Hawai‘i
Domestic Violence Intervention Program Standards

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Finalized by:

The Judiciary, State of Hawai‘i
Hawai‘i State Coalition Against Domestic Violence

ʻAʻohe hana nui ke alu ʻia.

Ōlelo Noʻeau #142
No task is too big when done together by all.
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Table of Contents

ACKNOWLEDGMENTS

The 2023 Hawai‘i Domestic Violence Intervention Program Standards builds upon the collaborative work previously done by Child & Family Service, Parents and Children Together, and the Hawai‘i State Judiciary, First Circuit as well as Lee Stein, MSW, CSAC.

The revision of these standards was an inclusive and informed process co-led by the Hawai‘i State Coalition Against Domestic Violence and the Hawai‘i State Judiciary in partnership with the Center for Justice Innovation. The process included the valuable input of survivors and DVI participants as well as numerous public and private agencies from across the state who work with domestic violence survivors and those who cause harm. Evidence-based, evidence-informed, and promising practices concepts and strategies have been included throughout the document. Where applicable, concepts from the Correctional Program Checklist were also integrated.

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Introduction

The intent of the Hawai'i Domestic Violence Intervention Program Standards is to ensure that service providers (individuals or organizations) maintain an overall level of quality, effectiveness, and consistency in their work with persons who commit intimate partner violence. A Domestic Violence Intervention Program (DVIP) is a community-based service within a larger coordinated community response that prioritizes survivor and child safety, by providing intervention with those who cause harm.

Specifically, these standards are written as a guide for intervention with clients who commit acts of intimate partner violence with the goal of establishing a minimum level of expectations for effective programs throughout the state.

There is a shift to gender-neutral language in these revised standards that is intentional and supports a more nuanced and inclusive analysis of intimate partner violence. While the majority of victims are women, recent data indicates that men are increasingly reporting intimate partner violence, with almost 1 in 2 women and more than 40% of men in the United States having experienced intimate partner violence in their lifetime (CDC, 2022)[1]. Further, the 2010 National Intimate Partner and Sexual Violence Survey found that 44% of lesbian women and 61% of bisexual women experienced intimate partner violence in their lifetime. Twenty-six percent of gay men and 37% of bisexual men experienced intimate partner violence in their lifetime (CDC, 2010)[2]. The 2015 U.S. Transgender Survey Report[3] found that 54% of respondents reported some form of intimate partner violence. In Hawai‘i the ALOHA Study found that 68.8% of the LGBT community surveyed experienced intimate partner violence. Program providers should work to meet the needs of these clients in these communities. It remains critical to addressing the role of sexism,misogyny, and patriarchy as the foundation of intimate partner violence.

Finally, it is important to remember that the effectiveness of Domestic Violence Intervention Programs must be seen within the larger context of collaborative multi-agency responses and the community.

1.0 VALUES FRAMEWORK

The following values are the cornerstone of the standards. They informed the revision of the standards and DVI providers are called to align with the values in implementing these standards in their work with those who commit intimate partner violence, survivors, other stakeholders, and other DVI programs.

Aloha Spirit – In acknowledging the Aloha Spirit as the first value, we acknowledge with wholehearted gratitude and deep respect, the primary influence of Native Hawaiian culture in every aspect of life in Hawai‘i and we recognize Aloha as the key (Pilahi Paki). Aloha may be defined in many ways, and we recognize that it is a lifelong practice to understand its depths. Aloha Spirit extends *Akahai* (kindness expressed with tenderness), *Lōkahi* (unity expressed with harmony), *‘Olu‘olu* (agreeable expressed with harmony), *Ha‘aha‘a* (humility expressed with modesty), and *Ahonui* (patience expressed with perseverance) with no obligation for anything in return. (HRS §5-7.5)[4] The Aloha Spirit compels our shared kuleana (responsibility/privilege) to end intimate partner violence and restore our communities in inclusive and intersectional ways. It also speaks to the truth that we can only do this together as a coordinated community response with aloha for each other no matter the circumstances.

Centering Survivor Support, Safety, and Empowerment – Survivor safety must be at the center of all work to end intimate partner violence. Ensuring that there are mechanisms in place to hear survivor voices, incorporate their perspectives, and ensure that they feel understood and supported is crucial.

Personal and System Accountability – People who cause harm through intimate partner violence must take active responsibility for the abuse and harm they caused to survivors and their children. This requires integrity, honesty, courage, personal growth, and behavior change. Providing consistent and high quality programming and wraparound services supports people who cause harm in their accountability process. System partners must ensure effective communication, collaboration, and information sharing and address the many barriers to successful program completion, behavior change, community safety, and survivor and family wellbeing. In the spirit of kākou (we’re all in this together), members of the coordinated community response must collaborate to share information, keep abreast of the latest trends and needs within the community and allow for feedback to improve responses that are holistic and trauma-informed.

Flexibility – Engagement and intervention strategies should be client-centered, moving away from one-size-fits-all approaches and meeting the unique needs of participants. Approaches should incorporate evidence-based practices while also making room for new evidence-informed or innovative practice-based evidence approaches. These strategies may include trauma-informed or trauma- focused approaches, restorative practices, different program length options, and may address co-occurring issues and parenting after violence strategies.

