Violence and Victims, Volume 36, Number 6, 2021

State Standards for Batterer Intervention Programs: A Content Analysis

Paulina Flasch, PhD
Maria Haiyasoso, PhD
Kevin Fall, PhD
Kaylyn Evans
Colleen Dunlap
Texas State University, San Marcos, TX
Tal Nesichi
University of Texas at Arlington, Arlington, TX

Batterer intervention programs (BIPs) provide treatment options for domestic violence offenders across the United States with varying degrees of standardization of programs required by law. The purpose of this study was to investigate the current State Standards for Batterer Intervention Programs (SSBIPs) in the United States. The primary research question was to discern the minimum requirements and mandates for BIPs of the 50 states. Results from the content analysis of the 44 states with SSBIPs indicated that there were some commonalities (e.g., approach to offender treatment) among the standards; however, there persisted varied minimum standards within SSBIPs for a majority of elements within BIPs (e.g., intake, screening, and assessment procedures; curriculum; training and educational requirements for BIPs providers and supervisors; and evaluation of the BIP programs). Recommendations and implications are discussed.

Keywords: batterer intervention programs; intimate partner violence; state standards

http://dx.doi.org/10.1891/VV-D-20-00079

Batterer intervention programs (BIPs) were first introduced in the 1980s after community efforts to recognize and target the problem of domestic violence gained traction (Garner et al., 1995). As the criminal justice system began to address domestic violence as a serious issue, an expansion of treatment options for domestic violence perpetrators emerged to meet the need for nonpenal methods of intervention. With the evolution of counseling as a means to address the crime of domestic violence came the need for guidelines and standards to help formalize treatment protocols and assess outcomes.

It is important to differentiate between BIPs and state standards for batterer intervention programs (SSBIPs). BIPs are traditionally privately operated treatment programs that must be certified by the state according to specific legal criteria, treatment requirements, and application processes (i.e., State Standards). Once certified, BIPs function as referrals for individuals who have been charged with domestic violence-related offenses and sentenced to complete an intervention program. State Standards, on the other hand, are the formal minimum standards set forth for BIPs to adhere to. They are based on penal and administrative codes and best practices in batterer treatment are often created by joint efforts of several government and community agencies (e.g., Department of Health and Human Services, Domestic Violence Agencies, Department of Corrections, Judiciary systems). Scholars (e.g., Babcock et al., 2016; Gelles, 2001; Hamberger, 2001; Richards et al., 2017) have explored the relative advantages and disadvantages of SSBIPs, with the conclusion being that though standards are needed to ensure positive treatment outcomes and protect victims, the specific elements of what should be included in the standards is undecided.

Despite the lack of consensus on the content of standards, standards were developed in many states. Researchers responded by examining the content of existing standards, often with mixed results. Austin and Dankwort (1999) completed the first content analysis of the state standards for BIPs available in 1997. They organized the standards by mandatory or voluntary participation, purpose and history of standards, protocols and procedures, and requirements of staff. Though they concluded that the effort to make the regulations consistent across the field had been "remarkably successful" (p. 165), they also noted that more work was needed in the areas of outcomes assessment, clinical rationales for treatment choices, and clear definitions of curriculum philosophy and content.

In 2001, Maiuro et al. examined the 30 states that reported BIP standards at the time. They compared the standards on the categories of minimum length of treatment; treatment method, curriculum, philosophy/approach (e.g., Duluth model, psychoeducation); permitted modalities (e.g., group, individual, couples); integration of research into treatment; and the methodology used for the development and revision of the standards. The researchers concluded that the steps to address critical elements related to the provision of treatment services to batterers had made substantial progress, but more attention was needed in several identified deficit areas. Specific concerns included poorly defined protocols for standard revision; lack of research integration into treatment; and an over-reliance on a singular "one-size-fits-all" approach to intervention (Maiuro & Eberle, 2008, p. 148).

In 2008, Maiuro and Eberle replicated the previous 2001 survey to review existing standards based on an "upswing in research on domestic violence" (p. 134). They examined 45 state standards and compared the results to those reported from the 2001 study. This study expanded the categories to scope of standards; screening and risk assessments; entity certifying standards; theoretical orientation of treatment; intervention methods; allowable modalities and approaches; research integration; minimum provider education require-

ments; and standard's revision policies. Their study revealed the following positive trends related to the content of the standards:

1) Clearer direction regarding treatment curriculum and philosophy: in 2001 only 27% provided treatment orientation, while in 2008 that number has increased to 76%. Although the 2001 study did not explore this aspect further, the 2008 study did look for themes in the curriculum orientation and reported 68% focused solely on power and control, 27% advocating power and control combined with other social psychological elements, and 5% promoting other evidence-based approaches.
2) Increase in required intake and lethality assessments: the 2001 survey noted 69% using some form of intake protocol, and in 2008 the percentage increased to 86%.
3) Increase in use of program evaluation: in 2001 30% supported program evaluation as compared to 33% including program evaluation in 2008.
4) Increase in collection of standardized data: the two main elements reported in both studies were substance use and ethical issues such as confidentiality. For substance abuse information, the percentages were 58% in 2001 and 63% in 2008 and for ethical documents, the study reported 69% in 2001 and 78% in 2008.
5) Increase in required minimum education requirement for providers: in 2001 the findings reported 20% requiring a bachelor's degree, while in 2008 the number rose to 40% requiring a bachelor's degree, and 15% requiring a graduate degree.

Despite these promising trends, the findings also revealed several areas for improvement including the need for enhanced victim safety protocols, better outcomes assessments, movement beyond one-size fits all treatments, implementation of screening tools, and improved risk assessments and referral processes for clients not appropriate for batterer intervention.

More recent research has focused on program perceptions of the implementation of state standards (Cannon et al., 2016; Price & Rosenbaum, 2009). Outcomes reflect the program struggle to consistently apply the standards as well as common disconnects between outside structures within the criminal justice system, state regulatory bodies, and the practice of clinical work. These scholars have also highlighted the consistent use of psychoeducational groups as the primary treatment approach in BIPs. With the inconsistency noted among programs, it seems worthwhile to focus energy on re-examining the elements of state standards.

It has been 11 years since the last study of the state standards for BIPs was published, and since then, 24 states updated or implemented their standards. The need for an updated and comprehensive review of current versions of the standards is warranted. Understanding the current state of practice for batterer treatment in the United States informs our knowledge of where we stand and where we need to go and may be used to expand recommendations and policy. Regular nationwide examinations of BIP state standards serve as important benchmarks to assess the current state of batterer treatment. Such assessments provide insight to both strengths and areas for growth in how batterer treatment is conceptualized and executed. Further, such undertakings allow for a critical analysis and comparison between current standards of practice and best-practice guidelines, the latter of which tends to precede legislation and policy and the former of which needs research-backed data to transform and improve. Thus, the aim of this study was to delve deeper into the content of the existing standards and explore the elements using a rigorous research methodology.

