A Comparative Analysis of State Standards for Domestic Violence Intervention Programs: Implications for Arkansas

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Abstract

Domestic violence is a pervasive issue in Arkansas and across the United States, affecting millions of people every year. It takes many forms and can have severe consequences for survivors, as well as affecting community well-being and intergenerational health. While intervention programs for domestic violence offenders are critical for reducing repeated harm and promoting accountability, states vary widely in their standards, implementation practices, and alignment with evidence-based models. This study conducted common practice research through a qualitative comparative analysis of domestic violence intervention program (DVIP) standards nationwide, combined with semi-structured interviews with DVIP/BIP practitioners across multiple states. Arkansas's current intervention standards were examined against these national guidelines to determine areas of strength and opportunities for improvement. The findings of this study have provided the Arkansas Coalition Against Domestic Violence (ACADV) with actionable recommendations for strengthening offender intervention programming, ensuring survivor safety, and promoting an effective response to domestic violence statewide. By situating Arkansas within a broader national landscape, this project contributes to ongoing efforts to refine domestic violence intervention practices and ensure that accountability-based programming is both effective and responsive to diverse community needs.

Background

Arkansas Code 9 § 9-15-103 defines domestic abuse as, “Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members,” and “Any sexual conduct between family or household members, whether minors or adults, that constitutes a crime under the laws of this state” (Child Welfare Information Gateway, 2021). This code also defines “family or household members” as including a spouse or former spouse, a parent, a child, including any minor residing in the household, persons related by blood within the fourth degree of consanguinity, persons who presently or in the past have resided or cohabited together, persons who have or have had a child in common, and persons who are presently or in the past have been in a dating relationship together. “Dating relationship” is defined as a romantic or intimate social relationship between two individuals that is determined by the length of the relationship, the type of the relationship, and the frequency of interaction between the two individuals involved in the relationship.

According to the Arkansas Coalition Against Domestic Violence (ACADV, n.d.), 40.8% of women in Arkansas and 34.8% of men in Arkansas experience intimate partner physical and/or sexual violence, 18.6% of Arkansas women will experience stalking in their lifetime, and, on average, three women are killed by a current or former intimate partner every day. Additionally, domestic violence is the number one cause of emergency room visits by women.

While physical violence is often what comes to mind when people hear “domestic violence” – acts such as pushing, slapping, punching, kicking, strangulation, use of weapons, or denying medical care – abuse manifests in many other forms. These include minimizing, denying, and blaming, intimidation, emotional abuse, isolation, coercion and threats, economic abuse, sexual abuse, and using children as leverage.

- **Minimizing, denying, and blaming** occurs when an abuser makes light of their behavior, denies it happened, or shifts blame to external factors such as drugs, alcohol, arguments, or past trauma.
- **Intimidation** can involve creating fear by smashing property, destroying personal belongings or documents, abusing pets, or driving recklessly.
- **Emotional abuse** includes insults, humiliation, lying, or infidelity.
- **Isolation** occurs when an abuser cuts off their victim's access to support systems, such as preventing them from driving, seeing friends and family, or communicating freely.
- **Coercion and threats** may include threatening violence, abandonment, suicide, or the removal of children.
- **Economic abuse** is common in relationships with income or status imbalances. Examples include preventing a partner from working, taking their money, restricting access to family income, or refusing to pay child support.
- **Sexual abuse** may involve coercion into unwanted sexual acts, refusal to use protection, coercing someone into pornography or prostitution, or guilt-tripping a partner for saying no.
- **Using children** can mean criticizing a partner's parenting, using children to send messages, threatening to take them away or harm them, teaching them to disrespect the victim, or directly abusing the children.

These dynamics are captured in the *Power and Control Wheel*, developed in the early 1980s by Ellen Pence, Michael Paymar, and Coral McDonald after consulting battered women's groups in Duluth, Minnesota (Power and Control, n.d.). Figure 1 illustrates this framework.

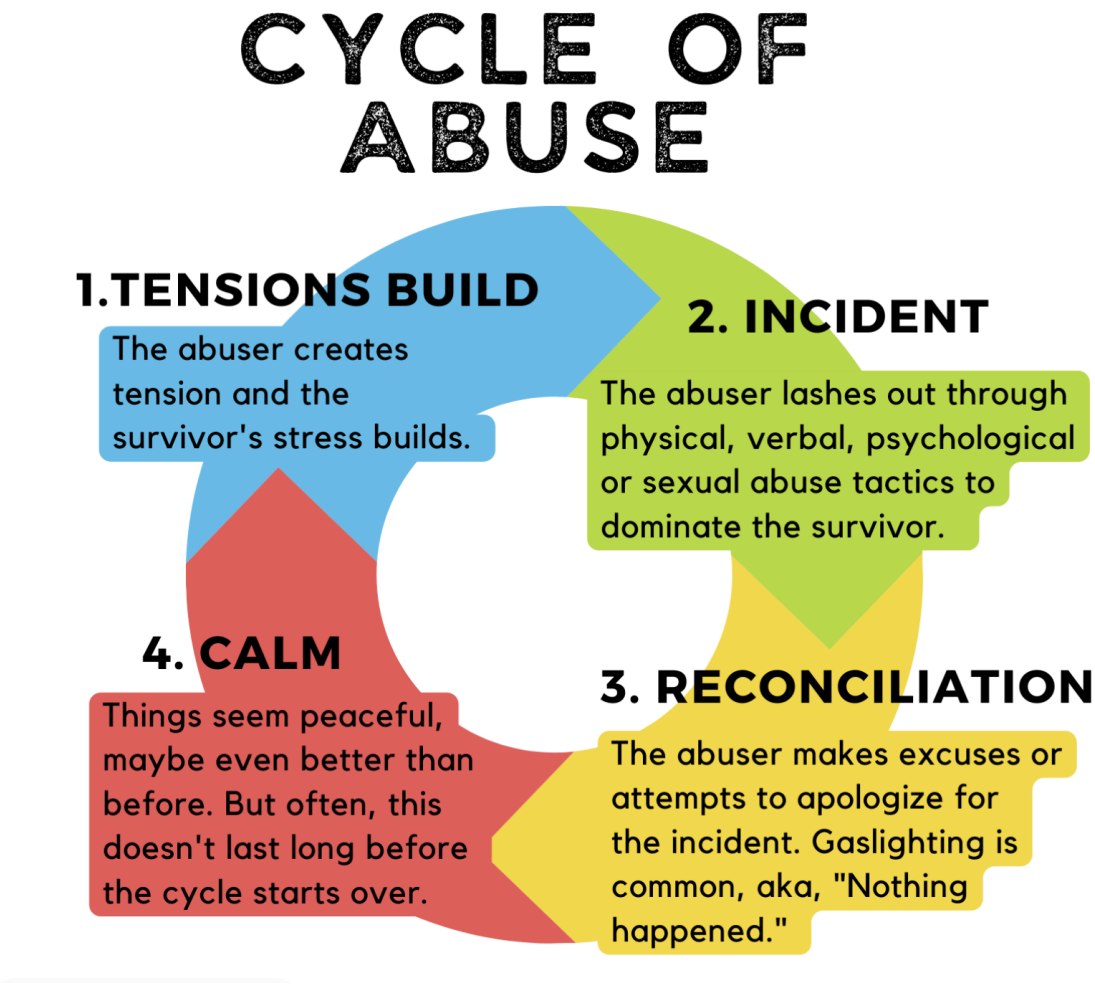
Figure 1: The Power and Control Wheel

Power and Control, Domestic Violence in America (n.d.)
https://powerandcontrolfilm.com/power-and-control-wheels/#:~:text=The%20power%20and%20control%20wheel,interviews%20are%20on%20this%20site.

Another model that highlights the nature of abuse is the *Cycle of Abuse*. This begins with **tension building**, when the abuser creates stress and fear through conflict, moodiness, or substance use. Next comes the **incident**, when abuse occurs physically, verbally, emotionally, or psychologically. This is followed by **reconciliation**, when the abuser apologizes, makes excuses,

or shifts blame. Finally, the **honeymoon stage** brings a temporary calm, sometimes making the relationship appear stronger before the cycle begins again. Figure 2 illustrates this cycle.

Figure 2: The Cycle of Abuse



Arkansas Coalition Against Domestic Violence (n.d.),
https://domesticpeace.com/resources/understanding-abuse/#power-control

While any gender can experience domestic violence, the majority of domestic violence victims are women. More than 90% of murder-suicides involving heterosexual couples are committed by men (ACADV, n.d.). Patriarchal ideals and traditional gender norms often fuel male abusers' desire for power and control over female partners. Common traits among abusers include low self-esteem, high needs for control, anger and hostility, depression, poor coping

mechanisms, and negative attitudes toward women. Many abusers have personal histories of family violence, have previously succeeded in using violence to exert control, and have never been held accountable for their actions.

The effects of abuse extend far beyond the immediate incidents of violence. Domestic violence takes severe physical, emotional, and psychological tolls on victims. People that have experienced domestic violence can also develop sleeping problems, anxiety/depression, low self-esteem, lack of trust, anger, poor relationships with loved ones, overall diminished health, and physical tolls, including death. Children that experience domestic violence are also vulnerable to these tolls. They may also feel powerless, confused, and worried about their future and/or the loss of a parent and begin to act aggressively with other children or siblings, have trouble in school, or develop physical illnesses. By watching one parent abuse another, children can become traumatized and learn dangerous beliefs, including that violence is normal in families and an appropriate way to solve problems, that women are beneath men, or they may feel responsible for their parents' behavior.

