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Frequently Asked Questions on Revised DVOMB Standards

FAQ

1-26-11

DVOMB Staff are available for technical assistance and to come to your community as well to provide assistance. Please contact our office for more details.

1.Question: What options are there to obtain free of charge the offender's criminal history?

Response: Sometimes Probation will provide a summary of the criminal history. Providers have the option of inquiring whether the District Attorney's office will provide a copy of the discovery packet. For a minimal fee, the Colorado Bureau of Investigations (CBI) website will provide a Colorado criminal history. The computerized criminal history (CCH) database contains detailed information of arrest records based upon fingerprints provided by Colorado law enforcement agencies. The website for this service is <http://cbi.state.co.us/id/> (click on CBI Internet Background Checks). Offender self-reports are not sufficient.

2.Question: What types of activities are considered a second clinical contact and what types are not?

Response: DEFINITION OF SECOND CLINICAL CONTACT FOR LEVEL B AND LEVEL C:

This clinical contact involves a therapeutic intervention and includes face-to-face therapy, individual sessions, group counseling sessions, treatment plan reviews, and crisis management. It does not include 12 step programs or other peer support groups.

The additional clinical contacts shall match the generally accepted best practices for addressing/treating the identified criminogenic need.

The purpose of this second clinical contact is to address risk factors identified on the DVRNA and/or the evaluation such as substance abuse or mental health issues. The second clinical contact might also include sessions to promote specific treatment goals or sessions to address specific competencies. The MTT shall ensure that the second clinical contact supports the offender treatment goals and the MTT shall approve that clinical contact.

The second clinical contact can be a domestic violence offender treatment session or can be treatment to address other criminogenic needs for example, substance abuse, mental health,

Strategies for Self Improvement and Change, or cognitive skills based treatment. The clinician shall be accepted as appropriate by the MTT based on the clinician's knowledge of domestic violence and the offender's treatment goals. The clinician shall also be part of the MTT and its communication to ensure that treatment goals are not conflicting and that they promote domestic violence offender treatment goals.

The second clinical contact sessions should typically be 50 minutes for individual sessions and 90 minutes for group sessions.

Discussion: There may be times during the treatment process where shorter second contact clinical sessions are indicated to provide check-ins and monitoring of specific issues, and/or when a standard second contact clinical session is prohibitive. The decision to provide a shorter second clinical contact session needs to be determined on a case by case basis, be time-limited, and must be approved by the MTT. These shorter second clinical contact sessions are intended to be rare and not for the duration of treatment.

3.Question: Do clients have to be sentenced before they can begin treatment?

Response: Clients who are not sentenced are considered voluntary clients. It is the decision of the treatment program whether they will accept “voluntary” clients.

4.Question: What should Providers do if a judge sentences someone to 36 weeks now with the revised *Standards* in effect?

Response: The MTT will have to make some determinations; one of which might be to inform the judge that the *Standards* have changed. If there is probation supervision, the PO can assist in determining whether or how to facilitate the communication with the judge. When communicating with the judge, refer to the sentencing statute (Title 18-6-801(1)(a), C.R.S.) that requires persons convicted of a crime, the underlying factual basis that has been found by the court to include an act of domestic violence shall be ordered to complete a treatment program that conforms with the *Standards*. The *Standards* do not specify a time frame.

5.Question: Do the *Standards* allow Providers to conduct an evaluation prior to sentencing and prior to pleading.

Response: The revised *Standards* continue to prohibit pre-plea evaluations. Title 18-6-801(1)(b), C.R.S., authorizes the court to order a treatment evaluation to be conducted prior to sentencing if the evaluation would assist the court in determining an appropriate sentence. When making a recommendation for treatment after performing a pre-sentence evaluation,

Providers need to clarify that the offender should attend and complete offender treatment. Furthermore, initial placement in treatment will be level A, B, or C and levels may change during treatment based on offender progress or changes in risk during treatment. Therefore, pre-sentence evaluations should not specifically state that an offender will “attend and complete A, B, or C” without the caveat of the possibility of level changes. In the rare event domestic violence offender treatment is not indicated, then *Standard 4.09 IV.E.3.D* must be demonstrated and criteria must be met.

6.Question: There have been concerns about Plea Agreements or Court Orders that are too specific. Do you have any suggestions how to deal with this issue?