The primary research question was to discern the minimum requirements and mandates of existing state standards for BIPs. To further explicate the main question, the standards examined: (a) which states have government-sanctioned standards for BIPs? (b) history, creation process, and purpose of each state's BIP standards? (c) qualification process for BIP participation? (d) logistical requirements? (e) intake, screening, and assessment procedures for participation? (f) modality of BIP treatment? (g) curriculum of the BIP treatment? (h) training and educational requirements for providers? (i) evaluation of the BIP program and of participant success?

METHODS

To answer our research questions, we used a content analysis research design. Content analysis entails "the systematic reading of a body of texts, images, and symbolic matter" for the purpose of analysis, categorization, and condensation (Krippendorff, 2004, p. 3). Though there are many approaches for content analysis, most share the following steps: (a) articulating research questions, (b) selecting the sample or content to be analyzed, (c) defining categories for analysis, (d) outlining the coding process and the coder training, (e) implementing the coding process, (f) determining trustworthiness, and (g) analyzing the results (Kaid, 1989).

Procedure

The lead researcher and two research assistants used a variety of methods to locate existing state standards. Because there is no government entity or national organization housing this information in a single space, locating up-to-date current versions of BIP State Standards and legal codes proved challenging. To locate the SSBIPs, we first referenced the Batterer Intervention Services Coalition of Michigan (BISCMI, 2013) list, which, to our knowledge, is the only source of the collected standards in existence. However, many of those links were no longer active or were linked to outdated versions of standards. Thus, we reviewed states' websites for domestic violence agencies, BIP credentialing bodies, government entities, community domestic violence and BIP organizations, private agencies, and law enforcement agencies. Some states had easily accessible documents, whereas other states provided no or minimal information regarding BIP standards and legal mandates. Finally, we placed phone calls and e-mailed state agencies and legal entities for answers to missing information.

The third step was to define the categories for analysis. The lead researcher utilized an emergent coding strategy (Haney et al., 1998) by reviewing previous articles on BIP standards (e.g., Maiuro & Eberle, 2008) and by reviewing the research team's assembled documents for analysis. The emergent coding strategy resulted in eight primary categories for analysis: (a) History, creation process, and purpose of standard, (b) The qualification process for BIP participation, (c) Logistical requirements, (d) Intake, screening, and assessment procedures, (e) Modality and philosophy of BIP treatment, (f) Curriculum for the BIP treatment, (g) Training and educational requirements for providers, and (h) Evaluation of the BIP program and of participant success.

For the fourth step, *outlining the coding process and the coder training*, the lead researcher identified the coding team, which included three faculty members, two graduate counseling students, and one graduate social work student. Because of the large amount

of data to organize, the lead researcher created a coding survey using the Qualtrics survey software. The survey was based on the eight primary coding categories and consisted of 80 multiple-choice and open-ended questions about BIP state standards that coders were asked to respond to for each state standard they reviewed. Sample questions included: "What entities are listed as contributors to the standards?," and "Are non-court-ordered participants allowed to attend?" For trustworthiness purposes, two coders were assigned to review each standard. Each coder was trained in the coding process by the lead researcher and completed a coding sample. For disputed ratings, a third coder was utilized to investigate and reconcile discrepancies (Miles & Huberman, 1994). We took several measures to ensure the trustworthiness of our findings. We created an extensive coding survey tool based on an emergent coding strategy, which enabled consistency across coders and data. We utilized a coder training system, multiple coders, and multiple coding steps designed to examine and resolve discrepancies. This aided in triangulation and the resolution of validity and reliability-related concerns.

RESULTS

In this section, we describe and list the findings from our content analysis in the following categories: (a) overview of the SSBIPs; (b) logistics and structure of BIPs as mandated by SSBIPs; (c) intake, screening, and assessment procedures; (d) modalities, approaches, and curriculum of BIPs as addressed in SSBIPs; (e) training and certification requirements for facilitators and supervisors; (f) evaluation of offender progress and BIP treatment. To access our extensive compilation of state standards and protocols, visit our website: https://www.txstate.edu/clas/Professional-Counseling/tivrl.html

Overview of the SSBIPs

Currently, 44 states have SSBIPs; states without current state standards include Arkansas, Mississippi, New York, Pennsylvania, South Carolina, and South Dakota. Since Maiuro and Eberle's review in 2008, 24 states updated or implemented their state standards for BIPs, whereas other states removed theirs. For example, Connecticut and Wyoming adopted state standards for BIP treatment, while South Carolina and Pennsylvania dropped theirs and moved away from a centralized process because of various legislative reforms. Further, some states (e.g., Alaska, Arizona, California, Florida, Montana, Washington, West Virginia) have legislation in place (e.g., penal code) for minimum requirements for batterer treatment, though the programs do not necessarily have to be certified by the state, nor follow a uniquely developed and encompassing set of standards and processes required by most states. For these states, little information was publicly available on requirements for BIP certification. However, we still included them in our analysis, since some legal requirements for BIPs was available and mandated by the state (e.g., length of treatment, modality). Out of the 44 states that currently have state standards for BIPs, 36 (81.8%) had comprehensive documents outlining explicit processes for BIP certification and offender treatment mandated by the state; information about the remaining 8 states' (18.2%) processes and mandates were collected and compiled from multiple sources (e.g., penal and administrative codes, state websites) by the research team.

TABLE 1. Contributors to State Standards

Contributor to Standards	Number of States	Percentage of States
Department of Corrections	19	43.2%
Domestic Violence Council	14	31.8%
Domestic Violence Agency	14	31.8%
Courts/Judiciary/Legal Entity	11	25.0%
Department of Health and Human Services	10	22.7%
Department of Public Safety/Criminal Justice	6	13.6%
Other Government Agency	6	13.6%
Mental Health Agency	1	2.3%
Other Contributor	16	36.4%
Not stated	2	4.5%

Note. Several state standards listed multiple contributors.

Percentages based on 44 states.

36 state standards (81.8%) addressed being part of a Coordinated Community Response (CCR) to IPV, collaborating and coordinating with agencies involved in combating IPV in the state. The most frequently mentioned contributors to the SSBIPs were the Department of Corrections and Domestic Violence state councils and agencies. Table 1 lists additional contributors of the SSBIPs.

Out of the 44 states that had SSBIPs, 23 (52.3%) listed the purpose of such standards as *setting minimum requirements for batterer intervention programs*; 15 (34.1%) listed *ending intimate partner violence*; 14 (31.8%) listed *holding perpetrators of IPV accountable*; and 13 (29.5%) listed *keeping victims safe*. Three states listed *other* or did not have a purpose stated in the SSBIP.

