Colorado's Innovative Response to Domestic Violence Offender Treatment: Current Achievements and Recommendations for the Future

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ABOUT THIS REPORT

The Domestic Violence Offender Management Board (DVOMB) is mandated by the Colorado legislature to ensure the effectiveness of domestic violence offender treatment in Colorado by overseeing the implementation and evaluation of the *Standards for Treatment with Court Ordered Domestic Violence Offenders* (referred to hereafter as *Standards*). This report reviews the process and risk assessment tool (Domestic Violence Risk and Needs Assessment – referred to hereafter as DVRNA) used in Colorado to assign domestic violence offenders to treatment intensity levels at intake and the decision-making processes regarding treatment outcomes. The current study also examines the distribution of offenders by treatment intensity level at intake and at final assessment to understand the process and reasons for offender movement across treatment intensity levels. This report further informs the DVOMB as to multiple stakeholders' views (treatment victim advocates, probation officers, and domestic violence treatment providers) about the implementation of the *Standards*. Given that critical risk factors require automatic placement in treatment intensity level B or C, this report informs the DVOMB as to the presence of critical risk factors among domestic violence offenders in Colorado. Finally, interviews with members of multi-disciplinary treatment teams (MTTs) highlighted several opportunities for strategic improvement of domestic violence offender treatment in Colorado. We present stakeholder employment of and fidelity to the state *Standards*, highlight current achievements, and provide actionable recommendations for improving upon the current model of domestic violence treatment in Colorado.

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MAJOR FINDINGS

- Among a sample of 3311 offenders who were court ordered to complete treatment, 10% were placed into treatment intensity level A, 43% were placed in level B, and 47% were placed in Level C.
- There was high consistency among level A and level B offenders, such that few offenders assessed as low (6%) or medium (5%) treatment intensity level at intake had been reassessed as needing more intensive treatment at discharge; 25% of offenders placed in treatment intensity level C at intake had been reduced to treatment intensity level B at discharge.
- The overwhelming majority (89%) of those placed in treatment intensity level A at intake successfully completed treatment, while 68% of those placed in treatment intensity level B at intake and less than half (48%) of those placed in treatment intensity level C at intake successfully completed treatment.
- Slightly more than half of treatment providers surveyed reported that their MTTs make decisions about offenders as a team. Comparatively, almost two thirds of probation officers and victim advocates reported that decision making was team driven.
- The majority of treatment providers surveyed endorsed that the 2010 Revised *Standards* had been fully implemented into their treatment program in terms of the DVRNA, differentiated treatment, and offender competencies. Slightly less than half of probation officers and victim advocates agreed.
- MTT members surveyed identified prior domestic violence as the most important critical risk factor domain on the DVRNA.
- MTT members reported consensus regarding what offenders should have learned and/or achieved upon successful treatment completion: accountability, empathy, and self-awareness.
- MTT members indicated that the lack of formal tools for assessing change complicated determinations regarding offender readiness for successful discharge.

INTRODUCTION

Domestic violence (DV) is the manipulative attempt by one person to obtain power and control over his or her intimate partner through a coercive, systematic pattern of abusive behavior.[1] The intense emotional involvement between the victim, offender, and oftentimes children, distinguishes DV from other types of crime. DV may include psychological, physical, and sexual violence, in addition to stalking behaviors. People who commit abusive offenses may engage in more than one pattern of offending and may have multiple victims. Offenders also vary in many other ways, including age, race, ethnicity, sexual orientation, gender, gender identity, mental health condition, profession, financial status, cultural background, and religious beliefs.

There is a considerable volume of research documenting the negative mental and physical health effects experienced by survivors of domestic violence (Adams et al., 2012; Fletcher, 2010). Survivors report higher rates of depression, post-traumatic stress disorder, and suicidal ideation and attempts when compared to the general population (Campbell et al., 2002; Coker et al., 2002; Rodriguez, Heilemann, Fielder, Ang, Nevarez, & Mangione, 2008). Victims may experience a myriad of physical health consequences including migraine headaches, stiff neck or chronic tension, eating disorders, sleeping problems, and even strokes (Brewer - et al., 2010). Further, estimates indicate that domestic violence is responsible for over $8 billion per year in lost productivity and medical care expenditures (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004). The significant direct and indirect consequences of domestic violence contribute to challenging nature of this policy issue for the prevention and treatment communities.

The 2013 annual report of the Domestic Violence Program in the Colorado Department of Human Services reported that they received 67,398 crisis calls and assisted 25,259 clients with residential, non-residential, or transitional housing (Colorado Department of Human Services, 2013). Comparatively, there were 15,522 victims associated with incidents of domestic violence reported to law enforcement in Colorado in 2013 (Colorado Bureau of Investigation, 2014).[2] Offense incidents included 26 homicides, 13,070 simple or aggravated assaults, 940 cases of intimidation, 75 robberies, and 971 cases of kidnapping (Crime in Colorado, 2013). The lingering effects of the recent economic recession exacerbated the impact of domestic violence – between 2012 and 2013 there was a 28% increase in the number of victims turned away from shelters, leaving 12,955 individuals seeking accommodation through motel vouchers or other domestic violence providers (Colorado Department of Human Services, 2013).

Since 1987, the state of Colorado has mandated court-ordered treatment for DV offenders (§18-6-803, C.R.S.). Like nearly all states, Colorado has *Standards* that articulate the guiding principles and processes for offender evaluation and treatment placement, provider qualifications and monitoring, and victim advocacy coordination. Colorado's *Standards* are overseen and monitored by the Domestic Violence Offender Management Board (DVOMB)[3]. Despite the widespread adoption of standards for domestic violence offender treatment by most states, very little is known about the extent to which these standards are implemented as intended and if so, whether they are effective in reducing recidivism.[4]

The purpose of DV offender treatment in Colorado is to increase victim and community safety by reducing offender risk of recidivism. Treatment provides the offender with the opportunity for personal change by challenging destructive core beliefs and teaching positive cognitive-behavioral skills; however, responsibility for change rests with the offender. Successful change depends on an offender's level of motivation and acceptance of responsibility; motivation for change can be strengthened by effective treatment and community containment.

DIFFERENTIATED DOMESTIC VIOLENCE TREATMENT

Colorado's reputation as one of the most progressive states in the U.S. with respect to domestic violence policy stems from its differentiated, non-time-driven approach to offender treatment. Many states apply the *same* time frame requirement for treatment to *all* DV offenders, despite the accumulating evidence indicating DV offenders are a heterogeneous group of people (Piquero et al., 2006; Richards et al., 2013; Richards et al., 2014). Until a few years ago Colorado operated with a one-size-fits all model of treatment where every offender was required to participate in a minimum of 36 weeks of treatment.

In 2010, Colorado revised their *Standards* to employ a non-time-driven differentiated treatment model that distinguishes between higher and lower risk offenders during treatment using a novel risk assessment: the Domestic Violence Risk and Needs Assessment (DVRNA). This evidence-based differentiation model drew from research recommending individualized treatment of high and low risk offenders (Lowencamp & Latessa, 2004). Specific levels of treatment are determined and assigned to Colorado offenders based on their DVRNA outcomes. While some offenders may remain in the same level throughout treatment, the model allows offenders to move between levels of treatment depending on their progress.

