Partner Abuse, Volume 11, Number 3, 2020

Domestic Violence Treatment in Colorado: An Overview of an Evidence-Based Approach

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In 2010, the State of Colorado revised its state standards to create consistency across the state for its domestic violence (DV) cases by placing emphasis on the integration of evidence-based practices into its DV treatment programming. Since then, Colorado has established a three-tiered differential treatment model informed by the principles of effective intervention (PEI), an evidence-based framework found in correctional programming. This article reviews the PEI framework, outlines the emerging research that explores the principles among DV offenders and their treatment, and provides an overview of Colorado's differentiated DV treatment model. Policy and research considerations are also discussed.

KEYWORDS: domestic violence; evidence-based practices; principles of effective intervention

INTRODUCTION

In response to the marginal effectiveness of domestic violence (DV) treatment programs (also referred to as batterer intervention programs) in reducing recidivism (Babcock, Green, & Robie, 2004; Eckhardt et al., 2013; Feder & Wilson, 2005), a recent paradigm shift in the approach to DV treatment has emerged. To increase DV treatment effectiveness, practitioners and researchers have proposed updating DV policies, treatment approaches, and state standards to incorporate evidence-based practices (Babcock et al., 2016; Cannon, Hamel, Buttell, & Ferreira, 2016). In alignment with the proposed call and paradigm shift, one prevailing approach has been to draw insight from effective correctional programming, namely the principles of

http://dx.doi.org/10.1891/PA-D-20-00007

effective intervention (PEI; Andrews et al., 1990; Bonta & Andrews, 2017), developed to address recidivism among general offenders (Radatz & Wright, 2016; Stewart, Flight, & Slavin-Stewart, 2013). The PEI framework offers empirically supported guidance in correctional treatment programming, that when followed, leads to significant recidivism reductions (Bonta & Andrews, 2017). The most well-known and utilized principles—risk, need, and responsivity—are commonly referred to as the RNR model. Research findings from scholars and practitioners indicate encouraging, albeit cautious, support for the evidence-based integration of the RNR model into DV offender treatment (Hilton & Radatz, 2018, in press; Richards & Murphy, 2018; Stewart, Gabora, Kropp, & Lee, 2014).

In 2010, the State of Colorado revised its state standards (hereafter *Standards*) to incorporate a differentiated treatment approach informed by the RNR model (Gover, 2011). In the years to follow, Colorado implemented a three-tiered differential treatment model emphasizing the RNR principles, the use of a newly developed DV risk and needs assessment tool, and collaborative efforts from a multidisciplinary treatment team (MTT; Hansen, Davis, Smith, & Hilkey, 2016). The intent of this article is twofold: First, we will briefly outline and review the PEI framework and initial research examining the principles among DV offenders and their treatment. Second, we seek to provide an overview of Colorado's differentiated treatment model, as well as offer a discussion on the practice, policy, and research considerations of adopting a more individualized approach using the PEI framework.

EVIDENCE-BASED PRACTICES AND DOMESTIC VIOLENCE

The PEI Framework

In 1990, James Bonta and Donald Andrews, along with a few of their colleagues, introduced the PEI framework following a call by correctional programming scholars to determine what works in reducing recidivism (Andrews et al., 1990; Bonta & Andrews, 2017; Gendreau, 1996). In the past three decades, the PEI framework has become synonymous with evidence-based practices in correctional programming, and there are hundreds of empirical studies validating their effectiveness in reducing recidivism among a variety of offenders (MacKenzie, 2006; Smith, Gendreau, & Swartz, 2009). As previously mentioned, the first three principles (RNR) garner the most attention and utilization by researchers and practitioners. The risk principle states that offenders should be assessed based on their risk for reoffending, classified into low-, medium-, and high-risk level categories, and matched with a corresponding treatment intensity (Bonta & Andrews, 2017). The need principle places emphasis on offenders' needs, which are divided into two categories: criminogenic and noncriminogenic. Criminogenic needs are modifiable risk factors most strongly correlated with recidivism (e.g., substance abuse, antisocial personality traits), whereas noncriminogenic needs are potential treatment needs that are relatively weakly correlated with recidivism (e.g., poor physical condition, low self-esteem; Bonta & Andrews, 2017).

Thus, the need principle dictates that treatment programs should place importance on assessing and attending to dynamic criminogenic needs, and only address non-criminogenic needs if doing so would impact an offender's criminogenic need (Bonta & Andrews, 2017).

The responsivity principle denotes offender programming should attend to how offenders respond to treatment more generally (e.g., program structure utilizes cognitive social learning strategies), as well as how offenders' specific characteristics may impede or assist their success during the intervention (e.g., an offender with a low reading comprehension level may require adjustments to written components of the curriculum). Collectively, the RNR principles emphasize that offenders are not homogenous, and they may have varying risks, needs, and characteristics that require varying consideration within a treatment program to ensure the recidivism reduction (Bonta & Andrews, 2017).

Two additional well-known principles, treatment and fidelity, emphasize focus on program delivery and evaluation. The treatment principle outlines that program staff should be well trained and maintain a firm-but-fair, respectful approach. Further, treatment services should incorporate cognitive social learning strategies (e.g., role playing, modeling, cognitive behavioral therapy), as well as dedicate 40%–70% of program time on acute services (Bonta & Andrews, 2017). The fidelity principle provides guidance on how treatment services should be delivered and evaluated. In particular, qualified program staff should be supervised and monitored. Further, all components of a treatment program should be routinely assessed and evaluated to ensure program integrity (Andrews, 2006).

The PEI Framework and DV

A handful of studies have examined the RNR principles among DV offenders and their treatment. In two separate studies, Connors and her colleagues (Connors, Mills, & Gray, 2012, 2013) measured attitudinal and program-related skills changes through pre-, mid-, and posttest self-assessment surveys among male DV offenders in moderate and high intensity DV treatment programs. The studies' findings revealed the DV offenders had significant improvement in measures of attitude, motivation, and program-related skills. Notably, each of the aforementioned studies (Connors et al., 2012; Connors et al., 2013; Stewart et al., 2014) utilized an existing and well-known DV risk assessment tool, the Spousal Assault Risk Assessment (SARA; Kropp & Hart, 1997; Kropp, Hart, Webster, & Eaves, 1998, 1999), to assist in their risk assessment and treatment intensity decisions. Similarly, Radatz and Hilton (2019) published an illustration of how another widely known and utilized DV risk assessment tool, the Ontario Domestic Assault Risk Assessment (ODARA; Hilton, Harris, & Rice, 2010; Hilton et al., 2004), could be used to assist in determining treatment intensity categories as prescribed by the PEI framework.

