant or Approved Provider. A request for reconsideration shall include supporting documentation that meets one of the following criteria:

- The documentation relied upon by the ARC was in error;
- There is new documentation relevant to the decision of the ARC was not available at the time for consideration;
- The ARC lacked sufficient grounds to support the decision made;
- The ARC failed to follow the DVOMB Administrative Policies.

2. ARC Review – The ARC will perform a subsequent review of its initial decision to deny, reduce, or remove an applicant or Provider from a specific listing status. The ARC will first determine if the request for reconsideration satisfactorily addresses the criteria for review. If the ARC determines the request for reconsideration meets criteria, then the ARC will deliberate and consider the documentation submitted. Upon review the ARC can vote to:

   a) Uphold the original decision of the ARC. This final decision by the ARC can be appealed to the DVOMB.

   b) Modify the original decision of the ARC. This final decision by the ARC can be appealed to the DVOMB.

   c) Reject the original decision of the ARC This final decision by the ARC can be appealed to the DVOMB.

3. Decision Notification – ARC communication of decisions will be provided in writing within 21 days after the ARC decision is made.

B. Appeal to the DVOMB

1. Submitting a Request to Appeal the Decision of ARC – Applicants or DVOMB Approved Providers must submit a request to appeal a final decision by the ARC in writing to the DVOMB within 30 days from the date of issuance of the notification letter to uphold or modify the ARC decision following the request for reconsideration. A request to appeal shall include supporting documentation and meet the following criteria:

   - The documentation relied upon by the ARC was in error;
   - There is new documentation relevant to the decision of the ARC was not available at the time for consideration;
   - The ARC lacked sufficient grounds to support the decision made;
   - The ARC failed to follow the DVOMB Standards or policy in making its decision.

2. Parties affected by the appeal may include an applicant, a Provider, or a complainant. All parties affected by an appeal will receive notification of the date, time and place of the appeal, along with the deadline for

submission of additional materials. These additional materials must be limited to 10-15 pages and be received by the DVOMB 60 days prior to the hearing. Materials received after the deadline or not prepared according to these instructions will not be reviewed at the scheduled appeal hearing.

3. DVOMB Review – The DVOMB will only consider information specific to the finding outlined by the ARC in the notification letter.

   a) Copies of the appeal materials (subject to redactions or other protections to comply with statutorily contemplated confidentiality concerns) considered by ARC will be provided to the DVOMB and parties involved at least 30 days prior to the hearing and the parties and the DVOMB are expected to make every effort to maintain confidentiality of the materials.

   b) Either party may request alternate electronic means to meet with the DVOMB in lieu of appearing in person. The request must be made in writing at the time of the request for the appeal.

   c) Appeals will be scheduled in conjunction with regular DVOMB meetings. The appellant must confirm, in writing, their ability to attend the scheduled appeal; failure of the appellant to do so may result in the appeal being dismissed. The DVOMB staff and the DVOMB chairperson will jointly review requests for an extension or to reschedule an appeal. The decision to extend or reschedule an appeal is within the discretion of the DVOMB Chairperson and program staff. Parties will be notified verbally or in writing, as applicable, regarding the decision on the request for an extension or to reschedule.

   d) Parties involved may bring one representative with them. Appeal hearings (in person or via electronic means) will be 80 minutes long: 20 minutes for a verbal presentation by the complainant (if available); 20 minutes for the identified provider; 20 minutes for presentation by the ARC; and 20 minutes for questions and discussion by the Board. Applicable time periods may be modified upon request, by either party or a DVOMB member, followed by a motion by a DVOMB member and a vote on the motion.

   e) There must be a quorum of the DVOMB to hear an appeal. ARC members count towards establishing a quorum, but must abstain from voting on the appeal per DVOMB By-laws.

   f) The DVOMB will consider appeals in open hearing and audio record the proceedings for the record unless certain material must be considered by the DVOMB in executive session pursuant to Section 24-6-402(3)(a)(III), C.R.S. Any vote will occur in open session.

   g) The DVOMB must vote on the original findings of the ARC. They must vote in one of the following three ways:

i. Uphold the decision of the ARC.
ii. Modify the decision of the ARC.
iii. Reject the decision of the ARC.

4. Decision Notification – The results of the appeal will be documented via letter sent to all parties within 30 days after the date of the appeal hearing.

   a) Founded complaint records will be retained for 20 years per the Division of Criminal Justice Records Retention Policy.

   b) The appeal process is the sole remedy for an applicant or Provider who is denied, reduced, or removed from a specific listing status on the Provider List, or resolution of a complaint(s). The decision of the DVOMB is final.

VIII. VARIANCES

The purpose of the Standards Variance Process is to allow for a DVOMB Approved Provider or applicant to seek approval for a temporary suspension of a specific Standard. The reasons for suspending a requirement of the Standards vary, but modifications to requirements of the Standards are limited to rare circumstances that are reviewed on a case-by-case basis. Variance requests can be related to the treatment for an offender or to request a modification to the approval process.

A. Submitting A Variance Request – A Provider who is unable to comply with the requirements of the Standards may submit a variance proposal to the ARC for review. The proposal should be identified as a Standard Variance Request and must include the following components:

   1. Identification of each Standard that is subject to the variance;

   2. An overview of the circumstances leading to the request for a variance and documentation why compliance with the Standards is not possible;

   3. A plan developed for the proposed variance of outlining the following:

      a) Victim safety including re-offense and lethality considerations

      b) Enhanced offender containment strategies

      c) Ongoing assessment of offender risk and progress

      d) Timeframe

      e) Written verification of MTT consensus

B. Preliminary Review – DVOMB Staff and at least one ARC member will perform an initial review of the request. If the request is acceptable, they will authorize preliminary approval of the plan until the ARC can conduct a formal review at the next meeting. If the request is not acceptable, the ARC member and the

Staff will work with the Provider to modify and address any questions or concerns. Variances that are not granted preliminary approval will be scheduled for formal review by the ARC at the next meeting. The Provider will be notified in writing of the decision to approve or deny preliminary approval of the variance.

C. ARC Review – The ARC will review the Standards Variance Request. If preliminary approval was granted, the ARC may uphold that decision or modify the variance. The ARC will ratify the Standards Variance Request and create a plan for conducting periodic reviews and any necessary documentation required for those

reviews. The ARC has the authority to set forth specific program conditions during the time frame of the variance request.

IX. TECHNICAL ASSISTANCE

Questions pertaining to the application and interpretation of the Standards can be directed toward the DVOMB staff who are available to provide clarification and support as needed and applicable on a case by case basis. DVOMB Approved Providers and other individuals who use the Standards are encouraged to contact DVOMB staff with questions when technical issues arise.

Appendix B: Overview for Working with Specific Offender Populations

The Board recognizes that domestic violence offender treatment is a developing specialized field. The *Standards and Guidelines* are based on the best practices known to date for the management and treatment of domestic violence offenders.

There is a growing awareness of the importance of designing and implementing specific treatment programs sensitive to diverse populations. ***The Standards and Guidelines do not specifically*** reflect awareness or sensitivity to differences within specific offender populations. ***These appendices are intended to supplement the Standards and Guidelines in these areas.*** The Board is committed to modifying and adapting treatment techniques, standards, and principles for those specific offender populations that are represented in the state of Colorado.

All of the guidelines for working with specific offender populations will follow the same general format that includes the following content areas:

- Competency, training and experience requirements for providers
- Assessment of offenders
- Treatment parameters and dynamics
- Curriculum of unique topic areas
- Supervision/consultation issues
- Victim advocacy
- Resources
- Bibliography
- Definitions

The Board will remain current on the emerging literature and research and will modify the documents included in this appendix ***as needed***. Because literature and research are evolving in nature, this appendix is a work in progress.

The governing philosophy of public ***and community*** safety and protection of victims will guide the Board in the development of the criteria for working with specific offender populations.

Appendix B: Specific Offender Population Best Practice Guidelines

I. For Providing Offender Treatment to Domestic Violence Offenders in Same-Sex Relationships

On June 9, 2006 the Domestic Violence Offender Management Board (DVOMB) formally adopted these Guidelines. The following Guidelines have been developed to address the unique aspects of treatment with individuals who have used violence against a same-sex partner. These Guidelines may be relevant to individuals who identify as gay, lesbian, bisexual, transgender, intersex, pansexual, questioning, or queer (see I. Definitions). While domestic violence research and treatment with some "sexual minorities" (i.e., transgender, intersex, pansexual individuals) is limited, the experience of marginalization and oppression crosses all of these orientationsand identities. Not only must the Treatment Provider demonstrate skill in addressing issues of violence in same-sex relationships (regardless of how the offender identifies: i.e., a "straight" identified male offender in a relationship with a male), the Provider must also recognize issues related to sexual orientation and identity. These Guidelines supplement the DVOMB *Standards and Guidelines* and are found in the Appendix of the Standards.

A Specific Offender Population Subcommittee of the DVOMB was established to develop these Guidelines. The Subcommittee, comprised of state and local experts in the field of same-sex partner abuse (including treatment providers, victim service providers and advocates, probation/ corrections officers, and others involved in the criminal justice system) collaborated in the creation of these Guidelines. Clinical and professional expertise, as well as a review of available research and literature, served as the foundation for these Guidelines.

The treatment issues unique to offenders in same-sex relationships require that providers working with this population have specific experience, knowledge, and assessment skills to effectively assess for and provide treatment to offenders. The following describes training, assessment, treatment, and supervision issues related to effective work with same-sex offenders.

The issues identified here should be integrated throughout treatment, rather than approached as separate from the core of the treatment curriculum.

A. Competency, training and experience requirements for providers

1. Minimum competencies–obtained through core or basic trainings (10.03 Training Hours)

    - Basic definitions/terminology: lesbian, gay, bisexual, transgender, queer (LGBTQ). See I. Definitions
    - Homophobia/heterosexism
    - Sexual orientation vs. Gender identity Stages of coming-out process (e.g., Cass, Coleman, La Pierre; see H. Bibliography)
    - Role of sex in relationships

- Gender stereotypes
- Same-sex relationship violence: power and control wheel
- LGBTQ outing
- LGBTQ hate crimes
- System discrimination: police, courts, treatment
- Societal marginalization: family, church, housing, employment
- Probable cause arrest laws/policies/procedures
- Dual arrest: predominant aggressor vs. co-combatant vs. true victim
- Familiarity with community resources for LGBTQ victims or offenders

2. Critical training areas – obtained through advanced trainings (See G. Resources and I. Bibliography)
   a. Internalized homophobia/heterosexism
   b. Stages of same-sex relationship development
   c. Role models in LGBTQ communities
   d. Healthy relationship dynamics and/or processes
   e. Parenting: adoption, foster, birth, co-parenting

3. Field experience requirements (10.04 Experiential Hours)

B. **Assessment of offenders**

1. Unique aspects of violence history (e.g., vulnerability to hate crimes)
2. Prior arrest and conviction history, including background check, criminal involvement related to partner. Prior criminal cases in which the offender was the identified victim.
3. Unique aspects of relationship history (e.g., more extensive than standard; relationship agreement regarding monogamy)
4. Unique aspects of drug/alcohol addiction and recovery. Addiction history: drug/alcohol evaluations (SSI, ASI, ASAM and/or DSM); "meth rage"; criminal activities related to addiction.
5. Unique sexual activity history
6. Gender stereotypes in relationship(s)
7. Unique health issues (e.g., HIV, cancer, hepatitis, STD)
8. Current offense/arrest information: level of aggression (predominant aggressor vs. co- combatant vs. true victim)
9. Level of internalized homophobia
10. Stage of LGBTQ socialization
11. Stage of coming out
12. Level of acceptance/rejection: family, friends, employer, landlord
13. Level of access to LGBTQ support resources
14. Unique stalking concerns
15. Relationship assessment
    - Current status of relationship
    - Mutuality assessment: Are both partners abusive? Only the defendant? Or only the "victim"? Stalking, harassment, potential violence by

current partner
- Lethality assessment as appropriate
- Prior violence: Was the defendant in other abusive relationships as either offender or victim?

16. Anger assessment: behaviors when angry; "triggers" for anger; emotional volatility
17. Rape, sexual abuse history, childhood history of victimization
18. Current offense/arrest information: level of aggression (predominant aggressor vs. co- combatant vs. true victim)
19. Self-defending victims

C. **Treatment parameters and dynamics (10.08 Sexual Orientation)**

1. Same-sex offender groups: benefits, challenges, boundaries, structure
2. Resistance
3. Uniqueness and Isolation
4. Unique methods of victimization: victim outing; victim invisibility; victim degenderization
5. Impact of uniqueness of community: limited confidentiality; current friends vs. future partners
6. Completion/Discharge
   - Unique aspects of accountability
   - Unique aspects of consistent use of time-outs
   - Higher expectation of more open and honest communication with victim
   - Less stereotypical roles in relationship
   - Less controlling social behavior
7. Unique safety issues

D. **Curriculum of unique topic areas working with same-sex relationship offenders (10.06 Offender Treatment Goals)**

1. The LGBTQ topic areas addressed here should be integrated throughout treatment, rather than approached as separate from the core of the treatment curriculum
2. Stages of LGBTQ coming-out process
3. Stages of LGBTQ relationship development
4. Role models in communities
5. Role of sex in relationships
6. Gender stereotypes
7. Homophobia/heterosexism
8. Outing
9. Hate crimes
10. System marginalization
11. System discrimination

E. **Supervision/consultation issues (10.05 Supervision)**

The supervisor/consultant should have expertise in working with both offenders and

victims and have the adequate training in both areas

F. **Victim advocacy (7.03 b)**

1. Unique advocacy considerations; e.g., "partner outreach"
2. Training recommendations
   a. Basic LGBTQ definitions/terminology
   b. Awareness of unique techniques of abuse (e.g., internalized homophobia, outing, medical status, stigmatization or isolation of victim)
   c. Unique safety concerns (e.g., minimization, lack of safe houses)
3. Resources: CAVP, Q center, private therapists, support groups

G. **Resources**

1. Community-based LGBTQ Relationship Violence Resources (e.g., Colorado Anti-Violence Program)
2. LGBTQ Centers
3. LGBTQ –skilled therapists
4. DVOMB/SOP approved treatment providers
5. DVOMB/SOP trainings

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I. **Definitions**

Throughout this document, the acronym “LGBTQ” is used to refer to “GLBTQ” and “GLBTIQA” as defined below.

1. ***GLBTQ & GLBTIQA:*** These letters are used as shorthand for the gay, lesbian, bisexual, transgender, questioning and allied community. "I" for intersex and "A" for ally are often included in this "alphabet soup."
2. ***Gay:*** The word gay is generally used to describe men who are romantically and sexually attracted to other men. It is sometimes used to refer to the general GLBTQ community, but most often refers to just gay men. There are many other terms used to refer to gay men, but much of the time they are derogatory, offensive and often painful and should not be used (i.e. fag, etc.).
3. ***Lesbian:*** The word lesbian is generally used to describe women who are romantically and sexually attracted to other women. This term originates with the female poet Sappho who lived in a community comprised predominantly of women on the Isle of Lesbos in ancient Greece. There are many other terms used to describe lesbians, but much of the time they are derogatory, offensive and often painful and should not be used (i.e. dyke, etc.).
4. ***Bisexual:*** The term bisexual is generally used to describe people who are romantically and/or sexually attracted to people of more than one sex or gender.
5. ***Sex & Gender:*** It is easy to confuse these two concepts and terms; however, they are different. Sex refers to the biological sex of a person. Gender refers to their societal appearance, mannerisms, and roles.
6. ***Transgender:*** The word transgender is an umbrella term used to refer to people who transcend the traditional concept of gender. Many feel as though they are neither a man nor a woman specifically, and many feel as though their biological sex (male, female, etc.) and their socialized gender (man, woman, etc.) don't match up. Some opt to change/reassign their sex through hormones and/or surgery and some change their outward appearance, or gender expression, through clothing, hairstyles, mannerisms, etc. Many people who identify as transgender feel as though they are confined in a binary system (male-female, man-woman) that does not match who they feel themselves to be. If we look at gender as a continuum and not an "either/or" concept, we have a better idea of understanding this issue.
7. ***Transsexual:*** Transsexual is used to describe those individuals who use hormone therapy and/or surgery to alter their sex.
8. ***Intersex:*** The word intersex refers to people who, on a genetic level, are not male or female. They are individuals whose sex chromosomes are not xx or xy, or who are born with ambiguous genitalia (hermaphrodites). Surgery performed in infancy or childhood, without informed consent, leaves some of these individuals feeling incomplete or altered. For more information, please refer to the web site for the Intersex Society of North America.
9. ***Questioning:*** People who are in the process of questioning their sexual orientation are often in need of support and understanding during this stage of their identity. They are seeking information and guidance in their self-discovery.
10. ***Ally:*** An ally is an individual who is supportive of the GLBTQ community.