Colorado DV offender treatment plans identify treatment goals based on each offender's criminogenic needs, competencies, and identified risk factors.[5] Offenders are required to comply with the conditions of their individualized treatment plans as stipulated in their written offender contract. In sum, Colorado's approach to domestic violence treatment recognizes that assessment and evaluation of domestic violence offenders is an ongoing process requiring differentiation to successfully treat a heterogeneous population of offenders.

THE COLORADO DOMESTIC VIOLENCE RISK AND NEEDS ASSESSMENT (DVRNA)

The Colorado DVOMB reviewed published research on recidivism risk factors and treatment responsivity for domestic violence and general offending to develop the evidence-based Domestic Violence Risk and Needs Assessment (DVRNA). The DVRNA is currently in use by treatment providers statewide to assign domestic violence offenders to one of three "levels" of differentiated treatment during their pre-sentence or post-sentence intake evaluation, with higher treatment levels warranting more treatment plan reviews and more intensive therapy contacts.[6]

The DVRNA comprises 14 empirically based static and dynamic risk factor domains (see Table 1). Of the 14 domains, 8 are dynamic risk factors, allowing the instrument to be used for reassessment during treatment. In scoring the DVRNA, the value of '1' is assigned for each presenting risk factor domain and therefore the potential range in scores is zero to 14. Some risk factors may not be present at the initial intake evaluation, but may emerge as an offender progresses through treatment thus resulting in a need to increase treatment level intensity. Similarly, progress in treatment may mitigate risk factors that were initially present during intake, thus resulting in the need to decrease treatment level intensity. Additionally, six of the fourteen DVRNA risk factor domains are considered to be *critical or significant, thus requiring* automatic placement in Level B or C, regardless of the DVRNA score.

TABLE 1:
DVRNA RISK FACTOR DOMAINS

- Prior domestic violence related incidents*
- Drug/alcohol abuse*
- Mental health issues*
- Use and/or threatened use of weapons in current or past offense, or access to firearms*
- Suicidal/homicidal*
- Criminal history (non-domestic violence related)*
- Obsession with the victim
- Safety concerns
- Violence toward family members, including child abuse
- Attitudes that condone or support partner assault
- Prior completed or non-completed domestic violence offender treatment
- Involvement with people who have a pro-criminal influence
- Separated from victim within last six months
- Unemployed

*denotes significant/critical risk factor resulting in automatic placement in treatment intensity level B or C.

MULTIDISCIPLINARY TREATMENT TEAMS

The *Standards* require members of a Multidisciplinary Treatment Team (MTT) to oversee decisions made about each offender's assigned level of risk and recommended treatment plan. The overall goal of the MTT is to reach consensus about initial treatment level placements, changes in levels, and decisions about discharge.

The MTT comprises a treatment provider, the supervising criminal justice agency (e.g., the probation officer, the court), a treatment victim advocate (referred to hereafter as victim advocate), and other agency representatives where applicable. According to the *Standards*, the containment process requires communication among all of the containment team members. As integral members of the MTTs, advocates bring balance to decision making on offender progress in treatment and on the prioritization of victim safety concerns. The *Standards* stipulate

victim advocacy as a critical component of offender treatment and advocates represent the best interests of the victim on the MTT when making decisions about offender treatment. The probation representative on the MTT regularly informs other members on the status of the probationer's supervision for purposes of continuing MTT collaboration, addressing victim and community safety issues, and probationer containment. The *Standards* indicate that MTTs determine the means (face to face versus non-face to face) and frequency of communication. Effective supervision and treatment of offenders is dependent upon open communication among the MTT members.

After completing the DVRNA during an offender's intake evaluation, the treatment provider reports the overall score, a summary of the findings, treatment level recommendation, and proposed treatment plan to the other members of the MTT.[7] MTT members are required to reach a consensus about the offender's treatment placement. The treatment plan includes goals that specifically address all clinical issues identified during the intake evaluation. MTT members have equal responsibility in an offender's initial placement in treatment, any changes in the level of treatment, and discharge. The MTT is also required to monitor progress during treatment, hold offenders accountable for lack of progress, and collaborate to establish consequences for offender noncompliance. Additionally, the Colorado *Standards* encourage providers to be involved in a coordinated community response to domestic violence, in addition to the MTT, that is inclusive of the criminal justice system, including domestic violence treatment providers and nonprofit victim service providers within the community, as well as representatives from other services agencies such as substance abuse treatment, mental health treatment, and/or child protective services when an offender's needs warrant their involvement.

DIFFERENTIATED TREATMENT LEVELS

Colorado domestic violence offenders are assigned to one of three treatment intensity levels: levels A, B, or C (See Figure 1, Appendix). Level A offenders have a DVRNA score of zero or one (indicating no risk factors or the presence of one risk factor), therefore allowing for placement in a less intensive treatment level. At the time of their initial assessment, Level A offenders have not demonstrated a pattern of ongoing abusive behavior. Correspondingly, Level A offenders participate in the least intensive treatment: group clinical sessions once per week. The DVOMB anticipates that a small percentage of offenders are assigned to Level A.[8]

Level B offenders have an overall DVRNA score of two to four (indicating the presence of two to four risk factors) and are appropriate for moderate intensity of treatment. Level B offenders are required to participate in weekly group clinical sessions and one additional clinical intervention at least once a month. These offenders have an identified pattern of ongoing abusive behavior; they may or may not have a pro-social support system and may have some criminal history in addition to substance abuse or mental health issues. The DVOMB anticipates that Level B offenders constitute the largest group of domestic violence offenders.

Level C offenders are those who have a DVRNA score of five or higher (indicating the presence of five or more risk factors) and are considered to be at the highest risk for recidivism. Level C offenders may have experienced chronic unemployment or financial instability, generally do not have a pro-social support system, and are likely to have a criminal history. Offenders placed in level C are required to have two clinical contacts each week: one focused on DV core competencies and another treatment session such as a cognitive skills, substance abuse, or mental health issues group. These offenders' criminogenic histories are likely to include substance abuse and mental health issues and therefore require the maximum amount of resources for offender monitoring and treatment requirements.[9] Level C offenders are anticipated to represent a small contingency of antisocial persons.

TREATMENT PLAN REVIEWS

Treatment plan reviews are completed for each offender every two to three months so that MTT members may discuss the offender's progress in treatment and identify whether a change in treatment intensity level is needed based on the presence of new risk factors or mitigation or minimization of initially presenting risk factors. Additionally, treatment plan reviews provide an opportunity to identify whether the offender has developed further clinical needs to achieve treatment goals. The MTT may reconsider the influence of critical or significant static factors that resulted in an automatic placement at a B or C level, and whether treatment progress suggests that the critical factors can be overridden to allow a reduction in treatment level. A decrease in treatment level may only occur at scheduled treatment plan reviews. During treatment plan reviews the probation officer provides input about the offender's compliance with their probation terms and new criminal history. The victim advocate provides general victim safety concerns (victim confidentiality is maintained), even if victim contact in a case has not been made. The MTT discusses any violations of an offender's contract or non-compliance with the treatment plan and whether these should lead to program termination.

OFFENDER DISCHARGE

There are three categories of offender discharge: 1) treatment completion; 2) unsuccessful discharge from treatment; and 3) administrative discharge from treatment. MTT consensus is required for an offender to be discharged. Offenders receive a discharge status of treatment completion when they have met all required competencies and conditions of their treatment plan and offender contract. Offenders are unsuccessfully discharged from treatment when they have not fulfilled one or more of their required competencies or conditions of their treatment plan or offender contract. Offenders are administratively discharged from treatment for circumstances such as medical leave, employment location transfer, military deployment, or when there is a clinical reason for a transfer.