Compassionate, Competent, and Authentic Engagement – Practitioners working with people who cause harm through intimate partner violence must create an authentic relational space for safety, transformation, healing, and well-being for people who cause harm. In recognizing the value of all people, believing in everyone's capacity to change, practitioners treat everyone with Aloha. To support their work, practitioners should receive extensive and ongoing training in order to practice competently, with deep understanding of effective intervention to end domestic violence. This includes using an intersectional lens, ensuring our responses reflect the diversity of the community and experiences that may include trauma and oppression, and leveraging the important values and practices that support and foster healthy relationships, families, and communities.

Community Engagement and Education – Intimate partner violence impacts not only the survivor, their children, and the person causing harm, but also the broader community. In order to break the cycle of domestic violence, community education about the impact of domestic violence, healthy relationships, and how to shift cultural and societal norms that justify discrimination and violence against women and groups who are oppressed, under-resourced, and/or face additional barriers to safety and healing, is critical.

Gender Equity and Social Justice - Though intimate partner violence can impact anyone, women and particularly people of color, including Native Hawaiians, Pacific Islanders, Indigenous people and Black people, and LGBTQ+ individuals and other underserved groups, experience intimate partner violence in specific ways and face unique challenges and barriers to resources. Responses should challenge social injustice and consider equity at every step.

2.0 THE PURPOSE OF DOMESTIC VIOLENCE INTERVENTION PROGRAM STANDARDS

2.1 The elimination of domestic violence by providing guidelines for ethical and accountable intervention practices with persons who commit domestic violence while protecting survivors, their families and the community. The safety and rights of survivors and their children are the highest priority for and are fundamental to DVI programs.

2.2 A guide for research based promising- and best-practices in the operation of domestic violence intervention programs; to maintain ethical, consistent and quality services across programs; and encourage individual and program responsibility in attaining these standards.

2.3 Collaboration and interaction among program providers and other pertinent important agencies and entities within the community is firmly established. Domestic violence is a serious public health and safety issue, affecting families and communities. It is recognized as unacceptable behavior and persons who cause harm are best held accountable through a coordinated community response (CCR) which relies on the timely response, support and sanctions of the legal justice system in addition to DVI programs and the community. DVI providers must recognize their responsibility to actively work toward the establishment and maintenance of this CCR by joining the efforts of other agencies, local coalitions and task forces

2.4 The establishment of minimum expectations of DVI providers for compliance review, monitoring and evaluation, and as guidelines for future program development, improvement and quality assurance.

2.5 To increase public confidence in the quality and consistency of domestic violence intervention services.

3.0 DEFINITION OF INTIMATE PARTNER VIOLENCE

For the purposes of this document, intimate partner violence is considered an ongoing patterned use of intimidation, coercion, violence, and other tactics of power and control to establish and maintain a relationship of dominance over the current or former partner.

3.1 Tactics of power and control are demonstrated through a pattern of behaviors. A singular act of aggression may not constitute intimate partner violence.

A. Physical violence: aggressive behavior including but not limited to hitting, punching, strangling, scratching, pinching, restraining, slapping, pulling, hitting with weapons or objects, shooting, stabbing, and damaging property or pets.

B. Sexual violence: use of coercion or physical force to make an individual perform any sexual act without consent. Other forms of sexual abuse include but are not limited to verbal attacks referring to the sexual parts of the person's body, treating them as a sex object.

C. Reproductive Coercion: forcing them to terminate a pregnancy, not allowing birth control, forcing them to view pornographic materials, and/or forcing them to engage in any other sexual activities to which they are unwilling, or forcing pregnancy.

D. Psychological violence: using the power gained through the threat or use of physical and sexual violence to control the actions and behavior of another person through the following types of abusive actions.

1) threats of physical or sexual violence; of taking away the person's livelihood; of committing suicide and/or homicide, etc.

1) acts of intimidation such as looks, gestures, tone of voice, destroying property, displaying weapons, threats to reveal HIV and other physical or mental health status, etc.

2) isolation of the partner by controlling choices, activities, relationships and contacts, restricting medical care and social services, etc.

3) emotional abuse such as name-calling, belittlement, degradation, humiliation, gas-lighting, telling you that you are defective because of your gender identify, and psychological torture, etc.

4) economic abuse such as withholding access to financial resources, limiting title to property and possessions, limiting and/or controlling employment choices, using credit cards without permission, making the other person ask for money, etc.

5) use of the children as a tool of control by threatening to harm the children or take them away, accusations of being an unfit parent because of identity or HIV status, relaying messages through the children, using visitation to harass, and interrogating the children, etc.

6) the use of privilege in patriarchal culture to claim entitlement of a superior status, treating the partner like a servant and presuming dominance in regard to decision making, etc.

7) stalking, defined as "a pattern of harassing or threatening tactics that are both unwanted and cause fear or safety concerns in a

victim". Stalking tactics can include:

- Unwanted following and watching of the victim.
- Unwanted approaching or showing up in places, such as the victim's home, workplace, or school.
- Unwanted use of global positioning system (GPS) technology to monitor or track the victim's location.
- Leaving strange or potentially threatening items for the victim to find.
- Sneaking into the victim's home or car and doing things to scare the victim or let the victim know the perpetrator had been there.
- Use of technology (e.g., hidden camera, recorder, computer software) to spy on the victim from a distance.
- Unwanted phone calls, including hang-ups and voice messages.
- Unwanted texts, emails, social media, or photos messages.
- Unwanted cards, letters, flowers, or presents.
- Using technology to socialize and communicate has its conveniences, but it can also make it easier for people to harass others in ways that might be frightening and threatening. (CDC, 2022)[5]

Defining intimate partner violence in greater detail, as done in the preceding points, is not an exhaustive list and is intended to alert providers to attend to all forms of violence and abusive behavior by persons who commit intimate partner violence. It is also important to attune to and address the nature and context of the behaviors.