They believe in the dignity and respect of all people, and are willing to stand up in that role.

11. ***Homosexual:*** The word homosexual is a scientific term invented in the 1800's to refer to individuals who are sexually attracted to their own sex/gender. This term is not widely used in the GLBTIQA community as it is seen as too clinical.
12. ***Heterosexual:*** The term heterosexual was created around the same time to describe individuals who are sexually attracted to the opposite sex/gender. These words are still widely used, though they tend to perpetuate an "us versus them" mentality and a dichotomous sex/gender system.
13. ***Straight:*** The word straight is a slang word used to refer to the heterosexual members of our community.
14. ***Heterosexism and Homophobia:*** The term heterosexism refers to the assumption that all people are heterosexual and that heterosexuality is superior and more desirable than homosexuality. "Homophobia" is defined as "the irrational fear and hatred of homosexuals." Both of these are perpetuated by negative stereotypes and are dangerous to individuals and communities.
15. ***Genderism:*** The term genderism refers to the assumption that one's gender identity or gender expression will conform to traditionally held stereotypes associated with one's biological sex.
16. ***Sexual Orientation:*** Ones sexual orientation refers to whom he or she is sexually or romantically attracted to. Some people believe that this is a choice (a preference) and others that it is innate (GLBT people are born this way).
17. ***Gender Identity:*** A person's gender identity is the way in which they define and act on their gender. Gender Expression is how they express their gender.
18. ***Coming Out of the Closet:*** The coming out process is the process through which GLBTQ people disclose their sexual orientation and gender identity to others. It is a lifelong process. Coming out can be difficult for some because societal and community reactions vary from complete acceptance and support to disapproval, rejection and violence. The Human Rights Campaign website has some very good information and resources on coming out.
19. ***Queer:*** The term queer has a history of being used as a derogatory name for members of the GLBTQ (and Ally) community and those whose sexual orientation is perceived as such. Many people use this word in a positive way to refer to the community; they have reclaimed the term as their own. Not everyone believes this and sensitivity should be used when using or hearing it as there are still many negative connotations with its use.
20. ***Pansexual/Polysexual:*** In recent years, the terms "pansexual" and "polysexual" have joined "bisexual" as terms that indicate an individual's attraction to more than one gender.

From the University of Southern Maine's Center for Sexualities and Gender Diversity website; Definitions assembled by Sarah E. Holmes (GLBTQA Resources Coordinator) and Andrew J. Shepard, 2000 and 2002.

Appendix B: Specific Offender Population Best Practice Guidelines

I. For Providing Offender Treatment to Female Domestic Violence Offenders

The following Guidelines have been developed to address the unique aspects of treatment with female domestic violence offenders. These Guidelines supplement the DVOMB *Standards and Guidelines* and are found in the Appendix of the Standards.

A Specific Offender Population Subcommittee of the DVOMB was established to develop these Guidelines. The Subcommittee, comprised of state and local experts in the field of women's treatment and female offenders (including treatment providers, victim service providers and advocates, probation/corrections officers, and others involved in the criminal justice system) collaborated in the creation of these Guidelines. Clinical and professional expertise, as well as a review of available research and literature, served as the foundation for these Guidelines.

The treatment issues unique to female offenders require that providers working with this population have specific experience, knowledge, and assessment skills to effectively assess for and provide treatment to female offenders. While some female offenders may share race, class or other similarities, treatment providers are cautioned not to approach their work with or assumptions about female offenders from a single-lens perspective. Women of color, for example, may have vastly different life experiences than do white women, including the challenge of negotiating both gender-based violence and racism in their lives. It is imperative that treatment providers are prepared to assess and respond to the diversity of experiences and needs within female offender populations. Providers must seek appropriate training to work effectively with women who are racial or ethnic minorities, non-English speaking, of limited economic means, involved in prostitution or sex work, or who identify as lesbian, bisexual or transgender. The following outlines general training, assessment, treatment, and supervision issues related to effective work with female offenders. Providers are encouraged to use these guidelines as a baseline and seek additional training to increase competence in working with diverse groups of women.

The issues identified here should be integrated throughout intake evaluation and treatment, rather than approached as separate from the core of the treatment curriculum.

A. Competency, training and experience requirements for providers

1. Minimum competencies –obtained through core or basic trainings (10.03 Training Hours)
    a. Sexism, gender stereotypes, including internalized sexism.
    b. Women's experience of race, ethnicity and cultural issues; including internalized racism.
    c. Assumptions of competency and adaptability of diverse cultures
    d. Unique impact of violence on women
    e. Origins of anger, modes of anger, levels of anger
    f. Women's trauma issues (e.g., miscarriage, stillbirth, abortion, rape,

sexual assault), including emotional/verbal abuse
g. Effects of domestic violence on victims
h. Victim support issues, including safety plans
i. Drug/alcohol issues for women and victims
j. Dual arrests: predominant aggressor vs. co-combatant vs. victim
k. Probable cause arrest laws/policies/procedures
l. Parenting issues

2. Critical training areas – obtained through advanced trainings (See "Resources" and "Bibliography")
   a. Women and anger: stereotypes of women's passivity or helplessness;
   b. Race and class biases in women's use of anger.
   c. Self-defending victims: distinguishing "self-defense" from "retaliation" or "perpetration"
   d. Working with "perpetrator", "retaliator" and "victim" issues in the same group
   e. A thorough understanding of Standard 4.06 and CRS 18-6-801(1)(a) for females who have been evaluated as inappropriate for domestic violence offender treatment.
   f. Addressing past criminal issues (e.g., DOC)
   g. Cultural competency training
3. Field experience requirements (10.04)

B. Assessment of offenders [assessment should be conducted in the offender's primary/dominant language]

1. Prior arrest and conviction history, including background check, criminal involvement related to partner (e.g., check fraud on behalf of partner, drug-related offenses with partner, prostitution/ sex work). Prior criminal cases in which the offender was the identified victim (e.g., domestic violence, sex assault cases)
2. Female offender's experience of violence in current relationship and barriers to accessing law enforcement and other services (e.g., class and economic issues, immigration status, institutional racism, language/cultural inaccessibility).
3. Potential retaliation by partner.
4. Physically abusive behaviors perpetrated in the past
5. Addiction history: drug/alcohol evaluations (SSI, ASI, ASAM and/or DSM); "meth rage"; criminal activities related to addiction (e.g., check fraud, sex work)
6. Assessment of predominant aggressor tactics
7. Relationship assessment
   a. Current status of relationship: Actual or threat of ongoing abuse by partner.
   b. Mutuality assessment: Are both partners abusive? Only the defendant? Or only the "victim"?
   c. Stalking, harassment, potential violence by current partner
   d. Lethality assessment as appropriate
   e. Prior violence: Was the defendant in other abusive relationships as either offender or victim?
8. Anger assessment: behaviors when angry; "triggers" for anger; emotional volatility
9. Rape, sexual abuse history, childhood history of victimization

10. Emotional, psychiatric and physical health issues acute for women (e.g., PTSD or other psychiatric issues related to adult/childhood victimization; reproductive difficulties, perimenopause, menopause; rate of suicidal ideation among female violence/trauma survivors)
11. Women's use of lethal violence (See "Bibliography") 12.Gender roles and attitudes toward women
12. Race/class stereotypes; internalized racism. In biracial couples, beliefs about self or partner's racial identity.
13. Dependency issues, including socialization of women to be emotionally and financially dependent on male partner
14. Criminal thinking patterns unique to women
15. Current offense/arrest information: level of aggression (predominant aggressor vs. co-combatant vs. true victim)
16. Self-defending victims

C. **Treatment Parameters and Dynamics (10.08)**

1. Gender-specific groups are required.
2. Treatment should be conducted in the offender's primary/dominant language
3. Treatment awareness/sensitivity to race, class, cultural, language, and sexual orientation differences within the group
4. Trauma issues impacting women (e.g., abortion, rape, miscarriage, stillbirth)
5. Clinical use of group processing (e.g., relational interaction dynamics vs. didactical topic discussion)
6. Clinical immediacy (e.g., "Here and Now" vs "Theoretical or Idealized")
7. Sexual empowerment vs. compulsion
8. Trauma response and its effect on group: "trauma glasses"
9. Ego strength building without splitting or polarizing
10. Correctional facilities (e.g., Department of Corrections) considerations: individual vs. group treatment, "in-jail" groups, specialized case management
11. Dual-diagnosis groups
12. Ostracism within the group (e.g., boundaries vs. isolation)
13. Completion/Discharge
    a. Unique aspects of accountability
    b. Unique aspects of consistent use of time-outs
    c. Less stereotypical roles in relationship 14.Unique safety parameters. Safety planning in response to ongoing abuse in the relationship Possibility of retaliation by the partner

Curriculum of topics unique/acute to women (10.07)

Different "types" of anger (e.g., entitlement anger, 'fear-of-abandonment'–based anger, residual anger from past relationship, residual anger from prior adult or child victimization, rage issues, and appropriate anger as healthy response to injustice/violence)

Issues experienced by women (e.g., abortion, miscarriage, stillbirth, grief, rape or

other sexual assaults, sexual harassment, emotional/verbal abuse). Perceived or actual social, racial, and/or class injustices experienced by some women. These issues may contribute to anger.

Integrating parenting and "motherhood" issues is critical for the treatment success of many female offenders. These concerns include child custody, children's safety, parenting skills, single parenting, reunification, step-children, childcare, attachment, custody, visitation, etc.
Child Protection Services intervention.

Arrest and incarceration trauma experienced by some female offenders Accountability for behavior, despite partners behavior (i.e. no blaming).

Supervision/consultation issues (10.05)

The supervisor/consultant should have expertise in working with both offenders and victims and have the adequate training in both areas

Victim advocacy (7.03b)

1. "Victim advocacy" to the system-defined victim may be described as "partner outreach" in recognition that the female defendant may in fact be the "predominant victim" in the relationship or that the system-defined victim may feel stigmatized by the term "victim".
2. Awareness of and training in predominant aggressor issues, dual arrests, and co-combatant arrests. (Reference CRS 18-6-803.6)
3. Training and expertise in providing advocacy/support in cases involving a victim-defendant inappropriately arrested.
4. Awareness of and training in working with diverse groups of women, including but not limited to race, class, sexual orientation, and gender identity differences.

Resources

Community-based domestic violence services/resources
For victims and offenders (heterosexual, same-sex, male, female, transgender) Local therapists specializing in women's issues and domestic violence DVOMB/SOP Approved Treatment Providers
DVOMB/SOP Recommended Trainings

Bibliography

Research/literature re women and mental health, suicide, trauma, addiction, and criminality.
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who successfully completed female-only programs were lower by approximately one-third, compared to women in coed programs". http://dcj.state.co.us/ors/pdf/docs/Comm_Corr_05_06.pdf

Warden In Pink, by Tekla Miller (former warden describes differences she noted between male and female offenders).

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Selected Definitions

[Not all relevant terms will be defined here. Definitions of clinical, treatment, and training terms and concepts (e.g., "Post Traumatic Stress Disorder" or "internalized racism") should be addressed in training and/or treatment curriculum materials.]

1. ***Predominant Aggressor:*** Refers to the individual who, in the incident or

historically in the relationship, maintains power and control over their partner through the use or threatened use of violence. Also refers to CRS 18-6-803.6(2) which directs peace officers to assess the following when evaluating complaints of domestic violence from two or more parties: "(a) any prior complaints of domestic violence; (b) the relative severity of the injuries inflicted on each person; (c) the likelihood of future injury to each person; and (d) the possibility that one of the persons acted in self-defense."

2. ***Victim-Defendant:*** System-defined "defendant" in the case who has historically been the victim in the relationship.

3. ***Partner Outreach:*** Advocacy or assistance provided to the system-defined "victim" in the case. In situations involving victim-defendant arrest, the system-defined "victim" may have a history of using violence or the threat of violence to intimidate or control the victim-defendant. Additionally, the system-defined victim may feel stigmatized by term "victim"

Appendix C: Glossary of Terms

Accountability: The full assumption of responsibility, without distortion, minimization, or denial, while also claiming responsibility for the abusive behaviors, accepting the consequences of those behaviors, and actively working to repair the harm and preventing future abusive behavior.

Aftercare Plan: An offender's written plan for utilizing concepts learned in treatment. This plan shall include ways to address individual risk factors, criminogenic needs and continued pro-social support systems in order to maintain non-abusive long-term change.

Anger Management Treatment: Is often a psycho-education and therapy based program to address a person's struggles or inability to manage their disruptive angry behavior. Anger management treatment shall never be a substitute for domestic violence offender treatment.

Application Review Committee (ARC): The Application Review Committee (ARC) is delegated the authority by the Domestic Violence Offender Management Board (DVOMB) within the Division of Criminal Justice (DCJ) to perform the functions identified in C.R.S. This includes reviewing all applications seeking approval in order to determine whether an applicant has met the requirements for listing status, including those applications by Approved Providers seeking a different status.

Approved Provider: An individual who advertises or sets him/herself forth as having the capacity, competencies, and training to evaluate and/or treat domestic violence offenders in the State of Colorado, and has been approved by the Domestic Violence Offender Management Board and whose credentials have been verified by the Department of Regulatory Agencies pursuant to Section 16-11.8-103, C.R.S.

Approved Provider Working with Specific Offender Populations: An Approved Provider who has demonstrated his/her ability to meet the criteria as described in the *Standards and Guidelines* and the application process for specific offender populations, and has been approved as a DVOMB provider by the Application Review Committee.

Assessment: An ongoing collection of facts to draw conclusions regarding an offender's progression or regression in treatment, which may suggest the proper course of action.

Assessment Tool: A tool used in conjunction with a thorough clinical assessment to determine diagnosis, risk factors, lethality, or the treatment needs of the offender.

Board: As defined in Section 16-11.8-102, C.R.S. The Colorado Domestic Violence Offender Management Board (DVOMB) is a policy board made up of 19 multi-disciplinary experts in the field of domestic violence who are charged with the responsibility for developing *Standards and Guidelines* related to the consistent and comprehensive evaluation, treatment, and continued monitoring of domestic violence offenders (16-11.8-101 C.R.S.). The DVOMB is organizationally located in the Colorado Department of Public Safety (CDPS), in the Division of Criminal Justice, Office of Domestic Violence and Sex Offender Management.

Case Management: The coordination and implementation of the cluster of activities

directed toward supervising, treating, and managing the behavior of domestic violence offenders.

Clinical Features of Domestic Violence and Abusive Behaviors: The following definition of domestic violence is a more comprehensive definition of domestic violence that shall be used for the purposes of evaluation, assessment and treatment of domestic violence offenders under these Standards and Guidelines. Caution should be exercised when applying this definition and list of abuse types in circumstances that have not been identified through the legal system. Not all domestic violence behaviors are illegal, but they may be abusive or harmful to the person who has experienced the behavior. This definition and list of abuse types serve a framework to broadly define domestic violence behaviors in a clinical context that can be used to holistically address all forms of abuse with an offender who has been referred for services.

Domestic violence is an emerging, cyclical, or established pattern of attitudes and/or behaviors that are abusive, controlling, harmful or predatory against a person. Such domestic violence behaviors are choices that attempt to cause a specific outcome rooted in power and control and often intersect with multiple forms of abuse. Domestic violence offenders can present with multiple areas of risk to reoffend (i.e., domestic violence reoffending, lethality, non-domestic violence reoffending). A domestic violence offender is a person who engages in a pattern of one or more of the following abuse categories: dominance, dependence, dissonance, vengeance, surveillance, and violence. This list is not an exhaustive list regarding the forms of abuse related to domestic violence and should be considered and used for clinical purposes.