Leaving an abusive relationship is often extraordinarily difficult. Victims may stay in violent relationships because leaving increases their risk of being killed or seriously injured by 75% (ACADV, n.d.). Financial dependence, children, cultural or religious pressures, or physical inability to escape are also barriers. Legal systems can be complex, and law enforcement or government officials may not always be equipped to respond effectively to domestic violence cases. While the consequences for survivors are devastating, meaningful progress depends on addressing the other side of the equation: holding abusers accountable.

Problem Statement

Domestic violence persists not only because of stigma and silence but also because abusers often evade accountability. The Arkansas Coalition Against Domestic Violence's intervention program addresses this by focusing on the root causes of abuse—challenging power and control, fostering healthier coping mechanisms, and requiring abusers to confront their actions. By holding offenders accountable through structured counseling and intervention, the program shifts responsibility away from survivors and onto those who cause harm, creating the potential for long-term change. However, it remains unclear how well Arkansas's current domestic violence intervention standards align with national guidelines and evidence-based practices, creating a gap in understanding where the state's programs may fall short or excel in comparison to broader best practices. Addressing this gap is essential if Arkansas is to reduce domestic violence, prevent intergenerational cycles of abuse, and create safe and healthy communities.

Significance and Impact

The purpose of this study was to conduct an analysis of domestic violence intervention programs across the United States, with a particular focus on identifying common practices for program design and implementation. This project sought to analyze how programs are structured, what approaches are most effective in fostering accountability among abusers, and how state standards—particularly those in Arkansas—align with or diverge from national trends.

This study is significant because it situates Arkansas's domestic violence intervention efforts within a broader national context. While many programs aim to hold abusers accountable and reduce repeated violence, their effectiveness depends heavily on program design, implementation fidelity, and alignment with evidence-based practices. By comparing Arkansas's

standards with those from around the country, this study highlights both strengths and gaps in the state's current approaches.

The findings will benefit the Arkansas Coalition Against Domestic Violence by offering a clearer picture of which program models are most effective in addressing patterns of abuse and promoting long-term behavioral change. Survivors of domestic violence in particular stand to gain when programs for abusers are grounded in best practices, because stronger intervention reduces the likelihood of repeated harm, shifts responsibility away from victims, and encourages survivor safety and healing. Communities also benefit when effective intervention programs are in place, as fewer repeated offenses contribute to safer neighborhoods, reduced strain on law enforcement and healthcare systems, and healthier family dynamics. Beyond state-level implications, this research contributes to the broader literature on batterer intervention programs by synthesizing lessons learned from across the country. Ultimately, this project underscores that meaningful progress in reducing domestic violence requires both localized implementation and alignment with national evidence-based standards.

Research Questions

The research questions that guided this project are:

RQ 1: What are the common practices for designing and implementing domestic violence intervention programs nationwide?

RQ 2: What common barriers and enabling factors affect the delivery and success of these programs across different states?

RQ 3: How do Arkansas's standards for batterer intervention/domestic violence intervention programs compare to national standards?

Literature Review

A review of literature was conducted in order to better understand the elements of the project, to explore the efficacy of domestic violence intervention programs, and to review guidelines for these programs across different states. Throughout the literature, three major themes were present: models and approaches to domestic violence intervention programs, the effectiveness and challenges of implementing these programs, and standards and policies across states. Analyzing these themes in previous research provides helpful information and baselines that the ACADV can utilize to strengthen their domestic violence intervention programs.

Models and Approaches to Domestic Violence Intervention Programs

The most widely used approach to addressing domestic violence in the United States and Canada is the Duluth Model (Bohall et al., 2016). Conceptualized in the early 1980s by Ellen Pence and Michael Paymar of the Domestic Abuse Intervention Programs in Duluth, Minnesota, the model's primary tool is the Power and Control Wheel mentioned previously. This model is grounded in feminist and sociocultural theories that intimate partner violence (IPV) is often utilized by men as a way to assert dominance and control over their female partners. The Duluth Model focuses on shifting blame off of domestic violence victims and holding perpetrators accountable through coordinated community responses (Domestic Abuse Intervention Programs, n.d.).

Although the Duluth Model is the predominant intervention for domestic violence abuse programs across the country, it has been criticized by some scholars. Dutton and Corvo (2006) posit that Duluth-type interventions rely too heavily on gender paradigms as a predictor of domestic violence, and that these programs ignore individual psychological, situational, and cultural risk factors. They argue that strong therapeutic bonds are much more likely to lead to

behavioral change as opposed to corrective or educational interventions, and that in Duluth-type programs, "No therapeutic bond can form and clients who comply will feel judged and disbelieved. Empathy is impossible, change is unlikely, group process is subverted, and clients' commitments to change are rarely internalized" (p. 463). Dutton and Corvo close their article by arguing that the Duluth Model is too strongly based on ideological assumptions and a "one-size-fits-all" approach, and they call on state and federal agencies as well as domestic violence researchers to support high-quality research and evidence-based practices when enacting domestic violence interventions and policies.

These critiques have been refuted, however, and there is strong support for the Duluth Model among domestic violence intervention practitioners. In response, Edward Gondolf (2007) asserts that Dutton and Corvo's interpretation of the Duluth Model lacks nuance and overlooks the empirical support for its approaches. Gondolf argues that the Duluth Model has established fundamental guidelines for domestic violence intervention programs that have been rigorously researched. He maintains a stance that a "one-size-fits-all" approach is inappropriate for domestic violence intervention programs, but that Dutton and Corvo did not account for programs that have adapted the original Duluth Model for their specific community needs. In his view, the Duluth Model is not static, and believing in its effectiveness does not mean one completely rejects the importance of psychological or therapeutic interventions.

From both critics and supporters of the Duluth Model, one thing is clear: domestic violence intervention programs must incorporate several approaches to strengthen outcomes. There is no "one-size-fits-all" model that will end domestic violence once and for all; rather, interventions must be flexible and adaptable to address both survivor safety and offender accountability. Programs should draw on evidence-based, multidisciplinary approaches that

integrate elements of the Duluth framework with cognitive-behavioral, trauma-informed, and culturally responsive practices.

Factors Affecting the Effectiveness and Challenges of Implementing Domestic Violence Intervention Programs

Although many intervention models share common goals of reducing recidivism and promoting accountability, their effectiveness often depends on how they are implemented and the barriers that programs encounter in practice. Radatz et al. (2021) discuss how integrating principles of effective intervention (PEI) into domestic violence intervention programs improves outcomes and reduces repeated offenses. These principles include risk, need, and responsivity (RNR), as well as treatment and fidelity (p. 611). The "risk" principle involves assessing domestic violence offenders based on their risk of reoffending (low, medium, high). The "need' principle encourages considering offenders' needs, including both criminogenic (directly related to reoffending: substance abuse, unemployment, personality patterns) and non-criminogenic (indirectly related to reoffending: low self-esteem, health conditions). The "responsivity" principle denotes that treatments should be tailored to an individual offender's strengths, abilities, and learning style. The "treatment" and "fidelity principles" emphasize that program staff should be qualified, respectful, and well-trained, and that services should utilize cognitive learning strategies and undergo regular evaluation.

The authors argue that these principles are crucial, but recognize the challenges that staff members may face when attempting to implement them. Specifically, implementing more comprehensive intake assessments, increasing training, and thorough program evaluations can be more time consuming and require more personnel – resources that underfunded and/or rural programs may not have. This article suggests that while data on the effectiveness of PEI is still

limited, current evidence is promising, and striving for these standards of treatment in domestic violence interventions is worthwhile.

A growing body of research also highlights the importance of culturally competent DV interventions, which can be linked to the PEI of tailoring treatments to individuals' specific needs. Satyen et al. (2022) note that traditional intervention models (like cognitive-behavioral and Duluth approaches) have historically been most frequently evaluated in North American contexts, and that there is little research on their effectiveness for ethnic and cultural minority groups. They conducted a systematic review of ten articles that detailed culturally specific domestic violence interventions with ethnically diverse participant groups and found that through several of these programs, compared to standard interventions, recidivism decreased, psychopathological symptoms among participants decreased (e.g. anger, depression, anxiety), and positive changes in cognitive biases and beliefs about women were reported. The review concluded that adherence to culturally competent implementation practices – such as employing facilitators who speak participants' preferred language, share their cultural background, or have specialized training in culturally responsive practice, as well as involving community leaders or elders – enhanced participant satisfaction and reduced attrition.

Involving survivors in planning and evaluation processes can also be beneficial in developing a domestic violence intervention. Jumarali et al. (2023) interviewed 24 survivors of intimate partner violence whose partners entered a relationship violence intervention program (RVIP). The authors state that while measuring re-arrest or re-offend rates is an important part of measuring the effectiveness of an intervention, these measurements don't allow for the depth of qualitative anecdotes from the offenders' victims. Through their interviews, the researchers found that many survivors wanted intervention programs to provide updates or information on

their partner's progress in the program; they wanted to know what the participants were being taught. Some interviewees described their perceptions of the RVIP as positive, explaining that their abusive partners had exhibited behavioral changes and better communication/conflict resolution skills. Other survivors had mixed or negative perceptions of the RVIP due to their partners only temporarily exhibiting behavioral changes before reverting to abusive tendencies. This study's main conclusion is that centering survivors and following up with them regularly is an integral part of ensuring that a domestic violence intervention program is achieving its intended outcomes.

