Colorado Domestic Violence Offender Management Board (DVOMB)
Provider Data Collection System
Teletherapy Policy Brief #1
5.24.24

Executive Summary

Domestic Violence Offender Management Board (DVOMB)

The Colorado General Assembly created the Domestic Violence Offender Management Board (DVOMB) in 2000 (§16-11.8-101-104, C.R.S.). The DVOMB is tasked with developing and implementing the Standards and Guidelines for the Assessment, Evaluation, Treatment, and Behavioral Monitoring of Domestic Violence Offenders (herein referred to as the Standards and Guidelines). The DVOMB will periodically publish policy briefs on important issues and topics utilizing the data collected from Approved Providers beginning in 2023. This marks the first policy brief using this data.

Policy Issue: Teletherapy

The issue addressed in this policy brief involves concerns about using teletherapy for treating domestic violence offenders. It is being prepared at the request of the DVOMB Application Review Committee because the effectiveness of teletherapy as a treatment option has been a topic of discussion at DVOMB meetings and among stakeholders.

DVOMB Treatment Standards and Guidelines

The *Standards and Guidelines* define domestic violence offender treatment as therapy, monitoring, and supervision to change the power dynamics, abusive thoughts, and behaviors that cause and perpetuate domestic violence. As per the Standards and Guidelines, group therapy is the best way to treat domestic violence offenders, and ***in-person therapy is the preferred and expected modality***. However, providers with specific telehealth approval are permitted to use teletherapy when it is suitable for meeting a client's needs. Appendix I: Requirements and Criteria for Teletherapy With Domestic Violence Offenders of the *Standards and Guidelines* was implemented on September 30th, 2022, formalizing the current post-pandemic requirements for teletherapy use that should be followed.

Literature Review: Telemental Health Therapy Effectiveness

The use of teletherapy for mental and behavioral health treatments has rapidly advanced since the pandemic, yet there remains a lack of understanding regarding its effectiveness for *offense-specific* treatments, including domestic violence offender treatment. Differences between mental health and offense-related treatments limit applying the findings from one type of treatment setting to the other. A literature review found teletherapy was as effective as in-person treatments in improving *mental health* symptoms, with the strongest evidence for cognitive-behavioral treatments of anxiety, depression, and post-traumatic stress disorder.

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Research Project: DVOMB Teletherapy Client Data

- Among clients who were discharged from treatment in 2023 (N=1,448), 46% had in-person only treatment, 45% teletherapy only, and 9% received a mixture.
- Teletherapy treatment was used more often with clients in Levels A and B than Level C treatment (risk) placement. The opposite was true for in-person treatment, which suggests risk was a factor in deciding treatment modalities.
- Teletherapy treatment was associated with more completed and fewer unsuccessful discharges than in-person treatment. However, this was largely due to a higher proportion of high-risk clients receiving in-person treatment. Additional analysis found a combined approach of group and individual treatment, whether in-person or through teletherapy, had a higher percentage of completed discharges for Level C clients than group treatment alone. A possible reason is that these options foster a better therapeutic relationship between the therapist and the client, resulting in greater engagement.
- The median length of treatment was 6.2 months for in-person and 7.8 months for teletherapy treatment. For mixed modalities, it was 8.3 months. However, this was because Level A clients took longer to complete teletherapy than in-person treatment and Level B clients spent longer in mixed modalities before unsuccessful discharge. Level B and C clients with completed discharges were similar regardless of modality.
- Statistical modeling identified that clients with Level C risk, more severe antisocial and criminal behaviors and attitudes, acute mental health needs, and limited success with high school are more likely to be unsuccessfully discharged from teletherapy. Additional analysis found that a history of violating the conditions of release and implicit attitudes supporting domestic violence were associated with unsuccessful discharge from teletherapy within the first 3 months of treatment.

Draft Recommendations

- Clients receiving teletherapy also have some face-to-face or individual teletherapy contact, particularly during the first 3 months of the treatment contract and when a Level C client.
- Teletherapy should not be the first choice of treatment modality for clients who are Level C and exhibit more severe antisocial and criminal behaviors on the DVRNA, have acute mental health issues, or have less than a high school diploma (see Table 1). Teletherapy may be an option after the client establishes a therapeutic relationship in treatment, has stable mental health, and shows progress toward treatment goals.
- Appendix I be updated to highlight the (i) benefit of using combined modalities rather than one teletherapy modality only and (ii) the particular need to attend to client engagement during the initial stages of teletherapy treatment contact.
- Appendix I emphasizes that following the guidelines will be part of compliance audits.
- The Application Review Committee discusses incorporating some of the teletherapy guidelines in Appendix I more explicitly within the Standards.

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The Colorado General Assembly created the Domestic Violence Offender Management Board (DVOMB) in 2000 (§16-11.8-101-104, C.R.S.). The DVOMB is tasked with developing and implementing the Standards and Guidelines for the Assessment, Evaluation, Treatment, and Behavioral Monitoring of Domestic Violence Offenders (herein referred to as the *Standards and Guidelines*).

Starting January 1, 2023, the DVOMB is required by statute to collect data from Approved Providers regarding the evaluation and treatment services they provide to adult domestic violence offenders.[1] All providers are required to submit this information when services are completed, regardless of the outcome of each service. The data is submitted through either the DVOMB Provider Data Management System (PDMS) or the ReliaTrax record system.[2] Annual reporting on the data is included in the DVOMB Annual Legislative Report starting in 2024. The DVOMB will also periodically publish policy briefs on important issues and topics utilizing the data obtained from Approved Providers. These briefs will supplement the information provided in the DVOMB Annual Legislative Report and the *Standards and Guidelines*. This marks the first policy brief using this data.

Policy Issue: Teletherapy

The issue addressed in this policy brief involves concerns about using teletherapy for treating domestic violence offenders. It is being prepared at the request of the DVOMB Application Review Committee because the effectiveness of teletherapy as a treatment option has been a topic of discussion at DVOMB meetings and among stakeholders. Concerns raised include low client engagement, lack of flexibility for clients to switch to in-person treatment, inconsistent monitoring of client sobriety, and victim safety issues.

The policy brief begins by outlining important points from the *Standards and Guidelines* regarding domestic violence offender treatment, including about the current use of teletherapy. It then provides a summary of recent research on the effectiveness of teletherapy in the behavioral-mental health field. The brief outlines a DVOMB research project that examines DVOMB provider data on the use of teletherapy for domestic violence offender clients treated in Colorado under the *Standards and Guidelines*. Finally, recommendations regarding the use of teletherapy as a treatment modality are provided based on the project findings.

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[1] See §16-11.8-103(4)(a)(IV), C.R.S. The data collection mandate involved approval of a data collection plan by the DVOMB in 2022.

[2] Data is entered through either the DVOMB Provider Data Management System (PDMS) or the ReliaTrax record system.The PDMS is maintained by the Colorado Department of Public Safety, while ReliaTrax is an electronic health record system operated by a private company that is used by a majority of DVOMB Providers.

