Best Practice Guidelines

for

Working with Youth Who Engage in Relationship Abuse

May 2021

STAND UP COLORADO
THE MOVEMENT TO END RELATIONSHIP VIOLENCE

DVOMB
Domestic Violence Offender Management Board

SOMB
Sex Offender Management Board

National Institute For Change

COLORADO
Division of Youth Services
Office of Children, Youth & Families

COLORADO
School Safety Resource Center
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The work of generating these Best Practice Guidelines was initiated by Stand Up Colorado, a project of Violence Free Colorado, in partnership with the Colorado Domestic Violence Offender and Sex Offender Management Boards (DVOMB and SOMB). The Guidelines were developed by a multidisciplinary group of committed professionals who recognized the gap in services for treatment of youth who use abusive, harmful, and/or illegal behaviors in the context of relationship violence. It is through the dedication, selflessness, and hard work of these professionals that the Guidelines were created. Our intention is that with the support of these Guidelines, additional professionals will be able and willing to do the important work of providing services to these youth, thereby increasing the availability of services to this population and decreasing the occurrence of youth relationship violence.

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Introduction

Early intervention and prevention of intimate partner violence, domestic violence, or alternatively relationship abuse is critical at the early stages of adolescent development. The intent of these Guidelines is to promote healthy relationships and to reduce relationship abuse during adolescence. Youth who engage in relationship abuse in their dating relationships during adolescence do not fall under the criminal definition of domestic violence[1] because domestic violence is codified in Title 18 of Colorado Revised Statutes (C.R.S.) pertaining to adults. There are limited interventions and treatment options for these youth in Colorado. **Unlike adult domestic violence offenders, there is no mandate for someone to be approved through the Colorado Domestic Violence Offender Management Board (DVOMB) to work with youth who engage in abusive, harmful, and/or illegal acts toward a dating partner.** As a result, these guidelines are designed to offer best practices and recommendations to Providers offering evaluation and treatment services to youth who engage in relationship abuse.

These Guidelines refer to issues of domestic violence, intimate partner violence, teen dating violence, and power and control, as defined under the general term of "relationship abuse". This term was chosen after focus groups conducted by Stand Up Colorado suggested that youth more readily identified with that term than the others. In recognizing that identifying youth who use abusive behaviors in their dating relationships as *offenders* may label them by their behavior or suggest they cannot live free of abusive behaviors, these Guidelines will use the terms: *youth who engage in relationship abuse*, *youth who engage in abusive, harmful, and/or illegal acts toward a dating partner*, *youth*, or in the evaluation and treatment section as *clients*.[2] The term *victim* is also problematic, and these Guidelines more often use the terms: *youth who experienced abuse* or *survivor*.

These Guidelines have application for youth ages 10 to 17, young adults ages 18 to 20, and individuals under the jurisdiction of a juvenile court regardless of age, who are engaging in relationship abuse either as adjudicated or non-adjudicated youth. For those individuals who are convicted of domestic violence as an adult, ages 18-25, please refer to the DVOMB Young Adult Appendix. The goal of these Guidelines is to create capacity and resources for youth who engage in relationship abuse to receive services at any point in time by a statewide network of qualified evaluation and treatment service providers (referred to as Providers). Referrals for services may originate through the juvenile justice system, school personnel, parents, or even youth who self-identify.

[1] 18-6-800.3 (1), C.R.S. "Domestic violence" means an act or threatened act of violence upon a person with whom the actor is or has been involved in an intimate relationship. "Domestic violence" also includes any other crime against a person, or against property, including an animal, or any municipal ordinance violation against a person, or against property, including an animal, when used as a method of coercion, control, punishment, intimidation, or revenge directed against a person with whom the actor is or has been involved in an intimate relationship.

[2] Tu, J. & Penti, B. (2020). How We Talk About "Perpetration of Intimate Partner Violence" Matters. *Journal of the American Board of Family Medicine, 33(5), 809-814.* DOI: https://doi.org/10.3122/jabfm.2020.05.200066.

Definition of Relationship Abuse

Terms such as relationship abuse, domestic violence, intimate partner violence, and teen dating violence are used to describe behaviors that are abusive, harmful, and/or illegal. Not all of these behaviors are illegal, but they may be harmful and/or abusive to the person who has experienced the behavior.

Relationship abuse is a pattern of coercive, intimidating, or manipulative behaviors -- usually a pattern of abusive behaviors over a course of time -- used to exert power and control over a current or former intimate or dating partner. Relationship abuse among youth may include the following five types of behavior:

- Physical violence: Any use of unwanted physical force that causes fear or injury, such as hitting, kicking, biting, shoving, or strangling.

- Sexual violence: Any action that forces or attempts to force a partner to take part in sexual activity, including rape, coercion, restricting access to birth control, or a non-physical sexual event (e.g., sexting) when the partner does not or cannot consent. *In situations that involve sexual violence refer to Sex Offender Management Board (SOMB) Standards and Guidelines for information on best practices and possible requirements.*

- Psychological or emotional abuse: Includes non-physical behaviors such as threats, name calling, bullying, shaming, intimidating, isolating, intentionally embarrassing, and constant monitoring.

- Stalking: A pattern of repeated, unwanted attention, harassment, or contact, including being followed or giving unwanted gifts by a partner that causes fear or concern for one's own safety or that of someone close to the person experiencing the stalking. Stalking can occur in-person or online.

- Digital Abuse: Use of technology and/or social media to intimidate, harass or threaten current or former dating partners such as demanding passwords, controlling posts, checking phones and other devices, cyberbullying, non-consensual sexting, or stalking on social media.

Unhealthy relationships can start early and last a lifetime. Youth may think some behaviors, like teasing and name-calling or checking a partner's phone or other devices, are a "normal" part of a relationship, but these behaviors can become abusive and develop into serious forms of violence. Additionally, many youth do not report unhealthy behaviors because they do not recognize them as such or because they are afraid to tell family and friends.

Primary Prevention

These Guidelines are oriented toward professionals working with at-risk (i.e., secondary prevention) and identified (i.e., tertiary prevention) youth engaging in relationship abuse. While the focus of these Guidelines is to present best practices for the assessment (informal, ongoing), evaluation (formal, structured), treatment, and supervision of youth engaging in relationship abuse, primary prevention is integral to this work and should not be overlooked. Primary prevention with these youth and communities will promote more systemic and cultural changes to support healthy relationships and the recognition of abusive behavior.[3] To prevent and reduce the onset and continued perpetration of relationship abuse, individuals, families, and communities alike need to promote cultural changes that support youth in developing and sustaining healthy relationships.

Violence prevention and intervention can work together at the same time to prevent various forms of violence, thereby broadening the impact of prevention on the community.[4] Providers can address the unique aspects of one form of violence, while still supporting joint action wherever possible. For those interested in integrating primary prevention efforts in their communities, consider the resources identified in the appendices.

Discussion points found throughout these Guidelines provide additional clarification on suggested best practices based on the professional opinion of the workgroup members who created this document.

Guiding Principles

Community and survivor safety, as well as the prosocial development of youth who engage in relationship abuse, are the primary goals of these Guidelines. It is intended that the safe treatment and supervision of youth will help promote these goals before the normalization of relationship abuse into young adulthood.

1. **SERVICES MUST PRIORITIZE THE SAFETY AND NEEDS OF SURVIVORS AND THE COMMUNITY.** Community safety and the rights and interests of those experiencing abuse, vulnerable persons, and potential victims, require paramount attention when developing and implementing assessment, treatment, and supervision of youth who have engaged in or are at risk of engaging in relationship abuse. Underlying issues related to relationship abuse also indicate the potential for violence to be committed against a larger population. Services are ultimately for the safety of the youth experiencing the abuse and the community.

    a. The safety, protection, developmental growth, and psychological well-being of

[3] Shorey et al., (2017). Age of Onset for Physical and Sexual Teen Dating Violence Perpetration: A Longitudinal Investigation. *Preventive Medicine, 105: 275-279*. DOI: 10.1016/j.ypmed.2017.10.008

[4] Higgins et al., (2018). Predictors of Physical and Dating Violence in Middle and High School Students in the United States. *Crime & Delinquency, 64(5), 625-649.* DOI: 10.1177/0011128717719428.

youth experiencing abuse and other potential survivors are priorities. Issues of confidentiality, survivor self-determination, and the limited capacity of schools to address relationship violence make it difficult to provide support to the person who has experienced the abuse.

i. There is a need for services that span a continuum of care for survivors, in order to provide appropriate options based on the needs and severity of individual cases.
ii. It is critically important for both youth experiencing and engaging in relationship abuse that prosocial and trusted adults be available to support the youth through this process.

b. To the extent possible, Providers and/or multi-disciplinary teams (MDTs) should safeguard personal information about the youth experiencing abuse in order to protect their identity, information, and safety. Individual team members should determine what information to share based on what is in the best interest clinically for the survivor and the youth who engaged in abusive, harmful, and/or illegal acts. Survivor and community safety is paramount when determining what information will be shared and survivor confidentiality should be respected.

2. YOUTH ARE A DIVERSE POPULATION REQUIRING INDIVIDUALIZED RESPONSES FROM ASSESSMENT, TREATMENT, AND SUPERVISION.[5]

a. Individualized Treatment – Youth who engage in relationship abuse may present with more than one problem and area of risk. Treatment should be based on the clinical evaluation and ongoing assessment of the youth, to include any co-occurring problems (e.g., mental health, substance abuse, prior trauma, family dysfunction, etc.). Services should be holistic and individualized, focusing on each youth's risks, needs, developmental level, strengths, family supports, protective factors, and responsivity factors.[6]

b. Research-Informed Practices – Research on effective interventions with youth who engage in relationship abuse is a developing field. Treatment and supervision should respond accordingly to the evolving research.

c. Environment and Culture Surrounding Youth - Interventions are informed by ecological factors, including family/caregiver involvement (e.g., intergenerational pattern of abuse), peer influences, community, culture, media, and societal messages on behaviors. It is important to view these influences through the

[5] See Case Management Section regarding Multidisciplinary Team.
[6] Chase, Treboux & O'Leary (2002). Characteristics of High-Risk Adolescents' Dating Violence. *Journal of Interpersonal Violence, 17(1):33-49*; Vagi et al. (2013). Beyond Correlates: A Review of Risk and Protective Factors for Adolescent Dating Violence Perpetration. Journal of Youth and Adolescence, 42(4):633-649.

framework of prosocial influences, resilience, and risk factors to each specific youth.[7]

d. General Delinquency – Treatment and supervision should address all types of abusive, delinquent, and problematic behaviors present in a youth's lifestyle and social context.[8]

e. Continuum of Care – There should be various levels and locations of care that include the type of treatment setting, treatment intensity, and approach. For the purpose of these guidelines, the continuum is not unidirectional.

f. The brains of youth are still changing and maturing. The prefrontal cortex, which in large part helps with complex decision making, impulse control, and being able to consider multiple options and consequences, is not yet fully developed.[9]

3. **SERVICES SHOULD BE SENSITIVE TO INDIVIDUALIZED NEEDS** (e.g., cultural, ethnic, racial, developmental, sexual orientation, gender identity, medical and/or educational issues or disabilities that are or become known.

   a. Providers must have specific knowledge about diverse populations and choose appropriate interventions. The individualization of evaluations, assessment, treatment, and supervision requires particular attention to social and cultural factors. Recognition of these factors is essential in managing encounters with youth from different social, cultural, and religious backgrounds. A basic premise is to recognize the youth's culture, the Provider's culture, and how both affect the client-provider relationship.