State Standards and Policy Variability in Domestic Violence Intervention Programs

While much of the literature on domestic violence intervention focuses on individual program models, comparatively less attention has been paid to the state-level standards and policies that shape how these interventions are implemented. These standards determine not only the structure and content of programs, but also their consistency and quality. Flasch et al. (2021) conducted a comprehensive content analysis of batterer intervention program (BIP) standards across the United States and found significant variations in how states regulate and guide domestic violence interventions. The analysis revealed inconsistencies in theoretical approaches, facilitator qualifications, program procedures, duration, coordination with community and governmental agencies, and requirements for evaluation. While most states emphasize accountability and victim safety, many do not provide details on evidence-based curricula, program fidelity, or evaluation procedures. The authors argue that future research should explore "…standards of county jurisdictions and policies in states that previously adopted [State Standards for Batterer Intervention Programs] but are no longer guided by them" and that "…consideration of a unifying national standard might be worthy of exploration" (p. 703).

In response to these disparities, national organizations have proposed more coordinated and data-driven approaches to domestic violence intervention. The National Network for Safe Communities at John Jay College (2021) developed a comprehensive strategy to reduce intimate partner violence that emphasizes collaboration between law enforcement, community members, social service providers, and victim advocates (p. 2). The NNSC framework underscores the importance of clear communication between these partners and strategically tailored interventions for offenders and supportive resources for survivors. The findings of Flasch et al. (2021) and the recommendations of the National Network for Safe Communities (2021) emphasize the need for consistent evidence-based standards and coordinated community responses.

The reviewed literature reveals both progress and persistent challenges in developing effective domestic violence intervention programs. Research demonstrates that while certain models, such as the Duluth approach and cognitive-behavioral frameworks, have laid a strong foundation for intervention practices, their success depends heavily on implementation quality and cultural responsiveness. This capstone project built on these findings by examining how Arkansas's domestic violence intervention standards compare to national common practices. Doing so helps the ACADV identify strengths, gaps, and opportunities to enhance both survivor safety and offender accountability within the state, contributing to a more practical and equitable response to domestic violence.

Methodology and Project Timeline

Data Collection

This project utilized a qualitative approach through comparative policy analysis of national standards for domestic violence intervention programs (DVIP) and semi-structured

interviews with DVIP/BIP providers. This approach appropriately blends written state standards with practitioner perspectives to identify common practices for improving offender accountability and survivor safety.

Publicly available DVIP/Batter Intervention Program (BIP) standards from multiple U.S. states were collected through the National Network of Abuse Intervention Programs through the Battering Intervention Services Coalition of Michigan (BISC-MI) website. Documents were included if they met the following criteria:

- Described state-level or statewide domestic violence intervention standards
- Outlined program philosophy, structure, or training requirements
- Were published or endorsed by a government agency or statewide domestic violence coalition

Semi-structured interviews were conducted with DVIP/BIP providers from different states. Interviews took place over Zoom or Google Meet and lasted approximately 30-45 minutes. Interviews were audio-recorded with participant consent and transcribed for analysis. Identifying information (names, organizations, or locations) remained confidential throughout the duration of the project. IRB exemption was obtained prior to conducting interviews.

Participants

Participants included program directors, facilitators, or coordinators who work or worked directly with domestic violence intervention curricula and had at least one year of professional experience in running or overseeing DVIP/BIP groups. Recruitment occurred through ACADV professional contacts, national domestic violence coalitions, and public directories of state-certified intervention providers, specifically through the BISC-MI and Association of Domestic Violence Intervention Providers websites.

State Standard Review Measures

State standards and policy documents were reviewed for the following components:

- Program philosophy or theoretical basis (e.g., Duluth-informed, CBT-based, trauma-informed)
- Facilitator qualifications and training requirements
- Program length, structure, and session format
- Evaluation and quality assurance measures
- Requirements for collaboration with courts, probation, or victim services
- Cultural competence and accessibility standards
- Provisions for victim safety and offender accountability

Interview Measures

Interview questions explored:

- Perceived effective strategies for reducing abusive behavior
- Implementation challenges and barriers
- How state policy or funding affects program delivery
- Recommended improvements to state standards or program design

The full interview script can be found in the appendix.

Analysis

Documents were analyzed using a qualitative content analysis. Coding was conducted to identify themes related to program philosophy, implementation requirements, and adherence to evidence-based practices. Interview transcripts were analyzed similarly; themes were developed inductively to capture recurring practitioner perspectives on what supports or hinders effective intervention programming. Findings from the policy analysis and interviews were then

synthesized to identify common practices for implementing DVIP/BIP programs across the country.

Timeline

This project was carried out over a four-month period, beginning in January 2026 and concluding in April 2026.

January–February: Recruitment and Initial Data Collection

While awaiting IRB exemption, work on the comparative policy analysis began. The state standards comparison table was created and updated throughout the duration of February. Recruitment emails were sent to DVIP/BIP practitioners near the end of February.

March: Interviews and Data Analysis

Once IRB exemption was obtained, interviews were conducted over the first two weeks of March. Audio recordings were transcribed using Zoom's automatic transcription feature and OtterAI software. The transcripts were then analyzed, and findings were synthesized with the findings from the comparative state standards analysis. The results and discussion section of the final report was drafted.

April – Final Report Writing:

In the final phase, results were organized into the final comprehensive report. This report outlines national common practices, summarizes practitioner insights, and compares Arkansas's standards to other states. The final step involved developing actionable recommendations for improving domestic violence intervention practices and policies in the state of Arkansas.

Ethical Considerations

This project presented minimal ethical risk because it involved analysis of publicly available state standards and voluntary interviews with DVIP/BIP practitioners as opposed to

domestic violence survivors. Participants were professionals discussing programmatic and policy-level issues, not disclosing personal victimization or criminal behavior. All interview participants received a verbal consent script outlining the purpose of the study, their right to skip questions or withdraw at any time, and assurances that no identifying information would be used in any reports or publications. Interviews were audio-recorded only with explicit consent and stored securely in a password-protected digital folder. Names, organizations, locations, and any potentially identifying details were removed during transcription. Because the project focused on program design rather than individual clinical cases, no protected health information or confidential client data was collected. Institutional Review Board (IRB) exemption was obtained prior to beginning interviews.

Results

In order to address how Arkansas can improve domestic violence intervention, findings are organized according to the study's three guiding research questions:

RQ 1: What are the common practices for designing and implementing domestic violence intervention programs nationwide?

RQ 2: What common barriers and enabling factors affect the delivery and success of these programs across different states?

RQ 3: How do Arkansas's standards for batterer intervention/domestic violence intervention programs compare to national standards?

Interview Results

To answer the first research question, a total of nine qualitative interviews were conducted with domestic violence intervention practitioners, researchers, curriculum developers, and training providers across multiple states, including California, Colorado, Georgia, Kansas,

Michigan, Pennsylvania, Utah, and Washington. Findings are organized across key domains: program philosophy, structure, approaches to offender accountability, collaboration with courts and community partners, cultural competency and accessibility, perceived strengths and challenges, and evaluation and assessment practices.

Program Philosophy/Theoretical Grounding

Across states, there was not a single dominant model or philosophy, but there were recurring themes and frameworks that were mentioned throughout the interviews. Many states utilized elements of the Duluth model, particularly its emphasis on power and control (e.g. Georgia, Utah, Washington), while others incorporated cognitive behavioral therapy (CBT) in their approaches (e.g. Colorado, Kansas, Michigan, Washington). While most participants recognized the significance of the Duluth model, some argued that it alone is not effective for all types of offenders, and that treatment should be adapted based on client needs instead of relying on a singular framework. Several respondents discussed taking a multidisciplinary approach, combining elements from multiple models including CBT, trauma-informed care, and accountability-based practices.

Some respondents explicitly rejected punitive approaches and emphasized the importance of making an offender feel seen, heard, and respected in order to understand their motivations for committing domestic or intimate partner violence (e.g. California, Colorado, Georgia, Kansas, Pennsylvania). One interviewee stated:

> You can't have an adversarial relationship with clients, even if you really strongly are grossed out or disapprove of their behavior…it doesn't work when you just judge them and you do what the judicial system has already done, which is to reprimand them and to,

> in some sense, shame them. You have to make them feel like you're working on their behalf.

Another practitioner reiterated this belief, stating:

> There's a quote that Martin Luther King made years ago, and it says we have very little persuasive power over someone when they can feel our disdain for them…when you have a lot of disdain towards a population, and you hold on to that disdain, you know, good luck on trying to facilitate change.

Importantly, the participants that champion this philosophy are clear that recognizing an offender's previous trauma(s) and/or listening to their hardships should not be confused with colluding with the offender. One program facilitator said:

> I remember a probation officer confronted me saying, "You're just letting these guys complain, you're just colluding with them." I said, "I don't think you get it. Stick around and wait and see. You know, we may let this guy come complain about his wife for two weeks in a row…at some point, I guarantee you that either the group or I will turn it around and make him start thinking about how he can respond differently."