Category	Description
Dominance	Coercive Control - engaging in a pattern of behaviors to gain control and power by eroding a victim's autonomy, self-efficacy, and self-esteem, marked by domination and entrapment that extends across the spectrum of violent tactics.[84] Cultural Abuse - using culture as a means to excuse, minimize, or otherwise justify their abusive behavior. This may include disparaging the victim's culture, forcing a victim to embrace the offender's culture, isolating a victim from mainstream culture, using culture to silence a victim, using language barrier to isolate a victim, using other language to shut a victim out, etc. Emotional Abuse - using non-physical behaviors that may be subtle or more obvious which are meant to control, isolate, or frighten the victim. This type of abuse may present as threats, insults, yelling, constant monitoring, excessive jealousy, manipulation, humiliation, intimidation, or dismissiveness. While these emotionally abusive behaviors do not leave physical marks, they do cause harm, disempower, and traumatize the victim who is experiencing the abuse. Financial Abuse – controlling, exploiting, limiting, or withholding access to economic assets, employment or resources to negatively impact the financial capacity of the victim. Psychological Abuse - An intense or repeated pattern of confusing or doubt inducing behavior that creates psychological stress, confusion or doubt in the victim. This may include threats or acts of self-harm or homicide, denial of abuse, gaslighting, or stalking.

[84] Dutton, M. A., Goodman, L., James, R. J. (2006). Development and Validation of a Coercive Control Measure for Intimate Partner Violence: Final Technical Report.

	Verbal Abuse - Using words or verbal iterations to as a means to control, coerce, manipulate, intimidate, ridicule, or degrade the victim and negatively impact their psychological health or otherwise cause harm. Collateral harm or abuse - causing harm to secondary victims whether directly or indirectly to harm, manipulate, intimidate or coerce in an abusive or controlling manner. Reproductive Abuse – using coercion, control, deceit, manipulation or threats to impact pregnancy, sabotage of contraceptives, use of contraceptives, access to contraceptives, and unilaterally decides reproductive choices as a method to gain power and control over another person(s).
Dependence	Immigration or Legal Status Abuse - Using or exploiting a victim or their family's lack of documentation, legal or illegal status, or citizenship as a means to threaten, control or, coerce the victim. Isolation and Social Abuse - attempting to foster conditions that aim to isolate a victim from their friends, family or community. These behaviors cause harm by cutting off healthy relationships, limiting social engagement, interfering with social networks, disrupting social interactions, or attempting to cause reputational harm.
Dissonance	Substance Abuse – using mood altering substances as a tool to perpetuate coercive control against the victim, including but not limited to sabotaging sobriety or limiting resources. The use of mood-altering substances by an offender does not cause domestic violence nor is it an excuse for abuse.[85] Intellectual Abuse - disrespecting another's learning style, ability, ways of thinking or intellectual interests. This can involve ridiculing a victim's ideas, devaluing a victim's opinions, or controlling the victim's access to educational or other learning opportunities. Gaslighting - attempting to create self-doubt and confusion in the victim's mind, by distorting reality and forcing the victim to question their own judgment and intuition. Spiritual Abuse - using faith, spirituality, religion, or the lack thereof as a means to intimidate, hurt, or control the victim.
Vengeance	Animal abuse - mistreating, threatening, or killing any pet or animal, such as torturing, tormenting, mutilating, maiming, poisoning, or abandoning to emotionally manipulate or coerce the victim.[86] Administrative Abuse through Systems - utilizing systems intended to provide safety to a victim to harass, threaten, intimidate and/or control the victim instead. Using children - using or manipulating children as a means to control, coerce, manipulate, or otherwise cause harm to a victim. Destruction of Property - damaging, destroying, devaluing or taking possession of the tangible property of the victim as an act to harm, retaliate or intimidate the victim.
Surveillance	Monitoring Abuse - using or manipulating the environment physically or virtually to gain access and gather information about a victim regarding their schedule, activities, whereabouts, and interactions. These behaviors are a violation of the victim's expectation of and right to privacy regardless of consent, awareness or knowledge. These behaviors can undermine a victim's sense of safety, sanity, and security. This definition may include unwanted advances by the domestic violence offender in the pursuit of the identified victim. Stalking - engaging in a pattern of behavior directed at a specific person that attempts to develop, expand or maintain a relationship with the victim. These behaviors can cause substantial emotional distress or fear for the victim's

[85] Rivera, E. A., Phillips, H., Warshaw, C., Lyon, E., Bland, P. J., Kaewken, O. (2015). An applied research paper on the relationship between intimate partner violence and substance use. Chicago, IL: National Center on Domestic Violence, Trauma & Mental Health.

[86] Fabres et al., (2014). Adulthood Animal Abuse Among Men Arrested for Domestic Violence. Violence Against Women, 20(9) 1059–1077.

	safety or the safety of others. Victims may or may not be aware of these behaviors.[87] Technology-Facilitated Abuse - using technologies to bully, harass, stalk or intimidate. These behaviors may include non-consensual image sharing.
Violence	Physical abuse - using any physical act or object (including weapons) with the potential for causing harm, injury, disability, or death to exert power and control over the victim. Such physical acts can include targeting anyone or anything the victim may have an attachment to. Physical abuse can include coercing other people to commit any physical acts against the victim. Strangulation[88] - impeding or restricting the airway or circulation of the blood of a victim by applying pressure to the neck or chest, or by blocking the nose or mouth.[89] Sexual abuse[90] - using any physical act, behavior, or exploitation that is sexual in nature and causes harm to the victim without consent.

Colorado Department of Public Safety (CDPS): Colorado Department of Public Safety is responsible for staffing the Board pursuant to Section 16-11.8-103, C.R.S.

Clock Hours: 60 minutes in an hour.

Co-facilitation: Experiential hours accumulated by a future applicant, which are completed in the physical presence of a Full Operating Level or a Domestic Violence Clinical Supervisor Level provider. Co-facilitation hours may only be accumulated while the future applicant is also being supervised by a Domestic Violence Clinical Supervisor during the period of time co-facilitation is taking place.

Competencies, Additional: Some offenders have additional risk factors that require demonstration of additional competencies. Additional competencies shall be required for offenders based on risk factors and individual treatment needs, as determined at the initial evaluation or during Treatment Plan Reviews. Examples of additional competencies are listed in *Standard* 5.08VI (A-G).

Competencies, Core: Core Competencies represent the goals of treatment and are measured throughout treatment by the MTT. There are 11 core competencies listed in *Standard* 5.08V (A-R). These competencies shall be demonstrated by offenders prior to discharge.

Containment: The process of restraining, halting, and preventing the offender from engaging in further violence against an intimate partner through the application of

[87] Woodlock, W. (2017). The Abuse of Technology in Domestic Violence and Stalking, Violence Against Women, 23(5) 584–602; Senkans et al. (2017). Assessing the Link
Between Intimate Partner Violence and Postrelationship Stalking: A Gender-Inclusive Study, Journal of Interpersonal Violence, 1–31.

[88] § 18-3-202(1)(g), C.R.S.: "With the intent to cause serious bodily injury, he or she applies sufficient pressure to impede or restrict the breathing or circulation of the blood of another person by applying such pressure to the neck or by blocking the nose or mouth of the other person and thereby causes serious bodily injury."
§ 18-3-203(1)(h)(i), C.R.S.: "With the intent to cause bodily injury, he or she applies sufficient pressure to impede or restrict the breathing or circulation of the blood of another person by applying such pressure to the neck or by blocking the nose or mouth of the other person and thereby causes serious bodily injury."

[89] Mcquown et al. (2016). Prevalence of strangulation in survivors of sexual assault and domestic violence. American Journal of Emergency Medicine, 34, 1281–1285; Thomas et al. (2014). "Do You Know What It Feels Like to Drown?": Strangulation as Coercive Control in Intimate Relationships, Psychology of Women Quarterly, Vol. 38(1) 124-137; Zilkens et al. (2016). Nonfatal strangulation in sexual assault: a study of clinical and assault characteristics highlighting the role of intimate partner violence, Journal of Forensic and Legal Medicine, 43, 1-7.

[90] §16-11.7-102(3), C.R.S.

supervision, surveillance, consequences, restrictions, and treatment as imposed by the courts, supervising agents of the courts, and approved providers.

Couples Counseling: A prohibited intervention while a domestic violence offender is receiving domestic violence offender treatment.

Criminal Justice System: Includes activities and agencies, whether state or local, public or private, pertaining to the prevention, prosecution and defense of offenses, the disposition of offenders under the criminal law and the disposition or treatment of juveniles adjudicated to have committed an act which, if committed by an adult, would be a crime. This system includes police, public prosecutors, defense counsel, courts, correction systems, mental health agencies, crime victims and all public and private agencies providing services in connection with those elements, whether voluntarily, contractually or by order of a court.

Criminogenic Needs: A term used to reference offender dynamic factors such as substance abuse (alcohol and other drugs), antisocial attitudes, personality traits, associates, employment, marital and family relationships, and other dynamic variables statistically shown to be correlated with criminal conduct and amenability to change (Andrews & Bonta, 1994). As dynamic risk factors, criminogenic needs may contribute towards criminal behavior (e.g., domestic violence), and if effectively addressed, should decrease level of risk (Andrews, 1989, Andrews & Bonta, 1994; Bonta, 2002).

Denial, Severe: This level of denial consists of offenders who deny committing the current offense and refuse to acknowledge responsibility for even remotely similar behaviors. Offenders may also appear excessively hostile or defensive. This type of denial is the most resistant to change and may require other interventions or may not be amenable for treatment. See Standard 5.06 and 5.08 for more details.

DVOMB Approved Provider List: The DVOMB Approved Provider List is a list that identifies the providers who are eligible to receive referrals to provide evaluation, treatment, and assessment services to domestic violence offenders in Colorado.

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

Domestic Violence Clinical Supervisor: An Approved Provider who meets the qualifications identified in *Standard* 9.0, and has been approved as such by the ARC as a Domestic Violence Clinical Supervisor.

Domestic Violence Risk Assessment: A valid and reliable assessment tool which identifies

risk factors for domestic violence recidivism. The most recent version of the instrument shall be utilized.

Department of Regulatory Agencies (DORA): The Department of Regulatory Agencies is responsible for supervision and control of the mental health professional boards and unlicensed psychotherapists pursuant to Section 12-43-101, et. seq., C.R.S.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. Providers who utilize this manual shall use the most current version.

Emergency Action: In the event of a public safety issue, the ARC Chair Person in conjunction with the ODVSOM Program Manager may remove a provider from the Approved Provider List and take any necessary action to inform the proper law enforcement and regulatory authorities.

Executive Session: The members of the DVOMB, or the ARC, upon affirmative vote of two-thirds of the quorum present may hold an executive session to discuss legal issues with the DVOMB attorney or to review personnel and confidential information as noted in the Colorado Open Meetings Law (Section 24-6-402(4), 24-6-402(3)(a)(III), 24-6-402(3)(a)(IV), 24-6-402(3)(a)(XII), 13-90-107 (1)(g), 13-90-107 (1)(k), C.R.S.).

Evaluator: An Approved Provider who conducts either pre- or post-sentence offender evaluations according to the Standards contained in this document, and according to professional standards. Only licensed mental health professionals who are Approved Providers shall conduct pre-sentence evaluations.

Face-to-Face Clinical Contact Hours: The actual time an applicant or Approved Provider spends with an offender in person, in the same room, at the same time conducting evaluations, sessions, or other therapeutic interventions. E-therapy is prohibited under these Standards.

Indigent Offender: Individual who is declared indigent by the courts based on the federal poverty guidelines.

Interstate Compact/Out-Of-State Domestic Violence Offenders: When a domestic violence offender seeks domestic violence offender treatment in Colorado, on a case from another state, the Approved Provider will comply with Section 17-27.1.101 et. Seq., and must receive approval from the Interstate Compact Office for each offender, prior to providing any clinical services to the offender. Failure to comply may result in legal and monetary penalties pursuant to Section 17-27.1-101(9)(a) and 17-27.1-101(7), C.R.S. Offender must be fingerprinted where attending treatment, not where person lives.

Intimate Partner: Pursuant to 18-6-800.3(2), an intimate relationship means a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time.

Lethality Assessment: Lethality assessment is the identification of risk factors that may be linked to intimate partner homicide (Jurik & Winn, 1990). Although there are overlapping concerns, risk assessment, lethality assessment, and safety planning are not the same. Victims may or may not be aware of their level of risk. This information can be used to identify potential risk in an offender and for safety planning for victims.

LGBTQIA+: Abbreviation for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual/Agender/Aromantic, etc. Umbrella term utilized to refer to victims and offenders in this community as a whole.

Multi-Disciplinary Treatment Team (MTT): A group of professionals comprised at a minimum of the DVOMB approved domestic violence offender treatment provider, judicial supervising officer and Treatment Victim Advocate, designed to collaborate and coordinate offender treatment.

Office of Behavioral Health (OBH): The Office of Behavioral Health, formerly Division of Behavioral Health (DBH), and Alcohol and Drug Abuse Division (ADAD), is responsible for licensing substance abuse programs, pursuant to Part 2 of Article 2 of Title 25, C.R.S.

Offender: Pursuant to Section 16-11.8-102, C.R.S, any person who on or after January 1, 2001, has been convicted of, pled guilty to, or received a deferred judgment and sentence for any domestic violence offense which includes any crime where the underlying factual basis as defined in Section 18-6-800.3 (1), C.R.S.

Offender Accountability: The offender claiming responsibility for his/her abusive behaviors, accepting the consequences of those behaviors, and actively working to repair the harm and preventing future abusive behavior.

Offender Contract: The signed treatment agreement between the Approved Provider and the offender that specifies the responsibilities and expectations of the offender, Approved Provider, and MTT. All items identified on section 5.05, II, A, B, C and D shall be included in the signed offender contract.

Offender Evaluation: The systematic collection and analysis of psychological, behavioral, and social information; the process by which information is gathered, analyzed, and documented for an offender to undergo a pre- or post-sentence evaluation prior to engaging in domestic violence offender treatment.

Offense: Any crime in which the underlying factual basis is an act of domestic violence.

Open Meetings: All meetings of the DVOMB or its committees shall be subject to the provisions of the Colorado Open Meeting Law (Section 24-6-401 et seq., C.R.S.).

Personal Change Plan: An offender's personal change plan includes a plan for preventing abusive behaviors, identifying triggers, identifying cycles of abusive thoughts and behaviors, as well as a plan for preventing or interrupting the triggers and cycles. This plan is to be designed and implemented during treatment and utilized after discharge as well.

Protection Order: A criminal or civil court order prohibiting or limiting offender access to victims and sometimes children or animals.

Protective Factors: Conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk in families and communities.

Responsible Criminal Justice Agency: The criminal justice agency that has jurisdiction and/or responsibility for supervision of the offender.

Responsivity: 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.

Risk: Services provided to offenders should be proportionate to the offenders' relative level of static and dynamic risk (i.e., low, moderate, or high risk) based upon accurate and valid research-supported risk assessment instruments (Bonta and Wormith, 2013). The risk principle indicates that criminal behavior is predictable and that treatment services need to be matched to an offender's level of risk.

Risk Assessment: A tool utilized to assess offender risk, treatment needs, aid in diagnosis, and which informs treatment planning.

Second Clinical Contact: Offenders who are higher risk to victims and the community require more intensive treatment and supervision designed to address an offender's criminogenic needs. Second clinical contacts require adjunct treatment interventions that are based on the offender treatment plan and shall comply with the Position Paper Regarding Second Clinical Contacts (November, 2013).

Sliding Fee Scale: As defined in Section 18-6-802.5, C.R.S., a sliding fee scale is a policy and procedure that is written and available to all clients and is based on criteria developed by the Approved Provider. The fee scale has two or more levels of fees and is based on the offenders' ability to pay. The fee scale is available to each offender. Approved Providers must not withhold this information from clients.

Specific Offender Populations: Defined as a group of individuals who share one or more common characteristics such as race, religion, ethnicity, language, gender, age, culture, sexual orientation and/or gender identity that would allow for the group to be considered homogenous.