Logistics and Structure of BIPs as Mandated by SSBIPs

Out of the 44 states with SSBIPs, 39 states (88.6%) listed minimum length of treatment in weeks. Massachusetts listed the lowest number of required weeks for treatment (8 weeks) and five states (California, Idaho, New Mexico, Oklahoma, and Washington) listed the highest number of required weeks of treatment at 52. The average number of required weeks was 27.6 weeks (standard deviation [*SD*] = 11.6). However, many states (n = 33) also listed a minimum requirement of total hours, with the lowest number of required total hours being 12 (Utah) and the highest number of required total hours being 104 (California). The average number of hours was 44.2 (*SD* = 20.8). The inclusion of the minimum number of total hours offset shorter weekly requirements. For example, Massachusetts had the lowest number of weekly requirements (i.e., 8 weeks), but a high number of total hourly requirement (i.e., 80 hours). Thus, a person could fulfill the BIP by attending 10 hours a week of a BIP for 8 weeks. Two states stated that length of treatment varied based on offender characteristics, and three states did not report minimum

length of treatment. In terms of length of individual meetings, state standards varied less. Most states (n = 25) required the meetings to last at least 90 minutes. Two states required 60-minute meetings, four states required 120-minute meetings, and 12 states did not specify length of meetings. See Table 2 for a state-by-state overview.

Though most participants in BIPs are arrested offenders of domestic violence, half of the SSBIPs allowed noncourt-mandated participants into treatment. The responsibility of payment was primarily the burden of the offender (n = 37). In other SSBIPs (n = 12), there were alternative methods for payment, such as sliding scale, combination of state and offender payment, or payment plans. One state paid for offender treatment and five states did not provide information on payment.

Further, the vast majority of BIPs were required to be run as groups (n = 42; 95.5%), with some groups separating participants based on specific characteristics. The most common reason for separating groups was gender (n = 30; 68.2%), followed by sexual orientation (n = 17; 38.6%), language and culture (n = 10; 22.7%), adolescent/minor status (n = 7; 15.9%), and intellectual disabilities (n = 2; 4.5%). Categorical separation was not addressed in 13 SSBIPs (29.6%).

Intake, Screening, and Assessment Procedures

Most SSBIPs (n = 40; 90.9%) required intake and screening procedures for participants, though 17 states (38.6%) did not include specific guidance on what that entailed. Some topics addressed during the initial intake process included social and family history (n = 19; 43.2%), demographic and background information (n = 12; 27.3%), treatment history and attitudes about treatment (n = 9; 20.5%), and legal status, including custody (n = 3; 6.8%). SSBIPs also required processes for risk assessment (n = 37; 84.1%). Out of the 44 states with SSBIPs, only 14 states (31.8%) required the use of formal assessment tools for risk assessment purposes. Other topics addressed in risk assessment of participants included mental status and substance use (n = 33; 75.0%), abuse and criminal history (n = 32; 72.7%), victim safety and lethality risks (n = 26; 59.1%), and other topics (n = 30; 68.2%). Eight states (18.2%) did not provide specific risk assessment strategies.

In terms of screening processes, SSBIPs listed certain characteristics that deemed participants unfit for BIP participation. The most common reason for nonacceptance to BIPs was participants' severe mental health and/or substance abuse issues (n = 22; 50%), followed by display or evidence of dangerous or disruptive behavior (n = 13; 29.5%). Participants deemed "not to benefit" from the group for a variety of reasons were also required to be screened out (n = 9; 20.5%), as were participants who did not fit the criteria of the group (e.g., gender, minor; n = 7; 15.9%) or who did not agree with the rules and regulations of the BIP (n = 2; 4.5%). Eight states (18.2%) listed "other" reasons, and nine states (20.5%) did not include criteria for screening out participants as part of their SSBIPs.

Confidentiality and its limits were addressed in all but two state standards (Arizona and Utah). Common limits of confidentiality included reports to parole and judiciary entities as part of sentencing requirements and victim safety. Most SSBIPs addressed victim safety and contact (n = 37; 84.1%). Table 3 provides more information on how SSBIPs addressed victim safety, contact, and confidentiality.

Modalities, Approaches, and Curriculum of BIPs as Addressed in SSBIPs

An overwhelming number of SSBIPs (n = 42; 95.5%) required group treatment as the primary intervention modality for offenders. Florida and West Virginia's standards did not mention modality. However, few standards required that BIPs (n = 11; 25%) tailored their treatment to specific participant characteristics (e.g., type and severity of offense and repeat-offender status), resulting in a one-size-fits-all model of group treatment. In addition to group treatment, a little more than half of SSBIPs allowed for supplemental modalities, including individual treatment (n = 21; 47.7%), family work (n = 2; 4.5%), and other referrals, such as mental health and substance abuse treatment (n = 11; 25%); 16 states (36.4%) did not include information on supplemental treatment.

In terms of the theoretical approach for BIP treatment, Table 4 notes the required approaches. The most commonly mandated therapeutic approach (n = 23; 52.3%) was a combination or choice between established evidence-based approaches for offender treatment that had to include specific content (see Tables 5 and 6 for specific curriculum content). Further, seven state standards (15.9%) listed the Duluth Model/power and control as the main approach; five state standards (11.4%) listed psychoeducation as the main approach, and only one state (Kansas) listed CBT as the main approach for delivering content. See Table 2 for more information about specific states. 18 SSBIPs (40.9%) listed group discussions as the primary method of dissemination of BIP curricula. It was followed by other educational strategies such as lectures (n = 8; 18.2%) and experiential activities (n = 6; 13.6%). As many as 25 states (56.8%) did not describe instructional methods.

Curriculum. Most SSBIPs addressed the curriculum for BIPs. For clarity, we divided content areas into the following categories: (a) forms of IPV, (b) impact of IPV, (c) IPV dynamics and contextual factors, (d) skill development, and (e) self-exploration. *Forms of IPV* included psychoeducation on and identification of all forms of IPV, such as physical, emotional, economic, sexual, and verbal, which were addressed in 26 SSBIPs (59.1%). Further, some states required BIPs to provide specific examples and discussions on sexual and physical abuse (n = 13; 29.5%), psychological, emotional and verbal abuse (n = 11; 25.0%), and financial abuse (n = 10; 22.7%). Only two states (Alabama and Kansas) required discussions and examples of destruction to property and violence toward pets. Seventeen states (38.6%) did not include any information related to forms of IPV in their SSBIPs. *Impact of IPV* was addressed by 35 states (79.5%) and included impact on children (n = 33; 75.0%), impact on the victim (n = 31; 70.5%), impact on the perpetrator (n = 10; 22.7%), and long term impact on victims (n = 9; 20.5%). Two states (4.5%) addressed the impact of IPV on the community, and nine states (20.5%) did not address impact of IPV in their SSBIPs.

IPV Dynamics and Contextual Factors was defined as psychoeducational elements intended to help perpetrators better understand IPV dynamics and the nature of IPV in society. 36 states (81.2%) addressed at least some elements of this, The most common topics in this category included the identification of personal, societal, and cultural values and beliefs that legitimized and sustained violence and oppression (n = 27; 61.4%), alternatives to violence and controlling (n = 27; 61.4%), and the identification of power and control tactics (n = 22; 50.0%). Table 4 lists additional topics addressed in this category.