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DVOMB Treatment Standards and Guidelines

The *Standards and Guidelines* define domestic violence offender treatment as therapy, monitoring, and supervision for individuals who have committed domestic violence offenses. The goal is to use a series of interventions to change the power dynamics, abusive thoughts, and behaviors that cause and perpetuate domestic violence. Clients receive different levels of treatment based on their risk of domestic violence recurrence: Level A for low-risk clients, Level B for moderate-risk clients, and Level C for high-risk clients. The number of therapeutic contacts, required components, and overall length of treatment correspond to each risk level while still allowing for individualized treatment.

As per *Standard 5.04*, group therapy is the best way to treat domestic violence offenders. Individual and adjunct treatments may also be appropriate for specific purposes. An Approved Provider is needed for all domestic violence offender treatment group and individual sessions. Group sessions must be at least 90 minutes long and contain a maximum of 12 clients. If co-facilitators are used, group sessions can have up to 16 clients. Treatment group programs must be specific to gender and sexual orientation. This means separate groups for heterosexual females, heterosexual males, homosexual females, and homosexual males. For individuals who are transgender or don't identify with these options, group placement is based on what would be most beneficial for the client.

The *Standards and Guidelines* state that ***in-person therapy is the preferred and expected modality for treating domestic violence offenders***. However, Approved Providers with specific telehealth approval can use teletherapy when it is suitable for meeting a client's needs. Teletherapy was allowed by the DVOMB as a treatment modality on March 13th, 2020, in response to the COVID-19 pandemic to limit disruption to the evaluation and treatment of domestic violence offenders that threatened undue risk to victim and community safety. Before this date, all teletherapy was prohibited, and treatment had to be in person.

The *Standards and Guidelines* for treating domestic violence offenders now allow teletherapy as an ongoing option as the field transitions to a post-pandemic normal. Appendix I: Requirements and Criteria for Teletherapy With Domestic Violence Offenders of the *Standards and Guidelines* came into effect on September 30th, 2022, formalizing the current requirements for teletherapy use. It outlines practical, clinical, and safety-related guidelines that should be followed. The implementation of these guidelines has been supported by regular training and technical assistance provided by the DVOMB.

As stated in *Appendix I*,

> "*The provision of services via teletherapy is considered to be a privilege that is intended to promote risk-reduction strategies and engagement in the therapeutic process for the client. If the use of teletherapy presents any unresolved concern(s) related to the safety of a victim, the client's compliance with the treatment contract, or their overall amenability, the Approved Provider shall document such reasons and determine if face-to-face services are more appropriate. Offenders may be subject to additional monitoring as a result of being allowed to engage in domestic violence offender treatment via teletherapy*".

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Literature Review: Telemental Health Therapy Effectiveness

The use of teletherapy for mental and behavioral health treatments has rapidly advanced since the pandemic. However, there is still a lack of understanding regarding how effective teletherapy is for *offense-specific* treatments. Few studies on this topic exist, and the ones that do focus on telemental health for crisis intervention and psychiatric consultations in correctional facilities (Batastini et al., 2020, 2021). It is important to note the differences between mental health and offense-related treatments when trying to apply the findings from one type of treatment to the other. Unlike in mental health settings, offense-related treatments are usually mandated, take place in a group setting, are delivered over longer periods of time, and prioritize victim safety. Additionally, individuals involved in the justice system often enter treatment with multiple criminogenic needs and responsivity factors that significantly impact treatment engagement. Therefore, while findings from mental health teletherapy research provide some relevant information, they do not directly apply to offense-specific treatment.

A literature review found five recent meta-analyses that examined teletherapy for mental health symptoms, which are summarized in **Appendix A**. Meta-analyses combine results from multiple studies to show an overall finding. The meta-analyses indicated teletherapy was as effective as in-person treatments in improving *mental health* symptoms, with the strongest evidence for cognitive-behavioral treatments of anxiety, depression, and post-traumatic stress disorder (Bastatini et al., 2021; Fernandez et al., 2021; Lin et al., 2022). The meta-analyses also explored how different client and program factors might affect the strength of treatment effects. They found that female clients responded better to teletherapy than male clients (Bastatini et al., 2021), therapeutic alliance was weaker in teletherapy compared to in-person therapy (Norwood et al., 2018), and trainee therapists had a higher attrition rate in teletherapy compared to fully licensed therapists (Lin et al., 2021).

Research Project: DVOMB Teletherapy Client Data

Starting January 1, 2023, Approved Providers began submitting information about domestic violence offender treatment provided to clients subject to the *Standards and Guidelines*.[3]

The DVOMB Application Review Committee posed four questions about teletherapy for domestic violence offender treatment to address using this data, namely:

1. Are there any differences between treatment placement levels for those receiving teletherapy and in-person therapy?
2. Are there any differences in discharge outcomes for those receiving teletherapy by treatment level?

[3] The data collection is statutorily required under §16-11.8-103(4)(a)(IV), C.R.S. and require that Providers submit information at the time of service completion, regardless of the outcome of the service. Providers submit data through either the DVOMB PDMS, which is maintained by the Colorado Department of Public Safety, or the ReliaTrax record system, which is an electronic health record system operated by a private company that is used by a majority of DVOMB Providers.

3. Are there any differences between the length of stay for those receiving teletherapy and in-person therapy?

4. Are there any distinguishing risk factors from the DVRNA that suggest the client is unsuitable for teletherapy, and are there any specific factors related to early discharge while using teletherapy?

A series of analyses was undertaken to address each research question, using various statistical methods to determine the significance of the results. However, the policy brief presents the main findings without detailing specific statistical tests or analyses.

Data Sample

Data available for the analyses were 1,448 client records entered in the DVOMB PDMS and Reliatrax data record systems between January 1, 2023, and January 23, 2024.[4] Each record contained information about a completed domestic violence offender treatment episode, irrespective of the type of discharge. Each record included the treatment modalities used with the client during the course of the domestic violence treatment. The options were:

- In-Person Group Treatment
- In-Person Individual Treatment
- Teletherapy Group Treatment
- Teletherapy Individual Treatment
- Teletherapy for Medical or Weather-Related Emergencies

Each record had one to five treatment modalities chosen, representing the combinations used with the client. As the data requirements did not include the number of treatment sessions per modality, there was no means to determine if one was primary when multiple were indicated. However, analysis showed the majority of clients received either teletherapy or in-person group treatment only (74%) or received a combination of group and individual treatment within the same modality (14%).[5]

Figure 1 shows the proportion of clients who received treatment in teletherapy only, in-person only, or mixed modalities.

Of the clients who received teletherapy only:

- 37% received teletherapy group treatment only
- 7% received a combination of teletherapy group and teletherapy individual treatment
- 1% received teletherapy individual treatment only.

Of the clients who received in-person treatment only:

[4] 20 additional client records were removed from the dataset as they had missing treatment modality information.

[5] Very few clients received teletherapy for medicinal or weather-related emergencies.