CURRENT STUDY

As described above, the Colorado *Standards* mandate (1) a multidisciplinary treatment team, (2) team decision making and consensus regarding offender treatment, (3) differentiated offender treatment based on the intake evaluation that includes the DVRNA risk assessment, and (4) offender discharge contingent on achievement of competencies. The DVOMB is mandated to examine the implementation of the *Standards* and to support research regarding their effectiveness as well as ways to improve domestic violence offender treatment in Colorado. This research informs the DVOMB by first describing the population of domestic violence offenders in Colorado and the presence of critical risk factors among offenders. Then, this study examines the distribution of offenders assigned to different levels of treatment and their corresponding treatment outcomes. Finally, we present stakeholder employment of and fidelity to the state *Standards* and provide actionable recommendations for improving upon the current model of domestic violence treatment in Colorado.

METHODS

The data summarized in this report represents data collection efforts from multiple stakeholders including treatment victim advocates, probation officers, and domestic violence treatment providers. The data are used to describe the population of domestic violence offenders in treatment in Colorado; the processes used in Colorado to assign domestic violence offenders to treatment intensity levels at intake as well as treatment plan reviews; and the decision-making processes regarding treatment outcomes.

STUDY AIMS AND RESEARCH QUESTIONS

I. Treatment Intensity Level and Treatment Outcome Analysis

- What is the distribution of the offenders by treatment intensity level at intake and treatment intensity level at final assessment?
- Do offenders move across treatment intensity levels from intake to discharge?
- What is the average length of treatment for offenders who were successfully discharged by treatment intensity level at intake?
- What is the relationship between treatment intensity level at intake and treatment outcome?
- What is the relationship between treatment intensity level at final assessment and treatment outcome?

II. *Standards* Implementation and Treatment Fidelity Analysis

- What is the level of implementation for the *Standards* in domestic violence treatment in Colorado?
- What is the decision-making process for determining the treatment intensity level for domestic violence offenders in Colorado?
- What are the most important critical risk factors identified by the DVRNA for domestic violence offenders in Colorado?
- What is the appropriate length of treatment for domestic violence offenders who successfully complete domestic violence treatment in Colorado by treatment intensity level?
- What does successful completion of treatment entail?
- What is the decision-making process for determining successful completion of treatment for domestic violence offenders in Colorado?

CHARACTERISTICS OF THE DATA AND ANALYTIC APPROACH

Tracking Offenders Sample (n=3311). The DVOMB collected data from Colorado treatment providers for 3311[10] offenders that recorded DVRNA treatment levels at intake and discharge, changes in DVRNA treatment levels over the course of treatment,

reasons for such changes, and final treatment outcomes (from June 1, 2011 to approximately November 31, 2012). The domestic violence offenders in this sample entered treatment between September 2, 2010 and August 8, 2012. The majority of offenders in the sample (61%) completed treatment, while 28% were unsuccessfully discharged and 11% were administratively discharged. Reasons for unsuccessful treatment discharge and administrative discharge in this sample are similar to those discussed above.

MTT Survey Sample (n=107). In a second data collection effort, the DVOMB worked with the University of Baltimore and University of Colorado Denver to gather information in order to better understand the implementation of the *Standards* for domestic violence offender treatment, the process of decision making for offender treatment levels, and the conditions under which an offender's treatment level might be reassessed. Specifically, a Survey Monkey® survey was disseminated to MTT members via email.[11] Responses were collected during October 2014. The MTT sample included domestic violence treatment providers (n=55), state probation officers (n=39), and victim advocates (n=13). The overwhelming majority of both treatment providers and victim advocates reported more than 5 years of experience working with domestic violence offenders, while approximately half of probation officers reported more than 5 years of experience with the domestic violence offender population. Most MTTs reported working in urban or suburban areas (65%), while 31% reported working in rural areas and 4% reported working in frontier areas.

MTT Interview Sub-Sample (n=14). MTT members who completed the online survey were also solicited for their participation in a follow-up telephone interview. At the end of the online survey, survey participants who were interested in the follow-up interview provided an email address where they could be later contacted to schedule the telephone interview. Seventeen participants indicated that they were willing to participate in the follow-up interview and provided an email address for follow-up contact, and after up to three email inquiries, 14 participants completed the interview (82% response rate). All MTT members who scheduled an interview completed the interview. Telephone interviews were conducted from October 29, 2014 to November 14, 2014; interviews were recorded, and then transcribed within seven days.

RESULTS

Treatment Intensity Level and Treatment Outcome Analysis

- ***What is the distribution of the offenders by treatment intensity level at intake and treatment intensity level at final assessment?***

We examined data from a sample including 3311 domestic violence offenders entering treatment in Colorado between September 2, 2010 and August 8, 2012. At intake, similar numbers of offenders were assessed as meeting the criteria for treatment intensity level C (n=1556; 47%) or level B (n=1427; 43%) on the DVRNA; 328 (10%) persons were placed into treatment intensity level A. Comparatively, at discharge, the majority of persons had been placed in treatment intensity level B (n=1758; 53%) while 1221 persons (37%) had been placed in treatment intensity level C and 320 (10%) had been placed in level A.

- ***Do offenders move across treatment intensity levels from intake to discharge?***

Further, we examined the distribution of individuals who moved across treatment intensity levels during the course of treatment (see Table 2). Results demonstrated high consistency among level A and level B offenders, such that few offenders assessed at treatment intensity level A (7%) or level B (3%) at intake were reassessed as needing more intensive treatment at discharge. Comparatively, 25% of offenders placed in treatment intensity level C at intake had been reduced to treatment intensity level B at discharge. Notably, in a departure from the *Standards*, 25 offenders initially placed in treatment intensity levels B or C were reduced to level A at their final assessment.

TABLE 2. *Changes in Treatment Intensity Level from Intake to Discharge (n=3311)*

	TREATMENT INTENSITY LEVEL AT INTAKE		
Treatment Intensity Level at Discharge	A (n=328)	B (n=1427)	C (n=1556)
A (*n*=320)	307 (94%)	23 (2%)	2 (<1%)
B (*n*=1758)	15 (5%)	1360 (95%)	383 (25%)
C (*n*=1221)	6 (2%)	44 (3%)	1171 (75%)

What is the average length of treatment for offenders who were successfully discharged by treatment intensity level at intake?

In regard to average length of treatment among offenders who successfully completed treatment, offenders placed in level A were supervised for an average of 24 weeks (SD=7.5 weeks, minimum=12 weeks, maximum=48 weeks), offenders placed in level B were supervised for an average of nearly 35 weeks (SD= 8 weeks, minimum=3 weeks, maximum=88 weeks), and offenders placed in level C were supervised for an average of 37 weeks (SD=10 weeks, minimum=2 weeks, maximum=120 weeks). Given the wide range of treatment lengths, even within treatment levels, the median treatment length provides a better description of the "normal" course of treatment among offenders in each treatment level: offenders placed in level A spent a median 24 weeks in treatment, offenders placed in level B spent a median 35 weeks in treatment, and offenders placed in level C spent a median 36 weeks in treatment.12

What is the relationship between treatment intensity level at intake and treatment outcome?