Skill Development referred to curriculum content addressed in SSBIPs that related to perpetrators developing skills as alternatives to violence. 30 states (68.2%) included skill development in their SSBIPs, with the most common skill being communication

TABLE 2. State Standards for BIPs Information and Requirements by State

State	2008	2020	Most Recent Revision	CCR	Intake/ Screening	Risk assess-ment	Min. Length of tx	Therapeutic approach	Min. Edu. Reqs for facilitators	Recertification for facilitators	Evaluation?
Alabama	Yes	CD	2001	Yes	Yes	Yes	16 w (32 h)	Comb/Ch	HS	5–9 h/a	Y
Alaska	Yes	Leg, MI	N/A	Yes	Yes	Yes	24 w	N/A	N/A	N/A	Y
Arizona	Yes	Leg, MI	N/A	N/A	Yes	Yes	12 w (18 h)	N/A	N/A	N/A	N/A
Arkansas	N/A	N/A									
California*	Yes	Leg, MI	1994	Yes	Yes	Yes	52 w (104 h)	N/A	N/A	15–19 h/a	Y
Colorado	Yes	CD	2008	Yes	Yes	Yes	N/A	Comb/Ch	BA	10–14 h/a	Y
Connecticut	N/A	CD	2014	Yes	Yes	Yes	N/A	Comb/Ch	BA	10–14 h/a	Y
Delaware	Yes	CD	1994	Yes	Yes	Yes	20 w (20 h)	PsyEd	BA	10–14 h/a	N/A
Florida	Yes	MI	2018	Yes	Yes	Yes	29 w (43.5 h)	Comb/Ch	BA	N/A	N/A
Georgia	Yes	CD	1996	Yes	Yes	N/A	24 w (36 h)	Comb/Ch	BA	10–14 h/a	Y
Hawaii	Yes	CD	2010	Yes	Yes	Yes	24 w (48 h)	Dul, Other	BA	20–24 h/a	Y
Idaho	Yes	CD	2011	Yes	Yes	N/A	52 w (78 h)	Dul, Other	BA	10–14 h/a	Y
Illinois	Yes	CD	2003	Yes	Yes	Yes	24 w (36 h)	Comb/Ch	N/A	15–19 h/a	Y

State	2008	2020	Most Recent Revision	CCR	Intake/ Screening	Risk assess-ment	Min. Length of tx	Therapeutic approach	Min. Edu. Reqs for facilitators	Recertification for facilitators	Evaluation?
Indiana	Yes	CD	2015	Yes	Yes	N/A	26 w (39 h)	Comb/Ch	N/A	10–14 h/a	Y
Iowa	Yes	CD	2014	Yes	Yes	N/A	24 w (36 h)	Dul, Other	N/A	<5 h/a	Y
Kansas	Yes	CD	2013	Yes	Yes	Yes	24 w (36 h)	CBT	BA	5–9 h/a	N/A
Kentucky	Yes	CD	2004	Yes	Yes	Yes	20 w (30 h)	Comb/Ch	BA	5–9 h/a	Y
Louisiana	Yes	CD	2015	Yes	Yes	Yes	26 w (39 h)	Comb/Ch	N/A	5–9 h/a	Y
Maine	Yes	CD	2018	Yes	Yes	Yes	48 w (72 h)	PsyEd	N/A	5–9 h/a	N/A
Maryland	Yes	CD	N/A	Yes	Yes	Yes	20 w	N/A	BA	N/A	N/A
Massachusetts	Yes	CD	2015	N/A	Yes	Yes	8 w (80 h)	Comb/Ch	N/A	5–9 h/a	Y
Michigan	Yes	CD	1998	Yes	Yes	Yes	26 w (39 h)	Comb/Ch	BA	20–24 h/a	N/A
Minnesota	Yes	CD	2003	N/A	Yes	Yes	24 w (36 h)	N/A	N/A	N/A	N/A
Mississippi	N/A	N/A									
Missouri	Yes	CD	2018	Yes	Yes	Yes	26 w (39 h)	Comb/Ch	BA	N/A	Y
Montana	Yes	MI	2017	N/A	N/A	N/A	N/A	PsyEd	BA	N/A	N/A

State	2008	2020	Most Recent Revision	CCR	Intake/ Screening	Risk assess-ment	Min. Length of tx	Therapeutic approach	Min. Edu. Reqs for facilitators	Recertification for facilitators	Evaluation?
Nebraska	Yes	CD	2016	Yes	Yes	Yes	30 w (45 h)	PsyEd	BA	10–14 h/a	Y
Nevada	Yes	CD	N/A	Yes	Yes	Yes	24 w (36 h)	Comb/Ch	BA	15–19 h/a	Y
New Hampshire	Yes	CD	2002	Yes	Yes	Yes	36 w	Comb/Ch	N/A	20–24 h/a	Y
New Jersey	Yes	CD	2004	Yes	N/A	N/A	26 w (39 h)	Dul	N/A	N/A	N/A
New Mexico	Yes	CD	2013	Yes	Yes	Yes	52 w (78 h)	Comb/Ch	N/A	5–9 h/a	Y
New York	N/A	N/A									
North Carolina	Yes	Leg, MI	2004	N/A	Yes	Yes	26 w (39 h)	Comb/Ch	N/A	20–24 h/a	Y
North Dakota	Yes	CD	2012	Yes	N/A	Yes	24 w (48 h)	Comb/Ch	N/A	N/A	N/A
Ohio	Yes	CD	2009	Yes	Yes	Yes	26 w	Dul	N/A	N/A	Y
Oklahoma	Yes	CD	2017	Yes	Yes	Yes	52 w (78 h)	Dul	MA	10–14 h/a	Y
Oregon	Yes	CD	2012	Yes	Yes	Yes	36 w	Comb/Ch	N/A	15–19 h/a	Y
Pennsylvania	Yes	N/A									
Rhode Island	Yes	CD	2007	Yes	Yes	Yes	20 w (30 h)	PsyEd	HS	10–14 h/a	Y
South Carolina	Yes	N/A									

State	2008	2020	Most Recent Revision	CCR	Intake/ Screening	Risk assess-ment	Min. Length of tx	Therapeutic approach	Min. Edu. Reqs for facilitators	Recertification for facilitators	Evaluation?
South Dakota	N/A	N/A									
Tennessee	Yes	CD	1999	Yes	Yes	Yes	24 w (36 h)	Comb/Ch	BA	5–9 h/a	Y
Texas	Yes	CD	2014	Yes	Yes	Yes	18 w (36 h)	Dul	N/A	20–24 h/a	Y
Utah	Yes	CD	2018	Yes	Yes	Yes	12 w (12 h)	N/A	MA	15–19 h/a	N/A
Vermont	Yes	CD	2015	Yes	Yes	Yes	26 w (39 h)	Comb/Ch	N/A	Varies	Y
Virginia	Yes	CD	2016	Yes	Yes	Yes	18 w (36 h)	Comb/Ch	BA	Varies	Y
Washington	Yes	MI	2006	N/A	Yes	Yes	52 w (78 h)	Dul	BA	N/A	N/A
West Virginia	Yes	MI	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Wisconsin	Yes	CD	2007	N/A	Yes	Yes	N/A	Comb/Ch	N/A	10–14 h/a	Y
Wyoming	N/A	CD	2010	Yes	Yes	Yes	24 w	Comb/Ch	BA	5–9 h/a	N/A

Note. CCR = Coordinated Community Response to Domestic Violence; *tx* = treatment; *min* = minimum; *edu* = education; *reqs* = requirements; *CEUs* = Continuing Education Units; *w* = weeks; *h* = hours; *CD* = complete document; *ND* = no document; *Leg* = legal, penal, administrative codes; *MI* = missing info; *CBT* = Cognitive Behavioral Therapy; *PsyEd* = Psychoeducation; *Dul* = Duluth/Power & Control Model; *Comb/Ch* = Combination/Choice of models with certain requirements; *HS* = High School Diploma; *BA* = Bachelor's Degree; *MA* = Master's Degree; *h/a* = hours annually; *N/A* = not available/not stated in the standards explicitly.