Initial research studies have shown DV offenders have criminogenic needs (Hilton & Radatz, 2018, in press; Stewart & Power, 2014). In 2014, Stewart and Power comparatively examined the criminogenic needs of DV offenders and non-DV offenders and determined that the DV offenders reported higher rates of risk and criminogenic needs. Furthermore, DV offenders reported having more learning disabilities, more mental health problems, and more widespread criminal histories than the non-DV offenders within the sample. In 2018, Hilton and Radatz sought to expand upon Stewart and Powers' (2014) work by examining and comparing the criminogenic and noncriminogenic needs of DV offenders, non-DV violent offenders, and nonviolent offenders. Their results indicated that DV offenders showed problems across all eight of the criminogenic and noncriminogenic need measures within the study. When compared to the other two groups, DV offenders had a significantly higher number of criminogenic needs, and exhibited the highest needs in all criminogenic domains except employment/school problems (Hilton & Radatz, 2018).

Most recently, Hilton and Radatz (in press) examined the criminogenic needs of DV offenders as they relate to recidivism, as well as how the number of criminogenic needs a DV offender has relates to ODARA treatment intensity categories (Radatz & Hilton, 2019). Their results indicated that DV offenders displayed problems across all six criminogenic need domains that they were able to measure, and that five of the six criminogenic needs (all except poor relationships) were significantly associated with DV recidivism. Moreover, the number of criminogenic needs a DV offender had was significantly correlated with ODARA treatment intensity categories.

At the programmatic level, Stewart and her colleagues (2014) conducted the only study to date that examined the effectiveness of DV treatment programs informed by the PEI framework, one of moderate treatment intensity and another of high treatment intensity. Their results revealed that high-risk offenders who attended the high treatment intensity DV program were significantly less likely to reoffend (for DV and non-DV violent offenses) compared to untreated offenders. Further, the moderate-risk offenders attending the moderate intensity treatment program revealed a similar trend in recidivism reduction, albeit not significant (Stewart et al., 2014).

In 2015, Scott and her colleagues evaluated the effectiveness of a Second Responder program, a program guided by a PEI framework that focused on risk factors and criminogenic needs of moderate- and high-risk offenders in London, Ontario. The intervention, offered to male IPV offenders who were awaiting trial, was delivered in a one-on-one setting between the offender and therapist. Their study findings indicated that offenders who had attended the intervention programming were significantly less likely to recidivate compared to a randomly selected control group of offenders who had not received the intervention (Scott, Heslop, Kelly, & Wiggins, 2015). Altogether, the empirical findings of these initial research studies examining the PEI and DV offenders and their treatment suggest the integration of the PEI into DV offender treatment may be a promising approach to increased effectiveness in reducing recidivism.

THE COLORADO INDIVIDUALIZED TREATMENT MODEL: AN OVERVIEW

Domestic Violence Offender Management Board and Updated State Standards

Like many other states, Colorado passed legislation (§16-11.8-103, C.R.S.) in 2001 that created the Domestic Violence Offender Management Board[1] (DVOMB) in an effort to create consistency for DV criminal cases and "so that such offenders will be less likely to offend again and the protection of victims and potential victims will be enhanced" (C.R.S. 16-11.8-101). Of its many statutory functions, the DVOMB is primarily a policy board mandated to develop state *Standards* for the evaluation, treatment, and monitoring of DV offenders.[2] In alignment with the fidelity principle, the DVOMB is mandated to periodically review, revise, and approve the *Standards* in response to emerging research, best practices, implementation challenges, or recent case law (Tunstall, Weible, Tomsich, & Gover, 2016). During the last significant revision, the DVOMB considered a broad spectrum of modalities and interventions designed to address intimate partner violence. The conclusion of these revisions produced *Standards* that embraced a PEI framework emphasizing research support.[3] Further, the DVOMB is charged with managing the regulatory process by which someone is deemed eligible to work with DV offenders. Only those who are identified and listed as DVOMB Approved Providers (hereafter Providers) are eligible to receive referrals for DV offender services. The purview of the DVOMB extends to offenders who have received a conviction, deferred sentence, plea-deal, or an underlying factual basis of DV found by the presiding court, including offenders placed on probation, private probation, community corrections, as well as those ordered by the Colorado Parole Board. Social services cases are generally referred to Providers approved by the DVOMB; however, the DVOMB maintains no purview in those cases and the *Standards* are used as a guideline, as Providers may choose how and to what extent the *Standards* for criminal cases should be used in conjunction with their professional and ethical judgment.[4]

The DVOMB has sought to review and incorporate empirical research when revisions to the *Standards* were explored. This reliance on research was pivotal in the adoption and integration of the RNR principles in 2010, which eliminated the previous minimum length of 36 weeks for all offenders. The rationale for this change was prompted by mounting concerns that the time-driven model was inadequate for addressing the diversity of criminological, pathological, and typological profiles and characteristics of DV offenders (e.g., Fowler, Cantos, & Miller, 2016; Johnson & Goodlin-Fahncke, 2015). Drawing upon the RNR research with general offenders, the DVOMB designed a differentiated and risk-informed model that emphasizes meeting individualized goals rather than the passage of time over a predetermined number of sessions (Gover, Richards, & Tomsich, 2015).

Multidisciplinary Treatment Team

The DVOMB *Standards* require a Multi-Disciplinary Treatment Team (MTT) that is comprised of at a minimum, the Provider, the referring criminal justice professional

(e.g., probation or parole officer, case manager), and a treatment victim advocate (TVA). As part of the process, offenders are required to sign releases of information for each member of the MTT. The MTT is required to reach consensus in the following phases of treatment: initial placement in treatment, at any suggested change in level of offender treatment, and at time of discharge. The MTT allows for each professional to share information, express emerging concerns, and gain consensus in the offender's evaluation and treatment in order to prevent offender triangulation, increase victim safety, and promote offender containment. All members of the MTT have input into decisions made throughout the offender's treatment. DV Providers have deference regarding clinical matters. The MTT was added to the *Standards* in 2010.

