Assessing States' Intimate Partner Violence Offender Treatment Standards using a Principles of Effective Intervention Framework

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Published on: Sep 06, 2021

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ABSTRACT

Court-ordered treatment programs are a widely used response to intimate partner violence (IPV) and many states have developed standards to guide programs. The current study provides an update to Maiuro and Eberle's (2008) review of states' standards and extends the literature by using the *principles of effective intervention* (PEIs; i.e., *risk, need, responsivity, treatment, and fidelity*) as an organizational framework to examine standards. Findings showed that 84% of states had standards in 2020, compared to 88% in 2007, and extensive changes both within and across states' standards had occurred. Regarding the PEIs, in line with the risk principle most states mandated the use of risk assessments; inconsistent with the needs principle, few states used these assessments to classify clients into risk-levels or inform individualized treatment. The majority of standards addressed the treatment principle by outlining a required structure and duration, but few attended to responsivity factors (e.g., identifying treatment modalities, attending to specific client factors). Regarding the fidelity principle, most standards outlined education or training requirements for staff and required periodic program reviews or audits, but few standards were evidenced-based and only about half required that programs collect data to measure effectiveness. Taken together, findings suggest that standards have continued to evolve, and that the integration of PEIs into IPV treatment is only just beginning. Standards provide a rich opportunity for future researcher-practitioner partnerships in the field of IPV intervention.

Key Words: Evidence-based practices, domestic violence, batterer intervention treatment

One of the criminal justice system's primary responses to intimate partner violence (IPV) is court-mandated treatment programs (Cannon et al., 2016; hereafter referred to as IPV treatment programs) and states have developed *standards* which outline the accepted practices for IPV treatment and provide operating guidelines for programs (Babcock et al., 2016; Gover, 2011). Two prior studies (Maiuro et al., 2001; Maiuro & Eberle, 2008) examined states' standards and provided data on their prevalence, scope, and content; however, it is likely that standards have changed in the intervening decade given factors such as paradigm shifts and funding changes as well as in response to evolving research.

Decades of research have provided mixed evidence regarding the impact of IPV treatment on recidivism (for a review see Chen et al., 2021) and some scholars (e.g., Radatz & Wright, 2016; Stewart et al., 2013) have suggested that IPV treatment programs would benefit from adopting the *principles of effective intervention* (PEIs) (Andrews et al., 1990; Andrews, Zinger, et al., 1990; Gendreau, 1996) commonly used in correctional programming. Research has shown that correctional programs or treatment models adhering to the PEIs result in the greatest reductions in recidivism (Andrews et al., 1990; Gendreau, 1996), and emerging evidence suggests that IPV treatment programs are adopting the PEIs and seeing positive client outcomes (Stewart et al., 2014; see also Radatz et al., 2021).

Given that standards provide operating guidelines for programs, any changes in standards afford a significant opportunity to affect widespread changes in IPV treatment programming. Likewise, although the use of the PEIs in IPV treatment has gained recent attention, to our knowledge there has yet to be an examination of the extent to which the PEIs are integrated into standards. Therefore, the goals of the present study are two-fold: (1) to present an updated assessment of standards for IPV treatment programs and (2) to advance the literature by examining the extent to which the PEIs have been incorporated into standards.

Intimate Partner Violence Offender Treatment Programs

Psychoeducational programs for individuals who perpetrate IPV are generally known as batterer intervention treatment programs, but some states have adopted program names that reflect more contemporary and/or less stigmatizing language (e.g., Maryland's Abuse Intervention Treatment programs, Vermont's Domestic Violence Accountability Programming; see appendix for list of state standards). In the present study, these programs are referred to as IPV treatment programs.

Although the exact number of IPV treatment programs is unknown, Cannon et al. (2016) suggests that there are between 1,100 and 3,000 IPV treatment programs in the United States, while Boal and Mankowski (2014) estimate that there are approximately 500,000 men participating in an estimated 2,500 programs annually nationwide. At the same time, research examining the impact of IPV treatment on IPV recidivism has shown varied results with small to moderate effects in some but not all studies (Chen et al., 2021). A meta-analysis by Chen and colleagues (2021) also found that offenders who completed IPV treatment had lower rates of IPV recidivism according to criminal justice system reports (i.e., lower arrests), but not according to reports by victim-partners.

Some scholars have called for the infusion of the PEIs from correctional programming into IPV treatment programs as a way to improve client outcomes (Radatz & Wright, 2016; Stewart et al., 2013). Correctional models following the PEIs have been associated with significant reductions in general recidivism with some studies showing decreases of 80-90% (e.g., Andrews et al., 1990). Calls for the integration of the PEIs into IPV treatment programs are rooted in research finding that the majority of offenders who are referred to IPV treatment programs have a history of other types of criminal behavior (i.e., they are not “IPV specialists”; Piquero et al., 2006; 2014; Richards et al., 2013) and that IPV treatment program clients share many of the same criminogenic risks and needs as offenders who have historically been the target of PEI research in correctional settings (Hilton & Radatz, 2018, 2021; Stewart & Power, 2014).