Though some minimum standards exist in California, individual districts and areas have their own more comprehensive standards.

TABLE 3. Confidentiality and Victim Contact

Confidentiality and Victim Contact	Number of States	Percentage of States
Provide resources to victim/safety plan	22	50.0%
Victim contacts when there is a potential threat from perpetrator	21	47.7%
Victim contacted when perpetrator enrolls in program	15	34.1%
Victim contact documentation must be in separate file	12	27.3%
Contact victim for regular safety checks	4	9.1%
Victim completes violence assessment at the end of BIP to measure effectiveness of BIP	1	2.3%
Not stated	7	15.9%

***Note*.** Several state standards listed multiple criteria for victim contact.

Percentages based on 44 states.

TABLE 4. Approaches to Treatment

Primary Approach Identified in Standard	Number of States	Percentage of States
Combined Approaches/BIPs choose which approach to use based on some requirements	23	52.3%
Duluth/Power and Control Approaches	7	15.9%
Psychoeducational Approaches	5	11.4%
Cognitive Behavioral Approaches	1	2.3%
Other/Unclear	5	11.4%
Not Stated	7	15.9%

Note. For some standards we designated "other" in addition to other approaches if there were unique additional or unclear aspects.

Percentages based on 44 states.

skills (n = 24; 54.5%). Other common skills included were conflict resolution skills (n = 16; 36.4%), empathy (n = 15; 34.1%), identification and management of emotions (n = 12; 27.3%), healthy expression of emotions (n = 10; 22.7%), and interpersonal skills (n = 9; 20.5%). Table 6 lists additional skills addressed in SSBIPs.

Finally, *Self-Exploration and Accountability* related to curriculum content addressed in SSBIPs that required self-reflection, accountability, and insight into one's own experiences. The most common topic addressed here was the responsibility of the batterer for the violence (n = 36; 81.8%), followed by the promotion of accountability (n = 31; 70.5%). However, fewer SSBIPs addressed insight-related topics: promotion of self-awareness (n = 13; 29.5%), changing pro-violent and irrational thoughts (n = 9; 20.5%), intergenerational patterns of IPV (n = 6; 13.6%; Colorado, Connecticut, Nevada, New Jersey, North Dakota, Washington), and the development of support systems (n = 4; 9.1%; Delaware,

TABLE 5. Content: Psychoeducation on IPV Dynamics and Contextual Factors

Psychoeducation on IPV dynamics and Contextual factors	Number of States	Percentage of States
Identification of personal, societal, and cultural values and beliefs that legitimize and sustain violence and oppression	27	61.4%
Alternatives to violence and controlling	27	61.4%
Identification of power and control tactics	22	50.0%
Relationships between substance abuse and domestic violence	18	40.9%
Raising consciousness about gender roles	17	38.6%
Identification of healthy relationships	14	31.8%
Equality between sexes	13	29.5%
Myths and beliefs of domestic violence (including myths of provocation)	11	25.0%
Identification of the behavioral, emotional, and physical cues that precede escalating anger	11	25.0%
Role of ethnicity and culture in view of domestic violence	10	22.7%
Self-control vs. power/dominance	6	13.6%
Identification of the 3-phase cycle of abuse	5	11.4%
Sexual respect	5	11.4%
Relationships between mental illness and domestic violence	5	11.4%
Identification of situational/conflict violence	1	2.3%
Not Stated	8	18.2%

Note. Several state standards listed multiple content areas.

Percentages based on 44 states.

Ohio, Texas, Wisconsin). Few states included requirements for trauma work (Connecticut, Wyoming), childhood experiences (Nevada), and improvement of self-esteem (Delaware). Four states (9.1%) did not address self-exploration content.

Prohibited and Supplementary Modalities and Approaches. SSBIPs also addressed certain prohibited treatment modalities, the most common one being couple's treatment (n = 35; 79.5%), family treatment (n = 29; 65.9%), bringing the victim to treatment (n = 25; 56.8%), and other approaches and curriculum content listed in Table 6. Two states (4.5%) did not address prohibited treatment approaches. The most common prohibited approaches included those that removed or lessened accountability for the violence from the perpetrator, including victim-blaming approaches (n = 27; 61.4%), circular causality and family systems approaches (n = 23; 52.3%), and anger management treatment (n = 22; 50.0%).

In addition to prohibited approaches to treatment, a minority of SSBIPs addressed certain supplemental treatment approaches that could be part of the overall treatment, but not

TABLE 6. Content: Skill Development

Skill Development	Number of States	Percentage of States
Development of communication skills	24	54.5%
Conflict resolution skills	16	36.4%
Teach/discuss empathy	15	34.1%
Skills on how to identify/manage emotions	12	27.3%
Offender's ability to express and articulate feelings	10	22.7%
Teach interpersonal skills	9	20.5%
Teach problem-solving skills	8	18.2%
Teach listening skills	7	15.9%
Negotiation	7	15.9%
Teach anger management and impulse control skills	6	13.6%
Fairness	5	11.4%
Stress management skills	4	9.1%
Goal setting skills	2	4.5%
Parenting	2	4.5%
Teach coping skills	2	4.5%
Cooperative and non-abusive forms of communication	1	2.3%
Promote assertiveness training	1	2.3%
Teach life skills	1	2.3%
Teach relaxation exercises	1	2.3%
Not Stated	14	31.8%

Note. Several state standards listed multiple content areas.

Percentages based on 44 states.

used as the primary approach. 36 states (81.8%) did not have a section that addressed such approaches. The most common supplemental approach included anger management (n = 6; 13.6%). Less than 10% of states included the following supplemental approaches: psychopathology, family systems approaches, communication enhancement, addiction models of violence, impulse control models, psychodynamic methods related to unconscious motivations, techniques for getting in touch with emotions, "fair fighting" strategies, and containment methods for de-escalating violence.

BIP Group Training and Certification Requirements for Facilitators and Supervisors

Facilitators. Out of the 44 states with SSBIPs, 23 (52.3%) addressed minimum educational requirements for BIP facilitators. 19 states (43.2%) required group facilitators to have at least a Bachelor's degree; 2 states (4.5%) required a Master's degree, and 2 states (4.5%; Alabama, Rhode Island) required a High School diploma. 21 state did not address minimum educational requirements. Out of the 21 states that required a Bachelor's or Master's degree, 17 states also required that the degree was in a social science or related

area. 34 states further addressed the minimum number of required hours of training for BIP facilitators. The most common number of training hours required was between 36 and 49 hours (n = 11; 25.0%), followed by 20–25 hours (n = 8; 18.2%) and 50–100 hours (n = 7; 15.9%), though this varied greatly among states, ranging from 11 required hours to over 100.

