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A Review of State Standards for Batterer Intervention Treatment Programs and the Colorado Model

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Many states aiming to improve domestic-violence-offender treatment have passed legislative standards for Batterer Intervention Treatment (BIT). This article reviews existing literature in relation to state standards for BIT in general and Colorado's unique model for BIT specifically. In addition, existing research focused on the Colorado model's adherence to evidence-based practices and principles is discussed, and ongoing research that examines the relationship between the novel elements of the Colorado model and BIT completion and recidivism is explained.

STATE STANDARDS FOR DOMESTIC-VIOLENCE-OFFENDER TREATMENT

There were few legal remedies available to victims of domestic violence before the 1970s.[1] Until that time, law-enforcement culture actively discouraged officers from inserting the law into private family matters.[2] In fact, law-enforcement training manuals explicitly indicated that arrest should be used as a last resort in cases of domestic violence.[3] Police officers' responses to domestic disputes often took the form of crisis mediation and encouragement to use informal resources, such as the extended family or the church. However, the 1980s saw a proliferation of mandatory arrest laws for domestic violence, which resulted in a corresponding surge in the arrest of "domestic-violence offenders" ("DV offenders") and the addition of these offenders to judicial dockets. Given the complicated nature of domestic violence (*e.g.*, complexities around offender/victim cohabitation and co-parenting, hesitance in victim cooperation, desire to preserve the family unit), judges, in general, were reluctant to sentence these offenders to jail; instead, courts began to seek avenues for rehabilitation through newly developed Batterer Intervention Treatment programs.[4] Although BIT programs were initially developed in the image of other types of treatment programs such as those focused on substance-abuse or mental-health problems,[5] it was realized that the treatment of domestic violence required a unique approach that recognized the complicated dynamics involved in domestic violence.

Today, the vast majority of convicted domestic-violence offenders are sentenced to complete BIT programs, with estimates indicating that upwards of 2.5 million American men attend BIT programs annually.[6] Given the increase in offenders attending BIT programs, the majority of U.S. states and the District of Columbia have adopted some form of official written standards to regulate BIT-program practices.[7] The purpose of establishing standards for BIT practices was to promote uniform modalities across programs and to prevent the use of strategies deemed harmful or controversial in cases of domestic violence, such as couples counseling or anger management.[8]

State standards often stipulate the minimum length of time offenders must attend a BIT program: statutes typically indicate that treatment must be "a minimum of XX weeks." For example, in most states, standards specify that BIT programs must be at least 24-26 weeks in length.[9] However, the minimum length of treatment varies widely, from 16 weeks in Alabama to 52 weeks in California. Furthermore, it has become common in nearly all states for judges to order offenders to the maximum number of weeks in treatment.[10] Thus, BIT programs have inherently become part of a "time-driven model" where all DV offenders in a state receive the same "one size fits all" treatment.

Footnotes

1. Raymond I. Parnas, *The Police Response to the Domestic Disturbance*, Wis. L. Rev. 914 (1967).
2. Jeffrey Fagan, The Criminalization of Domestic Violence, Promises and Limits, National Institute of Justice Research Report (1996).
3. International Association of Chiefs of Police, Training Key 16: Handling Disturbance Calls (1967).
4. Ellen Pence, *Batterer Programs: Shifting from Community Collusion to Community Confrontation*, *in* Violence Against Women: Classic Papers 388 (Raquel Kennedy Bergen, Jeffrey L. Edelson & Claire M. Renzetti eds., 1989).
5. *Id.*
6. Ashley L. Boal & Eric S. Mankowski, *Barriers to Compliance with Oregon Batterer Intervention Program Standards*, 29 Violence & Victims 607 (2014).
7. Roland D. Maiuro & Jane A. Eberle, *State Standards for Domestic Violence Perpetrator Treatment: Current Status, Trends, and Recommendations*, 23 Violence & Victims 133 (2008).
8. Michele Bograd & Fernando Mederos, *Battering and Couples Therapy: Universal Screening and Selection of Treatment Modality*, 25 J. Marital & Fam. Therapy 291 (1999); Robert A. Geffner & Alan Rosenbaum, *Domestic Violence Offenders*, 5 J. Aggression, Maltreatment & Trauma 1 (2001).
9. Juliet B. Austin & Juergen Dankwort, *Standards for Batterer Programs: A Review and Analysis*, 14 J. Int'l Violence 152 (1999).
10. Domestic Violence Offender Treatment Programs, compiled by the Arizona Supreme Court and the National Council of Juvenile and Family Court Judges (2015) (on file with authors).