Another facilitator had similar thoughts, stating:

> The thinking in previous decades has been that, "Oh, if you start talking about the offender's trauma, you're going to let them off the hook, it'll become all about them." Well, we don't let them off the hook, but rather, it's an added responsibility.

Across all interviews, focusing on offender accountability emerged as a guiding principle even if it was not tied to a specific named model. These findings indicate that while programs draw from a range of theoretical frameworks and approaches, there is consistent emphasis on integrating multiple models alongside a shared focus on offender accountability.

Program Structure and Delivery

Program structures and lengths varied across states, but some patterns were apparent. All of the programs discussed in the interviews took place in a group setting with sessions typically held weekly, but there was a wide variety of week or session requirements. Curriculum content across states typically included psychoeducational content targeting communication skills, coping strategies, and the impacts of violence.

Some program administrators discussed the benefits of holding sessions in groups. One administrator said, “Group is a great place to keep people accountable. You've got other people in there who, you know, walk the same walk, talk the same talk kind of thing. So they get to call each other out.” A different administrator had the same belief, stating, “We want in-person groups, because there's a special dynamic. When you have a bunch of offenders in a group setting, they hold each other accountable, they support each other, they lift each other up.”

When comparing state standard documents, most states set maximum group sizes ranging from 10 to 20 participants, with several states recommending or requiring a second facilitator when groups exceed a certain threshold. The facilitator from California emphasized the importance of keeping groups relatively small, advising programs not to exceed eight or nine participants in a group.

Some interviewees argued that allowing for greater flexibility in program design and implementation is beneficial. For example, Colorado does not mandate a specific program length, instead requiring participants to demonstrate knowledge and understanding of core competencies before being able to complete their treatment. When asked what advice they would give to another state or program trying to strengthen their domestic violence interventions, a

curriculum developer from another state said, “Making sure that the standards are not *so* rigid that it doesn't leave room for new research and new findings of what works.”

Overall, while group-based, long-term programming was common amongst all interviews, variation in program length and curriculum structure reflects differing state standards and implementation philosophies. These differences are more clearly outlined in the table.

Approaches to Offender Accountability

All programs emphasized offender accountability, though techniques and practices varied. Common strategies included:

- Attendance requirements
- Structured assignments and homework (California)
- Behavioral contracts/agreements (Georgia, Pennsylvania)
- Peer accountability within group settings (Colorado, Utah)
- Development of a “personal change plan” or “personal safety plan” (Colorado)

Several programs supported active confrontation and refusal to tolerate victim-blaming, while others focused on fostering internal accountability through individual responsibility, reflection, and self-regulation (Pennsylvania). Washington described creating conditions where “accountability becomes unavoidable,” while Michigan emphasized the process of “operationalizing accountability” (Cape & Garvin, n.d.) within structured programming.

Collaboration with Courts and Community Partners

Most programs reported some level of collaboration with courts, probation officers, and victim service agencies. This often took the form of:

- Regular reporting to probation officers (Kansas, Pennsylvania)
- Direct oversight and monitoring by probation departments (California)

- Multidisciplinary treatment teams (Colorado)
- State-level coordinating bodies (Georgia)

Colorado is unique in their collaboration efforts. As stated above, the state utilizes a multidisciplinary treatment team for every offender that consists of, at minimum, a treatment provider, a supervision officer (probation or parole officer), and a victim advocate. Other parties can be involved if, for instance, the offender is considered high-risk; the offender in this case would need a "second contact" on the treatment team, meaning an additional clinically relevant service such as a substance use treatment provider, a mental health clinician, or facilitator from a parenting program.

Participants from both Colorado and Georgia emphasized the importance of a coordinated community response (CCR) to enhance survivor safety. The Georgia Commission on Family Violence, particularly, has 37 members that consist of judges, law enforcement officers/probation officers, and victim advocates. These findings suggest that while collaboration is a common feature across programs, the depth and structure of these partnerships differ substantially by state.

Cultural Competency and Accessibility

Approaches to cultural competency varied widely across states, but there were several recurring themes amongst the interviewees. Most agreed that respect and understanding for different cultural backgrounds are integral to the effectiveness of treatment. Multiple programs offered specialized treatment and developed specific curricula for LGBTQ+ individuals (Colorado, Georgia, Kansas, Utah).

Most programs also offered groups in Spanish and/or had their materials translated to Spanish. The participant from Kansas specifically sought out Spanish-speaking facilitators from

out-of-state to ensure that their organization had the most effective and culturally-aware treatment providers possible. In addition to language accessibility, some programs made efforts to ensure materials were understandable to participants with varying literacy levels; for example, the administrator from Washington reported that its program materials are written at a sixth-grade reading level. However, many participants perceived non-English and non-Spanish speaking clients to be at a disadvantage.

The interviewee from Utah described several community partnerships that their organization maintains to address culturally specific needs, including the National Alliance on Mental Illness (NAMI), the Polynesian Resource Center, Utah Pride Center, Sacred Circle Healthcare (owned and operated by the Goshute nation), and the Asian Association of Utah. They also stressed the importance of individualized care, ensuring that clients are in the appropriate language group and asking the client the preferred gender of their therapist.

Overall, while many programs have taken meaningful steps to address cultural and linguistic needs, significant gaps remain in ensuring equitable access for all participants.

In order to answer the second research question, specific interview questions were asked to participants about the barriers and enabling factors that affect the delivery and success of their programs.

Perceived Strengths of Programs

Participants identified several strengths across program models. These included:

- **Group-based formats**, which foster peer accountability and support (Colorado, Utah)
- **Respectful but firm facilitation styles** (“tough love”) that balance empathy with accountability (California, Kansas, Georgia)

- **Individualized or flexible approaches** that account for client needs, including mental health and literacy (Colorado, Utah, Michigan)
- Use of **motivational interviewing and rapport-building**, which were associated with improved retention (California, Utah)

Additionally, several participants highlighted the importance of state standards in improving program quality and consistency, particularly in states where standards replaced less appropriate interventions (e.g., anger management in Georgia). The participants asserted, though, that in order to be effective, state standards should be evidence-based, developed multidisciplinarily, and avoid extreme rigidity. Both providers from California and Pennsylvania made clear that while the Duluth model has its strengths, it should **not** be mandated as the only option for domestic violence intervention. The administrators from Colorado both expressed their belief that state-mandated week or session requirements for domestic violence intervention programs are not completely necessary; rather, a demonstration of knowledge and understanding is more valuable.

Implementation Challenges

Despite these strengths, participants also identified several challenges to the implementation and effectiveness of their programs:

- Funding limitations, including clients being unable to pay for services (Kansas, Michigan, Utah, Washington)
- Participant enrollment and retention (Pennsylvania)
- Barriers in rural areas, including lack of providers (Colorado)
- Difficulties enforcing accountability in non-criminal cases (Colorado, Georgia)

Some participants also noted challenges related to program fidelity and ensuring consistent implementation across providers (Utah, Washington).

Additionally, some participants discussed tensions with court systems, most notably a lack of consistency with sentencing. The administrator from Utah stated, “My research found that courts were less than 50% following the law themselves in terms of sentencing and orders for domestic violence. So I think there's a lack of consistency across the board.” The provider from Michigan had similar issues with judges and sentencing, stating:

> That is something that is difficult, having judges think that they can come to a conclusion about what somebody needs by looking at them. We call that the ocular pat-down. You know, I can look at this person and say, oh, they look like they need 10 sessions. You don't look like you need 52 sessions…which is absurd, and there's no way that you can look at somebody and come to that conclusion unless you're relying on your implicit bias. You know, the guy in the suit looks like he needs less than the guy who's wearing a dirty t-shirt and jeans.

These findings reveal the difficulties on both micro and macro levels that domestic violence intervention experts face in attempting a successful program implementation.

Evaluation and Assessment Practices

Evaluation and assessment practices were inconsistent across programs. Some states reported more structured approaches, including:

- Risk tools, treatment plan reviews, and needs assessments (Colorado, Utah)
- Recidivism tracking, monitoring new arrests/restraining order requests (Kansas, Washington)
- Phase-based progress evaluations (Washington)

However, others reported limited or informal evaluation methods, such as facilitator observation or client self-report. Several participants acknowledged a lack of standardized outcome and evaluation measures, highlighting a broader gap in program evaluation.

State Standards Comparison

In order to answer the third research question, this table was created to provide a comprehensive comparison of state-level standards for domestic violence intervention programs, including program philosophy or theoretical basis (e.g., Duluth-informed, CBT-based, trauma-informed), facilitator qualifications and training requirements, program length, structure, and session format, outcome measures and evaluation, requirements for collaboration with courts, probation, or victim services, and cultural competence and accessibility standards. All information was obtained from the Battering Intervention Services Coalition of Michigan (BISC-MI) website, specifically, the "A Review of State's Standards" resource (https://www.biscmi.org/statestandardsanalysis/).