The principle duties of facilitators related to the primary roles of facilitators, how they conducted groups, disseminated content, and related to group participants. These included facilitating or co-facilitating BIP groups (n = 35; 79.5%), teaching and modeling problem-solving, healthy communication, and respect (n = 14; 31.8%), recognizing, confronting and processing denial, minimization, and violence in BIP participants (n = 13; 29.5%), and setting boundaries (n = 8; 18.2%). Five states (11.4%) listed principle duties as including basic counseling skills, such as reframing, reflecting, and paraphrasing, and four states (9.1%) listed eliciting self-disclosure, feedback, and processing among members. Seven states (15.9%) listed "other" duties, and nine states (20.5%) did not include statements on principle duties for facilitators.

In terms of offender treatment training, facilitators were required to have training in specific curriculum areas, the most common being what the researchers coded as "general training" on IPV (n = 31; 70.5%). This included topics related to, for example, dynamics and types of IPV, power and control, characteristics of perpetrators, and lethality risks. Other training areas included victim-focused issues, such as impact on victims and children (n = 23; 52.3%) and the cultural context of IPV (n = 14; 31.8%). Table 7 lists additional areas of training required. Notably, only three states required facilitators to have training in behavior-modification (Delaware, Hawaii, Massachusetts) and trauma-informed care (Delaware, Massachusetts, Virginia), and only two states required facilitators to have any training related to counseling skills (Delaware) and group facilitation (North Dakota). Five states did not specify training areas for facilitators (11.4%).

Most states (n = 32; 72.8%) listed requirements for continuing education (CE) for facilitators. The annual hourly requirements varied, 19 states (43.2%) requiring between 5 and 14 hours and 10 states (22.7%) requiring between 15 and 24 hours. Only Iowa required less than five annual hours of training, and Vermont and Virginia had varying requirements based on the facilitator's level of experience. Twelve states (27.3%) did not list CE requirements.

SSBIPs also required BIP facilitators to embody certain professional and personal characteristics, such as leading violence-free lives (n = 34; 77.3%), being free of drug and alcohol abuse (n = 23; 52.3%), being free of convictions (n = 19; 43.2%), refraining from victim-blaming (n = 16; 36.4%), and being multiculturally competent and sensitive (n = 13; 29.5%). Between one and three states included other characteristics, such as refraining from sexual or personal relationships with BIP participants, requirement to have worked through personal history of IPV, showing dignity and respect, and being open to feedback and self-examination. Eight states (18.2%) did not list characteristics of BIP facilitators.

Supervisors. Only 15 states (34.1%) listed supervisor educational requirements in their SSBIPs. Of these, ten required a Master's degree and five required a Bachelor's degree. In terms of training and qualification, 16 state standards (36.4%) required supervisors to have a certain number of years of clinical BIP experience; 11 states (25.0%) required a licensure in a mental health field; 6 states (13.6%) required extensive training in IPV and BIPs; 5 states (11.4%) required ongoing CE; Kansas and Massachusetts required specialized training in group facilitation; and only Colorado required BIP supervisors to have special-

TABLE 7. Prohibited Primary Theoretical Approaches/Belief Models

Theoretical Approaches and Beliefs	Number of States	Percentage of States
Victim coercion, blame, victim responsibility, or victim participation	27	61.4%
Circular causality or family systems approaches to violence	23	52.3%
Focus on anger management	22	50.0%
Addiction models of violence	15	34.1%
Impulse control models	14	31.8%
Psychodynamic methods linking violence to past experience or unconscious motivations	7	15.9%
Any method including psychopathology as reason for violence	7	15.9%
Containment methods to de-escalate violence	5	11.4%
Communication enhancement	3	6.8%
Fair fighting strategies	3	6.8%
Getting in touch with emotions techniques	2	4.5%
Other	5	11.4%
Not Stated	5	11.4%

Note. Several state standards listed multiple prohibited theoretical/belief models. Percentages based on 44 states.

ized training in supervision. 17 states (38.6%) did not address training and qualification requirements for BIP supervisors.

Evaluation of Offender Progress and BIP Treatment

Out of the 44 states with SSBIPs, 28 states addressed evaluation. Of these, 21 (47.7%) addressed procedures or requirements for evaluating offender progress during the program, though these varied in scope. Seven states (15.9%) included a requirement of informal evaluations of offenders in the form of observations of the offenders during their program completion. Another seven states (15.9%) required formal reports of offender progress, often during specific intervals during the completion of the program. Six states (13.6%) required reports to the referral source (e.g., courts, probation). Five states (11.4%) employed other evaluation processes for offenders, and 23 states did not address offender evaluation in their SSBIPs. However, almost all state standards (90.9%) failed to delineate a definition of participant "success" outside of participants completing the program, making such difficult to measure and evaluate.

Follow-up requirements were also scarce in the SSBIPs, and 32 states (72.7%) failed to address offender follow-up. Five SSBIPs (11.4%; Alabama, Alaska, New Hampshire, North Carolina, Ohio) required BIPs to track recidivism for a certain amount of time using primarily arrest records. The Illinois, Iowa, and Wyoming standards required BIPs to provide offenders with resources and referrals for continuing programs. Only Alaska and Maryland required a follow-up interview with the victim, and only Delaware required

some minor follow-up, such as a mailed survey to the offender. New Mexico encouraged follow-up but did not require it.

Program evaluation was addressed in 19 SSBIPs (43.2%) but was often vaguely defined. Nine states (20.5%) required program evaluations to be completed at certain intervals, such as quarterly or annually. Six states (13.6%) required "other" forms of evaluation. Connecticut, Georgia, and Tennessee standards addressed the requirement for BIPs to maintain communication and coordination with the CCR for the purposes of adhering to best practices. Additionally, Georgia, Vermont, and Wisconsin's standards required data and reports to be delivered to stakeholders and partners. Oregon and Rhode Island's standards required BIPs to evaluate and update their programs based on new research and knowledge. 25 states (56.8%) did not address program evaluation in their SSBIPs.

DISCUSSION

TABLE 8. Areas of Training Required by States for Facilitators

Areas of Training Required by States for Facilitators	Number of States	Percentage of States
IPV generally (definitions, dynamics, power & control)	31	70.5%
Victim-related issues (effect on victims and children, etc)	23	52.3%
Cultural context of IPV (cultural, gender, racism, sexism, history, familial, homophobia)	14	31.8%
Laws and ethics (BIP group policies, duty to warn, confidentiality, custody, child abuse, reporting)	12	27.3%
Risk-factors related to homicide, suicide, IPV, violence, lethality, etc)	11	25.0%
Safety-related (e.g., Safety planning)	9	20.5%
Community referrals and resources	8	18.2%
Recognizing change vs denial and minimization	5	11.4%
Training in behavior modification	3	6.8%
Training in trauma & trauma-informed care	3	6.8%
Training in basic helping/counseling skills	1	2.3%
Training in group counseling & facilitation	1	2.3%
Training in psychoeducation	0	0%
Other	5	11.4%
Not Stated	5	11.4%

Note. Several state standards listed multiple areas of training required.