      Diversity, culture, and context serve as the backdrop for the interpersonal dimension of service delivery. As such, they inform the conceptualization of services that meet the needs of a truly diverse clientele and must be taken seriously by Providers. Service delivery is often intercultural; the dynamics of cross-cultural clinical and community work are critically important to

[7] Banyard (2008). Consequences of teen dating violence: understanding intervening variables in ecological context. *Violence Against Women, 14(9):998-1013*; Laporte et al. (2011). The Relationship between Adolescents' Experience of Family Violence and Dating Violence. *Youth & Society, 43(1):3-27*; Makin-Byrd (2013). Individual and family predictors of the perpetration of dating violence and victimization in late adolescence. *Journal of Youth and Adolescence, 42(4):536-50*.

[8] Ouytsel et al., (2017). The Association Between Substance Use, Sexual Behaviors, Bullying, Deviant Behaviors, Health, and Cyber Dating Abuse Perpetration. *The Journal of School Nursing*, 33(2): 116-122. DOI: 10.1177/1059840516683229.

[9] Sturman, D. & Moghaddam, B. (2011). The Neurobiology of Adolescence: Changes in brain architecture, functional dynamics, and behavioral tendencies. *Neuroscience & Biobehavioral Reviews – Journal, 35(8): 1704-1712*; Teicher et al., (2002). Developmental neurobiology of childhood stress and trauma. *Psychiatric Clinics of North America, 25: 397-426*.

understanding and refining our services and practices. Refer to Key Resources for Promoting Equity and Reducing Disparities (samhsa.gov).
This premise extends to all professional members of the MDT and positive support persons and is essential in creating an equitable and inclusive environment regardless of differences in culture or lifestyle.

Culturally responsive interventions include translated and interpreted interventions, culturally adapted interventions, and culturally specific interventions which include sensitivity and awareness.[10]

b. Attempts should be made to elicit information regarding a youth's characteristics in advance of providing any services for the purposes of designing an individualized treatment/case plan.

c. Youth who have engaged in relationship abuse are fundamentally different from adults who have abused an intimate partner (e.g., lack of unequal power dynamics, lack of financial dependence, peer influence, etc.) and require a different set of guidelines with respect to assessment, intervention, and public policy approaches. Sanctions and treatment approaches developed for adults should not be applied to youth except in rare cases (e.g., when developmentally appropriate and research supports their use).[11]

4. **SERVICES SHOULD BE COLLABORATIVE.** It is best practice for those working with youth in treatment to collaborate with the youth's support network in the context of their home environment, school, neighborhood, and larger community. With informed consent, this collaboration should include ongoing communication about information that will assist in reducing a youth's risk to the community and developing their prosocial skills, temperament, cognition, and interpersonal relationships.

Discussion Point: *When considering family therapy or other family services, the Provider should assess family dynamics to determine if there are safety concerns for the youth or other family members, if family therapy/services are appropriate, and/or if there are any issues that need to be addressed with the youth prior to engaging in family therapy/services.*

5. **SERVICES SHOULD PROMOTE HEALTHY, PROSOCIAL ATTRIBUTES/SKILLS.** The purpose of these interventions is to break the cycle of violence through fostering healthy thoughts, emotions, behaviors, and situations in their relationships and help youth who engage in relationship abuse heal from their own experiences. This includes:

[10] Glass et al. (2003). Adolescent Dating Violence: Prevalence, Risk Factors, Health Outcomes, and Implications for Clinical Practice. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 32(2):227-238.*
[11] Mulford et al., (2008). Teen Dating Violence: A closer look at adolescent romantic relationships. *National Institute of Justice Journal*. NIH Journal 261; Oudekerk et al., (2014). Teen Dating Violence: How Peers Can Affect Risk & Protective Factors. U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, NCJ 248337.

a. Support youth in understanding and comprehending the positive outcomes associated with healthy and supportive relationships including both the internal (e.g., increased self-esteem/acceptance, empathy, self-efficacy, etc.) and external outcomes (e.g., respect, social acceptance, positive relationships, etc.).

b. Support youth in understanding and comprehending the negative consequences associated with continued abusive, harmful, and/or illegal behaviors, including both the internal (e.g., negative self-perception, damage to social connectedness and interactions with others, etc.) and external consequences (e.g., legal, direct, indirect, etc.).

6. **SERVICES MUST BE HUMANE, ETHICAL, AND NON-DISCRIMINATORY.** Evaluation, assessment, treatment, and behavioral monitoring of youth who have engaged in relationship abuse should be non-discriminatory, humane, and bound by the professional code of ethics and law.

7. **SERVICES MUST BE DELIVERED BY WELL-TRAINED PROVIDERS.** Due to the nature and seriousness of relationship abuse, it is imperative that professionals who work with youth have knowledge, training, and specific competencies in domestic violence dynamics, youth development, and survivor and community safety. Those providing counseling and therapeutic services must be licensed, certified, or registered with the Colorado Department of Regulatory Agencies (DORA).

8. **SERVICES MUST REMAIN HOPEFUL OF YOUTHS' CAPACITY TO MAKE POSITIVE CHANGES.** Youth are capable of change and shall not be labeled as if their relationship abuse and violent behavior defines them.

   It is imperative in understanding, treating, and intervening with youth to consider their relationship abuse and violent behavior in the context of the many formative aspects of their personal development. As youth grow and develop, their behavior patterns and self-image constantly change. There is some research to suggest that subgroups of youth who are exposed to intimate partner violence prior to the age of 18 are at greater risk for both violence perpetration and victimization in young adult relationships.[12] Because identity formation is a significant developmental task during adolescence, labeling youth based solely on their offending behavior may cause potential damage to long-term prosocial development.

9. **SERVICES MUST UTILIZE PRACTICES THAT HELP ENGAGE AND MOTIVATE YOUTH.** Successful completion of treatment and supervision depends upon a youth's willingness and ability to cooperate. Accordingly, professionals should employ practices designed to

[12] Duval et al. (2018). A Systematic Review of Dating Violence Risk Factors Among Undergraduate College Students. Trauma, Violence, & Abuse, 1-19. DOI: 10.1177/1524838018782207.

maximize the participation and engagement of the youth and their family. Progress in treatment is measured by the achievement of change rather than the passage of time.

a. A direct and empathic therapeutic approach contributes to a youth's motivation to change.

b. The degree of progress in treatment is based on a youth's application of relevant changes in their daily functioning. Treatment should foster character traits that are linked to development of healthy relationships.

c. Treatment planning must include goals relevant to decreasing the risk of further offending, decreasing all types of abusive, harmful, and/or illegal behavior while increasing overall health. Individualized treatment plans for youth who have engaged in relationship abuse should address all needs and issues which the evaluation and assessment process has identified. Treatment plans must designate measurable outcomes that will indicate successful completion of treatment.

10. **SERVICES SHOULD BE GUIDED BY INITIAL AND ONGOING ASSESSMENTS.** Treatment and supervision decisions should be guided by clinically-informed evaluation and ongoing assessments.

11. **SERVICES SHOULD ADDRESS PAST ADVERSITY (TRAUMA-INFORMED).** Treatment and supervision should consider and address, if clinically indicated, any experiences of trauma, including victimization, maltreatment, loss, abandonment, neglect, and exposure to violence in the home or community. Services should be trauma-informed and focus on enhancing a youth's resiliency and responsiveness to adversity.[13]

12. **SERVICES SHOULD BE HOLISTIC.** Treatment should be holistic and enhance overall health and protective factors.

    Many youth who engage in relationship abuse may face multiple life challenges and areas of risk. Assessment and treatment must address areas of strengths, risks, and concerns to increase a youth's ability to be successful and to decrease the risks of further abusive or criminal behaviors. Treatment plans should specifically address the risks of further relationship abuse, other risks that might jeopardize safety, and successful prosocial functioning. Treatment plans should also reinforce developmental and environmental assets.

13. **SERVICES MUST PROMOTE STABLE, POSITIVE SUPPORT SYSTEMS.** Treatment and supervision decisions regarding youth who have engaged in relationship abuse should maximize caregiver stability and exposure to positive peers and adult role models.

[13] Davis et al., (2018). How Childhood Maltreatment Profiles of Male Victims Predict Adult Perpetration and Psychosocial Functioning. *Journal of Interpersonal Violence 33(6), 915-937.* DOI: 10.1177/0886260515613345.

As youth move through the continuum of services, emphasis should be given to maintaining positive and consistent relationships, including both in and out of a school setting. Research indicates that association with delinquent peers[14], the absence of prosocial adult role models, and the disruption of caregiver relationships increase the risk of delinquent development.

[14] Dishion et al., (1999). When Interventions Harm: Peer Groups and Problem Behavior. *American Psychologist*, *54(9):755- 764*.

Legal Considerations

The following is a general list of important statutes of which professionals should be aware and consider when providing services to youth who engage in relationship abuse. This is not an exhaustive list of statutes and should not be construed as legal advice. Providers should contemplate case specific circumstances in conjunction with these legal requirements and consult with legal counsel, when necessary, prior to and throughout the course of engaging in providing services.

