COLORADO

Department of Regulatory Agencies

Colorado Office of Policy, Research & Regulatory Reform

2016 Sunset Review:

Management of Domestic Violence Offenders

October 14, 2016

COLORADO
Department of
Regulatory Agencies
Executive Director's Office

October 14, 2016

Members of the Colorado General Assembly
c/o the Office of Legislative Legal Services
State Capitol Building
Denver, Colorado 80203

Dear Members of the General Assembly:

This year, Colorado's sunset review process celebrates its 40th anniversary with the publication of the 2016 sunset reports. The Colorado General Assembly established the sunset review process in 1976 as a way to analyze and evaluate regulatory programs and determine the least restrictive regulation consistent with the public interest. Since that time, Colorado's sunset process has gained national recognition and is routinely highlighted as a best practice as governments seek to streamline regulation and increase efficiencies.

The Colorado Office of Policy, Research and Regulatory Reform (COPRRR), located within my office, is responsible for fulfilling these statutory mandates. To emphasize the statewide nature and impact of this endeavor, COPRRR recently launched a series of initiatives aimed at encouraging greater public participation in the regulatory reform process, including publication of a new "Citizen's Guide to Rulemaking" (available online at www.dora.colorado.gov/opr).

Section 24-34-104(5)(a), Colorado Revised Statutes (C.R.S.), directs the Department of Regulatory Agencies to:

- Conduct an analysis of the performance of each division, board or agency or each function scheduled for termination; and
- Submit a report and supporting materials to the office of legislative legal services no later than October 15 of the year preceding the date established for termination.

Accordingly, COPRRR has completed the evaluation of the Department of Public Safety's (Public Safety's) involvement in the management of domestic violence offenders through the Domestic Violence Offender Management Board (DVOMB). I am pleased to submit this written report, which will be the basis for COPRRR's oral testimony before the 2017 legislative committee of reference.

The report discusses the question of whether there is a need for the oversight provided under Article 11.8 of Title 16, C.R.S. The report also discusses the effectiveness of the DVOMB and the staff of Public Safety in carrying out the intent of the statutes and makes recommendations for statutory and administrative changes in the event this program is continued by the General Assembly.

Sincerely,

Joe Neguse
Executive Director

COLORADO
Department of Regulatory Agencies
Colorado Office of Policy, Research & Regulatory Reform

2016 Sunset Review
Management of Domestic Violence Offenders

SUMMARY

What Is Regulated?
The Domestic Violence Offender Management Board (DVOMB), housed within the Department of Public Safety (Public Safety), Division of Criminal Justice, Office of Domestic Violence and Sex Offender Management (Office), is a 19-member board tasked with developing and maintaining the *Standards for Treatment with Court Ordered Domestic Violence Offenders (Standards)*, approving mental health providers to evaluate and treat domestic violence offenders and researching and analyzing the effectiveness of the *Standards*.

Why Is It Regulated?
To ensure the consistent and comprehensive evaluation, treatment and continued monitoring of domestic violence offenders who have been convicted of, pled guilty to, or received a deferred judgment or prosecution for any crime the underlying factual basis of which includes an act of domestic violence, the General Assembly created the DVOMB. The goal of this system is to reduce recidivism and to protect victims and potential victims.

How Is It Regulated?
The DVOMB has promulgated the *Standards* to provide a consistent framework within which domestic violence treatment is provided. The DVOMB also approves treatment providers (who must also be credentialed mental health providers) at four distinct levels: provisional level, entry level, full operating level and clinical supervisor. Each level has its own, correspondingly higher level of required training and experience.

What Does It Cost?
In fiscal year 15-16, the Office allocated 2.8 full-time equivalent employees to, and spent $267,600 in support of the DVOMB.

What Activity Is There?
In fiscal year 15-16, a total of 190 treatment providers were approved to work with domestic violence offenders: 3 provisional level, 24 entry level, 106 full operating level and 41 clinical supervisors. In fiscal year 14-15, the DVOMB and Office staff sponsored 36 trainings, which were attended by 690 approved providers.

Key Recommendations

Continue the management of domestic violence offenders and the DVOMB for five years, until 2022.
To ensure the consistent and comprehensive evaluation, treatment and continued monitoring of domestic violence offenders who have been convicted of, pled guilty to, or received a deferred judgment or prosecution for any crime the underlying factual basis of which includes an act of domestic violence, the General Assembly created the DVOMB. The goal of this system is to reduce recidivism and to protect victims and potential victims.

Amend the qualifications of the mental health professionals serving on the DVOMB to repeal the profession-specific limitations, to require three of the five to be licensed and to require three of the five to be approved treatment providers and the remaining two to have experience in the field of domestic violence. Additionally, name the Executive Director of Public Safety as the appointing authority, rather than the Executive Director of the Department of Regulatory Agencies.
Among the DVOMB's 19 members are five mental health providers, one each representing marriage and family therapists, professional counselors, social workers and psychologists, and one representing unlicensed practitioners (certified addictions counselors and registered psychotherapists). Two of the five must be approved treatment providers. Although treatment providers are approved by the DVOMB and the DVOMB develops and continues to revise the *Standards* under which they work, they have only two representatives on a board of 19. Therefore, the statute should be amended to repeal the discipline-specific representation, and instead require that three of the five mental health professionals be licensed, that three of the five be approved treatment providers and that the remaining two have experience in the field of domestic violence.

Methodology

As part of this review, staff of the Colorado Office of Policy, Research and Regulatory Reform attended DVOMB and committee meetings; interviewed Public Safety staff, DVOMB members, domestic violence offender treatment providers, members of the legal community, officials with state and national professional associations and representatives of victim advocacy organizations; conducted a survey of approved domestic violence treatment providers and reviewed Colorado statutes and rules.

Major Contacts Made During This Review

Colorado Association for Victim Assistance
Colorado Association of Addiction Professionals
Colorado Association of Marriage and Family Therapists
Colorado Association of Psychotherapists
Colorado Bar Association
Colorado Coalition Against Domestic Violence
Colorado Department of Human Services
Colorado Department of Law
Colorado Department of Public Safety
Colorado Department of Regulatory Agencies
Colorado District Attorney's Council
Colorado Judicial Department
Colorado Mental Health Professionals
Colorado Psychology Association
Colorado Public Defender's Office
National Board for Certified Counselors
Project Safeguard

What is a Sunset Review?

A sunset review is a periodic assessment of state boards, programs, and functions to determine whether they should be continued by the legislature. Sunset reviews focus on creating the least restrictive form of regulation consistent with protecting the public. In formulating recommendations, sunset reviews consider the public's right to consistent, high quality professional or occupational services and the ability of businesses to exist and thrive in a competitive market, free from unnecessary regulation.

Sunset Reviews are prepared by:
Colorado Department of Regulatory Agencies
Colorado Office of Policy, Research and Regulatory Reform
1560 Broadway, Suite 1550, Denver, CO 80202
dora.www.colorado.gov/opr

Table of Contents

Background

Introduction

Enacted in 1976, Colorado's sunset law was the first of its kind in the United States. A sunset provision repeals all or part of a law after a specific date, unless the legislature affirmatively acts to extend it. During the sunset review process, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) within the Department of Regulatory Agencies (DORA) conducts a thorough evaluation of such programs based upon specific statutory criteria[1] and solicits diverse input from a broad spectrum of stakeholders including consumers, government agencies, public advocacy groups, and professional associations.

Sunset reviews are based on the following statutory criteria:

- Whether regulation by the agency is necessary to protect the public health, safety and welfare; whether the conditions which led to the initial regulation have changed; and whether other conditions have arisen which would warrant more, less or the same degree of regulation;
- If regulation is necessary, whether the existing statutes and regulations establish the least restrictive form of regulation consistent with the public interest, considering other available regulatory mechanisms and whether agency rules enhance the public interest and are within the scope of legislative intent;
- Whether the agency operates in the public interest and whether its operation is impeded or enhanced by existing statutes, rules, procedures and practices and any other circumstances, including budgetary, resource and personnel matters;
- Whether an analysis of agency operations indicates that the agency performs its statutory duties efficiently and effectively;
- Whether the composition of the agency's board or commission adequately represents the public interest and whether the agency encourages public participation in its decisions rather than participation only by the people it regulates;
- The economic impact of regulation and, if national economic information is not available, whether the agency stimulates or restricts competition;
- Whether complaint, investigation and disciplinary procedures adequately protect the public and whether final dispositions of complaints are in the public interest or self-serving to the profession;
- Whether the scope of practice of the regulated occupation contributes to the optimum utilization of personnel and whether entry requirements encourage affirmative action;

[1] Criteria may be found at § 24-34-104, C.R.S.

- Whether the agency through its licensing or certification process imposes any disqualifications on applicants based on past criminal history and, if so, whether the disqualifications serve public safety or commercial or consumer protection interests. To assist in considering this factor, the analysis prepared pursuant to subparagraph (i) of paragraph (a) of subsection (8) of this section shall include data on the number of licenses or certifications that were denied, revoked, or suspended based on a disqualification and the basis for the disqualification; and
- Whether administrative and statutory changes are necessary to improve agency operations to enhance the public interest.

Types of Regulation

Consistent, flexible, and fair regulatory oversight assures consumers, professionals and businesses an equitable playing field. All Coloradans share a long-term, common interest in a fair marketplace where consumers are protected. Regulation, if done appropriately, should protect consumers. If consumers are not better protected and competition is hindered, then regulation may not be the answer.

As regulatory programs relate to individual professionals, such programs typically entail the establishment of minimum standards for initial entry and continued participation in a given profession or occupation. This serves to protect the public from incompetent practitioners. Similarly, such programs provide a vehicle for limiting or removing from practice those practitioners deemed to have harmed the public.

From a practitioner perspective, regulation can lead to increased prestige and higher income. Accordingly, regulatory programs are often championed by those who will be the subject of regulation.

On the other hand, by erecting barriers to entry into a given profession or occupation, even when justified, regulation can serve to restrict the supply of practitioners. This not only limits consumer choice, but can also lead to an increase in the cost of services.

There are also several levels of regulation.

Licensure

Licensure is the most restrictive form of regulation, yet it provides the greatest level of public protection. Licensing programs typically involve the completion of a prescribed educational program (usually college level or higher) and the passage of an examination that is designed to measure a minimal level of competency. These types of programs usually entail title protection – only those individuals who are properly licensed may use a particular title(s) – and practice exclusivity – only those individuals who are properly licensed may engage in the particular practice. While these requirements can be viewed as barriers to entry, they also afford the highest level of consumer protection in that they ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Certification

Certification programs offer a level of consumer protection similar to licensing programs, but the barriers to entry are generally lower. The required educational program may be more vocational in nature, but the required examination should still measure a minimal level of competency. Additionally, certification programs typically involve a non-governmental entity that establishes the training requirements and owns and administers the examination. State certification is made conditional upon the individual practitioner obtaining and maintaining the relevant private credential. These types of programs also usually entail title protection and practice exclusivity.