The TVA is unique to the Colorado *Standards.* Each offender in treatment must have a TVA assigned to the identified victim in the case. The TVA makes contact with the victim at time of the offender evaluation, and communicates options for continued communication. In an effort to promote victim safety, the identified victim may choose to be informed of offender absences, and concerns related to the offender's progress. Additionally, the victim may also choose to report any positive changes they see in the offender. Victims are not obligated to participate in this process; however, MTT members report that when an identified victim engages with the TVA, they perceive that this additional layer of connection helps to keep victims and often their children safer. The TVA is employed by or contracted with the Provider, and must have a minimum level of certification through the Colorado Organization for Victim Assistance (COVA), and must maintain that certification. In order for the TVA to share information with the MTT, the identified victim must sign a release of information. Because victims have a right to self-determination, at times victims choose not to sign releases of information for the TVA to communicate with the MTT. In these situations, the TVA may still communicate with the victim, yet may not share any information with the MTT from the victim.

The MTT mimics a mini coordinated community response. Each MTT has the freedom to design their mode of communication. Though in-person is preferred to strengthen relationships, some MTTs communicate via e-mail, phone calls, or through electronic medical records. The *Standards* require the MTT to meet at least quarterly in order to perform timely treatment plan reviews (TPR); although not required, some providers report that often the MTT meets on a monthly basis, with additional communications in between meetings to address offender concerns in a timely manner. The MTT relies heavily on a larger coordinated community response of all systems involved with the offender from time of arrest, to sentencing, probation, and law enforcement interventions if necessary.

The Domestic Violence Risk and Needs Assessment

The aforementioned policy work resulted in the creation of the Domestic Violence Risk and Needs Assessment (DVRNA), which served as the basis for designating the initial classification of offender risk and designated level of treatment (as prescribed by the risk principle). The DVRNA is a structured actuarial risk assessment instrument for use with adults (aged 18 years and older) who have been arrested and are in the

criminal justice system for a DV offense. Development of the DVRNA was informed by the Level of Service Inventory (LSI, LSI-R; Andrews & Bonta, 1995; Andrews & Bonta, 2001) — the primary risk assessment tool utilized in PEI-informed correctional programming for general offenders—and several well-known and validated DV risk assessment tools, including the SARA (Kropp & Hart, 1997; Kropp et al., 1998; Kropp, Hart, Webster, & Eaves, 1999), the ODARA (Hilton et al., 2010; Hilton et al., 2004), the Domestic Violence Screening Instrument (DVSI; Williams & Houghton, 2004), and the Danger Assessment (Campbell, Webster, & Glass, 2009).

The DVRNA contains 14 static and dynamic risk factors, and is used to assess and classify DV offenders into one of three levels of treatment intensity: Level A (low), Level B (moderate), and Level C (high). The DVRNA assesses several significant and critical risk factors (i.e., prior DV history, drug/alcohol abuse, mental health issues, non-DV criminal history, suicidal/homicidal), as informed by empirical research. The presence of significant, critical risk factors from an offender's assessment will automatically place the offender at a treatment Level B or C, even if no other domains are scored. Each level of treatment is programmed to increase the intensity and duration of treatment based on the offender's level of assessed risk. Subsequent changes in risk are assessed throughout treatment in order to continue to deliver the most appropriate level of care, as well as inform treatment planning. Importantly and as outlined by the risk and need principles, the risk classification process differentiates and separates high-risk from low-risk offenders and identifies specific criminogenic needs that become the basis for treatment goals related to DV and co-occurring issues. The DVRNA is administered and scored by a Provider as part of an offender's evaluation prior to the start of treatment. Dynamic risk factors identified in the DVRNA are then incorporated into a treatment plan where goals with measurable objectives are identified. The DVRNA has content and face validity, and is currently undergoing a validation study through the Colorado DVOMB.

Offender Initial Evaluation Process

When a DV offender is found to have an underlying factual basis of DV found by the presiding court, Colorado Revised Statues require the offender to be evaluated and subsequently sentenced to treatment by a DVOMB approved treatment Provider. Typically, the offender will meet with their Probation officer postsentence, and the officer will then construct a detailed referral packet to send to the Provider in order to prepare for the evaluation. The referral packet is imperative for the completion of the evaluation, as it often includes a report of the index offense, a summary of criminal history, relevant testing, victim impact statements, and any other relevant information useful to the Provider. The offender is fiscally responsible for the evaluation and treatment; however, limited offender services funds from State Probation may be utilized to partially assist an offender starting treatment.

The evaluation is individualized and comprehensive for each offender. In the evaluation, the Provider is required to include three major, required sections: minimum sources of information, assessment instruments, and minimum content of the

offender clinical interview. The minimum sources of information include: the offense report, criminal history, victim input (if available), available collateral information directly related to the current offense, and previously completed relevant evaluations, including any postconviction, presentence evaluations completed on the offender. The required assessment instruments include: the DVRNA, at least one additional DV risk assessment instrument (e.g., ODARA; Hilton et al., 2004), one substance use screening instrument (e.g., Substance Abuse Subtle Screening Inventory [SASSI-4]; Lazowski & Geary, 2019), Adult Substance Use Survey—Revised (ASUS-R; Wanberg, 2004), one mental health screening instrument (e.g., Patient Health Questionnaire [PHQ-9]; Kroenke, Spritzer, & Williams, 2001), Beck Depression Inventory (BDI; Beck & Steer, 1993), Beck Anxiety Inventory (BAI; Beck & Steer, 1990), Psychopathy Checklist-Revised (PCL-R), and one cognitive screen. Apart from the DVRNA, the Provider selects the remaining instruments (depending on their level of experience and credentialing) to utilize in the evaluation. Each assessment instrument selected and utilized by the Provider must demonstrate reliability, validity, and be the most current version of the tool. The minimum content of offender clinical interview includes: psychosocial history, criminogenic needs, offender accountability, motivation for and amenability to treatment, responsivity factors, individual and familial history of substance abuse and mental health, relationship history with attention to DV dynamics and any issues related to power and control, prior history of trauma or adverse experiences, and substance abuse and mental health history.