Further, while nearly all states with BIT standards have delegated the oversight responsibility for BIT programming to a government agency, these bodies vary tremendously from state to state. For example, according to the Oregon statute, the Attorney General established a Batterer Intervention Program Advisory Board that developed, and now oversees, the state BIT standards. In Georgia, the Commission on Family Violence and the Department of Corrections crafted the standards, which are administered by the Georgia Department of Corrections. And in Alabama, the state standards are the responsibility of "a coalition of agency members." States without standards or enforceable statutes to regulate BIT-program operations include Arkansas, New Jersey, New York, North Dakota, Pennsylvania, South Dakota, and Wisconsin.

COLORADO STANDARDS & MODEL OF DOMESTIC-VIOLENCE-OFFENDER TREATMENT

In Colorado, BIT has been mandated for domestic-violence offenders since 1987.[11] And in 2000, the Colorado Legislature created the Domestic Violence Offender Management Board (DVOMB),[12] with its oversight agency being the Department of Public Safety's Division of Criminal Justice, to implement and oversee Colorado's Standards.[13] Colorado's Standards mandate the process for approving treatment providers' eligibility to provide DV treatment, establish policies for oversight of providers delivering court-ordered treatment, and specify the acceptable modalities of treatment delivery and implementation, among other requirements.

One of the reasons Colorado maintains a reputation as one of the most progressive states in the U.S. with respect to domestic-violence policy[14] stems from its differentiated, non-time-driven approach to offender treatment. As previously mentioned, many states apply the *same* time-frame requirement for treatment to *all* DV offenders despite the accumulating evidence showing that DV offenders are a heterogeneous group of people with a correspondingly diverse set of treatment needs.[15] Further, empirical research suggests that when the intensity of treatment corresponds to offender risk for offenses in general, there is a greater possibility for reductions in recidivism.[16] Accordingly, the Colorado revised Standards recognize that treatment should vary by offenders' treatment needs and that needs can change during the treatment process, depending on the offender's progress.

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Until 2010, Colorado's Standards indicated that BIT-program participants must complete "up to 36 weeks of treatment" and were routinely sentenced by judges to this maximum allowable time in treatment.[17] However, when Colorado's DVOMB revised Colorado's Standards in 2010, changes included the introduction and statewide implementation of an empirically based risk assessment, the Domestic Violence Risk and Needs Assessment (DVRNA). The DVRNA informs decisions regarding each offender's BIT-program experience, including setting standards and milestones that offenders must reach that go beyond length of treatment, effectively ending the previous 36-week time-driven model. The implementation of the DVRNA in Colorado has drastically changed the administration of domestic-violence-offender treatment for offenders statewide.

DOMESTIC-VIOLENCE RISK AND NEEDS ASSESSMENT

The DVOMB used five risk-assessment instruments in its design of the DVRNA: the Level of Supervision Inventory (LSI VII),[18] the Spousal Assault Risk Assessment Guide (2nd edition),[19] the Domestic Violence Screening Instrument (DVSI),[20] the Ontario Domestic Assault Risk Assessment (ODARA),[21] and the Danger Assessment Scale.[22] Fourteen empirically based static and dynamic risk-factor domains are included in