While the aforementioned requirements can still be viewed as barriers to entry, they afford a level of consumer protection that is lower than a licensing program. They ensure that only those who are deemed competent may practice and the public is alerted to those who may practice by the title(s) used.

Registration

Registration programs can serve to protect the public with minimal barriers to entry. A typical registration program involves an individual satisfying certain prescribed requirements – typically non-practice related items, such as insurance or the use of a disclosure form – and the state, in turn, placing that individual on the pertinent registry. These types of programs can entail title protection and practice exclusivity. Since the barriers to entry in registration programs are relatively low, registration programs are generally best suited to those professions and occupations where the risk of public harm is relatively low, but nevertheless present. In short, registration programs serve to notify the state of which individuals are engaging in the relevant practice and to notify the public of those who may practice by the title(s) used.

Title Protection

Finally, title protection programs represent one of the lowest levels of regulation. Only those who satisfy certain prescribed requirements may use the relevant prescribed title(s). Practitioners need not register or otherwise notify the state that they are engaging in the relevant practice, and practice exclusivity does not attach. In other words, anyone may engage in the particular practice, but only those who satisfy the prescribed requirements may use the enumerated title(s). This serves to indirectly ensure a minimal level of competency – depending upon the prescribed preconditions for use of the protected title(s) – and the public is alerted to the qualifications of those who may use the particular title(s).

Licensing, certification and registration programs also typically involve some kind of mechanism for removing individuals from practice when such individuals engage in enumerated proscribed activities. This is generally not the case with title protection programs.

Regulation of Businesses

Regulatory programs involving businesses are typically in place to enhance public safety, as with a salon or pharmacy. These programs also help to ensure financial solvency and reliability of continued service for consumers, such as with a public utility, a bank or an insurance company.

Activities can involve auditing of certain capital, bookkeeping and other recordkeeping requirements, such as filing quarterly financial statements with the regulator. Other programs may require onsite examinations of financial records, safety features or service records.

Although these programs are intended to enhance public protection and reliability of service for consumers, costs of compliance are a factor. These administrative costs, if too burdensome, may be passed on to consumers.

Sunset Process

Regulatory programs scheduled for sunset review receive a comprehensive analysis. The review includes a thorough dialogue with agency officials, representatives of the regulated profession and other stakeholders. Anyone can submit input on any upcoming sunrise or sunset review on COPRRR's website at: dora.colorado.gov/opr.

The functions of the Department of Public Safety's (Public Safety's) Domestic Violence Offender Management Board (DVOMB), as enumerated in Article 11.8 of Title 16, Colorado Revised Statutes (C.R.S.), shall terminate on September 1, 2017, unless continued by the General Assembly. During the year prior to this date, it is the duty of COPRRR to conduct an analysis and evaluation of the administration of the DVOMB pursuant to section 24-34-104, C.R.S.

The purpose of this review is to determine whether the currently prescribed program to approve domestic violence offender treatment providers and to promulgate the standards used in treating domestic violence offenders in court-ordered domestic violence treatment should be continued and to evaluate the performance of the DVOMB and the staff of Public Safety. During this review, the DVOMB and Public Safety must demonstrate that the program serves the public interest. COPRRR's findings and recommendations are submitted via this report to the Office of Legislative Legal Services.

Methodology

As part of this review, COPRRR staff attended DVOMB and committee meetings; interviewed Public Safety staff, DVOMB members, treatment providers, members of the legal community, officials with state and national professional associations and representatives of victim advocacy organizations; conducted a survey of treatment providers and reviewed Colorado statutes and rules.

In June 2016, COPRRR staff conducted a survey of all 174 approved treatment providers. Links to the survey were sent to individuals via email addresses supplied by Public Safety. All surveys were successfully delivered[2] and 94 recipients responded. This represents a response rate of 54 percent. Survey questions and responses may be found in Appendix A.

Profile of Domestic Violence and Offender Treatment

According to one national organization, domestic violence is

> the willful intimidation, physical assault, battery, sexual assault, and/or other abusive behavior as part of a systematic pattern of power and control perpetrated by one intimate partner against another.[3]

The Colorado Criminal Code defines domestic violence as

> 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.[4]

Consistent between these two definitions is the proposition that domestic violence is differentiated from other violence when an intimate relationship exists between the perpetrator and the victim.

An intimate relationship exists between spouses, former spouses, past or present unmarried couples, or people who are both the parents of the same child regardless of whether the people have been married or lived together at any time.[5]

In 2014, the last year for which data are available, at least 16,700 Coloradans were the victims of domestic violence.[6] The actual number of victims is generally thought to be higher, due to underreporting by victims.

[2] Successful delivery is deemed to have occurred when the email sending the survey was not returned or did not fail.
[3] National Coalition Against Domestic Violence. *Domestic Violence in Colorado.* Retrieved on June 27, 2016, from www.ncadv.org/files/Colorado.pdf
[4] § 18-6-800.3(1), C.R.S.
[5] § 18-6-800.3(2), C.R.S.
[6] Colorado Bureau of Investigation. *2014 Domestic Violence Report*. Retrieved on June 27, 2016, from crimeinco.cbi.state.co.us/cic2k14/supplemental_reports.html

On a national scale, one in three women and one in four men have been victims of some form of domestic violence within their lifetimes. This results in victims losing a total of 8 million days of paid work each year. The financial cost of domestic violence is estimated to exceed $8.3 billion per year.[7] Additionally, domestic violence inflicts incalculable physical and emotional costs.

Anyone convicted of a crime in Colorado, the underlying factual basis of which has been found by a state court to include an act of domestic violence, must be ordered to complete a domestic violence evaluation and treatment program that conforms to the standards promulgated by the DVOMB.[8] To this end, the DVOMB has developed the *Standards for Treatment with Court Ordered Domestic Violence Offenders* (*Standards*).

Upon conviction, a criminal justice agency, such as a probation department, will refer a domestic violence offender to a DVOMB-approved treatment provider to obtain a domestic violence treatment evaluation and then complete a domestic violence treatment program. Only treatment providers approved by the DVOMB may conduct such evaluations and provide such treatment.

There are three primary levels of treatment providers:[9]

- Entry Level Provider is an introductory level;
- Full Operating Level Provider is a treatment provider who has satisfied all of the necessary educational, training and experiential requirements; and
- Clinical Supervisor is a Full Operating Level Provider who is a licensed metal health care provider and who has obtained the additional training and experiential requirements for supervisors and who provides supervision in accordance with the *Standards*.

A fourth level of treatment provider is the Provisional Provider, a level which is designed for communities with a demonstrated need. This level of approval is typically applicable to rural areas where offender needs are underserved or unmet. An individual Provisional Provider is approved to work only in a specifically designated area of the state. The training and experiential requirements for such individuals are generally relaxed.[10]

[7] National Coalition Against Domestic Violence. *Statistics*. Retrieved on June 27, 2016, from www.ncadv.org/learn/statistics
[8] § 18-6-801(1)(a), C.R.S.
[9] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 9.0: Provider Qualifications.
[10] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standards 9.0: Provider Qualifications and 9.07: Provisional Approval.

The requirements for becoming an approved provider vary depending on the level of approval sought, as well as prior academic preparation. Regardless, all approved providers must hold a mental health credential (registration, certification or license) issued by one of the mental health boards in DORA, obtain a specific number of hours of training in domestic violence and complete a specific number of hours of supervised experience working with domestic violence offenders. Each approved provider must also complete a specific number of hours of continuing education to renew his or her approval.

Additionally, approved providers may elect to work with specific populations, such as female offenders or offenders who are in same sex relationships. In such cases, the approved provider must obtain additional, population-specific training.

When conducting a domestic violence offender treatment evaluation, the approved provider must use the DVOMB-created Domestic Violence Risk and Needs Assessment instrument (DVRNA). The DVRNA requires the approved provider to score the domestic violence offender on 14 risk-factor domains. This score significantly impacts the provider's recommendation as to the initial treatment level into which the offender should be placed.

The 14 domains are:

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

A value of "1" is assigned for each presenting domain. This score is then used to determine the initial treatment level. However, within the first six domains, highlighted above in italics, are various risk factors that are characterized as significant or critical. The existence of any one of these results in placement in either of the two more intensive treatment levels.

There are three treatment levels that correspond to the risk levels identified in the DVRNA:

- Level A is low intensity treatment. Offenders placed in this level scored a "1" or lower on the DVRNA and none of the significant/critical risk factors are present. Treatment consists of weekly group sessions.[11] Although there is no predetermined length of treatment, on average, offenders placed in Level A complete 24 weeks of treatment.[12]

- Level B is moderate intensity treatment. Offenders placed in this level scored between "2" and "4" on the DVRNA or one or more of the significant risk factors are present. Treatment consists of weekly group sessions plus at least one additional clinical contact each month to cover topics such as denial or resistance, evaluation or monitoring of additional mental health issues or substance abuse treatment.[13] Although there is no predetermined length of treatment, on average, offenders placed in Level B complete 35 weeks of treatment.[14]

- Level C is high intensity treatment. Offenders placed in this level have scored "5" or above on the DVRNA or several of the significant or any of the critical risk factors are present. Treatment consists of two weekly group sessions—one to address domestic violence directly and one to address additional issues such as cognitive skills, substance abuse or other mental health issues.[15] Although there is no predetermined length of treatment, on average, offenders placed in Level C complete 37 weeks of treatment.[16]

In general, domestic violence offenders may transition to different levels as treatment progresses and as risk factors are either discovered (warranting placement at a higher level) or mitigated (warranting placement at a lower level). Importantly, an offender who is placed at Level B or C can never move to Level A.[17]

Although the DVOMB does not maintain statistics regarding individual offenders and their progress through treatment, one study found that for Colorado offenders entering treatment between September 2010 and August 2012, approximately 10 percent of offenders were placed in Level A, 43 percent were placed in Level B and 47 percent were placed in Level C.[18]

---

[11] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.06(VI): Levels of Treatment: Level A (Low Intensity).
[12] Angela Gover, et al, *Colorado's Innovative Response to Domestic Violence Offender Treatment: Current Achievements and Recommendations for the Future*, Buechner Institute for Governance, (2015), p. 7.
[13] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.06(VII): Levels of Treatment: Level B (Moderate Intensity).
[14] Angela Gover, et al, *Colorado's Innovative Response to Domestic Violence Offender Treatment: Current Achievements and Recommendations for the Future*, Buechner Institute for Governance (2015), p. 7.
[15] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.06(VIII): Levels of Treatment: Level C (High Intensity).
[16] Angela Gover, et al, *Colorado's Innovative Response to Domestic Violence Offender Treatment: Current Achievements and Recommendations for the Future*, Buechner Institute for Governance (2015), p. 7.
[17] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.06: Levels of Treatment.
[18] Angela Gover, et al, *Colorado's Innovative Response to Domestic Violence Offender Treatment: Current Achievements and Recommendations for the Future*, Buechner Institute for Governance (2015), p. 6.