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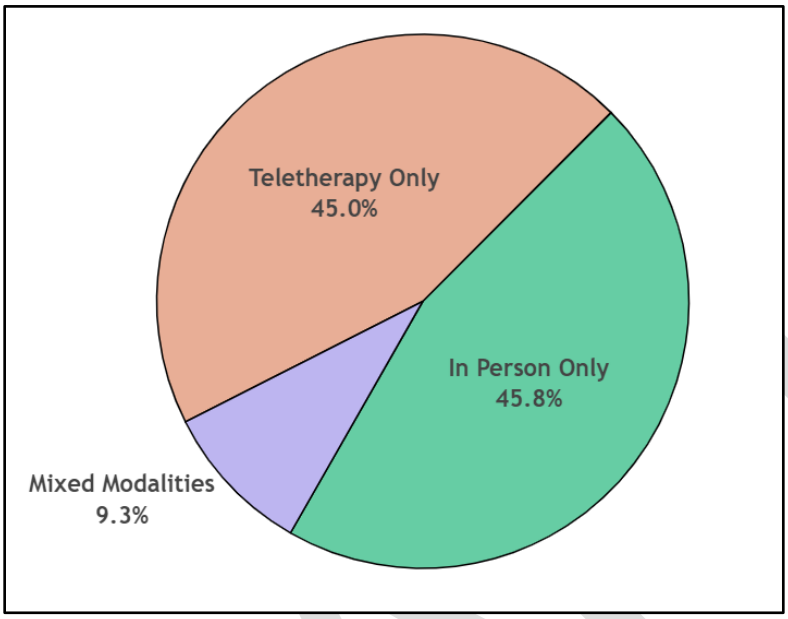
- 37% received in-person group only
- 7% received a combination of in-person group and in-person individual treatment
- 2% received in-person individual treatment only.

Figure 1. Treatment Modality Combinations (n = 1,448). See Appendix B1 for the data table.



Q1. Are there any differences between treatment placement levels for those receiving teletherapy and in-person therapy?

Clients are assigned a risk level using evaluation with the Domestic Violence Risk Need Assessment (DVRNA) to determine their treatment placement level. The treatment placement levels are categorized as A, B, and C, corresponding to low-risk, moderate-risk, and high-risk. The treatment placement level determines the extent of treatment contact, required components, and general duration of treatment. The intensity of required treatment increases with higher client risk.

Figure 2 displays the number and percentage of clients in each treatment level who received either in-person, teletherapy, or mixed treatment modalities. More clients in Level A and Level B received teletherapy only than in-person only treatment. In contrast, more clients in Level C received in-person treatment than teletherapy treatment. This suggests that client risk level influenced whether they were offered teletherapy or in-person treatment modalities.

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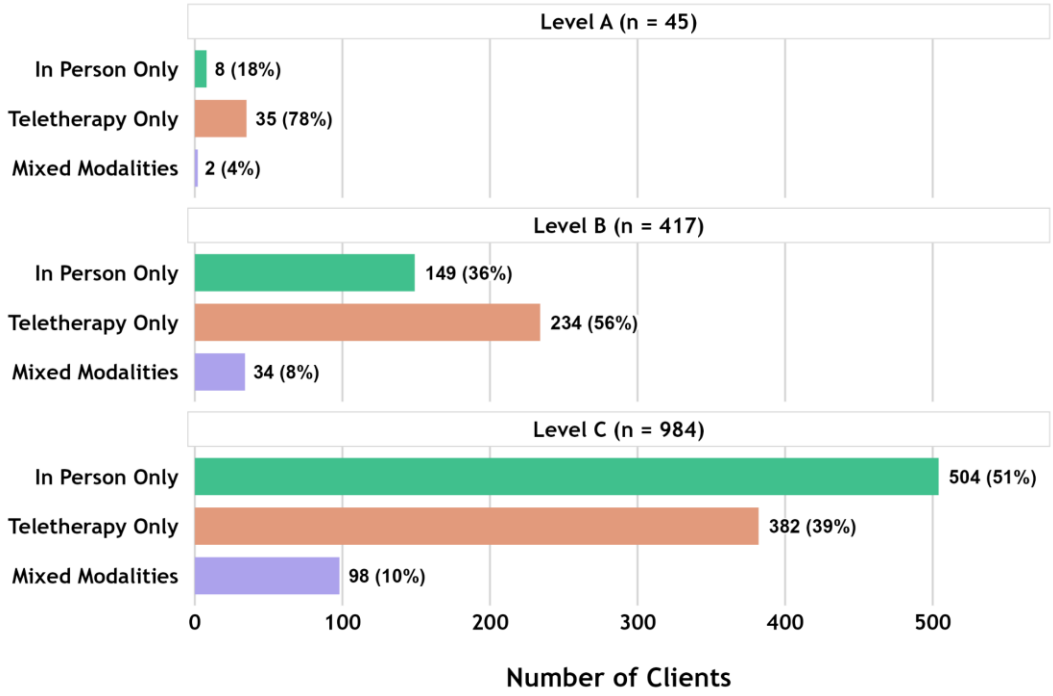
Figure 2. Distribution of Treatment Modalities by Treatment Level Placed. See Appendix B2 for the data table.



Q2. Are there any differences in discharge outcomes for those receiving teletherapy by treatment level?

The *Standards and Guidelines* have three treatment discharge types: completed treatment, unsuccessful, and administrative. A completed treatment discharge is when the client has successfully completed their treatment plan. An unsuccessful discharge is when the client has not met all required treatment plan reviews or the competencies and conditions in the treatment plan.[6] An administrative discharge is when the client ends treatment because of valid issues that interfere with treatment completion, such as medical issues or relocation.

Figure 3 displays the different types of discharge based on the treatment modality received. Clients who had in-person only treatment had fewer completed discharges and more unsuccessful or administrative discharges compared to clients who received teletherapy only or mixed modalities. However, it is important to consider client risk levels when interpreting this finding.

Figure 4 further breaks down the data based on treatment (risk) level. It shows that the lower completion rate for in-person only treatment was largely due to a higher proportion of high-risk clients receiving this treatment modality.

[6] This occurs when clients consistently fail to participate in treatment or progress, are significantly disruptive in sessions, have excessive absences, violate sentencing conditions, re-offend, or breach other aspects of the treatment contract.

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Figure 3. Distribution of Treatment Modalities by Discharge Type. See Appendix B3 for the data table.

