Washington State Department of Commerce

Domestic Violence Intervention Treatment Workgroup Report

Report on Domestic Violence Intervention Treatment Workgroup per Sec. 126(137(a)) of Chapter 376, Laws of 2024

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Report to the Legislature

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OFFICE OF CRIME VICTIMS ADVOCACY

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Executive summary

Domestic violence (DV) and intimate partner violence (IPV) pose serious public health and safety issues, requiring an adaptive and comprehensive response. Domestic Violence Intervention Treatment (DVIT) refers to a program that provides domestic violence assessments or intervention treatment to perpetrators of IPV. It is certified[1] by the Washington State Department of Social and Health Services (DSHS)[2] and is recognized as a crucial element of Washington's response to domestic violence.[3] The cost of DVIT has been of particular interest in making this treatment accessible and affordable in the hopes of reducing IPV perpetration, recidivism, and rehabilitating a wide range of offenders.

In June 2018, the Washington State Legislature released the report "Domestic Violence Perpetrator Treatment: A Proposal for an Integrated System Response (ISR).[4] In this report, costs associated with DVIT were highlighted as prohibitive and non-reimbursable by insurance. This lack of financial support could lead courts to order perpetrators to participate in treatment options that are not state-certified or facilitated by Department of Health (DOH)-credentialed counselors. A later report released by the Washington State Legislature in October 2020, "Domestic Violence Intervention Treatment: Removing Obstacles to Implementation"[5] identified the creation of a reliable funding scheme for court-ordered DVIT as a top concern. The 2020 report noted that the "insurance option" potentially created a hurdle in funding DVIT because there were no billable codes[6] that were specific to treating perpetrators of domestic violence. These reports also highlighted the need for recording data on court-ordered therapy in IPV cases.

Medicaid and commercial insurers do not consider therapeutic treatment for IPV perpetrators a medical necessity because IPV is not recognized as a treatable medical illness or mental disorder, viewing it instead as a criminal behavioral issue. While abusive behavior may be connected to mental health issues, the violent act(s) are not considered a diagnosable disease. Instead, it is addressed as a behavioral and legal problem. The treatment for IPV is specifically designed to hold the offender accountable for their actions, to change violent or abusive behavior, and therefore reduce recidivism. Because these treatments are legally mandated and specifically designed to treat IPV, which is considered a criminal act, DVIT falls outside of current thresholds associated with Medicaid and insurance billing.[7]

The Legislature appropriated $200,000 for fiscal year 2024 for the Washington State Department of Commerce (Commerce) to convene a workgroup (Workgroup members) to develop a roadmap for Medicaid and insurance billing for DVIT, assess educational pathways for providers, and identify necessary statutory and funding changes. The DVIT workgroup convened regularly to discuss and review these issues, examine barriers, and find potential solutions. The workgroup also reviewed other concerns brought forward by members and from listening sessions. The issues raised included the involvement of tribal court members, tribal DVIT Providers, and tribal DV Advocates, as well as the expansion of DVIT provider networks and knowledge. Workgroup members, while supportive of DVIT in practice, are reluctant to recommend billing codes for Medicaid and commercial insurance. This concern is examined in detail throughout this report.

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[1] Any program that provides domestic violence treatment to perpetrators of domestic violence must be certified by the Department of Social and Health Services (DSHS) and meet minimum standards for domestic violence treatment purposes. DSHS adopts rules for standards of approval of domestic violence perpetrator programs per RCW 43.20A.735: Domestic violence perpetrator programs.
[2] Washington Administrative Code (WAC) 388-60B outlines Domestic Violence intervention treatment program standards.
[3] Domestic Violence Manual for Judges, Chapter 3 - The Legislative Response to Domestic Violence (Revised 2022).
[4] Domestic Violence Perpetrator Treatment: A Proposal for an Integrated System Response (ISR). Report to the Washington State Legislature (2018).
[5] Domestic Violence Intervention Treatment: Removing Obstacles to Implementation. Report to the Washington State Legislature (2020).
[6] ICD Code Lists - Centers for Medicare and Medicaid Services.
[7] Court-Ordered Therapy.

Roadmap for insurance and Medicaid billing

The Domestic Violence Intervention Treatment Workgroup convened for nine months to provide input in developing the following roadmap and to identify the necessary steps toward its implementation. The workgroup determined that each step in the roadmap was feasible, but would require significant public, private, interagency, and intergovernmental coordination to achieve.

Some elements of the roadmap, including the modification or creation of new billing codes, are outside state control because they require federal changes. Throughout this report, billing codes refer to the diagnostic codes needed by service providers to assign the correct diagnosis necessary to determine treatment services. While the details on each milestone on the roadmap are included in this report, at their highest level, they are summarized below:

A) A Medicaid state plan amendment or 1115 waiver is necessary to allow Medicaid billing for domestic violence intervention treatment.

B) Modification of existing billing codes, or creation of new billing codes to bill Medicaid and private insurance for DVIT will be necessary since existing codes are insufficient.

C) A master's level behavioral health credential and licensure is required for providers to bill insurance or Medicaid for domestic violence intervention treatment.

D) Educational pathways currently exist to become a domestic violence intervention treatment provider and are detailed in Figure 1 - DVIT Education and Provider requirements

E) Statutory changes or funding when identifiable to implement the roadmap.

Workgroup conclusions

The DVIT workgroup met for a period of nine months and was comprised of 27 individuals representing a breadth of professional experience in mental health care and DVIT. These individuals are dedicated to the provision of treatment of intimate partner violence and domestic violence but were not all in alignment as to the methods for how to provide such treatment. Some indicated that general complications with Medicaid and commercial insurance billing would preclude their acceptance of insurance. Others indicated that the requirements associated with these billing systems would require additional training or staff that they don't have. Collectively, the workgroup was in alignment that they **did not support moving forward with pursuing Medicaid and commercial insurance billing as a method to pay for DVIT in Washington**. Significant work remains to bring the greater practitioner and provider communities on board with extending eligibility for DVIT in the Medicaid and commercial insurance systems.

Introduction

Legislative mandate

Sec. 126(137(a)) of Chapter 376, Laws of 2024 instructed the Department of Commerce's Office of Crime Victims Advocacy to address domestic violence:

(a) $200,000 of the general fund—state appropriation for fiscal year 2025 is provided solely for the office to convene a work group to create a roadmap that provides a detailed pathway describing the steps necessary for insurance billing for domestic violence intervention treatment in Washington state.

(i) In developing the roadmap, the work group must:

(A) Determine if a Medicaid state plan amendment or 1115 waiver would be necessary to allow Medicaid billing for domestic violence intervention treatment;

(B) Determine if existing billing codes would work for Medicaid and commercial insurance, or if new billing codes would be necessary;

(C) Identify any healthcare certification or credentials needed for providers to be able to bill insurance for domestic violence intervention treatment;

(D) Identify the educational pathways that exist to become a domestic violence intervention treatment provider; and

(E) Identify any statutory changes or funding necessary to implement the roadmap.

(ii) The work group members must include representatives of:

(A) Organizations that provide domestic violence intervention treatment;

(B) Individual clinicians that provide domestic violence intervention treatment;

(C) Social workers;

(D) Licensed marriage and family therapists;

(E) Domestic violence survivors;

(F) The domestic violence treatment program administered by the department of social and health services;

(G) Staff from the department of health with expertise in licensing and credentialing of health professionals;

(H) Staff from the health care authority who work on insurance billing for Medicaid, the public employees' benefits board, and the school employees' benefits board;

(I) The office of the insurance commissioner;

(J) Medicaid managed care organizations; and

(K) Commercial insurance carriers.

(iii) The office of crime victims advocacy must provide staff support for the work group.

(iv) The work group must submit a preliminary report including the roadmap to the appropriate committees of the legislature by December 31, 2024.

A preliminary report was submitted to the Legislature.

Domestic violence background

Domestic violence was first recognized as a serious crime in Washington in 1970,[8] and the Administrative Office of the Courts (AOC) offered its inaugural judicial training on domestic violence in 1984. The Domestic Violence Manual for Court Judges was published more than 30 years ago. It provides a framework for sentencing domestic violence perpetrators in the Washington court system. Several updates have been made to the Manual as the understanding of these crimes has changed (updates in 1993, 1997, 2001, 2006, 2016).[9]

Domestic Violence (DV) includes, but is not limited to, 18 different crimes[10] committed by one family or household member against another family or household member, or by one intimate partner against another intimate partner. In Washington, an intimate partner includes a spouse, state-recognized partner, romantic partner, or past or present date.[10] Intimate partner violence (IPV) is a sub-category of DV involving physical, sexual, emotional, verbal, psychological, and economic abuse, as well as coercive control. This distinction is key because DVIT applies exclusively to IPV cases, rather than the broader category of DV crimes, which includes family and household members.

Domestic Violence Intervention Treatment

DVIT[11] is a Washington state-certified program specifically designed to address intimate partner violence, often through court-ordered[12] therapeutic services. These evidence-based services are aimed at increasing the safety of communities and victims while offering rehabilitative efforts for the perpetrator to stop abusive behavior and reduce rates of recidivism.[13] DVIT standards include staff qualifications, treatment modalities, continuing education requirements, and treatment parameters, which are set and maintained by the Department of Social and Health Services (DSHS).[17] DSHS ensures that certified programs provide perpetrator intervention in accordance with the state laws and rules specifically designed for DVIT.[14] As recently as 2023, an 82% reduction in abusive behaviors was self-reported at the completion of DVIT state-certified programs.[15]

Currently, Washington has 65 DVIT state-certified providers offering in-person and internet-based therapeutic intervention treatment to perpetrators. See Appendix G: Map of State-Certified DVIT Providers for the locations of DVIT providers in the state.[16] State-certified DVIT providers are required to understand core competencies (Appendix D) by the end of their training. Providers assess the level of risk, needs, responsiveness, and lethality of the perpetrator prior to treatment. Based on this behavioral assessment, court records, consultation with the victim

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[8] This shift occurred throughout the United States of America in response to the Women's Liberation Movement and Battered Women's Movement. National Library of Medicine (2015). Domestic Violence in the 1970s, Confronting Violence Archives.
[9] Ganley, Anne L. "Domestic Violence: The What, Why, and Who as Relevant to Criminal and Civil Court Domestic Violence Cases", Chapter 2, Domestic Violence Manual for Judges (2015 Version).
[10] RCW 10.99.020: Definitions.
[11] Any program that provides domestic violence treatment to perpetrators of domestic violence must be certified by the Department of Social and Health Services (DSHS) and meet minimum standards for domestic violence treatment purposes. DSHS adopts rules for standards of approval of domestic violence perpetrator programs. RCW 43.20A.735: Domestic violence perpetrator programs. RCW 43.20A.735: Domestic violence perpetrator programs.
[12] DVIT is for anyone who needs to stop their abusive behavior. While often court-ordered, it is not required for DVIT.
[13] Berlin, Lucy, Merchant, Laura, Roberts, Amie and Martin, David "CBT Guide for Intimate Partner Violence" (2020).
[14] WAC 388-60b.
[15] Washington State Department of Social and Health Services, Economic Services Administration, Community Services Division, Domestic Violence Intervention Treatment (2023).
[16] DSHS. DVIT Programs by County - 1 DVIT state certified provider is not on this map, they are in Idaho but certified and provide treatment in WA state.