That same study explored the transition of offenders from one level of treatment to another, and found that:[19]

- Of the offenders placed in Level A at intake, 94 percent remained at Level A at discharge, but 5 percent had transitioned to Level B and 2 percent had transitioned to Level C.

- Of the offenders placed in Level B at intake, 95 percent remained at Level B at discharge, but 2 percent had transitioned to Level A[20] and 3 percent had transitioned to Level C.

- Of the offenders placed in Level C at intake, 75 percent remained at Level C at discharge, but less than one percent had transitioned to Level A[21] and 25 percent had transitioned to Level B.

The evaluation and treatment processes are overseen by a multidisciplinary treatment team (MTT), which consists of an approved provider, the criminal justice agency responsible for referring the offender to the treatment provider (typically probation), a treatment victim advocate and others, as are deemed necessary. The MTT is designed to collaborate and coordinate domestic violence offender treatment. The work of the MTT includes staffing cases, sharing information, and making informed decisions related to risk assessment, treatment, behavioral monitoring and management of offenders.[22] The MTT must reach consensus regarding initial placement in treatment, any changes in treatment level and offender discharge.[23]

The treatment victim advocate is the point of contact between the MTT and the victim. The treatment victim advocate assists the victim in determining whether and what information to share with the MTT. The role of the treatment victim advocate is to enhance victim safety through greater communication of all involved parties. This includes identifying erroneous beliefs or attitudes of the offender and, in some cases, the other members of the MTT. The inclusion of a treatment victim advocate encourages deeper dialogue for the MTT to understand the meanings and purposes of the behaviors of the offender and the victim.[24]

[19] Angela Gover, et al, *Colorado's Innovative Response to Domestic Violence Offender Treatment: Current Achievements and Recommendations for the Future*, Buechner Institute for Governance (2015), p. 6.
[20] This transition from Level B to Level A occurred despite the *Standards'* clear prohibition.
[21] This transition from Level C to Level A occurred despite the *Standards'* clear prohibition.
[22] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.02: Multi-disciplinary Treatment Team (MTT).
[23] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.02(VII): Multi-disciplinary Treatment Team (MTT): MTT Consensus.
[24] *See. Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 7.02: Role of Treatment Victim Advocates.

Effective October 1, 2016, the *Standards* provide for two levels of treatment victim advocate: Entry Level and Fully Qualified. Entry Level treatment victim advocates must possess 30 hours of domestic violence-specific training and 70 hours of experience working with domestic violence victims. By the end of the second year of working at this level, treatment victim advocates must apply for certification by the Colorado Organization for Victim Assistance (COVA) or the National Organization for Victim Assistance (NOVA). [25]

To become a Fully Qualified treatment victim advocate, one must be certified by COVA or NOVA and possess an additional 30 hours of training within the first year of being an Entry Level treatment victim advocate and an additional 70 hours of experience within the first two years.[26]

Domestic violence offender treatment focuses on 18 core competencies in which the domestic violence offender:[27]

- Commits to the elimination of abusive behavior;
- Demonstrates change by working on a comprehensive personal change plan;
- Completes a comprehensive personal change plan;
- Develops empathy;
- Accepts full responsibility for the offense and abusive history;
- Identifies and progressively reduces the pattern of power and control behaviors, beliefs and attitudes of entitlement;
- Becomes accountable;
- Accepts that one's behavior has, and should have, consequences;
- Participates and cooperates in treatment;
- Develops the ability to define the types of domestic violence;
- Understands, identifies and manages the offender's own personal pattern of violence;
- Understands the intergenerational effects of violence;
- Understands and uses appropriate communication skills;
- Understands and uses "time-outs";
- Recognizes the existence of financial abuse and manages finances responsibly;
- Eliminates all forms of violence and abuse;
- Does not purchase, possess or use firearms or ammunition; and
- Identifies and challenges cognitive distortions that play a role in the offender's violence.

[25] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 7.03(III)(D): Qualifications for Treatment Victim Advocates Working with an Offender Treatment Program.
[26] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 7.03(III): Qualifications for Treatment Victim Advocates Working with an Offender Treatment Program.
[27] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.08(V): Offender Competencies: Core Competencies.

Throughout treatment, victim safety is the priority[28] and offenders are prohibited from participating in any couples counseling.[29]

There are three types of discharge from domestic violence offender treatment:[30]

- Treatment Completion. This occurs when the offender has mastered the core competencies and other terms of treatment.
- Unsuccessful Discharge from Treatment. This occurs when, for example, the offender has an excessive number of absences from treatment sessions, is subject to new criminal charges or has failed to comply with the sobriety requirements of probation. In short, this type of discharge occurs when the offender's behavior demonstrates an unwillingness or inability to progress in treatment. Consequences of such discharge vary, but may include revocation of probation, new terms of probation, transfer to a different treatment provider or incarceration.
- Administrative Discharge from Treatment. This occurs when treatment is not completed through no fault of the offender. Examples of such occurrences include an offender whose treatment provider retires or an offender who is in the military is deployed or transferred. In such instances, the MTT is expected to assist the offender in transitioning to a new treatment provider.

Regardless of the type, MTT consensus is necessary to discharge an offender from treatment.[31]

Although the DVOMB does not maintain statistics pertaining to treatment level at the time of discharge relative to the time of intake, one study of 3,311 Colorado domestic violence offenders who began treatment between September 2010 and August 2012 found that:[32]

- Of the offenders placed in Level A at intake, 89 percent successfully completed treatment, 8 percent were discharged as unsuccessful and 4 percent were administratively discharged.[33]
- Of the offenders placed in Level B at intake, 68 percent successfully completed treatment, 23 percent were discharged as unsuccessful and 9 percent were administratively discharged.
- Of the offenders placed in Level C at intake, 48 percent successfully completed treatment, 37 percent were discharged as unsuccessful and 15 percent were administratively discharged.

[28] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.01(II): Basic Principles of Treatment: Victim Safety.
[29] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.10: Couple's Counseling.
[30] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.09: Offender Discharge.
[31] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 5.09: Offender Discharge.
[32] Angela Gover, et al, *Colorado's Innovative Response to Domestic Violence Offender Treatment: Current Achievements and Recommendations for the Future*, Buechner Institute for Governance (2015), p. 7.
[33] Figures do not add up to 100 percent, possibly due to rounding.

Legal Framework

History of Regulation

Prior to 1979, domestic violence offenders in Colorado received offense-specific treatment on a voluntary basis, as no formal court referral system existed. Over the course of the next 20 years, domestic violence offender treatment in Colorado evolved from a community-centric, patchwork approach to a more consistent state-wide endeavor culminating in the creation of the Domestic Violence Offender Management Board (DVOMB) in 2000.

House Bill 00-1263 created the DVOMB within the Department of Public Safety (Public Safety) and directed that the DVOMB promulgate statewide standards for domestic violence treatment and a process to approve treatment providers. The initial DVOMB comprised 18 members, representing a diverse array of mental health providers, victim advocates, members of the legal community and law enforcement.

House Bill 07-1315 expanded the DVOMB to 19 members by adding an individual to represent private criminal defense attorneys.

In 2007, the DVOMB underwent its first sunset review. Among other things, the resulting legislation (House Bill 08-1232):

- Continued the DVOMB for nine years,
- Implemented a mandatory continuing education requirement for approved treatment providers,
- Authorized the DVOMB to take disciplinary action against approved treatment providers,
- Raised the application fee from no more than $125 to no more than $300, and
- Authorized the DVOMB to develop a renewal process.

Legal Summary

To ensure the consistent and comprehensive evaluation, treatment and continued monitoring of domestic violence offenders who have been convicted of, pled guilty to, or received a deferred judgment or prosecution for any crime the underlying factual basis of which includes an act of domestic violence, the General Assembly created the DVOMB.[34] The goal of this system is to reduce recidivism and to protect victims and potential victims.[35]

[34] § 16-11.8-101, C.R.S.
[35] § 16-11.8-101, 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.[36]

An intimate relationship is a relationship between spouses, former spouses, past or present unmarried couples, or people who are both the parents of the same child regardless of whether the people have been married or lived together at any time.[37]

Anyone convicted of a crime, the underlying factual basis of which has been found by a court to include an act of domestic violence, must be ordered to complete a domestic violence evaluation and treatment program that conforms to the standards promulgated by the DVOMB. If the evaluation discloses that sentencing to a treatment program is inappropriate, the offender must be referred back to the court for alternative disposition.[38] Mandatory treatment does not apply to those sentenced to the Colorado Department of Corrections.[39]

The DVOMB, which is housed in Public Safety, comprises 19 members. Table 1 describes the membership and the appointing authority for each seat.

[36] § 18-6-800.3(1), C.R.S.
[37] § 18-6-800.3(2), C.R.S.
[38] § 18-6-801(1)(a), C.R.S.
[39] § 18-6-801(2), C.R.S.

Table 1
DVOMB Membership[40]

Number of Individuals	Population Represented	Appointing Authority
1	Colorado Judicial Department	Chief Justice of the Colorado Supreme Court
1	Judges	
1	Colorado Department of Corrections	Executive Director of the Colorado Department of Corrections
1	Colorado Department of Human Services	Executive Director of the Colorado Department of Human Services
1	Colorado Department of Regulatory Agencies	Executive Director of the Colorado Department of Regulatory Agencies
5	One each representing social workers, psychologists, marriage and family therapists, licensed professional counselors and one unlicensed mental health provider[41]	
1	Prosecuting attorneys	Executive Director of the Colorado District Attorney's Council
1	Public defenders	Colorado State Public Defender
1	Private defense attorneys	Executive Director of Public Safety
2	Domestic violence victims and victim organizations	
1	Rural areas and local coordination of criminal justice and victim services advocacy for domestic violence	
1	Urban areas and local coordination of criminal justice and victim services advocacy for domestic violence	
1	Law enforcement	
1	Public Safety	

A single term of office is four years,[42] and no member may serve for more than eight consecutive years.[43] All members serve without compensation.[44] The Executive Director of Public Safety appoints the presiding officer or chair from among the DVOMB's members.[45]

[40] § 16-11.8-103(1), C.R.S.
[41] All of these mental health providers must be credentialed as such by the appropriate board within the Colorado Department of Regulatory Agencies, and at least two of them must be approved treatment providers. The unlicensed mental health provider could be a certified addictions counselor or a registered psychotherapist.
[42] § 16-11.8-103(3)(a), C.R.S.
[43] § 16-11.8-103(3)(c), C.R.S.
[44] § 16-11.8-103(3)(a), C.R.S.
[45] § 16-11.8-103(2), C.R.S.