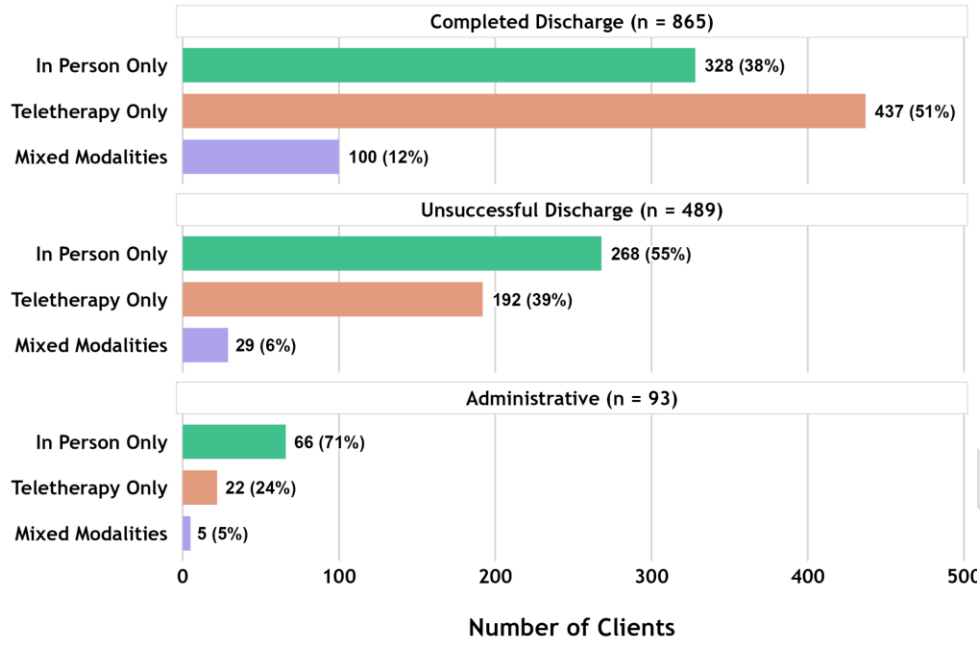
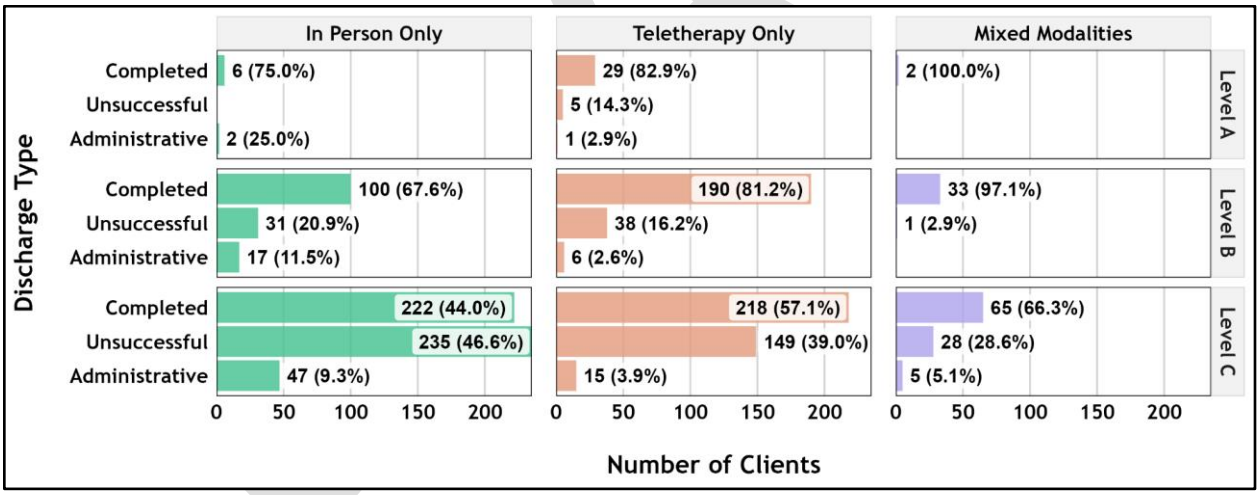


Figure 4. Discharge Outcome by Treatment Modalities and Risk Level. See Appendix B4 for the data table.



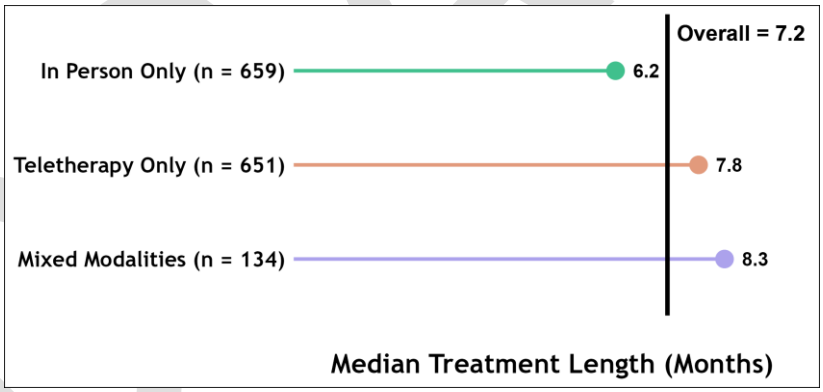
In **Appendix C**, we provide an additional analysis that examines discharge outcomes for different combinations of group and individual treatments. It demonstrates that a combined approach of group and individual treatment, whether in-person or through teletherapy, had a higher percentage of completed discharges than group treatment alone for Level C clients.

Q3. Are there any differences between the length of stay for those receiving teletherapy and in-person therapy?

The length of time clients spend in treatment is determined by their level of risk and the type of treatment they require. Each treatment level has specific requirements that must be achieved before the treatment is finished. As a result, clients with lower risk levels typically have shorter treatment periods, while higher-risk clients may have longer treatment durations. However, since clients have personalized treatment plans and progress at different rates, each treatment level has no fixed length.

Figure 5 displays the median length of treatment for treatment modalities.[7] Clients who had teletherapy only or mixed modalities spent more time in treatment compared to clients who received in-person only treatment. **Figure 6** provides a more detailed analysis based on treatment (risk) level and discharge type. It shows that Level B and C clients who completed treatment had similar median treatment lengths regardless of the treatment modality. However, Level A clients took more than double the time to complete teletherapy treatment compared to in-person treatment. For clients who were unsuccessful or administratively discharged, the median treatment length was substantially shorter for all treatment modalities except for Level C clients in the mixed modalities.

Figure 5. Median Treatment Length by Modality Type. See Appendix B5 for the data table.



[7] A *median* reflects the mid-point or 50th percentile for all members of the group.