3.2 Additional behaviors. In addition to the above definitions, it should be noted that persons who commit intimate partner violence may exhibit one or more of the following characteristics:

E. Not willing to accept responsibility through minimization, denial and blaming the survivor.

F. Have little or no concern for the consequences of their behavior.

G. Have little or no empathy for the survivor/victim, family members, or others who are impacted.

H. Objectify the survivor and children.

I. Display a pattern of recurrent violence and abusive behavior that may escalate in frequency and severity.

J. Demonstrate expectations of patriarchal and hierarchical privilege.

K. Display an attitude of entitlement to special rights and privileges without accompanying reciprocal responsibilities, which is used to justify abusive behavior.

3.3 DVI is not anger management. There are well documented concerns regarding the "anger management approach" to working with persons who commit intimate partner violence primarily because anger management does not “get to the root of domestic violence; that is, the issues of power and control and one person’s need and/or perceived right to dominate another.” (Battering Intervention Services Coalition of Michigan, 2019)[6]

4.0 ETHICAL STANDARDS

The foundational ethical imperative for providing DVI services is the protection of survivors while holding persons who commit intimate partner violence accountable for their behavior. In order to accomplish this mandate, programs providing these services should have formal policies and procedures that support and maintain the following ethical and professional conduct from the agency and all staff, volunteers and contractors. Those individuals should also operate within the constraints and be governed by the ethical standards of their professional licensing body such as social workers, therapists, etc.

4.1 Professional Integrity and Competence: Competence is the requisite knowledge, skills, and attitudes necessary to perform tasks and responsibilities essential to the provision of effective DVI. Providers must perform their stated service and not misrepresent their experience and capabilities to present evidence based interventions with appropriately qualified, trained and supervised staff, contractors and volunteers, who must:

A. Be emotionally and physically violence-free in their personal lives; not abuse alcohol or other drugs; and be vigilant regarding one's own power and control issues.

B. Not hire an employee or recruit individuals such as, but not limited to, volunteers or practicum students who have committed domestic violence unless the program director is satisfied that the individual has successfully completed a domestic violence intervention program and has remained violence free for a minimum of five years prior to hire.

C. Not exhibit sexist, racist, homophobic, heterosexist, misogynistic, classist, or victim blaming attitudes and behaviors.

D. Model appropriate communication and conflict resolution behavior at all times and maintain a personal demeanor that is consistent with a professional appearance and attitude.

E. Treat all clients with dignity and respect and honor their right to self-determination.

4.2 Transparent Information Management Policies: Providers must be transparent with clients, survivors, and community partners about how they disclose and protect information about individuals. To support that transparency, all policies should be in plain language and should be shared with clients and survivors before any intake or interview process begins. Provider policies must address the following:

A. Policy for managing client information: Providers must have a policy that describes how client information will be collected, stored, protected, and disclosed. The policy shall be communicated in plain language to clients at the beginning of services.

The policy for managing client information should be distinct from any policy for managing survivor information, and should be tailored to the unique services of a DVI program.

If any confidentiality laws apply to the provider's DVI program, then the policy must comply with those applicable laws. Providers should assess whether or not HIPAA applies to their DVI services. Providers can use the resources at https://www.hhs.gov/hipaa/for-professionals/covered-entities to support the HIPAA assessment.

Policies must address the following issues:

1) Routine disclosure: The policy should identify any disclosures that are routinely made as a condition of participating in services. A common example of routine disclosures may be confirmation of participation in DVI to court, to probation/parole, and to survivors.

2) Disclosure to the survivor of the client: The policy should identify what client information, if any, will be shared with the survivor of the client. Additionally, the policy can describe whether any information shared in services will be protected from disclosure to the survivor of the client.

3) Disclosure of serious threats: The provider shall have a policy about when and how the program will disclose that a client poses a threat to themself or someone else. At a minimum, the policy must describe any legal duties requiring disclosure. Additionally, the provider can adopt a policy to make discretionary disclosures that go above and beyond legally mandated disclosure. In adopting policies, providers should prioritize the safety of survivors and compliance with any laws

applicable to the provider.

4) Disclosure of violence by clients: The policy should identify when, how, and to whom the program will disclose that a client has committed violence while participating in the program.

5) Reporting of abuse or neglect to children or vulnerable adults: The policy should identify when the program will make a formal report of abuse or neglect to the Department of Human Services. The policy must comply with any applicable law mandating reports by certain persons, and can also allow for discretionary reporting. In adopting this policy, providers should prioritize the safety of victims and compliance with any laws applicable to the provider.

6) Response to subpoenas/court orders: The policy should describe how the provider will respond to subpoenas or court orders. The policy should describe how the provider will notify the client that information has been formally requested and/or disclosed.

B. Policy for managing information of survivors and their children: Providers must have a policy that describes how information collected from survivors will be collected, stored, protected, and disclosed. The policy shall be communicated in plain language to survivors before any information is collected.

The policy for managing survivor information shared with a DVI program should be distinct from any policy for managing survivor information shared with survivor counselors or survivor mental health providers. DVI providers are not covered by victim counselor privilege under Hawai‘i law. They are also not covered by federal victim services confidentiality. The policy should provide the greatest amount of confidentiality possible to survivor information, and should accurately describe the risk of forced disclosure through the court process.