Table 1: State Standards Comparison

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Alabama	Victim-centered and accountability -focused	State certification required; annual recertification by Dept. of Economic and Community Affairs for facilitators, supervisors, and trainees	Not specified in available data	Not specified in available data	Court-ordered participation	Fee waiver for those at or below 125% federal poverty level; intersectional approach in understanding and addressing the root causes of racial, gendered, economic, and all other forms of oppression
Alaska	Victim-centered and accountability -focused	Minimum 40 hrs training required, supervisor requires 1+ yr experience with both perpetrators and victims; background checks required (no DV history/felony convictions within 3 yrs)	Min. 24 weeks	Conduct regular, formal case reviews of the progress of program participants (monitor attendance, payment, participation, updated lethality assessments, & regularly conducted safety check info), recidivism monitoring of all program participants for not less than 12 months following their compliance with the discharge or termination from the program	Written policies require regular communication with local victim advocacy agencies AND criminal justice agencies; court/probation/ parole notification of violations, threats, non-compliance	Approved staff must have the ability to work in a multi-cultural environment; must consider culture, heritage, traditions, and language of populations served, must receive training on the impact of sexism and racism on DV and training on topics relating to the delivery of the program's service

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Arizona	Power and control, accountability -focused	Must be a behavioral health professional with 6+ months full-time experience with DV or criminal offenders, or supervised by one; annual training requirements per employee	1st offense: 26 sessions 2nd offense: 36 sessions 3rd+: 52 sessions; no less than 3 months & no more than 12 months	Not specified in available data	Court referral system	Not specified in available data
Arkansas	Victim centered, accountability -focused, Power and control/ Duluth-informed; psychoeduca-tional	Bachelor's degree preferred/HS diploma required; must be certified in ACADV-approved curriculum, 40 hrs initial training, 40 hrs co-facilitation before leading group; 20 hrs annual CE; background checks required including sex offender/child maltreatment registries; must sign non-abusive relationship agreement	Min. 26 sessions, virtual sessions allowed with strict protocols (camera on, alone in room, appropriate equipment)	Evidence-based pre and post-screening tools (Domestic Violence Inventory, VAW Scale)	CCR required including courts, probation/ parole, law enforcement, DV programs, CPS, mental health, substance abuse, schools, legal services, faith community, and culturally specific organizations	Required training on cultural diversity, sexism, racial bias, oppression, LGBTQIA+; ADA compliance required for language interpretation and culturally relevant needs

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
California	Power and control, accountability -focused	40 hrs basic core training, experience working with batterers for three years & a minimum of 2 yrs working with batterers' groups, 16 hours CE	52 weeks	Court-monitored progress reports	Written referral from the court or probation department	Required program content that provides cultural and ethnic sensitivity, minimum of 8 hrs training in multicultural, cross-cultural, and multiethnic diversity and domestic violence
Colorado	Power and control, RNR	Must be on DVOMB Approved Provider List; licensed mental health professionals governed by DVOMB standards; ongoing training required; DVOMB training center offers multiple formats; core competencies section specifies required knowledge areas	No length or session requirements, focus is on meeting goals associated with core competencies	Participant progress monitored by the Multi-Disciplinary Treatment Team (MTT)	CCR, law enforcement, victim services, advocates	Required sensitivity to cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues, or disabilities that are or become known
Connecticut	Power and control, accountability -focused, psycho-educational	Bachelor's degree in social science, human service or related field & min. of 40 hrs training on DV and offender services	Behavioral change is emphasized rather than a completion of certain number of sessions	Not specified in available data	Collaboration with court, family relations, probation, bail, and/or prosecutor	Training on gender roles, cross-cultural issues, ethical practices, sexism, racism, classism, homophobia, & oppression

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Delaware	Power and control, Duluth-informed, trauma-informed, accountability -focused	Bachelor's degree in a social science, human service, or a similar field, 104 hrs of direct contact co-facilitating DV intervention groups, 90 hrs of training in victim-centered training, elective training, offender training	Min. 15 sessions for low-risk offenders, up to 25 weeks for high-risk offenders	DV Coordinating Council Treatment Committee oversight; certification panel reviews programs; data collection required to evaluate utilization and efficacy; monitoring and assessment system in place	CCR that includes courts, probation and parole, legal and law enforcement systems	Require programs to be culturally informed, gender diverse, facilitators should be trained and experienced on best practices of working with LGBTQIA+ populations
Florida	Power and control, accountability -focused, psycho-educational or CBT	Background checks required, bachelor's degree or two years of experience working with DV victims and batterers, 40 hrs DV training, 12 hrs CE annually	Min. 29 weeks and min. 24 group sessions, sessions are 1 ½ hrs	State certification required & must be renewed annually	Program must coordinate its efforts within the community, including local justice system, social service agencies, DV centers, and state & local governments	Services shall not be denied to any person because of race, ethnicity, national origin, religion, age, gender, sex, sexual orientation, or disability; program conducting a non-English speaking group shall have a facilitator who is fluent in that language
Georgia	Power and control, accountability -focused	Background checks, 14 hr FVIP basic training & 20 hr subsequent training, 24 hr annual CE	24 group sessions (90 mins), one per week	Monitoring visits by Commission staff and/or designated monitors; both administrative review & class observation	Collaboration with courts, victim liaisons, law enforcement, etc.	Non-discrimination on race, age, religion, education, ethnicity, handicaps, sex, gender, orientation, or SES

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Hawaii	Power and control, accountability -focused, trauma-informed	Background check, bachelor's degree preferred, at least 3 yrs working in DV and 2 yrs supervisor experience, min. 25-40 hrs basic training, extensive knowledge & attitude requirements	Min. 24 sessions, weekly sessions, min, 2 hrs	Programs must establish minimum expectations for compliance review, monitoring, & evaluation	CCR, collaboration with courts, probation/ parole departments, & victim advocates	Gender-neutral language; LGBTQ+ data cited extensively; barriers for Native Hawaiian/Pacific Islander/Indigenous/ Black communities considered, Aloha Spirit framework, gender equity & social justice; fee schedule with provisions for indigent clients required
Idaho	Power and control, accountability -focused, RNR	Service provider: Bachelor's degree in behavioral science-related field or equivalent work-related exp., min. 60 hrs education in DV topics, min. 150 hrs of supervised intervention exp., 60 hrs CE every 3 yrs Program Supervisor: Master's or doctorate, min. 500 hrs supervised intervention exp.	Min. 52 weeks, 90 minute group sessions	Programs will be monitored at least once in a 2 yr period, documented offender progress	Staff shall collaborate with judicial system personnel and other appropriate parties	Staff must be aware of and responsive to how issues of power & control relate to abusive behavior and that issues of classism, cultural bias, racism, sexism, heterosexism, and gender identity may need to be addressed

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Illinois	Accountability -focused	40 hrs basic training and an additional 20 hrs of Department approved training in abuser services, 6 hrs of CE credits annually	Min. 24 sessions, min. 36 hrs of direct program contact	Not specified in available data	Not specified in available data	Staff must respect rights & individuality of all participants, including not discriminating on basis of race, religion, gender, ancestry, age,l disabilities, sexual orientation, or economic circumstances
Indiana	Victim-centered, accountability -focused, power and control, approved curricula include Duluth, EMERGE, Family Peace Initiative	Participation in an ICADV AIP Academy, proof of participation (certificate) in the programs' AIP curriculum; must attend 2 CE trainings per yr	Min. 26 sessions, once per week, min. 90 minutes	Certified programs must submit an Annual Report at the conclusion of each calendar year; on-site or virtual monitoring sessions	CCR, communication between referral source, court, prosecutor, police, probation, child protective agency as needed	Non-discriminatory on basis of race, class, age, religion, education, ethnicity, disabilities, sex, gender identity, sexual orientation, or economic condition; accommodations for language access, literacy, disability
Iowa	Not specified in available data	Training includes enforcement of civil & criminal remedies in abuse matters, causes of DV, techniques for intervention in DV cases	Not specified in available data	Not specified in available data	District departments collect fees and coordinate services	Not specified in available data, fee waivers available

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Kansas	Victim-centered, accountability-focused	Background check, baccalaureate degree or 2 yrs of experience involving direct contact work with victims and/or offenders, 25 hrs of DV specific training including completing KDVOA and Making Victim Contacts in a Batterer Intervention Program, 12 hrs DV-specific CE every two yrs	Min. 24 weeks, weekly group, min. 90 mins but not more than 2 hrs; Completion of program should also be based on demonstration of goal completion & skill acquisition	Programs shall maintain documentation of offender progress during course of intervention (attendance, participation, attitude, cooperation with program rules, freedom from violent behavior, compliance with financial responsibility)	Community-based approach, work in cooperation with victim services, DV programs, courts, prosecutors, law enforcement, probation officers	Fees should be based on participant's ability to pay; non-discriminatory on basis of race, gender, ethnicity, education level, social and economic class, sexual orientation, religion, and physical & mental ability
Kentucky	Power and control, accountability-focused	Bachelor's degree, 24 hrs DV training, 2 yrs of post-degree work experience related to DV, 16 hr CE every 2 yrs	Min. 30 weeks, session min. 90 mins	Cabinet may conduct periodic provider reviews	Communication between courts, prosecutors, probation or parole officers, law enforcement	Providers shall not discriminate based on race, ethnicity, gender, age, religion, or disability
Louisiana	Power and control, Duluth/ EMERGE	40 hrs of direct experience co-facilitating BI groups, 10 hrs CE per year, must have completed nationally-recognized training in providing batterer intervention	Min. 26 weeks, weekly sessions, 1 ½ to 2 hrs	Programs should implement efficient systems for attendance, fee, and data collection and tracking	Contact with law enforcement if necessary	Not addressed in standards document