Evidence-Based Practice Research and DV Treatment

The PEIs include the principles of *risk*, *need*, *responsivity*, *treatment*, and *fidelity* (Andrews et al., 1990; Andrews, Zinger, et al., 1990; Bonta & Andrews, 2017; Gendreau, 1996). A review by Radatz and Wright (2016) addressed the application of the PEIs in IPV treatment programming. As noted by Radatz and Wright, regarding the *risk* principle, IPV treatment programs should use risk assessments to identify an offender's criminogenic risk factors during the intake assessment (Bonta & Andrews, 2017). The results of risk assessments should be used to categorize IPV offenders into low, medium, and high-risk groups and corresponding intensities of treatment based on their level of risk (e.g., high-risk offenders should receive high-intensity treatment while low-risk offenders should receive minimal to no treatment) (Lowenkamp et al., 2006). Next, the *need* principle focuses on assessing an offender's specific criminogenic needs (dynamic and modifiable factors linked to recidivism) and tailoring treatment to address such needs (Bonta & Andrews, 2017). Prior research has demonstrated that IPV offenders have extensive criminogenic needs (e.g., substance use, low educational attainment, unemployment) (Hilton & Radatz, 2018, 2021; Stewart & Power, 2014); however, little evidence suggests that IPV treatment programs routinely provide interventions for criminogenic needs (e.g., referrals to substance abuse treatment or GED preparation programs, job training) (see Babcock et al., 2016). Further, IPV treatment programs can make use of individualized treatment plans or offender contracts that identify treatment goals based on each offender's criminogenic risks and needs and outlines specific strategies to address them.

The next PEI, *responsivity*, focuses on the relationship between treatment styles and modalities and offender characteristics. Responsivity includes general factors that pertain to the program as a whole, and specific factors that focus on individual clients (Bonta & Andrews, 2017). In regard to general responsivity, research suggests that group-based, cognitive-behavioral treatment is the favored treatment modality for IPV treatment, and that more structured treatment is preferable to less structured treatment (Babcock et al., 2016). Specific responsivity also addresses individual offender characteristics such as education level, literacy, and culture which can affect treatment engagement, and in turn, treatment success (Bonta & Andrews, 2017). Likewise, the responsivity principle suggests that IPV treatment programs should regularly evaluate what clients are learning in treatment and whether and how this learning impacts client outcomes (Radatz & Wright, 2016).

The *treatment* principle suggests that programs rely heavily on social learning techniques such as role playing, skill building, and problem-solving applications (Bonta & Andrews, 2017). The treatment principle is also concerned with the structure and duration of the program with research suggesting that group-based models lasting roughly 26 weeks (meeting 1 to 1.5 hours per week) is the preferred dose for moderate intensity treatment (see Radatz & Wright, 2016). Finally, *fidelity* focuses on therapeutic integrity by requiring program staff to be qualified, trained, and participate in continued education and on the job training (Bonta & Andrews, 2017). IPV treatment program staff should also understand responsivity factors and be trained in the implementation and administration of risk assessment tools (Radatz & Wright, 2016). In addition, programs should collect data on their program, staff, and participants and complete regular process and outcome evaluations. Evaluations should be used to guide programmatic changes. Taken together, scholars suggest that IPV treatment programs that adhere to the PEIs will be associated with better client outcomes such as higher rates of treatment completion and lower rates of recidivism (Radatz & Wright, 2016; Stewart et al., 2013). While the PEIs have been used to address improvements in IPV offender treatment at the programmatic level (e.g., Radatz et al., 2021; Stewart & Powers, 2014), they may also serve as a valuable framework to assess macro-level factors such as state standards for IPV offender treatment.

Prior Reviews of State Standards for IPV Treatment

As IPV treatment programs grew in popularity nationwide, states developed *standards* which outline the accepted practices for the implementation and delivery of offender

treatment, and aim to serve as quality assurances that IPV treatment programs are being implemented as planned (Babcock et al., 2016; Gover, 2011). While there is a paucity of research on standards, two widely-cited studies provided in-depth reviews of standards from the 1990s (Maiuro et al., 2001) and mid-2000s (Maiuro & Eberle, 2008). Below a detailed summary of these findings are provided and organized according to the PEIs.