Once the evaluation is complete, the Provider analyzes all assessment and screening instrument outcomes, along with the information gathered by other collateral information and clinical interview, and conceptualizes the data. In a succinct manner, the Provider articulates in a summary the issues that constitute the risk of the offender, the offender's needs for treatment, and the responsivity necessary in order to provide the best opportunity for the offender to succeed in treatment. From these recommendations, specific treatment goals are recorded in the initial treatment plan, including goals addressing all dynamic risk factors and criminogenic needs. Additionally, the identification of the initially recommended level of a treatment is also reported in the summary.

As noted previously, three DVRNA treatment level outcomes are possible. Treatment Level A is reserved for offenders who have scored a zero or one on the DVRNA, indicating an offender has none or one risk factor present. Level A is a low treatment intensity category, and necessitates an offender to attend one DV treatment session per week and requires a minimum of two TPRs Treatment Level B is assigned to offenders who have a DVRNA score of two, three, or four, and is earmarked as a moderate treatment intensity category. Level B instructs an offender to attend one DV treatment session per week, as well as one additional session per month to address any other clinical concerns, and requires a minimum of three TPRs. Treatment Level C is designated for offenders who score a five or higher on the DVRNA, and is considered a high treatment intensity category. Level C instructs an offender to attend one DV treatment session per week, and one additional second contact per week (e.g., substance abuse, cognitive skills, mental health). Further, Level C mandates an

offender to complete a minimum of three treatment plan reviews. These TPRs serve as the basis for the ongoing assessment of an offender's progress, maintenance, or regression in treatment, and are used to modify the treatment plan accordingly. TPRs occur every two to three calendar months and require MTT input. More importance is given to the meeting of all treatment goals rather than the passage of a specific amount of time because offenders progress in treatment at different rates. If there are no additional TPRs recommended, the Standards [Italicized] allow for an offender to complete treatment between 16 weeks and 24 weeks for Level A offenders, and between 24 weeks and 36 weeks for Level B and C offenders. Programmatic data suggest that the time frames for each of these levels is longer than what is minimally required.[5]

Additional reviews may occur at any time, should they be warranted. If an offender violates the terms of the offender contract, the MTT then communicates and makes decisions as soon as possible in order to provide a consequence to the offender in a timely manner. For example, if the offender produces a positive urine sample, commits a new crime, or fails to fulfill financial responsibilities, the MTT then examines what the details around the violation are, what responsivity factors may need to be adjusted, if any treatment goals need to be amended or added to the treatment plan, and what immediate consequence to the behavior must be placed upon the offender. An example of an MTT response to a positive urine test may include increased urine tests, recommendation or increased substance abuse treatment, individual sessions to further explore reasons for the use of substances, and so forth. Typically, it is the DV Provider working with the offender who communicates directly with the MTT.

Offender Treatment Plan

As denoted earlier, the initial evaluation results in an initial treatment plan following a MTT consensus decision. Designed and informed by empirical research (e.g., Coulter & VandeWeerd, 2009; Radatz & Wright, 2016; Webster & Bechtel, 2012), the treatment plan has the following required minimum elements: Initial level of placement based on the DVRNA, specific and measurable objectives to target criminogenic needs, methods for enhancing positive and prosocial factors, second contact interventions (e.g., treatment options that are most relevant to addressing the most significant criminogenic need for Level B and C offenders; not applicable for Level A offenders), supervision or monitoring recommendations needed to enhance the safety of the victim and offender containment, and treatment goals. If necessary, considerations for specific offender populations, such as female offenders or LGBTQ+ offenders, are also included. During the initial evaluation, individualized treatment goals and objectives are set for the identified dynamic risk factors and criminogenic needs an offender has. Close attention to responsivity factors is also an integral part of the treatment plan. For example, if the offender is a monolingual Spanish speaker, it is important for the group to be lead by a Provider who speaks this language, and that the other offenders are also Spanish speaking. As well, if an offender is a transitional age adult

(18–25 years old), it is important to have a group available with similarly aged group members. The offender is then scheduled to enroll into treatment as soon as possible, often, the week following the evaluation appointment.

Offender Treatment Process

The Colorado *Standards* provide parameters around the delivery of DV offender treatment. Providers are required to utilize a cognitive behavioral treatment approach as the foundation of program services provided.[6] Approved Providers hold varying levels of mental health and substance abuse credentialing, and this flexibility provides a minimum standard to follow, yet allows for more sophisticated and specialized treatment when appropriate. Group treatment is preferred, yet individual sessions are also conducted when clinically indicated. Groups are gender specific, and specific to the sexual orientation of the relationship represented in the index offense. Treatment groups are no larger than 12 offenders, and each group session runs for 90 minutes.

The treatment program places emphasis on 18 core competencies, which are utilized to assess offender treatment progress.[7] The three main core competencies require offenders to acknowledge and accept full responsibility of their prior history of abusive behavior and consequences, commit to the elimination of their abusive behavior, and commit to the ceasing all other violent acts. Offenders must also demonstrate change through engagement and work on a comprehensive "personal change plan." Other core competencies include: the development of empathy; the identification and reduction of patterns of power and control behaviors/beliefs and entitlement; participation and cooperation in treatment; demonstrate an ability to define types of DV; understanding, identification, and management of one's personal pattern of violence; display an understanding of intergenerational effects of violence; show understanding and appropriate use of communication skills; demonstrate an understanding and use of "time-outs"; display a recognition of financial abuse and management of financial responsibility; and show an understanding of the identification and challenge of cognitive distortions that play a role in their violence. Lastly, offenders are prohibited from purchasing, possessing, or using firearms or ammunition. The core competencies provide the offender an opportunity to identify, understand, and change the thinking around the issues that contribute, or a part of the power and control patterns they have developed. Though there is no set structure to assessing the core competencies, and many Providers have developed their own curriculums to address all core competencies identified in the *Standards* (Richards & Gover, 2018). Providers also develop curriculum content to address other goals of individuals in the group. Treatment providers are permitted to add additional competencies, as needed depending on each individual offender's needs and criminogenic needs. The latitude to create curriculum within the aforementioned parameters provides discretion to Providers who wish to address specific issues (e.g., simple and complicated grief, trauma history) affecting individual offenders.