Confidentiality for Youth who Engage in Relationship Abuse

- Mental Health Practice Act C.R.S. § 12-43-213
  Mental health professionals are prohibited by Colorado law from disclosing confidential communications without client consent. That includes information received by clients as well as advice given to them. This general provision has specific exceptions which are set forth by statute and relate to matters of public safety, as well as lawsuits or administrative proceedings alleging malfeasance or threatening behavior.

- Limits of Confidentiality C.R.S. § 19-3-304 and C.R.S. § 12-245-220
  Despite the confidential nature of the relationship between mental health professionals and their clients when disclosures raise reasonable suspicion that a client has been subjected to abuse or neglect, or observations are made that a child is being subject to conditions which would reasonably result in abuse or neglect, the professional is mandated by law to immediately report such suspicions or observations to law enforcement or child protection officials. This mandate applies to mental health professionals, including psychologists, counselors, psychotherapists, school employees, juvenile parole, and probation officers, and workers for the Department of Human Services (DHS), among others.

  Similarly, mental health licensees are not prohibited from sharing disclosures of threats or threatening behavior with schools or other persons of concern and have an affirmative duty to warn in certain circumstances. Refer to the Mandatory Reporting and Exceptions section outlined on the next page. Nor are Providers prohibited from disclosing knowledge learned in the professional relationship related to lawsuits or administrative proceedings alleging malfeasance.

- Parental or Guardianship Privilege C.R.S. § 12-43-202.5
  Although youth 12 years of age and older are entitled to access outpatient psychotherapy in Colorado without parental consent, there remains uncertainty as to whether the parents or guardians of those youth may access their confidential mental health records. Providers treating these youth should exercise caution not to over promise on the issue of confidentiality until clarification is provided through further guidance or judicial interpretation.

Mandatory Reporting and Exceptions

Discussion Point to Summarize Reporting Obligations: *Youth should be informed upon initial contact and as appropriate during subsequent contacts that information they may share could result in a requirement to report such information to other professionals, including law enforcement. Informing youth of this should be done in a manner that encourages open communication and facilitates discussion sensitive to the potential ramifications to the youth.*

Providers should notify all clients of the limits of confidentiality imposed by the mandatory reporting laws and any exceptions, pursuant to statute.

- Abuse and Neglect C.R.S. § 19-3-304, 307 and C.R.S. § 18-6-401
  All Providers have a responsibility and shall report suspected abuse or neglect of children, at-risk elders, and at-risk adults with an Intellectual or Developmental Disability (IDD). *(Reference C.R.S. § 18-6.5-108 for at-risk adults).*

- Reporters are afforded immunity from liability for reporting abuse when the report is made in good faith C.R.S. § 19-3-309
  Conversely, per C.R.S. § 19-3-304(4), mandated reporters face penalties for failure to report, up to and including conviction of a misdemeanor, punishable by time in jail and/or monetary penalties.

- Duty to Warn C.R.S. § 13-21-117
  Providers have a duty to warn and protect and shall make reasonable and timely efforts to notify the specific location or entity of the threat as well as law enforcement.

School Safety Requirements for Safeguarding and Releasing Information

School districts have different policies about school mandates concerning the age a youth may consent to treatment and can set parameters around referrals to interventions and treatment services. School personnel, including educators, administrators, counselors, and school resource officers (SROs), are encouraged to refer to the following references for guidance:

- Colorado Attorney General's Office Formal Opinion 18-01 regarding the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99): no-18-01.pdf (coag.gov)

- C.R.S § 19-1-303(2)(b)(II) – Requires that any information or records (except mental health records) relating to incidents that rise to the level of a public safety concern be shared by schools and law enforcement authorities. This includes, but is not limited to threats made by students, any arrest or charging information, any information regarding municipal ordinance violations, and any arrest or charging information relating to acts, that, if committed by an adult, would constitute misdemeanors or felonies.

- C.R.S. § 19-1-304(5) – Whenever a petition is filed that alleges a child between the ages of 12 to 18 years old has committed a crime of violence or unlawful sexual behavior, the Children's Code requires the immediate release of basic identification information, along with the details of the alleged delinquent act or offense, to the school district in which the child is enrolled.

- C.R.S. § 22-33-106.5 – Whenever a student under the age of 18 is convicted or adjudicated for an offense constituting a crime of violence, unlawful sexual behavior, or offenses involving controlled substances, the convicting court must notify the school district in which the student is enrolled of the conviction or adjudication.

- C.R.S. § 22-43-202.5 – In 2019, Colorado lowered the age of consent for outpatient psychotherapy services from 15 to 12 years old. This new law is intended to help minors who are hesitant to discuss their mental health with parents or legal guardians to obtain outpatient psychotherapy services before they reach a crisis level. *Refer to* the *potential confidentiality concerns outlined on pages 13-14.*

Discussion Point: *Whenever a case involves a youth engaging in abusive behavior that includes an underlying factual basis of unlawful or abusive sexual behaviors defined by C.R.S. § 16-22-102, school staff should refer to the SOMB Reference Guide for School Personnel.*

Release of Information

The youth who has engaged in the abusive, harmful, and or illegal behavior, or the person who holds the legal privilege should sign appropriate releases of information for the exchange and disclosure of information to relevant professionals. This includes other members of the MDT for the purposes of evaluation, treatment, supervision, and case management. Release of information shall be based on complete informed consent of the parent/legal guardian and voluntary assent of the youth, including information of alternative outcomes that may occur in the absence of consent/assent. Effective supervision and treatment of youth who have engaged in relationship abuse is dependent upon open communication among the MDT members.

Safeguarding and Protecting Survivor Confidentiality

Community-based domestic violence organizations focus on services for people experiencing domestic violence, sexual assault, and stalking for the purposes of increasing safety, providing support, and enhancing options. These programs may offer non-residential services to adolescent survivors ages 12 years or older without parental consent. Community-based advocates work on behalf of the person experiencing abuse to help them navigate safety throughout many areas of their lives. Pursuant to C.R.S. 13-90-107, community-based advocates are mandated to ensure information about survivors is confidential and programs offer shelter and services to survivors.

- C.R.S. § 24-2.1-302.5 – The Victim Rights Act (VRA) applies in cases reported to law enforcement, including SROs who are sworn law enforcement officers. Best practices are that all persons experiencing abuse are ethically entitled to applicable guaranteed survivor rights as outlined in the VRA (Refer to appendix 6).

- Title IX[15] requirements specify how recipients of federal financial assistance, including elementary and secondary schools, must respond to allegations of sexual harassment and assault, dating violence, domestic violence, or stalking (as defined by the Clery Act as amended by the Violence Against Women Reauthorization Act [20 U.S.C. §1092]) consistent with Title IX's prohibition against sex discrimination.

Discussion Point: *Title IX Coordinators should work with district legal counsel to understand how the 2020 regulations affect the district's Title IX policies and procedures and make revisions, as necessary. The new regulations went into effect August 14, 2020.* ***Please note that a new administration could impact the enforcement of these regulations****. The new Title IX Regulations' definition of sexual harassment replaces the previous Title IX definition of sex-based harassment. Under the new regulations, sexual harassment, as defined by Title IX, is conduct on the basis of sex that meets one or more of the following descriptions:*

- *A school employee conditioning an educational benefit, service, or an individual's participation in an educational activity upon unwelcome sexual conduct ("quid pro quo"),*
- *Unwelcome conduct determined by a reasonable person to be "so severe, pervasive and objectively offensive" that it effectively denies the victim access to the school's education programs, and*
- *Crimes defined under the Clery Act (20 U.S.C. §1092(f) (2018)) and the Violence Against Women Act (42 U.S.C. sections 13701 through 14040).*

Sexual harassment can include conduct that is verbal, physical, or other types of conduct that targets a person based on their sex and that the person finds unwelcome. Anyone, regardless of race, sexual orientation, disability status, or gender identity might be a victim or perpetrator of sexual harassment.

Gender-based harassment, also covered under Title IX, is unwelcome conduct based on an individual's actual or perceived sex, gender identity, or nonconformity with sex stereotypes. Gender-based harassment may include:

- *Acts of verbal, nonverbal, or physical aggression, and/or*
- *Intimidation or hostility based on sex or sex-stereotyping or failure to conform to perceived sex or sex-stereotypes.*

Such acts are considered to be gender-based harassment ***even if they do not involve conduct of a sexual nature*** *because the conduct is sex-based.*

[15] 20 U.S.C. §1681 *et seq*.

Title IX prohibits sexual harassment and gender-based harassment of all students, regardless of the sex of the harasser or the target and regardless of the actual or perceived sexual orientation or gender identity of the harasser or the target.

- C.R.S. § 24-10-106.3 - Claire Davis Act - This Act imposes a limited waiver of sovereign immunity for schools if a school fails to exercise "reasonable care" to protect all students, faculty, and staff from "reasonably foreseeable" acts of violence that occur at school or a school-sponsored activity. "Crime of violence" means that the person committed, conspired to commit, or attempted to commit one of the following crimes: murder; first degree assault; or a felony sexual assault as defined in section C.R.S. § 18-3-402.

Case Management and Multi-Disciplinary Coordination

The purpose of the MDT is to support, manage, and supervise the youth who engaged in relationship abuse through shared information. The individualized evaluation, information from all caregivers, survivor input, and ongoing assessments provide the basis for team decisions related to risk assessment, treatment, and behavioral monitoring. Decision-making related to the youth and their family should occur as a team and should include assessment/reassessment of risk and need of each individual youth based on clinical indicators, risk assessment, least restrictive level of supervision and containment available to meet the needs of the youth while still prioritizing the needs of the youth who experienced abuse and community safety. No sole decisions related to the above items should occur without consulting with members of the MDT. Collaboration amongst the MDT should be paramount and should occur from the onset of the case. MDTs shall ensure that all decisions related to the youth are consistent with any existing court orders.

There are two ways that a youth who engages in relationship abuse may be identified and referred for services:

- After an adjudication or a deferred adjudication has been entered, and a referral to probation, parole, or out-of-home placement has been made, the youth should be referred to a Provider who uses these Guidelines and the formation of an MDT, consisting of the members identified below should be convened as soon as possible to manage the youth during the term of supervision. Members of the MDT may change as the treatment and supervision plan evolves. Each member is responsible for making sure the MDT is formed, convened, and communicating on a regular basis. This process may also occur at the pre-trial stage.