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Maine	Power and control, accountability -focused	Background check, staff must receive training in a curriculum that is based upon models developed by nationally recognized programs, minimum observation of 6 sessions of a group, 6 hrs CE per year	48 weeks, weekly sessions, 90 mins	Monitors are to attend a DVIProgram class at least quarterly; monitoring must be provided by staff of a DV center or by a third party monitor	CCR, communication between referral sources (prosecutor, DHHS), probation officers, judges, etc.	Staff shall not discriminate against an offender, victim, current intimate partner, or other person based on age, race, ethnicity, religion, gender, sexual orientation, disability, national origin, or socioeconomic status
Maryland	Accountability -focused	Bachelor's degree, min. 30 hrs training from a comprehensive intimate partner violence victim service agency, min. 30 hrs training specific to working with perpetrators of DV; supervisors must have at least a master's degree	Min. 20 weeks for groups, min. 12 weeks for individual	Any program documents may be available for inspection and audit at any time	Provide a minimum of monthly updates on participants supervised by the Division of Parole & Probation	Not specified in available data

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Massachusetts	Power and control, accountability -focused, Batterer Intervention Risk Assessment and Management instrument or comparable tool	24 hrs training from a DPH-approved Intimate Partner Abuse Education training program, observation of at least 6 group sessions led by staff from a DPH-approved training program	Min. 80 hours (including intake)	Authorized personnel of the Department may conduct site visits and/or inspect programs at any reasonable time without prior notice	Information sharing between courts, probation, adjunctive behavioral health providers, intimate partners, DV counselors, other third parties	Programs shall incorporate tenets of cultural and linguistic competency and sensitivity into their policies so as to contribute to the elimination of racial and ethnic health disparities; must be inclusive of all cultures while specifically designed to address the needs of racial, ethnic, and linguistic minority groups
Michigan	Accountability -focused, identify/ confront excuses for abusive behavior	Bachelor's degree, or 2 yrs of equivalent experience involving direct contact work with victims and/or batterers, 40 hrs of direct facilitating or co-facilitating experience in batterer intervention groups, 40 hrs additional DV training, 20 hrs CE per year	Min. 26 sessions, recommended 52, min. 90 mins, max. 2 hrs	Staff monitoring of offender participation, not enough information	CCR, must report offender progress/ behavior to courts and/or probation	Each program must analyze how it is responding to cultural differences among participants and staff; must have a plan for culturally competent practice which may include referrals to appropriate culturally-based services

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Minnesota	No standards	–	–	–	–	–
Mississippi	No standards	–	–	–	–	–
Missouri	Victim-centered, power and control, accountability -focused	50 hrs training, min. 24 hrs of direct co-facilitation, ongoing education to increase knowledge on topics related to DV; recommended master's or bachelor's degree in related field, with 2+ yrs of direct service in DV advocacy or group work with batterers	Min. 26 weeks, weekly sessions, min. 90 mins	Provides guidelines for program evaluation, frequent monitoring of facilitators	CCR, requires collaborative relationships with DV programs, judges, law enforcement, probation/ parole, CPS, faith organizations, etc. when necessary	Any program receiving federal funding must be in compliance with federal laws in providing language access, provides guidance on reaching underserved populations, standards for providing services to LGBTQ+ individuals
Montana	No standards	–	–	–	–	–
Nebraska	Power and control, approved curricula include EMERGE or Duluth	Bachelor's degree in a human service-related area or equivalent combination of college courses and/or applied exp., 60 hrs DV training, 12 hrs CE training annually	Min. 30 weeks, weekly sessions, min. 90 mins	Must have a mechanism for measuring the progress of offender in the program, including attendance, participation, completion of assignments, behavior & attitudinal changes	Communication between offender, victim, & the court	Programs must not discriminate against any applicant based on race, class, age, physical handicap, religion, educational attainment, ethnicity, national origin or sexual preference

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Nevada	Not specified in available data	Master's or doctorate degree in clinical human services, at least 2 yrs exp. in a supervisory role in services to victims or offenders or at least 5 yrs exp. in the direct provision of services to victims or offenders, 60 hrs of formal training in DV	Min. 26 weeks, min. 36 hrs	Not specified in available data	Communication with courts, probation/ parole, and prosecuting attorney concerning behavior of offender in the program and the number of treatment sessions the offender successfully completed	Not specified in available data
New Hampshire	Power and control, accountability -focused	Not specified in available data	6-8 months, meeting weekly	Court-based referral; New Hampshire judicial branch oversight	Judicial task force review; Supreme Court oversight	Not specified in available data
New Jersey	Power and control, accountability -focused	Min. 40 hrs of DV victim and batterer intervention training is strongly recommended	Min. 26 weeks, 52 or longer is preferred, 1 ½ hrs min. per session	Required participation in Dept. of Children and Families (DCF) training and evaluation activities, regular DCF monitoring	Programs must maintain working relationships with DV victim services agencies, courts, probation services, mental health & substance abuse providers	Programs shall identify and develop, accessible culturally responsive services, e.g. language services & transportation; supervisors must be culturally competent and responsive

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
New Mexico	Power and control, accountability -focused	Completion of the Ontario Domestic Assault Risk Assessment (ODARA) Training Program and complete the ODARA certification, min. 40 hrs of DV training, 8 hrs annual retraining, extensive education requirements	52 weeks	Ongoing risk assessment, ongoing monitoring and evaluation by Children, Youth and Families Department, Behavioral Health Division Domestic Violence Unit	CCR, encouraged law enforcement, prosecution, and judicial cooperation and education	Explicit mentions of concerns for Native American populations, LGBTQ+ community, extensive non-discrimination policy
New York	No standards	–	–	–	–	–
North Carolina	Victim-centered, approved training certificates include Duluth, Emerge, Men Stopping Violence	Min. 1 yr of experience/training working in DV field; initial training should include: observing groups, reviewing books, videotapes, & articles on DV, attending volunteer training at local battered women's shelter, observing their hotline, & training in the BIP curricula used by the agency	26 weeks, weekly sessions, 90 mins	Continuous lethality assessments must be built into both the intake and the group process to protect the safety of abuse victims and group providers	Not specified in available data	The commission shall not discriminate against any abuser treatment program or its providers because of age, race, sex, creed, color, national origin, or disabling condition

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
North Dakota	Power and control, accountability -focused, psycho-educational, Duluth-informed	Bachelors' degree in a human-related field, exp. working with both victims and offenders of DV, knowledge on client ethics required, must complete a formal DV intervention training program (i.e. provided by DAIP, EMERGE, AWARE)	Min. 24 weeks	Not specified in available data	CCR including police, courts, probation services, victim advocates, offender specific intervention programs, schools, & CPS	Encourage facilitator training in cultural competency and diversity; recognizes the need for other specialized programs to treat LGBTQ+ individuals
Ohio	Power and control, accountability -focused	Ongoing training in multiple areas of DV education	Min. 6 months	Extensive guidelines on monitoring; BIPs shall engage in regular empirical self-evaluation which may include recidivism rate check through the court records	CCR, communication with courts about participant attendance/ progress, exchange info with referring agencies; also recommended to exchange info with other service providers, such as mental health counselors and medical doctors if appropriate	BIPs shall strive to be inclusive of all populations represented within the community they serve; recommended that BIPs cultivate collaborative relationships with marginalized communities; encouraged to provide training for staff to improve ability to work with diverse populations

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Oklahoma	Accountability -focused	Min. 30 hrs DV training, 16 hrs annual ongoing training, graduate degree in a behavioral health or criminal justice related field and 1 yr related work exp., or bachelor's degree in a behavioral health or criminal justice related field and 2 yrs related work exp.	Min 52 weeks, 90 mins per session	Office of Attorney General (OAG) oversight	CCR, not enough information	Cultural sensitivity training required, programs shall offer services that are free from all forms of unlawful discrimination based on race, sex, color, age, national origin, genetic information, religion, disability, & immigration status
Oregon	Power and control, accountability -focused	80 hrs training on DV-related issues, 32 hrs CE every 2 yrs; min. of 200 hours of face-to-face contact co-facilitating BIP groups or classes (bachelor's degree counts for 50 hrs, master's degree counts for 100 hrs)	36 weeks, sessions lasting 1 ½ – 2 hrs each	Advisory committee appointed by Attorney General (AG) shall evaluate the operation of these standards and recommend amendments to the AG	BIP is encouraged to use the power of the criminal justice system to hold batterers accountable for their battering	Cultural competence training required, extensive requirements for culturally informed interventions
Pennsylvania	No standards	–	–	–	–	–
Rhode Island	No standards	–	–	–	–	–