In alignment with the PEI framework, treatment groups are separated by level of intensity, meaning offenders from different DVRNA treatment intensity levels

are not placed in the same group. Treatment includes a composite of therapy and psychoeducational processes. While following the *Standards*, the Provider has the discretion to facilitate group sessions as they deem appropriate. Each provider consistently measures the level of competencies gained, identifies additional treatment plan items, and helps the offender move toward successful completion of treatment.

The offender must demonstrate progress made in group treatment and individual appointments with the supervising Provider. An offender's progression through the treatment program is further monitored by the MTT. Within the MTT, a TVA offers insights from an offender's victim regarding the offender's progress, lack thereof, or any concerns. Progress is measured through treatment plan reviews conducted by the MTT Regularly scheduled treatment plan reviews allow for the MTT to review an array of information and discuss considerations an offender may need. Such considerations may include: a review of the offender's progress in treatment; a discussion of whether or not a change in level is warranted; a review of the offender's compliance with probation requirements and any new criminal behavior, violation or noncompliance with the signed contract; the presence of new risk factors; any changes to previously identified risk factors; and status of core competencies (e.g., attained, deficient, no change).

An offender can be discharged from treatment services through one of the following: a successful treatment completion; unsuccessful treatment completion; or an administrative removal. MTT consensus regarding the status of an offender is required for an offender to be discharged from treatment services. Once the MTT has achieved consensus on the achievement of all treatment plan goal, the offender is then prepared for discharge. For an offender to be considered eligible for a successful treatment discharge, the offender must complete the minimum required treatment plan reviews, demonstrate adherence to all required competencies, and satisfy all conditions of the treatment plan and offender contract. In the event that the offender fails to fulfill the designed treatment plan, options for unsuccessful discharge are available. At times, despite the utilization of motivational interviewing, appropriate adjustment for responsivity factors, and efforts of the MTT, offenders are not ready to make changes in their lives. Prior to an unsuccessful discharge, the MTT provides the offender multiple opportunities to address violations. For example, if the offender accumulates unexcused absences, the MTT will likely place the offender on an attendance contract. This contract would identify the current violations, a plan to mitigate the issue around absences, and specific consequences to continued absences. Though the plan is designed by the MTT, offenders are permitted to provide their input as part of the therapeutic process and as a way to personalize the contract (e.g., options for corrections of the behavior, appropriate consequences). If the offender is able to remediate the issues, the MTT is then able to continue to utilize what has worked with the offender to address any other issues moving forward throughout treatment.

It is important to note that the MTT works with the offender to provide all possible opportunities for successful completion of treatment, so long as the designs in treatment safeguard the victim's safety. An unsuccessful discharge results in

the offender returning to court for review and evaluation for subsequent criminal justice consequences (e.g., custody, confinement, revoke/reinstate probation). In the event an offender's treatment attendance is significantly impacted by uncontrollable circumstances (e.g., significant illness, receives orders of military deployment) the *Standards* allow for an administrative discharge. Though rarely utilized, the administrative discharge places a hold on the offender's progress within the program until the offender is able to complete treatment. Providers have suggested that the *Standards* further define the means by which offender competencies are measured so as to create fidelity in how they are interpreted and applied for discharging offenders from treatment. At the time of this publication, the DVOMB is currently exploring possible revisions, which may include suggested methods for measuring offender competencies. However, there discussions are premised upon the need for recidivism data that may be correlated to the offender's core competencies in assessing their overall readiness for discharge.

Identified Limitations and Challenges of the Colorado Model

The DVOMB has nearly a decade of experience instituting mandate practices be grounded in the RNR principles and informed by empirical DV literature. Prior research has documented partial to full implementation of state standards highlighting some of the challenges associated with fidelity and compliance (Boal & Mankowski, 2014), and specific mandates associated with RNR programming (Richards, Gover, Tomsich, Hansen, & Davis, 2017). Research examining DV treatment programming has placed extensive focus on the varying theoretical approaches endorsed and used by practitioners; however, the existing literature on the substantive aspects of state mandated standards has received less attention, despite calls for the infusion of evidence-based practices into DV treatment (e.g., Corvo, Dutton, & Chen, 2008; Gondolf, 2012; Radatz & Wright, 2016). While the Colorado model has been promoted as a novel and promising framework for policymakers and practitioners to contemplate, several important considerations warrant further analysis and discussion in the movement toward infusing evidence-based practices into DV programming (e.g., Gover et al., 2015; Richards & Gover, 2018).

Risk Assessment and Treatment Planning. Within the context of DV, risk assessment instruments have become a routine cornerstone to contemporary approaches for DV offenders (e.g., Cannon et al., 2016). The use of risk assessment instruments have allowed for professionals to communicate risk in a way that can inform safety planning for victims and convey risk factors for general and DV recidivism, as well as lethality (e.g., Hilton & Eke, 2017). Validated instruments that use either structured professional judgment or actuarial methods for predicting outcomes have since replaced previous methods of unstructured professional judgment. In 2013, Nicholls and colleagues reported there were more than 11 DV risk assessment instruments with the predictive validity generally ranging from 0.56 to 0.92 on the area under the receiver operating characteristic curve (AUC). Although risk assessment for DV is not an exact science per se, developments in the sensitivity,

specificity, and overall reliability of risk assessments has led to an increase in their reported use by DV treatment facilitators (Babcock et al., 2016).

As noted by Radatz and Wright (2016), the adoption of risk assessment instruments throughout DV treatment providers can be viewed as a step toward infusing the PEI framework into DV treatment; however, if the information gleaned from the assessment instruments is not used to subsequently classify DV offenders into appropriately matched treatment intensity categories, the use of instrument falls short of following the RNR principles. Risk classification serves as a means of increasing the intensity and duration of treatment dosage for higher risk offenders, while also protecting lower risk offenders from iatrogenic effects (Bonta & Andrews, 2017). Empirical research has demonstrated that lower risk offenders have worse treatment outcomes when comingled with higher risk offenders (Bonta & Andrews, 2007; Bonta, Wallace-Capretta, & Rooney, 2000). Notably, this presents a common ethical mandate for mental health and behavioral health providers, as they are to do no harm to the individuals they serve. In theory, the creation of separate treatment intensity programs based on risk is possible, but in practice, can present some logistical and case management challenges, especially for rural areas. Results from a state funded process evaluation of the Colorado *Standards* revealed the distribution of DVRNA levels among Levels A, B, and C were skewed toward higher intensity, as only 9.9% (n = 328) of DV Offenders were assessed as Level A (Gover et al., 2015). Providers reported that many Level A offenders receive individual sessions due to their relative scarcity.