(if chosen by the victim), and the severity/lethality of domestic violence charges, perpetrators are assigned to different levels of treatment,[17] resulting in a tailored approach (Appendix E). Although DVIT is court-ordered treatment, it should be noted that it is not offered within the Department of Corrections, which means that some of our most violent and lethal offenders may never receive this crucial treatment.

DVIT programs span between six, nine and 12 months, with some rare instances extending beyond one year of treatment, depending on the level of care required. Although the time associated with treatment, as determined by the behavioral assessment, varies, all perpetrators are expected to understand and accept certain competencies. These competencies include recognizing different types of abuse, identifying belief systems associated with abusive patterns, understanding the impact of abuse on children, and taking accountability for actions personally, legally, and financially. During and after treatment, DVIT participants are asked to provide feedback on services and the effectiveness of treatment to DSHS.

DVIT providers offer regular updates to the court and/or probationary services as required throughout the therapeutic process. During assessment, at a mid-point check-in, and at the conclusion of treatment,[18] DVIT providers reach out to the victims of their clients. This outreach aims to ensure the victim's safety, identify any unauthorized contact by their client, and assess whether the victim requires additional services. Notably, half of the training to become a state-certified DVIT provider focuses on DV victim services, due to the necessary outreach during treatment. This specialized training is unique to state-certified DVIT providers and underscores the victim-centered care within this perpetrator treatment program.[17]

Methods and workgroup formation

The Domestic Violence Intervention Treatment Workgroup (Workgroup members) convened on September 25, 2024, and maintained a regular monthly meeting schedule through April 2025. Per Sec. 126(137(a)) of Chapter 376, Laws of 2024. 27 workgroup members were identified and recruited to provide expertise in developing the roadmap and identifying barriers to its implementation.

Workgroup meetings were utilized to understand barriers and opportunities to billing insurance and Medicaid, as well as educational needs for providers. Commerce also met individually with subject matter experts to better understand gaps, opportunities, and barriers to offering DVIT throughout Washington. These subject matter experts included the Commerce Office of Tribal Relations, the Administrative Office of the Courts (AOC), the Regence Insurance Team, court personnel (judges, probationary services, court records management staff, and court coordinators), the Department of Corrections, the Office of Firearm Safety and Violence Prevention, researchers from the Domestic Violence Intervention Project, researchers specializing in DV and DVIT and the Health Alliance for Violence Intervention (HAVI).

Roadmap for DVIT integration with Medicaid and commercial insurance

The following sections describe the steps necessary to bill Medicaid and private insurance for DVIT and introduce some of the existing barriers to their implementation as identified by the workgroup.

[17] WAC Chapter 388-60B, Domestic Violence Intervention Treatment Program Standards.
[18] Appendix F: The Need for DVIT (It is difficult to accurately assess the need for DVIT without examining a wide range of data that is often incomplete or out of date)

Develop partnerships

Research findings and workgroup feedback indicate that the road to incorporating DVIT into Medicaid and commercial insurance billing is a long process. It would require the collaboration of various state and federal agencies, non-profit organizations, institutional advocacy, and greater support from the general community. The first step will be to develop the partnerships needed to carry out this effort and grow support among the broader statewide community of DVIT stakeholders. Such partnerships could be developed through a more permanent workgroup or advisory committee dedicated to the advancement of DVIT in the nation's healthcare system.

Making Substance Use Disorder (SUD) a treatable and billable condition to insurance took national movements and nationwide efforts among government agencies, treatment professionals, courts, and advocates. The national movement behind SUD took well over 40 years[19] and included several federal acts,[20] [21] [22] research, funding,[23] as well as the drug court movement. Washington state was not the sole actor in the SUD movement, and the monumental task of making DVIT billable under insurance and Medicaid will also require nationwide assistance. The financial costs, time commitments, and legal changes necessary for a nationwide movement are difficult to determine and would require funding beyond Washington state.

Medicaid billing

Medicaid and Waiver 1115 background

While intimate partner violence (IPV) spans cultural and socio-economic boundaries, between 80% and 90% of defendants found guilty of these crimes are indigent and often unable to afford court-ordered treatment.[24] Despite DVIT being well supported by research findings, the lack of insurance or Medicaid coverage creates financial barriers, discouraging judges from ordering these services in sentencing.

The Medicaid state plan is a federal government health insurance program administered by the state that pays for medical services for people with limited income and resources.[25] The state plan serves as a written agreement between Washington and the federal government outlining details of the Medicaid Program, including eligibility, covered services, and how providers are reimbursed.[26] Within Washington, approximately 1.8 million people currently utilize Medicaid as their primary insurance. Medicaid can be used for some court-ordered therapies, such as substance use disorder (SUD/SUDP) treatment, court-ordered institutional holds, and/or involuntary treatment;[27] but it can't be used for DVIT. Covering DVIT would require changes in both federal and state systems to establish a new diagnosis and ensure specific treatment eligibility.

Washington state's Section 1115 demonstration waiver, established between the state Health Care Authority (HCA) and federal Centers for Medicare and Medicaid (CMS), is an innovative project that enables the state to test new approaches for delivering healthcare services. The waiver aims to improve the overall healthcare system and

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[19] The first instance of this movement occurred in 1956 when alcoholism was recognized as a disease by the American Medical Association, but in 1987 the AMA officially termed addiction as a disease. Bettinardi, Katy and Angres, Danial. Journal of Nursing Regulation, Understanding the Disease of Addiction (2018).
[20] Centers for Medicare and Medicaid, the Mental Health Parity and Addiction Equity Act.
[21] Medicaid, Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act: Section 1003.
[22] McGinty EE, Daumit GL. Integrating Mental Health and Addiction Treatment Into General Medical Care: The Role of Policy. Psychiatry Serv. (2020).
[23] Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health [Internet]. Chapter 6 Health Care Systems and Substance Use Disorders. (2016).
[24] Delostrinos, C., Bellmer, M. & McAllister, J. "The Price of Justice: Legal Financial Obligations in Washington State" (2022).
[25] Washington State Department of Social and Health Services, ALTA-Medicaid.
[26] Washington State Health Care Authority, What is the State Plan.
[27] Washington State Health Care Authority, Involuntary Treatment Act (ITA).

expand Medicaid coverage.[28] On June 30, 2023, CMS[29] approved the continuation of Waiver 1115 for five more years. Currently, DVIT is not covered under Waiver 1115 and would not be eligible for inclusion until the next review in June 2028.

Medicaid and Waiver 1115 medical necessity

Currently, DVIT does not reach the threshold of medical necessity utilized by the federal Centers for Medicaid and Medicare (CMS) or by the HCA. Medicaid and Waiver 1115 use a federally approved standard of medical necessity treatment to determine which services will be covered. The term 'medical necessity' refers to a requested service that is determined necessary to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the client. These conditions endanger life, cause suffering and pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. The requested service must be demonstrated, and it must be shown that there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service.[30] Intimate partner violence (IPV) is not recognized as a diagnoseable medical condition. Because IPV is not recognized as a medical diagnosis, treatment for it is not considered a medical necessity.

Amending the state plan or creating an addition to Waiver 1115 has similar barriers. Modifying the definition of medical necessity would require changes to the mental health parity law in Washington state, along with federal inclusion of DVIT under CMS. Mental health parity laws are designed to ensure equal coverage (and access) for mental health conditions and substance use disorders, rather than treatments for criminal behavior. Designating DVIT as a medical necessity would require strict state guidelines, as IPV includes a broad range of criminal offenses. Changes to state mental health parity law could be extensive, covering various crimes and behaviors associated with IPV.

Existing Medicaid billing codes

Billing DVIT to Medicaid requires either modifying existing codes or establishing new codes to ensure coverage. The International Classification of Diseases (ICD) is a global[31] medical classification system used for billing and standardizing descriptions of diseases, causes of death, treatments, and health statistics.[32] ICD codes are federally controlled within the United States by the Centers for Disease Control and Prevention (CDC)[33] and they provide a diagnosis that allows treatments such as group therapy, individual therapy, and assessments to be covered.[34] Diagnostic codes, like ICD-10, identify a patient's medical condition, while treatment codes describe the specific services or procedures provided to treat that condition. In essence, diagnostic codes explain "why" a service is being performed, and treatment codes explain "what" is being done. Throughout this report, billing codes refer to the diagnostic codes needed by service providers to assign the correct diagnosis necessary to determine treatment services.

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[28] Washington State Health Care Authority, Medicaid Transformation Project (MTP).
[29] Medicaid is a state-run program. Approval and extension of services, such as Waiver 1115 is offered through Medicaid but receive federal approval from CMS.
[30] Washington Advisory Code 182-500-0070.
[31] The ICD is produced and maintained by the World Health Organization, changes to codes or changing the way codes are applied within the United States is under CDC guidance
[32] Center for Disease Control, ICD-10.
[33] Centers for Disease Control, ICD-10 Coordination and Maintenance Committee.
[34] Current CPT (Current Procedural Terminology) for group, individual, and assessment codes could be applied after a new diagnostic code is created.