First, Maiuro and colleagues (2001) assessed standards for 29 states and the District of Columbia regarding six domains: specification of treatment length; treatment orientation, methods, and content; allowable and preferred modalities of treatment; research findings to support standards; minimum education for providers; and methods for developing and revising standards. These domains included indicators from the responsiveness, treatment, and fidelity principles. For example, inconsistent with the responsiveness principle, results indicated that nearly all standards prescribed a one-size-fits-all treatment approach and few standards provided detailed information on treatment content. Further, none mandated a specific manualized curriculum. In line with the treatment principle, most programs specified a treatment duration (here a minimum of 16 weeks), nearly all (90%) specified the use of group treatment and 65% indicated that groups should be gender-specific; 55% also allowed individual therapy. Regarding the fidelity principle, 40% of states included at least some reference to research to support the positions taken in their standards, but Maiuro and colleagues discussed limitations regarding the included references (e.g., the age of the references). Further, only 5% included a qualified researcher on the working group that developed the standards. Twenty percent of standards required treatment providers to have a bachelor's degree and very few standards recognized that treatment for IPV offenders requires specialty training. Finally, the majority of standards did not specify a clear process for developing and/or revising the standards and 30% referenced the need for program evaluation.

Maiuro and Eberle (2008) conducted an updated examination of states' standards by examining the six domains reported on by Maiuro et al. (2001) for 45 states and the District of Columbia ($n = 46$) as well as new domains: administrative entity for certifying standards (fidelity principle) and screening and risk assessment protocols (risk principle) to determine whether and how the field had progressed over time. Results indicated that 92% (all but 3 states) continued to prescribe a one-size-fits-all treatment approach, but most standards expanded the language around preferred treatment approaches and treatment content. Once again, no standard went so far as to identify a specific manualized curriculum. Most standards continued to include

treatment duration and the average minimum length of treatment increased to 24 to 26 weeks. The percent of states mandating the use of group treatment increased to 98% and the percent of states that allowed individual therapy was reduced by almost half, to 23%. Regarding research to support standards, the percent of states including research decreased to 25%, but the percent of states requiring treatment providers to have at least a bachelor's degree doubled to 40%. Finally, 33% of standards mentioned program evaluation and/or research as a desirable activity; however, only 18% of standards required actual data collection related to the effectiveness of the programs.

Regarding oversight bodies, Maiuro and Eberle (2008) first noted that, "standards may not always be formalized within legal statute, existing instead as a policy or set of guidelines for programs receiving public funding or referrals" (p. 135); however, they did not indicate how many or which states had codified their standards into statute or administrative code. Relatedly, they listed community coalitions, social/health agencies, and judicial boards as entities responsible for regulating and enforcing standards, and noted that states with codified standards were more likely to use the courts or a social/health agency to regulate their standards. In line with the risk principle, the majority of standards had incorporated the use of risk assessments primarily for mental health and substance abuse as well as measures of lethality at intake; however, only Colorado included a measure of IPV recidivism risk (i.e., Spousal Assault Risk Assessment or SARA; Kropp et al., 1994). Overall, the researchers asserted that between the 2001 and 2008 studies there had been "positive trends" in standards, but emphasized the need for continued research and assessment of the evolution of standards (p. 147).

Current Study

Although Maiuro and colleagues (2001) and Maiuro and Eberle (2008) provided valuable data on the prevalence, scope, and content of standards, these reviews are quite dated. As both studies demonstrated, different states adopt and repeal standards, and standards within individual states change and evolve over time. Further, similar to Maiuro et al. (2001), the present research is guided by a timely discussion regarding whether standards "are based in scientific evidence" (p. 11), herein the extent to which they align with the PEIs. As such, the present study aims to: (1) present an updated assessment of states' standards for IPV treatment programs and (2) advance the literature by examining the extent to which the PEIs have been integrated into states' standards.

Methods

Data

The present analysis assesses standards for all 50 states and the District of Columbia (D.C.) ($n = 51$). There is no national repository for standards, so the authors began their search by accessing the domestic violence coalition website for each state and D.C. For domestic violence coalition websites that did not reference standards, the authors contacted that domestic violence coalition directly through email or phone. Using these two strategies, the authors were able to confirm (1) whether each state/D.C. had current standards, and for those that had standards, (2) obtain a copy of the standards.

Coding Scheme

As reviewed above, Radatz and Wright (2016) identified a series of empirically based indicators for the PEIs that were specific to IPV treatment programs. For the present research, a coding sheet was developed that includes these indicators. The coding sheet was loaded into Qualtrics survey suite so that individual coders could easily complete a coding sheet for each standard and submit it to Qualtrics for efficient data storage and eventual calculation of descriptive statistics. A list of the PEIs and corresponding indicators is provided below; each indicator was scored as present or absent in the standard (no = 0, yes = 1).

Risk

Five indicators were used to assess the risk principle including whether the standard (1) mandated the use of risk assessment at intake, (2) classified offenders into risk levels, (3) used differentiated treatment based on risk level, (4) reviewed offenders' criminal/court records to assess risk factors, or (5) specified that IPV treatment providers had a duty to warn or alert victims regarding potential threats from the offenders.

Need

Eight indicators were used to assess the need principle including whether the standard mandated risk assessments to assess (1) IPV recidivism, (2) lethality, (3) criminal history, (4) mental health, (5) substance use, or (6) children/family relationships; mandated (7) the use of individualized offender treatment contracts or (8) referrals to substance use and/or mental health treatment.

