

Frequently Asked Questions on Revised DVOMB Standards

FAQ II

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.

Question (1): Can Providers use parenting classes as a second clinical contact as defined in *Standard 5.06(VIII)(B)* for Level C offenders.

The MTT should determine what is needed in terms of the second clinical contact. For offenders in Level C, the focus of the contact should be on the issues of greatest clinical need. Generally, parent classes should not be used as a second clinical contact unless determined by the MTT to be the greatest need.

Question (2) There is an intern in our agency who is providing individual therapy. Would this session fall under the definition of a second clinical contact?

Unless an intern is an Approved Treatment Provider, the intern cannot provide domestic violence treatment. However, the intern may be qualified to provide general mental health counseling for such issues as grief, codependency, or Dialectical Behavior Therapy (DBT). Please refer to the paper created by the Board on November 12, 2010 entitled *“Definition of Second Clinical Contact for Level B and Level C.”*

Question (3) For the second clinical contact for Level C offenders, I am using Moral Reconation Therapy (MRT) cognitive skills class. May I have both males and females in the same cognitive skills class or do they have to be gender specific?

If the second clinical contact is a group that clinically allows for mixed gender groups, such as substance abuse treatment or cognitive skills group, then it is acceptable to have both males and females in the same group.

Question (4) Can an intensive session with an offender’s Probation Officer qualify as the second clinical contact for Level C offenders?

No, contact with Probation is not a clinical contact and does not fulfill the requirement for a second clinical contact.

Question (5) For many Level C offenders it is a challenge to find sufficient funds for the second clinical contact. Do you have any suggestions how to address this problem?

This is an ongoing issue and one remedy may be the use of a sliding scale. Offenders can often find money for things that they are motivated to accomplish. Additional treatment to address risk and responsivity is beneficial; therefore we need to continue motivating offenders to value treatment and subsequently attempt to obtain money to pay for the second clinical contact.

Question (6) Can an offender's treatment be accelerated by doubling up on weekly treatment?

The previous *Standards* did not allow for doubling up on treatment sessions nor do the Revised *Standards*. Progress and treatment are unrelated to time. Progress in treatment is based on achieving treatment competencies, not completing a certain number of weeks. Therefore doubling up on the number of clinical contacts each week will not necessarily accelerate treatment completion. The idea of Level C is to provide more intensive treatment for higher risk offenders; not to accelerate their treatment so they can complete treatment sooner. Twice a week sessions are designed to mitigate risk and provide greater community safety. In Level B, the concept of that extra session once a month (at a minimum) is to address risk and not to accelerate treatment.

Question (7): In some areas of the State, the Court has been placing DV offenders on unsupervised Probation. Is there any information that you could provide that would assist us in explaining to the Court the impact of unsupervised Probation.

Title 18-6-801, C.R.S. (the domestic violence sentencing statute) requires that treatment program and treatment evaluation conform with the *Standards for Treatment with Court Ordered Domestic Violence Offenders (Standards)*. The *Standards* require an evaluation and treatment supervised by the Multi-disciplinary Treatment Team (MTT) of which Probation is a member. Subsequently, because the MTT is supervising the offender, any probationary period (or Deferred Sentence) is supervised by a Probation Department.

There exist areas of the State where offenders are not on supervised Probation. A suggestion would be for Treatment Providers to contact the judge to see who or how they want the Court's supervision represented on the MTT.

Question (8): Are victim advocates required to complete eight (8) hours of training for specific offender populations [Standard 7.03 (b)] if the Provider they work with only has one group of female offenders? Can the number of required hours be prorated?

No, the hours cannot be prorated. The Standard requires at least 8 hours of training. Even though a Provider has only one group of a specific-offender population, the knowledge required is still the same.