To align with the need and responsivity principles, initial assessment and evaluation of DV offenders should include the assessment of criminogenic needs and responsivity factors. The identified risk factors, criminogenic needs, and responsivity factors highlight preeminent targets for treatment and the styles and modes an offender may learn best from. Risk assessment instruments designed for assessing DV risk pose various definitions of what that risk is and may include static risk factors (e.g., age, history of antisocial personality traits, prior criminal history) that are unchangeable with treatment. While static risk factors are important and should not be overlooked, dynamic risk factors ought to be the basis for which progress is measured and continuously assessed throughout the treatment process (as outlined by the RNR principles). The creation of the DVRNA has allowed Providers in Colorado to formulate treatment targets that adhere to the RNR principles without removing a Provider's ability to address underlying clinical aspects of coercive control. For practitioners who are unfamiliar with the PEI framework and its application to DV treatment, the concept and prominence of risk factors, criminogenic needs, and responsivity factors can be challenging to translate into practice. In line with the fidelity principle, providers considering the infusion of the RNR principles into their DV treatment programs should prepare and ensure the availability and requirement of frequent and detailed trainings on the PEI framework for practitioners.

The accuracy of the DVRNA, similar to other risk assessment instruments, is predicated on the information available to score it. Therefore, one challenge associated with scoring the DVNRA has been securing access to the collateral information required by the *Standards* to be reviewed as part of the offender evaluation. Access

to offender records (e.g., prior criminal history, criminal justice documents, victim contact or victim impact statements, previously completed treatment records) may be limited if local policies limit the disclosure of information to treatment providers. It is also important to note that reliance on victim-provided information to score the DVRNA is discouraged to the extent possible; priority is given to other sources for the completion of the DVRNA. This priority is not to discredit or dismiss the victim's account or impact, but rather to protect a victim's safety. The Provider and the MTT use information gleaned from a victim in other ways. For instance, the victim's description of the offense may be used to understand an offender's coercive control dynamics and offense history. Should offenders learn that their classification at a higher level of treatment intensity was due to information provided by the victim, adverse outcomes may occur (e.g., escalated offender aggression and violence toward the victim). To avoid these unintended consequences, the DVOMB offers trainings for Colorado Providers related on appropriate strategies for obtaining information about an offender without compromising victim safety unnecessarily.

Resources and Risk Management Strategies for High-Risk Offenders. There is potential within DV cases that the crime of conviction may not be indicative of an offender's risk. For example, an offender convicted of a misdemeanor offense, such as trespassing, simple assault, stalking, or harassment, against his intimate partner may present as low risk. Upon further examination through the offender's evaluation, details about the offender's risk may be significantly higher and require additional resources (e.g., more frequent contacts or home visits, Global Positioning System (GPS) monitoring, and other adjunct services for substance abuse or mental health) to manage. This level of risk may not be commensurate with the sentence imposed and the level of supervision required while placed in the community. Many aspects of abusive behavior may not be identified as criminal behavior; further, prior DV may not have been reported through the criminal or legal system. Municipalities may not share criminal records and may not enforce requirements for an offender to attend treatment. In some instances, DV cases in Colorado have resulted in offenders receiving sentences for unsupervised probation or diversion. These cases are problematic to Providers, as the MTT requires active involvement on the part of a supervising officer or agent to assist with assessing risk, progress toward the competencies, and judicial monitoring to address violations while under supervision of the court or agency. The absence of a supervising officer or agent places the Provider in a precarious dual role of acting as the therapist and an agent to the court concurrently. This dual role can deteriorate an effective therapeutic alliance and obfuscate the ethical balance of treatment, accountability, and victim safety. Another notable concern arises in DV offenders who have been sentenced to time-limited probation (e.g., 12–18 months). In these instances, higher risk offenders may not be eligible for discharge and may need an extension to complete treatment along with any other co-occurring issues.

The DVRNA captures several high-risk and lethality factors such as strangulation, suicidal and homicidal ideation, access to weapons, and psychopathy. Research connecting DV with psychopathy suggests that those with severe antisocial traits

may not be amenable to traditional forms of treatment, such as those that focus on empathy development, cognitive processes, and interpersonal skills (Huss, Covell, & Langhinrichsen-Rohling, 2006). The rationale for this is based upon evidence suggesting that these approaches and techniques may contribute to an increase in violent recidivism following treatment (Hare, Clark, Grann, & Thornton, 2000; Rice, Harris, & Cormier, 1992). Guidelines for the treatment of psychopathy with general offenders has been examined in more recent years (e.g., Polaschek & Skeem, 2018), yet there are no parameters specific to DV offenders; however, more practical challenges remain. In Colorado, the psychopathy of an offender is often challenging to assess for and is an optional part of the offender evaluation through the PCL-R (Hare, 2003). Similarly noted, Juodis and colleagues (2014) point out that practitioners lack the training, qualifications, and financial resources to administer the PCL-R. As a result, it is possible that DV offenders who have severe psychopathic traits are admitted into treatment without the proper diagnostic testing from highly trained therapists. The DVOMB *Standards* give discretion to Providers to recommend against or discontinue treatment if there is sufficient evidence that suggests treatment is contraindicated due to psychopathy. Still, the absence of proper screening and treatment presents victim and community safety concerns that are not isolated to Colorado. As such, DV treatment providers exploring the integration of the PEI framework into their programming should consider if there are suitable policy measures to address high-risk, high-need populations, as well as provide discretion in determining a DV offender's amenability for treatment.