Responsivity

Eight indicators were used to assess the responsivity principle. Six indicators pertained to general responsivity including whether the standard (1) required use of cognitive-behavioral treatment modalities, (2) prohibited use of couples counseling, (3) prohibited anger management as sole or primary focus, (4) attended to cultural competency, (5) included strategies for same-sex couple violence, and (6) required that treatment be in client's primary language or fluent language. Two additional indicators pertained to specific responsivity including whether IPV treatment programs were required to (7) use a sliding fee scale or (8) provide programming across levels of client literacy.

Treatment

Five indicators comprised the treatment principle including whether the standards specified (1) the number of weeks for treatment or that it was a non-time driven approach, (2) the length of each treatment session, (3) the use of group treatment, (4) that groups must be gender specific, (5) that individual treatment could be used, or (6) the specific requirements for treatment completion.

Fidelity

Eight indicators were used to assess the fidelity principle including whether the standard required (1) degree requirements for providers, (2) domestic violence-specific training for providers, or (3) continuing education for providers; whether the standard (4) was rooted in research (i.e., included references), required (5) periodic audits, reviews, or re-certification of programs or (6) for programs to collect data on program effectiveness; and whether standards were (7) formalized in legal statute or administrative code or (8) specified an enforcement strategy for the mandates in the standard.

Procedures and Analytic Strategy

A copy of each standard was reviewed independently by two researchers. One tenured faculty member and one doctoral-level research assistant served as a coder for each standard. After independent coding, the data were reviewed for coding discrepancies. Coding discrepancies resulted when one of the first two coders made an error in their initial review and coding, e.g., a coder overlooked that an indicator was included in the standard. In the case of discrepancies, a third doctoral-level research assistant reviewed the standard and rectified the error. Consistent with Maiuro and Eberle

(2008), inter-rater reliability was not calculated because all coded data represented information that was explicitly included or excluded in the standard.

The results were exported from Qualtrics as a SPSS 21 file and descriptive statistics were computed for each of the indicators and organized by the PEIs. Qualitative examples were then drawn from various standards for purposes of “illustration, critique, and discussion” (Maiuro et al., 2001, p. 24).

Results

After an exhaustive search, standards were identified for 43 states (82%): Arkansas, Mississippi, New York, South Dakota, Pennsylvania, New Jersey, South Carolina and D.C. did not have standards as of October 1, 2020 (See Appendix for list of standards). The most recent analysis by Maiuro and Eberle (2008) found that Arkansas, Mississippi, New York, South Dakota, Connecticut and Wyoming did not have standards. Thus, Pennsylvania, New Jersey, South Carolina, and D.C. repealed their standards, and Connecticut instituted standards since Maiuro and Eberle’s previous review. Furthermore, many standards changed since Maiuro and Eberle’s research – 80% of current standards were issued since 2010 and 12 standards were issued in the previous two years (2018-2020) (e.g., Montana, Nevada, Iowa) (see Appendix for list of standards).

Integration of PEIs into Standards

Standards were reviewed with attention to the aforementioned indicators of the PEIs including (1) risk, (2) need, (3) responsivity, (4) treatment, and (5) fidelity within IPV treatment. Descriptive statistics for each indicator are presented in Table 1.

Qualitative examples from standards are also provided to highlight areas of alignment with the PEIs or to provide points for consideration.

Risk

Regarding the risk principle, 72% of standards specified that programs should use risk assessments at intake; however, only 14% required programs use these assessments to classify clients by their level of risk and/or to provide differential treatment based on a client’s risk. Specifically, Colorado, Delaware, Iowa, Utah, Washington, and Wyoming specified the use of risk assessments, risk categories, and differential treatment. For example, Utah’s (2018) standards explained how the determination of offenders’ risks and needs resulted in differentiated treatment for offenders: “Offenders are assessed for IPV and general criminogenic risk factors using the ‘Domestic Violence Risk and

Needs Evaluation' (IPVRNE) and the 'Level of Service/Risk, Need, Responsivity' (LS/RNR)". Based on the presence/absence of risk factors, offenders are placed into low, medium, or high-risk treatment categories. Offenders presenting with certain risk factors receive a higher intensity and duration of treatment. Further, Utah's treatment model recognizes that offenders' risks can change and allows for risk levels to be reassessed, and should it be necessary, move an offender to another level.

Similarly, Washington differentiated treatment by placing offenders into one of four levels of treatment based on a behavioral assessment. In Washington (2020),

A participant must complete an individual interview and behavioral assessment with a certified program prior to starting any level of treatment. (2) The purpose of the assessment is to determine: (a) The level of risk, needs, and responsivity for the participant; (b) The level of treatment the program will require for the participant; and (c) Behaviorally focused individualized treatment goals or objectives for an initial treatment plan (p. 38).

Thus, practitioners determine an individualized treatment plan for participants reflecting a unique set of goals, approaches, and interventions based on the distinctive set of participant needs and risk factors.