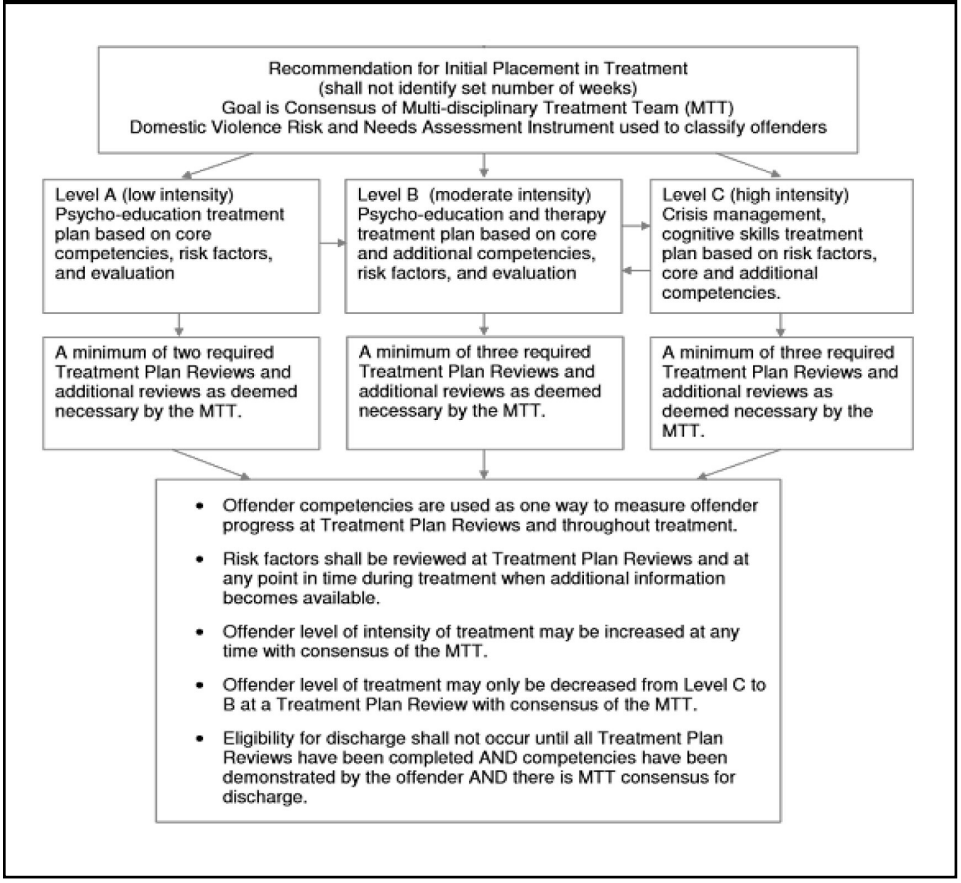
11. See Colo. Rev. Stats. § 18-6-803.
12. The DVOMB comprises 19 multidisciplinary members with seven appointing authorities: the Department of Corrections, the Department of Human Services, the Department of Regulatory Agencies, the Department of Public Safety, the Colorado District Attorneys Council, the Chief Justice, and the Colorado State Public Defender.
13. Colorado-specific standards are denoted with capitalization.
14. Angela R. Gover, *New Directions for Domestic Violence Offender Treatment Standards: Colorado's Innovative Approach to Differentiated Treatment*, 2 Partner Abuse 95 (2011).
15. Alex R. Piquero et al., *Assessing the Offending Activity of Criminal Domestic Violence Suspects: Offense Specialization, Escalation, and De-Escalation Evidence from the Spouse Assault Replication Program*, 4 Pub. Health Rep. 409 (2006); Tara N. Richards et al., *A Longitudinal Examination of Offending and Specialization Among a Sample of Massachusetts Domestic Violence Offenders*, 28 J. Interpersonal Violence 643 (2012); Tara N. Richards et al., *Survival Time and Predictors of Domestic and Non-domestic Violence Recidivism Among Domestic Violence Offenders: A Ten-Year Follow-Up*, 29 Violence & Victims 1 (2014).
16. Colorado Domestic Violence Offender Management Board, Standards for Treatment with Court Ordered Domestic Violence Offenders (2010).
17. Angela R. Gover, Tara Richards & Elizabeth A. Tomsich, Colorado's Innovative Response to Domestic Violence Offender Treatment: Current Achievements and Recommendations for the Future 1 (2015).
18. Don A. Andrews & James Bonta, The Level of Service Inventory–Revised (1995).
19. Randall P. Kropp & Stephen D. Hart, *The Spousal Assault Risk Assessment (SARA) Guide: Reliability and Validity in Adult Male Offenders*, 24 Law & Hum. Behav. 101 (2000).
20. Kirk R. Williams & Amy Barry Houghton, *Assessing the Risk of Domestic Violence Reoffending: A Validation Study*, 28 Law & Hum. Behav. 437 (2004).
21. Zoe N. Hilton, Grant T. Harris, Marnie E. Rice, Ruth E. Houghton & Angela W. Eke, *An Indepth Actuarial Assessment for Wife Assault Recidivism: The Domestic Violence Risk Appraisal Guide*, 32 Law & Hum. Behav. 150 (2008).
22. Jacqulyn C. Campbell, Daniel W. Webster & Nancy Glass, *The Danger Assessment: Validation of a Lethality Risk Assessment Instrument for Intimate Partner Femicide*, 24 J. Interpersonal Violence 653 (2008).