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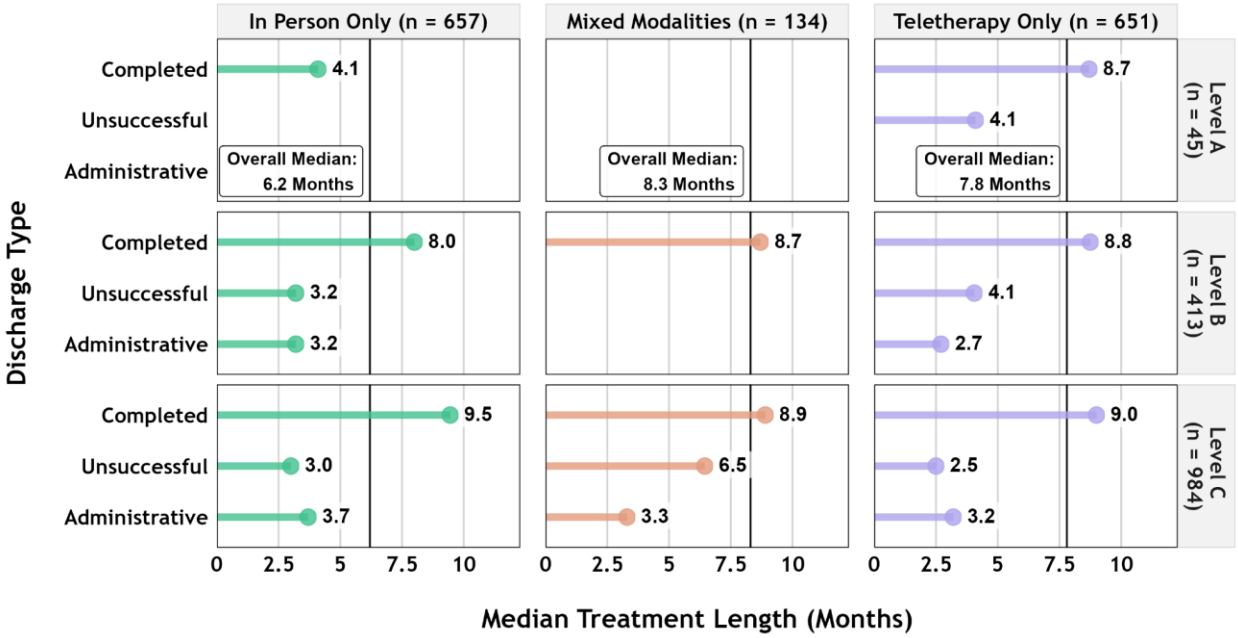
Figure 6. Median Treatment Length by Modality Type, Treatment Level, and Discharge Type. See Appendix B6 for the data table.



Q4. Are there any distinguishing risk factors from the DVRNA that suggest the client is unsuitable for teletherapy, and are there any specific factors related to early discharge while using teletherapy?

The Domestic Violence Risk and Need Assessment (DVRNA) instrument includes 14 risk areas and 46 individual risk factors. It is completed during evaluations and included in the data record.

Statistical modeling was used to examine the risk factors associated with unsuccessful discharge from teletherapy. The final model identified several key factors, as detailed in **Table 1**. The odds ratio statistic shows the likelihood of an unsuccessful discharge compared to a completed discharge when that factor is present.[8] Overall, the factors in the model explained 21.2% of the difference between unsuccessful and completed discharges. The results indicate that higher risk, more severe antisocial and criminal behaviors and attitudes, acute mental health needs, and limited high school education increase the likelihood of unsuccessful discharge from teletherapy.

Additional modeling examined the risk factors associated with early discharge from teletherapy within the first 3 months of treatment.[9] The results identified that clients with a history of violating the conditions of their release and those with implicit attitudes supporting domestic violence fared worse in teletherapy only and were at greater risk of early unsuccessful discharge.

[8] For instance, an odds ratio of 2.0 means there is twice the likelihood of an unsuccessful discharge when that factor is present rather than absent.

[9] Early unsuccessful discharge was defined as unsuccessful discharge within the first 3 months of teletherapy, as this was the median time by which 50% of clients had ended contact.

Table 1. Prediction of Unsuccessful and Early Discharge from Teletherapy Only.

Factor (DVRNA Item)	Odds Ratio	Odds Ratio Effect Size Interpretation
Risk Level C	2.107	small-medium
Substance abuse/dependence (B1)	1.624	small
Illegal drug use (DVRNA B3)	2.931	medium
In need of mental health evaluation (C7)	2.353	medium
On supervision when offended (F1)	1.619	small
Prior non-DV violence convictions (F3)	1.561	small
Explicit domestic violence attitudes (J1)	3.996	large
Age (younger)	.977	small
Less than a high school diploma	3.050	medium-large

Summary

- Research indicates teletherapy is effective for treating various *mental health* conditions, but there is a lack of understanding about its effectiveness for offense-specific treatments, including for domestic violence offender treatment.
- Among clients who were discharged from treatment in 2023 (N=1,448), 46% had in-person-only treatment, 45% had teletherapy-only, and 9% received a mixture.
- Teletherapy treatment was used more often with clients in Levels A and B than Level C treatment (risk) placement. The opposite was true for in-person treatment, which suggests risk was a factor in deciding treatment modalities.
- Teletherapy treatment was associated with more completed and fewer unsuccessful discharges than in-person treatment. However, this was largely due to a higher proportion of high-risk clients receiving in-person treatment. Additional analysis found a combined approach of group and individual treatment, whether in-person or through teletherapy, had a higher percentage of completed discharges for Level C clients than group treatment alone. A possible reason is that these options foster a better therapeutic relationship between the therapist and the client, resulting in greater engagement.
- The median length of treatment was 6.2 months for in-person treatment and 7.8 months for teletherapy treatment. For mixed modalities, it was 8.3 months. However, this was because Level A clients took longer to complete teletherapy than in-person treatment

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and Level B clients spent longer in mixed modalities before unsuccessful discharge. Level B and C clients who completed treatment had similar treatment lengths regardless of modality.

- Statistical modeling identified that clients with Level C risk, more severe antisocial and criminal behaviors and attitudes, acute mental health needs, and limited success with high school fare worse in teletherapy only modality and are more likely to be unsuccessfully discharged from teletherapy. Additional analysis found that a history of violating the conditions of release and implicit attitudes supporting domestic violence were associated with unsuccessful discharge within the first 3 months of treatment.

Draft Recommendations

- Clients receiving teletherapy also have some face-to-face or individual teletherapy contact, particularly during the first 3 months of the treatment contract and when a Level C client.
- Teletherapy should not be the first choice of treatment modality for clients who are Level C and exhibit more severe antisocial and criminal behaviors on the DVRNA, have acute mental health issues, or have less than a high school diploma (see Table 1). Teletherapy may be an option after the client establishes a therapeutic relationship in treatment, has stable mental health, and shows progress toward treatment goals.
- Appendix I of the *Standards and Guidelines* be updated to highlight the (i) benefit of using combined modalities rather than one teletherapy modality only and (ii) the particular need to attend to client engagement during the initial stages of teletherapy treatment contact.
- Appendix I of the Standards and Guidelines be updated to emphasize that following the teletherapy guidelines will be part of compliance audits.
- The Application Review Committee discusses incorporating some of the teletherapy guidelines in Appendix I more explicitly in sections of the Standards.