Additionally, 51% of states required that programs review clients' criminal records to help determine their level of risk and 63% of standards specified that programs have a duty to warn or alert victims and relevant criminal justice system personnel (e.g., police, probation/parole) if a client reveals information that serves as a threat of danger to the victim.

Need

The need principle asserts that clients must be assessed across a host of criminogenic risks and needs; however, standards varied regarding which risks and needs must be assessed at intake. Twenty-one percent of standards required a specific assessment of IPV recidivism while 63% mandated assessment of lethality risk. For example, Michigan's standards (1991) required IPV treatment client's lethality to be assessed as an ongoing process. Examples of lethality indicators used in Michigan included the degree of "ownership" the client expresses regarding the victim; threats of homicide; threats of suicide; possession of or access to weapons; rage; history of past abuse; fantasy of homicide or suicide; obsessiveness about victim (or the victim's family/friends); centrality of victim to the client; and a history of stalking (p.8).

Twenty-one percent of standards also specified that information regarding children and familial relationships be collected. In comparison, 56% of standards required that criminal history data be collected while 77%, respectively, required clients' mental health and substance abuse history be assessed. In addition, 70% of standards required a treatment contract between the IPV treatment program and the client, while 56% specified the use of referrals to substance use and/or mental health treatment for clients with these needs.

Responsivity

General

About one-quarter (26%) of standards specified the use of cognitive-behavioral treatment modalities in IPV offender treatment, while 77% prohibited the use of couples counseling and 74% prohibited anger management as the sole or primary focus of treatment. The prohibition of couples counseling stems from a desire to hold the perpetrator accountable and maximize the safety of victims and avoid blaming or punishing victims by requiring their participation in their abuser's treatment (Tomsich et al., 2015). Likewise, as seen in New Hampshire's standards (2002) the use of anger management is disallowed because "Anger management programs assume the abuser has no control over his or her behavior, whereas batterer intervention programs assume the defendant chooses when and whom to abuse" (p. 89). Further, only Iowa required the use of a specific IPV treatment curriculum - Achieving Change Through Values Based Behavior (ACTV); Nebraska's standards noted that program providers must be trained in either the Duluth or Emerge models, but it did not specify that these curriculums be used in IPV treatment.

The need for IPV treatment programming to consider clients' culture is specified in 67% of standards, while about one third (33%) mandated that programs provide treatment specific to same-sex couple violence. Nebraska's standards, for example, required programs to develop treatment policies to guide same sex offender treatment. Likewise, Delaware's standards required separate groups for participants who are in same sex relationships and those in heterosexual relationships.

In addition, 47% of standards specified that treatment must be provided in the client's primary language or a language in which the client is fluent. For example, Ohio's standards (2010) explained that, "in case the participant has limited English proficiency (LEP), the BIP shall, to the extent possible, provide the services to them in the native language, or arrange interpretation and translation services..." (p. 13).

Specific

Less than half of the standards (42%) required that programs use a sliding scale regarding programming fees. Twenty-one percent (21%) of standards discussed the need to provide IPV treatment to clients across different levels of literacy.

Treatment

Treatment Structure

All standards (100%) addressed the length of IPV treatment by either specifying a minimum length of treatment, a specific length of treatment, or a non-time driven model. Among programs that specified treatment length, the average minimum length required was 30 weeks, with a range of 18 to 52 weeks. Additionally, 58% of standards addressed the duration of each treatment session: the average duration of treatment session was 91 minutes with a range of 60-120 minutes. Forty-one (95%) standards specified that group treatment was the sole or preferred method for IPV treatment, and 74% of standards further noted that group treatment must be gender-specific. In addition, 60% of standards allowed the use of individual treatment in certain circumstances and/or to augment group treatment. For example, while Connecticut's standards (2019) indicated a preference for group treatment,

Where group participation is genuinely not possible due to a specific, demonstrated need that cannot be accommodated in a group setting, a planned, structured program of individual interventions may be considered. All aspects of such work with offenders should adhere to the principles and approaches of the state's offender program standards and cover the same topics, skills, and goals. Program providers may also augment group work with individual sessions when demonstrated to be clinically necessary (p. 14).

Finally, 70% of standards specified requirements for treatment completion. In Colorado, for example, "Treatment Discharge is based on an offender demonstrating an understanding and application of all required competencies, completion of treatment goals, mitigation of risk, and other factors as identified in the Treatment Plan" (2010, p. 41). Missouri's standards required programs to develop requirements for participants' completion, but specified minimum standards for treatment completion including, for example, "paying all program fees, fulfilling all program guidelines, and taking responsibility for personal abusive behaviors without blaming others" (2018, p. 22).