Significant differences were revealed regarding domestic violence treatment outcome across DVRNA treatment intensity levels designated at intake (x^2 =251.78, *df*=4; $p < .001$). Findings are presented in Table 3. The overwhelming majority (89%) of those placed in treatment intensity level A intake completed treatment, while 68% of those placed in treatment intensity level B at intake and 48% of those placed in treatment intensity level C at intake completed treatment. Comparatively, 8% of persons placed in level A at intake were unsuccessfully discharged; 23% of offenders placed in level B and 37% of those placed in level C were unsuccessfully discharged from treatment.

TABLE 3. *Relationship between Treatment Intensity Level at Intake and Treatment Outcome (n=3311)*

	TREATMENT INTENSITY LEVEL AT INTAKE			
Treatment Outcome	A (*n*=328)	B (*n*=1427)	C (*n*=1556)	x^2
Completed treatment	291 (89%)	973 (68%)	742 (48%)	
Unsuccessful discharge	25 (8%)	322 (23%)	582 (37%)	251.78, *df*=4; p < .001
Administrative discharge	12 (4%)	132 (9%)	232 (15%)	

What is the relationship between final treatment intensity level and treatment outcome?

Significant differences were also uncovered in offenders' treatment outcome by final treatment intensity level ($x2$ =568.50, *df*=4; $p < .001$). Results are presented in Table 4. Similar to the previous model, the majority (88%) of those placed in treatment intensity level A at their last DVRNA assessment successfully completed treatment. In addition, 73% of those placed in treatment intensity level B at their final DVRNA assessment and 35% of those placed in treatment intensity level C at their final assessment successfully completed treatment. Comparatively, 8% of persons placed in level A at their final DVRNA assessment were unsuccessfully discharged, while 19% of offenders placed in level B and 47% of those placed in level C were unsuccessfully discharged from treatment.

TABLE 4. *Relationship between Final Treatment Intensity Level and Treatment Outcome (n=3311)*

	TREATMENT INTENSITY LEVEL AT FINAL ASSESSMENT			
Treatment Outcome	A (*n*=332)	B (*n*=1758)	C (*n*=1221)	x^2
Completed treatment	293 (88%)	1289 (73%)	424 (35%)	
Unsuccessful discharge	27 (8%)	328 (19%)	(47%)	568.50, *df*=4; p < .001
Administrative discharge	12 (4%)	141 (8%)	223 (18%)	

STANDARDS IMPLEMENTATION AND TREATMENT FIDELITY ANALYSIS

What is the level of implementation for the Standards in domestic violence treatment in Colorado?

We examined survey data from 109 of MTT members – including domestic violence treatment providers (n=55), state probation officers (n=39), and victim advocates (n=13) –collected during October 2014. Among the treatment providers surveyed, the majority endorsed that the 2010 Revised Domestic Violence Standards had been fully implemented into their treatment program. Further, 94% of treatment providers surveyed agreed that all offenders in their program are assessed with the DVRNA prior to beginning treatment, 91.5% endorsed that they use different levels of treatment, and 94% agreed that they utilize offender competencies in their program; 62.5% also reported

that treatment plan reviews had been fully integrated into their treatment model. Comparatively, slightly less than half of probation officers and victim advocates sampled endorsed that the Standards had been fully implemented; 73% agreed that all offenders are assessed with the DVRNA prior to beginning treatment, 84% endorsed that they use different levels of treatment, and 67% agreed that they utilize offender competencies in the programs with which they work.

What is the decision-making process for determining placement in treatment for domestic violence offenders in Colorado?

Among treatment providers surveyed, slightly more than half reported that their MTTs make decisions as a team regarding offender placement in treatment. However, 48% of treatment providers indicated one team member determined the treatment intensity level of offenders, most commonly the treatment provider, or at times the probation officer. Comparatively, almost two thirds of probation officers and victim advocates reported that, in their experience, decision making regarding offender placement in treatment intensity level was made as a team. Consistent with reports by treatment providers, among probation officers and victim advocates reporting that offender placement was determined primarily by one team member, the majority identified that placement was determined by the treatment provider followed by the probation officer. Interestingly, one victim advocate indicated that the judge in her community determined placement in treatment intensity level.

In the follow-up interviews, MTT members reported a wide variation in the ways in which MTTs communicate – or do not communicate – and provided context for how the decision-making process regarding offender treatment intensity level unfolded, whether the process was made by one team member or by the team as a whole. For example, some MTT members explained that decisions were made in a "silo" – primarily by the treatment provider. One domestic violence treatment advocate who noted that the domestic violence treatment provider primarily made decisions regarding offender placement explained, "The treatment provider does the evaluation…does her recommendations… and once the evaluation is done, I see it and I can choose to just agree with it or to be like, 'Hey, why isn't this noted?'… or if I think that there's something missing chime in…I feel like it's pretty much the treatment provider having to do it and then if I wanna give input I can." Insufficient communication of treatment provider decisions presented another complication for one probation officer, who explained, "We make the referral, we'll send the paperwork for the offender to get in and get the evaluation. I would say, on average, there is at best, a 2-3 month lag time between completion of the paperwork and the interview piece for the evaluation and when we find out what level of treatment the offender's been placed at. So the offender's attending treatment, we don't know what level of treatment they've been assigned until we get the evaluation which is at least 2-3 months out."

Comparatively, other respondents noted collaborative efforts that engaged different MTT members in the process, with some describing extensive, ongoing communication. One probation officer who reported team-based decision making indicated, "The DV provider and I are in communication on a daily basis either through phone or email, but the team itself, who expands outside of just the DV provider and myself meet face to face every month and if there's emergency cases, every case is staffed that month, and for cases that are not needing immediate attention or no problems or concerns are staffed every few days." The degree to which probation officers rely on the expertise of treatment providers increases the importance of communication. One probation officer stated "…I really think it's a collaborative approach but as a person in probation/parole I'm really going to rely on that treatment provider to guide me because they're the ones who are trained in the rest of the competencies and doing those evaluations. But definitely we have open communication." Another treatment provider who reported making decisions as a team also explained the need for some leadership and balance between maintaining constant communication and the constraints on MTT members' time. The treatment provider noted, "It's made as a team…however, there's got to be a lead in the team, and so as the treatment provider I have found that I customarily assume that role because I get a referral after I get the police report and the criminal history of the clients. If there's a concern, especially if the victim is petrified…the input of the victim's advocate plays into it as well...It's [communication] primarily through an e-mail because…the case-loads everybody's carrying and just the whole concept of stepping away from everything that you have to be responsible for and having these face-to-face meetings, I think that that's an ideal situation, but in practice is not very realistic. If there's a problem with clients, I pick up the phone pretty quickly and call [probation]."

What are the most important critical risk factors identified by the DVRNA for domestic violence offenders in Colorado?

When asked to identify the two most important critical risk factors identified by the DVRNA, all of the MTT members who completed follow-up interviews identified prior domestic violence as a top risk factor. MTT members noted that prior domestic violence indicates a pattern of behavior, and for offenders who had prior convictions for domestic violence and who had previously

engaged in treatment, a pattern that is not easily broken. For example, one probation officer explained: "There's a pattern, there's a history there, and I guess looking forward, a predictor of DV is previous DV." Another probation officer suggested, "They've done it once, and are gonna do it again, you're just wondering how many times they've done it and haven't gotten caught," and a domestic violence treatment provider similarly stated "most people who are abusive repeat that abuse." Further, a third probation officer indicated, "When someone has shown that they're a 'frequent flyer' so to speak in the system, and specifically towards DV, what it's showing is that they've been through this process before, they've had negative consequences and they're willing to let that go and it doesn't have an impact on them. Likelihood for success moving forward diminishes the more times we see someone." Another treatment provider also suggested, "It's really important to know previous DV cases and… we need to know, did they get treatment? Did they not get treatment? How long ago was it…So that we know how to address the specific client, because if they've been in multiple treatments, they may need group and individual just to make sure we're getting, and they're getting, the process, they're getting the understanding of the competencies."