Currently, IPV is not classified as a primary treatable condition in the ICD. Instead, it falls under V and Z codes, which represent environmental and societal factors rather than a billable diagnosis. These codes cannot be used as the primary basis for treatment[35] because of the current Medicaid billing practices set by HCA and CMS.[36]

Creating new Medicaid billing codes

A proposal must be submitted to the ICD-10 Committee within the National Centers for Disease Control and Prevention (CDC) to establish a new federal ICD code or modify existing Z and V codes.[37] The proposal must be supported by clinical evidence from multi-phased studies and be accompanied by peer-reviewed supporting research,[38] to establish a new diagnosis or designate a condition as treatable.[39] Proposals are submitted in June of each year, with hearings taking place the following October. Public comments remain open on proposals for the duration of that year. Approximately one year after hearings, decisions regarding new codes are either approved or denied.[40]

After the approval of a new ICD code, the state legislature would have the option to amend the definition of medical necessity or medically necessary to include DVIT. These changes would fall under what are known as health parity laws. Once changes were adopted into statute, the Office of the Insurance Commissioner would ensure the new code was integrated into insurance requirements while also adhering to current RCWs and WACs, which regulate insurance practices in Washington.[41] [42] Following this process, collaboration with the AOC, HCA, DOH, and DSHS would support providers in navigating billing while ensuring that judges and court coordinators understand how Medicaid can be utilized when ordering DVIT.

Waiver 1115 - preventative services

Once new federal ICD codes have been created, Medicaid coverage for DVIT would need to be approved by Washington. The Washington State Health Care Authority would need to classify it as a medical necessity, which would require a new or amended state mental health parity law — unless it qualifies as a preventative service. If designated as a Section 13C Preventative Service,[43] no amendment would be necessary. In making the federal determination for a 13C Preventative Service, Washington's HCA would make this recommendation to the U.S. Preventative Services Taskforce.[44] This Taskforce would approve or deny DVIT as a preventive service. Medicaid pilot projects for prevention are often tested in this way. A pilot project is currently being conducted in North Carolina, where expanded prevention measures to integrate intervention services for interpersonal violence, including IPV, are being tested[45] During the 2028 Waiver 1115 application cycle, HCA could evaluate DVIT as a

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[35] Current CPT (Current Procedural Terminology) for group, individual, and assessment codes could be applied after a new diagnostic code is created

[36] Washington State HCA Mental Health Services Billing Guide (2021).

[37] The World Health Organization (WHO) collaboratively develops the ICD. Changes, maintenance, application, and regulation of ICD 10 within the United States occurs within the CDC.

[38] The clinical trial must be deemed "safe" to reach Phase 1, preferably these trials are submitted in Phase 2-4 where they are evaluating the success of treatment based on an average population in both size and variation - Burt, Tal, Roffel, Ad, Langer, Oliver, Anderson, Kristen, DiMasi, Joseph. 2022. Strategic, feasibility, economic, and cultural aspects of phase 0 approaches
And ICD Proposal Process - ICD-10-CM Proposal Process | Classification of Diseases, Functioning, and Disability | CDC

[39] Center for Disease Control and Prevention, ICD 10- CM Proposal Process.

[40] Center for Disease Control and Prevention, ICD 10-CV Committee Meetings.

[41] Office of the Insurance Commissioner, Laws and Rules. Laws & Rules | Office of the Insurance Commissioner

[42] To ensure coverage, a change to rulemaking within the Office of the Insurance Commissioner may also be required

[43] Medicaid State Plan - Attachment 3, General Provisions.

[44] The U.S. Preventative Services Taskforce is an independent, volunteer group of national experts in prevention and evidence based medical prevention services who recommend clinical preventative services. Home page | United States Preventive Services Taskforce

[45] Blue Cross Foundation of Carolina, "North Carolina's experience as the first state in nation to offer interpersonal violence services in Medicaid" (2024).

preventative service for a potential pilot project in collaboration with DSHS, HCA, providers, Managed Care Organizations (MCOs), and Behavioral Health - Administrative Service Organizations (BH-ASOs).

Commercial billing

Commercial insurance background

Close to 4 million residents in Washington are covered by private insurance.[46] Between employee-sponsored insurance, Medicaid, and the individual marketplace, only 5-6% of Washingtonians are uninsured.[47] If insurance were to cover DVIT treatment in Washington, many residents could bill insurance as a form of payment. In Washington, the Office of the Insurance Commissioner (OIC) regulates commercial health insurance. Amendments are made through rulemaking, which establishes, amends, or repeals insurance regulations to ensure industry compliance and consumer protection.[48]

The OIC does not create new diagnostic billing codes for behavioral health conditions such as DVIT. Creating a new nationally recognized diagnostic code for billing insurance would take place through either a new federally regulated ICD code, as outlined in Creating new Medicaid billing codes, or in creating a new diagnosis within the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and then creating a new federally regulated ICD code.

Medically necessary

In 2025, legislation was passed to consolidate several definitions of medically necessary into a singular definition.[49] Chapter 227, Laws of 2025 expanded the definition of medically necessary but excluded criminal behaviors like IPV and treatment for it, such as DVIT. The term medically necessary refers to a service or product addressing the specific needs of the patient for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is: in accordance with generally accepted standards of mental health and substance use disorder care; clinically appropriate in terms of frequency, extent, site, and duration of service or product; and not primarily for the economic benefit of the insurer or purchaser or for the convenience of the patient.

To designate IPV-related court-ordered treatment as medically necessary, a new or amended state mental health parity law is required, in a process similar to that described in the subsection Creating new Medicaid billing codes to include DVIT. However, this change would not establish a new insurance code, which is regulated at the federal level.

Commercial insurance billing code requirements for DVIT

Billing DVIT to commercial insurance requires either modifying existing codes or establishing new codes to ensure coverage. Commercial insurers base their coverage of mental disorders on diagnoses and treatment covered by the DSM, a reference book on mental health and brain-related conditions published by the American Psychiatric Association[50] and the ICD. The current Diagnostic and Statistical Manual (DSM-5) makes several references to domestic violence and intimate partner violence, but there is no specific disorder or diagnosis associated with

[46] Washington Sources of Insurance Coverage.
[47] Association of Healthcare Journalists. Washington Sources of Insurance Coverage.
[48] Understanding the rulemaking process.
[49] State of Washington, House Bill 1432.
[50] Insurance Implication of the DSM 5.

being a victim or perpetrator of domestic violence.[51] Although abuse of a spouse or intimate partner is listed within the ICD and DSM, it is considered a secondary V code or tertiary Z code, which cannot be used in diagnosis. Z codes indicate factors that can influence a patient's health status and contact with healthcare providers and/or services. V codes are used to identify issues that focus on clinical attention or affect the primary diagnosis, course of treatment, or prognosis of the patient's condition but are not billable as the primary diagnosis or condition.[52]

Creating new commercial insurance codes

To bill commercial insurance for DVIT, new federally regulated ICD codes must be created or existing Z and V codes modified. Since IPV is not recognized as a treatable diagnosis in the DSM, collaboration with the American Psychiatric Association (APA) is necessary to advocate for its inclusion.[53] To incorporate DVIT treatments for IPV perpetrators into the DSM, coordination with the APA is required. This step ensures that the proposal is peer-reviewed and meets standards set by the APA. The APA evaluates proposals through a steering committee and workgroup to ensure they are evidence-based and address key clarifications.[54] Once treatment for IPV perpetrators is included in the DSM, the federal process of receiving a new ICD code would be more feasible.

A proposal for a new diagnostic category to recognize DVIT as a treatable condition is typically submitted through a district branch of the American Psychological Association.[55] This proposal, like that of an ICD proposal, may be submitted by any individual, organization, or agency. Successful proposals for such large-scale changes would require a broader national movement like that which occurred for SUDP.

Once the DSM has been updated and a new ICD code created federally, the Washington Legislature would need to amend mental health parity law to include DVIT. Separately, creating a new ICD code as outlined in Creating new Medicaid billing codes will also be necessary as a parallel step in this process. Following this process in Washington state, collaboration with the Office of the Insurance Commissioner, AOC, HCA, DOH, and DSHS would support providers in navigating billing while ensuring that judges and court coordinators understand how Medicaid can be utilized when ordering DVIT.

Credentials required for Medicaid and insurance billing background

If a new billable code for DVIT is created, only providers with a master's degree and a Behavioral Health credential[56] would be eligible to bill insurance or Medicaid for services. While state-certified DVIT providers adhere to established standards for education and continuing education, state certification alone does not allow for insurance or Medicaid billing.

Within the broader category of programs designed to intervene or treat perpetrators of IPV, there are different educational requirements for providers:

- Domestic Violence Moral Reconation Therapy (DV MRT) requires providers to complete a four-day (32-hour) virtual training, with no additional certification.[57]

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[51] Kulpinski, Amber, Bank, Stella, and Blasdell, Raleigh (2023). Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and Domestic Violence. In: Shackelford, T.K. (eds) Encyclopedia of Domestic Violence. Springer, Cham.
[52] Diagnosing IPV as a treatable mental health condition has historically received pushback from victim services and advocates -Batterer's Intervention: What Every Victim Advocate Needs to Know
[53] American Psychiatric Association, Revising the DSM.
[54] American Psychiatric Association, Submit Proposals for Making Changes to DSM-5-TR. Psychiatry.org - Submit Proposals for Making Changes to DSM-5-TR
[55] American Psychaitic Association, Guide to Submitting Proposals for Changes to DSM-5.
[56] Licensed Mental Health Counselor (LMHC), Licensed Marriage and Family Therapist (LMFT), Licensed Independent Clinical Social Worker (LICSW/LASW)
[57] Correctional Counseling, Training for Domestic Violence Treatment.

- Strength at Home (SaH) certification involves a two-day intensive training, participation in at least 15 weekly group or individual consultations, and facilitation of two treatment groups, but no further certification is needed.[58]
- Internal Family Systems (IFS) requires a master level behavioral health credential and supervised training.
- The Seattle Municipal Court's Domestic Violence Intervention Project (DVIP)[59] utilizes DVIT state-certified providers.
- Washington State certified DVIT providers must have at least a bachelor's degree and a counseling credential from DOH, and to serve as a DVIT supervisor, they must have a master's degree and 100 hours of clinical practice in DVIT.