Specific Offender Populations – Assessment Criteria: A section of the Appendix B containing criteria based on research and literature for working with specific offender populations. This section may be periodically modified.

Stalking: Pursuant to 18-3-602(1), C.R.S., a person commits stalking if directly, or indirectly through another person, the person knowingly:

a) Makes a credible threat to another person and, in connection with the threat, repeatedly follows, approaches, contacts, or places under surveillance that person, a member of that person's immediate family, or someone with whom that person has or has had a continuing relationship; or

b) Makes a credible threat to another person and, in connection with the threat, repeatedly makes any form of communication with that person, a member of that

person's immediate family, or someone with whom that person has or has had a continuing relationship, regardless of whether a conversation ensues; or

c) Repeatedly follows, approaches, contacts, places under surveillance, or makes any form of communication with another person, a member of that person's immediate family, or someone with whom that person has or has had a continuing relationship in a manner that would cause a reasonable person to suffer serious emotional distress and does cause that person, a member of that person's immediate family, or someone with whom that person has or has had a continuing relationship to suffer serious emotional distress.

Standards Compliance Review: A process undertaken by the ARC to conduct a review of an Approved Provider in order to determine the level of compliance with the *Standards and Guidelines*, areas for improvement or sustainment, and to identify any best practices.

Supervising Agents: The probation, parole, community corrections case manager to whom the offender's case is assigned.

Therapeutic Alliance: The formation of a positive relationship between the client and the therapist which consists of the following core elements: (1) an agreement on the treatment goals, (2) collaboration on the tasks that will be used to achieve the goals (specific interventions), and (3) an overall bond that facilitates an environment of progress and collaboration. However, developing a therapeutic alliance is often a dynamic and challenging process with forensic populations due to the involuntary nature of mandated treatment (Skeem et al., 2007).

Supervision Contract: Contract between Domestic Violence Clinical Supervisor and supervisee (applicant or approved provider), delineating agreements of supervision, agreements of supervisor and agreements of supervisee.

Training: Specific education instruction that supports the philosophy and principles as described in the *Standards and Guidelines*.

Training, Demonstrated Equivalent Experience and Training: The ability to document the equivalent experience and training for a specific requirement.

Treatment: As defined in Section 16-11.8.102, C.R.S, treatment means therapy, monitoring, and supervision of any domestic violence offender which conforms to the *Standards and Guidelines* created by the DVOMB. Consistent with current–research and professional practices, domestic violence offender treatment is the comprehensive set of planned therapeutic experiences and interventions designed to uniquely change the power and control, abusive thoughts, and behaviors. Such treatment specifically addresses the occurrence and dynamics of domestic violence and utilizes differential strategies to promote offender change. Much more importance is given to the meeting

of all treatment goals than the passage of a specific amount of time, since offenders make progress in treatment at different rates. Treatment is more successful when it is delivered consistently and with fidelity to the individual needs of the offender.

Treatment Amenability: Amenability to domestic violence treatment refers to the

offender's capacity to effectively participate, function, and understand treatment concepts. Significant cognitive (e.g., thinking) impairments can preclude an individual's ability to sufficiently pay attention during treatment sessions, learn new information, and/or self-reflect. Similarly, some cases of acute mental illness may interfere with participation due to the presence of impaired reality testing (e.g., delusions or hallucinations).

Treatment Plan: The written Treatment Plan shall include goals that specifically address all clinical issues identified in the intake evaluation. The treatment goals shall be based on offender criminogenic needs, offender competencies, and identified risk factors. A Personal Change Plan and an Aftercare Plan shall be components of the Treatment Plan. Treatment plan must include Personal Change Plan and Aftercare plan. See Standard 5.05, I.

Treatment Plan Review: The purpose of the Treatment Plan Review is to re-assess offender degree of progress and risk, and to make any necessary modifications to the Treatment Plan and goals. All offenders shall have at least the minimum number of required Treatment Plan Reviews at identified intervals based on level of treatment and individual Treatment Plan(s). See Standard 5.07.

Treatment Program: A program that provides treatment as defined in Section 16-11.8.102 (4), C.R.S. by one or more approved providers.

Treatment Report: At a minimum of once a month, approved providers shall submit a written report to the supervising criminal justice agency that includes results from most recent offender Treatment Plan Review; progress regarding competencies; recommendations related to discharge planning; level of treatment; evidence of new risk factors; and offender's degree of compliance with fees, attendance, and level of participation. See Standard 8.0.

Treatment Victim Advocate: The person who works in conjunction with the Approved Provider and the domestic violence community to provide advocacy to the victim, as outlined Section 7.0.

Vicarious Trauma: A state of tension or emotional distress by professionals working in a service related field due to a preoccupation with the thoughts, behaviors, and reenactments of the abuse by offenders against victims. Sometimes referred to as compassion fatigue, vicarious trauma can impact a person's professional or personal life, such as relationships with friends and family, as well as the person's overall health, both emotional and physical.

Victim: A person who is or has been the target of domestic violence as defined in the Glossary.

Victim Advocate: See Treatment Victim Advocate.

Victim, Secondary: Secondary victims are children, relatives, or other individuals who are impacted emotionally, psychologically, or physically by virtue of their relationship or involvement with the trauma suffered by the primary victim.

Appendix D – Language Interpretation Services

I. Introduction

This appendix outlines specific requirements regarding working with domestic violence offenders who require language interpretation services. The following guidelines serve as a reference for both evaluation, assessment, and treatment services provided by an Approved Provider. This appendix does not replace any mandates currently required in the DVOMB Standards and Guidelines. With the use of clinical and professional expertise, as well as a review of new interpretation options, this appendix will be updated and revised periodically to incorporate new clinical and professional expertise, research, and options for interpretation services. Whenever possible, Approved Providers should strive to utilize interpretation services. When interpretation services are not available, translation services may be utilized.

II. Background

Colorado continues to become more multicultural and diverse. Colorado's population has been growing, ranked the sixth highest among U.S. states during 2010-2020, though the pace has slowed down. Aging is becoming an issue and migration is playing a larger impact on Colorado population change. As a result, Colorado is becoming more racially and ethnically diverse (DeGroen, 2021). About one in eight workers in Colorado is an immigrant and the top five immigrant sending countries to Colorado include Mexico, India, China, Vietnam and Canada (American Immigration Council, 2020).

Client-level data collected from DVOMB Approved Providers from January 1st, 2023 through June 30th, 2023 offer a glimpse of the diversity for those referred for domestic violence offender services. A total of 437 client records were submitted by DVOMB Approved Providers/ Highlights from the demographic data include that 81% of clients identified as male and 19% of clients identified as female. Further, 98% of clients with a known sexual orientation identified as Heterosexual. On average, clients were 34 years old at the time of their offense, with client age ranging from 17 to 64 years. Of clients with educational information available, half reported having a high school degree or equivalent (50%). Of the 402 clients with documented race/ethnicity, 45% self-identified as white and 38% as Hispanic. When asked to characterize their Hispanic origin, of the 271 clients with responses to this question, the majority identified that they were Not of Hispanic Origin (59%), and 31% identified that they were of Mexican origin. It is important to note that information regarding individuals who identify as multiple racial/ethnic groups is not fully represented in this data, as Approved Providers are limited to indicating one racial/ethnic category per question.

In 2021 the Domestic Violence Offender Management Board (DVOMB) created the Diversity Equity Inclusion and Belonging (DEIB) Committee with the intention of:

- Exploring and making recommendations regarding DVOMB policies and procedures to support diversity, equity, inclusion and belonging efforts;
- Exploring and making recommendations regarding DVOMB Standards and Guidelines to enhance service delivery in areas related to cultural competency, implicit bias, trauma and broader social justice issues of racism and intersectionality.

- Identifying possible training content areas for future DVOMB meetings and for Approved Providers.

The DEIB Committee met and developed the language included in this Appendix observing that more nuanced and detailed information was necessary for Approved Providers working with clients who require language interpretation services.

III. Considerations for the Use of Interpreters

At the time of the referral, the Approved Providers shall assess the need for language interpretation for foreign languages and sign language. This assessment should consider how a language barrier would impact the outcome of the evaluation and any follow-on treatment services with a client. If an Approved Provider suspects a client may require language interpretation, the Approved Provider shall notify the referral source and make alternative recommendations including Approved Providers who speak the primary language of the client, if available.

***Discussion Point**: Approved Providers should approach translation services on a case-by-case basis. Group facilitation with live translation can become a distraction and can negatively interfere with the dynamic for the client needing translation as well as the other group members. If a group in the client's spoken language is not available, the Approved Provider should evaluate other options including but not limited to teletherapy groups and individual sessions to accommodate the client as a best practice. While other creative options may be explored by an Approved Provider from time-to-time based on client needs, it is important to note efforts to accommodate a client can be resource intensive for the Approved Provider. As a result, it may be challenging to sustain or replicate some unique accommodations from one client to another.*

It is imperative for Approved Providers to follow the ethical mandates of their credentials regarding sensitivity, awareness, understanding and responsiveness of cultural humility.

It is best practice and in the best interest of the client when the referring agent informs the DVOMB Provider of any language interpretation needs. Referring agents are able to search the DVOMB Provider public database and search for specific Providers who speak specific languages.

***Discussion Point**: The use of an interpreter may bring some inherent difficulties including delays in conversations, difficulty translating specific words or concepts between languages, and dynamics that may emerge between the client and the interpreter. The introduction of a third party may impact the client's overall comfort level, including discussion of personal or sensitive information. When indicated the Provider may need to discuss ethnic or cultural implications of domestic violence with the interpreter. It is important for the Provider to be mindful of these potential challenges and provide information about how this may impact the evaluation or treatment process.*

An interpreter can be requested at any point by a client or the Approved Provider if there are indications one is needed. If a request is made, the Approved Provider shall coordinate with the referral source and allow for one to be present. A court approved court or certified interpreter should be used when possible. In coordinating for an

interpreter, the MTT shall:

- Verify the appropriateness of the interpreter, (i.e. background check, views and attitudes about domestic violence, and victim input regarding the interpreter's appropriateness to fill this role).

- Discuss secondary trauma, provide resources for self-care, and provide opportunities to debrief.

- Inform the client and interpreter that the information discussed is confidential and remind the client of the limits of confidentiality.

If a court approved or certified interpreter is not available, the interpreter shall not be a client's identified victim, current, or past intimate partner, children, including adult children.

A. Provider shall provide the following disclosures, information, and expectations to the interpreter in advance of any service to the client, which shall include but not be limited to the following information:

1. The content and context of the evaluation and treatment. Specifically, the client will be asked about details of the domestic violence offense, violent and abusive behaviors, or other content that may be explicit or sensitive in nature.

2. Information for the interpreter regarding power and control, types of domestic violence, the cycle of domestic violence, information regarding details of the specific case, and an opportunity for the interpreter to ask questions before meeting with the client.

3. The importance of translations that accurately convey the content and essence of questions and answers. The interpreter should be informed of the impacts of paraphrasing and summarizing.

4. Arranging time after to ensure the accuracy of the translated information, resolution of any discrepancies, and questions or concerns from the interpreter.

B. The Provider shall document the following regarding the use of interpreters:

1. Any request or recommendation for a language interpreter, by the client, referral source, Court, or evaluator;

2. If the client accepts or rejects interpreter services.

3. Any barriers, limitations, issues, or potential impacts which may arise from the use, absence, or presence of a language interpreter.

1. Any other impacts on the evaluation or treatment processes such as the inability to complete certain assessments, due to the use of a language interpreter

Appendix E: Resource and Guide to Terms and Concepts of the Pre- Sentence or Post-Sentence Evaluation Standards

Please Note: This document is designed to be a resource guide for working with, assessing, and evaluating offenders. It is intended that approved providers will utilize their expertise along with this guide in working with offenders. Approved providers will make their own decisions regarding the degree of information that needs to be gathered for each offender and how to collect that information.

I. Accountability

A. Definition

Accountability refers to "taking full responsibility for the effects of one's actions." In domestic violence intervention there are many aspects of accountability to consider and there are many ways to assess or measure it at various points of treatment. For example, accountability includes individual and unilateral responsibility (i.e., taking full unilateral responsibility for the effects of one's own words or actions regardless of the influence of anyone else's words or actions). Accountability can be diminished by unhealthy and self- limiting shame as differentiated from appropriate guilt. Low or limited levels of offender accountability can be correlated to high or extensive risks of offender reoffense. Low levels of empathy for the victim can also be correlated to high incidence of recidivism by the offender (Bancroft, 2002).

B. Assessment

Accountability can be assessed by considering the following:

1. Does the offender take responsibility for his/her abusive actions in the police report of the incident? In the victim report? In the other witness report(s)?
2. Does the offender take responsibility for his/her own actions regardless of the actions of the victim or witness(es)?
3. Does the offender take responsibility for any other reports of abuse in the relationship? In other relationships?
4. Is the offender willing to talk in treatment about his/her acts of abuse? Patterns of abuse?
5. Is the offender willing to write about his/her abusiveness?
6. Is the offender willing to receive input/feedback/confrontations from the therapist about the abuse? From the group?
7. Can the offender identify personal deficiencies/challenges/struggles that have played a role in his/her abusiveness?
8. Can the offender identify and describe personal tools/strategies/ interventions to be used to prevent future abusiveness?
9. Is the offender willing to commit to ceasing the abuse?

C. Measurement

Accountability can be measured by the following:

1. Offender verbal statement of accountability
2. Offender written statement of accountability
3. Offender written "as-if" letter of accountability to the victim. This letter is intended to be a therapeutic exercise and shall not be shared with the victim.

Accountability should be assessed continually:

1. At intake
2. Prior to any change in level of treatment
3. Following any change in risk of reoffense
4. Prior to discharge from treatment

II. Motivation for Treatment

A. Definition

Motivation or "readiness" for treatment refers to the degree to which an offender engages in the process of change. It includes considerations of how receptive the offender is to learning new information and receiving feedback about his/her behavior. Utilizing concepts from the Stages of Change model (Prochaska et al., 1994), the process of change occurs through several "stages" involving different thought processes, emotional responses, and behaviors. Though originally applied to substance abuse treatment, the Stages of Change model has since been applied to domestic violence treatment (Levesque et al, 2000; Eckhardt et al, 2004).

In domestic violence offender treatment the motivation for change refers to an individual's "contemplation" of problematic or abusive behaviors, his/her receptivity toward this self-reflection, and the acknowledgement of the benefits of changing behaviors. Thus, self-awareness will increase motivation to change. Conversely, the tendency to blame others for one's actions will decrease motivation for change, as others are seen as the "real" problem.

B. Assessment and Measurement

The following are considerations for assessing an offender's level of motivation:

1. What is the offender's attitude toward treatment? Is he/she compliant? Resistant? Open? Defensive? Dismissing?
2. How receptive is he/she to learning new information and receiving feedback about his/her behavior?
3. How willing is he/she to acknowledging and examining the effects of his/her behavior on others?
4. What is his/her level of personal insight?
5. Does he/she tend to externalize or blame others for his/her behavior?
6. Are there factors, such as a significant lack of empathy, which might interfere with a treatment alliance or engagement in the treatment

process?

Consider the following for assessing motivation for change:

1. The Transtheoretical Model (TTM) and the Stages of Change (DiClemente et al., 1992).
2. URICA-DV developed by Levesque utilizes the Stages of Change with domestic violence offenders (Levesque *et al.*, 2000).

C. Treatment Considerations

1. Motivational Interviewing Model (Rollnick & Miller, 1995) has demonstrated utility with resistant clients.
2. The Transtheoretical Model (TTM) and the Stages of Change (DiClemente *et al.*, 1992).

III. Amenability to Treatment

Please Note: This document is designed to be a resource guide for working with, assessing, and evaluating offenders. It is intended that approved providers will utilize their expertise along with this guide in working with offenders. Approved providers will make their own decisions regarding the degree of information that needs to be gathered for each offender and how to collect that information.

A. Definition

Amenability to domestic violence treatment refers to the offender's capacity to effectively participate, function, and understand treatment concepts. Significant cognitive (e.g., thinking) impairments can preclude an individual's ability to sufficiently pay attention during treatment sessions, learn new information, and/or self-reflect. Similarly, some cases of acute mental illness may interfere with participation due to the presence of impaired reality testing (e.g., delusions or hallucinations).