Fidelity

Training for Staff

Standards typically stipulated the education and/or experience required for IPV treatment staff and supervisors; 35% of standards specified that IPV treatment facilitators must hold an Associate's degree or higher, while 67% required facilitators to have specific domestic violence training. Seventy-nine percent of standards required continuing education for IPV treatment program staff. Among standards that specified requirements for continuing education, the average number of hours of continuing education required was 15 with a range of 3 to 60 hours.

Evaluation

Twenty-one percent of standards included academic sources to support program policies; however, in most cases these references were quite dated (over 10 years old). In addition, 79% of standards specified that programs were subject to periodic audits, reviews, or re-certifications. Further, 56% of standards required programs collect data to assess program outcomes (i.e., program effectiveness). Hawaii's standards (2010), for example, encouraged best practice research by requiring treatment providers to conduct evaluations of their programs and augment practices according to developing research. Standards in Illinois (2002) are more specific regarding program research tasks by stipulating that:

Partner Abuse Intervention Programs (PAIPs) must collect data and measure outcomes to determine the effectiveness of the program. The Department will notify PAIPs of the standardized outcomes and required reporting process. PAIPs must develop and implement a written plan for evaluating their program effectiveness. The plan must address data collection and analysis and demonstrate how information will be used for program improvement (p. 28).

Enforcement

In 19 (44%) states, the standards were codified in the state statute or administrative code, while five (12%) were issued by a state agency (e.g., Department of Corrections) or state commission (e.g., Governor's Office of Crime Control and Prevention), eight (19%) were issued by the state's domestic violence coalition, and the remaining 11 (26%) were issued by a state-backed task force or working group (e.g., state coordinating council).

Relatedly, states differed regarding whether and how the standards were enforced. As previously mentioned, 44% of standards were codified in the state statute or administrative code, and thus, required IPV treatment programs to be certified (or licensed) to operate in the state. Among states that did not have codified standards ($n = 24$), 17 (40%) specified a certification process for IPV treatment programs and/or an enforcement strategy for compliance: in eight states (19%) only certified programs were eligible to receive referrals to serve court-ordered IPV treatment clients and in another four states (9%), only standard-compliant programs were included on a list provided to referral sources (e.g., the courts, probation). Indiana and Montana had novel strategies for incentivizing program certification. In Indiana, the certification process required that a program join the Indiana Coalition Against Domestic Violence (and pay an annual fee). Certified IPV treatment programs received the benefits of Coalition membership; however, it was unclear as to whether non-certified programs operated in the state, and if so, whether they received referrals. In Montana, only certified programs were eligible for grant funds, but again, the standards did not specify whether there were non-certified programs and/or whether non-certified programs were still eligible to serve court-ordered clients. Finally, seven (16%) states – Hawaii, Louisiana, Missouri, North Dakota, New Mexico, Ohio, and Utah – clearly identified that their standards were *suggested* best practices, were not required for IPV treatment programs to operate in the state, and that there was no incentivization or enforcement strategy.

Table 1

Integration of Principles of Effective Intervention in IPV Treatment Standards

PEIs	Elements in IPV Treatment Standards	Yes		No	
		<i>n</i>	%	<i>n</i>	%
Risk	Risk assessment at intake	31	72%	12	28%
		6	14%	37	86%
	Classification of offenders	6	14%	37	86%
		22	51%	21	49%

27		63%	16	37%	
Needs	Risk assessments to identify criminogenic needs: . Standardized measure of IPV (e.g., SARA) .				
		9	21%	34	79%
		27	63%	16	37%
		24	56%	19	44%
		33	77%	9	23%
		33	77%	9	23%
		9	21%	34	79%
		30	70%	13	30%

24		56%	19	44%		
Responsi vity	General	11		26%	32	74%
	·	33		77%	10	23%
	Requires	32		74%	11	26%
	use of	29		67%	14	33%
	cognitive-	14		33%	29	67%
	behavioral	20		47%	13	53%
	treatment	18		42%	25	58%
	modalities	9		21%	34	79%
	·					
	Prohibits					
use of						
couples						
counseling						
·						
Prohibits						
anger						
manageme						
nt as						
sole/prima						
ry focus						
·						
Attention						
to cultural						
competenc						
y						
·						
Strategies						
for same-						
sex couple						
violence						
·						
Treatment						
must be in						
client's						
primary						
language/f						

Treatment	Standards specify the number of weeks for treatment or non-time driven approach	43	100%	0	-
	Standards specify the length of each treatment session	25	58%	18	42%
	Standards specify group treatment	41	95%	2	5%
	Groups are gender specific	32	74%	11	26%
	Standards allow for individual treatment	26	60%	17	40%
	Standards specify requirements for treatment completion	30	70%	13	30%

Fidelity	<i>Training for Staff</i>	15	35%	28	6%
	.	29	67%	14	33%
	Specify degree requirements for providers	34	79%	9	21%
	.	9	21%	34	79%
	Require domestic violence-specific training	34	79%	9	21%
	.	24	56%	19	44%
	Require continuing education	19	44%	24	56%
	<i>Evaluation</i>	35	81%	8	19%
	.				
	Standards rooted in research (i.e., includes references)				
	.				
	Require periodic audits, reviews, or re-certification of programs				
	.				
	Requires				