Among these programs, only IFS and state-certified DVIT providers with a master's degree and a behavioral health credential[60] could be able to bill insurance and Medicaid, if a new billable code for DVIT is created.

Novel credential for DVIT providers

A new credential[61] is not required to bill insurance but could serve as a regulatory pathway for providers. It could reduce the number of providers and, therefore, reduce IPV treatment options in Washington. The cost of creating and maintaining a new credential is both costly and time-consuming. Creating a new credential is costly due to administrative work, licensing, and certification regulations. Fees associated with these costs are often passed on to credential holders, which could be high given the limited number of providers.[62] Several providers could also be excluded based on the educational requirements of a new credential. If a new credential is created, housing it within DSHS would be beneficial because they currently maintain state certification standards for DVIT providers and programs.[63]

Current educational pathways to become a DVIT provider

Educational requirements for state-certified DVIT providers consist of three certification pathways: trainee, staff, and supervisor (Figure 1 - DVIT Education and Provider requirements). DSHS assists new providers in selecting the most suitable route, securing required supervision, and accessing cost-effective educational opportunities based on their location in Washington.

Representatives of domestic violence survivor services on the workgroup emphasized the value of DVIT providers having training on survivor perspectives and needs and having skills for working effectively with survivors, in addition to the skills they learn for working with DVIT participants. Half of the educational requirement for state-certified DVIT providers focuses on victim issues, needs, and perspectives. Throughout a perpetrator's DVIT treatment, providers actively engage with victims to amplify their voices and ensure they receive the support they need. This approach places victims and survivors at the core of DVIT, prioritizing their well-being and emphasizing an end to the abusive behavior of the perpetrator.

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[58] Strength at Home Trainings.
[59] Domestic Violence Intervention Project - DVIP
[60] LMFT, LMHC, LMSW
[61] A new credential was explored to determine if it provides more regulation on those providing DVIT and would make billing insurance easier
[62] 65 state-certified DVIT providers, numbers of those certified in other research projects is unknown
[63] Washington State Department of Social and Health Services, Domestic Violence Intervention Treatment.

Roadmap: Statutory changes and funding required

While statutory changes are identifiable, funding estimates are indeterminate

This research identifies the steps necessary to incorporate DVIT as a covered treatment under Medicaid and commercial insurance through a complex set of procedures, many of which are outside of state control. Of these, updating national insurance billing codes presents the greatest challenge. Updating the billing codes is essentially a national undertaking that is largely centered on a complex, multistate, and multiorganizational process over a time period that cannot accurately be estimated. There is precedent for Washington -- the SUD billing code update process that took place more than 40 years -- but even for that process, an accurate assessment of actual costs as incurred by the state of Washington is unavailable. Due to the unknown and possibly lengthy national process for creating new billing codes, cost estimates for subsequent steps within the control of the state of Washington, such as insurance rulemaking and updating Medicaid waiver 1115, are not possible since those steps would presumably occur many years from now.

For this reason, this report is unable to provide reasonable funding or cost estimates for steps in the roadmap due to their interdependency with a national partnership-led process likely outside of state control. The magnitude and sequential nature of some of these steps, such as developing new national billing codes, make the development of reasonable cost estimates impossible.

Developing partnerships: Build a coalition and broader support

The methodology for developing this report identified a broad range of public and private stakeholders representing many, but not all, of the interests that will require consultation in advance of establishing DVIT as allowable under Medicaid and commercial insurance billing. Through the course of the meetings of the DVIT workgroup and feedback received from numerous other state subject matter experts, there was an overwhelming sense of hesitance to pursue DVIT billing under Medicaid and commercial insurance billing. For any successful effort to incorporate such a path in Washington state, these stakeholders and other related interests will need to be incorporated into the statewide effort to build support.

As explained in this report, the process will be nationwide and will require broad collaboration among other states and national entities to come to fruition. For Washington state to play an influential role in this process, a more unified voice among stakeholders will help ensure that the outcomes of the process best serve the needs of Washington residents. Much like SUD, a national movement to respond to an epidemic of intimate partner violence is needed, and Washington cannot do it alone.

To build support for this effort within the state and to participate in a broader national effort with a more unified voice, Washington state could form a permanent task force or advisory committee. The individuals involved would work through and resolve outstanding concerns prior to moving these concepts forward at the national level as required to meet the standards for updating billing codes. Such an advisory committee would serve two purposes: to be a collaborative place to build statewide support, and to serve as the point of coordination among the other national stakeholders that would be working towards the same broader objectives.

Medicaid and commercial billing

As detailed in the roadmap, the process to undertake an update to the national ICD billing codes is federally regulated and would involve many partners outside the state of Washington. If Washington state wishes to play a lead role in this endeavor, a lead agency could be designated to coordinate state participation in the lengthy and complex national process. The process to update or develop these new billing codes is a prerequisite for subsequent steps in the roadmap.

Medicaid and Section 1115 waiver

Once new federal ICD codes have been created, Washington state would need to approve Medicaid coverage for DVIT. The Washington State Health Care Authority would need to classify it as a medical necessity, which would require a new or amended state mental health parity law. More specifically, amending the definition of "Medically necessary" in RCW 48.43 to include Domestic Violence Intervention Treatment explicitly.[64]

Credentialing

The state may direct an agency to create a new credential for DVIT providers. At the time of writing this report, a new credential is not warranted or needed for insurance or Medicaid billing purposes prior to changes at a federal level.

Insurance rulemaking

Once new federal ICD codes have been created, changes will be required in the Office of the Insurance Commissioner (OIC) through rulemaking. The rulemaking process takes one to two years, during which the OIC will ensure that any RCWs and WACs are updated to reflect any necessary changes required to ensure coverage. This rulemaking process takes place through a petition[65] and requires input from stakeholders, a public hearing, and a period of open comment.

[64] Chapter 227, Laws of 2025.
[65] Petition for Adoption, Amendment, or Repeal of a State Administrative Rule.

Barriers identified by the workgroup

Overarching barriers

The DVIT workgroup brought together a set of diverse interests and professional experiences in public health as it relates to DVIT. Members were supportive of the use of DVIT and of efforts to increase its use and availability throughout the state. Through the course of this research and workgroup meetings, however, workgroup members consistently and overwhelmingly were less supportive of pursuing Medicaid and commercial insurance billing as a method to increase the use of DVIT. Some of the concerns are outlined below, detailing complications in reimbursement rates, plan participation, and the lack of authorized providers. Workgroup members overwhelmingly were in favor of supporting DVIT as an option for violence intervention, but not through the Medicaid or commercial insurance systems as currently established.

Provider perspective

DVIT providers and participants in the listening sessions shared concerns about incorporating court-ordered DVIT into the Medicaid and commercial insurance systems.

Mental health providers face challenges with low Medicaid reimbursement rates, making it difficult for patients to access timely and sustainable mental health care.[66] [67] Providers often cap the number of Medicaid patients to remain financially viable. Due to low reimbursement rates, prior authorization requirements, claim denials, delayed payouts, audits, and administrative burdens, approximately 34% of psychologists in Washington do not accept any form of insurance.[68] [69] [70] Mental health providers on the workgroup confirmed these concerns and indicated they would not be likely to accept any form of insurance for DVIT services.

Currently, Washington has 65 state-certified DVIT providers with only three serving the highest-risk offenders. This shortage is driven by the overall lack of mental health professionals, high occupational burnout,[71] limited funding and overwhelming demand.[72] Most state-certified DVIT providers function on a private pay model, where participants pay out of pocket. Many providers offer a sliding-scale fee, but some participants still cannot afford these services.[73] If the state wishes to promote the increased use of DVIT through the Medicaid and commercial insurance billing systems, a commensurate effort will be needed to address the lack of qualified mental health professionals in Washington.

State-certified DVIT providers are most often sole proprietors and unable to afford the administrative costs associated with insurance and Medicaid billing. Many areas of the state lack state-certified DVIT providers, and since most IPV offenders are indigent and would rely on Medicaid if a new code were approved, this would create a potential financial strain and administrative burden for providers, which may lead them to limit or cap services or potentially end their practice. State-certified providers on the workgroup confirmed these concerns, with some indicating they would never accept insurance for their services due to these and other related complications.

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[66] WA mental health providers say insurance reimbursement isn't enough.
[67] Washington State Medical Association.
[68] American Psychological Association, "Insurance challenges limit psychologists' capacity to address ongoing mental health needs" (2025).
[69] Busch Susan, Ndumele Chima, Foster Christine, Kyanko Kelley. Patient characteristics and treatment patterns among psychiatrists who do not accept private insurance. (2019).
[70] Henry, Tanya. Fixing prior auth: Nearly 40 prior authorizations a week is way too many. American Medical Association (2025).
[71] Bahner, Angela and Berkel, LaVerne, "Exploring burnout in batterer intervention programs" (2007).
[72] ADHD Advisor, State with the biggest mental health care desserts (2024).
[73] This out-of-pocket expense may lead to courts not ordering DVIT treatment

Listening sessions with providers revealed a significant challenge in accessing survivor-centered education, which constitutes half of the required training for state certification in DVIT. This gap has been identified as a barrier to obtaining DVIT state-certified certification.

Court data and need for DVIT

Washington courts do not have a system to track IPV or separate it from domestic violence,[74] making it difficult to assess the need for DVIT. The lack of standardization could stem from IPV not being classified as a formal charge. Instead, related offenses—such as assault, harassment, or property damage are not linked to IPV unless explicitly documented. The absence of specific notations for court-ordered IPV treatments complicates efforts to track assessments and mandated interventions like DVIT, DV MRT, or other research practices.

Additional solutions identified by the workgroup

Better tracking of IPV and court-ordered treatment

Because court-ordered IPV treatment lacks a standardized recording system, it is difficult to determine the need for mandated treatment. Without proper tracking, assessing treatment needs, analyzing effectiveness, and understanding recidivism rates where DVIT is ordered is difficult. The absence of data also prevents tracking outcomes for offenders sentenced in courts that do not mandate treatment.

A standardized coding system for IPV cases would allow courts within Washington to better track court-ordered DVIT treatments, completion rates of these court orders, understand the treatment's impact on recidivism, and aid in determining the need for DVIT. This data would enable a cost-benefit analysis, and additionally improve understanding about the efficacy of treatment, support ICD/DSM updates, and potentially strengthen the case for DVIT insurance coverage. The Administrative Office of the Courts could develop this system[75] in collaboration with judges' associations.