- Outside of the legal system, in response to an identified need by professionals due to a referral by family/caregivers, school, sports, youth groups, etc., the youth should be referred to a Provider who uses these Guidelines and an MDT should be formed with the available professionals who are involved with the youth, if applicable. These members may be more limited, but the Provider should seek their involvement to the extent possible.

The MDT is formed around a particular youth and membership may change over time based upon who is currently involved with the youth. The MDT may include any of the following individuals necessary to ensure the best approach to managing and treating the youth. The MDT may consist of:

- The supervising professional, if assigned (probation, diversion officers or counselors, client manager/parole officer, case managers, etc.)

- School personnel (administrator, school mental health professionals), school districts or their designees, if assigned

- The Provider
- Survivor and/or Survivor representative
- DHS caseworker (when applicable)
- The Division of Youth Services (DYS) client manager (when applicable)
- Therapeutic care provider (when applicable)
- Parents, caregivers, and other natural support systems (when applicable)
- Court appointed legal representatives (GAL, CASA volunteer) (when applicable)
- The individual client who engaged in abusive, harmful, and/or illegal acts toward others

The MDT may also include extended family members, other clinical professionals, law enforcement, church leaders, peers, survivor advocates, survivors, coaches, SROs, employers, and other individuals as deemed appropriate.

It is recommended that these Guidelines be utilized as best practice in the following situations where there are concerns of abusive, harmful, and/or illegal behavior:

- Youth and families who are seeking intervention regarding abusive behavior that has been disclosed through self-report or evaluation

- Following a comprehensive evaluation which identifies a concern related to abusive behavior for:
    - Youth who have been adjudicated for a non-sexual offense,
    - Youth placed on diversion, or
    - Youth who are the subject of a Dependency and Neglect (D&N) petition, or
    - A youth with a developmental/intellectual disability who has engaged in an abusive offense is either found incompetent to stand trial or is not charged with an offense but is under the court's jurisdiction due to a D&N petition or a delinquency petition, or
    - A youth is receiving services for abusive behavior provided by a County Department of Humans Services/Social Services (DHS/DSS) without a legal requirement.

The MDT should demonstrate the following operational norms:

- An ongoing, open flow of information among the members of the team, as appropriate.
- Team members fulfill their assigned responsibilities in the management of the juvenile.

Discussion Point: *When members of the MDT wish to attend group or other treatment sessions it must be for specifically stated purposes relative to the treatment of the youth. Providers should prepare youth and their parents/caregivers in advance for attendance of the MDT member. It is understood that Providers may set reasonable limits on the number and timing of visits to minimize any disruption of the treatment process.*

- Team members are committed to the team approach and settle among themselves conflicts and differences of opinion that might make them less effective in presenting a unified response.
- Team members should seek assistance through supervision with conflicts or alignment issues that occur.
- The supervising professional has final authority in all decisions regarding conditions set by a court or parole board and regarding court orders.
- To protect the youth who experienced the abuse, community and/or the youth who has engaged in relationship abuse, critical situations may arise that require an MDT member to make an independent decision. Independent decisions should be the exception rather than the rule. These decisions must be reviewed as soon as possible with the MDT.
- Team members should share behavioral observations relevant to the youth's current functioning and information regarding cooperation/compliance with the conditions of community supervision and safety plans.
- The MDT is encouraged to work diligently together before involving a court/parole board. The MDT should be mindful of the level of decision-making that would require the involvement of a court or parole board for intervention and seek this remedy only after inner-team solutions have been deemed unattainable by the team members. In the event of a court review or parole board hearing, MDT members should provide reports to the court/parole board as a team with dissenting opinions in the absence of team consensus. Copies of such reports should be forwarded to the pertinent MDT members.
- The MDT should carefully consider survivor and community safety before making a determination of completion of treatment.

Responsibilities of the Supervising Professional in MDTs

The primary responsibility of these supervising professionals is to ensure the youth is in compliance with the conditions of community supervision. All members of the MDT share the responsibility of ensuring the MDT is formed, convened, and has on-going communication.

Discussion Point: *In the absence of an adjudication or a deferred adjudication, if a school has an agreement with a youth who has engaged in relationship abuse to participate in services in lieu of suspension/expulsion, and/or other discipline, appropriate school personnel may serve in the role of the supervising professional to ensure that the youth complies with the recommended requirements of these Guidelines.*

Confirmation by the supervising professional that the youth is receiving required supervision, treatment, evaluation, assessment, and support from the MDT and parents/caregivers is paramount for survivor and community safety. If the youth is not receiving the required services, the supervising professional should make a referral for the required service. The youth should complete an intake and evaluation with a mental health professional who demonstrates compliance with Guiding Principle 7 and who has the advanced expertise necessary to serve youth. Youth should comply with the recommendations as directed by the MDT.

- Refer all youth to whom these Guidelines apply for evaluation, assessment, and treatment to Providers who work with youth and have expertise in relationship abuse treatment. When making a referral for services for specific populations of youth (e.g., female, LGBTQ+, developmental/intellectual disabilities, youth of color, etc.), it is imperative that the supervising professional ensure the individual providing treatment/services has specific training, expertise, and cultural competence with the specific population.

- When providing services to specific populations of youth who are using abusive behaviors, services should be based on expertise and cultural competence specific to these populations. See Guiding Principle 3 for more information.

- Best practices dictate that parental responsibility terms and conditions be presented to the parent(s) or guardian(s) and that expectations, including but not limited to, participation in treatment, sharing information, and supervision of the youth be explained by the supervising professional.

- Require written individualized safety plans in conjunction with the MDT as a precondition for decisions regarding activities. The supervising professional should use the treatment, safety plan, school supervision plan, and other pertinent orders and plans to measure and assess safety and compliance. The purpose of this process is to find the appropriate level of supervision required to provide the youth with expanded opportunities for success.

- Refer the youth to the Duty to Warn protocol regarding disclosure.

- Ensure supervision levels and behavioral monitoring that meet the risk level and the individual needs of the youth.

- For youth on probation/parole or under a court order, a copy of the youth's terms and conditions of supervision/court order should be shared with all members of the MDT, including Interstate Compact (legal agreement between states), if applicable.

- Develop the supervision plan on the basis of the individualized evaluation, ongoing assessments, and reports of current behavioral observations by the MDT.

- Confer with the MDT (if still convened) prior to requesting early termination of supervision. Early termination may be possible in rare cases, but only after successful completion of treatment and fulfillment of court requirements.

- The supervising professional should not allow a youth who has been unsuccessfully discharged from a treatment program to enter another program unless the MDT has modified the treatment plan to meet the needs of the survivor, community, and youth. Documentation should address the reasons and underlying issues for unsuccessful discharge and the rationale for a revised plan. A notation should be entered describing whether or not the level of care is the same or more or less intensive than the previous program. The treatment plan should follow the youth from one placement and program to another.

Discussion Point: *The purpose of this recommendation is to discourage movement among Providers by youth and their families as a way of avoiding the requirements of treatment.*

- A youth's termination from treatment should not be based solely on the family's unwillingness to support the goals of treatment.

Discussion Point: *There are times when family dynamics play a role in the youth's failure to attain treatment goals. Supervising professionals should be cognizant of family dynamics and should not impose punitive consequences on the youth when the youth is progressing, but family members are refusing to participate in or are sabotaging the youth's treatment. Alternatives to support the youth's adherence to supervision and management requirements should be sought by the MDT including possible return to court to address the respondent's compliance.*

- Seek a means of continued court-ordered supervision, for example, through an extension or revocation and re-granting of probation/supervision for a youth who has been otherwise compliant but has not achieved their treatment goals by an approaching supervision expiration date. Promote discussion with the MDT to determine what the youth has been able to bring to the process.

- Receive initial and annual training related to youth who have engaged in abusive, illegal, and/or harmful acts toward others. It is also desirable for MDT member supervisors to complete similar training. These trainings may not be appropriate for non-professional members of the MDT. Such training includes, but is not limited to, the following:
    - Prevalence of relationship abuse
    - Risk and re-offense
    - Youth characteristics
    - Differences and similarities between adults and juveniles who engage in relationship abuse

- Evaluation/assessment of youth
- Current research
- Community management
- Interviewing skills
- Survivor dynamics and safety considerations
- Domestic violence offender treatment
- Qualifications and expectations of Providers offering evaluation and treatment services

Continuity of Care and Information Sharing

Continuity of care is the process of delivering seamless service through integration, coordination, and the sharing of information between MDT members, including Providers. To maintain protective factors and reduce negative impacts to the youth, it is important for all members of the current MDT to collaborate with one another to avoid disruption to the continuity of care, keeping in mind continuity of care pertains to those youth beginning treatment, those returning to treatment, as well as those in aftercare programs.

Continuity of care values the progress a youth has achieved in treatment and supervision, and increases the youth's investment in treatment by aligning services with individual needs.

- Members of the MDT should prioritize continuity of care through collaboration with past and present supervising professionals, treatment providers, and school mental health professionals, as available. Examples include, but are not limited to, a youth being sentenced to DYS after a period of community supervision, transitions between judicial districts, and youth in the custody of DHS stepping down to community providers.

Evaluation and Treatment Service Guidelines for Mental Health Professionals

Introduction

Mental/behavioral health professionals, including school health professionals, (hereafter Providers) play a critical role in providing interventions and support to youth who engage in abusive, harmful, and/or illegal acts toward others. For the purposes of this document, abusive, harmful, and/or illegal acts include behaviors directed at oneself where the intent is to negatively impact another person. Colorado Revised Statutes define the term "mental/behavioral health professional" and define the practice of psychology, social work, marriage and family therapy, professional counseling, addictions counseling, and school health professionals. For more information on these professions refer to C.R.S § 12-43-303, §12-43-403, §12-43-503, §12-43-602.5, §12-43-803, and §22-96-102.3.

These guidelines apply to licensed, registered, or certified professionals who *choose* to provide services to youth who engage in abusive, harmful, and/or illegal acts. As such, these principles should guide the responses of the education system, criminal justice system, survivor advocacy, clinical interventions, and human services.

It is important for professionals to understand and respect the limitations of their practice and the advanced expertise required to properly serve youth, per C.R.S § 12-43-202(1), which states, "Notwithstanding any other provision of this article, no licensee, registrant, or certificate holder is authorized to practice outside of or beyond his or her area of training, experience, or competence."