Standards Implementation Variation Across Treatment Providers. As mentioned previously, the *Standards* indicate that the DVOMB is tasked with periodically reviewing and assessing the *Standards* in response and relation to emerging research, best practices, implementation challenges, or recent case law related to effective DV treatment. Therefore, with support from the DVOMB, Gover et al. (2015) conducted a process evaluation examining the implementation of the *Standards* by Providers. In a mixed method research design, the researchers administered online surveys to 107 MTT members (treatment providers, state probation officers, and victim advocates), with 14 of the 107 completing an additional follow-up telephone interview. Results revealed that many of the MTT members reported the *Standards* were being implemented; however, variation in the extent to which the *Standards* were implemented existed.

Findings from this study prompted several proposed recommendations by the research team, including: the continued practice of evaluating the implementation of the *Standards* in relation to treatment length; the continued practice and support of empirical research that explores the effectiveness of DV treatment in Colorado; the enhancement of monitoring the application of the *Standards* among all MTT stakeholders (e.g., Providers, probation officers, victim advocates); the promotion and delivery of *Standards* training among criminal justice system practitioners (e.g., law enforcement, attorneys, judges); establish and employ standardized instruments to assess offenders' progress and change; develop and integrate a centralized process for MTT member grievance policies; and expand and cultivate protocols for offenders

who have co-occurring mental health and/or substance abuse concerns (Gover et al., 2015).

In response to these and other recommendations, the DVOMB has taken significant steps toward increasing the access and availability of training and technical assistance to members of the MTT. The redesigned training amounts to 35 hours of curricula focused on the Standards using a combination of both online and in-person formats and is provided nearly every 4 months. These trainings are offered at no cost to stakeholders in Colorado seeking to learn more about the Standards. Furthermore, the process by which a Provider becomes approved to work with DV offenders was also overhauled in the Standards. The previous system placed unnecessary weight on arbitrary training and experiential hours to measure one's ability to deliver services in accordance with the Standards. The revisions introduced a new competency-based supervision model where a Domestic Violence Clinical Supervisor (DVCS) assesses a prospective Provider's clinical and administrative competencies. This process has empowered the supervision process to be more detailed and individualized so potential areas of improvement can be identified during supervision and prior to approval. This process has attracted more experienced mental health professionals who would have otherwise chosen to work in other forensic fields.

Among all of the efforts undertaken by the DVOMB, of critical importance is the philosophical change to how it approaches its engagement, governance, and oversight of MTT members. Instead of a doctrine that pursues compliance with the Standards through sanctions and punishment, the DVOMB shifted its regulatory focus to first prioritize support, technical assistance, and remediation when necessary. The underlying emphasis to support Providers and MTT members has benefited implementation and increased fidelity to the *Standards*. Providers and MTT members are encouraged to contact the DVOMB with questions about the *Standards* and now regularly attend committee and board meetings. Although the DVOMB does not have authority to oversee and regulate aspects of supervision from probation and parole, this philosophical change provides an avenue for better MTT coordination and collaboration throughout the state. These efforts have helped ameliorate instances where MTT disagreements require outside consultation and guidance.

In a subsequent, external evaluation of the Colorado differentiated treatment model, Gover and Richards (2018) examined treatment providers' approach to integrating the 18 core competencies into their treatment curriculum, as well as how the providers' evaluated the DV offenders' comprehension of the competencies. Though the study had some sample size limitations, the findings offered valuable insight. Through curriculum reviews and treatment provider interviews, the researchers determined the treatment providers integrated the core competencies into their respective curriculums to varying degrees. Further, the study findings revealed that one or more core competencies were absent in some providers' curricula, and some curricula covered material beyond the parameters of the core competencies. With regard to treatment providers' evaluation of offenders' core competencies, the study results indicated treatment providers more often relied on clinical judgment rather than the

use of standardized instruments, and the providers used an array of strategies to determine an offender's successful treatment attainment of core competencies. Since this study, the DVOMB has convened a committee to revise the treatment section of the *Standards* and plans to explore ways to consolidate and reorganize the core competencies, which may include methods to measure competencies.

MTT Composition and Treatment Victim Advocate Roles. As noted previously, a MTT includes (at a minimum) a treatment Provider, a referring criminal justice professional (e.g., probation officer), and a TVA. Richards and Gover (2018) conducted a study to examine the experiences and perspectives of TVAs working within the Colorado model. The study results indicated variation in the TVAs' role in MTT decision-making regarding offender treatment, with some advocates reporting that they felt they did not have an equal voice as the other individuals on the MTT. The DVOMB revised the Standards to create a more professional identity and certification of TVAs in 2016. The efforts to create this certification process sought to increase the TVAs visibility, credibility, and overall status with the MTT. Additionally, these revisions required Providers to include and consult with the TVA as part of the MTT. Administratively, the DVOMB requires that each Provider has a TVA and affords the TVA opportunities to report concerns about their involvement with MTT decision-making during the initial application process and when Providers seek to renewal their listing status.

CONSIDERATIONS AND FURTHER SUGGESTIONS

Policy Considerations

DV offenders represent a heterogeneous group that necessitates a correspondingly diverse and individualized approach to treatment. While advancements have prompted new directions and innovations in DV treatment services, there are still a number of policy-related barriers to differential treatment rooted in the PEI framework. Judicial approaches to supervising DV offenders are an important component to any coordinated community response. However, policies driving the sentencing structure and case management may limit DV treatment providers' ability to appropriately implement the PEI framework. Additionally, as emergent research unfolds regarding the overlap between DV offenders and general offenders (Piquero, Theobald, & Farrington, 2014; Richards, Jennings, Tomsich, & Gover, 2013), policymakers and criminal justice professionals may question the necessity of specialized programming for DV. This is especially important given the larger context of limited governmental resources and the minimal effectiveness of current DV programming not rooted in evidence-based practices.

Many states continue to mandate policies that support a one-size-fits-all approach (Cannon et al., 2016). Standards that fail to incorporate empirical research may be mandating DV treatment providers to deliver less than effective treatment (Corvo et al., 2008). Scholars and practitioners have questioned the impact of state standards and have called for a greater role for evidence-based practices in state standards

(Babcock et al., 2016; for a review of positive and negative attributes of state standards, see Maiuro & Eberle, 2008). Furthermore, the need for individualized treatment is not isolated to DV offenders, as substance abuse and sexual offending fields have incorporated the RNR principles into their treatment services (Hanson, Bourgon, Helmus, & Hodgson, 2009; Taxman, 2000). Policymakers, practitioners, criminal justice professionals, and victim advocates serve important roles in the case management of DV offenders; therefore it is important to raise and promote awareness and education surrounding empirical research and its infusion into the practical realm.