Expand DVIT provider care networks

Providers identified the lack of survivor-centered education as a barrier to DVIT certification. To address this and increase the number of DVIT providers, they recommended the development of an online training database to provide information about courses on DV survivor services and DVIT education, benefiting both providers and DV victim advocates.[76] Stakeholders recommended that the Washington State Coalition Against Domestic Violence (WSCADV) and DSHS develop and maintain the database, with dedicated funding provided by the legislature.

Listening sessions revealed a significant gap in awareness among behavioral and physical health professionals regarding DVIT, revealing that many were not aware of the existence of state-certified providers, referral processes, and available DVIT treatment plans. To address this, the workgroup recommends incorporating a DVIT-focused training course into the Health Equity Continuing Education[77] series provided by the Department of Health (DOH). This mandatory training, required every four years, would educate a wide range of healthcare professionals on how to access and refer patients to DVIT providers. DOH and DSHS could develop and maintain this course, with dedicated funding provided by the legislature.

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[74] Conflating IPV and DV in court records was found to be an issue in previous reports to the Legislature - Domestic Violence Perpetrator Treatment: A Proposal for an Integrated System Response (ISR), (pages 25-33). June 2018.
[75] This system has previously been suggested in the 2018 report but was deemed too costly at the time- Domestic Violence Perpetrator Treatment: A Proposal for an Integrated System Response (ISR), (pages 25-33). June 2018.
[76] Zegree, Joan "Batterer's Intervention: What Every Victim Advocate Needs to Know" (2008). WSCADV.
[77] Department of Health, Health Equity Continuing Education.

Expand DVIT treatment by establishing fee-for-service contracts with DVIT programs

Funding fee-for-service programs would allow DVIT providers to offer evidence-based treatment for low-income individuals at free or reduced cost. Since the overwhelming majority of offenders ordered to DVIT treatment are indigent, this funding would directly benefit many people who could not otherwise afford DVIT services.

In a 2024 decision package submitted to OFM, DSHS estimated that $4.8 million in the 2025-27 biennium would allow for contracts with 55 state-certified DVIT programs. If funded, the program would have provided DVIT services for at least 639 individuals in its first year, ramping up over time to serve at least 2,462 individuals in FY29.[78] The funding was ultimately not included in the 2025-27 enacted budget.

Funding DVIT services for low-income participants will reduce violence, prevent homicides, and increase safety for victims and children. Funding treatment for low-income individuals supports public safety goals and improves equity for low-income individuals and families.

Conclusion

Ensuring sustainable access to DVIT is essential to breaking the cycle of intimate partner violence in Washington. DVIT has demonstrated effectiveness in addressing intimate partner violence while prioritizing survivor and public safety. Given its unique nature, it requires a dedicated diagnostic code to bill insurance plans and Medicaid.

While insurance and Medicaid could help expand access, significant financial and regulatory obstacles remain. Creating or modifying diagnostic codes for insurance and Medicaid involves complex federal policy changes and revisions to state mental health parity laws. These changes would require a significant investment of time and resources by state agencies, providers, advocates, and other stakeholders.

Ensuring access to DVIT for both providers and clients may require alternative solutions. Strengthening provider networks and expanding education opportunities could help grow Washington's DVIT system, making treatment more accessible and affordable. Improved court record-keeping would allow for a more accurate assessment of DVIT needs, leading to effective treatment strategies that enhance public health and safety.

Expanding provider networks and streamlining access to DVIT are critical for long-term success. A deeper understanding of the demand, achieved through better court data, will support efforts to break cycles of violence and better protect communities throughout Washington.

[78] Dept of Social and Health Services - Program 060_Economic Services Administration - 2025-27 Regular Budget Session Policy Level_U9_DV Intervention Treatment

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Table 1: DVIP vs. DV MRT vs. Anger Management[79]

	DVIP	MRT-DV	Anger Management
State certification required?	Yes	No	No
Risk/Needs Assessment Required?	Yes	No	No
Input required from victims?	Yes	No	No
Associated laws/regulations	RCW 43.20A.735 WAC 388-60B	None	None
Special training required to conduct?	Yes	Yes	No
Continuing education required?	Yes	No	No
Credentials required to facilitate?	Counseling credential from DOH	No	No
Behavior change required to complete?	Yes	No	No
Addresses underlying trauma?	Yes	No	No

[79] This table comes directly from Dr. Tara Richards' research and preliminary results in the Domestic Violence Intervention Project through Seattle Municipal Courts.

Figure 1 - DVIT Education and Provider requirements[80]

Trainee level requirements

Be currently Licensed or registered as a counselor under Chapter 18.19 RCW

Be in good standing with DSHS

Have a **bachelor's degree** from an accredited university in counseling, psychology, social work, or a similar services related field.

Have a minimum of **thirty hours** of domestic violence training from an established **domestic violence victim or survivor** services program

AND

Have a minimum of **thirty hours** of training on the provision of domestic violence intervention assessment and services, provided by an established and certified **domestic violence intervention treatment services program or other organization**

TRAINEE LEVEL QUALIFICATION COMPLETED

Staff level requirements

Have a minimum of **fifty hours** of experience **working with victims** of domestic violence

Have a minimum of **fifty hours** of supervised, direct treatment **services to domestic violence** participants in a certified **domestic violence treatment program**.

STAFF LEVEL QUALIFICATION COMPLETED

Note: Each direct treatment staff must complete a minimum of twenty hours of cornuting education each year after the program is certified, or each year the staff person is added to the staff list.

Supervisor level requirements

Have at least **one hundred hours** of experience working with **victims** of domestic violence.

AND

Have a minimum of **two years of experience in facilitating domestic violence intervention** treatment groups at a certified program. At least **two hundred and fifty hours** of direct treatment contact with participant in a certified **domestic violence intervention treatment program**.

SUPERVISOR LEVEL QUALIFICATION COMPLETED

Note: A supervisor must have a **master's degree** from an accredited university in counseling, psychology, social work or similar field.

[80] This information comes directly from WAC 388-60B-0210, WAC 388-60B-0230, WAC 388-60B-0240, WAC 388-60B-0250, WAC 388-60B-0270.

Appendix A: Medicaid Reimbursement Rates

Current average rates for state certified DVIT[81]
Assessment (Criminal Court): $326.39

Assessment (family-court referral): $838.33

Group Therapy (per session): $46.39

Individual Therapy (per session): $90.58

Maximum Allowable Fee for Medicaid Reimbursement[82]
Assessment (behavioral identification): $19.17

Assessment (behavioral identification supporting assessment): $60.00

Group Therapy (per session) The average group size is 8, so rates for 6+ applied: $9.06

Individual Therapy: $12.65

[81] Data provided by DSHS of 2024 average rates for state certified providers
[82] Washington State HCA Treatment Fee Schedule (2024).

Appendix B: Terminology Defined

Behavioral Assessment: Contains demographic information and a detailed description of the participant's history of violence in familial relationships, as the perpetrator and victim (including sexual assault). Also included are active or expired protective orders, parenting assessments (including complete supervision orders), and history of parole or probation. The evaluation of the participant's views on current and past violent incidents include but are not limited to their thoughts and feelings towards their victim(s), any information collected from these incidents such as victim advocate statements, 911 calls, and any information the victim would like applied to their assessment is also taken and documented.[83] The treatment plan and level for each participant consider acute and critical factors for lethality in recidivism.

Behavioral Health Administrative Services Organizations (BH-ASOs): These organizations can provide services to help clients access mental health or substance use disorder (SUD) treatments. BH-ASOs are funded through state and federal block grant funding.[84]

Centers for Medicare and Medicaid Services (CMS): Agency within the U.S. Department of Health and Human Services that administers health programs, including Medicare, Medicaid, Children's Health Insurance Programs, and the Health Insurance Marketplace.

Claim Denial: When an insurance claim made by an insured person(s) is denied by their insurance (including Medicare, or Medicaid). There are several reasons why an insurance claim may be denied.[85]

Diagnostic and Statistical Manual for Mental Health Disorders (DSM): A handbook used by healthcare professionals in the United States as a guide to diagnose mental disorders. The DSM contains symptoms, descriptions, and other criteria for diagnosing mental disorders.[86]

Domestic Violence (DV): Involves physical harm, bodily injury, assault, or the infliction of fear of physical harm, bodily injury, or assault by an intimate partner, family member, or household member.[87] Also included are nonconsensual sexual conduct, nonconsensual sexual penetration, coercive control, unlawful harassment, or stalking by an intimate partner, family member, or household member.[88]

Domestic Violence Intervention Program: A DSHS certified program providing domestic violence assessments or intervention treatment to perpetrators of intimate partner violence.[88]

Domestic Violence Intervention Project (DVIP): This multidisciplinary treatment program within Seattle Municipal Courts provides treatment to level 1-3 offenders. It involves collaboration between DVIT counselors, probation officers, court personnel, community partners, researchers, and informal advisory members. The program also examines the effectiveness of Domestic Violence Intervention Treatment.[89]

Domestic Violence Intervention Treatment (DVIT): A Washington state-certified court-ordered therapeutic program designed to address intimate partner violence. These services focus on increasing safety for the community and victim(s) while increasing rehabilitative efforts for the perpetrator to reduce rates of recidivism. The Department of

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[83] WAC 388-60B-0400:
[84] Washington State Health Care Authority. Behavioral Health - Administrative Service Organizations Fact Sheet.
[85] Washington State Office of the Insurance Commissioner.
[86] Kulpinski, Amber, Bank, Stella, and Blasdell, Raleigh (2023). Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and Domestic Violence. In: Shackelford, T.K. (eds) Encyclopedia of Domestic Violence. Springer, Cham.
[87] Chapter 7.105, RCW 7.105.010: Definitions. (Effective until July 1, 2025).
[88] WAC 388-60B-0015.
[89] Seattle Municipal Court, Domestic Violence Intervention Project.