Promising Practices for Providing Services to Youth who Engage in Relationship Abuse

Evaluation, assessment, treatment, and monitoring services for youth who engage in relationship abuse should adhere to the Guiding Principles to the extent possible and follow current practices that are grounded in research. Providers should monitor on-going research and incorporate emerging practices as appropriate. The content of treatment should focus on decreasing abusive, harmful, and/or illegal behavior, increasing prosocial behaviors, and improving overall health.

Professionals may use a variety of terms referencing persons who are subject to these Guidelines. The terms that are frequently used in the Guidelines include *youth who engage in abusive, harmful, and/or illegal acts*; *youth who engage in relationship abuse*; *youth*; and *client*. This section of the Guidelines will refer to youth who engage in abusive, harmful, and/or illegal acts as ***clients***. This recognizes that use of the term *domestic violence offender* may unintentionally label youth by their behavior or suggest that clients who undergo treatment

cannot live a violence and abuse free life. Professionals are encouraged to use language that will promote a client's engagement and prosocial behavioral development appropriately.

Evaluation and Assessment Services

The purpose of an evaluation is to assess and determine what type of treatment is needed (if any), and identify the risk factors, protective factors, and any additional needs the client may have related to support, stabilization, and safety. While the evaluation provides valuable information and recommendations, Providers should continuously assess each client as new information emerges during the course of treatment and tailor the treatment plan to address those changes.

Through the process of completing an evaluation of the client, it is critical for the Provider to assess the extent to which abusive, harmful, and/ or illegal acts are indicative of relationship abuse. If no such clinical indicators exist, the Provider should consider alternative treatment or intervention options as needed and appropriate.

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

Discussion Point: *Concerns about client self-harm and suicidal ideation should be taken seriously and addressed through appropriate safety planning practices. Clients may also present with self-harm and suicidal ideation to create distractions for the Provider and MDT, establish influence upon the youth experiencing the abuse, or to avoid treatment requirements.*

Assessing risk with clients who engage in relationship abuse is necessary for the identification of issues related to community safety, treatment, family support, and placement options. The evaluation and assessment of clients who have engaged in relationship abuse is best seen as a process. Progress in treatment and level of risk are not constant over time and may not be directly correlated. Ongoing evaluation and assessment must constantly consider the dynamic nature of the client's development and changes in their family and community for positive growth and development of the client.

Discussion Point: *While many risk assessments have been shown to have validity for youth of color, they may not have been officially normed on this population. A concern with risk assessments is that they often rely, in part, on official records (police contacts, arrests, adjudications, etc.) and research has shown that official record is often racially biased. When conducting risk assessments, it is important to be aware of how much emphasis is put on official record in determining risk. To reduce the impact of any racial bias, professionals should consider all collateral information (previous records, information from clients, information from caregivers, behavioral observations, etc.) as well as any limitations or disclaimers identified by the instrument developers.*

It is important to understand that risk assessment measures have limitations and that findings need to be used appropriately (i.e., within the scope of their empirically-established limits). While there are no validated risk assessments for youth who engage in relationship abuse, domestic violence risk assessments may be used for informational purposes, in addition to any general delinquency or violence risk-based instruments. Examples of these assessment instruments include but are not limited to the Youth Level of Services/Case Management Inventory (YLS/CMI), the Youth Assessment and Screening Instrument (YASI), and the Structure Assessment of Violence Risk in Youth (SAVRY).

Discussion Point: *It may be beneficial to clarify the purpose and limitations of risk assessment instruments. To manage risk, minimize the opportunities for re-offense, and support positive growth and development of clients, ongoing assessment should form the basis for decisions concerning restrictions and intensity of supervision, placement, treatment, and levels of care.*

Treatment Services

Treatment is defined as the comprehensive set of planned therapeutic experiences and interventions designed to uniquely change the power and control dynamics, abusive thoughts, and behaviors.[16] Such treatment should specifically address the occurrence and dynamics of relationship abuse through a developmental framework. Strategies to promote change should emphasize meeting treatment goals rather than the passage of a specific amount of time. Treatment is more successful when it is delivered consistently and with fidelity to the individual needs of the client. Treatment should aim to foster conditions that allow the client to: (a) manage the individual factors that contribute to abusive and problematic behaviors; (b) identify and change thoughts, feelings, and actions that may contribute to abusive thoughts and behaviors; (c) develop resilient strengths and competencies; and (d) establish and maintain stable, meaningful, and prosocial lives.

Treatment Modalities

- Cognitive Behavior Therapy (CBT)/Skills-based
- Interventions to decrease risk and increase protective factors in client's ecology
- Caregiver involvement and family therapy

Caregiver Involvement Discussion Point: *Providers should assess, understand, and plan for the opportunity of healthy, strengths-based, and positive integration of the parent/caregiver. Conversely, Providers should be cognizant of the potential of parental/caregiver interference or barriers to the client's progression in treatment. These circumstances may arise when parents or caregivers present as unsupportive of the treatment goals and/or present with, abusive, harmful, and/or illegal, behaviors in the family dynamic.*

[16] Taylor et al., (2017). Romantic Relationship Characteristics and Adolescent Relationship Abuse in a Probability-Based Sample of Youth. *Journal of Interpersonal Violence.* DOI: 10.1177/0886260517730566.

- Strengths-Based Model
- Transformative justice / Restorative justice / Letter of accountability
- Affect regulation
- Healthy relationships
- Family therapy
- Competency and resiliency building
- Use of peer support groups to increase normalization, build healthy interpersonal relationship skills, and establish social supports
- Dialectical Behavior Therapy (DBT)
- Trauma-Focused Cognitive Behavior Therapy (TF-CBT)/Eye Movement Desensitization and Reprocessing (EMDR)
- Motivational Interviewing (MI)

Treatment Content Areas

Providers should consider the following treatment content areas for appropriateness based on the individual and ecological needs of the client, in consultation with the MDT, and include applicable content in an individualized treatment plan:

- Identify the origins of their delinquent behavior and/or antisocial behavior
    - Recognition and management of dynamic risk factors and adaptive skills to mitigate those risk factors

- Ability to define all types of abusive behavior (e.g., physical, psychological, emotional, etc.)

- Demonstrate accountability through the acceptance of responsibility for offending and abusive behaviors[17]

- Demonstrate awareness and discuss the intent of previous grooming tactics

- Awareness of survivor impact and empathy

[17] Zosky, D. (2010). Accountability in Teenage Dating Violence: A Comparative Examination of Adult Domestic Violence and Juvenile Justice Systems Policies. *Social Work, 55(4), 359-368*.

- Provide opportunities for the client to engage in Survivor Clarification Work as defined in Appendix 3 regardless of whether the process progresses to face-to-face sessions involving the survivor (Refer to Appendix 3)
- Enhance client insight into impact of adverse childhood experiences and past trauma

- Development of prosocial and adaptive coping skills for managing adverse childhood experiences and past trauma[18]

- Increase understanding of family dynamics and patterns, including but not limited to intimacy and boundaries, parent/guardian child relationships (parenting and attachment styles), sibling relationships, criminality, and mental health needs

- Recognition of how attitudes of family, peer group, community, and culture influence tolerance of abusive, harmful, and/or illegal behavior[19]

- Identification of dynamic patterns of thoughts, beliefs, feelings, and behaviors associated with abusive, harmful, and/or illegal behaviors

- Identification of prosocial goals (e.g., completing education, obtaining job skills and training, life skills, recreational activities, etc.)

- Increase skill development of:
    - Emotional regulation, communication, anger management[20], conflict resolution, problem solving, stress management, delayed gratification, etc.
    - Alternatives to maladaptive coping strategies

- Recognition and management of co-occurring factors:
    - Mental/behavioral health treatment needs and development of on-going support
    - Teen Parenting
    - Substance use[21]
    - Depression, anxiety, and post-traumatic stress disorder (PTSD)

- Develop understanding of the dynamics associated with healthy sexuality/healthy relationships
    - Consent and equality

[18] Felitti et al., (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14(4), 245–258*. https://doi.org/10.1016/S0749-3797(98)00017-8

[19] Miller et al., (2020). Male Adolescents' Gender Attitudes and Violence: Implications for Youth Violence Prevention. *The American Journal of Preventative Medicine, 58(3): 396-406.*

[20] Armenti et al., (2018). The Role of Trait Anger in the Relation Between Juvenile Delinquency and Intimate Partner Violence in Adulthood. *Crime & Delinquency 64(5), 587-605.* DOI: 10.1177/0011128716685813.

[21] Temple et al., (2013). Substance Use as a Longitudinal Predictor of the Perpetration of Teen Dating Violence. *Journal of Youth and Adolescence, 42(4):596-606*.

- Psycho-education regarding:
    - Accurate information about healthy relationships
    - Information on parameters of human behaviors in response to interpersonal violence, including extreme behaviors

- Development of safety plans to address risk factors and potentially risky situations

- Survivor safety considerations

- Restorative justice (RJ)[22] if applicable (Refer to Appendix 4)

- Crisis management

- Community reintegration and prosocial networks and prosocial activities

- Continuity of care

Discharge Planning

Successful completion of treatment should be determined by the Provider based on all clinical indicators. Such a determination will be based on the client's overall change as measured by the goals and outcomes identified in the client's treatment plan, including risk level and the client's sustained ability to integrate treatment concepts and tools (e.g., a prosocial living plan) into daily life. The Provider should discharge the client regardless of the length of time the client remains under supervision. The Provider should consult with the MDT regarding completion or discharge from treatment. When a Provider is considering making a recommendation to the MDT for completion or discharge from treatment, the following factors shall be considered:

- The most recent evaluation recommendations
- The individualized treatment plan and progress on each goal
- Ongoing risk assessment
- Collateral information from all sources
- Document all the above (clinical indicators) in preparation for a meeting with the MDT

[22] Wilson et al., (2017). Effectiveness of Restorative Justice Principles in Juvenile Justice: A Meta-Analysis. *U.S Department of Justice Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention* Grant No. 2015-JF-FX-0063

Appendices

Appendix 1: Definitions

Accountability: Quality of being responsible for one's conduct: being responsible for causes, motives, actions, and outcomes.