1) Disclosure to the client: The policy should explain that information given by the survivor will be withheld from the client, including the fact that the survivor had contact with the DVI provider. If a survivor requests that information be shared with the client, then the survivor must give written consent for that.

4.3 Cultural Humility: Defined as a lifelong process of self-reflection and self-critique, cultural humility encourages the development of a respectful attitude toward diverse points of view and requires historical awareness. Cultural humility does not require a master of lists of “different” or peculiar beliefs and behaviors supposedly pertaining to different cultures.(Hogg Foundation for Mental Health 2019)

4.4 DVI providers and their staff, contractors and volunteers should:

A. Deliver program curricula that reflects a historical understanding of and respect for the cultural diversity of their clients and the application of culturally responsive intervention strategies in order to meet the diverse needs of their local community. This includes, but is not limited to:

1) Awareness of own cultural values and biases.

2) Awareness of clients' worldviews, values and knowledge.

3) Awareness of the interaction of the above factors.

4.5 Collaboration: Providers must work collaboratively with a broad alliance of community agencies and entities. DVIs will work with involved systems in order to assist the establishment and maintenance of a coordinated community response (CCR) to domestic violence. Providers must:

A. Collaborate with agencies that provide services to survivors in order to maximize survivor safety. This may include partnering to be certain that "safety checks" with the survivors/partners of the clients in the program are contacted in a safe and appropriate manner.

B. Maintain open inter- and intra-agency communication by discussing disagreements, problems, and issues with parties and/or entities involved.

4.6 Research Based Practices: Providers should design, implement and evaluate programs consistent with these standards. As experience and research expands the field of knowledge, philosophical and programmatic changes should be made to incorporate and maintain best-practices.

4.7 Reporting DVI client progress. Any communication regarding program completion should include a statement similar to the following: "Program completion is not predictive of future nonviolence or non-abusive behaviors, and signs of change in program participation are no guarantee that real change is taking place".

4.8 Compliance with all state and federal laws and regulations.

5.0 EDUCATION AND TRAINING REQUIREMENTS AND COMPETENCIES

Quality of DVI delivery is a significant factor in successful intervention outcomes. Program and staff expectations and performance should be measured against established comprehensive and consistent competency standards. A competency approach should include adequate initial training and experience in this very specialized field, regular and effective supervision, ongoing relevant training, and regular staff and facilitator job performance evaluations that help them develop and maintain necessary proficiency.

All staff and facilitators providing DVI services must be knowledgeable about the following:

5.1 Attitudes, Knowledge and Skills Domains

A. Attitudes:

1) The values framework that guides the work.

2) The definitions and dynamics of coercive control, violence, abuse, domination, and oppression.

3) Cultural, societal and gender issues related to use of violence in intimate relationships.

4) The tactics used to maintain dominance and oppression.

5) The effects of intimate partner violence on victims/survivors, children and those who use violence including the impact of trauma.

6) The dynamics of power and control in relationships.

7) Cognitive distortions.

8) Laws related to DV.

9) Safety Planning.

B. Knowledge:

1) The ways children may be used as part of a pattern of abuse.

2) Child protection resources, referrals and definitions and dynamics of child abuse/neglect.

3) Skills to respond sensitively to the issues posed by those who abuse who are also parents.

4) A well developed understanding of what constitutes effective parenting, co-parenting, its importance and how to parent children who have been exposed to domestic violence.

C. Skills:

1) Facilitation and counseling orientation, knowledge and skills.

2) Strengths-based approaches.

3) Trauma-informed approaches.

4) Knowledge of and ability to use attitudes and skills of motivational interviewing.

5) Skills and strategies for use in responding to resistance so as to support movement toward behavior change and accountability.

6) Stages of change theory.

7) Individual counseling skills and strategies.

8) Group counseling skills and strategies including knowledge and skills in dealing with group dynamics

9) Recognition of and ability to work sensitively and effectively within a multi-cultural environment and among individuals with diverse learning styles.

D. Assessment, interviewing and crisis intervention skills and strategies:

1) Ability to use risk of recidivism, risk of re-assault and lethality to inform work.

2) Placing survivor safety at the center of any assessment and response to lethality or risk factors.

3) Interviewing skills.

4) Screening for additional needs, e.g., substance misuse or mental health concerns.

5) Recognize and respond to suicide, crisis situations and de-escalate aggressive behavior.

E. Plan services so that client needs are matched with the skills and approaches of the staff delivering the services:

1) Effective preparation for individual or group sessions.

2) Participate in regular supervision and debrief of sessions.

3) Maintain program integrity.

4) Establish and maintain appropriate boundaries with clients.

5) Maintain case records and complete paperwork in a timely fashion.

The standards below are desired expectations and requirements for DVI providers to work toward. They include the following:

5.2 Educational and Other Requirements

A. Entry level requirements for DVI staff and facilitators:

1) Those who provide DVI services are encouraged to have, at minimum, a Bachelor's Degree or higher in a behavioral science area of study from an accredited college or university or the equivalent in training and experience, including lived experience. Alternatively, any combination of education and lived or work experience that would provide the necessary knowledge, skills, and abilities to perform the essential functions of the position should be considered.

2) Individual and/or group counseling experience.