While some impairments may be the transient effects of medications or some other treatable physiological condition or disease process including mental illness, other conditions may be more longstanding or identified as permanent deficits. Examples of permanent deficits may include mental retardation, dementia, severe learning disabilities, or acquired brain dysfunction. The role of the approved provider is to assess whether the individual has the current capacity to effectively participate in, and benefit from treatment considering these deficits.

Additionally, the approved provider should identify what limitations exist and distinguish those that require accommodation and those that would indicate a lack of amenability. If the approved provider can accommodate, or refer to an approved provider who can accommodate limitations, the offender is expected to participate in treatment.

B. Assessment

1. Amenability to treatment can be assessed as part of the mental health

assessment, though a more in-depth and specific evaluation may be warranted in some cases.

2. Various cognitive abilities should be assessed and accommodated (where appropriate) relative to the ability of the offender to effectively participate in treatment, including:
   a. Attention
   b. Memory (i.e., the ability to learn new information and/or to recall previously learned information)
   c. Language comprehension
   d. Reading comprehension
   e. Verbal reasoning and abstract thinking or the ability to understand similarities between events and to learn from past experience
   f. Executive functioning (e.g., planning, organizing, sequencing)
3. Cognitive impairment that should be assessed and accommodated (where appropriate) relative to effective offender participation includes, but is not limited to:
   g. Mental retardation (i.e., significantly sub-average intellectual functioning with concurrent deficits in present adaptive functioning)
   h. Dementia (i.e., a progressive decline in cognitive functioning)
   i. Acquired brain dysfunction (e.g., traumatic brain injury)
   j. Effects of medications and/or other physical conditions and treatments
4. Acute untreated or poorly managed mental health disorders may also interfere with an offender's capacity to participate in domestic violence treatment, particularly in a group setting. Approved providers need to assess whether these disorders can be accommodated in treatment. Some examples include, but are not limited to:
   k. Schizophrenia with prominent symptoms of hallucinations, delusions, or disorganization
   l. Bipolar disorder with acute mania
   m. Major depressive disorders with the significant suicidal ideation
   n. Social phobias that interfere with group treatment
   o. Post traumatic stress disorder (PTSD) with severe symptoms of dissociation and/or intrusive re-experiencing
   p. Significant psychopathy or antisocial personality features

C. Measurement

Cognitive screenings may be conducted as part of a mental health evaluation using well-known assessment instruments including but not limited to:

- The Mini Mental Status Examination (MMSE)
- The Galveston Orientation Assessment Test (GOAT)

The more detailed assessment of cognitive status often involves neuropsychological tests, IQ tests, and/or achievement tests, which evaluate specific clinical questions and abilities. Such evaluations are typically completed only by professionals with specialized training in the assessment of cognition; such as neuropsychologists, developmental or

educational psychologists, and/or speech-language pathologists.

Mental disorders may be measured using the same instruments used during a mental health status assessment (e.g., Beck Depression Inventory, MMPI-2, MCMI-3), though psychopathy is commonly measured using the Hare Psychopathy Checklist (PCL-R) requiring specialized training.

D. Treatment Considerations
   1. Accommodations for illiterate, hearing, or visually impaired offenders
   2. Mental health and/or monitoring of medication management
   3. In cases where the approved provider determines that an offender is not amenable to treatment, according to these guidelines, then the approved provider shall refer the offender back to the court with an alternative recommendation for treatment. The approved provider shall provide verifiable documentation to support the findings.
   4. Though research varies on the effectiveness of treatment of psychopathy (Gacono, 2000; Skeem *et al.*, 2003; Vien & Beech, 2006), a number of studies have identified various nonspecific treatments that are considered inappropriate with psychopathic offenders, and may even contribute to an increase in violent recidivism following treatment (Hare *et al.*, 2000; Rice *et al.*, 1992). Generally, many psychopathic offenders may be considered inappropriate for domestic violence interventions as they tend to be disruptive during the treatment process in the absence of very highly structured treatment settings, and may be more likely to learn more effective ways to manipulate, deceive, and use others rather than change their violent-prone behaviors.
   5. Regarding offenders with disabilities, Reference Standard 10.10 Offenders with Disabilities or Special Needs.

IV. Criminogenic Needs

A. Definition

Criminogenic needs is a term used to reference offender dynamic factors such as substance abuse (alcohol and other drugs), antisocial attitudes, personality traits, associates, employment, marital and family relationships, and other dynamic variables statistically shown to be correlated with criminal conduct and amenability to change (Andrews & Bonta, 1994). Criminogenic needs are aspects of an offender's situation that when changed are associated with changes in criminal behavior (Bonta, 2002). As dynamic risk factors, criminogenic needs may contribute towards criminal behavior (e.g., domestic violence), and if effectively addressed, should decrease level of risk (Andrews, 1989, Andrews & Bonta, 1994; Bonta, 2002).

Non-criminogenic needs are factors that may change but are not empirically related to a reduction in recidivism. Some examples are weight problems, self esteem issues, or witnessing domestic violence as a child.

B. Assessment

There are assessment instruments that capture information about these dynamic factors. An example is the Level of Service Inventory (LSI) that is often utilized by probation. The Spousal Assault Risk Assessment (SARA) is another example of a validated reliable instrument that is designed to be used as a clinical guide.

Various areas may be assessed to identify an offender's criminogenic needs, including:

1. Substance abuse
2. Antisocial attitudes (e.g., minimization, denial, or blaming)
3. Low levels of satisfaction in marital and family relationships
4. Antisocial peer associations
5. Identification and association with antisocial role models
6. Poor self-control and self-management
7. Poor problem solving skills
8. Poor social skills
9. Unstable living environments
10. Financial problems
11. Unemployment
12. Social isolation
13. Mental health

C. Measurement

A variety of measures have been created to assess criminogenic needs. Some are broader (e.g., risk-needs classification instruments such as the LSI-R), while others are more specific (e.g., measures of substance abuse, anger and hostility, antisocial attitudes). Examples of more specific measures include:

1. Addiction Severity Index
2. Simple Screening Inventory (SSI)
3. Aggression Questionnaire
4. Criminal Sentiments Scale (CSS)

D. Treatment Considerations

1. Substance abuse assessment and treatment
2. Development of pro-social attitudes
3. Development of a pro-social support system
4. Monitoring of employment status in collaboration with probation
5. Mental health assessment and treatment

V. Risk Principle and Needs Principle

A. Definition

The risk principle is an endorsement of the premise that criminal behavior is predictable

and that treatment services need to be matched to an offender's level of risk. Thus, offenders who present a high risk are those who are targeted for the greatest number of interventions. When offenders are properly screened and matched to appropriate levels of treatment, recidivism is reduced by an average of 25 to 50 percent (Carey, 1997).

The needs principle pertains to the importance of targeting criminogenic needs and providing treatment to reduce recidivism. Criminogenic needs/dynamics risk factors are rehabilitative targets for treatment (Andrews & Bonta, 1994).

B. Treatment Considerations

Under treatment of high risk offenders and over treatment of low risk offenders is not effective. Therefore, offender risk needs to be matched to the level of treatment interventions. Additionally, when criminogenic needs are addressed in treatment, there is a likelihood of reduction in recidivism.

VI. Responsivity Principle and Factors

A. Definition

Responsivity factors are those factors that may influence an individual's responsiveness to efforts that assist in changing his/her attitudes, thoughts, and behaviors. These factors may or may not be offender risk factors or criminogenic needs. These factors play an important role in choosing the type and style of treatment that would be most effective in bringing about change for offenders (Andrews & Bonta, 1994).

B. Assessment (Bonta, 2000)

Thinking style: It is beneficial to gather information regarding offenders' thinking styles. Consider the following questions in your assessment:

1. Are they more verbally skilled and quick to comprehend complex ideas or are they more concrete and straightforward in their thought processes?
2. Will they be more responsive to treatment that requires abstract reasoning skills, or will they be more responsive to more straightforward and direct treatment modalities?

Anxiety regarding treatment: Evaluate whether offenders are anxious about treatment. Consider the following questions:

1. Are they more likely to better respond initially to individualize versus group treatment?
2. Is there some type of acute mental disorder such as delusions or a thought disorder, which may need to be managed in order for offenders to respond to treatment?

Personality dynamics: Consider whether there are personality dynamics that might influence the offender's response to treatment.

1. For example, many individuals with antisocial personality features tend to be more responsive to treatment that is highly structured as opposed to a more process- oriented style. Given a chronic level of low stimulation, such individuals may need a treatment style that is more active and stimulating as opposed to open discussion and quiet readings.
2. For offenders with various personality clusters, consider how these features can be utilized in treatment to assist the offender in engaging in treatment. For example, can reinforcement of changes be emphasized with the narcissistic offender to focus on his/her successes in treatment? Can the dependent offender learn to depend more on strategies learned in treatment and depend less on the victim?

Learning style: Consider the offender's learning style:

1. Is the offender an auditory, visual, or kinesthetic (experiential) learner?
2. Would the offender benefit more from a role play exercise or a reading assignment?

Personal and demographic: Consider whether the offender will respond better to treatment when other personal and demographic factors are considered and addressed. This might include geography, gender, ethnicity, language, sexual orientation, age, and/or other cultural factors.

VII. Lethality Assessment

This section is for informational purposes and is not synonymous with the term risk assessment. Lethality assessment is a subset of risk assessment.

A. Definition

Lethality assessment is the identification of risk factors that may be linked to intimate partner homicide (Jurik & Winn, 1990). Although there are overlapping concerns, risk assessment, lethality assessment, and safety planning are not the same. Victims may or may not be aware of their level of risk. This information can be used to identify potential risk in an offender and for safety planning for victims. Assessment of dangerousness or lethality risk of the offender is recommended by most experts (Ganley, 1989; Hart, 1988, Campbell, 2001).

Research studies suggest that there are differences in the reasons why men and women kill their intimate partners. There is considerable support for the gender role and self- protection models.

These models suggest that "women's violence is often an outgrowth of the structural inequalities between men and women, and the resulting threat of men's violence against women (Dobash & Dobash, 2000). When women kill, it is often in response to physical threat from their male victims (Browne, 1987). Such defensive reactions may be especially common among individuals who lack resources and access to legal responses (Black, 1983; also Williams & Flewelling, 1987:423). Compared to men, women more frequently kill in

situations in which their victim initiated the physical aggression."

"The most dramatic differences between homicides by men and women are found when examining the relationship history and situational dynamics leading up to the victim's death. Women typically kill intimates-especially male partners-with whom they have experienced a long history of violent conflict (Chimbos, 1978; Totman, 1978; Silver & Kates, 1979; Daniel & Harris, 1982).

B. Assessment and Measurement

The Danger Assessment Instrument created specifically for female victims (Campbell et al., 2003) or Barbara Hart's assessment of whether batterers will kill (1990), in addition to other information from multiple sources should be reviewed.

C. Treatment Considerations

1. Safety planning and education regarding risk factors and lethality factors with victims
2. Ongoing risk assessment from multiple sources
3. Monitoring for indicators that offender is escalating/de-escalating, decompensating, or becoming more stable

VIII. Mental Health Assessment

Please Note: This document is designed to be a resource guide for working with, assessing, and evaluating offenders. It is intended that Approved Providers will utilize their expertise along with this guide. Approved providers will make their own decisions regarding the degree of information that needs to be gathered for each offender and how to collect that information.

A. Definition

In the context of domestic violence offender treatment, mental health "assessment" refers to the process of assessing an offender's current mental health status and identifying any factors that might directly impact level of risk for future violence or for re-offense. Some mental health conditions (e.g., social anxiety) may also indirectly increase level of risk by interfering with effective involvement in interventions.

Whereas a mental health assessment tends to cover a fairly broad domain, a mental health "evaluation" refers to a more formal procedure, normally requested by the court or other referral source. This evaluation normally targets a specific clinical question or issue (e.g., capacity to participate in treatment). A mental health evaluation may incorporate various sources of information, including psychological testing, into a written report that details significant findings.

B. Assessment

Consideration should be given to whether or not there are contributing factors to the offender's mental health history or to his/her current status that may increase level of risk. Various aspects of an offender's mental health history or current status that should be assessed include, but are not limited to the following:

1. Psychotic disorders (e.g., schizophrenia, schizoaffective disorder, delusional disorder)
2. Mood disorders (e.g., bipolar disorder, major depression)
3. Anxiety disorders (e.g., post-traumatic stress disorder, panic disorder, obsessive compulsive disorder)
4. Personality disorders with anger, impulsivity, and poor behavioral controls (e.g., DSM –IV-R Cluster B personality disorders, or psychopathic/antisocial, borderline, narcissistic, or histrionic personality features).
   Personality disorders have also been identified as a risk factor for spousal assault (Magdol, et al., 1997). *Further, personality disorders have been associated with increased risk for criminal behavior, including violence and violent recidivism (Hare, 1991; Harris et al., 1993; Sonkin, 1987), and recidivistic spousal assault* (Bodnarchuk, et al.,1995; Gondolf, 1998).
5. Past neurological trauma and/or current neurological symptoms

When mental health factors are identified in the assessment, a variety of issues should be considered:

1. What is the severity of the mental health condition?
2. Are symptoms current or historical?
3. Have symptoms ever resulted in psychiatric hospitalization?
4. Has an aspect of the mental health disorder (i.e., a delusion or hallucination) motivated or triggered past violence toward others?
5. Has an aspect of the mental disorder (i.e., a delusion or hallucination) motivated or triggered past suicide attempts or threats?
6. To what extent do symptoms disrupt or interfere with aspects of the offender's everyday life? (e.g., work, relationships)
7. Is there a concurrent substance abuse disorder that contributes toward an increase or worsening of symptoms?
8. Is the offender actively compliant with medication management?

The empirical literature suggests a positive correlation between psychosis and past violence (Swanson, Holzer, Ganju, & Jono, 1990; Monahan, 1992), and that treated psychosis is associated with a decreased risk for violent recidivism (Rice, Harris, & Cormier, 1992). Psychotic and/or manic symptoms are associated with an increased

short-term risk for violence (Binder & McNeil, 1988; Link & Stueve, 1994), and
that these symptoms may be associated specifically with spousal assault (Magdol, et al., 1997). Additionally, certain anxiety disorders may interfere with effective participation in treatment (Reference Section III.)

Most, if not all DSM-IV-R Axis I disorders can now be effectively treated with medication, psychotherapy, or both. Therefore, treatment becomes a significant mediating factor in the degree to which the disorder contributes toward ongoing risk of future violence or re-offense. Intervention is likely to be effective, though in some cases long-term treatment is the only effective intervention. Assessment questions related to mental health treatment may include the following:

1. Is the offender currently in treatment? (e.g., medications, psychotherapy)
2. How long has the offender been in treatment?
3. Is the offender compliant with treatment?
4. Has treatment been effective or helpful?
5. Has the offender been involved in any violent or abusive behavior while in treatment?
6. Are offender symptoms currently being managed?

C. Measurement

All approved providers should perform an initial screening or preliminary assessment. When further assessment is needed, the approved provider will perform this if he/she has the appropriate qualifications, or he/she will refer the offender to an approved provider who is qualified.

***Discussion Point**: A variety of psychometric instruments or tests may be useful in assessing an offender's mental health status. Some advanced and lengthy instruments, such as the MMPI-2, are restricted in their use based upon clinical training qualifications or specific coursework involving a given instrument. Other brief instruments, such as the Beck Depression Inventory, have less specialized training requirements. Such instruments are typically used to supplement or augment collateral information, such as the clinical interview.*

A few possible instruments that may be used to assess mental health status include, but are not limited to the following:

1. Minnesota Multiphasic Personality Inventory (MMPI-2)
2. Millon Clinical Multiaxial Inventory (MCMI-3)
3. Personality Assessment Inventory (PAI-2)
4. Mini Mental Status Exam (MMSE)
5. Beck Depression Inventory (BDI-2)

6. Beck Anxiety Inventory (BAI)

D. Other Considerations:

1. Personality Clusters

Research studies (Hamburger & Hastings, 1986) have indicated that domestic violence offenders tend to possess several types of personality clusters when tested utilizing the MCMI-3. The main clusters exhibited by domestic violence offenders include the following:

a. Dependent, which constitutes about 35 percent of the offender population
b. Narcissistic, which constitutes about 50 percent of the offender population
c. Antisocial, which involves a multitude of various associated personality elevations and constitutes about 15 percent of the offender population

Research (Gondolf, 2001) has suggested that personality disorders are not correlated with risk of reoffense. However, clinical expertise sometimes reveals that offenders with certain personality elevations respond better to treatment when the clinical interventions are presented in a manner consistent with their specific personality.