Question (9): A Protection Order was issued on an offender in 2010 (before the effective date of the Revised Standards) that included the condition of abstention from alcohol. Subsequently the offender tested positive for alcohol and was ordered to restart treatment in November 2010. Does a violation of a Protection Order [DVRNA Domain A(2)] that does not involve the victim qualify as a new offense; and consequently is placement in Level C mandatory?

A violation of a Protection Order does not constitute a new domestic violence conviction unless it involved a crime against the victim. Alcohol use would not be categorized as a crime against a victim. According to Domain A on the DVRNA, violation of a Protection Order indicates placement in at least Level B. The MTT then determines if the violation, on case by case basis, warrants an increase to Level C.

Question (10) Regarding the DVRNA Risk Factor Domain I(1)- Violence and/or threatened violence toward family members including child abuse – Current or past social services case(s). Should this risk factor be scored if the social services intervention is voluntary for the offender?

If a social services case has no formal finding, there is no court order for social services, and there is not an open case, then this does not meet the criteria for Domain I(1).

Question (11) An offender struck his son on the head with his lanyard causing bruising. Client was arrested for child abuse and domestic violence. Would this incident be scored in DVRNA Risk Factor Domain E2- “Use and/or threatened use of a weapon in current or past offense”?

The SARA Manual, which is one of the sources of research used for this Domain states “the use of weapons ... that cause fear in victims are associated with increased risk for future violence.” Based on this definition and the perception of the victim regarding the object as a weapon, you would score the use of the weapon in this offense, as well as child abuse.

Question (12) Regarding DVRNA Risk Factor Domain L (Victim separated from offender within the previous six months). Is that interpreted as within the previous six months of the date of completing the DVRNA or of the incident?

If the victim initiates separation at any time during treatment this would be scored. This includes the six months prior to the evaluation.

Question (13) *Standard 4.06(II)* states that when an offender mental health assessment is indicated and the Provider is not a licensed mental health professional, the Provider is required to refer the offender to a mental health professional for further assessment. Does the licensed mental health professional have to be a DV Approved Provider?

In the best of circumstances the answer is yes, however, the assessment can be performed by a licensed mental health professional who is not a DV Provider. The licensed mental health professional needs to consult with the DV Provider and the offender would need to sign a release with both clinicians.

Question (14) I have written a Pre Sentence Investigation Report for an offender who has been diagnosed with Schizo-Affective disorder and Bipolar. At this time, I do not believe that he can manage in a group setting. What is the procedure for attaining approval for individual DV counseling in lieu of group?

If DV offender treatment is indicated and it is just a need for individual instead of group counseling, then the MTT can make that decision without needing to use *Standard 4.09 IV(E)*. Other professionals may be included in the MTT, such as the offender's case manager or mental health professional for this mental illness.

If the Provider after completing the evaluation believes that DV offender treatment is inappropriate, the Provider then utilizes *Standard 4.09 IV(E)* and must specify that the criteria are met to justify an alternative recommendation to DV offender treatment. The MTT then needs to be in agreement regarding the recommendation.

Question (15) If a child is either witnesses to (or is present) during a domestic violence incident, do the Standards require that the offender complete a parenting program?

Children present during the offense or in the vicinity are considered a risk factor on the DVRNA Risk Factor Domain I. The *Standards* do not specifically require parenting classes; this requirement needs to be an agreement by the MTT and should be determined on an individual basis, not an automatic requirement. The priorities for treatment should be the criminogenic needs ascertained from the evaluation and the DVRNA. Therefore, in many cases there may be a priority that supersedes the need for parenting classes.

Question (16) If I have a client who recently reached the age of 18 and has a history of substance abuse as a minor, should that be taken into consideration when scoring the DVRNA.

The DVRNA is a scoring instrument for adults. The risk factors that occurred for an offender prior to age 18 should not be scored. However the MTT should consider the history of substance abuse and incorporate it into the treatment plan.

Question (17) If there is a court order that permits the offender to possess a gun, do we still score it as "access to firearms"?

Yes, it is still a risk factor.

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