3) A current background check of state criminal history records.

a) Shall not have a conviction for a state or federal misdemeanor or felony, or have accepted a court plea of guilty or nolo contendere to the same if that violation is related to the perpetration of domestic violence or other crimes that may interfere with the effective provision of DVI.

4) Demonstrated values, attitudes and ability to communicate and work effectively with people of diverse social, economic, age, gender identities, cultural and racial backgrounds.

B. Requirements for DVI supervisors:

5) In addition to the requirements identified in 5.2A, at least 3 years working in domestic violence and 2 years supervisor experience. Supervisors should demonstrate proficiency in the competency and standards they are themselves supervising.

5.3 Supervision Requirements

A. Mandatory minimum supervision will be provided to DVI staff including volunteers a minimum of twice a month, for at least one (1) hour. This can be accomplished in a group setting, or individually, by phone, video conferencing

or in person. Supervision will include observation of and feedback on group facilitation and/or other service delivery.

B. It is recommended that internal supervision include audio/video taping of actual sessions with participants.

Supervision should regularly review at least the following:

1) Case coordination within the agency and with other providers including the criminal justice system and survivor's services.

2) Each staff members' services are provided to clients.

3) Staff members services, intervention strategies and evaluation of client progress.

4) Ethical and cultural issues.

5) Laws and standards relative to domestic violence.

6) The application of appropriate motivational responses, transference and countertransference and other ethical and boundary issues.

C. Regular performance evaluation of staff and volunteers.

1) Documentation of strengths, challenges, continuing education and a performance improvement plan.

5.4 Training Requirements

A. Staff must receive a minimum of 25-40 hours of basic training in domestic violence dynamics, which will include all areas listed in 5.1 A above, at a minimum, and complete an additional 20 hours of continuing education related to DVI per year.

6.0 DOMESTIC VIOLENCE INTERVENTION GOALS AND METHODOLOGY

Domestic Violence Intervention Programs, by themselves, will never stop gender-based violence or other forms of violence. However, provider programs can and must actively participate in a collaborative community effort designed to eliminate that violence.

The goals of DVI providers shall be to increase the safety of the survivors, children and the community through the reduction and elimination of coercive, dominating, isolating and violent behavior and its replacement with pro-social, non-abusive attitudes, skills and behaviors.

6.1 Intervention programs must focus on working with participants to acquire the skills to change their beliefs and behaviors to end violence and abuse. Toward this end providers should incorporate power and control theory, with emphasis on accountability while providing structured social learning opportunities with skill development and rehearsal to support behavior change.

A. During all levels of intervention staff shall focus on client, not survivor, behavior. Staff shall confront instances of denying, blaming, minimizing, justifying, and rationalizing of behavior by clients, regardless of current stress factors or their previous trauma.

Providers shall assist participants in recognizing that intimate partner violence involves choices they make regardless of circumstances, and that they are solely responsible for their responses, including the use of violence/abuse.

B. During all levels of intervention, staff shall not explore with clients the alleged role of the survivor in any conflict or incident. It is incumbent on providers to assist the client in identifying and creating alternative responses to any and all situations and in taking responsibility for their own actions.

6.2 Evidence-based approaches to service delivery shall be utilized by staff adequately trained in modalities that target areas of risk for battering/domestic violence. Areas to target should include:

- Change in attitudes and values that support gender-based violence in general, and specifically intimate partner violence, including coercive control;
- De-escalation skills for anger/hostility levels;
- Reducing problems associated with substance abuse via referral;
- Replacing the violent and manipulative behavior with pro-social, skill-based alternatives;
- Replacing the tendency to minimize, deny, blame, rationalize, and gaslight with honesty and accountability;
- Increasing self-awareness of the choice to be violent/abusive and using non-violent problem solving skills;
- Acknowledging harm done to survivor and children;
- Improving skills in interpersonal conflict resolution.

Evidence-based interventions and skills shall include but are not limited to:

- Motivational Interviewing to enhance motivation toward behavior change (support positive reinforcement of appropriate change in behavior);

- Cognitive-Behavioral approaches;

- Stages of Change Theory;

- Strengths-Based strategies;

- Assessment of recidivism of a dv-related incident;

- Targeting violent behavior (and behaviors that support abuse) with appropriate interventions at the appropriate intensity; and

- Positive behavioral reinforcement strategies and techniques to encourage new skills and prosocial behavior.

6.3 Group Format - DVI programs shall use group modality as their mode of intervention. Group interventions are most effective because they: 1) provide a greater opportunity for accountability and confrontation of attitudes, values and behaviors than does individual counseling/interventions; and 2) are more successful in decreasing the person's isolation and dependence on the partner.

Where group work is genuinely not possible - for example, in remote rural areas or for clients with unusual additional needs - a planned, structured program of individual intervention may be considered. This intervention should adhere to the same principles and standards as for group and should cover the same topics, approaches and skills practice.

A. DVI programs will be restricted to persons who abuse their partner in a current or former intimate or dating relationship. Groups shall be gender specific in composition and content.

B. Providers will, at a minimum, conduct weekly group sessions a minimum of 2 hours in length for a minimum duration of 24 sessions. Each participant must complete this minimum number of sessions. Participation in the DVI program may be extended beyond any term of community supervision.

C. Group sessions shall include an opportunity for clients to actively participate in discussions, practice and demonstrate their skills as well as receive constructive feedback.