Social and Health Services (DSHS) sets and maintains treatment standards, including staff qualifications, treatment modalities, continuing education requirements, and focus of treatment.[88]

DVIT Continuing Education: This is a requirement for training for DVIT providers and service programs with DSHS certification to be completed annually. The training must include ten or more hours on DVIT, nine or more hours on DV Victim Services, and one or more hours on suicide prevention. Providers who facilitate Level 4 are required to complete an additional four or more hours of continuing education bi-annually. This supervisor specific training must cover criminogenic factors, risk issues, psychopathy, and related topics.[90]

Domestic Violence Moral Reconation Therapy (DV MRT): This is a workbook-based domestic violence treatment used as a primary treatment method by many programs for perpetrators. The workbook, "Bridging Peace to Relationships," is divided into 24 modules to be completed within six months in open-ended group settings. Correctional Counseling, Inc. provides training to become a DV MRT Facilitator, which requires a four-day, 32-hour training.[91]

Health Equity Continuing Education: The Department of Health (DOH) has implemented Chapter 276, laws 2021. The law requires that health care professionals be credentialed under Title 18 RCW, and subject to continuing education requirements, complete health equity continuing education training. This training must be taken at least once every four years. The department, in consultation with health profession boards and commissions, was required to adopt model rules but can adopt rules that exceed the minimum standards.[92]

International Classification of Diseases (ICD) Codes: A standardized system used to classify and code diagnoses, symptoms, medical conditions, morbidity data, and procedures in healthcare.[93]

Intimate Partner: The spouse, state-recognized partner, romantic partner, or date of another person presently or in the past. Also included is any person who has one or more children in common with another person, regardless of whether they have been married, in a domestic partnership with each other, or lived together at any time.[88] All therapeutic processes discussed within this document are solely utilized for intimate partner violence.

Intimate Partner Violence: Is abusive behavior that is used by one intimate partner against the other and can include, but is not limited to, a categorization of domestic violence offenses as defined in RCW 10.99.020. Examples of offenses include physical, sexual, emotional, verbal, psychological, and economic abuse. It can also include coercive control, which is the infliction or threat of harm against an intimate partner and is directed at achieving compliance from or control over that intimate partner. Also included is the improper use of children to control the victim.

Level of Care: Is the treatment plan a participant is recommended, required, or currently receiving as determined by a certified program through a behavioral assessment, standardized testing, and the "risk, needs, and responsivity" form.[88] The level of care can range from one to four and corresponds to a set time-period of treatment, with level four being treated by supervisors only. This treatment plan can be updated at any time based on the participant's needs, other criminal or civil charges, contact with the victim, and/or other pertinent information obtained by the provider.

- Level 1: Minimum 6 months of treatment (26 weekly group or individual sessions)
- Level 2: Minimum 9 months of treatment (39 weekly group or individual sessions)

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[90] WAC 388-60B-0270.
[91] Correctional Counseling, Inc., Domestic Violence - Moral Reconation Therapy - MRT.
[92] Department of Health, Health Equity Continuing Education.
[93] National Center for Health Statistics, Classification of Diseases, Functioning, and Disability.

- Level 3: Minimum 12 months of treatment (52 weekly group or individual sessions)
- Level 4: Minimum 18 months of treatment (78+ weekly group or individual sessions)
- Level 4 can only be treated by Supervisors who receive additional training and continuing education.

Managed Care Organizations (MCO): A health plan that uses managed care to provide healthcare while controlling costs. MCOs in Washington State are Amerigroup, Coordinated Care, Community Health Plan of Washington, Molina, Wellpoint, and United Healthcare.[94]

Medicaid Pilot Project: Tests new approaches to improve care and services for Medicaid beneficiaries.[95]

Medical Necessity: A requested service that is determined necessary to prevent, diagnose, correct, cure, alleviate, or prevent worsening of conditions in the client. These conditions endanger life, cause suffering and pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. The requested service must be demonstrated or proven that there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service.[96]

Medically Necessary: A service or product addressing the specific needs of the patient, for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is: in accordance with generally accepted standards of mental health and substance use disorder care; clinically appropriate in terms of frequency, extent, site, and duration of service or product; and not primarily for the economic benefit of the insurer or purchaser or for the convenience of the patient.[97]

Prior Authorization: When a health plan requires healthcare providers get approval prior to providing healthcare services or prescribing prescription medication.[98]

Preventative Services: Refers to the section in the Medicaid State Plan that outlines the requirements for providing Community Health Worker services as a type of preventative care, which must be recommended by a licensed practitioner.[99]

Promising practices: Programs and strategies with scientific research or data showing positive outcomes in delaying a negative outcome but aren't yet generalizable to a broader population.[88]

Sex Offender Therapy Provider (SOTP): a certified affiliate sex offender treatment provider who is licensed as a psychologist, marriage and family therapist (including associate), social worker, mental health counselor (including associate), independent clinical social worker associate, advanced social worker associate, or psychiatrist as defined in RCW 71.05.020.

Stipulated Order of Continuance: A pretrial diversion agreement where the defendant agrees to certain conditions. If those conditions are met, the case is dismissed at the end of the agreement period.[100]

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[94] Healthier Washington Collaboration Portal, MCO Collaborative Workgroups.
[95] Washington State Medicaid Transformation Project 2.0 Demonstration, Section 1115 Quarterly Report.
[96] Washington Advisory Code 182-500-0070.
[97] Engrossed Second Substitute House Bill 1432.
[98] National Association of Insurance Commissioners, What Is Prior Authorization?
[99] Medicaid State Plan - Attachment 3, General Provisions.
[100] "Criminal Case Dispositions", Chapter 7, Domestic Violence Manual for Judges (2015 Version, Updated 2016).

V Codes: identify issues that focus on clinical attention or affect the primary diagnosis, course of treatment, or prognosis of the patient's condition. V, W, X, and Y codes describe an environmental event causing injury but do not describe the nature of the injury and can't be utilized for primary diagnosis.[101]

Victim services program: A nonprofit program or organization that primarily provides information, assistance, and advocacy for domestic violence victims through medical, legal, immigration, human services, and financial assistance systems. The broad range of domestic violence services can include crisis intervention, individual and group support, referrals, safety assessments, planning, securing shelter, emergency transportation, self-help services, culturally specific services, legal advocacy, and economic advocacy. Not considered domestic violence services programs are those associated with or under the direct supervision of a court, law enforcement, a prosecution agency, or the child protective services section of the department as defined in RCW 26.44.020.[102]

Waiver 1115: is a demonstration project that allows the state to test new ways to deliver Medicaid and is also referred to as the Medicaid Transformation Project.[103]

Z Codes: do not diagnose a condition but indicate factors that can influence a patient's health status and contact with healthcare providers and/or services. Z codes are considered a social determinant of health or environmental factors, not the cause of the disease, injury, or justification for treatment, and therefore cannot be utilized for primary diagnosis.[104] [105]

[101] ICD-9-CV Official Guidelines for Coding and Reporting (2011).
[102] Revised Code Washington 26.44.020: Definitions, (Effective until July 1, 2025).
[103] Medicaid Transformation Project (MTP) Waiver 1115.
[104] Centers for Medicare and Medicaid Services, Office of Minority, Utilization of Z Codes for Social Determinants of Health among Medicare Fee-for-Service Beneficiaries (2019).
[105] ICD-10-CV Official Guidelines for Coding and Reporting (2019).

Appendix C: Glossary of Acronyms and Abbreviations

APA - American Psychological Association

BH-ASOs – Behavioral Health Administrative Services Organizations

C&E – Continuing Education

CMS – Center for Medicare and Medicaid

DOC– Department of Corrections

DOH- Department of Health

DSHS – Department of Social and Health Services

DSM – Diagnostic and Statistical Manual for Mental Health Disorders

DV – Domestic Violence

DVIT – Domestic Violence Intervention Treatment

DVIP – Domestic Violence Intervention Project

DV MRT – Domestic Violence Moral Reconation Therapy

HCA – Health Care Authority

ICD – International Classification of Diseases

IPV – Intimate Partner Violence

MCO – Managed Care Organization

MER – Medicaid Enrollment Ratio

NVDRS - National Violence Death Reporting System

SaH – Strength at Home

SOTP – Sex Offender Treatment Providers

SUDP – Substance Use Disorder Professional

USPSTF – United States Preventative Services Taskforce

Appendix D: 25 Core Competencies

The following core competencies are required for State-certified Domestic Violence Intervention Treatment Providers by the Washington State Department of Social and Health Services. After completing training,[17] providers should:

- Be able to explain different types of intimate partner violence, including common types of coercive and controlling behaviors
- Know the differences between DVIT and anger management treatments
- Be familiar with what victims hope DVIT can provide
- Understand your own biases and how to incorporate cultural competency into your DVIT program
- Be familiar with WAC 388-60B, where to find information you're likely to need, and what office to call for assistance
- Be able to explain why the legal status of a participant does not influence an assessment or treatment plan – see the participant, not their charge or lack thereof
- Be practiced and have skills for increasing victim safety, making contact with victims during the DVIT process, and protecting the confidential information victims may share
- Have an understanding of participant confidentiality requirements and when confidentiality must be broken
- Be familiar with what the latest research on DVIT tells us about the most effective treatment approaches
- Be able to identify, and have contact information for, your nearest coordinated community response group (or similar type of DV task force)
- Have a list of DVIT counselors who you can call for confidential case consultations and support
- Be familiar with your personal challenges as a counselor, and have a practice of self-care
- Be able to describe some common attributes and possible differences between participants in DVIT
- Be able to explain the RNR model and how it is adopted in the assessment, treatment plan and delivery of DVIT
- Know your treatment scope, determined by education, DOH credential, experience and training
- Be able to name various types of trauma-informed treatment models, explain the difference between trauma and complex trauma, and how DVIT is trauma-informed
- Have an understanding of what makes forensic counseling unique and how to prevent and manage collusion with participants
- Have experience facilitating a small group, and be knowledgeable about group treatment strategies and how to use them
- Be practiced in conducting a DVIT behavioral assessment and at least two types of risk and lethality tests for domain seven
- Be practiced in filling out an RNR form and creating a treatment plan
- Be able to explain the premise of cognitive behavioral therapy and be familiar with three CBT treatment models
- Have an understanding of the University of Washington Harborview curriculum and how to use the manual
- Have an understanding of how to document the cognitive and behavioral changes participants are required to make in DVIT
- Know the core competencies and completion criteria participants must meet in order to successfully complete DVIT
- Have experience writing a discharge summary and know how to assist participants with filling out the confidential feedback form when they are discharged from DVIT

Appendix E: Sequence of Events for DVIT - Referral to Discharge



Referral and Screening | **Behavioral Assessment and Victim Contact** | **Placement Levels 0-4** | **Treatment planning** | **DVIT Ancillary Treatment** | **Cognitive and Behavioral Changes** | **Discharge and Data Outcomes**

1) DVIT programs **screen referrals** to their program from courts, DCYF, probation departments, DOC and other sources. A DVIT program has the authority to accept or reject any referral for assessment or enrollment into its program (WAC 388-60B-0300 (1)).