Response: The MTT may want to review the court order and determine whether it needs to request a modification of the order. If a Plea or Court Order is too specific it may reduce the effectiveness of Probation and the MTT. The recommendation from the Judicial Department has been to keep the court orders general and to require the offender to attend and complete the evaluation and treatment according to *DVOMB Standards for Treatment with Court Ordered Domestic Violence Offenders*. As a Provider or as a member of the MTT you can provide education in your professional community on why this is important. You may want to educate the community on the role of the MTT and its related team decision making. Additionally you could provide information on the DVRNA the new risk assessment instrument, and the fact that it’s empirically based and used to guide these treatment decisions.

7.Question: Is there a timeframe designated when Providers must contact Probation after conducting the intake evaluation?

Response: *Standard 4.01* addresses the “Initial Contact.” If no time frame was included with the referral, the Provider shall notify the criminal justice agency within one week if the offender does not contact the Provider. However, there is no timeframe designated in the *Standards* for contact after an intake evaluation is conducted. A time frame was not included because it may be difficult for some Providers to obtain all the information necessary for the evaluation (e.g. criminal history).

Additionally *Standard 5.06III* refers to situations when the MTT does not have all the information necessary for initial placement. A Temporary Placement to treatment Level B may be indicated because the missing information may be related to risk factors. The MTT is required to make a determination within 30 days of the offender intake evaluation.

8.Question: Are Probation Officers required to conduct a SARA or is this assessment supposed to be completed by the Provider.

Response: Each judicial district has a policy concerning whether they will conduct the SARA on an offender and when they may conduct one. In certain circumstances Probation conducts the SARA and can forward the results to the Provider. In other cases when the SARA has not

been completed by Probation, the Provider will complete one. When Providers receive a SARA conducted by Probation they should update this and then communicate their findings to Probation.

9.Question: Can Probation or the Court override anything on the Client Contract or on the Core Competencies?

Response: The *Standards* do not direct the role of Probation or the Court. However, the *Standards* address MTT consensus and the need for these professionals to work toward agreement. Approved Providers and other MTT members may also design competencies based on offender risk or individual treatment needs. Additional competencies shall be approved by MTT consensus. But the Core Competencies are designed for all offenders. The only exception may be that the development of empathy is not appropriate for some psychopaths.

10.Question: Is it a requirement that Providers submit the completed DVRNA to Probation?

Response: Providers are being encouraged not to send the completed assessment instrument to non clinicians, including Probation. Generally accepted Standards of Practice for clinicians discourages sharing any assessment instrument. It is only appropriate to share the findings. Providers are required per the *Standards* to provide all MTT members with the findings from the DVRNA. Please refer to the document entitled ***Implementation Resources and Tools for the MTT, December 2010, Distribution of DVRNA Scoring Sheet and other Clinical Assessment Instruments***, which may be found on the DVOMB website under Standards, Implementation Resources and Tools.

11.Question: What are the expectations for payment of sessions conducted under the new treatment model that does not limit the number of weeks?

Response: All providers are required to offer a sliding scale (Title 18-6-802.5, C.R.S.) based on the offender's ability to pay. Payment for treatment is a component of accountability. Providers and the MTT should carefully consider the offender ability to pay and acknowledge that manipulation by the offender may be a tactic regarding paying for treatment. In addition, Providers may look for resources such as community based substance abuse treatment that may have funding for the indigent. There is no requirement in the *Standards* that Providers must offer treatment to those who cannot pay.

12.Question: Does the MTT have the authority to override the results of the DVRNA when Level C is indicated but the offender cannot afford the number of clinical contracts for this level.

Response: The MTT does not override the raw score of the DVRNA, but may override the findings of the DVRNA and level of treatment recommendation. However, The MTT needs to discuss this issue and find alternate avenues to temporarily accomplish the two contacts per week given the financial challenges. For example, are there resources available that the client needs that are free of charge or offered at a reduced rate? Also, is it possible for the Provider to provide treatment for the offender for 15 or 30 minutes temporarily for the second contract to address the issue of affordability and accountability? The MTT should not reduce the level to B because the offender cannot afford Level C. This is an inappropriate reason for an override.

13.Question: Is it the responsibility of the MTT to review and approve the Provider's scoring of the DVRNA?

Response: The concept is that the entire team (MTT members) knows the results of the evaluation and the DVRNA and then reaches consensus on the initial placement in treatment. MTT members are not required to sign the scoring sheet. The Provider needs to provide verification that all team members were contacted and in agreement.

14.Question: I understand that Domain A(1) of the DVRNA includes guilty pleas and deferred judgments. Does that mean that plea bargains to a lesser charge with a DV enhancer would be scored?

Response: Yes. Any arrest or conviction that was identified as domestic violence would be scored.