[T]he model allows for adjustment to a higher or lower level of treatment as offenders' needs change.

the DVRNA.[23] Overall, the risk factors are most commonly associated with domestic-violence mortality, domestic-violence re-offense, and general criminal recidivism. Of these, eight are dynamic (*i.e.*, subject to change) and seven are static (*i.e.*, not subject to change). With a range of 0-14, offenders are assigned one point for each risk-factor domain present. Offenders are then placed in one of three treatment-intensity levels, based on their total score: A (low intensity), B (moderate intensity), or C (high intensity) (see Figure 1). However, offenders presenting with any one of six* risk-factor domains deemed most critical are automatically placed in Level B or C, notwithstanding their total score on the DVRNA.

Because eight of the fourteen DVRNA risk factors are dynamic, treatment providers are able to continually assess and amend offenders' treatment plans through the course of treatment. Treatment-plan reviews account for additional risk factors that may emerge after the initial intake evaluation, therefore requiring an increase in treatment-level intensity. Likewise, offenders who exhibit progress in their treatment and a lowering of their risk factors may benefit from a corresponding decrease in treatment-level intensity. Thus, while some offenders' treatment levels remain the same, the model allows for adjustment to a higher or lower level of treatment as offenders' needs change.

Figure 1: Overview of Treatment-Intensity Levels for Domestic-Violence Treatment in Colorado



MULTIDISCIPLINARY TREATMENT TEAMS

The Colorado treatment model also utilizes collaborative "Multidisciplinary Treatment Teams" (MTTs) to determine and maintain appropriate treatment levels for offenders. As outlined in Colorado's Standards, the MTT consists of a treatment provider, a victim advocate, and a probation officer. These professionals work in partnership through the treatment process to make decisions concerning the appropriate treatment level for each offender and to evaluate ongoing treatment progress. Each member of the MTT has an equal voice in the decision-making process, as noted in the Standards: "While there is acknowledgement that there is a supervising agent for the court, the intent and goal are to work collaboratively."[24] MTTs are required to reach a consensus in determining the offender's risk levels at intake, making any changes in risk levels as a result of periodic treatment-plan reviews and discharging the offender at the completion of treatment. The sharing of professional expertise between MTT members provides a valuable element to effective treatment management. Members of the MTT also work to ensure that victim privacy is prioritized and respected throughout the treatment process.

TREATMENT PLANS AND CORE COMPETENCIES

Colorado's Standards mandate that offenders attain certain core competencies, as established by the DVRNA, to demonstrate progress in reaching the goals outlined in their individualized

23. The 14 risk-factor domains in the DVRNA are: (1) prior domestic-violence-related incidents*; (2) drug/alcohol abuse*; (3) mental-health issues*; (4) use and/or threatened use of weapons in current or past offenses or access to firearms*; (5) suicidal/homicidal ideation*; (6) criminal history (non-domestic-violence related)*; (7) obsession with the victim; (8) safety concerns; (9) violence toward family members, including child abuse; (10) attitudes that condone or support partner assault; (11) prior completed domestic-violence-offender treatment; (12) involvement with people who have pro-criminal influence; (13) separated from victim within last six months; and (14) being unemployed.
24. COLORADO DVOMB, *supra* note 16.

treatment plans. Eighteen core competencies are included in Colorado's treatment Standards.[25] Primary competencies include a commitment by the offender to eliminate abusive behaviors, a commitment to eliminate all other forms of violent behaviors, and acceptance of complete responsibility for their full history of committing abuse. Individualized treatment plans may require the offender to attain additional competencies as indicated by their individual risk factors and treatment needs, as determined by their DVRNA and the MTT at intake and during periodic treatment-plan reviews.