Percentages based on 44 states.

In accordance with previous literature, we found continued inconsistency across various domains in the SSBIPs. The findings revealed noteworthy changes from previous

reviews of the standards. At present, 44 states have established SSBIPs, which is one state fewer than the number of states reviewed in Maiuro and Eberle's (2008) study. However, the states without standards have changed. In 2008, the following states were without standards: Arkansas, Connecticut, Mississippi, New York, South Dakota, and Wyoming (Maiuro & Eberle, 2008). Since 2008, Connecticut and Wyoming added state standards for BIPs, while Pennsylvania and South Carolina dropped theirs.

Additionally, there was a 10% increase in states that mandated BIPs to be a part of a CCR. Increased partner agency involvement in contribution to the standards may have led to more engagement with these agencies overall. Since 2008, there was a 4.9% increase in states requiring intake evaluation and screening and a 9.1% increase in states requiring the use of formal risk assessment tools for screening participants. Such increases positively reflect the recommendations proposed in Maiuro and Eberle's (2008) study, though additional screening and risk assessment continues to be warranted and described in many states' SSBIPs.

In the present study, we found that group treatment remained the primary intervention mandated by SSBIPs, with supplemental modalities allowed for more than half of states with standards. Despite this, little information was provided on what constituted "group" for participants. Group counseling is a specific therapeutic modality with its own set of knowledge, skill, and best-practice guidelines. With an absence of direction on what constitutes a group in state standards, the reality of what occurs in practice could look very different, even within the same agency. The lack of consistency could greatly impact the treatment outcomes and victim safety.

In 2008, 91% of states prescribed a "uniform course of treatment for all perpetrators," referring to a one-size-fits-all model of treatment (Maiuro & Eberle, 2008, p. 139). That is, there was no mandated differentiation in treatment based on offender characteristics identified in the intake process, such as, for example, severity of offense, repeat-offender status. In the current study, we found that 25% of states allowed for some forms of tailored treatment for participants based on characteristics of the offender and the offense. In 2008, 32% of state standards endorsed utilizing a treatment philosophy that focused on areas *beyond* power and control (Maiuro & Eberle, 2008). In this present review, we found that 52.3% of standards allowed choice or a combination of evidence-based approaches, with only 13 state standards (29.5%) requiring treatment from single approaches such as a power and control, psychoeducation, or CBT. This shift suggests increased flexibility and deferment to individual BIPs for which theoretical approach they choose to disseminate curriculum content. Previously, 63% of standards focused on the impact IPV has on children, and this increased to 75% of states currently having designated focus on children in their documented SSBIPs. Another notable observation is the continued lack of state standard requirements of insight-and-awareness-related content for offenders, including trauma. It appears most states are reticent to include content requiring offenders to self-examine their past experiences, perhaps in fear of violating prohibited approaches (e.g., removing accountability, blaming childhood experiences on abusive behaviors). However, consistent with most psychological understanding of mechanisms of change, insight, awareness, and understanding of self are often precursors to sustained change. Future researchers may examine these seemingly contradicting factors and explore best-practice

approaches to resolving them. In sum, states' BIP curricula are a work in progress with continuous revisions.

There is inconsistency among SSBIPs in current requirements for training and education level of the facilitators. Just over half of states (23; 52.3%) addressed minimum education requirements in the standards, revealing a 3.2% increase in states requiring a Bachelor's degree. 34 states (a 2% increase from 2008) required training hours, widely ranging from 11 to over 100 hours. Similarly, 34% of states (n = 15) delineated a wide range of required education level and experience of supervisors. The current findings, though more detailed and descriptive, are in line with previous findings on the varied requirements for professionals facilitating and/or supervising treatment in BIPs. There was a 14.7% increase in states addressing evaluation of the effectiveness (e.g., offender progress) of their BIPs. However, there remained ambiguous references to program evaluation and little offered on what constitutes offenders' progress. Again, this finding is congruent with previous research, yet the increase in mandated program evaluation indicates that more states recognize the need for tracking offender progress and effectiveness of BIPs.

Limitations

The current findings add to the body of literature on SSBIPs; however, there were limitations in the study. Maiuro and Eberle (2008) noted that county jurisdictions may house different standards, even within the same state. Given that our aim was to learn about SSBIPs, we solely focused our inquiry on state level standards. Therefore, our search for state standards resulted in findings that do not account for singularities of counties within the states. Also, it is possible that the research team overlooked current information for SSBIPs because some states' materials were stored in various locations (e.g., states' websites for domestic violence, community, and law enforcement agencies; BIP credentialing bodies and/or organizations) and were not easily accessible. The research team coded a vast number of data points, and although we used methods of trustworthiness (i.e., coding survey, coder training, triangulation through multiple coders and multiple coding steps, and an additional coder to resolve discrepancies), it is possible that assumption or human error informed how some items were coded. Because of the vast amount of data reviewed, we at times grouped categories and terminology from the SSBIP in order to organize the data in this article. Though this process did not diminish the validity or content of the findings, it may at times be inconsistent with terminology used in SSBIP documents.

In terms of SSBIP and BIP trends, it may be that more recent and updated SSBIP documents make explicit reference to mandated criteria for BIPs (e.g., evidence-based practice, tailored treatment, curriculum topics), suggesting trends toward inclusivity, evidence-based practice, and growth for BIPs that may be misleading and not in actuality reflect how individual BIPs have practiced under previous guidelines compared to now. That is, because the SSBIPs mandate *minimum* standards for BIPs, it is possible that individual BIP programs have utilized more advanced and current practices than were stated in the SSBIPs for their states. Without in-depth comparison of previous and current state standards as well as individual BIPs, it is challenging to adequately note trends and future directions for BIPs specifically.

Recommendations for Training and Policy

The minimum requirements for SSBIPs are varied from state to state regarding format and theoretical approaches to treatment. Group counseling is the prevailing modality, with states allowing for tailored treatment approaches and/or using combination approaches increased in the current state standards. The expansion of available approaches is largely due to the attention practitioners and researchers have paid to enlarging the lens through which intimate partner violence is conceptualized and addressed. With this evolution comes the need for better training and CE as the field is getting more complex. Thus, facilitators and supervisors should be well trained and highly prepared to not only teach the curriculum, but to attend to cultural diversity, to manage group dynamics and processes, as well as develop skills to participate, and in many ways, coordinate, a community wide response to domestic violence. It is noted that 35 state standards (79.5%) included reference to collaboration through the CCR. We recommend each state to work in tandem with and be a part of a CCR when possible. The mutual investment in victim safety allows BIPs to benefit from collaboration with partner agencies and to contribute to the success of CCRs (Austin & Dankwort, 1999).