MTT members also identified the use/threat of use of weapons and suicidal/homicidal ideation as critical risk factors that were of top priority. For example, one probation officer noted, "Obviously with DV, partners are often killed as a result of weapons being involved, and if people are…having suicidal/homicidal [thoughts] it also increases the risk to the victim and the community." Another probation officer indicated, "I feel like the homicidal/suicidal is a huge indicator of where that person is in the present time mentally, where their stability is, what they're talking/willing to do."

What is the appropriate length of treatment for domestic violence offenders who successfully completed treatment in Colorado by treatment intensity level?

Survey results from DVOMB approved treatment providers, demonstrated generally high rates of consensus regarding the estimated treatment lengths among clients at the A, B, and C treatment intensity level who successfully completed treatment; between 40 and 75% of treatment providers were in agreement regarding the number of weeks level A, B, and C offenders spent in treatment before successful discharge from their respective programs. Among A level offenders who successfully completed treatment, the majority of treatment providers (75%) indicated that A level offenders who successfully completed treatment spent 25 weeks or less in treatment. However, several treatment providers noted in the survey and follow-up interviews that their caseloads rarely included offenders placed in treatment intensity level A. For offenders place in treatment intensity level B, estimated treatment lengths ranged from 24 weeks to 52 weeks with the greatest number of treatment providers (44%) estimating treatment lengths from 31-36 weeks. Estimated treatment lengths of offenders placed in treatment intensity level C who successfully completed treatment ranged from 24 to 96 weeks, with the greatest rates of treatment providers (40%) endorsing 31-36 weeks.

What does successful completion of treatment entail?

As one probation officer noted, "We always tell our clients there's no magic number anymore, it's really about meeting competencies." We asked MTT members specifically about what they wanted to "see" from offenders or what they wanted offenders to have "learned" upon successful discharge from treatment. One treatment provider looked for across-the-board improvement, for indicators that "They've learned the definitions of abuse, anger management tools, communication skills, healthy relationship components, effects on children, taking responsibility, they are sober, they have committed to sobriety (doesn't mean they're gonna do it but they've committed)...they've changed their thinking choices and behaviors – because that's primary with me. They have realistic goal-setting, they're employed and don't hop from job to job, they are no longer angry at having to be in class…" However, most MTT members including probation/parole officers, domestic violence treatment providers, and victim advocates specified one or two skills that aligned with the Core Competencies that, in their experience, were the most important.

Overwhelmingly, MTTs identified "Competency G: Accountability" as the competency/skill that they wanted offenders to have gained upon successful completion of treatment. For example, a probation officer looked for "High accountability for what happened. It has to be in the eyes of myself and the therapist, more the therapist than me, something genuine," while another probation officer prioritized, "Ownership, and they're making amends with the victims involved. Not just the direct victim, but the community...." Another probation officer closely reviewed offender writing assignments, such as letters of accountability or personal change plans, stating, "…when they write that, I think you can really get a feel for their empathy and their accountability for their actions so it's helpful and validating that treatment's working when you see them take accountability." Likewise, a domestic violence treatment provider indicated, "I don't want to hear any more talking about 'she's crazy,' or 'she sucks,' or 'he sucks,' or 'he's this or that.' We're done. You need to own your choices. If you can recognize that the behaviors, attitudes, and beliefs that you are operating with, the harm that this is causing...that's the first place. And if I don't get them to that place, they're not going to get out of treatment." MTT

members identified Competency D: "Empathy" as a key step in redirecting offenders from victim blaming to accountability. One probation officer revealed that "All of our clients in our district have to attend a victim empathy panel prior to being looked at for discharge and that's often very enlightening for the defendants to participate in as well."

In addition to accountability and empathy, MTT members noted that self-awareness, as aligned with Competency K: "Understand, identify, and manage self's pattern of violence," was an important skill for offenders to have obtained in order to successfully complete treatment. Specifically, one treatment provider looked for "…self-awareness in regard to their triggers and behaviors that created the domestic (violence). Often we're finding that they're [the perpetrator] becoming very vulnerable to owning the fact that…it's their own inadequacies that create the power control." Another interviewee, a probation officer, emphasized the importance of self-awareness in preventing recidivism. "My guys and ladies I work with are really able to figure out what's driving that behavior and identify…those triggers, red flags, so they can hopefully see those in future relationships or just figure out what makes you tick so you're responding in a different way."

- ***What is the decision-making process for determining successful completion of treatment for domestic violence offenders in Colorado?***

Although MTT members mostly reached consensus regarding what offenders should have learned and/or achieved upon successful treatment completion, some ambivalence emerged regarding how to measure these skills and achievements, especially among probation officers. For example, one probation officer noted this about determining offender change: "There's no real formal tools to be like ok, you can put a stamp on it and they got it. That's the hardest part for us right now." MTT members indicated that the lack of formal tools for assessing change complicated determinations regarding offender readiness for successful discharge. One probation officer reported, "We do all these assessments in the front end to figure out where they're at and it comes down to them basically telling us what we wanna hear. We have the victim's advocate sometimes talking to the victim, but sometimes they can't reach them or [the victim reports] 'Oh, everything's fine,' but that's not really helpful. I think I would like some type of tool that we could see what's going on with them... Are they really getting this or are they just memorizing what they're told." He further noted that, "Some of these guys are really good and it sounds like they really get it but you always wonder if you're getting played or not." One victim's advocate reflected on the MTT's obligation to the victim and the court when discussing the need for a tool measuring achievement of competencies, suggesting that "… making sure that they [treatment providers] are definitively confident that they could in court say that this person met all of the criteria to be successfully discharged…" would be ideal.

In addition to measuring competencies for overall completion of treatment, probation officers reported the need for a tool to help offenders (and MTTs) measure treatment progress along the continuum. For example, one probation officer noted hearing questions from offenders regarding their progress in treatment such as, "I've been here for three weeks, where am I at with that?" The officer indicated that, "It'd be nice to just be able to sit down and be like 'Ok you've hit competencies in ABC and F, but we need you to hit these ones.'"

A standardized offender achievement of competencies tool may also prevent conflicts among MTT members in decision making. One victim's advocate reported that the power dynamic between (some) probation officers and treatment providers may result in offenders being successfully discharged prior to achieving the competencies. The advocate reflected, "I know it's not just the provider that I work with…we can't piss off probation, they're a giant referral source. And that's a power dynamic and that's the thing that doesn't work for me. It feels like a huge power [structure], and probation is at the top even when they're not taking any action. And, then there's the treatment provider, and then if there is a treatment advocate, they're way down on the list." The advocate noted that a standard tool to measure competencies would provide some written justification regarding when to successfully discharge an offender.

The challenges of measuring offender competency achievement without a standardized tool spurred innovation among some MTT members. One probation officer praised the approach of particular treatment providers, stating "Some of the really good treatment providers have incorporated the core competencies into a monthly report that we receive so they list out the core competencies and some of them have a rater scale of 1-5 that covers not met, met, and a couple boxes in between. So treatment does score them on the core competencies and probation is kind of just piggy backing off of that monthly report to see if we're hearing the same things that treatment is hearing regarding those core competencies." Another probation officer indicated that "They're [the treatment provider] working to try to get a better testing system to try to ensure that these clients are meeting what they've outlined for them." In addition, the probation officer's own assessment process integrated materials such as offender homework assignments completed in treatment.