Achievement of the core competencies is theorized by the DVOMB to be a significant factor in reducing recidivism. To complete treatment, all offenders must exhibit a clear understanding of the competencies to their personal treatment provider, who documents the progress for the MTT. Once offenders demonstrate that they have attained all the required competencies and conditions included in their treatment plan as well as fulfilled all terms of their offender contract, they receive a discharge status of treatment completion under the Standards.

EXISTING RESEARCH: IMPLEMENTING COLORADO'S STATE STANDARDS

In cooperation with Colorado's DVOMB, Gover, Richards, and colleagues have collaborated on several empirical studies pertaining to Colorado's domestic-violence-offender treatment.[26] Their ongoing research has focused on a range of topics regarding the implementation of state-mandated domestic-violence-offender-treatment standards. Specifically, they have examined the perceptions and experiences of MTT members' (*i.e.*, treatment providers, probation officers, and victim advocates) decision-making processes for domestic-violence-offender treatment and the challenges members have experienced with the implementation of Colorado's Standards, as well as the specific role of "treatment victim advocates" on MTTs.

To examine MTT members' experiences with the implementation of the Standards, Richards et al. contacted all members by email to participate in an online SurveyMonkey® survey that asked questions about their perceptions of the level of implementation of the Standards in domestic-violence treatment.[27] Results indicated that 87% of treatment providers surveyed reported that the 2010 *Revised Domestic Violence Standards* had been fully implemented into their treatment program. Comparatively, 46% of probation officers and 54% of victim advocates surveyed reported that the Standards had been fully implemented.[28] Further, 94% of treatment providers, 69% of probation officers, and 85% of victim advocates surveyed agreed that all offenders in their program are assessed with the DVRNA before beginning treatment.

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Further, Gover et al. analyzed a sample of 3,311 domestic-violence offenders who entered treatment after the new differentiated treatment model had been implemented in Colorado (between 2010 and 2012) to assess treatment-intensity levels at intake and at discharge and movement in treatment-intensity level over the course of an offender's treatment process.[29] Among offenders in the sample, 10% were assigned to level A, 43% were assigned to level B, and 47% were assigned to level C at intake. Findings demonstrated movement across intensity levels during treatment, with the majority of offenders discharged from level B (53%), while 37% and 10% were discharged from level C and level A, respectively. Results further demonstrated high consistency among level A and level B offenders over the course of treatment, such that few offenders assessed at treatment-intensity level A or level B at intake were reassessed as needing more intensive treatment at discharge: 7% and 3%, respectively (*i.e.*, few offenders were assessed as becoming more risky over the course of treatment). Comparatively, 25% of offenders placed in treatment-intensity level C at intake had been reduced to treatment-intensity level B at discharge—indicating a reduction in risk factors over the course of treatment. Notably, in a departure from the Standards, 2% of offenders initially placed in treatment-intensity levels B or C were reduced to level A at their final assessment.

Richards et al. also reported interview data from MTT members, which revealed that there was a need for additional training regarding the Standards for criminal-justice-system personnel such as judges, law-enforcement officers, district attorneys, and other relevant practitioners.[30] Overall, interview responses suggested the need for a better understanding of

25. Core competencies include: (A) commitment to the elimination of abusive behavior; (B) demonstration of change by working on the comprehensive personal-change plan; (C) completion of the personal-change plan; (D) development of empathy; (E) acceptance of full responsibility for the offense and abusive history; (F) identification of and progressive reduction of a pattern of power and control behavior, beliefs, and attitudes of entitlement; (G) offender accountability; (H) acceptance that one's behavior should and does have consequences; (I) participation and cooperation in treatment; (J) ability to define types of domestic violence; (K) understanding, identification, and management of one's personal pattern of violence; (L) understanding of intergenerational effects of violence; (M) understanding and use of appropriate communication skills; (N) understanding and use of "time-outs"; (O) recognition of financial abuse and management of financial responsibility; (P) elimination of all forms of violence and abuse; (Q) prohibition of purchasing, possessing, and using firearms or ammunition; and (R) the identification and challenge of cognitive distortions that play a role in the offender's violence.
26. Gover et al., *supra* note 17; Tara N. Richards & Angela R. Gover, *Domestic Violence Offender Treatment and Multidisciplinary Treatment Teams: The Role of "Treatment" Victim Advocates*, Int'l J. Offender Therapy & Comparative Criminology (2016); Tara N. Richards et al., *The Implementation of State Mandated Standards for Batterer Intervention Programs: The Colorado Experience*, Violence & Victims (forthcoming 2017).
27. Richards et al., *supra* note 26.
28. *Id.*
29. Gover et al., *supra* note 17.
30. Richards et al., *supra* note 26.