Research Considerations

Within the last decade, the research and practical realm explorations into the integration of the PEI framework into DV offender treatment has unfolded, with preliminary findings revealing cautious promise. The State of Colorado was the first state to update its legislation surrounding DV offender treatment to include a mandate for the integration of evidence-based practices. As is the nature of pioneering a new approach, researchers and practitioners alike can benefit from the information gleaned from Colorado's innovative approach. At the heart of the potential "lessons learned" is the critical need for researcher–practitioner partnerships, wherein both researchers and practitioners work together to identify best practices in DV offender treatment. Funding for research, as well as the capabilities to conduct research, may be limited for states, agencies, and organizations seeking to infuse the PEI framework into their DV treatment programming. Researcher–practitioner partnerships promote multidisciplinary work that is well suited for current federal funding opportunities (e.g., National Institute of Justice).

Though emerging research has provided insight on the risk factors, criminogenic needs, and responsivity factors DV offenders may have (e.g., Connors et al., 2012, 2013; Hilton & Radatz, 2018, in press; Stewart & Power, 2014), further exploration is warranted to ensure generalizability and applicability of the PEI to DV offenders and their treatment. Relatedly, given the integral component of the DVRNA to the Colorado model, it is recommended that researchers seek to examine the validity of the instrument (as the instrument has yet to be validated), as well as compare its predictive power against other validated and well-known risk assessment instruments (e.g., ODARA, SARA).

In accordance with the fidelity principle, it is also recommended that researchers conduct implementation, process, and outcome evaluations on a variety of elements within the Colorado model. Building off the work of Gover and Richards (2018; Gover et al., 2015), emphasis should be placed on the examination of how well Colorado treatment providers adhere to the PEI framework, the *Standards*, and their implementation (also referred to as program integrity) into DV treatment services. To date, no outcome evaluations have been conducted on the Colorado model; therefore, it is suggested researchers examine both short-term and long-term outcome measures, as recommended by Radatz and Wright (2016), to determine the effectiveness of the

Colorado model, as well as elements of the model that may impact various outcomes (e.g., treatment completion and attrition).

CONCLUSION

This article aimed to provide an overview of the PEI framework, the emerging research findings related to the PEI and its application to DV offenders and their treatment, and the Colorado three-tiered differentiated treatment approach informed by the PEI. The initial research results, as well as the Colorado practitioners' experiences, have revealed cautious optimism for the infusion of the PEI framework into DV offender treatment. We offer this article as a platform to showcase not only the benefits of Colorado's innovative approach to DV treatment, but also to provide important considerations that may impact the integration of evidence-based practices, specifically the PEI, into DV offender treatment services.

NOTES

1. The DVOMB is comprised of 19 appointed members who represent a wide range of professional disciplines and who serve voluntarily.
2. The criminal definition of domestic violence in Colorado is codified in §18-6-800.3(1), C.R.S. which states domestic violence is "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."
3. Other specific modalities and interventions such as couples counseling were considered and either not included or prohibited based on the research reviewed at the time.
4. The Standards do not define cognitive behavioral treatment (CBT). The *Standards* defines treatment as the following: "As defined in Section 16-11.8.102, C.R.S, treatment means therapy, monitoring, and supervision of any court ordered domestic violence offender which conforms to the Standards created by the DVOMB. Consistent with current research and professional practices, domestic violence offender treatment is the comprehensive set of planned therapeutic experiences and interventions designed to uniquely change the power and control, abusive thoughts, and behaviors. Such treatment specifically addresses the occurrence and dynamics of domestic violence and utilizes differential strategies to promote offender change. Much more importance is given to the meeting of all treatment goals than the passage of a specific amount of time, since offenders make progress in treatment at different rates. Treatment is more successful when it is delivered consistently and with fidelity to the individual needs of the offender."
5. In regard to average length of treatment among offenders who successfully completed treatment, offenders placed in level A were supervised for an

average of 24 weeks (*SD*) = 7.5 weeks, minimum=12 weeks, maximum=48 weeks), offenders placed in level B were supervised for an average of nearly 35 weeks (*SD*) = 8 weeks, minimum=3 weeks, maximum=88 weeks), and offenders placed in level C were supervised for an average of 37 weeks (*SD*) =10 weeks, minimum=2 weeks, maximum=120 weeks). Given the wide range of treatment lengths, even within treatment levels, the median treatment length provides a better description of the "normal" course of treatment among offenders in each treatment level: offenders placed in level A spent a median 24 weeks in treatment, offenders placed in level B spent a median 35 weeks in treatment, and offenders placed in level C spent a median 36 weeks in treatment" (Gover et al., 2015, pg. 7).

6. The Standards do not define cognitive behavioral treatment (CBT). The *Standards* define treatment as the following: "As defined in Section 16-11.8.102, C.R.S, treatment means therapy, monitoring, and supervision of any court ordered domestic violence offender which conforms to the Standards created by the DVOMB. Consistent with current research and professional practices, domestic violence offender treatment is the comprehensive set of planned therapeutic experiences and interventions designed to uniquely change the power and control, abusive thoughts, and behaviors. Such treatment specifically addresses the occurrence and dynamics of domestic violence and utilizes differential strategies to promote offender change. Much more importance is given to the meeting of all treatment goals than the passage of a specific amount of time, since offenders make progress in treatment at different rates. Treatment is more successful when it is delivered consistently and with fidelity to the individual needs of the offender."
7. Portions of the offender competencies were obtained and adapted from the Colorado Adult Sex Offender Standards.

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Disclosure. The authors have no relevant financial interest or affiliations with any commercial interests related to the subjects discussed within this article. The findings and opinions expressed in this manuscript reflect solely the views of the authors and are in no way endorsed by the Colorado Division of Criminal Justice or the Domestic Violence Offender Management Board, and do not represent government policy or views. The authors would like to thank N. Zoe Hilton, Tara N. Richards, and Emily M. Wright for their helpful comments on earlier drafts of this manuscript.

Funding. The author(s) received no specific grant or financial support for the research, authorship, and/or publication of this article.

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