DISCUSSION AND RECOMMENDATIONS

Like most states, Colorado has state standards that regulate what domestic violence offender treatment looks like and how it is implemented across the state. After the *Standards* were revised in 2010 it is likely that treatment providers, probation officers, and advocates in Colorado had to adapt existing program practices to the new *Standards* over time. The DVOMB is committed to carrying out its legislative mandate to enhance public safety and the protection of victims and potential victims , and the results of this report support the DVOMB's oversight of this mandate. Survey results indicate conflicting reports by MTT members regarding the level of implementation of the 2010 Revised Domestic Violence *Standards* in Colorado, with greater proportions of treatment providers reporting full implementation of the standards than probation officers and victim advocates. Specifically, treatment providers reported greater usage of the DVRNA in assessing offender risk, higher usage of different levels of treatment, and more use of offender competencies than did probation officers and victim advocates. While the DVOMB is responsible for monitoring the implementation of the *Standards* they do not have a formal monitoring system to ensure that the *Standards* are implemented as intended. Colorado is not unique in this instance as other states such as Oregon (Boal and Mankowski, 2014b) report similar problems with monitoring the implementation of state standards.

ACHIEVEMENTS IN COLORADO'S APPROACH TO DOMESTIC VIOLENCE OFFENDER TREATMENT

- Colorado's Domestic Violence Offender Management Board has demonstrated a commitment to models and programs that are research based.
- Domestic violence offender treatment in Colorado now follows a non-time driven model that differentiates treatment intensity using the Risk-Need-Responsivity principle.
- Treatment providers now utilize an empirically based risk assessment tool, the DVRNA, to guide offender placement in differentiated treatment intensity levels.
- Offender treatment intensity level and treatment outcome decisions are made using multi-disciplinary treatment teams (MTTs).
- Colorado has incorporated victim safety into their treatment model by requiring a victim advocate to represent general victim issues on the MTT.

RECOMMENDATIONS

1. More cautious reassessment of offenders over the course of treatment

Findings demonstrate that 25% of offenders placed in treatment intensity level C at intake were placed in treatment intensity level B at their final assessment. Offenders who are progressing well in treatment may urge MTT members for a reduction in treatment intensity level, and given high case-loads and the finite length of probation supervision, treatment providers and probation officers may be moved to reduce treatment intensity levels for offenders who are progressing in treatment. Given that a reduction in treatment intensity level from level C to level B corresponds with a reduction in the number of weekly clinical contacts, a reduction in treatment intensity level must be completed with caution. Additionally, 25 offenders who were initially placed in treatment intensity level B or C were placed in level A at their final assessment – a reduction that is expressly prohibited by the *Standards*. Reductions to treatment intensity level A correspond to both a reduction in the number of overall clinical contacts as well as the removal of individual meetings (versus group meetings) from the recommended modalities for such contacts.

2. Continue to evaluate the level of implementation of the *Standards* regarding length of treatment

Results suggest that some treatment providers may be successfully discharging offenders after only a few treatment sessions – too little time to have achieved the range of competencies outlined by the *Standards* (e.g., less than 12 weeks even among offenders placed in treatment intensity level C). While such findings may be anomalies among only a few providers, these results nonetheless provide reason for pause. MTTs must utilize achievement of the core competencies as the "yard stick" regarding length of time in treatment. At the same time, evidence does suggest that MTTs are using differentiated lengths of treatment. Almost 40% of offenders placed in treatment intensity level A spent greater than the previously required 36 weeks in treatment, while nearly 20% of offenders in level B and 43% of offenders in level C spent more than the previously required 36 weeks in treatment.

3. Continue research regarding effectiveness of batterer intervention treatment models in Colorado

Almost 40% of offenders engaged in domestic violence offender treatment were unsuccessfully discharged from treatment. Unsuccessful discharges were clustered among offenders placed in treatment levels B and C, with almost half of offenders placed in treatment intensity level C at the final assessment unsuccessfully discharged from treatment. Such findings suggest additional

research is necessary to determine the level of effectiveness of batter intervention treatment programs in Colorado, especially among offenders placed in high intensity treatment. More specifically, research should target the efficacy of (1) specific treatment modalities and (2) individual treatment providers in Colorado that are most successful with offenders placed in treatment intensity level C to determine best practices. Future evaluations should also focus on the course of treatment among C level offenders – many of whom have prior non-domestic violence and domestic violence offenses and have previously been engaged in domestic violence treatment; such offenders may not respond to the same course of treatment as C level offenders without a criminal history. Such evaluations could be informed by the existing literature on the principles of Risk-Needs-Responsivity (Bonta and Hodge, 1990) among high-risk offenders (for a review see Drake and Aos, 2012). Finally, future should employ a longitudinal research design to examine the relationship between DVRNA risk factor domains and treatment outcome and subsequent recidivism

4. Increase monitoring of *Standards* across stakeholders

A review of the decision-making process among MTTs interviewed regarding offender placement and successful discharge of offenders revealed significant frustration across MTT members regarding the consistency of the application of the *Standards* as well as team member "buy-in" to a collaborative practice. Probation officers, for example, reported directing referrals to specific providers who they knew adhered to the *Standards*, with one probation officer sharing, "I steer them [offenders] towards the people [providers] who I know are gonna give me monthly reports and I know are gonna provide a quality evaluation." A treatment provider concurred, stating, "I think that the level of treatment is, and I don't know, this is an outrageous thing to say I guess but, I think there's a huge difference in outcomes based on the therapist…"

Both probation officers and treatment providers expressed a desire for greater oversight by the DVOMB. One probation officer suggested regular check-ins would support MTT members to more effectively collaborate, stating, "I think it would be nice for the DVOMB to be in touch with us on a regular basis and ask us how things are going on our end, and they could just as well, and I would encourage it, for them to be asking the providers how we're doing and just make sure everybody's on the same page when it comes to the expectations." Comparatively, treatment providers emphasized the need for DVOMB oversight to address conflicting experiences with private probation officers versus state probation officers and problems with individual probation officers regarding responsiveness and collaboration. For example, one treatment provider noted, "I've expressed my concern to DVOMB (regarding private probation officers), and so have other providers, and our response from them is, 'Talk to the state Chief Probation officer and let that person know your concerns.' Well, I've done that. And other people have done that. And at least in our county, it has done absolutely no good, so it needs to be something more from the DVOMB that controls what kinds of offenders private probation gets."

Stakeholder concerns with oversight appear to be a common issue for state domestic violence offender treatment programs. Boal and Mankowski's (2014) evaluation of Oregon demonstrated that while standards affect a limited number of program practices as intended, other important practices commonly addressed by legislative standards remain unchanged. Recommendations include formal compliance monitoring, research that identifies possible barriers to compliance with social policies, and implementation strategies based on the findings to address those barriers (Boal and Mankowski, 2014).