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Colorado's approach to domestic-violence-offender treatment and the empirical basis for such an approach among members of the criminal-justice community in Colorado overall, and particularly among judges. In terms of training for judges, at a minimum, the DVOMB and interviewed staff identified the need for adding such training modules to preexisting annual judicial trainings. For example, the DVOMB staff and board members are currently in discussions to provide training at the next annual judicial conference.

At the same time, there is overwhelming agreement among stakeholders that a majority of Colorado judges have embraced the idea of a differential, non-time-driven treatment model. However, there is still the occasional case where a judge imposes a sentence, or condition(s) of probation, that runs counter to what the Standards require. The most common example of this is when a judge orders couples counseling, which the DVOMB has prohibited for numerous reasons (most of which relate to issues of victim safety) or when a judge orders an offender to a specified number of weeks in treatment, which does not comport with the use of the DVRNA. Since the purview of the Standards includes Colorado domestic-violence treatment providers, not the court, it is important that judges receive training specific to the Standards, dynamics of domestic violence, and victim issues inherent to abusive relationships, to support accurate implementation of the Standards at all levels of the criminal-justice system.

NEW, ONGOING RESEARCH: THE RELATIONSHIP BETWEEN OFFENDER RISK, TREATMENT CONTENT, AND OFFENDER OUTCOMES

Currently, Gover and Richards are in the process of completing an in-depth examination of domestic-violence-offender treatment in Colorado in an attempt to identify best practices for DV treatment in the state. Specifically, this research assesses linkages between an offender's DVRNA risk score, DV-treatment content and offender competencies, and DV-treatment outcome and recidivism. At present, Gover and Richards have conducted in-depth interviews with randomly selected treatment providers about their treatment philosophy and approaches to achieving treatment competencies with clients. Treatment content information (*e.g.*, materials used during group or individual sessions, homework, etc.) has also been collected from providers and coded regarding relevance to the competencies outlined in the Standards. "Enrollment" of clients currently receiving domestic-violence-offender treatment with the sampled providers is also in progress.

Next steps will include the collection of information from domestic-violence-offender treatment files regarding an offender's DVRNA risk score at intake and at their last treatment-plan review, information from the Spousal Assault Risk Assessment (SARA), information regarding the offender's dose of treatment (including their number of group and individual sessions and the treatment content and modalities to which they were exposed); information regarding their treatment outcome (*i.e.*, administrative discharge, successful discharge, and unsuccessful discharge) at discharge date will also be collected. In addition to treatment information, Gover and Richards will also obtain recidivism data for offenders at 12 and 18 months from the State Court Administrator's Office.

Data will be examined to determine the relationship between exposure to different DV-treatment content and treatment outcomes (offender recidivism at 12 and 18 months and successful treatment completion vs. unsuccessful discharge). It is hypothesized that providers using social-learning or cognitive-behavioral-therapy models and program content that adheres to the offender competencies outlined in the Standards will be associated with offenders with greater rates of successful treatment discharge and lower rates of recidivism. Also, it is hypothesized that treatment providers who use other treatment modalities and programs including treatment content that is not associated with the competencies will have lower rates of successful treatment completion due to drop out and higher recidivism rates among offenders.

The present study is aligned with the notion that intervention programs must be studied through rigorous research and proven empirically effective (*i.e.*, *evidence-based practices* (EBPs)). Important topics of study for EBP research in correctional settings are "Principles of Effective Intervention" (PEIs), including acknowledgment of the target population's risk, need, and responsivity, and programs' treatment and fidelity to the model.[31] Research has been conducted on the use of EBPs and PEIs in many aspects of correctional programming; however, there are fewer research studies focusing specifically on EBPs and PEIs in domestic-violence-offender treatment.