Discussion and Conclusions

The present research aimed to provide an updated examination of standards, and advance this line of inquiry by using the PEIs as a framework for assessment. Specifically, standards were reviewed regarding indicators of (1) risk, (2) need, (3) responsivity, (4) treatment, and (5) fidelity within IPV treatment programming. The current study first provided an update to the most recent national examination of standards conducted by Maiuro and Eberle (2008) over ten years ago. Their review found that 45 states and D.C. had standards at the time of their data collection, and since their analysis, Pennsylvania, New Jersey, South Carolina, and D.C. have fully repealed their standards, while Connecticut has instituted standards. Furthermore, the overwhelming majority of standards (80%) previously assessed by Maiuro and Eberle had been revised.

In line with our second aim to assess the integration of the PEIs into standards, findings showed that consistent with the risk principle the majority of standards required that risk assessments be conducted at intake; however, most standards also specified a one-size-fits-all model of treatment which clients complete over a specified number of weeks. In comparison, six states (i.e., Colorado, Delaware, Iowa, Utah, Washington, and Wyoming), used risk assessments to categorize offenders into different risk levels for the provision of differentiated treatment; these findings presented an increase from 3 states in Maiuro and Eberle's (2008) prior review. Although offenders in one-size-fits-all programs may receive consistent standardized treatment, this approach is not ideal given the heterogeneity among the client population of IPV treatment programs (Piquero et al., 2006; 2014; Richards et al., 2013). Contrary to the one-size-fits-all approach, research supports the use of differentiated treatment that is attentive to clients' risks and needs such as criminal history, mental illness, and substance use, among others (see Babcock et al., 2016; Cantos & O'Leary, 2014).

The intended purpose of using risk assessments with offenders is to identify their risks and needs in order to place them in appropriate treatment strategies (Andrews et al., 2017). Taken together, the present findings show that most states' standards (1) mandated the use of a one-size-fits-all treatment strategy, (2) did not include assessment of the range of known criminogenic risks and needs, and (3) failed to use data gleaned from risk assessments to inform clients' treatment. As such, it is clear that the risk and need principles are not being used to its fullest potential in the case of treatment for IPV offenders. Next steps for future research might include

investigating how stakeholders make decisions regarding the range of risk and need factors assessed by IPV treatment providers, or if and how risk assessments are used by program providers in states that do and do not specify their use in states' standards. Further, standards must specify that screening should be linked to services; co-locating or providing direct referrals to supportive services such as GED classes, parenting supports, job training, and mental health treatment would help facilitate service intervention to meet clients' needs beyond those addressed in group treatment (see Radatz et al., 2021).

In terms of responsivity, although research suggests that group-based, cognitive-behavioral treatment is the favored treatment modality for IPV treatment (Babcock et al., 2016), only 26% of standards specified that programs use cognitive-behavioral treatment modalities. Consistent with prior research demonstrating that couples counseling may be detrimental in cases of IPV (Tomsich et al., 2015) and that anger is not the impetus for IPV (McMurrin, & Gilchrist, 2008), the majority of standards prohibited the use of couples counseling and anger management therapy. Further, consistent with Maiuro and Eberle (2008) standards did not specify a curriculum or model that must be used by treatment providers; the lone exception was Iowa which mandates the use of ACTV.

Additionally, the majority of standards noted the importance of attention to cultural competency as encouraged by a number of scholars (e.g., Eckhardt et al., 2013; Ferreira & Buttell, 2016). Culturally-based interventions account for a communities' particular stressors, social conditions, and spirituality/religion (Babcock et al., 2016). At the same time, standards provided little specific information regarding how programming attends to cultural competency. Fewer standards addressed client language, literacy, or economic conditions, all of which may serve as barriers to treatment engagement and retention.

Further, it is concerning that only 33% of states' standards addressed specific treatment strategies for same-sex couple violence. Thus, it is likely that in a majority of states clients involved in same-sex and opposite-sex couple violence attend treatment in the same groups, or clients who commit same-sex couple violence only have access to individual treatment. According to Messinger (2011), however, unique risk factors associated with minority stress contribute to IPV among same-sex couples. As a result, innovative programs and interventions developed specifically for the LGBTQIA+ communities which are based on the specific experiences of this population are needed (see Babcock et al., 2016). The ability to provide specific treatment groups for same-

sex couple violence is likely related to client numbers; however, given the recent dramatic expansion of tele-counseling (Bray, 2021), including the use of online platforms for IPV group treatment, states might consider using remote strategies to extend access to same-sex IPV group treatment by pooling clients referred from multiple jurisdictions.