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Appendix A. Summary of Meta-analyses of Teletherapy Treatment Effectiveness

Publications	Study Design	Treatment Features	Main Results
Fernandez et al. (2021). Live psychotherapy by video versus in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment. *Clinical Psychology & Psychotherapy, 28*, 1535-1549.	One meta-analysis examined the effectiveness of video-delivered teletherapy for a mental health condition (56 studies; 1,681 participants). A second meta-analysis compared the effectiveness of teletherapy to in-person therapy for a mental health condition (47 studies; 3,564 participants). 68 unique published studies across the two separate meta-analyses.	The treatments addressed a broad range of conditions, including ADHD, anxiety, depression, eating disorders, OCD, PTSD, pain, psychiatric disorders, psychological distress, and stuttering. The treatments included cognitive-behavioral and other approaches (e.g., relational, short-term psychodynamic, family-based).	Receiving teletherapy was associated with a large treatment benefit; clients reported a significant improvement in symptoms between the start and end of teletherapy. Receiving teletherapy was more effective than being on a waiting list. Teletherapy was similar in effectiveness to in-person psychotherapy. It was not better or worse at improving the symptoms of the primary condition.
Lin et al. (2022). The efficacy of synchronous teletherapy versus in-person therapy: A meta-analysis of randomized controlled trials. *Clinical Psychology: Science and Practice, 29*(2), 167-178.	Meta-analysis comparing the effectiveness of teletherapy to in-person therapy for a mental health condition using randomized control studies only (17 studies; 2,004 total participants). Participants were randomly assigned to receive either teletherapy or in-person treatment. In each study, the teletherapy and in-person psychotherapy followed the same treatment protocol.	The teletherapy treatments included telephone-administered or video-delivered live interactive treatment. The treatments addressed a range of conditions, including anxiety, depression, eating disorders, PTSD, insomnia, and pathological gambling. The treatments were different types of cognitive-behavioral treatments.	Receiving teletherapy was associated with a large benefit. Teletherapy had a similar effectiveness to in-person psychotherapy that remained at 3- to 6-month follow-up. Telephone and video-conferencing teletherapy were equally effective. The attrition rate was greater for video teletherapy than for telephone teletherapy and trainee therapists compared with licensed therapists.

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Publications	Study Design	Treatment Features	Main Results
Bastatini et al. (2021). Are videoconferenced mental and behavioral health services just as good as in-person? A meta-analysis of a fast-growing practice. *Clinical Psychology Review,* 101944.	One meta-analysis compared the effectiveness of teletherapy to in-person therapy for mental health conditions (43 studies; 4,336 participants). The meta-analysis examined the influence of a range of potential factors that may have moderated the effectiveness of treatments. A second meta-analysis examined the reliability of assessments conducted via video compared to in-person (14 studies; 332 participants).	The treatments addressed a range of conditions, including depressive or mood disorder, trauma, anxiety-related, OCD, schizophrenia spectrum and other psychotic disorders, neurocognitive disorders, and disruptive, impulse control, and conduct disorders. The treatments were different types of cognitive-behavioral treatments.	Teletherapy was similar in effectiveness to in-person psychotherapy. It was not better or worse at improving the symptoms of the primary condition. Client gender moderated the degree of treatment effectiveness. Female clients responded more favorably to teletherapy than in-person treatment, while male clients tended to respond more favorably to in-person treatment than teletherapy. Teletherapy and in-person assessments did not appear to lead to different diagnostic decisions.
Bastatini et al. (2016). Telepsychological services with criminal justice and substance abuse clients: A systematic review and meta-analysis. *Psychological Services, 13*(1), 20-30.	A meta-analysis comparing the effectiveness of teletherapy to in-person therapy for justice-involved individuals or substance-abuse treatment-seeking individuals (5 studies, 342 total participants). The studies were a mix of randomized control or matched evaluations.	The 2 substance abuse evaluations involved comparing group treatments, while the 3 justice-involved evaluations were of crisis intervention, psychiatric assessment, and psychotropic medication consultations.	Teletherapy had similar effectiveness to receiving in-person psychotherapy for mental health symptom reduction, rating of therapeutic processes, program attendance, and service satisfaction. The review of studies highlighted the lack of systematic empirical evaluation of teletherapy upon which to form conclusions for justice-involved populations.

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Publications	Study Design	Treatment Features	Main Results
Norwood et al. (2018). Working alliance and outcome effectiveness in videoconferencing psychotherapy: A systematic review and noninferiority meta-analysis. *Clinical Psychology & Psychotherapy, 25*, 797–808.	Descriptive discussion of studies that compared the degree of therapeutic working alliance obtained for teletherapy (12 studies). Meta-analysis comparing the degree of a therapeutic working alliance between teletherapy and in-person therapy (4 studies, 246 participants)	The treatments addressed a range of conditions, including depressive or mood disorders, trauma, anxiety-related disorders, OCD, and eating disorders. The treatments were cognitive-behavioral interventions, ranging from 1 to 25 sessions.	Teletherapy delivery was associated with lower working alliance compared to in-person delivery. Target symptom reduction was similar between teletherapy and in-person delivery.

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Appendix B. Data Tables

B1. Treatment Modality Combinations (n = 1,448)

Treatment Modality	Number of Cases	Percent (%)
Teletherapy Only	651	45.0%
In Person Only	663	45.8%
Mixed Modalities	134	9.3%

B2. Distribution of Treatment Modalities by Treatment Level Placed (n = 1,446)

Treatment Modality	Level A (n = 45)	Level B (n = 417)	Level C (n = 984)
In Person Only	8 (18%)	149 (36%)	504 (51%)
Teletherapy Only	35 (78%)	234 (56%)	382 (39%)
Mixed Modalities	2 (4%)	34 (8%)	98 (10%)

B3. Distribution of Treatment Modalities by Discharge Type (n = 1,447)

Treatment Modality	Completed Discharge (n = 856)	Unsuccessful Discharge (n = 489)	Administrative Discharge (n = 93)
In Person Only	328 (38%)	268 (55%)	66 (71%)
Teletherapy Only	437 (51%)	192 (39%)	22 (24%)
Mixed Modalities	100 (12%)	29 (5%)	5 (5%)

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B4. Discharge Outcome by Treatment Modalities and Risk Level (n = 1,445)

Level A (n = 45)

Treatment Modality	Number of Completed Discharges	Number of Unsuccessful Discharges	Number of Administrative Discharges	Total Number of Cases (%)
Mixed Modalities	2	0	0	2 (4.4%)
Teletherapy Only	29	5	1	35 (77.8%)
In Person Only	6	0	2	8 (17.8%)

Level B (n = 416)

Treatment Modality	Number of Completed Discharges	Number of Unsuccessful Discharges	Number of Administrative Discharges	Total Number of Cases (%)
Mixed Modalities	33	1	0	34 (8.2%)
Teletherapy Only	190	38	6	234 (56.2%)
In Person Only	100	31	17	148 (35.6%)

Level C (n = 984)

Treatment Modality	Number of Completed Discharges	Number of Unsuccessful Discharges	Number of Administrative Discharges	Total Number of Cases (%)
Mixed Modalities	65	28	5	98 (10.0%)
Teletherapy Only	218	149	15	382 (38.8%)
In Person Only	222	235	47	504 (51.2%)

B5. Median Treatment Length by Modality Type (n = 1,444)

Treatment Modality	Median Treatment Length (months)
In Person Only (n = 659)	6.2
Teletherapy Only (n = 651)	7.8
Mixed Modalities (n = 134)	8.3
Overall Median	**7.2**

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B6. Median Treatment Length by Modality Type, Treatment Level, and Discharge Type (n = 1,442)

Level A (n = 45)

Modality Type	Completed Discharge Median Treatment Length (months)	Unsuccessful Discharge Median Treatment Length (months)	Administrative Discharge Median Treatment Length (months)
In Person Only	4.1	*	*
Mixed Modalities	*	*	*
Teletherapy Only	8.7	4.1	*