D. The suggested maximum number of participants in the groups is 16-18 with two trained facilitators. It is recommended that co-facilitators of groups

include both genders, for the purpose of modeling equality in a relationship, as well as to assist with the maintenance of a productive group dynamic. When resources do not permit for two facilitators, it is suggested that the maximum number of participants in the groups be 10.

E. Programs that provide group intervention for non-intimate partner violence will screen participants to determine if intimate partner violence is also present. Any violence-control group participants that are identified to have committed intimate partner violence shall be moved to an appropriate DVI group where both issues shall be addressed.

6.4 Curriculum - DVI curricula shall minimally include:

A. Providers should primarily develop and utilize research-based curricula modules that emphasize social learning activities, techniques and tools, communications skills practice, cognitive restructuring exercises and role playing that target the risk factors for domestic violence recidivism. Participants should have the opportunity to demonstrate, rehearse, and practice pro-social alternatives to violence. As participants advance through the program curriculum, opportunities to practice new skills in increasingly difficult scenarios should occur that are designed to assist participants in anticipating and coping with risk situations. The provision of constructive feedback by staff is integral to these processes.

B. Identification and skillful confrontation of coercive, controlling and abusive behaviors committed against participant partners and children.

C. The gendered nature of domestic violence shall be central to program philosophy. All forms of abuse described on the "Power and Control Wheel" shall be identified and examined in relation to client attitudes, values and behaviors.

D. The responsibility of those who cause harm for their actions and the need to avoid victim blaming and other justifications and excuses for their abusive behavior.

E. The impact of abuse, battering, and coercive control on children and the incompatibility of violence and abuse with responsible parenting. The short and long term effects of violence on partners and children shall be examined to expose the seriousness and damage of exposure. The development of empathy for others, especially women and children, is critically important.

F. Providers shall ensure that the following items are included in the portion of the curriculum pertaining to the effects of domestic violence in children:

1) Discussion, skill building exercises and the roleplays designed to make participants aware of the effects of their violence toward their partners and/or children.

2) Basic information on the impact of domestic violence at the different stages of a child's development as well as realistic and unrealistic expectations of children at various ages.

G. Non-violence planning and maintaining non-abusive behavior - Providers shall ensure that the following topics and issues are included:

1) Awareness of each participant's individual abusive/violent behavior and patterns.

2) Specific violence cessation skills, techniques and rehearsal practice.

3) The application of cognitive-behavioral skills..

4) Non-violence maintenance planning.

5) Non-threatening behavior.

6) Respect, trust and support.

7) Honesty and accountability.

8) Responsible parenting.

9) Shared responsibility.

10) Economic partnership.

11) Negotiation and fairness.

H. Attitude and belief changes -- Providers shall ensure that the curricula they use promote the following attitudes and beliefs:

1) Taking responsibility for one's abusive behavior and taking action to stop it;

2) Participant’s awareness of the nature, impact, and intent of (their) abusive behavior;

3) Belief in egalitarian partnerships and treating others with dignity

and respect;

4) How to manage and appropriately express difficult thoughts and feelings; and

5) Participant's empathy for their victims'/partners' and children's experiences and the negative effects of their abuse.

I. The following attitudes and beliefs should be challenged:

1) Entitlement

2) Rigid gender-role stereotypes.

3) The belief that violence and aggression is a legitimate approach to conflict resolution.

4) The linkages of violent attitudes and sociocultural perspectives such as patriarchy, misogyny, oppression, domination, sexism, racism, heterosexism, and transphobic.

5) That those who cause harm are victims of the legal system and their partners.

J. Providers should emphasize that abuse is a choice and solely the responsibility of the client. Denial, minimization, blaming, rationalization and excuses will be confronted during group.

K. The identification and practice of cooperative and non-abusive forms of communication will be practiced and skills developed. Participants are expected to re-learn communication skills that are non-abusive and respectful.

L. Cultural and social influences that contribute and support abusive behavior including those that impact the LGBTQ+ community will be explored and alternatives presented.

6.5. Individual Counseling - Program providers should make every effort to make reasonable accommodations for language and disability access so that participants can participate in the intervention group. Individual counseling sessions may be necessary in order to augment DVI groups and/or crisis and other situations. While participants may prefer individual to group interventions, group interventions are supported by research and are to be the primary mode of service delivery. Referrals for individual counseling non-domestic violence related issues should only be made to a counselor experienced and trained in the dynamics of domestic violence.

It is not appropriate to substitute individual therapy/counseling as a legitimate alternative to DVI group sessions due to a participant's "discomfort in talking in groups" or other methods that reinforce a participant's sense of entitlement to special treatment.

6.6 Inappropriate Methods of Intervention-- Interventions that neither reduce the participant's responsibility for violence or are not sensitive to the needs of survivors are unacceptable. The following methods are inappropriate and inadequate when working with persons who commit intimate partner violence:

A. Couples counseling, DVI providers should not offer any form of couples counseling, marriage counseling or marriage enhancement to address battering/abusive behavior change. (Programs for Men Who Batter, Aldarondo and Mederos, 2002) Couples counseling may be appropriate only after:

- the client has successfully completed DVI.
- there has been a complete cessation of violence and coercive control.
- only when the survivor is not fearful of the person who has caused harm.

B. Psychodynamic individual or group therapy which assumes the primary cause of the violence to be one or more of the following: stress, lack of impulse control, previous victimization, or substance abuse.

C. Anger management techniques which lay primary causality for violence on anger, communication problems or conflict. Please also see 3.3.