The DVOMB is required to:

- Adopt and implement a standardized procedure for the treatment evaluation of domestic violence offenders;[46]
- Adopt and implement guidelines and standards for a system of programs for the treatment of domestic violence offenders;[47]
- Develop an application and review process for treatment providers that includes criminal history background checks, the verification of qualifications and credentials and mandatory continuing education;[48]
- Develop a treatment provider renewal process;[49] and
- Research and analyze the effectiveness of the treatment evaluation and treatment procedures and programs developed by the DVOMB.[50]

The DVOMB is required to work with the Colorado Department of Regulatory Agencies (DORA) on a number of matters. Those seeking to become approved treatment providers must submit their applications to the mental health board within DORA that issued their mental health provider credential. DORA is then directed to implement the qualification and credential verification processes developed by the DVOMB.[51]

Additionally, the DVOMB and DORA must jointly publish a list of approved treatment providers on at least an annual basis.[52]

Finally, notwithstanding any action taken by a mental health board within DORA, the DVOMB may take action against a treatment provider, including removing that treatment provider from the list of approved treatment providers.[53]

The application fee for initial approval as a treatment provider may not exceed $300.[54]

No domestic violence offender may contract with any individual or entity to provide a domestic violence offender treatment evaluation or treatment services unless the individual is a DVOMB-approved treatment provider.[55]

[46] § 16-11.8-103(4)(a)(I), C.R.S.
[47] § 16-11.8-103(4)(a)(II), C.R.S.
[48] § 16-11.8-103(4)(a)(III), C.R.S.
[49] § 16-11.8-103(4)(a)(III.5), C.R.S.
[50] § 16-11.8-103(4)(a)(IV), C.R.S.
[51] § 16-11.8-103(4)(a)(III)(B), C.R.S.
[52] § 16-11.8-103(4)(a)(III)(C), C.R.S.
[53] § 16-11.8-103(4)(a)(III)(D), C.R.S.
[54] § 16-11.8-104(2)(b), C.R.S.
[55] § 16-11.8-104(1), C.R.S.

Program Description and Administration

The Domestic Violence Offender Management Board (DVOMB) is housed in the Colorado Department of Public Safety's (Public Safety's) Division of Criminal Justice, Office of Domestic Violence and Sex Offender Management (Office). The 19-member DVOMB has three primary tasks:

- Develop and maintain standards for the evaluation and treatment of domestic violence offenders,
- Develop processes to approve domestic violence treatment providers, and
- Conduct research and analyze the effectiveness of the evaluation and treatment standards.

The DVOMB meets monthly, typically at Public Safety's headquarters in Lakewood, but occasionally at other locations around the state. Meetings are generally well attended by both DVOMB members, as well as members of the public (including approved treatment providers, probation officers and victim advocates).

The DVOMB has created several standing committees through which it completes the bulk of its work. Committees in existence at the time of this writing include:

- Application Review Committee (ARC)—reviews new applications and complaints about approved providers, and conducts Quality Assurance Reviews (QARs) of selected approved providers.

- Executive Committee—works to keep the DVOMB focused on its goals. This committee works to ensure efficient DVOMB meetings by creating the agenda for such meetings.

- Implementation Science Committee—explores and utilizes the use of implementation science to improve implementation of the *Standards for Treatment with Court Ordered Domestic Violence Offenders (Standards)*.

- Victim Advocacy Committee—works to improve the implementation of the victim advocacy standards throughout the state. Most recently, this committee drafted revisions of the victim advocacy standards.

- Treatment Providers and Best Practices Committee—works to improve the implementation of the *Standards* by treatment providers. This committee works to ensure that the *Standards* remain current with any emerging research.

- Training Committee—identifies training needs, reviews the content of trainings and makes recommendations to the DVOMB on training topics. This committee identifies national speakers and evaluates post-training survey feedback.

- Young Adult Domestic Violence Offenders Committee—works to create a document recommending treatment and evaluation considerations for working with young adults (approximately 18 to 25 year olds) under the *Standards*.

While only members of the DVOMB may serve on the ARC and Executive Committee, anyone may serve on the other committees. Indeed, participation by non-DVOMB members is highly encouraged. Most committees meet on a monthly basis.

Two additional committees are expected to form in 2016 or 2017, resources permitting:

- Dissemination of Legal Information Workgroup—will strategize on the best way to disseminate information related to the *Standards* to judges and lawyers.

- *Standards* Revision Committee for 9.0 and 10.0—will explore ways in which current requirements for becoming and renewing provider approval status may be revised.

Agency Fiscal Information

The DVOMB is funded through three primary sources: provider fees, training fees and the state's General Fund.

Table 2 illustrates, for the fiscal years indicated, the level of funding from each source.

Table 2
Funding Sources[56]

Fiscal Year	Provider Fees	Training Fees	General Fund		Total Funding
			Operating	Personal Services	
10-11	$9,753	$19,816	$34,752	$187,383	**$251,704**
11-12	$33,693	$15,627	$34,752	$189,075	**$273,147**
12-13	$38,400	$17,898	$34,752	$205,497	**$296,546**
13-14	$2,326	$9,252	$34,752	$210,721	**$257,051**
14-15	$5,463	$20,130	$34,752	$229,348	**$289,693**

Provider fees are those fees paid by treatment providers upon seeking initial approval and when renewing their approvals. Office staff attributes the substantial amounts realized through provider fees in fiscal years 11-12 and 12-13 to accounting issues, whereby fees were collected and processed over a calendar year, rather than over a fiscal year. This created issues with projecting revenue and reporting, so changes were implemented that now reconcile this issue.

[56] Figures may not add up to Total Funding due to rounding.

Training fees are those fees paid by treatment providers for pre- and post-approval trainings sponsored by the DVOMB. Office staff attributes the fluctuations to increased trainings surrounding a major revision of the *Standards* in 2010. The increase in fiscal year 14-15 is attributed to increased interest in more advanced offerings.

Table 3 illustrates, for the fiscal years indicated, total DVOMB expenditures, as well as the number of full-time equivalent (FTE) employees allocated to supporting the DVOMB.

Table 3
Agency Fiscal Information

Fiscal Year	Total Program Expenditures	FTE
10-11	$222,135	2.7
11-12	$223,827	2.5
12-13	$240,249	2.8
13-14	$245,473	2.8
14-15	$267,600	2.4

Though staffing levels have remained relatively constant, fluctuating by mere fractions of an FTE, spending steadily increased over the reporting period. Office staff attributes this increase to payouts to retiring employees and a position reclassification.

In fiscal year 15-16, the Office comprised 2.8 FTE:

- Manager (0.05 FTE Program Management II) serves as the first-level program supervisor for the Office, which administers both the DVOMB and the Sex Offender Management Board.
- Program Coordinator (1.0 FTE Administrator V) oversees the day-to-day management of the DVOMB program, providing subject matter expertise to and staffing for the DVOMB, developing strategic plans and work processes for the DVOMB and implementing plans and processes necessary for meeting legislative mandates.
- DVOMB Standards Coordinator (0.75 FTE Administrator IV) maintains the approved provider list and works with the ARC to provide leadership, advice and guidance relative to the statutorily mandated work of the ARC.
- Program Assistant (0.8 FTE Program Assistant I) provides general administrative support to the DVOMB program, maintains databases that support the functioning of the DVOMB, maintains the DVOMB's website and performs budget tracking, forecasting of budget needs, prepares budget documents and oversees compliance with budget guidelines.
- Statistical Analyst (0.2 FTE Statistical Analyst III) collects and analyzes data for the purpose of recommending necessary policy or *Standards* changes and identifies training needs.

Due to a reorganization of the Office in summer 2016, the allocation of staff to the DVOMB is 2.6 FTE as of the writing of this sunset report.

Evaluation and Treatment Standards

Pursuant to its statutory mandate to develop standards to be used in the evaluation and treatment of domestic violence offenders, the DVOMB has published and continues to revise the *Standards*.

The *Standards* cover 10 broad subjects:

- Guiding Principals
- Offender Evaluation
- Offender Treatment
- Offender Confidentiality
- Victim Advocacy
- Coordination with Criminal Justice System
- Provider Qualifications
- Specific Offender Populations
- Administrative Standards

Finally, the *Standards* include nine appendices, which are intended to serve as resources for approved treatment providers:

- Evaluation and Treatment of Non-court Ordered Domestic Violence Offenders
- Overview for Working with Specific Offender Populations
- Glossary of Terms
- Administrative Policies
- Resource and Guide to Terms and Concepts of the Pre-Sentence or Post-Sentence Evaluation Standards
- Bibliography
- Domestic Violence Risk and Needs Assessment Instrument
- Guidelines to Promoting Healthy Sexual Relationships
- Interactive Electronic Therapy

The DVOMB periodically revises various of the individual standards. Most recently, the standard pertaining to victim advocacy was substantially revised in March 2016.

Provider Approval

Anyone convicted of a crime, the underlying factual basis of which has been found by a court to include an act of domestic violence must be ordered to complete a domestic violence evaluation and treatment program that conforms to the standards promulgated by the DVOMB.[57] Only treatment providers approved by the DVOMB may provide court-ordered domestic violence treatment and the related evaluations.

[57] § 18-6-801(1)(a), C.R.S.

There are three primary levels of treatment providers:[58]

- Entry Level Provider is an introductory level;
- Full Operating Level Provider is a treatment provider who has satisfied all of the necessary educational, training and experiential requirements; and
- Clinical Supervisor is a Full Operating Level Provider who is a licensed metal health care provider and who has obtained the additional training and experiential requirements for supervisors and who provides supervision in accordance with the *Standards*.

A fourth level of treatment provider is the Provisional Provider, a level which is designed for communities with a demonstrated need. This level of approval is typically applicable to rural areas where offender needs are underserved or unmet. An individual Provisional Provider is approved to work only in a specifically designated area of the state. The training and experiential requirements for such individuals are generally relaxed.[59]

Table 4 illustrates, for the fiscal years indicated, the total number of approved providers.

Table 4
Total Number of Approved Providers

Fiscal Year	Total Number of Approved Providers
10-11	220
11-12	Not Available
12-13	195
13-14	Not Available
14-15	201

Figures in Table 4 reflect the number of approved providers at the time of biennial renewal. Although Office staff has not maintained historical data that would indicate the total number of providers for each year, or the breakdown by provider level, as of the end of fiscal year 15-16, a total 190 treatment providers had been approved: 3 provisional, 24 entry level, 106 full operating level and 41 clinical supervisors. Additionally 16 approved providers are in a status referred to as "not currently practicing."

Regardless, the number of approved providers decreased appreciably in fiscal year 12-13. During this period, the DVOMB adopted new treatment standards. Office staff speculates that some providers opted to leave the field, rather than adapt to the new treatment model.

Table 5 provides a summary of the qualifications necessary to obtain the indicated level of treatment provider approval.

[58] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standard 9.0: Provider Qualifications.
[59] *Standards for Treatment with Court Ordered Domestic Violence Offenders*. Colorado Domestic Violence Offender Management Board. Standards 9.0: Provider Qualifications and 9.07: Provisional Approval.