2) The DVIT program conducts a **behavioral assessment** (WAC 388-60B-0400), which must include collateral information (WAC 388-60B-0400 (3)(a)), testing (WAC 388-60B-0400 (14)) and contacting the victim when they are able (WAC 388-60B-0325 (3)(a)). The assessment includes a diagnostic evaluation when it is completed by mental health professional practicing within their scope of practice (WAC 388-60B-0400 (10)(a)).

3) Once a behavioral assessment is complete, a Risk, Needs and Responsivity form is filled out for the client (WAC 388-60B-0400 (2)(a)) to determine which level of DVIT to recommend for **placement** (WAC 388-60B0410).

4) Before a client begins treatment, a **treatment plan** must be completed and be individualized for the client with measurable goals and objectives. The treatment plan must identify critical or acute factors and co-occurring treatments recommended or required for the client (WAC 388-60B-0405).

5) DVIT is facilitated in group or individual sessions (WAC 388-60B-0320 (2)). There are 15 areas of treatment focus the DVIT program must address in treatment (WAC 388-60B-0415). Clients must achieve **cognitive and behavioral changes** as well as core competencies in order to complete treatment successfully (WAC 388-60B-0430).

6) Once a client is discharged from DVIT, the program must complete a discharge summary which includes a summary of cognitive and behavioral changes the client demonstrated in treatment, the goals and objectives the participant met, the program's assessment of the client's current risk factors, any recommendations for treatment after discharge and the client's eligibility to return to DVIT if necessary (WAC 388-60B-0435 (4)). A **Data Outcomes** Form is given to the client to fill out anonymously and return to DSHS to track demographic information and some program effectiveness (WAC 388-60B-0125 (2)(f)). The anonymous data is analyzed by DSHS, compiled and then shared with DVIT programs.

Appendix F: The Need for DVIT

Prevalence of Intimate Partner Violence

Assessing the actual need for Domestic Violence Intervention Treatment (DVIT) is challenging, in part because intimate partner violence (IPV) is often underreported. Victims may fear retaliation,[106] face stigma and victim blaming,[107] or struggle with economic dependency and financial constraints,[108] all of which deter reporting. Additional factors—including concerns about privacy, socio-economic status, cultural influences, mandatory arrest policies, inadequate legal consequences, and distrust in reporting systems—further contribute to underreporting.[109]

Marginalized populations, in particular, experience higher barriers to reporting, making it even more difficult to estimate the true need for DVIT and identify victims of IPV.[110] Research and workgroup findings highlight these challenges, showing that underreporting skews available data. Additionally, the lack of standardized reporting within Washington Courts makes it even harder to accurately assess the demand for DVIT and ensure appropriate intervention.

The Washington State Department of Health (DOH) reports that 1 in 8 Washington adults report having been injured by an intimate partner.[111] The National Coalition Against Domestic Violence reports that approximately 41.4% of women and 31.7% of men in Washington have experienced domestic violence at the hands of an intimate partner. According to the Washington Association of Sheriffs and Police Chiefs, 64,554 domestic violence offenses were reported in 2023,[112] making up 13.7% of all violent crimes reported within Washington. The most recent data provided by the National Domestic Violence Hotline shows that 7,624 contacts reporting DV incidents were made to the hotline from Washington in 2023.[113] When we consider that these numbers are under-reported, the lack of tracking of those who need DVIT treatment and survivor services becomes more dire.

A research gap identified was the absence of updated data on Intimate Partner Violence (IPV), including its lethality and the demographic groups most affected by IPV in the aftermath of COVID-19. The data presented here represents the most up to date research currently available.

Fatalities of Intimate Partner Violence

A recently published cross-sectional study[114] of the National Violence Death Reporting System (NVDRS) found that of the 7,352 intentional violent deaths reported in Washington between 2015-2022, 12.9% had known DV histories.[114] Of the group with known DV histories, 44% had prior contacts with social services or the legal system, with civil protection orders and calls to 9-1-1 being the most common. Circumstances of DV were most common among females who died by homicide, 204 of 312 females who died by homicide (65.4%) died in connection to DV compared with 156 of 880 males who died by homicide (17.7%). Among suicides, proportions with DV

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[106] Sefton Women's and Children's Aid, Why is domestic abuse often not reported?
[107] Connection for Abused Women and Children, Stigma and Domestic Violence (2023).
[108] Gurum, Balbier and Marchbank, Jennifer "Chapter 8: Why Survivors Don't Report" (2020).
[109] YWCA Spokane "Barriers to Reporting" (2024).
[110] Heron, Rebecca, Maarten, Eisma. "Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research" (2021).
[111] Washington State Health Assessment (2018).
[112] Washington Association of Sheriffs and Police Chiefs, Crime in Washington Annual Report (2023).
[113] This is voluntary reporting data requested from the national domestic violence hotline for the calendar year from contacts who reported their location as WA state. These years were chosen to represent data post COVID 19.
[114] Kafka Julie, Adhia, Avanti, Martin, David, Mustafa, Ayah, Rowhani-Rahbar, Ali, and Rivara, Frederick "Deaths Related to Domestic Violence in Washington State" (2024).

circumstances were similar for males (468 of 4701 [10.0%]) and females (120 of 1459 [8.2%]). When children under the age of 10 were killed in a homicide, DV was common most of the time, (47 of 51 [92.2%]).

Non-fatal strangulation, often referred to as "the last warning shot"[115] was only recently identified as one of the most lethal forms of IPV despite being a strong indicator of DV-related homicide by firearm. Washington State defines non-fatal strangulation as compressing a person's neck to obstruct blood flow or breathing or doing so with the intent to cause such obstruction.[116] No hospital or emergency facility costs for examining a domestic violence victim of nonfatal strangulation, when conducted to gather evidence for prosecution, shall be billed to the victim. These costs are covered by the state under RCW 7.68.803.[117] In 2022, the Crime Victim's Compensation Program received 77 claims related to non-fatal strangulation in cases of IPV.[118] Homicides in the United States by violent partners with a firearm have increased by 36% between 2014 and 2023.[119] It is estimated that gun violence costs Washington an average of $5.3 billion every year and perpetrators of IPV use firearms more often than other weapons combined.[120] In Washington State, American Indian, and Alaska Native women are our highest-risk population for gun violence and IPV, and are 2.8 times more likely to die at the hands of an intimate partner.[121] IPV-related homicides and crimes are costly to our communities and an economic burden felt throughout the state. The message is clear: intimate partner violence is devastating our communities, is costly to Washington, and that ending these cycles of violence is a life and death situation.

Domestic Violence Intervention Treatment and Courts

Although IPV has been recognized as an issue within Washington courts for over 30 years, DVIT as a form of treatment, often court ordered, is far more recent.[122] Washington Administrative Code (WAC) 388.60B, which outlines the criteria for state-certified providers, programs, and staff, was comprehensively updated in 2018, with more minor updates in 2019 and 2025. WAC 388.60B outlines procedures for DVIT services in meeting court orders, assessing lethality and risk, competencies required for clients/perpetrators, level of care, and an advisory committee containing court personnel. As recently as 2023, an 82% reduction in abusive behaviors[123] was self-reported by participants at the completion of DVIT state-certified programs. Although DVIT is successful, it is not the most court-ordered treatment, due in part to cost.

Charges and cases related to IPV are heard in County, Municipal, and Superior courts, spanning both criminal and civil litigation. The most common outcome for individuals convicted of domestic violence offenses is being placed on supervised probation for two years.[124] The court may also order court-ordered therapies such as DVIT, parenting classes, alcohol or drug classes, and/or sexual deviancy treatment depending upon the charges. Nearly 2.4 million domestic violence cases were filed in Washington State's criminal courts between 2001-2012 with 78% of those being misdemeanor offenses.[125] DV convictions are the greatest predictor of future criminal acts and violent

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[115] Alliance for Hope International, Strangulation 101: The Last Warning Shot.
[116] RCW 9A.04.110.
[117] RCW 7.68.803 Nonfatal strangulation - Payment of costs for medical examination. Prior to 2022, treatment for non-fatal strangulation was not explicitly compensated for crime victims.
[118] Senate Bill Report SB 5070.
[119] Everytown Research analysis of FBI Supplemental Homicide Report (SHR) data from 2014–2023 (2024). America's Uniquely Lethal Intimate Partner Violence Problem.
[120] Women's Commission, Washington State, Biennial Report 2021 - 2022.
[121] Washington State Coalition Against Domestic Violence, Washington State Domestic Violence Fatalities Involving Native People in Washington State (2012).
[122] DSHS has established and monitored DVIT standards since 1991 (Engrossed Substitute Senate House Bill 1884, Section 7 (Pg 14)) - but it is unclear how long courts have ordered treatment in Washington.
[123] SELF-reported BY PARTICIPANTS at the completion of state-certified DVIT programs
[124] Seattle Municipal Court, What Happens in Cases.
[125] Washington State Institute for Public Policy, Recidivism Trends of Domestic Violence Offenders in Washington State (2013).

crimes;[126] however, these cases are notoriously difficult to prosecute, under-reported, and often result in pleas or stipulated order of continuance (SOC).

Data provided by the Administrative Office of the Courts (AOC) shows that from 2023-2025, 1,937 Defendants in IPV cases were pled and proved guilty,[127] while 2,656 were either dismissed, awaiting sentencing, or unknown at the time of this report. Prior to 2023, there was little to no information available on ordered therapeutic treatment in IPV cases. Previous reports to the Legislature have highlighted the challenges in assessing the need for DVIT because IPV and DV are not distinctly categorized or flagged within the Washington Court System.[128] This lack of separation may create the false impression of fewer IPV cases when, in reality, they simply go unmarked in official reporting.