D. Family and other systems theory that conceptualize causality across all members of the family and focus on survivor behavior.

E. Addiction counseling in lieu of DVI.

F. Gradual containment or de-escalation methods as opposed to an insistence on immediate cessation of abuse

G. Methods which identify psycho pathology as a primary cause of the violence. Methods which identify co-dependence as the primary cause of the violence.

H. Violence ventilation techniques.

I. Restorative Justice practices that are not survivor-centered and do not

take into account the power and control dynamics of domestic violence.

7.0 INTAKE AND ASSESSMENT

The DVI provider shall make every effort to initiate an intake and assessment within two (2) business days from the individual's referral or contact with the provider in order to determine suitability to participate in DVI services, and/or whether referrals to other appropriate resources may be necessary. For example, after evaluating appropriateness for DVI the provider may refer an individual to mental health or substance use treatment prior to or concurrent with DVI.

7.1 Intake Assessment. Providers shall obtain the following information from the individual, at a minimum. Other collateral sources of information should also be explored as available (criminal history check, police reports, protective orders, etc.).

If the provider chooses to obtain any information from the survivor, it should be done voluntarily and with their safety in mind. As described in 4.2 above, the provider shall have a policy on how to manage information from survivors. That policy shall be communicated in plain language to the survivor before any information is collected.

A. Current and past use of violence, including a specific history of violence and stalking.

B. Child abuse and/or neglect, and other abusive behaviors including sexual abuse, in current and past relationships.

C. History of threats, assaults, ideation of homicide or suicide, homicidal or suicidal attempts.

D. History of drug, alcohol or other substance use, abuse or dependency.

E. History of mental health problems and current mental health status.

F. Criminal history, protective orders and police reports.

G. Possession of, access to, or a history of using weapons.

H. Nature of current relationship with the victim/partner.

I. Accurate and detailed description of the most recent violent incident.

J. Employment status and information about social networks.

K. History of generalized violence.

L. Relevant medical history.

M. Partner and/or survivor name.

N. Children's names and with whom they reside.

O. Contact information of the participant including place and hours of employment.

If it is determined that the participant is a risk to themself or others, DVI staff must immediately warn potential victim(s). Police must be informed immediately as well. The policy for informing potential victims and police must be described in the information management policies required in 4.2 above.

7.2 Risk Assessment. In working with people who commit intimate partner violence it is important to assess each client's risk of intimate partner violence recidivism as well as risk of increased danger or lethality. This assessment differs from a program eligibility or suitability assessment, it is imperative to use a standardized and validated instrument with proper interpretation of the results. This type of assessment also requires an assessor with finely tuned professional judgment and understanding of the dynamics of risk and danger in the context of domestic violence. The results of such assessments shall be used for the purpose of understanding and addressing risk of recidivism and lethality potential.

7.3 Participant Monitoring. This standard is designed to have providers assess client's continuing progress in DVI services and referrals. Information to consider includes:

A. Attendance and participation levels.

B. Compliance with program guidelines and requirements.

C. Freedom from violence and/or abusive behavior.

D. Abstaining from alcohol and other drugs for a 24-hour period before DVI sessions.

E. Information from collateral contacts such as probation, parole, DHS social workers, supervised visitation, etc..

F. Personal accountability as it relates to parenting, court orders, employment, financial obligations including child support.

8.0 PROGRAM CRITERIA-ACCEPTANCE, COMPLETION, REFUSAL, TERMINATION, AND FEES

8.1 Program Acceptance Criteria**:** The provider shall establish criteria for acceptance into the program.

8.2 Program Completion Criteria: It is important for providers to develop criteria that participants must achieve prior to completion. Participants should demonstrate an understanding of the curriculum and an ability to apply the principles to their own lives. It is critical, however, that no person be assumed to be non-abusive because that person has completed the required sessions in the program. *Caution: information regarding continued violence/abuse from the survivor or others sources can only be used if it will not endanger the survivor.*

A. Providers shall ensure that all decisions regarding participants achieving criteria for "program completion" are consistent and objective.

B. Satisfactory completion of DVI requirements includes meeting measurable objectives that reflect the content of curriculum as described above (in Section 6.4).

C. The following are examples of suggested measures of behavior change while in program to indicate successful program completion. They can be evaluated based on observable skill acquisition, belief and attitude change, participation in group discussion, role plays, other group exercises and homework assignments.

1) Has accepted responsibility for their violent/abusive behavior.

2) Not engaging in violent, controlling or abusive behavior during program participation according to survivor and collateral reports, as well as self-reports. Status should be supported by periodic risk and lethality assessments conducted during program participation.

3) Has cooperated in sessions by openly processing attitudes and emotions, and actively participating in replacement attitude, belief and skill development.

4) Completion of a detailed prevention plan to prevent future perpetration of intimate partner violence

5) Demonstrates the acquisition of new attitudes, beliefs, skills and behavior.

6) Has demonstrated an understanding of and concern for the impact of domestic violence on children.

7) Demonstration of use of respectful language regarding their partner, women in general and other disenfranchised communities.

8) Completion of any other DVI requirements.

8.3 Program Exclusion Criteria - Program exclusion occurs when an individual fails to meet program acceptance criteria. The program shall establish criteria for refusal or admittance into the program. Providers shall provide written documentation with reasons for refusal to admit DVI to the court and/or probation/parole department within one week (1) of referral or contact. Examples of possible reasons for program exclusion include, but are not limited to:

- Individuals with severe mental health problems (chronic depression, schizophrenia, anti-social personality disorder, or suicidal or homicidal ideation).
- Disruptive behavior.
- Severe chemical dependence.
- Serious generalized violence.