Table 5
Treatment Provider Qualifications

Requirement	Provisional	Entry Level	Full Operating	DV Clinical Supervisor
DV Specific Training Hours	MA – 35 hours BA – 70 hours	MA – 77 hours BA – 112 hours	MA – 154 hours BA – 203 hours	No additional training hours beyond Full Operating Level
DV Experiential Hours (Co-facilitation of DV treatment with approved provider)	MA with 1,000 post graduate general clinical hours requires 54 hours MA with less than 1,000 post graduate general clinical hours or BA requires 108 hours (36 weeks x 1.5 hour group = 54 hours)	MA – 108 hours BA – 216 hours (54 hours x 2 groups = 108 54 hours x 4 groups = 216)	MA – 162 hours BA – 324 hours (54 hours x 3 = 162 54 hours x 6 = 324)	75 hours in addition to Full Operating Level requirement
Supervision (Supervisor or staffings shall include victim advocate at least quarterly)	A minimum of 1 hour per month of DV clinical supervision for up to 10 client contact hours, and 2 hours per month for 10 or more client contact hours or additional supervision as determined by supervisor. Licensed provisional providers are eligible to do peer consultation rather than supervision beginning their second year of practice.	A minimum of 2 hours per month of DV clinical supervision or additional supervision as determined by supervisor. (Variance may be requested for rural areas.) Applicants may have less if small caseload.	Minimum of 2 hours per month of peer consultation required for all providers at this level, no clinical supervision required. (Applicants are required to have supervision based on size of caseload.)	Minimum of 2 hours per month of peer consultation required with another approved and licensed provider.
Continuing Education	14 hours per year	14 hours per year	28 hours every 2 years	28 hours every 2 years
Additional/Special Requirements	Eligibility – Only for communities that demonstrate need, such as no existing provider, approval is only for that community. A letter of support for approval from the provider that co-facilitated treatment.	None	None	Licensed mental health professional. 21 hours training in clinical supervision within past 5 years.

MA = master's degree in counseling related field BA = bachelor's degree in human services related field
DV = Domestic Violence
Providers may remain at the Provisional or Entry Levels but are encouraged to apply for the next level once qualifications are met.

As Table 5 illustrates, the higher an individual's formal training (e.g., a master's degree versus a bachelor's degree), the fewer domestic violence-specific training and experiential hours that are required. Additionally, more advanced levels of approval require additional hours of training, experience and supervision.

The DVOMB's Training Committee is charged with coordinating various types of training for the DVOMB. Table 6 illustrates, for the fiscal years indicated, the number of trainings offered and the number of attendees.

Table 6
Treatment Provider Trainings

Fiscal Year	Number of Trainings	Number of Attendees
10-11	30	480
11-12	18	415
12-13	26	448
13-14	33	534
14-15	36	690

No distinction is made between pre- and post-approval trainings. The topics covered in the respective trainings vary widely, but some have covered issues such as offender competencies and the level of treatment, treatment victim advocacy and domestic violence evaluations.

Note the substantial decrease in the number of trainings in fiscal year 11-12. This coincides with the release of substantially revised *Standards* in 2010, after which the overall number of trainings was reduced given that the trainings offered tended to be more intensive.

Note also the substantial increase in attendees in fiscal year 14-15. This coincides with the DVOMB's creation of the Training Committee. One of the accomplishments of this committee has been to secure the services of speakers from outside of Colorado who tend to present on non-standard or specialized topics. These presentations generate greater interest and thus increased attendance.

In June 2016, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) conducted a survey of approved providers. Complete results are presented in Appendix A. As part of this survey, COPRRR asked a series of questions relating to the cost, availability and quality of domestic violence-specific trainings. Here are some results:

- 44.1 percent of respondents either agreed or strongly agreed that trainings are offered on a reasonably consistent basis, while 30.1 percent either disagreed or strongly disagreed.

- 52.7 percent of respondents either agreed or strongly agreed that trainings are reasonably priced, while 23.7 percent either disagreed or strongly disagreed.

- 33.7 percent of respondents either disagreed or strongly disagreed that trainings are offered throughout the state, while 25 percent either agreed or strongly agreed.

- 42.4 percent of respondents either agreed or strongly agreed that trainings are of an acceptable quality, while 28.2 percent either disagreed or strongly disagreed.

- 45.7 percent of respondents either agreed or strongly agreed that the training and experience requirements correspond to what is minimally necessary to protect the public, while 28.3 percent either disagreed or strongly disagreed.

These survey results indicate that a plurality of respondents finds that trainings are of an acceptable quality, are offered on a consistent basis and are reasonably priced, but they are not offered throughout the state.

Additionally, the survey results indicate that a plurality of respondents finds that the required provider qualifications correspond to what is minimally necessary to protect the public.

Practitioners may seek initial approval at the provisional level, entry level or full operating level, and there is no requirement to move up the approval ladder. In other words, a treatment provider may remain at the provisional level for his or her entire career.

Regardless of the approval level sought, all initial applicants must submit to state and federal fingerprint-based criminal history background checks and pay the associated fee of $39.50 at the time of application.

Additionally, applicants must submit evidence that they comply with the various qualifications, as summarized in Table 5. They must also provide samples of their work product in the form of domestic violence offender evaluations, treatment plans and contracts.

Application fees vary depending on the level of approval sought, and they are in addition to the fees associated with the fingerprint-based criminal history background checks. Table 7 illustrates the current application fees for each level of approval.

Table 7
Application Fees

Provider Level	Application Fee
Provisional	$110.50
Entry Level	$160.50
Entry Level to Full Operating Level[60]	$100.00
Initial Full Operating Level[61]	$260.00

There is no fee to apply to become a clinical supervisor.

Once Office staff deems the application complete and the results of the fingerprint-based criminal history record check have been received, the application is forwarded to the ARC for review. The ARC may approve the application, deny it or request that certain items, most typically an offender evaluation, be redrafted and resubmitted.

Table 8 illustrates, for the fiscal years indicated, the number of new applications received, approved and ultimately denied.

Table 8
New Provider Applications[62]

Fiscal Year	Applications Received	Applications Approved	Applications Denied
10-11	19	18	1
11-12	15	14	1
12-13	11	9	2
13-14	19	16	3
14-15	16	14	2

The data in Table 8 clearly indicate that most (88.7 percent) applications are ultimately approved. According to Office staff, the most typical reasons for ultimate denial include failure to provide supplemental/updated information, failing to meet the required qualifications and negative references.

According to Office staff, most applications are eventually approved within two or three months.

[60] These are applicants who are currently approved at the entry level and are seeking to move up to the full operating level.
[61] These are applicants who are not currently approved at any level and are seeking to be approved at the full operating level.
[62] Figures in this table pertain to individuals filing new applications to the provisional, entry and full operating levels. They do not include applications to move from one level of approval to another, to work with specific offender populations or to become clinical supervisors.

Since fiscal year 12-13, provisional and entry level providers have had the ability to take advantage of a streamlined application process to "move up." That is, rather than submit an entirely new application, these providers can submit streamlined applications to transition from the provisional level to entry level or full operating level, or from the entry level to the full operating level. For the three-year period ending in fiscal year 14-15, seven such applications were submitted, and all but one were approved.

COPRRR's June 2016 survey asked a series of questions regarding application processing:

- 43.5 percent of respondents either disagreed or strongly disagreed that the overall approval process is fair and equitable, while 41.3 percent either agreed or strongly agreed.

- 52.7 percent of respondents either disagreed or strongly disagreed that the overall process takes a reasonable amount of time, while 27.9 percent either agreed or strongly agreed.

- 46.8 percent of respondents either disagreed or strongly disagreed that the approval process is transparent and easily understood, while 29.3 percent either agreed or strongly agreed.

- 34.1 percent of respondents either disagreed or strongly disagreed that when applications are denied, the reasons are clearly articulated, while 31.8 percent agreed or strongly agreed.

- 39.5 percent of respondents either disagreed or strongly disagreed that the reasons for denial are fair and legitimate, while 24.4 percent either agreed or strongly agreed.

These survey results indicate that a plurality of respondents finds that the approval process takes too long, that it is unfair and that when applications are denied or rejected, the reasons are neither clearly articulated nor fair.

The approval of treatment providers must be renewed every two years. Prior to 2011, the renewal process consisted of a re-application process, during which approved providers were again required to provide verification of their education, training and experience, as well as samples of their work product. Data analysis conducted by Office staff concluded that less than 20 percent of treatment providers were not compliant, so the process was reformed. Since 2011, treatment providers submit a brief renewal packet. The renewal fee is $200, regardless of level.

Table 9 illustrates, for the fiscal years indicated, the number of treatment provider approvals that were renewed.

Table 9
Treatment Provider Renewals

Fiscal Year	Number of Renewals
10-11	190
11-12	Not Applicable
12-13	164
13-14	Not Applicable
14-15	195

Treatment providers can also opt to work with specific offender populations (female offenders or offenders who are in same sex relationships) or to become clinical supervisors. Table 10 illustrates, for the fiscal years indicated, the number of applications submitted for one of these additional approvals.

Table 10
Clinical Supervisor and Specific Offender Population Applications

Fiscal Year	Number Received	Number Approved	Number Denied
10-11	18	17	1
11-12	20	20	0
12-13	12	10	2
13-14	14	12	2
14-15	14	13	1

Office staff attributes the significant decline in applications beginning in fiscal year 12-13 to a 2010 change in the DVOMB's process for approving treatment providers who seek to work with specific offender populations. Since that time, the number of applications received has increased.

In all cases of denials, applicants failed to meet the required qualifications.

To ensure continued compliance with the *Standards* by treatment providers, the DVOMB created the annual Quality Assurance Review (QAR) process, whereby selected treatment providers are required to submit samples of their work product for the ARC to review.

Each year, four treatment providers are selected to participate in the QAR process. Two are selected at random. The remaining two—selected by the ARC in consultation with Office staff—are considered "for cause." In short, these are individuals who are considered higher risk and might be individuals who have been placed on a Compliance Action Plan (CAP)(indicating past difficulties in complying with the *Standards*), have been disciplined by one of the mental health boards in the Department of Regulatory Agencies (DORA) or for some other reason.

The QAR process is a type of practice audit, whereby the treatment provider is required to submit evidence of compliance with the DVOMB's continuing education requirements, two clinical evaluations of domestic violence treatment offenders, and a few other items.

The ARC then reviews these documents and if there are no problems, the treatment provider is informed of such. If the ARC identifies problems, however, more information may be sought. If the ARC identifies problems that can be remediated, the treatment provider may be placed on a CAP. If remediation seems unlikely, the ARC may seek to delist the treatment provider, rendering that practitioner ineligible to work with domestic violence offenders.

Table 11 illustrates, for the fiscal years indicated, the number of QARs performed along with the results.

Table 11
Quality Assurance Reviews

Fiscal Year	Number of QARs	Successful Completion of QAR Process	Non-compliant with QAR and Placed on CAP	Non-compliant with CAP or QAR and Delisted	Successful with CAP and Approved for Continued Listing
10-11	4	2	0	2	0
11-12	4	3	0	1	0
12-13	4	3	1	1	0
13-14	4	2	2	1	1
14-15	4	3	1	0	1

These data suggest that the majority (65 percent) of treatment providers participating in the QAR end with successful completion and no further action. Of the 13 treatment providers who had initial difficulty completing the QAR process, at least five were ultimately delisted.