The treatment principle is concerned with the structure and approach of treatment provided. Nearly all standards specified the preference for group-based treatment. Research suggests that group therapy provides an optimal environment for attitude and behavior change within offender treatment (Babcock et al., 2016). Furthermore, group formats facilitate opportunities for clients to relate to and challenge one another to confront their denial, work through their shame, and continue treatment (Maiuro et al., 2001). Relatedly, most standards mandated that groups be gender-specific. Approximately 60% of states also allowed for the provision of individualized treatment in certain cases such as for clients referred for same-sex couple violence or in instances where clients need more intensive counseling services; this is a dramatic increase from the 23% of states which allowed individual therapy in Maiuro and Eberle's previous review (2008).

Consistent with findings from Maiuro and Eberle (2008) the present review found that the majority of standards specified a minimum and/or the overall length of treatment and the duration of each treatment session. The present research found an average minimum treatment length of 30 weeks, an increase from 24 to 26 weeks in Maiuro and Eberle (2008) and 16 weeks in Maiuro et al. (2001). At the same time, there is little research to date to guide these mandates (see Babcock et al., 2016). In practical terms, longer interventions provide more opportunity time for observing and supervising client behavior; however, given that few states use differentiated treatment it is likely that low-risk clients are receiving more intensive treatment than is necessary and research demonstrates this type of treatment mismatch can lead to higher rates of recidivism (e.g., Bonta & Andrews, 2017). Seventy percent of standards specified requirements for treatment completion. Primarily these requirements included attendance and participation in group meetings and payment of program fees. In states with differentiated treatment models (e.g., Washington, Colorado), clients were expected to meet specific "competencies" before successful discharge from treatment; however, it was not wholly clear how client's achievement of such competencies are assessed (see also Gover & Richards, 2018). Future research must focus more attention on how risk reduction is achieved prior to treatment discharge.

The fidelity principle focuses on therapeutic integrity as it relates to training for staff, program evaluation, and enforcement (Bonta & Andrews, 2017). The majority of standards required domestic violence-specific training, continuing education for staff, and periodic audits, reviews, or recertification of programs while 56% of standards required programs to collect data on program effectiveness. Standards that required programs to conduct research, however, were not specific about outcomes that should be measured. Furthermore, it is likely difficult for many programs to find the time and resources needed to conduct research and some programs may not have staff with the necessary expertise to lead these efforts.

Finally, only 44% of states' standards were actually formalized in legal statute or administrative code. Another 17 states required certification and had an associated enforcement strategy, but it was unclear as to whether non-certified providers can and do operate in the state. The remaining seven states' standards are *suggested* best practices, and thus there is no mandate to follow them and no entity tasked with incentivizing and/or enforcing their use. It is unclear whether these suggested best practices should actually be considered state standards for IPV offender treatment. Standards are only useful if they are properly implemented and consistently enforced.

Likewise, it is important to address the implementation of standards in practice, especially in light of heavily constrained program budgets. IPV treatment programs regularly struggle to secure and sustain financial streams for their program operations which likely create logistical challenges for the implementation of standards. The incorporation of PEI's into treatment delivery, however, may make IPV treatment programming eligible for new funding sources. For example, when a statewide evaluation of Abuse Intervention Programs (AIP) in Maryland demonstrated a positive impact of treatment on general and IPV recidivism, AIPs were then considered *evidence-based programs* (see Radatz et al., 2021). As such Maryland AIPs became eligible for funding from the state's Justice Reinvestment Act grant project. Thus, the incorporation of the PEIs – an evidence-based correctional model – into IPV may lead to a greater availability of resources for programs.

While the present research provides an updated review of states' standards as well as novel findings regarding the integration of the PEIs in standards, it is not without limitations. Consistent with the prior studies by Maiuro and colleagues (2001) and Maiuro and Eberle (2008), the results must be understood as an assessment of standards on paper, as these data cannot provide information on how standards are implemented in practice. For example, prior research by Boal and Mankowski (2014)

suggests that the implementation of standards may not result in widespread programmatic changes, while Gover and Richards (2018) highlight some of the challenges with consistent implementation of revisions in a state's standards. In addition, there is no consistent repository for standards and more than half of the standards reviewed here were not codified in state statute or administrative code. Thus, the findings presented here pertain to the most up-to-date standards the authors could locate at the time of coding. It would be a highly beneficial to all IPV stakeholders if standards were reliably and publicly accessible (e.g., on the state's domestic violence coalition website). Relatedly, as both the states that have standards and states' standards themselves have changed since Maiuro and Eberle's 2008 review, it was not always clear as to whether or the degree to which changes in standards represented progress in IPV treatment within a given state. In order to help facilitate replication, researchers must make a concerted effort to specify the version of policies included in studies, so that future researchers can make direct comparisons. Finally, while numerous indicators associated with the PEIs were including in the coding scheme, this study is not exhaustive and must be viewed as the first, and not the last assessment of the integration of the PEIs into standards. As outlined above, these findings uncover many natural "next steps" for future research.

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Appendix: State Standards as of October 2020

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