2. A history of significant central nervous system trauma (e.g., traumatic brain injury, seizures or epilepsy, brain disease) has been identified as other factors that can contribute toward impulsive violence or aggressive behavior (Meloy, 2000). More specifically, frontal and/or temporal lobe dysfunction has been shown to be associated with various types of violent offending (Raine & Buchsbaum, 1996).

IX. Principles for Differentiating Treatment

A. Theories and Examples

There are a variety of constructs described below that can be used for differentiating offender treatment. The following principles may be applied to more broadly differentiated groups of offenders (e.g., offenders differentiated by language, male or female GLBT offenders, or male or female heterosexual offenders).

1. The first principle for differentiating treatment, repeatedly found to be valid in criminal justice interventions, is that higher and lower risk offenders should not be treated together (Lowencamp & Latessa, 2004).
    a. "Lower risk offenders" can be more reliably identified with the use of researched risk assessment procedures (e.g., SARA) than by clinical judgment alone.
    b. Efforts should be made to accentuate the natural strengths of lower

risk offender groups. This includes avoiding overly intensive and costly intervention, avoiding exposure to more anti-social or violent associates, and/or utilizing overly remedial programming. It is also important to promote and to strengthen natural pro-social networks.

2. A second principle for differentiating treatment is that anti-social offenders need different programming from moderate and higher risk offenders.
   a. Anti-social offenders should be treated in a separate group because they will contaminate other more pro-social members by interfering with the group process.
   b. Anti-social offenders need a different treatment approach that focuses on their self-interest. Treatment should be more didactic and less process-oriented than other groups. Treatment should continue to be strongly oriented towards a containment model and strive to disrupt anti-social support networks. Treatment should not include victim empathy content that may be used against victims by these offenders.
3. A third principle for differentiating treatment for other moderate and higher risk offenders involves the differentiation of offender treatment based on criminogenic needs. Offenders with severe substance abuse problems, problematic personality traits, entrenched power and control issues, mental health disorders, etc., could be placed in different programming based on the resources and/or numbers of offenders in any given district. Examples include the following:
   a. A domestic violence/substance abuse program for offenders with prominent substance abuse involvement and resulting lifestyle instability.
   b. An "enhanced domestic violence treatment program", which is a group for moderate and higher risk offenders who are not highly anti-social.
   c. A review of offender criminogenic needs will guide decision making regarding ancillary or adjunctive treatment recommendations. For example, an offender with bipolar disorder may need to be medically stabilized prior to participating in domestic violence treatment. An unemployed offender may need vocational assistance in addition to domestic violence treatment.
3. While offender responsivity issues should be considered in regard to making decisions about treatment for all offenders, when possible, responsivity can also guide differentiation in treatment programs (Reference Section VI). Examples include the following:
   a. A cognitive/behavioral approach utilized regardless of other responsivity factors.
   b. Staff expertise, strengths, and/or approach matched with client needs. For example, anxious clients do poorly with highly confrontational therapists; less experienced therapists may be

more easily manipulated by anti-social offenders.

c. Accommodation for intellectual levels/learning styles

X. Multi-disciplinary Treatment Team (MTT)

A. Definition, Purpose, Function,

The Multi-disciplinary Treatment Team (MTT) includes, at a minimum, three members: the supervising criminal justice agency (e.g., probation officer, the court), the approved provider, and the treatment victim advocate. The treatment victim advocate working with the approved provider is a critical member of the MTT. Whether or not the victim has been contacted, the victim advocate still has expertise and perspectives that are valuable to the MTT related to offender treatment planning and management. Other professionals relevant to a particular case may also be a part of the MTT.

The MTT's purpose is to review and consult on offender cases as a team. Each member's expertise and knowledge contributes something of value to the case coordination.

Where and when the MTT meets, and how the MTT functions are at the discretion of the MTT. This is purposefully designed to be flexible so that each community can determine how to best review cases.

Overview of the Multi-disciplinary Treatment Team (MTT)

1. MTT Membership: The MTT consists of approved provider, responsible criminal justice agency and treatment agency victim advocate at a minimum. Other professionals relevant to a particular case may also be a part of the MTT.

2. MTT Purpose: The MTT is designed to collaborate and coordinate offender treatment. Therefore the work of the MTT needs to include staffing cases, sharing information, and making informed decisions related to risk assessment, treatment, behavioral

monitoring, and management of offenders. The MTT by design may prevent offender triangulation and promote containment.

3. MTT Consensus: Consensus is defined as the agreement of the majority of the team members. The MTT shall have consensus as its goal in managing offenders. The MTT shall attempt to reach consensus for the following phases of treatment, at a minimum: initial placement in treatment, when treatment planning indicates a change in level of offender treatment and discharge. The supervising agent for the court will have the ability to overrule the decision of the team.

4. Potential conflict within the MTT: MTT members have the goal of

settling conflicts and differences of opinion among themselves, which assists in presenting a unified response. The MTT may also request a meeting with a probation supervisor to review recommendations. In cases where consensus cannot be reached, the other team members may choose to justify in writing, utilizing offender competencies and risk markers, the reason for their recommendations for treatment.

Appendix F: Bibliography

For a list of research citations and references used for designing and developing the Standards and Guidelines, you review Appendix F - Research Citations and Reference here.

Appendix G: Working with DV Offenders Involved In the Military

Adopted (August 12, 2016)

The following Guidelines have been developed to address the unique aspects of treatment with domestic violence offenders who also have military experience. These Guidelines supplement the DVOMB *Standards and Guidelines* and are found in the Appendix of the Standards.

The treatment issues unique to military require that providers working with this population have specific experience, knowledge, and assessment skills to effectively assess for and provide treatment. It is imperative that treatment providers are prepared to assess and respond to the myriad of experiences and needs within military offender populations. Providers must seek appropriate training to work effectively with this population. Providers are encouraged to use these guidelines and seek to increase their competence in working with diverse groups of offenders who have had military experience.

A. Recommended Competencies for Providers

1. PTSD – Post Traumatic Stress Disorder (PTSD) current research indicates that PTSD is not a causal factor in domestic violence. Research further demonstrates that combat exposed veterans are more likely to exhibit symptoms of combat operational stress (combat operational stress reactions COS-R) than an actual full blown PTSD diagnosis. Clinicians should understand the diagnostic criteria for PTSD as well as be versed in combat operational stress.

2. TBI – Traumatic Brain Injury is a significant neurological injury and should be evaluated and treated by a neurologist. Providers should obtain a release of information and consult with the treating neurologist. The key issues to explore would be the offender's ability to participate meaningfully in the treatment process, the offender's ability to retain new information and the offender's ability to emotionally self-regulate.

3. Deployment cycle, also known as the Army Force Generation (ARFORGEN) cycle, is the military's training and deployment cycles. It affects both the Service Member and the family as Service Members are typically either deploying or preparing to deploy. What stage a Service Member is in may affect their ability to participate in weekly treatment as well as potentially create significant stress factors for the military family.

4. Military culture and customs – The military has a unique culture which is steeped in history, values and traditions. The DVOMB considers understanding the military and its unique culture a cultural competency issue for practitioners.

5. Uniform Code of Military Justice (UCMJ) is the legal code which governs

Service Members and their behaviors. Even if a Service Member is sentenced in a civilian court of law, their actions can still be adjudicated under UCMJ. Understanding judicial and administrative actions can assist a provider in understanding a Service Member and also potentially assist in managing risk. Providers treating military personnel should know the offender's First Sergeant (1SG) and Company Commander, have a release of information for both and coordinate care with one or both throughout treatment.

The offender should provide the treatment provider with the Command and 1SG's contact information. NOTE: You will need a release of information to speak with either the Commander or a 1SG as confidentiality limits apply.

6. Protective orders can be civil (temporary protection order –TPO, or permanent protection order – PPO, or military protection order - MPO). A MPO is issued by the Commander and is typically time limited. Unless the Commander specifically processes the MPO through the Military Police, the MPO is ONLY valid ON POST. This is important to note as a MPO will not protect a victim off post UNLESS the Commander has had the MPs put the MPO into NCIC. It is extremely rare for a Commander to do this as the MPOs are time limited, typically 1 week to 1 month.

7. Service Members with a MPO can and do still have access to weapons. In order to restrict access to weapons, the Service Member must voluntarily surrender them OR an on post Behavioral Health Provider must write a weapons profile. Conversely, if a Service Member has a PPO, they are prohibited from owning and possessing personally weapons. However, they may still use a weapon are part of their military duty (i.e. they can still deploy and be issued a government weapon).

B. Assessment Considerations

1. Deployments – the number and frequency of deployments is a significant assessment consideration. Ideally, a Service Member is granted one year stabilization between deployments. However, if a Service Member returns from deployment and moves to a new unit, that unit may be preparing to deploy and thus the Service Member and the military family would have repeated back to back deployments. Assessment considerations would include, stress, separation and reunification issues, parenting issues and finances.

2. Combat exposure – not all deployments involve combat exposure. Many deployments result in what Service Members refer to as being a "Fobette" meaning they stayed on the FOB (Forward Operating Base) the entire deployment. Assessment considerations in this scenario would include boredom, morale and separation issues as well as meaningfulness of service issues.

3. Disability issues – a Service Member may have a service related disability. Again, research has failed to establish a causal factor between combat and domestic violence. However, serving on active duty with a disability creates significant stress for the Service Member and the unit. Additionally, the process for obtaining a medical discharge is lengthy and frustrating for the Service Member and the military family. Assessment considerations would include financial concerns, loss of purpose, fear of the unknown, unit support or lack thereof, guilt, etc.

4. Collateral loss (loss of battle buddies/fellow Service Members) is a significant issue for Service Members. Assessment considerations would include survivor's guilt, COS-R and/or PTSD symptoms.

5. Insomnia – a significant number of Service Members report significant and long term sleep disruptions. On post behavioral health offers many sleep specific programs to help Service Members with their sleep issues. Conversely, as clinicians, we know that long term sleep deprivation is a significant clinical issue which requires intervention for any therapeutic program to be effective.

6. Substance abuse – Service Members who struggle with substance abuse can seek confidential substance abuse treatment via Army Substance Abuse Program (ASAP). If the Service Members waits until their substance abuse issues become known to Command, their career could be negatively affected. Clinicians may want to encourage Service Members to seek voluntary, confidential help if they suspect any substance abuse issues are present. Once Command becomes aware of any use/misuse issues, they will Command direct the Service Member to complete an evaluation. Confidentiality for the Solider is EXTREMELY limited in these cases, so it may be best that a Service Member self refers for a substance use/abuse treatment or education. Currently, Service Members who are identified as having substance abuse issues could face separation from the military.

C. Treatment Parameters and Dynamics

1. Understanding the functional power structure of defense – Providers treating military personnel should consider the efficacy of the power and control structure that is embedded within the military culture.

2. Providers should consider the unique way in which military personnel define "threat" and seek to assist Service Members in exploring the ways in which the military requires/trains them to respond to threats versus how a family would need them to define and respond to a perceived threat.

3. The military, by virtue of the ARFROGEN cycle, significantly disrupts family

attachment, roles and routines. Continued deployment and redeployment can create significant disruption to familial roles, expectations and family processes. This can and often does create significant conflict. Assessment considerations would include family roles and rules, attachment patterns, expectations regarding parenting and child development. Additionally, due to how rapidly children develop and grow, Service Members often have to grieve the loss of the child(ren) they knew when the left versus the child(ren) that greets them upon redeployment. Spouses, similarly, may change and grow over the course of repeated deployments, which can create significant disruptions to the military family.

D. Supervision/consultation issues

1. The provider working with military families should assure that they have adequate training and support for themselves and for their victim advocate.

2. The Provider should have a working relationship with the closest military base's Department of Behavioral Health (DBH), Family Advocacy Program at DBH and Family Advocacy Program via Army Community Services (ACS). If the Service Member has been discharged, the provider should have resources and connections with the local VA Hospital and outpatient clinic.

E. Victim advocacy

1. Similar to the treatment provider, a treatment victim advocate working with military victims should know and understand PTSD, TBI and COS-R. Moreover, they should seek to help victims understand that PTSD is not an excuse for domestic violence.

2. Treatment victim advocates should be connected to the unique benefits available to military victims to include medical care, MPOs and transitional compensation.

3. A treatment victim advocate must be able to help victims discuss the pros and cons of a civilian versus a military protection order and the implications for both.
4. A treatment victim advocate working with military victims should understand the unique implications (i.e. UCMJ actions) which can and often do affect pay, restrictions to post and ultimately discharge from active duty. These are serious concerns for military victims which ideally should be explored and discussed so that the victim can make an informed decision for themselves and their families. The treatment victim advocate will need a release of information to speak with a military victim advocate. The treatment victim advocate should discuss what the military victim advocate would have to report to the MEDCOM Family Advocacy Program prior to sharing any information. A military victim advocate does not serve in the role as a treatment victim advocate.

5. Military victims have a right to "restricted" versus "unrestricted reporting" and military victim advocate should be well versed in these two reporting options. It may behoove a military victim to file a restricted report with a military victim advocate as later, should they need it, they can unrestrict the report and document that they did share concerns with ACS.

Resources
http://www.dtic.mil/doctrine/dod_dictionary/
http://www.defense.gov/About-DoD/insignias

Appendix H: Guidelines for Promoting Healthy Sexual Relationships
Adopted 10/11/2013

I. Introduction

The following guidelines have been developed to address the issue of interpersonal sexual violence than can accompany domestic violence. The purpose of these guidelines is to help identify resources for treatment providers that can be used throughout offender treatment that promotes appropriate intimacy and communication. These guidelines supplement the DVOMB Standards and Guidelines and are found in the Appendix B of the Standards. The DVOMB expresses its appreciation to the Sexual Abuse Competencies Committee for the development of this document.

The DVOMB recognizes that the issue of promoting healthy sexual relationships is not a stand-alone competency but rather touches on a number of competencies. As such, the weaving of healthy sexuality throughout treatment is emphasized.

II. Related Competencies:

Excerpted from DVOMB *Standards and Guidelines*. PLEASE NOTE: Promoting healthy sexual relationships can be added to and explored along with any of these competencies at a minimum.

Domestic Violence and General Criminality

Clients shall meet the following required competencies related to Domestic Violence and General Criminality:

1. Define all types of domestic violence and abusive behavior (reference working clinical definition of domestic violence) and demonstrates acceptance of accountability and responsibility for offending and abusive behaviors.
2. Identify the history of current and former patterns of domestic violence behaviors and thoughts regarding onset, frequency, and persistence. This includes awareness and discuss the intent of previous grooming tactics.

   ***Discussion Point**: Clients may invoke their 5th Amendment right for current or pending cases. While Approved Providers shall not unsuccessfully discharge an offender from treatment solely for refusing to answer incriminating questions, a treatment provider may opt to discharge a client from treatment or not accept a client into treatment if the provider determines a factor(s) exists that compromises the therapeutic process.*

3. Identify and challenge cognitive distortions and belief systems that plays a negative or unhealthy role in the client's thoughts, emotions, and behaviors.

   ***Discussion Point**: The research on the intrinsic factors that motivate a client's offending behaviors and attitudes is still emerging. Approved Providers are encouraged to explore the underlying sources of offending. This May include specific personality traits or disorders, certain types of cognitive schemas, and other considerations.*

4. Recognize and manage dynamic risk factors and adaptive skills to mitigate those risk factors.

Potential Competencies – The following potential competencies may be required when clinically indicated for General criminality:

- Recognize and manage current procriminal attitudes and behaviors.
- Identify, acknowledge, and manage use of mood-altering substances.
- Identify the history of current and former pro-criminal behaviors, thoughts, and associates

Self-Regulation and Self-Care

Clients shall meet the following required competencies related to Self-Regulation and Self-Care:

5. Demonstrate and implement self-regulation skills to include but not limited to emotional regulation, stress management, communication skills, anger management, conflict resolution, problem solving, delayed gratification, parental and financial responsibility, etc.