5. Increase training on *Standards* across criminal justice system personnel

In addition to greater monitoring of the application of the *Standards*, MTTs revealed in interviews a need for further training regarding the *Standards* for criminal justice system personnel such as judges, law enforcement officers, district attorneys, and other relevant practitioners. For example, one probation officer said, "It would also be helpful if the DVOMB did more hands-on training with our judges, too," while a treatment provider noted, "I think that it should be mandatory that the judges and DAs [district attorneys] and attorneys and police officers in all the legalities in all cities should have training… I know where I live, the police officers never go to training and therefore they don't know anything about the new standards, they don't know how to identify a self-defending victim from the main perpetrator. They don't have that information because they don't go to training." Overall, interview responses suggest the need for a better understanding of Colorado's approach to domestic violence offender treatment and the empirical basis for such an approach among members of the criminal justice community in Colorado overall, and particularly among judges. While the DVOMB and the Division of Criminal Justice have prioritized MTT member training about domestic violence risk assessment and the connection between offender risk, need, and treatment, general trainings on the dynamics of domestic violence that other practitioners in the criminal justice system rarely include specifics about criminogenic needs and risk assessments. As Colorado's revised *Standards* recognize that specialized domestic violence training is required among MTT members for an effective team, results from this study suggest system-wide, specialized training

on critical topics among criminal justice practitioners is viewed as necessary to achieve the *Standards*' overall goals of victim safety and reduced recidivism.

6. Utilize a standardized tool(s) to demonstrate treatment milestones and success

Great interest was expressed in the utilization of a standardized instrument to assess achievement of the competencies for both probation officers and treatment providers. Currently, the DVOMB website provides sample tools such as "Personal change plans" and "Participant's copy of core competencies" created by various treatment providers as samples that may be used to assess completion of competencies; however, the findings suggest that use of these tools is not ubiquitous. Further, the resources the DVOMB website provides specifically for probation officers to assess the achievement of the core competencies are not user-friendly and assume substantial knowledge of psychosocial concepts such as empathy. Specifically, this tool consists of a list of questions regarding each competency and notes that probation officers should elicit responses from offenders on these questions to gauge the offender's achievement of the competencies; however, no information regarding how offenders should answer the questions is provided (i.e., no sample responses are provided). In addition, some respondents noted that the non-time driven treatment model results in frustration among offenders given that there is no treatment completion date delineated at the outset of treatment engagement.

We recommend that standardized tool(s) to assess offender progress and change (i.e., achievement of the core competencies) be adopted by MTTs as a best practice. Existing tools such as the "Personal change plans" and "Participant's copy of core competencies" that are used by some MTTs may serve as the foundation for such a tool. This tool should provide tangible examples of offender responses representing achievement of competencies. A thorough review of the current literature regarding domestic violence treatment outcomes uncovered no existing measure (for a recent discussion see Radatz and Wright, 2015). As such, we recommend that the DVOMB form a committee to direct this effort and that research be conducted to pilot this measure prior to state-wide adoption.

Just as survey respondents reported widespread use of the DVRNA and great appreciation for the usefulness of the tool, similar implementation and buy-in could be achieved for a competencies assessment tool. Further, just as the DVRNA assists in MTT consensus regarding initial treatment placement, a standard assessment of competencies tool may also assist individual MTT members to "make a case" for their recommendations regarding treatment progress and outcome. In turn, a standard tool for documentation of achievement of competencies may ease problems between some probation officers and treatment providers regarding differential power dynamics.

7. Streamline grievance policies for MTT members

Respondents repeatedly noted frustration regarding the inconsistencies in the quality of treatment across treatment providers and the level of collaboration among probation officers in their jurisdictions. Further, the role of differential power dynamics obstructed collaborative decision making for treatment placement, reassessment, and treatment outcome among some MTT members. MTTs expressed frustration and confusion regarding the pathway(s) for recourse in such situations. Therefore, we recommend that the DVOMB develop a standardized grievance process that allows MTT members an avenue for sharing concerns with the DVOMB directly.

8. Develop best practices for offenders with co-occurring disorders

Offenders engaged in domestic violence treatment who suffer from a co-occurring mental health and/or substance abuse issues pose a significant challenge to MTTs – especially treatment providers – given the narrow scope of domestic violence treatment compared to these persons' expansive needs. Treatment providers shared frustration and confusion regarding how to access referrals for MH/SA treatment for such clients in the community; this issue is exacerbated among low income and uninsured clients. We could find no documented best practice for coordinating care for domestic violence offenders who have addiction disorders or mental health diagnoses in the *Standards*. Protocols for the prioritization of MH/SA care or concurrent care must be established so that persons with co-occurring disorders can address their MH/SA disorders before or in the course of engaging in treatment for domestic violence. While domestic violence treatment providers may offer support groups to maintain sobriety and adherence to mental health treatment plans as part of domestic violence treatment, such groups alone cannot substitute for in-patient/outpatient care or mental health treatment. Increased partnerships should be explored across community stakeholders including judges, drug court and mental health court personnel (where available), community treatment agencies, and probation/parole; moreover, best practices should be developed to streamline the treatment process so that offenders' co-occurring conditions can be stabilized prior to or concurrent with entering domestic violence treatment.

SUMMARY OF RECOMMENDATIONS FOR IMPROVING THE DELIVERY OF DOMESTIC VIOLENCE OFFENDER TREATMENT IN COLORADO

- Continue to evaluate the level of implementation of the *Standards* regarding length of treatment.
- Continue research regarding effectiveness of batterer intervention treatment in Colorado.
- Increase monitoring of *Standards* across stakeholders.
- Increase training on *Standards* across criminal justice system personnel.
- Utilize a standardized tool(s) to demonstrate treatment milestones and success.
- Streamline grievance policies for MTT members.
- Develop best practices for offenders with co-occurring disorders.

LIMITATIONS

Several limitations to the present report should be noted. First, the data analyzed here stems from samples of convenience. As such, findings may be subject to sample selection bias – whereby survey respondents may be more likely to hold strong feelings about the *Standards* (albeit either strong positive or strong negative feelings) rather than indifference to the *Standards*. And, results may not be representative of stakeholders who were not actively implementing (or had previously implemented) the *Standards* at the time of survey (October 2014). Additionally, given that there is no central list of probation officers who serve on MTTs in Colorado is it likely that not all victim advocates and/or probation officers were invited to participate in the survey. Further, determining a response rate for probation officers was not possible. In light of these issues, we recommend that the DVOMB move towards more centralized record keeping of all MTT stakeholders. Although identifying and maintaining names and contact information for all MTT members in Colorado will be logistically challenging, it is necessary for the DVOMB to rigorously meet its legislative mandate to research the implementation of and fidelity to the *Standards*.

CONCLUSION

Colorado has achieved many successes in their efforts to implement the revised *Standards* (see page 11). Domestic violence offender treatment in Colorado now follows a non-time driven model that differentiates treatment based on offender risk and need. Additionally, an empirically based risk assessment tool (DVRNA) is being used statewide for offender treatment intensity level assignments. Further, Colorado has made a successful transition to the utilization of a team approach to offender treatment and containment with findings from the current study indicating that MTTs are achieving consensus in their decision making. Finally, Colorado has incorporated victim safety into their treatment model by requiring a victim advocate to represent general victim concerns on the MTT.

In the current sample of offenders (n=3311), the majority of offenders were placed in level B (47%) or level C (43%) treatment, with just 10% placed in the least intensive level of treatment and containment, level A. MTT members identified prior domestic violence offenses, use or threatened use of a weapon, and homicidal/suicidal ideation as central critical risk factors in assessing offender treatment needs. Few offenders' treatment intensity levels at intake were higher than their treatment intensity levels at discharge, but approximately one quarter of offenders assessed into level C at intake were placed in level B at their final assessment.