The data in Table 11 are more or less consistent with COPRRR's June 2016 survey of treatment providers, which contained a series of items related to the QAR process. Since only 10 survey respondents (10.9 percent of the overall total) indicated that they had participated in the QAR process, the data are of limited use. However, it is noteworthy that half of the respondents characterized the QAR process as very or somewhat positive and half found the process to be very or somewhat negative.

Complaints/Disciplinary Actions

Recall that treatment providers must hold a valid credential (registration, certification or license) issued by one of the mental health licensing boards within DORA.

Although the Office has not maintained historical data pertaining to the types of DORA-issued credentials held by approved providers, such data is available for fiscal year 15-16:

- 171 Certified Addictions Counselors
- 135 Licensed Professional Counselors[63]
- 56 Registered Psychotherapists
- 32 Licensed Addictions Counselors
- 23 Licensed and Licensed Clinical Social Workers
- 11 Licensed Psychologists
- 8 Licensed Marriage and Family Therapists[64]

Note that an individual may hold multiple DORA-issued credentials. Anecdotally, the most common "add on" credential is certified addictions counselor.

Regardless, these ratios are relatively consistent with COPRRR's June 2016 survey, which solicited such demographic information from respondents, and indicated:

- Licensed Professional Counselor—51.6 percent
- Certified Addictions Counselor—42.9 percent
- Registered Psychotherapist—18.7 percent
- Licensed Addictions Counselor—13.2 percent
- Licensed Clinical Social Worker—7.7 percent
- Licensed Social Worker—3.3 percent
- Licensed Marriage and Family Therapist—3.3 percent
- Licensed Psychologist—1.1 percent

Again, an individual may hold multiple DORA-issued credentials.

Complaints against treatment providers are taken by the DORA board responsible for issuing the individual treatment provider's mental health provider credential. As part of the investigatory process, the DORA board will solicit input from the DVOMB, through the ARC, as to whether the *Standards* have been violated.

Table 12 summarizes, for the fiscal years indicated, the number of complaints against treatment providers and the outcomes.

[63] This total includes 10 Licensed Professional Counselor Candidates.
[64] This total includes one Licensed Marriage and Family Therapist Candidate.

Table 12
Summary Statistics of DORA Complaints

Fiscal Year	Number of Individual Treatment Providers with Complaints	Number of DORA Complaint Cases Pertaining to the *Standards*	Number of Cases Dismissed by DORA	Number of Cases Resulting in Discipline by DORA	Number of Treatment Providers Receiving Action by the DVOMB
10-11	9	14	9	5	3
11-12	11	30	18	12	8
12-13	23	47	31	16	7
13-14	7	13	8	3	0
14-15	9	23	14	1	1

Because an individual treatment provider may hold more than one DORA-issued credential, and each DORA board opens its own case, the total number of cases in the second column exceeds the number of providers indicated in the first column.

Note the spike in the number of DORA cases in fiscal year 12-13. Recall that the *Standards* were substantially revised in 2010. For the ensuing two years, the DVOMB focused on educating treatment providers on the new *Standards*, rather than enforcement. In fiscal year 12-13, this philosophy shifted, resulting in an increase in cases for that year.

The DVOMB, acting through the ARC, may take action against a treatment provider based on any action taken by a DORA board, or independent of it. Among the DVOMB's more common actions are delisting a treatment provider (thereby preventing the treatment provider from working with domestic violence offenders), selecting the treatment provider for a "for cause" QAR or placing the treatment provider on a CAP.

In very general terms, a CAP is a type of practice monitoring, whereby the treatment provider contracts with a clinical supervisor (with the approval of the ARC) to review the treatment provider's case files for a predetermined period of time. Although the Office has not historically maintained statistics on the number of times a CAP or QAR has resulted from the complaint process, Table 13 illustrates the number of times treatment providers have been involuntarily delisted.

Table 13
Involuntary De-listings

Fiscal Year	Number of Involuntary De-listings
10-11	1
11-12	1
12-13	3
13-14	0
14-15	1

As Table 13 indicates, very few treatment providers are involuntarily delisted.

A treatment provider who is involuntarily delisted must, in general, cease practicing within two to four weeks. During this time, clients must be transferred to other treatment providers.

The treatment provider may appeal the ARC's decision by petitioning the ARC to reconsider. At the treatment provider's option, the treatment provider may personally appear before the ARC.

If the ARC refuses to reinstate the treatment provider, he or she may appeal the ARC's decision to the full DVOMB. The decisions of the DVOMB at this point are final and are not subject to further appeal.

Research and Analysis of the Effectiveness of the Standards

Section 16-11.8-103(4)(a)(IV), Colorado Revised Statutes (C.R.S.), requires the DVOMB to, among other things:

- Research and analyze the effectiveness of the *Standards*,
- Prescribe a system for implementing the *Standards*, and
- Prescribe a system for tracking offenders.

The DVOMB has undertaken several projects to fulfill these statutory mandates. Highlights of some of the more recent projects appear in the sections below.

Effectiveness of the *Standards*

The *Standards* were substantially revised in 2010 and included the publication of the *Domestic Violence Risk and Needs Assessment* instrument (DVRNA), which is used to evaluate offenders at the time of intake. As a result, the DVOMB commissioned two research projects, one of which was the *DVRNA Validation Study*. To be meaningful, both studies required the submission of case files from treatment providers. After two years, however, less than 100 case files had been submitted to the *DVRNA Validation Study* while over 2,000 cases had been submitted to the other study (*Tracking Offenders in Treatment Study)*, which is discussed in greater detail below.

In 2013, the DVOMB launched the *DVRNA Validation Study Phase 2.0*. More providers were recruited to participate and when data collection ended in 2015, over 400 case files had been submitted. The DVOMB is now waiting for time to elapse to better evaluate recidivism.

Finally, the DVOMB, in collaboration with the University of Baltimore and the University of Colorado Denver's School of Public Affairs, participated in a DVOMB process evaluation study. This study built on the data obtained through the *Tracking Offenders in Treatment Study* along with data obtained through surveys of MTT members. The project culminated in the publication of the *Standards for Treatment with Court Ordered Domestic Violence Offenders: A Process Evaluation* in May 2016.

IMPLEMENTING THE *STANDARDS*

Following the 2010 revision of the *Standards*, the DVOMB devoted considerable resources to conducting outreach, providing trainings and offering technical assistance to MTTs. As part of these efforts, three new committees were created:

- Training Committee,
- Standards Implementation Committee, and
- Implementation Science Committee.

The Training Committee identifies training needs, reviews the content of trainings and makes recommendations to the DVOMB on training topics. This committee identifies national speakers and evaluates post-training survey feedback.

The Standards Implementation Committee existed from 2012 through 2013 and provided the DVOMB with recommendations that were subsequently assigned to other committees. One of the outcomes of this committee was the creation of a series of informational brochures, which, among other things, provides resources to MTTs on matters such as the roles and responsibilities of individual MTT members, working with offenders who have financial challenges and integrating the Diagnostic Statistical Manual 5 (DSM-5) into offender treatment.

The Implementation Science Committee explores and utilizes implementation science to improve implementation of the *Standards*. This committee has served as the lead on the DVOMB's efforts to work with local communities in exploring how the DVOMB can improve its capacity to train, engage and receive feedback from local communities. Toward this end, this committee has piloted a project with the Domestic Violence Treatment Team in Pueblo.

TRACKING OFFENDERS

One of the research studies commissioned by the DVOMB after the 2010 revisions to the *Standards*, was the *Tracking Offenders in Treatment Study*. Treatment providers were asked to submit one-page discharge forms that included basic information related to treatment. With over 2,000 cases submitted, the DVOMB suspended data collection after preliminary results were reported in 2013 so as to encourage greater participation in other DVOMB-commissioned research projects. This study explored the distribution of offenders among the three treatment levels, the frequency of successful discharge from treatment and the average length of time spent in treatment for offenders in each of the three treatment levels.

Collateral Consequences – Criminal Convictions

Section 24-34-104(6)(b)(IX), C.R.S., requires COPRRR to determine whether the agency under review, through its licensing processes, imposes any disqualifications on applicants or licensees based on past criminal history, and if so, whether the disqualifications serve public safety or commercial or consumer protection interests.

All treatment providers must pass a fingerprint-based criminal history background check as part of the approval process. However, prior to submitting a formal application, prospective candidates with any criminal history are encouraged to submit a request for an ARC determination of whether such a history could be a public safety issue or interfere with their ability to practice under the *Standards*. If the ARC concludes that the applicant's criminal history will pose a problem, it may recommend that the applicant not submit an application. Table 14 illustrates, for the fiscal years indicated, the number of requests for such determinations and the outcomes.

Table 14
Criminal History Pre-Screens

Fiscal Year	Number of Criminal History Determinations Requested	Number of Determinations Resulting in Recommendation to Submit an Application	Number of Determinations Resulting in Recommendation to Not Submit and Application
10-11	Not Available	Not Available	Not Available
11-12	5	4	1
12-13	5	4	1
13-14	2	1	1
14-15	1	0	1

The applicant in fiscal year 11-12 who the ARC recommended to not submit an application had been convicted of child abuse. The applicant in fiscal year 12-13 had multiple convictions for mail fraud related to Medicare billings. The applicant in fiscal year 13-14 had filed restraining orders on intimate partners in 2012 and 2013. The applicant in fiscal year 14-15 had multiple drug and prostitution-related convictions, including assault on a police officer. None of these individuals submitted formal applications to the DVOMB.

Analysis and Recommendations

Recommendation 1 – Continue the management of domestic violence offenders and the Domestic Violence Offender Management Board for five years, until 2022.

In 1987, the Colorado General Assembly mandated that all individuals convicted of a crime with an underlying factual basis of domestic violence receive treatment. A "State Commission" was established to promulgate treatment standards, but the implementation of those standards and the approval of treatment providers were left to individual certification boards in each of the state's judicial districts. As a result, treatment occurred on an inconsistent basis across the state.

In response, the General Assembly created the Domestic Violence Offender Management Board (DVOMB) in 2000, and charged it with developing treatment standards, approving treatment providers and conducting research.

Though some may disagree with some of the philosophies enshrined in the *Standards for Treatment with Court Ordered Domestic Violence Offenders* (*Standards*) and argue that the treatment provider approval process is lengthy and less than transparent, most agree that the treatment received by domestic violence offenders today is consistent across the state.

The first sunset criterion asks whether the program under review is necessary to protect the health, safety and welfare of the public. The program created under the DVOMB accomplishes this task in several ways.