6. Demonstrate the ability to discuss past experiences and how any unresolved trauma may impact offending behavior as a way to adopt effective coping strategies.

***Discussion Point**: The goal of this competency is to understand how past experiences have impacted the client and what ways they can deal with these issues differently in non-abusive ways.*

7. Develop and maintain prosocial activities and networks to include but not limited to completing education, maintaining employment, obtaining stable housing, life skills, recreational and social activities, etc.

Potential Competencies - The following potential competencies may be required when clinically indicated for the client to meet:

- Identify, acknowledge, and manage mental health needs and the development of supports.

- Identify, acknowledge, and manage the need for crisis management and stabilization (i.e. suicidal or homicidal ideation, housing insecurity, client decompensation).

- Identify, acknowledge, and manage their own reintegration into the community.

- Identify, acknowledge, and manage boundaries.

- Identify and promote healthy sexual behavior, intimacy, and relationship skills.

- Increase ability to recognize attachment issues.

Survivor Impact and Community Safety

Clients shall meet the following required competencies related to Survivor Impact and Community Safety:

8. Demonstrate insight about the impact of their domestic violence offense on all individuals and promote victim empathy when clinically indicated.

   ***Discussion Point**: Demonstration of this competency regarding the impact of a domestic violence offense can include, but is not limited to accountability letters, victim empathy panels, and surrogate offender and victim dialogue. Opportunities for any therapeutic work between the client and the identified victim or secondary victims may be done after the client has completed domestic violence offender treatment during aftercare.*

9. Increase understanding of how intergenerational patterns of family, peer group, community, and culture can normalize domestic violence and foster attitudes and responses that condone and tolerate domestic violence.

10. Develop and implement safety plans to address risk factors and potentially high-risk situations.

11. Cooperate with supervision requirements, court orders, and the terms and conditions.

Potential Competencies - The following potential competencies may be required when clinically indicated for the client to:

- Increase understanding and demonstration of parental responsibility to enhance and ensure the wellbeing of the children.

  ***Discussion Point**: If the offender has abused any pregnant partner, this*

may need to be addressed as an additional competency. In such cases, the client should demonstrate an understanding and insight that abuse during pregnancy may present a higher risk to the victim and unborn child.

III. Guidelines

I. Victim Considerations/Safety

Providers, Victim Advocates and others on MTT should have knowledge about the following:

1. Short and Long Term Impact
   a. Guilt, fear, shame, depression, hyper vigilance, anxiety
   b. Unhealthy coping skills
   c. Decreased sense of self
   d. Lack of recognition of what has happened to them
   e. Struggles with trust
   f. Safety planning
   g. PTSD
   h. Expense for victims of including counseling services and medical costs
   i. Unintended consequences of reporting

2. Role of Victim Advocate
   a. It is ***not*** the role of the advocate to inquire about or investigate sexual abuse or experiences of the victim.
   b. To understand that victims are not being asked to report or discuss sexual abuse, but we do want to advise victims there are resources IF the victims wants to discuss these issues
   c. Advocates should be prepared to handle spontaneous disclosures and seek training or support around this as needed
   d. Safety planning
   e. To communicate the curriculum utilized for offenders
   f. To communicate offender's level of integration of treatment concepts and behaviors (where appropriate)

3. Competencies for Advocates
   a. Information about normalizing the range of response to sexual abuse
   b. Help understanding what has happened to them: Some victims might not perceive they have experienced sexual abuse (societal beliefs, expectations in relationships)
   c. Knowledge about coping mechanisms for victims
   d. Symptoms of trauma and PTSD
   e. Knowledge of predictors for sexual abuse in an intimate relationship (Reference item B.2)
   f. Resources for victims
      i. Know your local resources and what's available to people in your community.

ii. CCASA: 303-839-9999, http://ccasa.org
iii. National Sexual Assault Hotline: 1-800-656-HOPE (4673)
iv. RAIN : Rape Abuse and Incest National Network, online hotline, www.rainn.org

4. Resources for advocate information only: scales from victim perspectives:
   a. Partner Directed Insults (PDIS)[91]
   b. Sexual Coercion in Intimate Relationships (SCIRS)[92]

II. Provider Competency

In order to provide effective interventions in this area, providers are encouraged to pursue specialized training in the following areas:
Please also refer to Section H. Resources and J. Bibliography

1. Knowledge about healthy sexual behavior
2. Knowledge about predictors for sexual abuse in an intimate relationship
   a. "Perceived" female infidelity,
   b. Male low self-esteem,
   c. Male alcohol and pornography consumption
   d. Male sexual jealousy,
   e. Men's partner directed insults,[93]
   f. Men's controlling behavior toward their partner
   g. Men's physical and psychological partner directed aggression[94]
3. Knowledge regarding intimate partner sexual violence
4. Knowledge about subtle sexual coercion
5. Impact of sexual abuse on victims
6. Provider comfort level with discussing sexual issues

***Discussion Point**: While research demonstrates that most perpetrators are male, there are female perpetrators. Although research is limited on female perpetrators, some exhibit unhealthy sexual behaviors and attitudes toward their partners/victims.*

III. Assessment Considerations

The goal is not to assess whether a client is a sex offender per statute nor is it to do a sex offense specific evaluation. However, it is important for treatment providers to begin exploring the following at evaluation and throughout treatment. Providers should begin to explore these issues with clients to normalize discussions on these topics.

1. Effective questions for exploring intimate partner sexual violence

[91] Items a-e: Starratt, V.G., et al. "Men's partner-directed insults and sexual coercion in intimate relationship." Journal of Family Violence 23.5 (2008): pg: 315-323
[92] Goetz, A.T., Shackelford, T.K., "Sexual Coercion in Intimate Relationships Scale (SCIRS)", Handbook of Sexuality- Related Measures, (2010) pg 125-127.
[93] Items a-e: Starratt, V.G., et al. "Men's partner-directed insults and sexual coercion in intimate relationship." Journal of Family Violence 23.5 (2008): pg: 315-323.
[94] Items f-g: Goetz, A.T., Shackelford, T.K. "Sexual Coercion in Intimate Relationships: A Comparative Analysis of the Effects of Women's Infidelity and Men's dominance and Control." Archives of Sexual Behavior 38.2 (2009): pg 226-234.

2. Effective questions for exploring healthy sexual behaviors
3. Familiarity with intimate partner sexual violence scales such as:
   a. Partner Directed Insults[95]
   b. Sexual Coercion in Intimate Relationships (SCIRS)[96]
   c. National Intimate Partner and Sexual Violence Survey (NIPSVS) 2010[97]
   d. Sexual Coercion Questionnaire[8]
   (Victimization Questions will have to be adjusted for use in working with the offender)

IV. Evaluation

1. DV Providers are not intended, expected, nor necessarily qualified to perform a sex offense specific evaluation.
2. DV Providers are not expected to do a separate assessment or evaluation on these issues, but to incorporate these areas into the normal evaluation and treatment.
3. Suggestions regarding assessment indicators are identified in Section B "Provider Competency" of this document.

V. Treatment Parameters and Dynamics

In order to provide effective interventions in this area, providers are encouraged to incorporate sexual abuse and healthy sexual behaviors in treatment content.

1. Incorporate into offender competencies such as those identified in Section II of this document
2. Discussion of sexual topics on a regular basis to normalize client/group comfort level with these issues
3. Referrals: When there is a conviction for an offense for which the underlying factual basis has been found by the court on the record to include an act of domestic violence, and the conviction includes a sex offense… that offender shall be evaluated and treated according to the *Colorado Sex Offender Management Board Standards and Guidelines For The Assessment, Evaluation, Treatment And Behavioral Monitoring Of Adult Sex Offenders*. (Standard 11.11) This would include consultation with probation and the SOMB provider.

VI. Curriculum Resources

Providers are encouraged to address healthy sexual behaviors in treatment as well as addressing the differences between consent, cooperation, compliance and coercion. The following are suggested resources (more information in bibliography):

[95] Items a-e: Starratt, V.G., et al. "Men's partner-directed insults and sexual coercion in intimate relationship." Journal of Family Violence 23.5 (2008): pg. 315-323.
[96] Goetz, A.T., Shackelford, T.K., "Sexual Coercion in Intimate Relationships Scale (SCIRS)", Handbook of Sexuality- Related Measures, (2010) pg 125-127.
[97] NISVS, "National Intimate Partner and Sexual Violence Survey, 2010 Summary Report" National Center for Injury Prevention and Control, Division of Violence Prevention.

1. Curriculums:
   a. "Intimate Partner Sexual Abuse: A Curriculum for Batterer Intervention Program Facilitators" Commonwealth of Massachusetts[98]
   b. Module I: Defining Intimate Partner Sexual Abuse and Assessing Its Prevalence, National Judicial Education Program, also listed here under H. Resources: (www. njep-ipsacourse.org)
   c. Steve Brown's Older, Wiser, Sexually Smarter, and Street Wise to Sex Wise
   d. Berman, Laura, *Loving Sex: The book of joy and passion*
   e. Leman, Kevin. *Sheet music: Uncovering the secrets of sexual intimacy in marriage*

VII. Supervision/Consultation Considerations

a. Consultation with SOMB providers as needed on specific cases
b. General consultation with SOMB providers; consultation could benefit both professions due to high crossover of these behaviors
c. Outreach to rape crisis staff, victim services such as Colorado Coalition Against Domestic Violence, Colorado Coalition Against Sexual Assault and local community based programs
d. Supervision regarding group dynamics or special cases with DV Clinical Supervisor or Peer Group

VIII. Resources

1. Trainings and Information
   a. SOMB website: http://dcj.state.co.us/odvsom
   b. DVOMB website: http://dcj.state.co.us/odvsom
   c. CCASA website: http://ccasa.org
   d. CCADV website: http://ccadv.org/
   e. National Judicial Education Program web course: Intimate Partner Sexual Abuse: Adjudicating this Hidden Dimension of Domestic Violence Cases. Module One, Two and Three. www.njep-ipsacourse.org
   f. CDC website: http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html
   g. National Institute of Health: multiple articles and research findings: nih.gob

IX. Definitions

Abusive Sexual Contact

- Intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person without his or her consent, or of a person who is unable to consent or refuse. http://www.cdc.gov/violenceprevention/pdf/SV_Surveillance_Definitionsl-2009-a.pdf

Assumption

[98] Rothman, EF, Allen, C, & Raimer, J. (2003). "Intimate Partner Sexual Abuse: A Curriculum for Batterer Intervention Program Facilitators". Commonwealth of Massachusetts, Executive Office of Public Safety: Boston, MA. http://www.mass.gov/eohhs/docs/dph/com-health/violence/bi-curriculum.pdf.

- Thinking you know something when you haven't checked it out. http://www. yesmeansyes.com/DEFINITIONS

Coercion

- Coercion is the use of emotional manipulation to persuade someone to something they may not want to do – like being sexual or performing certain sexual acts. Examples of some coercive statements include: "If you love me you would have sex with me.", "If you don't have sex with me I will find someone who will.", and "I'm not sure I can be with someone who doesn't want to have sex with me."…Being coerced into having sex or performing sexual acts is not consenting to having sex and is considered rape/ sexual assault. http://www.clarku.edu/offices/dos/survivorguide/definition.cfm

- ***Bribes, lies, threats, guilt:*** Methods of manipulation and coercion used to force or trick someone to be sexual. May be used to force someone to consent, to say yes, to sexual acts they don't really want to do. http://www.yesmeansyes.com/DEFINITIONS

- ***Emotional Pressure:*** Taking advantage of the level of trust or intimacy in a relationship. Exploiting the emotions or threatening to end the relationship. Making you feel guilty about not engaging in sexual activity and wearing him/her down by using the same tactic over and over again. Phrases like these may be used: "If I don't get it from you, I will get it from someone else." "I want to show you how much I care about you." "If you love me, you will have sex with me." "You have had sex before, what's the problem?" http://www.afspc.af.mil/news/story.asp?id=123222934

- ***Verbal Pressure:*** Begging, flattery, name calling, tricking, arguing, lying or misleading. http://www.afspc.af.mil/news/story.asp?id=123222934

Consent

- ***Colorado Revised Statues:*** Consent means cooperation in act or attitude pursuant to an exercise of free will and with knowledge of the nature of the act. A current or previous relationship shall not be sufficient to constitute consent. Submission under the influence of fear shall not constitute consent. Source: 18-3-401(1.5) (1992).

- A mutual, verbal, physical, and emotional agreement that happens without manipulation, or threats. http://www.yesmeansyes.com/DEFINITIONS

- Is clear permission between intimate partners that what they are doing is okay and safe. To consent to something – like being sexual – means both parties confidently agree to do it based on their own free will without any influence or pressure. A person cannot legally consent if

they are drinking or under the influence of drugs as their ability to consent has been impaired. http://www.clarku.edu/offices/dos/survivorguide/definition.cfm

- ***Inability to Consent*** - A freely given agreement to have sexual intercourse or sexual contact could not occur because of age, illness, disability, being asleep, or the influence of alcohol or other drugs. http://www.cdc.gov/violenceprevention/pdf/SV_Surveillance_Definitionsl-2009-a.pdf

Cooperation

- A victim may cooperate in order to protect one's self based on fear, or an effort to prevent bodily harm and/or fear of death, this is not consent.

- A victim's cooperation may look like consent, but it's not if they are cooperating to protect themselves.

Intimate Partner

- ***Colorado Revised Statues:*** Intimate relationship means a relationship between spouses, former spouses, past or present unmarried couples, or persons who are both the parents of the same child regardless of whether the persons have been married or have lived together at any time. Source: 18-6-800.3(2) (1994).

Non-physical sexual coercion

- The imposition of sexual activity on someone through the threat of nonphysical punishment, promise of reward or verbal pressure rather than through force or threat of force. Sexual activity forced upon a person by the exertion of psychological pressure by another person. http://quizlet.com/dictionary/sexual- coercion/ These tactics can include the use of lies, guilt, false promises, continual arguments, and threats to end the relationship, or ignoring verbal requests by the victims to stop (without using force). Understanding Perpetrators of Nonphysical Sexual Coercion: Characteristics of Those Who Cross the Line

Sexism

- Sexism is the system of attitudes, assumptions, actions and institutions that treat {one gender} as inferior and make {that gender} vulnerable to violence, disrespect and discrimination. Sexism is intensified and compounded by other systematic imbalances of power because of class, race, age, sexual orientation and physical/ mental ability. In our country, its generally women that are seen as inferior and are in general more susceptible to violence.
  http://www.clarku.edu/offices/dos/survivorguide/definition.cfm

Sexual Abuse

- Coercing or attempting to coerce any sexual contact or behavior without consent. Sexual abuse includes, but is certainly not limited to: marital rape, attacks on sexual parts of the body, forcing sex after physical violence has occurred, or treating one in a sexually demeaning manner. Office on Violence Against Women, US Department of Justice

- Sexual abuse is any sort of non-consensual sexual contact. Sexual abuse can happen to men or women of any age. Sexual abuse by an intimate partner can include: derogatory name calling, refusal to use contraception, deliberately causing unwanted physical pain during sex, deliberately passing on sexual disease or infections and using objects, toys, or other items (e.g. baby oil or lubricants) without consent and to cause pain or humiliation.
  http://www.pandys.org/whatissexualabuse.html

Appendix I: Requirements and Criteria for Teletherapy With Domestic Violence Offenders

May, 2022

I. INTRODUCTION & BACKGROUND

On March 13th, 2020, the Domestic Violence Offender Management Board (DVOMB) authorized the use of teletherapy with domestic violence offenders subject to the DVOMB Standards and Guidelines. Prior to this date, all forms of teletherapy were prohibited and required for in-person, face-to-face services. The DVOMB made this change in response to the COVID-19 pandemic as a measure to limit any disruption to evaluation and treatment services for offenders that may have caused undue risk to victim and community safety.