In examining offenders who were successfully discharged, results indicate the average length of treatment was 24 weeks for level A offenders, 35 weeks for level B offenders, and 37 weeks for level C offenders. In comparison, the average length of treatment reported by BIPs in a national sample of programs was 31 weeks (Price and Rosenbaum, 2009). Almost 9 out of 10 offenders who were placed in level A during intake completed treatment, versus approximately 7 out of 10 in level B and 5 out of 10 in level C. These findings highlight the need for longitudinal research regarding what treatment modalities work best for domestic violence offenders in Colorado, especially among offenders with a history of domestic violence and/or non-domestic violence offending. However, MTT members identified accountability, empathy, and self-awareness as the competencies essential to successful offender treatment.

Interviews with MTT members highlighted several opportunities for strategic improvement of domestic violence offender treatment in Colorado. Whereas most treatment providers reported that the *Standards* had been fully implemented, fewer than half of probation officers and victim advocates agreed. This discrepancy may reflect the extent to which treatment providers' direct decision-making in offender treatment, and/or insufficient communication. Nonetheless, interviewees identified a need for greater oversight by the DVOMB, particularly regarding consistency of treatment quality between providers, probation officer responsiveness and collaboration, and awareness of the ongoing concerns of MTT members. Such oversight may require

greater clarity of the roles and responsibilities of each MTT member, regular check-ins with MTTs, and the development of a standardized grievance process. Interviewees also expressed the desire for a tool to assess offender progress in treatment and readiness for successful discharge. Treatment providers carry significant obligations to the victims and the court, and respondents indicated such a tool would support standardized oversight and discharge of offenders to ensure successful achievement of competencies. Lastly, respondents identified the need for additional training of criminal justice system personnel such as judges, law enforcement officers, and district attorneys to raise awareness regarding the dynamics of domestic violence and the evidence-based nature of Colorado's differentiated treatment model. Continued research and evaluation of the implementation of the *Standards* will support the DVOMB to further refine its cutting edge, empirically driven approach to treating offenders of domestic violence.

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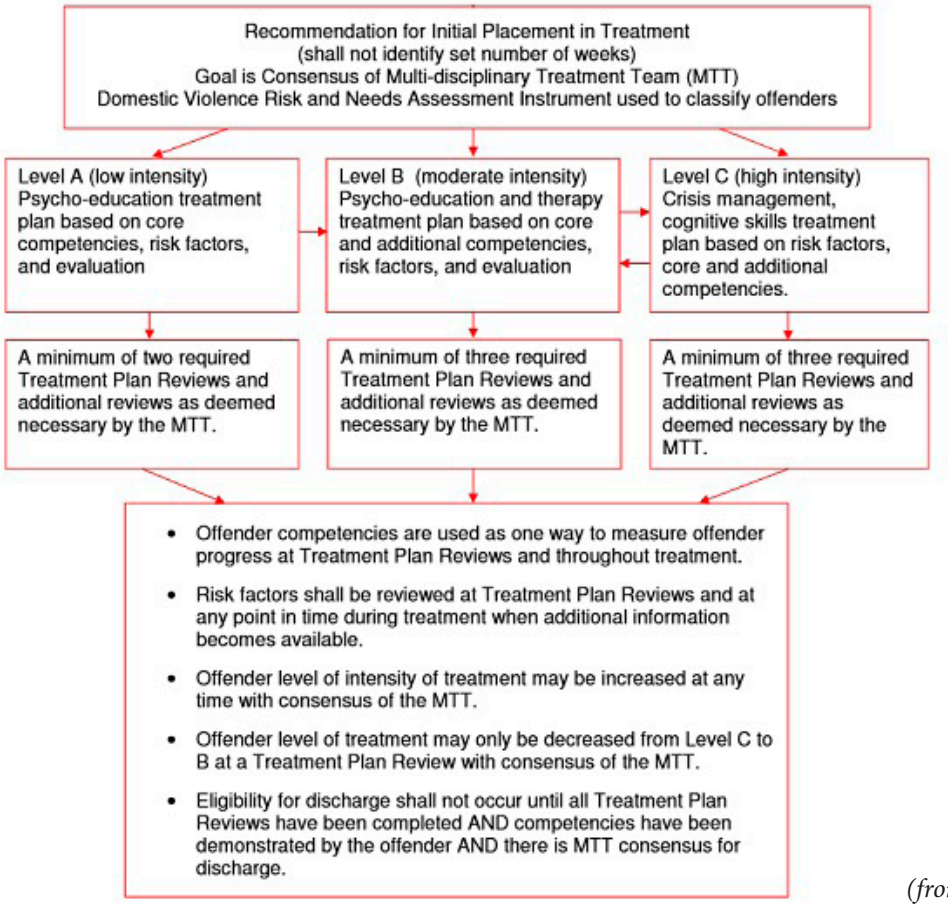
APPENDIX

FIGURE 1: *Treatment Intensity Level Placement Flow-Chart*



(from DVOMB, 2013, p. 55)

ENDNOTES

1. According to CRS 18-6-800.3 (2014): "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. "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.
2. It is important to note that some Colorado law enforcement agencies do not report statistics to CBI.
3. The 19 member DVOMB was created in 2000 by the Colorado General Assembly (§16-11.8-101).
4. One recent exception is Boal and Mankowski (2014a), which identified challenges and barriers experienced by batterer intervention programs when implementing standards statewide in Oregon.
5. Criminogenic needs include dynamic factors statistically shown to be related to criminality and amenability to change, such as substance abuse (alcohol and other drugs), antisocial attitudes, personality traits, employment, and marital and family relationships (Andrews and Bonta, 1994).
6. According to the *Standards* (2013), the minimum required sources of information for evaluations of domestic violence offenders "shall include external 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" (p. 4-3). Further, the minimum required assessment instruments include the Spousal Assault Risk Assessment (SARA), substance abuse screening instruments (with demonstrated reliability and validity), and the DVRNA (p. 4-4). The DVRNA is informed by all of the aforementioned sources. Given the various risk and needs presented by offenders as well as differential practices by providers, specific evaluation protocols may vary.
7. If the Approved Provider completing the DVRNA identifies the need for further substance abuse and mental health assessment, the offender is appropriately referred to a Certified Addictions Counselor (CAC II, III) or Licensed Addictions Counselor (LAC) for a substance abuse assessment and a licensed mental health professional for additional mental health assessment.
8. Offenders initially placed in level A can be moved to level B or level C during treatment depending on progress in treatment or change in risk. Offenders, however, initially placed in levels B or C may not be moved to level A.
9. Offenders in level C who make progress during treatment by mitigating risk factors may be moved to Level B.
10. 83 cases were omitted due to missing original DVRNA level information; 69 cases were omitted because time in treatment was unavailable; 55 were omitted due to missing discharge information; 37 were omitted due to missing county information; 26 cases were omitted due to missing gender information; and 24 were omitted due to missing DVRNA level at discharge information.
11. 99 victim advocates and 193 treatment providers were invited to complete the survey, yielding response rates of 13% and 28% respectively. For probation officers, the State Judicial Office forwarded the invitation for participation to all Chief Probation Officers, who then sent it to probation offers with domestic violence offenders on their caseloads. Thus, the exact number of probation officers who received the email invitation is unknown.
12. Further, among A level offenders the modal treatment length was 24 weeks with 39.5% of offenders spending greater than 24 weeks in treatment. Comparatively, for both B and C level offenders the modal treatment length was 36 weeks, with 21% of B level and 42.5% of C level offenders spending more than 36 weeks in treatment.

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