First, domestic violence offenders have been convicted of a crime. Without the treatment dictated by the *Standards* and provided by approved treatment providers, such individuals may never receive any treatment at all or they may receive treatment that fails to meet the needs of their community. While treatment may have many goals, one of them is to provide offenders with the tools they need to continue to be productive members of society. Thus, the DVOMB and the *Standards* serve to protect the public in this manner.

Next, one of the guiding principles of the DVOMB and the *Standards* is victim safety. For every domestic violence offender, there is at least one victim. Many times, the victim and the offender continue their relationship post-conviction. The *Standards* mandate not only the manner in which offender treatment is provided, but they also create a system through which offenders are managed.

Each domestic violence offender has a dedicated multidisciplinary treatment team (MTT) consisting of a DVOMB-approved treatment provider, a treatment victim advocate and, most typically, the offender's probation officer. The MTT is expected to meet on a periodic basis to monitor offender behavior and progress through treatment.

A significant voice on the MTT is the treatment victim advocate. This individual is tasked with serving as the point of contact between the MTT and the victim. This allows a two-way flow of information and can serve to confirm or contradict what the offender reports to probation and/or the treatment provider. In this way, treatment and offender management are enhanced, but so, too, is victim safety.

The second sunset criterion asks whether the existing program is the least restrictive consistent with the public interest. The DVOMB has two primary functions—approving providers and developing the *Standards*. Since the *Standards* now exist, they would continue to exist even if the DVOMB and the provider approval process were to sunset. Thus, it is necessary to inquire as to the anticipated effectiveness of the *Standards* without a provider approval process.

Such a discussion requires little more than reflection back to the period between 1987 and 2000, when a set of standards existed and there was no consistent method for approving providers or ensuring their adherence to the treatment standards. Most acknowledge that treatment, if it occurred at all, was inconsistent across the state. Assuming the consistent treatment and management of offenders is in the public interest, it is reasonable to conclude that the current model satisfies the second sunset criterion.

Therefore, the General Assembly should continue the DVOMB and the management of domestic violence offenders for five years, until 2022. This sunset report makes several recommendations (such as altering the composition of the DVOMB) that warrant a shorter continuation period. Additionally, a discussion as to whether and how the DVOMB should be authorized to promulgate standards for juvenile offenders is far from settled. Perhaps some consensus will emerge within the next five years.

Recommendation 2 – Amend the qualifications of the mental health professionals serving on the DVOMB to repeal the profession-specific limitations, to require three of the five to be licensed and to require three of the five to be approved treatment providers and the remaining two to have experience in the field of domestic violence. Additionally, name the Executive Director of the Department of Public Safety as the appointing authority, rather than the Executive Director of the Department of Regulatory Agencies.

Among the 19 members of the DVOMB are five appointed by the Executive Director of the Department of Regulatory Agencies (DORA):[65]

- One licensed social worker/clinical social worker;
- One licensed psychologist;
- One licensed marriage and family therapist;
- One licensed professional counselor; and

[65] §§ 16-11.8-103(1)(g)(I and II), C.R.S.

- One unlicensed mental health professional, who could be a certified addictions counselor or a registered psychotherapist.

Two of these five must be approved treatment providers.[66]

Thus, although treatment providers are approved as such by the DVOMB and the DVOMB develops and continues to revise the *Standards* under which treatment providers work, they have only two representatives on a board of 19.

In June 2016, the Colorado Office of Policy, Research and Regulatory Reform (COPRRR) conducted a survey of approved treatment providers. One series of survey items pertained to DVOMB composition. Two items specifically addressed the issue of DVOMB membership and status as a treatment provider:

- 57 percent of respondents agreed or strongly agreed that all mental health professionals serving on the DVOMB should be approved providers, while 23.6 disagreed or strongly disagreed.

- 43.1 percent of respondents disagreed or strongly disagreed that there should be a mix of approved providers and non-providers, while 36.6 percent agreed or strongly agreed.

Although these two items attempted to solicit opinions on the same topic, the questions were phrased differently and received differing responses. Regardless, these two items indicate that either a clear plurality or a clear majority of respondents agree that the mental health professionals serving on the DVOMB should be approved providers.

Requiring all mental health professionals serving on the DVOMB to be approved providers could pose some challenges in terms of member recruitment. In fiscal year 15-16, there were many more addictions counselors (203) and licensed professional counselors (135), than there were licensed psychologists (11) or licensed marriage and family therapists (8) who were approved providers. Thus, retaining the current structure of one seat for each mental health discipline, while requiring each member to be an approved provider, could create insurmountable challenges in filling all of those seats. There may simply not be enough providers, let alone willing providers, to fill the seats.

A reasonable solution is to repeal the requirement that these seats be reserved for specific mental health disciplines. Indeed, this solution aligns with COPRRR's stakeholder process, where most stakeholders (though certainly not all) did not find the distinction between disciplines sufficient to justify the current DVOMB composition.

[66] § 16-11.8-103(1)(g)(III), C.R.S.

Furthermore, requiring all five mental health professionals to be approved providers, while ideal, could pose additional complications with respect to recruiting individuals to serve on the DVOMB, or when DVOMB members retire from practice. Therefore, requiring at least three of the five to be approved providers, and requiring the remaining two to have experience in the field of domestic violence at least ensures that individuals with expertise in the field serve on the DVOMB.

Additionally, COPRRR's stakeholder process raised the issue of whether the license status of such individuals is important. That is, whether it is important to retain a certain percentage of licensed mental health professionals vis-à-vis unlicensed (such as registered psychotherapists or certified addictions counselors).

As a result, COPRRR's survey contained two items addressing this issue:

- 48.9 percent of respondents agreed or strongly agreed that all mental health providers serving on the DVOMB should be licensed, while 28.3 percent disagreed or strongly disagreed.

- 47.3 percent of respondents agreed or strongly agreed that there should be a mix of licensed and unlicensed mental health professionals on the DVOMB, while 30.8 percent disagreed or strongly disagreed.

Though these two items sought input on what amounts to the same issue, the results were somewhat different. Regardless, while a plurality stated that all mental health professionals serving on the DVOMB should be licensed, a smaller plurality found that a mix of licensed and unlicensed individuals is desirable.

In analyzing these data, it should be noted that, due to a drafting oversight, the first item offered no explanation as to the meaning of "licensed", whereas such an explanation was offered in the second item. Thus, the reliability of the responses to the first item is clouded, since "licensed" could reasonably have been interpreted to mean credentialed, as in licensed, certified or registered.

Since it seems clear that some number of licensed treatment providers is desirable, that number should be three. Recall that under the current composition, four are licensed. Thus, the reduction to three is minimal, yet acknowledges the possible challenges related to recruiting treatment providers to serve on the DVOMB.

Finally, the Executive Director of DORA is the appointing authority for the mental health professionals serving on the DVOMB. This makes a modicum of sense, given that these individuals are licensed by boards within DORA. However, if, as this Recommendation 2 proposes, the focus shifts from mental health discipline to status as an approved treatment provider, it makes more sense for the Executive Director of the Department of Public Safety (Public Safety), as the home agency of the DVOMB, to be the appointing authority for these five seats.

For all these reasons, the General Assembly should 1) amend the qualifications of the mental health professionals serving on the DVOMB so that at least three of the five must be approved treatment providers and the remaining two have experience in the field of domestic violence; 2) repeal the requirement that they represent their individual mental health disciplines; 3) require that three of the five be licensed mental health professionals; and 4) name the Executive Director of the Public Safety as the appointing authority for all five.

Recommendation 3 – Authorize the DVOMB to directly elect its presiding officer.

Section 16-11.8-103(2), Colorado Revised Statutes (C.R.S.), directs the Executive Director of Public Safety to appoint the presiding officer of the DVOMB from among the DVOMB's members. As a matter of practice, the DVOMB votes to nominate one of its members as presiding officer, and that nomination is then forwarded to the Executive Director. Office staff does not recall a single occasion upon which the DVOMB's nomination was rejected by the Executive Director.

So as to streamline the elections process, the General Assembly should authorize the DVOMB to directly elect its presiding officer.

Recommendation 4 – Repeal the requirement that DORA play an active role in the provider approval process and in the enforcement of the DVOMB's continuing education requirements.

Section 16-11.8-103(4)(a)(III)(B), C.R.S., directs the DVOMB to:

> develop an application and review process for the verification of the qualifications and credentials of the treatment providers. The applications shall be submitted to [DORA] and forwarded to the appropriate [mental health board. DORA] shall be responsible for the implementation of this subparagraph (B) of the application and review process. The [DVOMB] shall require that treatment providers complete mandatory continuing education courses in areas related to domestic violence.

This provision is problematic for several reasons. First, the actual application submission process does not comport with this statutory mandate. Individuals seeking approval as treatment providers submit their applications directly to the DVOMB, not to DORA. DORA's mental health boards play no active role in treatment provider approval.

Presumably, this provision was enacted to ensure that applicants possessed the required DORA-issued mental health credential. However, this can now easily be verified by visiting DORA's website.

Finally, the last sentence of this statutory provision creates an awkward situation in which DORA is directed to enforce the DVOMB's continuing education requirements. Again, DORA plays no active role in this process and the DVOMB ensures compliance with its continuing education requirements by way of the biennial approval renewal process and the Quality Assurance Reviews it conducts.

Therefore, the General Assembly should repeal the requirement that DORA play an active role in the provider approval process and in the enforcement of the DVOMB's continuing education requirements.

Recommendation 5 – Repeal the requirement that DORA participate in the publication of the list of approved treatment providers.

Section 16-11.8-103(4)(a)(III)(C), C.R.S., requires

> [DORA] and the [DVOMB to] jointly publish at least annually a list of approved providers. The list shall be forwarded to the Office of the State Court Administrator, the Department of Public Safety, the Department of Human Services, and the Department of Corrections. The list of approved providers shall be jointly updated and forwarded as changes are made.

Presumably, this provision exists to ensure that those state agencies primarily responsible for referring domestic violence offenders to treatment, as well as the offenders themselves, have current lists of the treatment providers approved to provide that treatment.

To satisfy this statutory mandate, the DVOMB's website contains a searchable database of approved treatment providers. This database is regularly updated and can be used to identify providers by name, location, those who work with specific offender populations (female offenders or offenders who are in same sex relationships) and those who offer treatment in languages other than English.

Additionally, Office staff periodically distributes memoranda to the departments enumerated above identifying changes to the approval status of relevant treatment providers. These updates help referring agencies to remain current on new providers in their area, as well as those providers who are delisted and no longer eligible to receive referrals.

Similarly, these updates provide a notification mechanism for the mental health boards in DORA, identifying which providers have been delisted. Such information may then be used to determine whether an investigation should be opened.

However, DORA plays no part in the compilation or the publication of either the list or the updates.

Therefore, the General Assembly should repeal the requirement that DORA participate in the publication of the list.

Recommendation 6 – Repeal language pertaining to initial appointments of DVOMB members.

Section 16-11.8-103(3), C.R.S., contains several references to the initial appointments of DVOMB members, stipulating differing terms of office so as to stagger subsequent appointments. Such language is no longer necessary. Therefore, the General Assembly should repeal this language.