Such referrals may not be appropriate for DVI and should be reported back to the referral source for appropriate interventions.

8.4 Program Termination Criteria: The provider shall establish criteria for termination from the program. The DVI provider should collaborate with the courts and probation/parole departments to encourage that an individual terminated from DVI services receives consequences and is held accountable. Termination without consequences weakens DVI effectiveness and sabotages the goal of survivor safety.

Program termination prior to program completion, or expulsion, occurs when an individual drops out or is expelled from the program. The following are suggested reasons for expulsion and should be examined within the context of the participant's circumstances:

1) A recurrence of violence or threats of violence.

2) Continual group disruption.

3) Coming to group sessions while under the influence of drugs or alcohol.

4) Unwillingness to actively participate in group sessions.

5) Excessive absences.

6) Violation of program rules.

8.5 Fee and Payment Scales and Procedures: If providers decide to charge a fee for their services, providers shall develop a written fee schedule including provisions for indigent clients. Note, the courts may have imposed fees as a condition of probation. It should be communicated to clients that financial consequences are one method of being held accountable for their behavior, and providers will work with them to assess their current financial situation including other court-ordered financial obligations such as restitution, the crime victim compensation fee, and child support. Non-payment of any program fee shall not prevent the client from completing the program.

9.0 PROGRAM ADMINISTRATION

9.1 Policies and Procedures.

A) DVI providers shall submit annually to the funding source(s) a cooperative working agreement with a victim services program in their county. If there is more than one victim services program in a county, the program must have a working agreement with at least one shelter from that county.

B) Paid or volunteer administrative support staff should, at a minimum, have
an understanding of program mission and policies as well as a basic understanding of domestic violence.

C) Providers shall have available for all employees, the following required organizational policies and procedures.

1) Program approved code of ethics.

2) Each DVI employee, volunteer and contractor providing direct service to persons who are justice involved should have the most recent version of the Hawai‘i Domestic Violence Intervention Program standards made available for guidance and also trained in the content.

D) Each program must develop an organizational or administrative manual that incorporates all written policies and procedures.

E) DVI providers shall develop record keeping policies and procedures that promote survivor safety and that store information from survivors in a separate file (or separate database profile) from information about clients. If a program must include information about the survivor in the DVI client's case

record, then it should be as brief as possible, with a minimum of identifying information that might put them in danger.

F) DVI programs shall inform clients of the information management policy required in 4.2 above.

G) Where the staff determines that there is probability of imminent physical injury to the DVI client themselves or to others, staff will take safety initiatives and may, if appropriate, notify medical or law enforcement personnel and/or the victim/partner, as stipulated by law. These procedures must be described in the information management policy required in 4.2 above.

1) Providers have the responsibility to report to the referral source any acts or threats of violence reported by a client who is court-referred to DVI. This reporting must be described in the information management policy required in 4.2 above. If a provider determines that any applicable laws prevent such reporting, then the provider must work with the court to determine a lawful procedure for making appropriate reports to the referring court or court-related entity.

2) Providers shall clearly document efforts to report recurring violence or threats.

9.2 Written Participant Agreements. DVI providers shall establish a written agreement signed by the participant that clearly delineates their obligations to the program and consequences for non-compliance with the agreement. The provider shall review the agreement with the participant and provide them with a copy. This agreement for services shall include the following participant obligations:

A) Cooperation with group rules.

B) Adhering to the written attendance policy.

C) Cessation of violent, abusive, threatening, and controlling behaviors, including stalking.

D) Non-abusive and non-controlling behavior toward other group members and group facilitators.

E) Development of and adherence to a non-violence plan as outlined in the curriculum.

F) Agreement to be drug and alcohol free while participating in program services.

G) Follow through with financial agreements made with the program. Providers shall also establish and provide a copy of a written agreement that clearly delineates the obligations of the program to the participants. The content of the written agreement shall include the obligation to:

1) Provide services in a manner that the participant can understand.

2) Provide a copy of all signed written agreements.

3) Notify the participant of changes in group time and schedule.

4) Provide feedback to the participant regarding the participant's status and participation.

5) Treat the participant with dignity and respect.

9.3 Quality Assurance - Each provider should have a clearly defined quality assurance protocol which includes:

A. Internal Quality Audits:

1) This should include regular monitoring of groups, file review and client case records that monitor client treatment progress by supervisory staff.

2) Regular observation or monitoring of staff by program supervisor with regard to delivering services/groups with feedback provided.

3) Formal program participant feedback on service delivery.

B. External Quality Audit:

Providers should anticipate evaluation of DVI services by external auditors (generally funding partners) to assure that the services being provided are high quality and consistently delivered. This can include regular periodic site visits, monitoring of groups, regular progress reports, file review, etc.

C. Participant Satisfaction:

Participants should be surveyed as to satisfaction with service/program. Can include exit surveys/interviews, post-completion surveys, phone calls, etc.

D. Participant Reassessment:

Periodic, objective re-assessment of participants on meeting target behaviors with tangible evidence in files. Indicators may include: pre and post-testing on target behaviors or attitudes; re-assessment using standardized instruments, monitoring the progress through a plan and making changes in the plan on a regular basis.

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