Adjudication: A determination by the court that it has been proven beyond a reasonable doubt that the youth has committed a delinquent act or has pled guilty to committing a delinquent act.

Non or Pre-adjudication: Prior to adjudication for children ages 10 and older, the school should consult with established community resources such as the probation department, human services agencies, mental health professionals, local law enforcement, or the district attorney's office in order to make an informed decision. Although students who have not been adjudicated are considered innocent until proven guilty, the school district has an obligation to provide safety in the educational environment.

It is strongly suggested that an intervention conference be set up with knowledgeable people in the field to determine if the available services can meet the needs of the youth and the school community.

It is also recommended that this approach be utilized with youth and their families who are seeking intervention regarding harmful or problematic behavior in their dating relationships that has been disclosed through self-report or an evaluation.

The Guidelines are also recommended with youth and their families seeking voluntary or proactive support regarding harmful issues in dating relationships.

Youth who have not been adjudicated, placed on diversion, or those who are the subject of a D&N order may be included in the same programs as those developed for adjudicated youth.

Deferred adjudication: In any case in which the youth has agreed with the district attorney to enter a guilty plea, the court, with consent of the youth and the district attorney, upon accepting the guilty plea, may continue the case for a period not to exceed one year from the date of entry of the plea. The court may continue the case for an additional one-year for good cause.

Any youth granted a deferral of adjudication under this section may be placed under the supervision of a probation department. The court may impose any conditions of supervision that it deems appropriate that are stipulated to by the youth and the District Attorney.

Upon full compliance with such conditions of supervision, the plea of the youth or the finding of guilty by the court shall be withdrawn and the case dismissed with prejudice.

Assessment: An initial and on-going process of gathering information, which might include the use of standardized measurement instruments intended for treatment planning and review purposes.

Coercion: Use of pressure through actions such as bribes, threats, or intimidation to gain cooperation or compliance, despite the person's stated or unstated unwillingness to participate, including after the individual says “no” or “stop.”

Community Supervision: When a youth is residing in any unlocked location (e.g., home, foster placement, residential treatment center [RTC] placement, etc.), the youth is considered to be under community supervision. The MDT, when in place, supervises the youth and often, there is a probation or parole officer assigned to the case. When the MDT has not been developed yet, the custodial agency and/or DHS caseworker is generally the supervising agent.

Continuum of Care and Services: The various levels and locations of care based on the youth’s individual needs and level of risk, including treatment intensity and approach and restrictiveness of setting. For the purpose of these Guidelines, the continuum is not unidirectional.

Consent: Agreement between individuals that includes all the following: 1) emotional and intellectual equality; 2) honesty; 3) understanding what is proposed, based on functioning and experience; 4) permission to disagree or refuse without penalty or harm; 5) understanding what is going to happen, including potential consequences and alternatives.

Developmental/Intellectual Disability (DD/ID): (Also referred to as Intellectual or Developmental Disability (IDD) in Colorado Statute) A condition manifested before age 22 which constitutes a substantial disability to the affected individual and is attributable to an impairment in general intellectual functioning or related conditions, which include cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person diagnosed with intellectual disability.

Impairment of general intellectual functioning means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15) as measured by an instrument which is standardized, appropriate to the nature of the person’s disability, and administered by a qualified professional.

AND/OR

Adaptive behavior means that the person has overall adaptive behavior which is significantly limited in two or more skill areas (e.g., communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as

measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional.

"Similar to that of a person with intellectual disability" means that a person's adaptive behavior limitations are a direct result of or are significantly influenced by impairment of the person's general intellectual functioning and may not be attributable to only a physical impairment or mental illness.

Domestic Violence/Relationship Abuse/Intimate Partner Violence: A pattern of behaviors used by one individual in a relationship to control, coerce, intimidate, manipulate, and/or exert power over another person in a current or past intimate or dating relationship. It also includes these behaviors being used against someone with whom the person thinks they have an intimate or dating relationship. Domestic violence may be physical, psychological/emotional, sexual, spiritual, digital, reproductive, and/or financial. People of any race, age, sexual orientation or identity, religion, gender, education level, or economic status can experience or perpetrate this abuse.

Domestic Violence Offender Management Board (DVOMB): The DVOMB was created to develop standards and guidelines for the assessment, evaluation, treatment, and behavioral monitoring of domestic violence offenders. The Board reviews, develops, and revises the standards and guidelines using a comprehensive, transparent public process.

Dynamic Risk Factors: Factors that increase the risk of abusive behaviors, which can be changed during the course of treatment. The youth is held accountable and responsible for managing individual dynamic risk factors.

Grooming: Subversive behaviors perpetrated with the intent to gain access, trust, power, and control over the victim and the victim's support system. Grooming behaviors create the opportunity for abuse to occur. Behaviors are victim specific, degrade the victim's self-esteem, and lead them to believe they are responsible for the abusive behavior.

Informed Consent: Consent means voluntary agreement, or approval to do something in compliance with a request. Informed means that a person's consent is based on a full disclosure of the facts needed to make the decision intelligently, (e.g., knowledge of risks involved, alternatives, etc.).

Parents, Caregivers, and Other Natural Support Systems: Parents or other adults who have a custodial responsibility to care for the youth. Caregiving is broadly defined as providing the nurturance, guidance, protection, and supervision that promotes normal growth and development and supports competent functioning.

Potential Victim: A person or group whom the youth intends or expresses a plan to harm. (Note: May require Duty to Warn action on the part of the Professional). Potential victims may

also include individuals outside the dyad of dating partners - including one's children, parents, siblings, friends, bystanders, or new dating partners.

Prevention:
Primary Prevention (aka universal interventions): The goal is to reduce the incidence of the violence by targeting the entire population, not just those at risk. Aimed at community in hopes that societal or environmental change will help resolve societal problems.

Secondary Prevention: Targets people exhibiting early signs of perpetrating or experiencing violence or at risk for doing so. The goal is to curtail and prevent progression of the violence – youth who have not been seriously violent but appear at risk for future violent behaviors and those most likely to perpetrate violence - from engaging in future violence. Most secondary interventions incorporate some aspects of treatment.

Tertiary Prevention: Treatment services for youth who have already displayed violent behavior. The goal is to decrease recidivism. Overall effects on population as a whole likely negligible.[23]

Safety Plan: In cases of relationship abuse, ensuring the immediate and ongoing safety of survivors is a key concern. A safety plan is a plan of action that includes ways to help reduce the risk of being hurt while in a relationship, planning to leave, or after leaving a relationship. It includes information specific to each survivor that will increase their safety at school, home, and other places that they go on a daily basis. It helps a survivor plan how they will respond to future abusive or violent incidents, prepare for the possibility of an incident happening, and plan how get to safety.

There are times when it may be appropriate for the Provider or MDT to develop a safety plan with the youth who is engaging in abusive behaviors. In this case safety planning is the recognition of daily/circumstantial/dynamic risks and the purposeful planning of preventive interventions which the youth and/or others can use to moderate risk in specific situations.

Sex Offender Management Board (SOMB): The SOMB was created by the Colorado General Assembly to develop standards and guidelines for the assessment, evaluation, treatment, and behavioral monitoring of sex offenders. The Board reviews, develops, and revises the standards and guidelines using a comprehensive, transparent public process.

Static Risk Factors: Static risk factors refer to those characteristics that are set, are unchangeable by the youth, and may be environmental, or are upon other observable or diagnosable factors.

Survivor/Victim: A survivor is someone who experiences relationship abuse. People of any race, age, gender, sexual identity or orientation, religion, ethnic group, education level, or economic status can experience relationship abuse. Abuse may occur between 1) people who are

[23] Fields, S. & McNamara, J. (2003) *The prevention of child and adolescent violence: A review.* Aggression and Violent Behavior

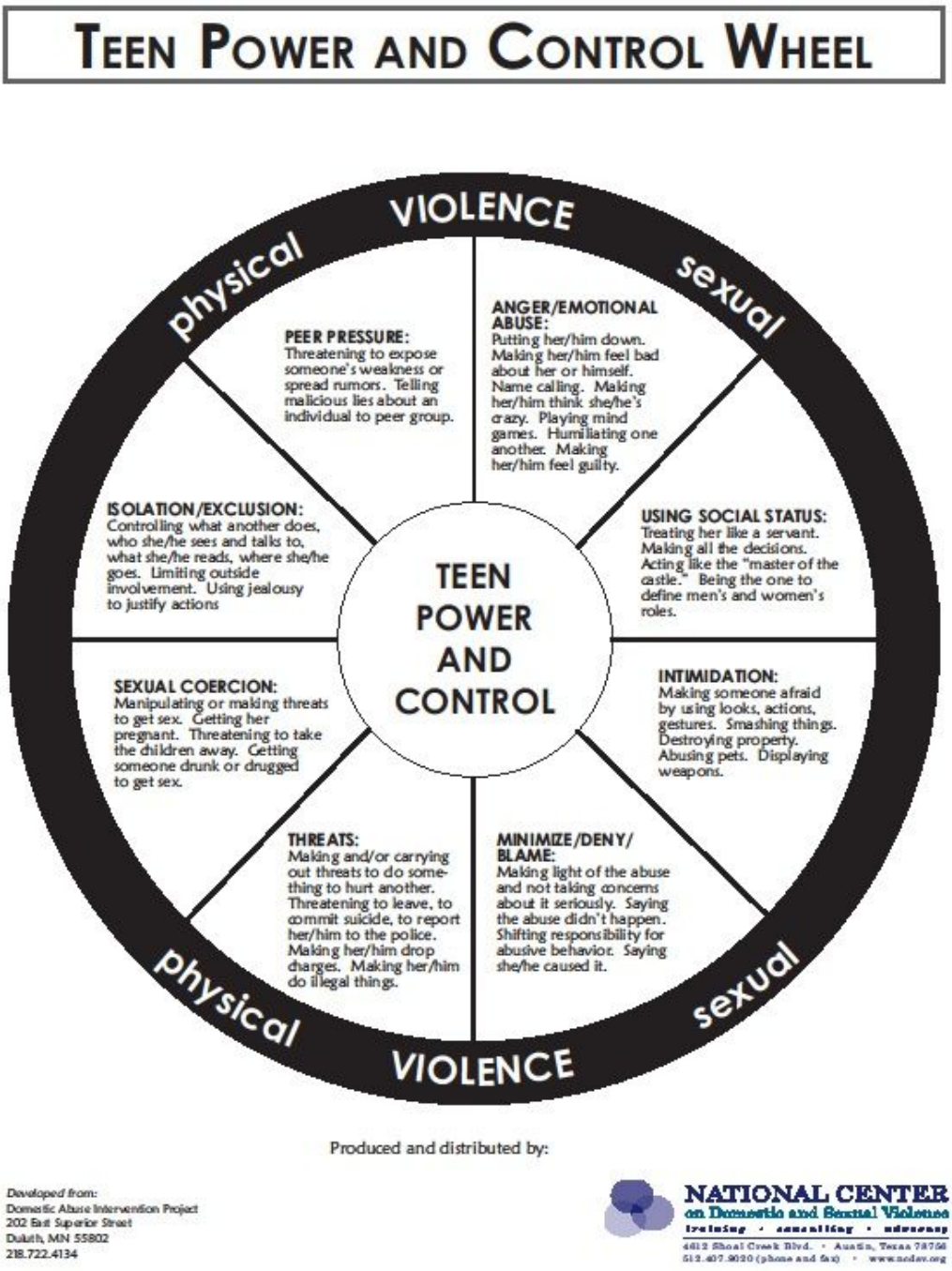
married, 2) unmarried people living together or in a dating relationship, or 3) people formerly in a relationship. It may also occur when the person using abusive behaviors incorrectly believes or wants to believe that a relationship exists.