*Data suppressed due to small sample size

Level B (n = 413)

Modality Type	Completed Discharge Median Treatment Length (months)	Unsuccessful Discharge Median Treatment Length (months)	Administrative Discharge Median Treatment Length (months)
In Person Only	8.0	3.2	3.2
Mixed Modalities	8.7	*	*
Teletherapy Only	8.8	4.1	2.7

*Data suppressed due to small sample size

Level C (n = 984)

Modality Type	Completed Discharge Median Treatment Length (months)	Unsuccessful Discharge Median Treatment Length (months)	Administrative Discharge Median Treatment Length (months)
In Person Only	9.5	3.0	3.7
Mixed Modalities	8.9	6.5	3.3
Teletherapy Only	9.0	2.5	3.2

*Data suppressed due to small sample size

Overall (N = 1442)

Modality Type	Median Treatment Length (months)
In Person Only (n = 657)	6.2
Mixed Modalities (n = 134)	8.3
Teletherapy Only (n = 651)	7.8

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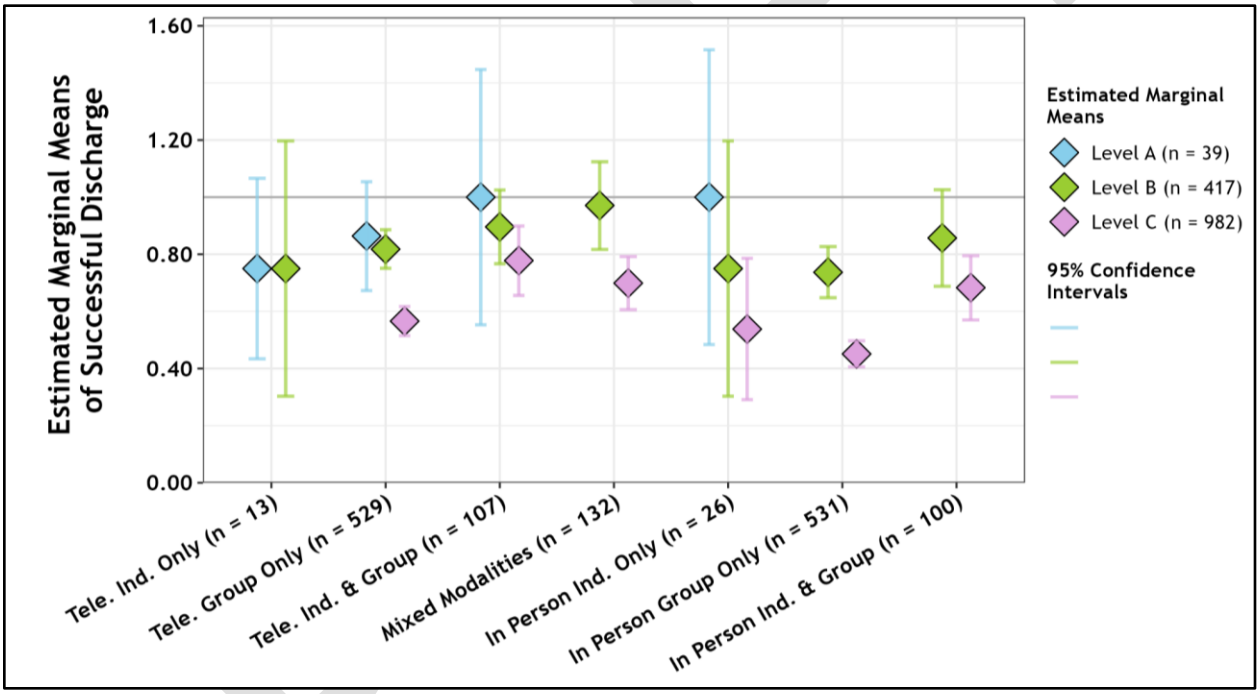
Appendix C. Analysis of Successful Discharges by Combinations of Group and Individual Treatment Modalities Across Risk Levels (A, B, C).

Figure C1 displays the successful discharge rate for clients who received different combinations of in-person and teletherapy group and individual treatment based on their risk level. The average (mean) successful discharge rate for each type of treatment is shown using colored diamonds, with different colors for each risk level. The bars extending above and below each average are the 95% confidence range for that value and can be used to determine if differences in the average values for categories are significantly different from each other ($p<.05$).[10] Further below, risk levels A, B, and C are shown separately in individuals figures to simplify comparisons within each risk level (see Figures C2, C3, and C4).

Figure C1. Estimated Marginal Means and 95% Confidence Intervals of Successful Discharge by Treatment (Risk) Level and Modality. See below for the data table.



***Note: Inestimable means and means for groups with a sample size less than three are excluded from this visualization.**

[10] Confidence intervals indicate the range within which the "true" value is likely to fall. These vary depending on the spread of scores within each category and the number of clients in each category. Where the confidence interval ranges overlap between two categories, the difference between the averages (means) does not reach statistical significance ($p<.05$). Where the confidence interval ranges do not overlap between categories, the difference between the averages are statistically significant and we have confidence that these reflect true differences in successful discharge rates ($p<.05$).

Key findings from this additional level of analysis are:

- The rate of successful discharges for **Level C** clients was greater for a combined group and individual approach, whether in-person or through teletherapy, than for group treatment alone.
- The rate of successful discharge for **Level A and B** clients was similar across the treatment combinations they received.
- **Level A** clients received individual and group treatments through teletherapy, but only individual treatments in person. Providers may have chosen not to mix low-risk clients with higher-risk clients in person to align with the principles of effective intervention. However, providers may have viewed virtual environments as less problematic.

Figure C2. Estimated Marginal Means and 95% Confidence Intervals of Successful Discharge by Treatment (Risk) Level A and Modality. See below for the data table C5.

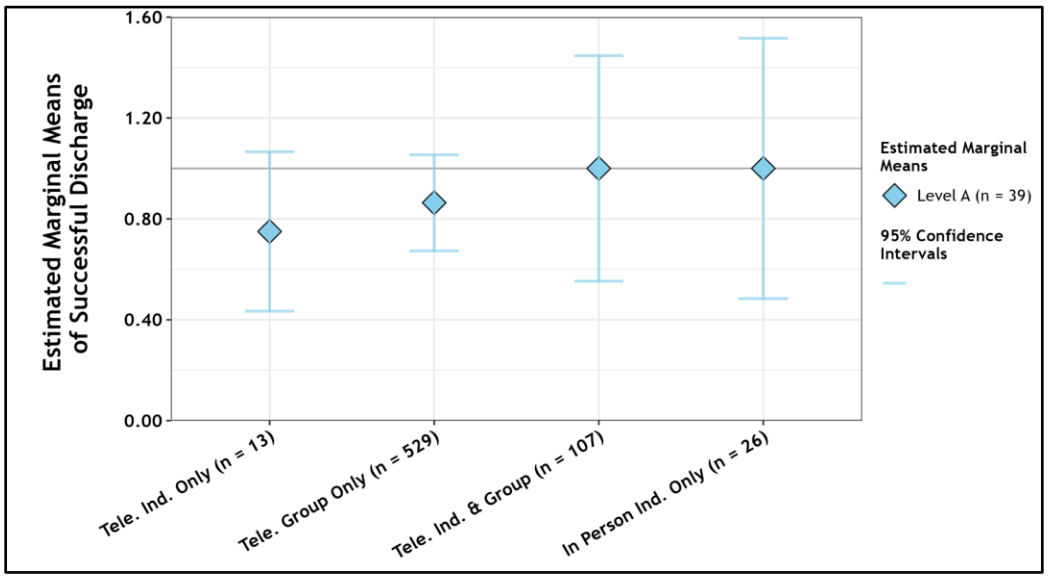


Figure C3. Estimated Marginal Means and 95% Confidence Intervals of Successful Discharge by Treatment (Risk) Level B and Modality. See below for the data table C6.