15.Question: I understand that Domain B requires a Division of Behavioral Health (DBH) approved screening instrument for drug or alcohol abuse. However, the only tool that identifies people as being substance abuse/dependent is DSM IV based. Since the SASSI and MAST are not DSM IV based, is it left up to interpretation?

Response: If an offender has been diagnosed with substance abuse or dependence [DVRNA Domain B(1)], it needs to have been assessed and evaluated with a DBH approved instrument and have met DSM criteria. The SASSI or MAST may assist in the evaluation for screening but are not sufficient instruments by themselves. If further assessment is indicated, the criteria defined in the DSM IV must be utilized.

16.Question: Many professionals believe that you cannot diagnose a DSM IV Axis I or II if you do not have a doctoral degree. I would appreciate a response to this issue.

Response: Title 12-43-201, C.R.S. (Mental Health Act – Department of Regulatory Agencies) defines the practice of psychotherapy to include diagnosis. However, all licensed and registered mental health professionals are prohibited from performing services outside of such person’s area of training, experience, or competence (Title 12-43-222(h), C.R.S.). It is the responsibility of each Provider to determine whether they have the training, experience, and competence to perform this type of diagnosis.

17.Question: Domain E refers to use and/or threatened use of a weapon in current or previous offenses. Is a cell phone considering a weapon or someone’s hands or feet?

Response: Cell phones or other objects may be considered a weapon. This domain is supported by the research based SARA risk factor that includes the definition of a weapon that include firearms, knives, and objects used as a club. The risk here is when someone uses an object directed at the victim intending to scare or do harm. Hands and feet are not considered a weapon, however, if someone had Martial Arts training and used that training the MTT could discuss the possibility of hands and feet being used as a weapon.

18.Question: Domain D of the DVRNA refers to suicide and/or homicide but Domain E refers only to the victim. If the offender threatens to kill himself if his girlfriend leaves him, how is this situation scored? Since he threatened himself and not his girlfriend, I am unsure how to score Domain E.

Response: In this situation it is unclear whether a weapon was used in front of the victim. It does need to be scored on Domain D for homicidal. Whether it is serious ideation and intent or ideation within the past 12 months will have to be determined. Regarding Domain E, if a weapon was used in front of the victim, then it would be scored as use of a weapon in the offense.

19.Question: Why is a domestic violence enhanced crime not included in Domain F?

Response: It is not included because Domain F is “Criminal History – Nondomestic Violence”. If it is domestic violence related, it is scored on Domain A.

20.Question: Certain domains in the DVRNA refer only to adult criminal history. If an offender has a former charge for false reporting at least 15 years prior and this information categorizes her in Level C, can a Provider use discretion if they believe the offender is not appropriate for Level C.

Response: Providers must score the DVRNA according to the facts and cannot use discretion. Only the entire MTT if they are all in agreement may override the treatment level determination, not the raw score. However, the actual score cannot be changed. The MTT identifies the actual score and explains why the offender will not be placed in that level. The reason must be justified in writing because it is contradictory to research, which was used to create the domains in the DVRNA.

21.Question: How would Domain H - Safety Concerns be reflected in a police report? The police responded to a telephone call but the victim was so scared she was unable to speak. Should that be interpreted as being concerned about her safety if she is the one who called the police or does she have to articulate that she is scared that he will hurt or kill her?

Response: Most likely, this domain will not get scored to protect the victim. But the police report may indicate that the victim reported the offender threatened her, that she was afraid, and/or that she was pregnant. Sometimes it is the excited utterances that are recorded. Do not assume anything in scoring any domain on the DVRNA. If it is not clear from the evidence do not score it.

22.Question: The DVRNA Domain H(2) Safety Concerns states “victim believes offender is capable of killing her.” Does this apply only to female victims? There is a case (documented in the police report) where the victim is male and his female partner, the defendant, threatened to kill him. Would Domain H(2) apply for male victims or should only domain H(1) be scored?

Response: Domain H(2) applies only to female victims for the purpose of scoring this instrument because the research is only validated for female victims. However, since we know anecdotally that this is a risk factor for male victims, it needs to be considered. Therefore, score the DVRNA without scoring this item. Then report this to the MTT and recommend that although the score of the DVRNA won't change, you recommend the MTT consider this information, and if appropriate, that the MTT override the placement findings and place this offender in a higher level of treatment. Domain D(1) or D(2) may need to be scored in this scenario because we have a documented homicidal ideation or intent. This needs to be explored further to identify how it would be scored on Domain D. Whether it is scored under Domain H(2) depends on whether the victim perceived this threat as credible.

23.Question: Regarding Domain J, do multiple offenses indicate implicit attitudes that support or condone spousal assault?