Secondary Victim: Secondary victims are friends, relatives, or other individuals who are impacted emotionally, psychologically, or physically by virtue of their relationship or involvement with the survivor.

Termination: Removal from or stopping specific treatment due to 1) completion; 2) lack of participation; 3) increased risk; 4) re-offense; or, 5) cessation of mandated specific treatment without completion (i.e., without accomplishing treatment goals).

Vulnerable Person: A person whom the youth objectifies, fantasizes about, is grooming, or is crossing the boundaries of. This may be someone the youth is in a relationship with. Vulnerable persons may also include individuals outside the dyad of dating partners – including one's children, parents, siblings, friends, bystanders, or new dating partners.

Appendix 2: Teen Power and Control Wheel



Appendix 3: Survivor Clarification

Disclaimer: *Prior to the commencement of survivor clarification procedures, it is imperative that the Provider understand what survivor clarification is, how it should be conducted, and when it is appropriate. It is important to note that the survivor clarification procedures outlined in this Appendix have been adapted from the victim clarification process affiliated with the Adult and Juvenile Standards and Guidelines of the Sex Offender Management Board (SOMB****). Be aware of the differences between populations who have committed sexual offenses and those who engage in relationship abuse as well as any requirements associated with each group, respectively.*** *Additionally, the use of survivor clarification has yet to be fully studied and tested with youth who engage in abusive, harmful, and/or illegal behaviors outside of those with a sexual component and subject to the SOMB Juvenile Standards and Guidelines. Providers should exercise caution when considering survivor safety and the survivor clarification process should only be considered when clinically appropriate.*

A. Survivor Clarification Work

Survivor clarification work is a multi-step process that should occur whether or not the process progresses to face-to-face sessions with the survivor. The first step involves the Provider understanding the needs of the survivor and assessing the readiness of the youth who has engaged in abusive, harmful, and/or illegal behaviors. This process requires collaboration with a survivor representative (whenever a survivor has been in therapy, the survivor's therapist is the preferred survivor representative and should be consulted regarding the clarification process). Survivor participation is never required, and clarification sessions should only occur based on the direction of the survivor(s), not the family or youth. Clarification is always survivor centered and based on survivor need. The Provider should discuss with the youth the clarification process and the importance of the process being survivor centered. Providers may consider the use of survivor clarification when evidenced by the following clinical indicators:

1. The youth is able to accurately self-disclose about the abusive behavior and acknowledge the survivor's statements without minimizing, blaming, or justifying. Any significant difference between the youth's statements, the survivor's statements and corroborating information about the abusive, harmful, and/or illegal behavior has been resolved to the satisfaction of the MDT.

2. The youth demonstrates empathic regard through consistent behavioral accountability, including an improved understanding of the survivor's perspective, the survivor's feelings, and the impact of the youth's offending behavior.

3. The youth has written letters of accountability to the survivor:

    a. Letters should be written in a manner assuming the survivor will receive the letters, regardless of whether or not the letters will actually be sent. Determination regarding sending the letters should be made by the survivor's representative. The survivor's therapist involved in the case is the preferred representative. In the

absence of a survivor representative, the Provider should consider consulting with a victim/survivor advocate.

b. Letters should be written in the youth's words and in a manner that the survivor can understand. It is imperative that letters are written based on the individual needs of the survivor.

4. The youth is prepared to answer questions and is able to make a clear statement of accountability to the survivor.

B. Survivor Clarification Face-to-Face Sessions (in-person or virtual)

The clarification process may progress to face-to-face sessions when approved by the MDT in consultation with the survivor's representative (the survivor's therapist involved in the case is the preferred representative). There is no requirement for survivor therapy, but if the process is going to progress to face-to-face sessions, it is highly recommended that the survivor have an identified support person (e.g., family, friend, therapist, counselor, victim advocate, etc.) who would prepare them for these sessions and support them should something that might trigger them come up during the sessions.

- The survivor requests clarification and the survivor's representative concurs that the survivor would benefit from face-to-face sessions.

- Parents/guardians of the survivor (if a minor) and the youth are informed of and give approval for the clarification process.

- The youth is able to demonstrate the ability to manage abusive, illegal and/or harmful thoughts/preoccupation specific to the survivor.

- Survivor clarification sessions will be survivor centered and occur at a location or via a medium chosen or acceptable to the survivor. MDTs may consider alternate forms of technology (e.g., video conferencing, on-line video communication, live or pre-recorded video presentations, etc.).

Appendix 4: Restorative Justice

If a survivor requests some type of restorative justice (RJ) process, it is imperative that a trained RJ practitioner be brought in to conduct the process. Similarly, if a Provider believes the client could benefit from an RJ process, consultation with a trained RJ practitioner is essential. Survivor safety is paramount.

The RJ process will be determined by the practitioner based on the individualized needs of the survivor. Refer to the Restorative Justice Facilitator Code of Conduct and Standards of Training and Practice for more information.

Appendix 5: Victim Rights Act and Victim Compensation

Crime Victim Rights Act (VRA) | Division of Criminal Justice (colorado.gov)

Colorado law guarantees certain rights for victims of crime. The Victim Rights Act (VRA) in Colorado ensures that crime victims are treated with fairness, respect, dignity and that they are free from intimidation, harassment, and abuse. The VRA also helps to ensure that victims are informed of critical stages of the criminal justice process and that they may be present for, and heard, at certain stages as well. Refer to the Colorado Crime Victim Rights Brochure 2021 VRA Brochure.pdf (state.co.us) for detailed information.

Crime Victim Compensation | Division of Criminal Justice (colorado.gov)

Victims of crime may be eligible to receive compensation for crime related costs, including medical expenses, lost wages, mental health treatment, burial expenses, the loss of medically necessary devices such as eyeglasses or hearing aids, the loss of support to dependents, and damage to home security devices such as doors, windows, and locks. Each Judicial District has a Victim Compensation fund. Persons convicted of a crime or a traffic offense pay into this fund. Contact your local District Attorney's office for information on how to apply for Victim Compensation How to File a Claim for Victim Compensation | Division of Criminal Justice (colorado.gov).

Appendix 6: Supplemental School Resources

Colorado Department of Education

- *See Reference Guide for School Personnel, below.* (In collaboration with the Division of Criminal Justice.)

- A Guide to School Mental Health Services. This 2007 resource was designed to assist school personnel, students, and their families in understanding and accessing mental health services in school and during transition from school.

- School Health and Wellness: State and Federal Legislation and Policy. This 2015 guide by the Colorado Education Initiative highlights state and federal policies, statutes, and regulations that influence local school and district health and wellness policies and practices.

Colorado Department of Human Services

- Colorado Sexual Health Initiative (CoSHI)

  CoSHI provides youth with age-appropriate, medically accurate and evidence-based strategies that are proven to help reduce the risk of unintended pregnancy and sexually transmitted infections (STIs).

  Each year CDHS awards funding to Human Service agencies and community-based organizations within Colorado communities. This funding enables the agencies to bring comprehensive sexual health education and programming to young people in Colorado along with trainings for trusted adults who would like to increase their skills in answering questions about sensitive topics.

Colorado Department of Law

- Colorado School Violence Prevention: A Legal Manual. This Manual begins by identifying the systems and policies required by state and federal law to help keep schools safe. Preventative systems range from adopting solid student conduct policies to having a designated threat assessment team.

- Formal Opinion No. 18-01. Provides guidance for educators on the intricacies and interplay of the Family Educational Rights Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA).

Colorado Department of Public Health & Environment

- Sexual Violence Prevention/Healthy Relationships
  "Sexual violence prevention isn't just the absence of violence. It's also giving youth the opportunity to practice skills for creating healthy relationships."

- Colorado Human Sexuality Education (CSHE) Grant Program
  The Comprehensive Human Sexuality Education bill (HB19-1032) funds CDPHE's sexual education grant program. The purpose of these funds is to support schools and school districts to implement comprehensive human sexuality education content that is medically accurate, culturally sensitive, and represents positive youth development principles. The Comprehensive Human Sexuality Education (CSHE) Program at CDPHE will manage this grant program and will provide technical assistance, support, and training for schools and school districts, in collaboration with community partners.

Colorado Department of Public Safety

- Reference Guide for School Personnel Who manage Juveniles Who Have Committed Sexually Abusive and Offending Behavior. This guide, published by the Division of Criminal Justice and Colorado Department of Education, provides a victim-centered, multi-disciplinary approach to school safety planning for youth who have caused sexual harm.

- School Safety Resource Center Home
  Phone: 303-239-4435

  Child Sexual Abuse and Assault Prevention Resource Guide. This resource is offered to satisfy legal mandates and community interest in implementing sexual abuse and assault prevention programs This information was compiled by the Colorado School Safety Resource Center in 2020 and is updated annually.