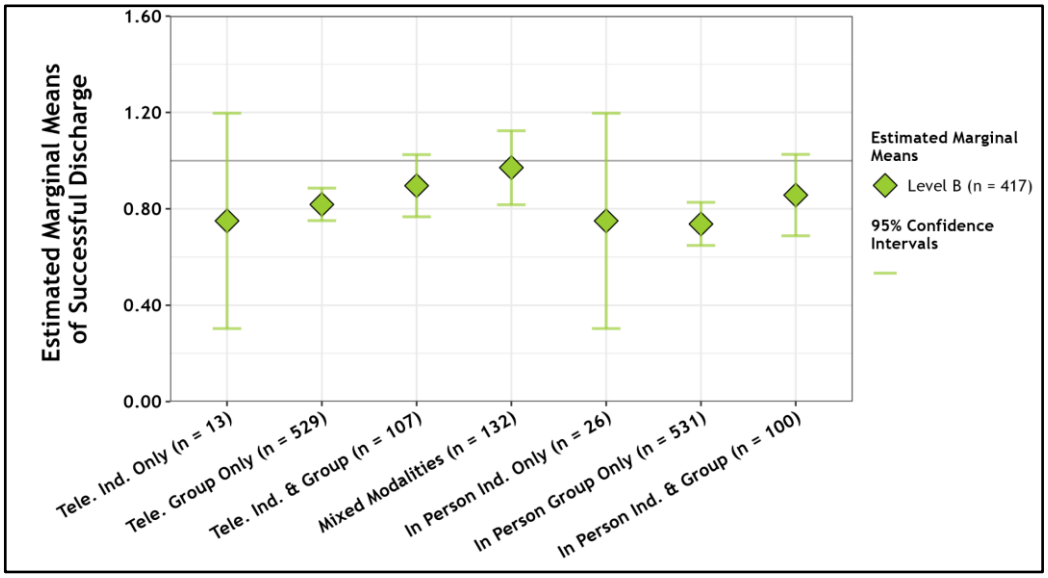
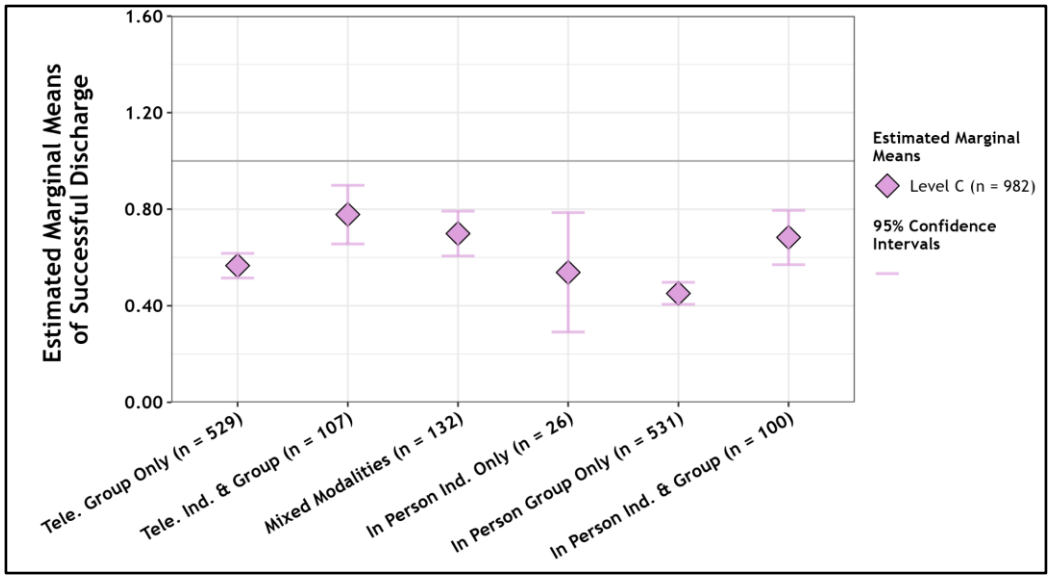


Figure C4. Estimated Marginal Means and 95% Confidence Intervals of Successful Discharge by Treatment (Risk) Level C and Modality. See below for the data table.C7



C5. Level A (n = 39) Data Table

Treatment Modality	Number of Clients	Estimated Marginal Mean	95% CI Lower Bound	95% CI Upper Bound
Teletherapy Individual Therapy Only	9	0.750	0.434	1.066
Teletherapy Group Therapy Only	22	0.864	0.673	1.054
Teletherapy Individual and Group Therapy	4	1.000	0.553	1.447
Mixed Modalities (Teletherapy and In Person Therapy)	*	*	*	*
In Person Individual Therapy Only	4	1.000	0.484	1.516
In Person Group Therapy Only	*	*	*	*
In Person Individual and Group Therapy	*	*	*	*

*Data suppressed due to small sample size

C6. Level B (n = 417) Data Table

Treatment Modality	Number of Clients	Estimated Marginal Mean	95% CI Lower Bound	95% CI Upper Bound
Teletherapy Individual Therapy Only	4	0.750	0.303	1.197
Teletherapy Group Therapy Only	182	0.818	0.751	0.886
Teletherapy Individual and Group Therapy	48	0.896	0.767	1.025
Mixed Modalities (Teletherapy and In Person Therapy)	34	0.971	0.817	1.124
In Person Individual Therapy Only	5	0.750	0.303	1.197
In Person Group Therapy Only	112	0.737	0.648	0.827
In Person Individual and Group Therapy	32	0.857	0.688	1.026

C7. Level C (n = 982) Data Table

Treatment Modality	Number of Clients	Estimated Marginal Mean	95% CI Lower Bound	95% CI Upper Bound
Teletherapy Individual Therapy Only	*	*	*	*
Teletherapy Group Therapy Only	325	0.566	0.515	0.617
Teletherapy Individual and Group Therapy	55	0.778	0.656	0.899
Mixed Modalities (Teletherapy and In Person Therapy)	98	0.699	0.606	0.792
In Person Individual Therapy Only	17	0.538	0.291	0.786
In Person Group Therapy Only	419	0.451	0.406	0.497
In Person Individual and Group Therapy	68	0.683	0.570	0.795

*Data suppressed due to small sample size

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