Administrative Recommendation 1 – The DVOMB should explore the viability of offering pre- and post-approval training online and on-demand.

The DVOMB has approved a total of 174 treatment providers. Not surprisingly, the vast majority of them reside and practice along the Front Range. Indeed, many of Colorado's rural counties have but a single approved provider, or none at all. Thus, a common theme throughout this review was the dearth of providers and conversations on how to improve the situation.

While a variety of factors play into why a mental health provider may choose to become an approved provider, one such issue may pertain to the availability of domestic violence-specific trainings.

In June 2016, COPRRR conducted a survey of approved treatment providers. One series of questions pertained to pre- and post-approval trainings offered by the DVOMB and Office staff. Here are some of the results:

- 44.1 percent of respondents either agreed or strongly agreed that trainings are offered on a reasonably consistent basis, while 30.1 percent either disagreed or strongly disagreed.

- 52.7 percent of respondents either agreed or strongly agreed that trainings are reasonably priced, while 23.7 percent either disagreed or strongly disagreed.

- 33.7 percent of respondents either disagreed or strongly disagreed that trainings are offered throughout the state, while 25 percent either agreed or strongly agreed.

- 25 percent of respondents either agreed or strongly agreed that trainings are available online, while 43.4 percent either disagreed or strongly disagreed.

- 62.4 percent of respondents either agreed or strongly agreed that trainings should be available online, while 21.5 percent either disagreed or strongly disagreed.
- 60.6 percent of respondents either agreed or strongly agreed that trainings should be available online and on-demand, while 19.1 percent disagreed or strongly disagreed.

Taken together, these survey data indicate a strong sense among approved providers that while live trainings are offered on a reasonably consistent basis (44.1 percent) and are reasonably priced (52.7 percent), they are not offered throughout the state (33.7 percent) and should be, at a minimum, offered online (62.4 percent) or online and on-demand (60.6 percent).

Not all trainings will necessarily lend themselves to an online or on-demand format, but the DVOMB should at least explore this opportunity. Online and on-demand trainings have become commonplace in a variety of settings and could extend the reach of such trainings to a larger population of providers. More importantly, they may assist in bolstering the population of approved providers, particularly in more remote areas of the state.

Administrative Recommendation 2 – The DVOMB should revisit the manner in which the Application Review Committee approves providers so as to ensure transparency and fairness.

In June 2016, COPRRR conducted a survey of approved treatment providers. One series of questions pertained to the provider approval process. Here are some of the results:

- 43.5 percent of respondents either disagreed or strongly disagreed that the overall approval process is fair and equitable, while 41.3 percent either agreed or strongly agreed.

- 52.7 percent of respondents either disagreed or strongly disagreed that the overall process takes a reasonable amount of time, while 27.9 percent either agreed or strongly agreed.

- 46.8 percent of respondents either disagreed or strongly disagreed that the approval process is transparent and easily understood, while 29.3 percent either agreed or strongly agreed.

- 34.1 percent of respondents either disagreed or strongly disagreed that when applications are denied, the reasons are clearly articulated, while 31.8 percent agreed or strongly agreed.

- 39.5 percent of respondents either disagreed or strongly disagreed that the reasons for denial are fair and legitimate, while 24.4 percent either agreed or strongly agreed.

Taken together, these data indicate a strong sense among approved providers that the approval process takes too long (52.7 percent), that it is neither transparent nor easily understood (46.8 percent) and that when applications are denied, the reasons are neither fair nor legitimate (39.5 percent). Respondents were divided almost in thirds in terms of whether the reasons for denial are clearly articulated with one-third indicating agreement, one-third indicating disagreement and one-third indicating no sense one way or the other.

These sentiments are fairly consistent with comments received during COPRRR's stakeholder process, where considerable distrust was expressed for the DVOMB in general, and the ARC in particular.

Without casting judgment on the veracity of any of the allegations or concerns expressed, the survey data indicate an opportunity for the DVOMB to better explain the approval process to treatment providers, and an opportunity to examine the practices of the ARC to ensure they are as transparent and as fair as is practicable.

Appendix A – Survey Results

In June 2016, staff of the Colorado Office of Policy, Research and Regulatory Reform conducted a survey of all 174 approved treatment providers. Links to the survey were sent to individuals via email addresses supplied by the Colorado Department of Public Safety. All surveys were successfully delivered [67] and 94 recipients responded, representing a response rate of 54 percent.

1. How long have you been an approved domestic violence treatment provider?

Less than five years	**25**	26.9%
5 to 10 years	**18**	19.4%
More than 10 years	**50**	53.8%

2. What level of approval do you currently hold?

Entry Level	**11**	11.8%
Full Operating Level	**53**	57%
Clinical Supervisor	**29**	31.2%

3. What mental health licenses/certificates/registrations do you currently hold?

Registered Psychotherapist	**17**	18.7%
Certified Addictions Counselor	**39**	42.9%
Licensed Addictions Counselor	**12**	13.2%
Licensed Marriage and Family Therapist	**3**	3.3%
Licensed Professional Counselor	**47**	51.6%
Licensed Social Worker	**3**	3.3%
Licensed Clinical Social Worker	**7**	7.7%
Licensed Psychologist	**1**	1.1%

4. Are you an approved sex offender treatment provider?

Yes	**13**	14.1%
No	**79**	85.9%

[67] Successful delivery is deemed to have occurred when the email sending the survey was not returned or did not fail.

5. Have you ever served on the DVOMB or any of its committees?

Yes	**26**	28%
No	**67**	72%

6. Please indicate the extent to which you agree with the following statements pertaining to representation of mental health professionals on the DVOMB.

a) All mental health professionals serving on the DVOMB should be approved domestic violence treatment providers.

strongly agree: 1	**37**	39.8%
2	**16**	17.2%
3	**18**	19.4%
4	**11**	11.8%
strongly disagree: 5	**11**	11.8%

b) There should be a mix of approved domestic violence treatment providers and non-providers.

strongly agree: 1	**14**	15.1%
2	**20**	21.5%
3	**19**	20.4%
4	**14**	15.1%
strongly disagree: 5	**26**	28%

c) All mental health professionals serving on the DVOMB should be licensed mental health professionals.

strongly agree: 1	**27**	29.3%
2	**18**	19.6%
3	**21**	22.8%
4	**9**	9.8%
strongly disagree: 5	**17**	18.5%

d) There should be a mix of licensed and non-licensed (such as registered psychotherapists or certified addictions counselors) on the DVOMB.

strongly agree:	1	**28**	30.8%
	2	**15**	16.5%
	3	**20**	22%
	4	**15**	16.5%
strongly disagree:	5	**13**	14.3%

e) Have you ever participated in a DVOMB research project?

Yes	**59**	62.8%
No	**35**	37.2%

f) If you have never participated in a DVOMB research project, what is the major reason?

I have never been asked	**10**	17.2 %
I have never been informed of any	**3**	5.2%
I do not have the time	**12**	20.7 %
I am concerned that the DVOMB will somehow use the information I submit against me	**8**	13.8 %
I have participated in at least one DVOMB research project	**25**	43.1 %

7. The following statements pertain to pre- and post-approval trainings.

a) Trainings are offered on a reasonably consistent basis.

strongly agree:	1	**14**	15.1%
	2	**27**	29%
	3	**24**	25.8%
	4	**21**	22.6%
strongly disagree:	5	**7**	7.5%

b) Trainings are reasonably priced.

strongly agree:	1	**23**	24.7%
	2	**26**	28%
	3	**22**	23.7%
	4	**16**	17.2%
strongly disagree:	5	**6**	6.5%

c) Trainings are offered throughout the state.

strongly agree:	1	**6**	6.5%
	2	**17**	18.5%
	3	**38**	41.3%
	4	**15**	16.3%
strongly disagree:	5	**16**	17.4%

d) Trainings are of an acceptable quality.

strongly agree:	1	**14**	15.2%
	2	**25**	27.2%
	3	**27**	29.3%
	4	**14**	15.2%
strongly disagree:	5	**12**	13%

e) Trainings are available online.

strongly agree:	1	**9**	9.8%
	2	**14**	15.2%
	3	**29**	31.5%
	4	**20**	21.7%
strongly disagree:	5	**20**	21.7%

f) Trainings should be available online.

strongly agree:	1	**40**	43%
	2	**18**	19.4%
	3	**15**	16.1%
	4	**9**	9.7%
strongly disagree:	5	**11**	11.8%

g) Trainings should be available online and on-demand.

strongly agree:	1	**39**	41.5%
	2	**18**	19.1%
	3	**19**	20.2%
	4	**5**	5.3%
strongly disagree:	5	**13**	13.8%

8. The following statements pertain to the provider approval process.

a) The overall process is fair and equitable.

strongly agree: 1	**13**	14.1%
2	**25**	27.2%
3	**14**	15.2%
4	**18**	19.6%
strongly disagree: 5	**22**	23.9%

b) The overall process takes a reasonable amount of time.

strongly agree: 1	**11**	11.8%
2	**15**	16.1%
3	**18**	19.4%
4	**13**	14%
strongly disagree: 5	**36**	38.7%

c) The process is transparent and easily understood.

strongly agree: 1	**7**	7.6%
2	**20**	21.7%
3	**22**	23.9%
4	**18**	19.6%
strongly disagree: 5	**25**	27.2%

d) The training and experience requirements correspond to what is minimally necessary to protect the public.

strongly agree: 1	**17**	18.5%
2	**25**	27.2%
3	**24**	26.1%
4	**15**	16.3%
strongly disagree: 5	**11**	12%

e) When applications are denied, the reasons are clearly articulated.

strongly agree: 1	**10**	11.8%
2	**17**	20%
3	**29**	34.1%
4	**16**	18.8%
strongly disagree: 5	**13**	15.3%

f) When applications are denied, the reasons are fair and legitimate.

strongly agree: 1	**8**	9.3%
2	**13**	15.1%
3	**31**	36%
4	**16**	18.6%
strongly disagree: 5	**18**	20.9%

9. The following questions pertain to Quality Assurance Reviews.

a) Have you ever been selected to participate in a Quality Assurance Review (QAR)?

Yes	**10**	10.9%
No	**82**	89.1%

b) If you have participated in a QAR, which of the following best describes your experience?

Very positive	**1**	1.4%
Somewhat positive	**4**	5.6%
Somewhat negative	**1**	1.4%
Very negative	**4**	5.6%
I have not participated in a QAR	**62**	86.1%

c) If you have participated in a QAR, which of the following best describes the outcome?

No problems were identified in my files	**6**	8.3%
Some problems were identified in my files, but no further action was required of me	**1**	1.4%
Some problems were identified in my files, and I was required to obtain a clinical supervisor	**2**	2.8%
Some problems were identified in my files, and attempts were made to revoke or otherwise restrict my approval as a domestic violence treatment provider	**0**	0%
I have not participated in a QAR	**63**	87.5%