A little over half (n = 23; 52.3%) of the states included minimal educational requirements for BIP facilitators, and 34 states discussed the training hours required. The majority of states set the minimum educational requirement to at least a Bachelor's degree, with 17 states specifying that the degree should be in a social science or related field. Yet, in our view, the duties assigned to BIP facilitators are similar to those of mental health professionals. Professional counselors, for example, are extensively trained in basic attending skills, orienting treatment toward goals, challenging clients to be genuine and honest in their self-appraisal, and modeling healthy communication. Moreover, professional counselors have several hundred hours of supervised training in individual and group therapy prior to even becoming provisionally licensed, which far surpasses the required educational and training hours required for BIP facilitators. Relatedly, only one state standard (Kansas) included a mental health agency as a contributor to the standards, yet it is clear that mental health professionals have a lot to offer by way of expertise and skills for developing mandates for treating individual, familial, and systemic concerns related to IPV.

In future investigations, researchers can explore standards of county jurisdictions and policies in states that previously adopted SSBIPs but are no longer guided by them (i.e., South Carolina and Pennsylvania). As the number of states adopting standards nears 50, consideration of a unifying national standard might be worthy of exploration. Researchers can also consider studying how BIPs compare in effectiveness across various markers of offenders' progress such as recidivism rates, arrests, reports, and updates from probation officers or child protection workers, and so on. Previous research findings indicate a need for further investigation into the effectiveness of tailoring treatment approaches to offender profiles (Aaron & Beaulaurier, 2017).

In the areas where there is some consistency, further research can explore how these standard elements impact outcomes. For example, although most states agree on a minimum level of education for treatment providers, how do various levels of education impact treatment outcomes? Treatment of domestic violence offenders is a challenging and complex process, so it seems counterintuitive to have individuals without a license or certification to practice mental health counseling facilitate these interventions.

Additionally, the confluence of ideas from the criminal justice, practitioner, violence against women's advocate, and research communities have yielded conflicting results,

with state standards tending to reflect the strongest voice in a particular state. Though the present study is not a comparative one, we noticed certain qualitative trends. For example, in states where domestic violence agencies were significant contributors, the standards seemed to be more focused on IPV-related skill-development and psychoeducation of IPV as a social problem rooted in psychosocial factors. In contrast, in states where the Department of Corrections or the Judiciary systems were primary contributors, the state standards seemed more focused on the inclusion of penal codes and legal jargon. Further exploration is warranted to explore correlations and relationships.

CONCLUSION

According to Aaron and Beaulaurier (2017), there is a need to better support BIPs. They are, to date, one of the best alternatives to incarceration and can contribute to the greater goal of protecting victims of IPV. The current findings suggest that positive shifts have occurred in the focus of treatment and design of BIPs. However, more research is needed to adequately address concerns related to treatment modalities, theoretical approaches, evaluation, and training for staff, facilitators, and supervisors. Continuing to explore, define, and refine the standards can further their primary purpose, which is to provide an effective treatment to intimate partner violence and ameliorate the present and future pain of its victims.

REFERENCES

Aaron, S. M., & Beaulaurier, R. (2017). The need for new emphasis on batterer intervention programs. *Trauma, Violence, & Abuse*, *18*(4), 425–432. http://doi.org/10.1177/1524838015622440

Austin, J. B., & Dankwort, J. (1999). Standards for batterer programs: A review and analysis. *Journal of Interpersonal Violence*, *14*, 152–168. https://doi.org/10.1177/088626099014002004

Babcock, J., Armenti, N., Cannon, C., Lauve-Moon, K., Buttell, F., Ferreira, R., Cantos, A., Hamel, J., Kelly, D. R., Jordan, C., Lehmann, P., Leisring, P., Murphy, C., O'Leary, K. D., Bannon, S. M., Lee Salis, K., & Solano, I. (2016). Domestic violence perpetrator programs: A proposal for evidence-based standards in the United States. *Partner Abuse*, *7*(4), 355–460. https://doi.org/10.1891/1946-6560.7.4.355

Batterer Intervention Services Coalition of Michigan. (2013). *Other state's standards*. https://www.biscmi.org/other_resources/state_standards.html

Cannon, C., Hamel, J., Buttell, F., & Ferreira, R. J. (2016). A survey of domestic violence perpetrator programs in the United States and Canada: Findings and implications for policy and intervention. *Partner Abuse*, *7*(3), 226–276. https://doi.org/10.1891/1946-6560.7.3.226

Garner, J., Fagan, J., & Maxwell, C. (1995). Published findings from the spouse assault replication program: A critical review. *Journal of Quantitative Criminology*, *11*(1), 3–28. https://doi.org/10.1007/BF02221298

Gelles, R. J. (2001). Standards for programs for men who batter? Not yet. *Journal of Aggression, Maltreatment and Trauma*, *5*, 11–20. https://doi.org/10.1300/J146v05n02_02

Hamberger, K. (2001). Musings of a state standards committee chair. *Journal of Aggression, Maltreatment and Trauma*, *5*, 265–286. https://doi.org/10.1300/J146v05n02_16

Haney, W., Russell, M., Gulek, C., & Fierros, E. (1998). Drawing on education: Using student drawings to promote middle school improvement. *Schools in the Middle*, *7*(3), 38–43.

Kaid, L. L. (1989). Content analysis. In P. Emmert & L. L. Barker (Eds.), *Measurement of communication behavior* (pp. 197–217). Longman.

Krippendorff, K. (2004). *Content analysis: An introduction to its methodology* (2nd ed.). Sage.

Maiuro, R. D., & Eberle, J. A. (2008). State standards for domestic violence perpetrator treatment: Current status, trends, and recommendations. *Violence and Victims*, *23*, 133–155. https://doi.org/10.1891/0886-6708.23.2.133

Maiuro, R. D., Hagar, T., Lin, H., & Olson, N. (2001). Are existing state standards for the treatment of perpetrators of domestic violence adequately informed by research? A question of questions. *Journal of Aggression, Maltreatment and Trauma*, *5*, 21–44. https://doi.org/10.1300/J146v05n02_03

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded source book* (2nd ed.). Sage.

Price, B. J., & Rosenbaum, A. (2009). Batterer intervention programs: A report from the field. *Violence & Victims*, *24*(6), 757–770. https://doi.org/10.1891/0886-6708.24.6.757

Richards, T. N., Gover, A. R., Tomsich, E. A., Hansen, J., & Davis, C. R. (2017). The implementation of state-mandated standards for batterer intervention programs: The Colorado experience. *Violence and Victims*, *32*(2), 279–298. https://doi.org/10.1891/0886-6708.VV-D-15-00091

Disclosure. The authors have no relevant financial interest or affiliations with any commercial interests related to the subjects discussed within this article.

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

Correspondence regarding this article should be directed to Paulina Flasch, Texas State University, Professional Counseling Program in the Department of Counseling, Leadership, Adult Education, and School Psychology, EDUC 4012, San Marcos, TX 78666. E-mail: paulina@txstate.edu