  CSSRC_Essentials_of_TA_2020.pdf (state.co.us). *Essentials of School Threat Assessment: Preventing Targeted School Violence* is intended as guidance to Colorado schools and was created with collaboration from the Threat Assessment Work Group of the Colorado School Safety Resource Center. Consultation with district legal counsel and local law enforcement is recommended. Additional consultation and template formats may also be obtained from the Colorado School Safety Resource Center, Department of Public Safety.

  Claire Davis School Safety Act Summary

External Resources

- Centers for Disease Control and Prevention
- Cyberbullying Research Center

  Digital Dating Abuse: A Brief Guide for Educators and Parents
- love is respect

  Healthy Relationship Middle School Educators Toolkit

  Healthy Relationship High School Educators Toolkit

Appendix 7: Resources for Treatment of Those Engaging in Abusive Behaviors

Domestic Violence Offender Management Board (DVOMB) LINK

DVOMB develops standards and guidelines for the assessment, evaluation, treatment, and behavioral monitoring of domestic violence offenders. A list of DVOMB approved treatment providers can be found on their website.

Stand Up Colorado LINK

Based on a proven model for creating the positive social and behavioral changes necessary for decreasing the incidence of relationship violence, Stand Up Colorado is a statewide, collaborative, multi-year prevention campaign that aims to alter behaviors around relationship violence and affect long-term social change.

Appendix 8: Resources for Teen Dating Violence

Ashley Doolittle Foundation LINK

Focuses on building awareness of and preventing teenage dating violence and helps victims connect with the right support groups that can provide counseling. Honoring Ashley's love of our western heritage the Foundation also works with 4-H and FFA to provide scholarships to graduating seniors.

love is respect LINK
Hotline: 866-331-9474
TTY: 866-331-8453

A project of the National Domestic Violence Hotline, love is respect offers 24/7 information, support, and advocacy to young people between the ages of 13 and 26 who have questions or concerns about their romantic relationships. We also provide support to concerned friends and family members, teachers, counselors, and other service providers through the same free and confidential services via phone, text, and live chat.

Project PAVE LINK
Phone: 303-322-2382

Ending violence by empowering youth to build healthy relationships. PAVE works with youth and families exposed to relationship violence and promotes alternatives to violence in youth relationships. They provide violence prevention education and early intervention services.

That's Not Cool – Decreasing Teen Dating Violence Online LINK

Print resources:

10 Signs of a Healthy Relationship - One Love Foundation (joinonelove.org)

10 Signs of an Unhealthy Relationship - One Love Foundation (joinonelove.org)

Dating Matters: Strategies to Promote Healthy Teen Relationships (cdc.gov)

Healthy relationships for young adults | love is respect

Is your relationship healthy? - love is respect

Top-Ten-Tips-Teens-Digital-Dating-Abuse.pdf (cyberbullying.org)

Dating Abuse Statistics.pdf (loveisrespect.org)

Love is Respect Safety Planning Guide: An interactive guide that will ask for information about your situation and help you create a safety plan.

Appendix 9: Additional resources

Local communities have resources to provide survivors with support and assistance. To find a local community-based victim advocacy program near you go to: Programs by County - Violence Free Colorado.

Victim advocates are also located at the police department, sheriff's office, or the district attorney's office.

Other resources include:

Address Confidentiality LINK
Phone: 303-866-2208
Toll Free: 888-341-0002
TTY: 800-659-2656

The Colorado Address Confidentiality Program (ACP) is a statewide program that provides survivors of stalking, sexual assault, and domestic violence with a legal substitute address and mail forwarding.

Asian Pacific Development Center (APDC) LINK
Admin: 303-923-2920 (Aurora)
Admin: 719-459-3947 (Colorado Springs)

Powered by its rich heritage of Asian American, Native Hawaiian, and Pacific Islander advocacy, APDC exists to serve and support all immigrant and refugee communities with a whole health, community-based engagement approach through health, education, and advocacy.

Blue Bench LINK
Phone: 303-329-9922
Hotline: 303-322-7273

Providing comprehensive sexual assault support and prevention services.

Colorado Coalition Against Sexual Assault (CCASA) LINK
Phone: 303-839-9999

A statewide organization providing leadership, advocacy, and support to address and prevent sexual violence.

Colorado Department of Public Health and Environment, Injury Prevention LINK
Phone: 303-692-2000
Toll Free: 1-800-886-7689
TDD: 711

Colorado Division of Criminal Justice Office for Victims of Crime LINK
Phone: 303-239-5719
Toll Free: 1-800-282-1080

The Office for Victims of Crime houses several programs, including support for local victim compensation, Victim Assistance and Law Enforcement (VALE) programs, victim rights compliance, supporting statewide human trafficking efforts, and supporting statewide responses to sexual assault.

Colorado Immigrant Rights Coalition (CIRC) LINK
Phone: 303-922-3344
ICE activity hotline: 844-864-8341

CIRC is a statewide membership-based coalition of immigrant, labor, interfaith, youth, and ally organizations founded to build a unified statewide voice to improve the lives of immigrants and refugees in Colorado and the United States.

Colorado Organization for Victim Assistance (COVA) LINK
Admin: 303-861-1160
Toll free: 800-261-2682

A statewide membership organization including personnel from the criminal justice system, nonprofit organizations aiding victims of crime, survivors of crime, concerned citizens, and members of allied professions.

The Conflict Center LINK
Phone: 303-433-4983

The Conflict Center provides youth and adult classes and conflict management workshops teaching practical skills and training to address everyday conflict and to use conflict as an opportunity to grow, learn, and create positive life changes.

DOVE (Deaf Overcoming Violence through Empowerment) LINK
Crisis: 303-831-7874 (an advocate will respond to you within 15 minutes)
Admin: 303-831-7932

DOVE works with Deaf, DeafBlind, DeafDisabled, and Hard of Hearing people of all ages and backgrounds who have experienced abuse (domestic and family violence, sexual assault, child abuse, adult survivors of childhood sexual abuse, bullying, stalking, and teen dating violence).

Denver Children's Advocacy Center (DCAC) LINK

DCAC works to improve the lives of children traumatized by sexual and physical abuse, neglect, and violence, as well as those who are at risk, with prevention, education, and direct services. They coordinate the multidisciplinary team (MDT) of first responders to reports of child abuse in the Denver metro area.

Denver Indian Family Resource Center (DIFRC) LINK
Phone: 303-871-8035

DIFRC provides services and programs to families who self-identify as American Indian and Alaskan Indian in the Denver area. They also provide Indian Child Welfare Act advocacy to support reunification efforts for families who are involved in the child welfare system.

Denver Indian Health and Family Services, Inc. (DIHFS) LINK
Phone: 303-953-6600

DIHFS is Denver's only Urban Indian Health Program providing culturally appropriate care for American Indian and Alaskan Native adults, children, and families. DIHFS services include primary care, dental care, behavioral health services, diabetes management/disease prevention, enrollment in health insurance, and referral to resources for other health needs.

The Initiative (for persons with disabilities) LINK
Admin: 303-839-5510/ 877-839-5510
Text: 720-503-9580

The Initiative advocates for persons with disabilities who have experienced abuse. They provide direct services, victim advocacy, and outreach focusing on making resources available to survivors of abuse who are persons with disabilities.

Kempe Center for the Prevention and Treatment of Child Abuse and Neglect LINK
Phone: 720-777-2715 CU Anschutz Link

A section of the Department of Pediatrics at the University of Colorado School of Medicine, The Kempe Center evaluates and diagnoses children who are suspected victims of abuse and neglect, provides treatment and therapy for abused and neglected children and their families, trains professionals such as doctors, teachers, and social workers to protect and heal abused children, and conducts studies that assist in program development and public policy making.

Muslim Family Services of Colorado (MFS) LINK
Phone: 303-298-8776

MFS offers counseling to victims of domestic violence and other crimes and makes referrals to address the additional needs of their clients such as refugee services, counseling, food banks, shelters, clothing, and bus tokens. MFS provides services while honoring Islamic principles.

Project Safeguard (legal advocacy services) LINK
Adams phone: 303-637-7761 (not a crisis line)
Arapahoe phone: 303-799-3977 (not a crisis line)
Broomfield phone: 720-887-2179 (not a crisis line)
Denver phone: 720-865-9159 (not a crisis line)

Project Safeguard aids victims of relationship violence through advocacy and assistance in navigating the court system, court accompaniment during protection order, divorce/custody and other court hearings, and other services.

Rape, Abuse & Incest National Network (RAINN) LINK
Phone: 800-656 HOPE (4673)

RAINN is the nation's largest anti-sexual violence organization. It operates the National Sexual Assault Hotline and also carries out programs to prevent sexual violence, help survivors, and ensure that perpetrators are brought to justice.

Rocky Mountain Children's Law Center LINK
Phone: 303-692-1165

Advocates for Colorado's abused, neglected, and at-risk children through representing their best interests in court and other settings.

Rocky Mountain Victim Law Center LINK
Phone: 303-295-2001

Provides free legal services to victims of crime in Colorado.

Servicios de La Raza (bilingual & bicultural services for Latin@ survivors) LINK
Crisis: 303-953-5930
Admin: 303-458-5851

Servicios offers culturally responsive, essential human services and opportunities including a specialized behavioral health clinic for outpatient mental health and substance use services, employment services for job seekers, services for victims of intimate partner violence, sexual assault, stalking, dating violence, general crime, and a variety of programs for youth.

Sungate Kids LINK
Phone: 303-368-1065

Provides expert forensic interviewing, victim and family advocacy services, therapeutic support programs and child abuse prevention education.

United Way **Call 2-1-1 for resources**
Phone: 866-760-6489 (if 2-1-1 does not work from your phone)

A confidential and multilingual service connecting people to vital resources across Colorado.

Violence Free Colorado LINK
Phone: 303-831-9632 or 888-778-7091

Colorado's domestic violence coalition works with hundreds of organizations throughout Colorado to prevent and end relationship violence and support those affected by relationship abuse. The website contains a comprehensive list of services across the state, by community.

Restorative justice practitioner resources:

Colorado Coalition for Restorative Justice Practitioners (CCRJP) LINK

CCRJP creates public access to high-quality restorative justice practices statewide. It is a statewide membership organization supporting the common interests of restorative justice practices.

Restorative Justice Colorado LINK
Phone: 720-625-5000

The State Restorative Justice Council advances restorative justice principles and practices throughout Colorado by providing gateways to information, networking, and support.