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
South Carolina	Not specified in available data	Min. 3 yrs exp. working with both perpetrators and victims of DV, 1 yr exp. in group facilitation, holds at least a master's degree in social work, counseling, or another related field	Not specified in available data	Not specified in available data	Not specified in available data	Not specified in available data
South Dakota	No standards	–	–	–	–	–
Tennessee	Power and control, accountability -focused	40 hrs training, 8 additional hrs annually, baccalaureate degree or relevant experience	Min. 24 sessions, weekly sessions, 1 ½ – 2 ½ hrs each	Regular monitoring by Domestic Violence State Coordinating Council	Must have procedure for sharing relevant info with law enforcement and judicial personnel responsible for monitoring batterers or responsible for victim safety, e.g. probation and parole departments, Department of Children's Services, other governmental service providers	Certified Programs should attempt to attract and retain personnel who reflect the racial, ethnic, and linguistic diversity within the community served; providers must be sensitive to racial, ethnic and linguistic diversity; referrals-out may be made for batterers for whom the program does not have appropriate services due to the batterer's gender, sexual orientation, or other traits

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Texas	Accountability -focused, intended for **male-to-female violence only**	40 hrs training (15 family violence & 25 batterer intervention)	Min. 18 sessions, min. 36 hours, sessions should not exceed one per week	Encouraged to conduct and document annual external program assessments regarding their services from all referral sources	Encouraged to establish a collaborative working relationship with courts, criminal and civil justice agencies, local district and/or county attorney's office, local law enforcement, & corrections agencies	Programs should adjust curriculum to account for participants' literacy levels and adult learning style, limited recommendations for specialized populations (female offenders, male same-sex offenders)
Utah	Accountability -focused, trauma-informed, Intimate Partner Violence Risk and Needs Evaluation (IPVRNE)	24 hours of pre-service training specific to DV; required to have 16 hours of ongoing training specific to DV annually	**Low risk**: 4-12 weeks **Medium risk**: 13-30 weeks **High risk**: 30-40 weeks; Sessions lasting 60-90 mins	Not specified in available data	Coordinate with law enforcement when performing offender evaluation	Encouraged to provide treatment in ways that are respectful to language needs, racial and ethnic minority needs, and LGBTQ+ specific needs when appropriate
Vermont	Accountability -focused, **intended for intimate partner violence**	Background check, specified training, must observe at least three groups within 1 month of employment, 10 hrs CE per year	Min. 26 weeks, weekly sessions, 1 ½ hrs each	Facilitators are observed 2 times per yr; programs must submit regular reports to Domestic Violence Accountability Committee	CCR, family & district courts, state's attorney, law enforcement, corrections, etc.	Programs should minimize disparities based on race, socio-economic status, education level, cognitive abilities, gender, etc.

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
Virginia	Victim-centered, accountability-focused, intended for **male-to-female violence only**	Min. 32 hrs DV training, 12 hrs CE annually, **non-exempt** setting requires licensure in an appropriate field (i.e. LPC, LCSW, LMFT), **exempt** setting requires Masters or Bachelors degree in an appropriate field with a min. 2 yrs exp. facilitating DV programming	Min. 36 hours over 18 weeks	Batterer Intervention Programs shall engage in internal monitoring	Programs are responsible for working with the criminal justice system to ensure that there is appropriate monitoring and consequences for batterers' noncompliance with the program	Program providers shall make every reasonable effort to provide for individual batterers' differences and needs; BIPs may not reject any batterer based on race, class, age, disabilities, religion, educational attainment, ethnicity, national origin, or ability to pay
Washington	Accountability-focused, CBT-approaches, motivational interviewing, trauma-informed	Currently licensed or registered as counselors, must be free of criminal convictions involving DV or moral turpitude, bachelor's degree in counseling, psychology, social work, or similar social services field, min. 30 hrs DV training, 20 hrs CE annually; extensive requirements for supervisor position	Weekly sessions, min. 90 mins, specific requirements for virtual sessions	Each treatment program must document program specific quality management procedures; each participant is given a treatment outcomes evaluation at discharge	Programs must require all participants to sign a release form that allows information to be shared with police, lawyers/ prosecutors, courts, probation/ parole officers, etc.	Quality management must include how a program reviews and improves cultural competency and how services are provided to individuals who need sign language or interpretation; program materials, publications, and audio-visual materials must be culturally aware, sensitive, and nondiscriminatory

State	Philosophy	Facilitator Requirements	Program Length/ Structure	Outcome Measures/ Evaluation	Court & Community Collaboration	Cultural Competence/ Accessibility
West Virginia	Power and control	Min. 30 hrs DV training, minimum high school diploma or high school equivalency diploma, 3 hrs CE annually	Min. 32 sessions	Programs shall have a formal procedure to evaluate, on an annual basis, all persons providing services for the batterer intervention and prevention program	Allow provider, to provide info about the batterer to relevant legal entities, including courts, parole/ probation officers, CPS, adult protective services, law enforcement, licensed DV programs, or other referral agencies if necessary	BIPs shall be in compliance with Title III of the ADA requirements or make arrangements to accommodate individuals with special needs; CE includes awareness and understanding of diversity and cultural differences
Wisconsin	No standards	–	–	–	–	–
Wyoming	No standards	–	–	–	–	–

**AIP – Abuse Intervention Program*
**BIP – Batterer Intervention Program*
**CCR – coordinated community response*
**CE – continuing education*
**DV – domestic violence*
**FVIP – Family Violence Intervention Program*
**RNR – risk, need, responsivity*
Information reflects publicly available state standards as compiled by BISC-MI; absence of information indicates lack of explicit mention in source material.

Discussion

The findings from both the qualitative interviews and the state standards comparison illuminate substantial variation in how domestic violence intervention programs are designed, implemented, and overseen across the United States. This section interprets those findings in relation to existing literature and theory, discusses the implications of observable patterns, and situates Arkansas within the broader national landscape.

Variation in Program Models and State Standards

One of the most consistent themes across interviews was the encouragement of hybrid, flexible program approaches rather than strict adherence to a single model. While the Duluth Model remains the most widely implemented framework nationally (Bohall et al., 2016), practitioners across multiple states argued that it should not be mandated as the only approach. This aligns with and contributes to the debate from the literature: Dutton and Corvo (2006) argued that Duluth-type programs are insufficiently responsive to individual psychological and situational risk factors, while Gondolf (2007) countered that the Duluth Model is not static and that many programs have successfully adapted it to incorporate individually responsive elements.

This study's findings suggest that in practice, most effective programs have already moved beyond this binary. The majority of interviewees described blending Duluth-informed accountability frameworks with CBT, trauma-informed care, and motivational interviewing. This convergence reflects the recommendation from the literature that interventions should draw on evidence-based, multidisciplinary approaches that integrate different practices (Flasch et al., 2021). The implication for Arkansas and other states is that standards should establish clear philosophical foundations while explicitly permitting and encouraging program flexibility rather than mandating a single curriculum.

Centrality of Accountability

Across all states, offender accountability emerged as the core unifying principle of domestic violence intervention. However, this study reveals that accountability is operationalized in meaningfully different ways, and these differences have distinct implications for program effectiveness.

Some programs use external accountability mechanisms such as mandatory attendance, behavioral contracts, homework, and court reporting. These structured approaches ensure consistency and provide clear metrics for compliance, which is valuable for programs that operate within court-mandated referral systems. However, Dutton and Corvo (2006) caution that compliance-focused models risk producing superficial behavioral change without genuine attitude shifts; offenders may complete requirements without internalizing accountability.

Other programs emphasize internal accountability—fostering self-reflection, self-regulation, and personal motivation to change. While this approach may produce deeper and more lasting behavioral change, it is more difficult to measure and may be less consistently applied across programs. Radatz et al. (2021) argue that the "responsivity" principle of effective intervention—tailoring treatment to individual strengths and learning styles—supports this more individualized approach. The challenge is that it requires well-trained, highly skilled facilitators and robust program evaluation, both of which are resource-intensive.

The implication for Arkansas is that while its current standards are accountability-focused, they are primarily structured around attendance-based compliance metrics. Incorporating competency-based completion criteria and internal accountability measures, as seen in Colorado, could strengthen the depth and sustainability of behavioral change among program participants.

Collaboration and CCR

Both the state standards comparison and the interview data underscore that the most effective programs utilize coordinated community responses (CCR) that integrate treatment providers, courts, probation officers, and victim advocates. This finding is directly consistent with the National Network for Safe Communities' (2021) framework, which emphasizes collaboration between law enforcement, social service providers, and victim advocates as essential to reducing intimate partner violence.

Colorado's multidisciplinary treatment team model and Georgia's state-level coordinating commission reflect the most formalized examples of CCR in this study. These structures ensure that accountability extends beyond just the program facilitators. When courts, probation officers, and victim advocates share information and coordinate responses, the likelihood that offenders can manipulate the system or face inconsistent consequences is reduced. Arkansas's standards already require a broad CCR that includes a range of community stakeholders. However, the interview findings suggest that the quality and depth of collaboration between community stakeholders varies substantially depending on local resources and relationships.

Persistent Gaps in Cultural Competence and Accessibility

While most states include some language around cultural competence and non-discrimination, this study confirms that this remains one of the most inconsistently enforced dimensions of domestic violence intervention standards. Interview data revealed meaningful efforts to address culturally-specific needs, such as translated materials, partnerships with community organizations, and LGBTQ+-specific curricula, but also acknowledged significant gaps, particularly for non-English- and non-Spanish-speaking populations, individuals with disabilities, and rural participants.