Colorado's Standards for DV treatment include some of the aforementioned PEIs. For example, the "risk" principle is included in the Standards through a differentiated, non-time-driven methodology where the DVRNA is used to differentiate high-risk and low-risk offenders and offenders are placed in a corresponding treatment-intensity level.[32] In addition, the "need" principle is included through the application of 19 competencies that offenders are required to master before successful completion of treatment, while the "responsivity" principle is reflected in the use of individual treatment plans and goals shaped by a particular offender's risk factors, competencies, and criminogenic needs (*i.e.*, relevant background factors relating to criminality).

At the same time, the principles of "treatment" and "fidelity" have yet to be fully integrated into Colorado's DV-treatment Standards. For example, specific treatment content remains unknown except to individual providers and the offenders they treat. Studies have shown that social-learning and cognitive-behavioral approaches are most effective to DV-

31. Dana L. Radatz & Emily M. Wright, *Integrating the Principles of Effective Intervention into Batterer Intervention Programming: The Case for Moving Toward More Evidence-Based Programming*, 17 Trauma, Violence & Abuse 72 (2015).
32. Gover et al., *supra* note 17.

offender treatment;[33] as such, these approaches should be connected to the 19 competencies required in Colorado's Standards. Further, the principle of "fidelity" requires that "implementation and adherence to PEIs, process evaluations, and outcome evaluations" be evaluated regularly.[34]

The current research aims to fill the gap in knowledge regarding treatment and fidelity to Colorado's model for domestic-violence-offender treatment. Gover and Richards intend for results to lead to the development of a portfolio of best practices for domestic-violence-treatment-program content in Colorado. These best practices will be directly linked to the competencies outlined in the Standards. Modalities currently in use that are not linked to competencies will be identified as well. Additionally, quantitative models testing the relationship between different treatment models and offender outcomes will allow for recommendations regarding "what works" to engage offenders in treatment (*i.e.*, what is associated with completion) and which modalities predict lower rates of recidivism.

CONTINUED EVOLUTION OF THE COLORADO MODEL

As designed, Colorado's differentiated treatment model is a unique approach to domestic violence that prioritizes offender behavior change, offender containment, and victim safety, and where treatment decisions involve a collaborative process among a three-member multidisciplinary team. The model also recognizes that the historical time-driven approach (*i.e.*, a standardized 36 weeks of treatment) is not inherently appropriate for all offenders, but instead, that treatment plans should align with an offender's risks and needs as determined by an empirically based risk assessment. Further, the Colorado model includes offender reassessment during treatment, and offenders are discharged according to their achievement of core competencies and treatment-plan completion, not simply the number of weeks they are in attendance.

Taken together, the Colorado model is quite progressive in its reliance on several principles of effective intervention—risk, need, and responsivity; however, less attention has been paid to the principles of treatment and fidelity. Indeed, the limited existing evidence suggests that there is room for improvement regarding the implementation of the model and, specifically, fidelity to "the model on paper," in practice.[35] However, these issues are not isolated to domestic-violence treatment in Colorado. Although state legislative standards for domestic-violence-intervention programs have been adopted nearly universally across the U.S., the extent to which such standards have been implemented—and whether they actually achieve the intended goal of affecting programs' policies and practices—is almost universally unknown.[36] And the extent to which these standards are effective in reducing domestic-violence recidivism is also unclear.

However, in Colorado, the legislature mandates that the DVOMB confirm the success of DV-offender treatment by directing the assessment of the Colorado Standards for DV treatment. The DVOMB is responsible for integrating the results of assessments into the Standards to improve best practices. Additionally, the Standards mandate the DVOMB to stay up to date on existing and emerging studies and literature to modify and improve the Standards according to new breakthroughs in understanding.[37] Finally, the DVOMB supports the facilitation of best practices through the reapproval process of treatment providers on a biannual basis. Given that this infrastructure is facilitative to conducting research and integrating empirical findings into the Standards, Colorado is a prime location for the development and proliferation of best practices for domestic-violence treatment.

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33. Radatz & Wright, *supra* note 31.
34. *Id.*
35. Gover et al., *supra* note 17
36. Boal & Mankowski, *supra* note 6; Richards et al., *supra* note 26.
37. Colorado DVOMB, *supra* note 16, at 2-2.