Since the authorization of teletherapy, much more information has been made available regarding its use with domestic violence offenders. There are numerous practical, clinical, and safety-related considerations regarding Teletherapy with domestic violence offenders. However, there is still much unknown and limited empirical research on the use of teletherapy with domestic violence offenders.

This appendix outlines the parameters, requirements, and considerations for the safe and effective use of teletherapy by DVOMB Approved Providers working with domestic violence offenders. This appendix does not replace any mandates currently required in the DVOMB *Standards and Guidelines*. Clinical and professional expertise, as well as a review of available research and literature, served as the foundation for this appendix. Subsequent revisions to this appendix will be made as new information becomes available regarding the use of teletherapy with this population.

II. DEFINITIONS

TELETHERAPY: "TELETHERAPY" means to deliver services through a secured telecommunications system that facilitates the synchronous, real-time, video-based assessment, evaluation, treatment, and behavioral management of a domestic violence offenders in locations different from the Approved Provider.

III. TELETHERAPY APPROVED STATUS

The provision of teletherapy services to individuals subject to the DVOMB *Standards and Guidelines* shall only be conducted by a DVOMB Approved Provider who has met the criteria established by Section 9.08 and who is listed as being Telehealth Approved. Online programs or individuals who are not listed on the DVOMB Approved Provider List do not meet the requirements set forth in 16-11.8-104, C.R.S.

IV. CONSIDERATIONS AND FACTORS FOR CLIENT AMENABILITY TO TELETHERAPY

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

In assessing if teletherapy would be an effective and appropriate modality for a client, the Approved Provider shall consider and mutually assess the following appropriateness criteria in the overall case conceptualization. Approved Providers shall utilize their best clinical judgement in consideration of these factors to determine the client's readiness and appropriateness for teletherapy. Such recommendations may include but are not limited to teletherapy only, teletherapy with some frequency of face-to-face services, time-limited teletherapy services, and face-to-face services only. Teletherapy may also be utilized as an incentive for clients who progress in treatment and demonstrate readiness for teletherapy that may not have been suitable at the start of treatment. In some cases, teletherapy may be an appropriate modality to meet the individual needs of the client.

***Discussion Point**: It is not a requirement that all appropriateness criteria be met, but that the Provider has assessed for and considered all of these contributing factors as part of the treatment planning process. For example, if a client's risk and criminogenic needs are high, but their stability in treatment is enhanced by attending sessions via teletherapy in order to not disrupt employment, teletherapy can be recommended.*

Appropriate and Readiness Criteria for Teletherapy are factors that serve as reasons as to why a client would benefit from teletherapy. Those who may be considered for teletherapy include any combination of the following:

i. Clients who do not have any of the following risk factors on the DVRNA:

   1. Prior conviction of domestic violence (A1).

   2. Substance abuse/dependence (B1) or illegal drug use (B3)

   3. In need of mental health evaluation (C7)

   4. Offender was on community supervision at the time of the offense (F1)

   5. Explicit domestic violence attitudes (J1)

   6. Any prior domestic violence offender treatment (K)

ii. Clients who are not assessed as having high criminogenic needs (e.g. LSI score) or procriminal pathologies suggestive that teletherapy can provide adequate containment.

iii. Clients with physical disabilities that affect their mobility, mild developmental disabilities, or mild cognitive impairments that affect their participation for in-person group settings.

iv. Clients who lack access to reliable private or public transportation which serves as an impediment to their ability to engage in treatment. This includes clients who reside in underserved areas where an Approved Provider may not be available for in-person services otherwise.

v. Clients whose primary and secondary language is a language other than English which requires an Approved Provider who may be at a distance and is fluent in that language.

vi. Clients who are progressing in treatment (good attendance, engagement, etc.) and whose engagement would be enhanced through teletherapy.

vii. Clients who present in a preparation stage of change, who is participating in treatment, exhibits a high level of accountability.

viii. Clients who exhibit behavior that is conducive of group culture, boundaries, and norms.

ix. Client who are able to navigate technology and can effectively participate via teletherapy (e.g., failing to login on time, requires ongoing technical assistance, does not use camera, etc).

x. Clients who have the adequate equipment (e.g., internet, computer) and physical space to confidentially engage in sessions.

Appendix J: Guidelines for Young Adult Offenders Adopted February 10, 2017

I. Introduction

The purpose of this appendix is to provide Multi-Disciplinary Treatment Teams (MTTs) with additional guidance on working with domestic violence offenders ages 18-25, who can be classified as young adults (note, this population is also sometimes referred to as transitioned-aged). This informational document provides MTTs with best practices guidelines, potential risk and protective factors, and suggestions for the treatment and case management of young adults. The guidelines in this appendix do not replace any of the mandates currently required in the *Standards*. A Young Adult Committee of the DVOMB was convened to develop these Guidelines. The Committee, comprised of state and local experts in the field of at-risk youth, delinquent juveniles, and young adult populations (including treatment providers, victim service providers and advocates, probation/corrections officers, and others involved in the criminal justice system) collaborated on the creation of this Appendix.
Clinical and professional expertise, as well as a review of available research and literature, served as the foundation for these Guidelines.

The Risk, Need, and Responsivity (RNR) principles are an evidence-based framework for evaluating, treating and supervising individuals involved with the criminal justice system. The RNR principles originated from numerous high-quality and generalizable studies in the broader criminological literature (Andrews & Bonta, 2010). The RNR principles state the following:

- Risk - Services provided to offenders should be proportionate to the offenders' relative level of static and dynamic risk (i.e., low, moderate, or high risk) based upon accurate and valid research-supported risk assessment instruments;

- Need - Interventions are most effective if services target criminogenic needs (both social and psychological factors) that have been empirically associated with recidivism; and

- Responsivity - Effective service delivery of treatment and supervision requires individualization that matches the offender's strengths, culture, learning style, and abilities, among other factors. (Please see Appendix E (VI) - Responsivity Principle and Factors).

The DVOMB recognizes that based on responsivity issues and the needs of young adults, a different approach may be needed when addressing the unique challenges of this population. Neurobiological research gives us a deeper understanding of adolescent, young adult brain development, and neuro-psychology.[99] This research indicates that the brains of young adults are more fluid, and are still developing and changing until the age of 25 (Perry, 2009; Spear, 2010, Teicher, 2002). As a result, some young adults may

[99] During adolescence, the human brain experiences increased growth, connectivity, and synaptic pruning (Spear, 2010). The rate at which the development of the neural pathways associated with regulation and reward sensitivity may provide insight into the characteristics of emerging adulthood.

not recognize the consequences of their behaviors and may present more like an adolescent rather than an adult. Research indicates that over-responding to non-criminal violations with this population can cause more harm than good for the offender, victim and community (Teicher, 2002). As a result, young adults are at higher risk for dropping out of treatment (Buttell & Carney, 2008; Jewell & Wormith, 2010), therefore, it is imperative for MTT members to assess and treat this population within a framework that is appropriate for this population.

Disclaimer of Risk and Safety Issues: The information outlined in this Appendix does not replace, change or supersede the risk factors identified by the Domestic Violence Risk and Needs Assessment (DVRNA) as part of the Offender Evaluation. These guidelines offer recommendations to lower risk and enhance responsivity by increasing treatment readiness and amenability to make positive behavioral change. Additional offender competencies are necessary to address specific issues unique to the development of the young adult population that may not be currently addressed by Standard 5.08. Appropriate interventions should be commensurate with the nature and severity of the behavior and the degree to which it relates to risk. Risk of harm to others must not be ignored and should be balanced when assessing impulsive behavior typical in adolescence versus more criminal and anti-social characteristics, which are indicative of heightened risk.

II. Guiding Principles

The Guiding Principles (described in Section 3.0) are designed to assist and guide the work of those involved in the management and containment of domestic violence offenders. For the purposes of this Appendix, the following guiding principles in the Standards may or may not be relevant or appropriate for young adult offenders.

Guiding Principle	Issue for Consideration with Young Adults
GP 3.06 - It is the nature of domestic violence offenders that their behaviors tend to be covert, deceptive, and secretive. These behaviors are often present long before they are recognized publicly.	Young adults may not have a prior history of domestic violence due to their age, and a history of delinquency may be more prevalent. Impulsivity and poor decision-making may be attributed to the index offense. As a result, deceptiveness and secrecy may not be as normative with young adults.
GP 3.13 - The preferred treatment modality is group therapy.	Research and clinical experience indicates that young adults tend to respond better to a combination of both individual and group sessions. If not, negative therapeutic outcomes may occur by exposing young adults to older adults who are higher risk and developmentally more mature (Abracen et al., 2016; Lowencamp & Latessa, 2004).

GP 3.15 - Offender treatment must address the full spectrum of abusive and controlling behaviors associated with domestic violence, and not just the legally defined criminal behavior(s).	Young adults may be at a developmental stage where maladaptive patterns of violence (with intimate partners and significant others) may not fully be present, but may or may not require an intervention that addresses the full-spectrum of abusive and controlling behaviors.

III. Young Adult Risk and Protective Factor Considerations

Given the emerging research on young adults, it is important for the MTT to evaluate an offender's problematic behavior and assess their developmental maturation. When responding to rule breaking or non-compliance, it is best to determine whether or not it signifies an increase in risk. If so, the MTT should assess what needs exist and what intervention best addresses those needs and manages risks appropriately. Such assessment should include strengths and protective factors.[100]

Contributing risk factors in young adults will likely be best mitigated by ensuring the MTT prioritizes the RNR principles and ensures all of these are assessed and addressed in treatment. The DVRNA is based on adult risk factors and does not address protective factors that may be present within young adult clients. Providers should consider research-supported developmentally-appropriate risk and protective factors in the ongoing assessment and case management of young adults (see attachment 1 for examples of potential risk and protective factors for this population). Providers should exercise clinical judgement with these cases in terms of identification of risk and protective factors, and consult with other professionals as needed.

IV. Risk Assessment Instruments and Collateral Information

The DVRNA instrument still applies to the young adult population. However, young adults may possess issues that require further assessment and consideration of risk and needs. Adult risk assessment instruments may or may not necessarily address the unique factors of the young adult population. After conducting a thorough evaluation, in accordance with Section 4.0 of the Standards, alternative risk assessments may be appropriate in some cases to use for juveniles under the age of 18 for informational purposes only. It is important to note that using a juvenile risk assessment instrument on an individual over the age of 18 is not a validated assessment of risk, but may be informative for case planning.

V. Responsivity Issues Affecting Young Adults to Consider

The MTT should individualize treatment and supervision for young adults, to the extent possible, in relation to their present development, deficits and amenability to treatment. Group-specific sessions for young adults should be considered and utilized by providers (where applicable), in order to minimize the exposure of young adults to older adults who are higher risk and developmentally more mature. Additionally, it may be more appropriate for young adults to receive individual sessions instead of group sessions based on the clinical judgement of a provider. Providers utilizing individual sessions with young adults should develop treatment plans that address the client's individual needs, their Core Competencies and other unique issues present.

[100] Protective factors are conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk in families and communities.

It is important for the MTT to also understand the characteristics of offenders that may be more likely to lead to treatment dropout. The research indicates that a client is more likely to complete treatment if they are older and employed (Buttell & Carney, 2008; Jewell & Wormith, 2010).

As a result, the challenges associated with emerging adulthood such as finding stable housing, employment and relationships may increase treatment dropout for young adults. Providers should consider any healthy and pro-social factors that may assist a young adult client's initial engagement in the therapeutic process and commitment over time, and focus on development of protective factors.

VI. MTT Guidelines for Decision-Making

MTTs are encouraged to assess and develop individualized treatment plans including containment efforts for young adults, based on their maturation and risk levels. Independent living skills, risk, and protective factors should be discussed by MTTs and factored into programming for the offender. MTTs should consult with other experienced adult and juvenile practitioners to assist in the development of effective treatment and supervision, and to identify possible resources that may aid in information gathering, where such experience is lacking.

Recommendations:

- Use an evidence-based, research-informed or best practice curriculum for this population (see for example, Gibbes, L. & Myers, L., 2011)
- Consider the following treatment Issues, among others:
  - Self-efficacy and self-identity
  - Empathy
  - Developmental stage
  - Appropriate boundaries and communication in relationship
  - Age appropriate healthy sexuality
  - Age appropriate healthy sexual behavior
  - Appropriate use of electronic devices and social media
  - Appropriate dating skills
  - Positive support groups and peer associations
- Consider additional core competencies, as appropriate (See Section 5.08, VI)
- Support ongoing research to better inform interventions with this population
- Stay current on research related to this population, including developmental issues
- Consult with other professionals as needed
- Participate in trainings on:
  - Human development and maturation of young adults
  - Brain development and neuro-psychology

VII. Links to Resource Documents

Gibbes, L. & Myers, L. (2011). Colorado Teen Dating Violence Prevention Final Report Primary Prevention of Teen Dating Violence in the Denver-Aurora Community: Best Practices and Strategy Recommendations. Colorado Department of Public Health and Environment.

Oudekerk, B., Blachman-Demner, D., & Mulford, C. (2014). Teen Dating Violence: How Peers Can Affect Risk & Protective Factors. U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, NCJ 248337.

Attachment 1 - Examples of Potential Risk and Protective Factors for this Population

This table is meant to be a resource that lists some possible risk and protective factors associated with youth that may be considered for young adults. This is not exhaustive list of risk or protective factors as there may be others that should be considered by the MTT. Providers should consider research-supported developmentally-appropriate risk and protective factors in the ongoing assessment and case management of young adults. Providers should exercise clinical judgement with these cases in terms of identification of risk and protective factors, and consult with other professionals as needed.

Table of Risk and Protective Factor Chart

Domains	Risk Factors	Adolescent Problem Behaviors						Protective Factors
	Risk factors increase the likelihood youth will develop problem behaviors	Substance Use	Depression/ Anxiety	Delinquency	Teen Pregnancy	School Dropout	Violence	**Protective factors help protect or buffer the risks of youth developing problem behaviors.**
Community	Availability of alcohol/ other drugs	x					x	1. Opportunities for prosocial involvement in the community 2. Recognition of prosocial involvement
	Availability of firearms			x			x	
	Community laws and norms are favorable toward drug use, firearms and crime	x	x	x			x	
	Transitions and mobility	x		x				
	Low neighborhood attachment and community disorganization	x		x			x	
	Media portrayals of violence	x		x			x	
	Extreme economic deprivation	x		x	x	x	x	
Family	Family history of problem behavior	x	x	x	x	x	x	1. Bonding to family with healthy beliefs and clear standards 2. Attachment to family with healthy beliefs and clear standards 3. Opportunities for prosocial involvement 4. Recognition for prosocial involvement
	Family management problems	x	x	x	x	x	x	
	Family management problems	x	x	x	x	x	x	
	Family conflict	x		x	x	x	x	
	Favorable parental attitudes	x		x			x	

Table of Risk and Protective Factor Chart, continued...

Domains	Risk Factors	Adolescent Problem Behaviors						Protective Factors
	Risk factors increase the likelihood youth will develop problem behaviors	Substance Use	Depression/ Anxiety	Delinquency	Teen Pregnancy	School Dropout	Violence	**Protective factors help protect or buffer the risks of youth developing problem behaviors.**
School	Academic failure beginning in late elementary school	x		x	x	x	x	1. Bonding and attachment to school 2. Opportunities for prosocial involvement 3. Recognition for prosocial involvement
	Lack of commitment to school	x		x	x	x	x	
Individual/ Peer	Early and persistent antisocial behavior	x		x	x	x	x	1. Bonding to peers with healthy beliefs and clear standards 2. Attachment to peers with healthy beliefs and clear standards 3. Opportunities for prosocial involvement 4. Increase in social skills
	Rebelliousness	x	x	x		x		
	Friends who engage in the problem behavior	x		x	x	x	x	
	Favorable attitudes toward the problem behavior	x		x	x	x		
	Early initiation of the problem behavior	x		x	x	x	x	
	Gang involvement	x		x			x	
	Constitutional factors	x	x	x			x	

Source: Hawkins, J., Catalano, R., Arthur, M. (2002). Promoting science-based prevention in communities. *Addictive Behavior,* 27(6):951-76.

DVOMB