These gaps have significant consequences. Satyen et al. (2022) found in their systematic review that culturally specific interventions were associated with reduced recidivism, decreased psychopathological symptoms, and positive cognitive changes. Cultural competence is a strong predictor of program effectiveness. For Arkansas, a state with significant racial, ethnic, and rural diversity, strengthening explicit cultural competence requirements represents an opportunity for improving outcomes. States must move beyond basic non-discrimination statements and actively invest in culturally specific training and partnerships.

Outcomes and Evaluation

The absence of consistent, standardized outcome measures across programs represents one of the most significant systemic gaps identified in this study, which mirrors Flasch et al.'s (2021) conclusion that many state standards fail to specify evaluation procedures. While some states have developed rigorous evaluation systems including risk-based treatment planning (Colorado), ongoing risk assessment (Utah), and recidivism tracking (Kansas, Washington), many others, including Arkansas, rely primarily on pre/post screening tools without longitudinal outcome tracking.

This has both practical and ethical implications. Jumarali et al. (2023) found that survivors themselves want to know what offenders are learning in intervention programs and whether behavioral change is occurring. This information can only be provided through systematic, ongoing evaluation. Outcome data is also essential for identifying which program components are working. These findings suggest that programs would benefit from implementing more structured outcome and evaluation measures, but another challenge persists in obtaining the funding and resources necessary to conduct more consistent and standardized evaluations.

Limitations

This study has several limitations that should be considered when interpreting the findings.

First, the sample size for the qualitative interviews was small, consisting of nine participants across eight states. While these interviews provided in-depth insights into program design and implementation, the sample may not fully capture the diversity of domestic violence intervention programs across the United States.

Second, this study relied on self-reported data from interview participants, which may be subject to bias. Participants may have emphasized strengths of their programs or underreported challenges. As a result, the findings may reflect participants' perceptions rather than fully objective assessments of program effectiveness.

Third, the comprehensive analysis of state standards was mostly based on secondary data obtained from the Battering Intervention Services Coalition of Michigan (BISC-MI). While this resource provides an overview of state standards, it may not include the most recent updates in implementation standards. Some links to state standard websites were broken or inaccessible, so information may not be accurately up-to-date.

Finally, this study focuses on program structure, philosophy, and implementation rather than participant outcomes. As a result, it does not assess the effectiveness of specific models in reducing recidivism or improving survivor safety. Future research should incorporate thorough outcome evaluations to better assess program effectiveness.

Despite these limitations, this study provides valuable insight into both the structural variations and practical implementation of domestic violence intervention programs across the country, highlighting key areas for future research and policy development.

Recommendations

Based on the findings from state standards and provider interviews, five actionable recommendations were developed to support the ACADV in their design and implementation of domestic violence intervention programs.

1. **Strengthen evaluation and outcome measurement.** Findings from the state standards analysis indicate that Arkansas primarily relies on pre- and post-screening tools, while interviews revealed that many programs across states struggle with inconsistent or informal evaluation practices. Several states incorporate more structured approaches, such as recidivism tracking, risk assessments, and ongoing progress monitoring, which are more aligned with evidence-based practices. Strengthening evaluation and outcome measurement would improve the ability to assess program effectiveness, monitor participant progress over time, and support data-driven decision-making at both the program and state levels.

   Key Actions:

   - Require standardized use of validated risk and needs assessment tools at intake and throughout treatment
   - Implement recidivism tracking measures (re-arrests, protection order violations)
   - Require periodic treatment plan reviews and documented progress evaluations
   - Develop statewide reporting guidelines to ensure consistency across providers

2. **Shift toward competency-based completion models.** Interview findings, particularly from Colorado, emphasized the benefits of requiring participants to demonstrate mastery of core competencies rather than completing a fixed number of sessions. This approach contrasts with more rigid, time-based models and reflects broader trends toward

individualized intervention. A competency-based model would allow programs to better assess whether participants have achieved meaningful behavioral change, rather than assuming completion based solely on attendance.

Key Actions:

- Develop core competencies related to accountability, emotional regulation, and power structures
- Require facilitators to assess participant understanding and behavioral progress before program completion
- Allow flexibility in program duration based on participant progress and risk level
- Provide training for facilitators on competency-based evaluation methods

3. **Clarify group size guidelines.** The analysis of state standards found that Arkansas does not specify a maximum group size, while many other states define clear limits and specific facilitator-to-participant ratios. Interview findings emphasized the importance of group dynamics in fostering accountability, suggesting that overly large groups may reduce participant engagement and limit facilitators' ability to effectively monitor behavior. Establishing clear group size guidelines would promote more effective facilitation, enhance participant engagement, and support the development of accountability within group settings.

   Key Actions:

   - Establish a maximum group size (commonly 8-15 participants in other states)
   - Require a minimum facilitator-to-participant ratio (e.g. two facilitators for larger groups)
   - Provide guidance on adjusting group size based on participant risk level or needs

4. **Improve rural access to services.** Interview participants identified geographic barriers and lack of providers as significant challenges, particularly in rural areas. Given that Arkansas is one of the most rural states in the country with approximately 41% of the population residing in rural communities (Slone, 2023), limited access to services may hinder program participation and completion. Improving rural access would increase program availability, reduce barriers to participation, and support more equitable access to intervention services across the state.

   Key Actions:

   - Provide funding incentives or grants to support rural program providers
   - Expand hybrid and telehealth service options where appropriate
   - Offer transportation assistance
   - Develop outreach strategies to increase awareness and engagement in underserved areas

5. **Incorporate Risk/Needs Assessments.** Both the state standards analysis and interview findings highlight the use of structured frameworks such as the Risk-Need-Responsivity (RNR) model and the Intimate Partner Violence Risk and Needs Evaluation (IPVRNE) in other states. These approaches are supported by research and were identified by interviewees as effective for tailoring interventions to individual participants. Incorporating risk and needs assessments would allow programs to better match participants with appropriate levels and types of intervention.

   Key Actions:

   - Require the use of validated risk and needs assessment tools at program intake
   - Use assessment results to inform individualized treatment planning

- Adjust program intensity and duration based on assessed risk level
- Provide training for facilitators on administering and interpreting assessment tools

Conclusion

Domestic violence intervention programs play a critical role in promoting offender accountability, reducing repeat harm, and supporting safer outcomes for survivors and communities. Findings from this study highlight substantial variation in program design, implementation, and oversight across states, alongside several shared practices, including group-based programming, emphasis on accountability, and collaboration with courts and community partners. However, gaps remain in areas such as evaluation, cultural competency, and accessibility.

In response to these findings, this study offered five recommendations that can be implemented in Arkansas. These include strengthening evaluation and outcome measurement practices, incorporating competency-based completion models, clarifying group structure guidelines, improving access to services in rural areas, and integrating risk and needs assessment frameworks such as the Risk-Need-Responsivity model. These recommendations are intended to support the Arkansas Coalition Against Domestic Violence in enhancing the consistency, effectiveness, and accessibility of domestic violence intervention programming across the state.

By identifying both strengths and areas for improvement in Arkansas's current standards, this study provides a foundation for policy and programmatic enhancements that better align with national practices and continually emerging research. Ultimately, strengthening these standards has the potential to improve program effectiveness, enhance offender accountability, and contribute to more coordinated and impactful responses to domestic violence at the state level.

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Appendix: Interview Guide for DVIP/BIP Providers

Thank you for taking the time to speak with me today. I'm conducting a project examining best practices in domestic violence intervention programs and how state standards influence program implementation. Your insights will help identify strengths, challenges, and opportunities for improving intervention practices.

Your participation is completely voluntary. You may skip any question or end the interview at any time. Your responses will be kept confidential to the extent allowed by law and University policy. Your name, your organization's name, and any other identifying details will not appear in the final report or any project materials. Any identifying information will be changed to a pseudonym during the transcription process. When I summarize findings, I will combine insights from multiple participants and use anonymous descriptions.

With your permission, I would like to audio-record the interview so that I can accurately capture your responses. The recording will only be used for transcription purposes and will be deleted after analysis is complete.

Background and Role

1. Can you briefly describe your role within your DVIP/BIP program?
2. How long have you been facilitating or overseeing domestic violence intervention services?

Program Structure and Approach

3. How would you describe the core philosophy or theoretical model guiding your program?
4. What does the structure of your program look like (program length, group or individual format, curriculum content or materials)?
5. How does your program emphasize offender accountability?

Implementation and Challenges

6. What do you feel works well in your current program structure or curriculum?
7. What are some of the biggest challenges your program faces in implementation?
8. Does your program collaborate with probation, courts, or domestic violence service agencies?
    - If yes: What does that collaboration look like?
    - If no: What barriers make collaboration difficult?

Cultural Competency

9. How does your program address cultural, linguistic, or community-specific needs?
10. Are there participant groups for whom the current model is less effective or accessible? If so, why?

State Standards and Policy Influence

11. How do your state's standards shape the design or operation of your program?
12. Do the current standards help or hinder your program's ability to meet participant needs?

Outcomes and Evaluation

13. How does your program assess participant progress or change over time?
14. Are there outcome areas you wish you could measure more effectively?

Closing

15. What advice would you give to another state or program trying to strengthen domestic violence intervention?
16. Is there anything else you feel is important that we didn't discuss today?

Thank you again for participating!