Response: No, one should not assume that multiple offenses imply attitudes. Information can be gathered from the evaluation and offender interview that would indicate the need to score this domain. The DVRNA is intended to be used as an ongoing assessment instrument.

24.Question: Regarding Domain K, if a client has been previously discharged for lack of payment, is it scored as a prior treatment episode?

Response: Yes, if it was from a prior offense. If it is the same offense, then the answer would be no.

25.Question: In this situation, an offender was previously convicted (2008) of domestic violence and sentenced to 36 weeks of treatment. He completed 34 of the 36 weeks and was discharged for absences and an outstanding balance. The offender returned to treatment and now expects to complete two treatments to satisfy the Court requirement. If he previously received a Deferred Sentence (client unsure) and the Deferred Sentence requires completion of 36 weeks of treatment, what would be the correct course of action? In completing the DVRNA, does the previous discharge from treatment count as prior non-completion of treatment if it is the same offense?

Response: Because the offender is re-entering treatment after two years, the current *Standards* would take priority and the offender will have to now complete treatment according to these *Standards*. Also, if the offender did not complete treatment in 2008, then Domain K of the DVRNA would not be scored because it is the same court order under which he is doing treatment.

26.Question: Can Level A and Level B clients be treated in the same group? For example, a female client is low Level B but fits well with Level A clients? Can she join the Level A group or is it necessary to create another group in the daytime for her?

Response: If the MTT agrees, the client could receive treatment with Level A clients.

27.Question: A Level C client is simultaneously attending classes for domestic violence and substance abuse. Who is responsible for ensuring that the client is having these two clinical contacts a week? Do the offenders need to submit documentation that they have attended or is it the responsibility of Probation or the Provider to ensure the classes are being attended?

Response: The Provider is responsible for ensuring that these clinical contacts take place. Additionally, the Provider is responsible for making sure that the other clinician is included as a member of the MTT and part of regular communication and consultation. The Provider and MTT will need progress reports and UA results as soon as they are available and reports from other clinicians regarding progress and success of treatment. There needs to be case management and treatment planning coordination between the clinicians so there are no

conflicts in treatment goals. The Provider should request information regarding absences and progress from the other clinician. This communication between the clinicians should be reported back to the MTT.

28.Question: Can a client participate in couples counseling with a partner who is not the victim?

Response: No, the *Standards* state that the offender cannot participate in couples counseling during domestic violence offender treatment.

29.Question: What are the consequences if an offender chooses couples therapy despite the prohibition in the *Standards*?

Response: The *Standards* require that as a condition of the Treatment Contract offenders are prohibited from participating in couples counseling. Offenders must sign this contract at the beginning of treatment. Therefore, offenders who choose couples therapy are in violation of their contract. The MTT needs to determine the consequences of this violation of the contract, which may include discharge from treatment. If the offender discontinues this treatment, there would be consequences in the treatment plan from the MTT for violating the condition of treatment. If the offender continues in couples therapy this would result in discharge.

30.Question: What if the offender is required by the Department of Social Services (DSS) to participate in couples counseling with his new partner?

Response: The *Standards* prohibit couples counseling if the offender is in domestic violence offender treatment. However, we recognize the challenges of the intersection of these two systems and currently have a committee addressing these challenges.

31.Question: What if the offender is required by DSS to participate in family counseling with the victim and children?

Response: The *Standards* prohibit couples counseling if the offender is in domestic violence offender treatment. The offender can participate in counseling with the children, but not with the victim. The DSS case worker will need to be included as a member of the MTT for sharing of information and for case management.

32.Question: There is a case that involves a DSS unification treatment plan that states the offender cannot have his children until he completes couples counseling with his wife (not the identified victim of record). This DSS plan states that the counseling will run concurrent with domestic violence offender treatment. Would *Standard 5.01* apply as it prohibits couples counseling while in offender treatment?

Response: The *Standards* do apply and couples counseling is prohibited. This is very challenging for DSS and the juncture between their responsibilities and mandates and the *Standards*. The *Standards* are not trying to prevent DSS from attaining their goals; however, a critical principle of the *Standards* is to maintain victim safety. The objective is to participate in case planning designed to assist everyone in reaching their goals in the safest way possible while the offender is in treatment.

33.Question: There is a DSS case that involves family counseling with the female (offender), her biological children, and the husband who is the identified victim. Is family counseling an option for this case?

Response: If the offender participates in family therapy without the victim (children only) then it is permitted.

34.Question: Can females and males be treated together strictly for educational portions of treatment?

Response: No