During the data-gathering process, the Administrative Office of the Courts (AOC) confirmed that IPV and DV are not separately categorized. These crimes are not flagged or marked as IPV or DV in sentencing. This absence of distinct data makes it difficult to assess the need for treatment, analyze recidivism rates, or determine the specific type of treatment a defendant has been ordered to complete. Additionally, it complicates efforts to evaluate the demand for insurance or Medicaid coverage and assess the cost-benefit implications of modifying insurance and Medicaid billing practices.

Promising Practices and Research

Promising Practices, as described in WAC 388-60B are programs or strategies that have illustrated a reduction in domestic violence perpetration, but the research and/or data are not yet generalizable to the broader state population. Meaning that these practices are typically offered or monitored by outside researchers to determine the most efficient, cost-effective, and evidence-based approaches are used within Washington State. A promising practice being utilized within Washington is the Domestic Violence Intervention Project (DVIP) Table 2: DVIP vs. DV MRT vs. Anger Management. Unlike DVIP, a promising practice, Strength at Home (SaH) and Internal Family Systems (IFS) are research projects that have been granted exceptions to the requirements to comply with standards under WAC 388-60B specifically for research purposes only. Unless otherwise stated, there is also no state regulatory agency overseeing current research detailed within this section.[129]

The Domestic Violence Intervention Project (DVIP) differs from Internal Family Systems (IFS) and Strength at Home (SaH) because it follows the regulations put forward in WAC 388-60B, to meet state-certified requirements of DVIT treatment. This research project is being conducted by University of Nebraska Omaha and the Urban Institute, operating within the Seattle Municipal Courts.[130] DVIP is unique in its approach, as it integrates court personnel into the assessment process and establishes a 'treatment team' led by a state-certified DVIT provider.[131] This occurs before the standardized treatment required under state-certified DVIT programs (Appendix E: Sequence of Events for DVIT - Referral to Discharge). The multidisciplinary approach incorporates probationary services, state-certified DVIT counselors, advocates for the victim, a DVIP coordinator, and community advisors. Preliminary data from Seattle Municipal Court indicates that individuals who completed the DVIP program exhibit significantly lower recidivism rates compared to those who began the program but did not finish. Among DVIP

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[126] Washington Association of Prosecuting Attorneys and the King County Prosecuting Attorney's Domestic Violence Unit, Prosecutors' Domestic Violence Handbook (2017).
[127] Administrative Office of the Courts pulled all data in which DV Assessment or Treatment was ordered. Because no standardization for this order exists, this data may not represent those who were ordered but instead gaps in recording.
[128] Domestic Violence Perpetrator Treatment: A Proposal for an Integrated System Response (ISR), pg 25-33. Report to the Washington State Legislature (2018).
[129] Domestic Violence Intervention Program (DVIP) is overseen by Seattle Municipal Courts
[130] Richard, Tara, Wright, Emily, and Nystrom, Alyssa, "A Formative Evaluation and Evaluability Assessment of the Seattle Domestic Violence Intervention Project" (2025).
[131] Domestic Violence Intervention Project - Seattle Municipal Courts.

completers, only 15% committed a new crime (4% non-DV; 9% DV-related offenses), whereas non-completers had a recidivism rate of 52% (20% non-DV; 28% DV-related offenses).

Strength at Home (SaH) has been granted an exception to WAC 388-60B during a clinical trial. The randomized control trial is currently being conducted by the University of Boston and funded under Sec. 126 (137(b)) of Chapter 376, Laws of 2024. SaH focuses on treating trauma and explaining how IPV is learned behavior. SaH ranges in duration from 12-26 weeks and is carried out by those certified by the primary program developer and his staff.[132] The SaH model focuses on developing offender accountability through group sessions, with the aim of encouraging perpetrators to change their behaviors and reduce violent or controlling behaviors. Results from previous controlled trials with military/veteran populations show a decrease in IPV recidivism. Currently, SaH accepts offenders at all levels. However, they do not conduct assessments, which may result in the levels of offenders being unknown within their study. In June of 2025, the clinical trial in Washington state will conclude, and the initial results will be provided by researchers to the Office of Crime Victims Advocacy.

Internal Family Systems (IFS) is another research project in its pilot phase being conducted by researchers at Harvard University in Washington state and funded under Sec. 126(137(b)) of Chapter 376, Laws of 2024. This program has current state-certified DVIT providers observe group therapy sessions and become trained in these services. IFS focuses on the self and helps "people heal by accessing and healing their protective and wounded inner parts."[133] While IFS has demonstrated positive results in other settings, this is the first time it will be used to treat IPV perpetration. Similar to SaH, IFS does not include a DVIT assessment of risk, needs, and responsivity and therefore takes all levels of offenders. In June of 2025, the pilot study in Washington state will conclude, and the initial results will be available.

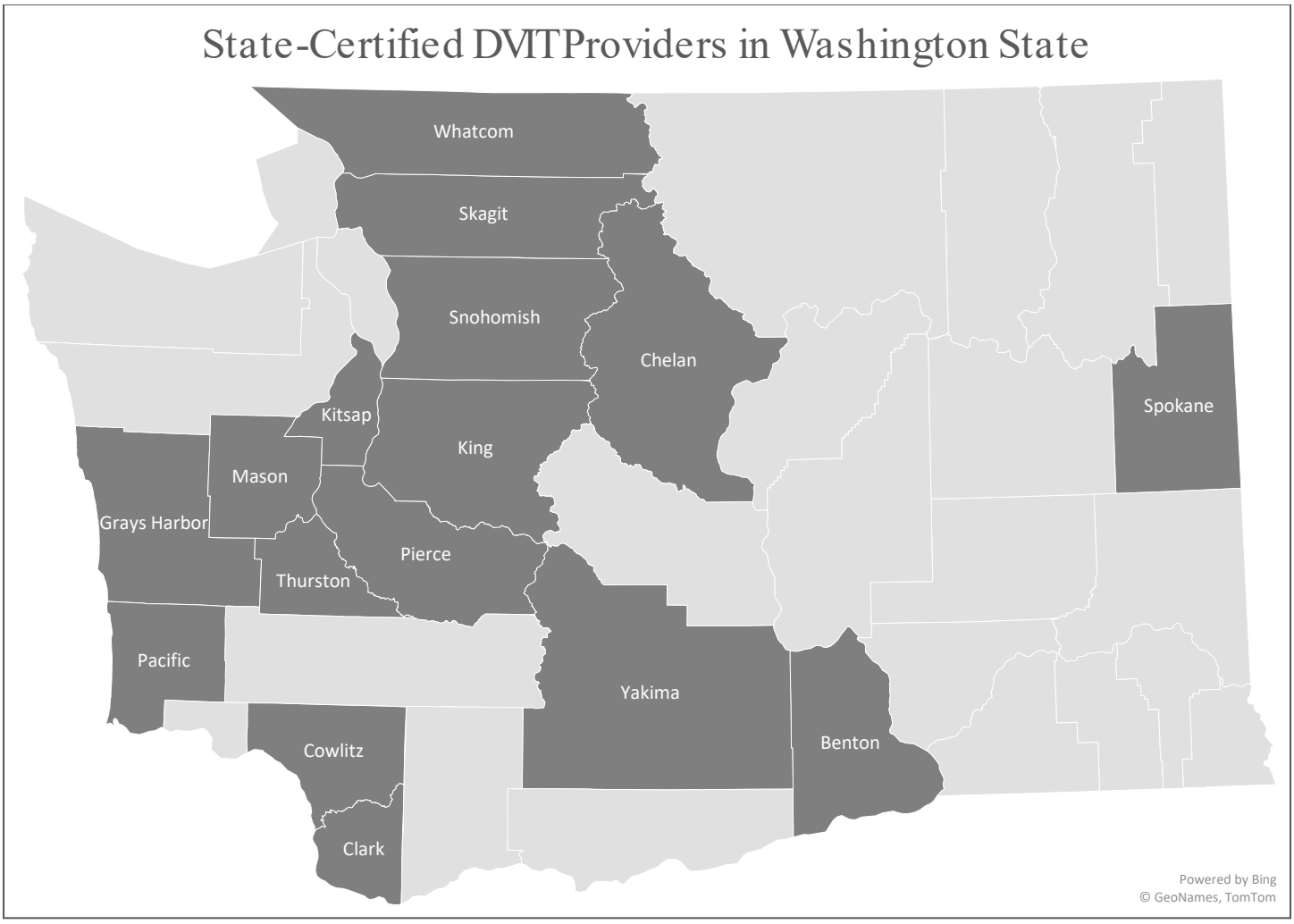
Domestic Violence Moral Reconation Therapy[134] (DV MRT), once a research project in Washington, this form of therapy is now the most widely used form of court-ordered intervention for IPV offenders in Washington. This program is usually carried out by an individual working in Probationary Services. The program is six months in duration, does not have an assessment, and is work-book based. The average cost is $135 for the entire 6-month long program and workbook. Although initial results were promising, "research showed that DV-MRT became less effective in the second year", though the treatment group still showed better outcomes than the comparison group receiving no therapy. The study authors recommended further long-term evaluations.[135] However, these evaluations were never completed, leaving a gap in understanding the long-term effects of this treatment.

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[132] Strength At Home.
[133] Internal Family Systems Institute.
[134] "The term "moral" refers to moral reasoning based on Kohlberg's levels of cognitive reasoning. The word "reconation" comes from the psychological terms "conative" and "conation," both of which refer to the process of making conscious decisions. MRT is a cognitive-behavioral treatment system that leads to enhanced moral reasoning, better decision making, and more appropriate behavior."
[135] Washington Courts: Press Release Detail. Gender and Justice Commission Research Finds Domestic Violence MRT Treatment is Effective, Low Cost (2022).

Appendix G: Map of State-Certified DVIT Providers

This map was created using the list of state-certified DVIT providers maintained by DSHS.[136] While state providers are limited in geographical location in Washington, DVIT can be offered virtually and is therefore accessible throughout the state.



[136] DVIT Programs by County.