BLUE BOLDED TEXT – Newly Added or Amended Language

Red Text with Strikethrough – Removed Language

5.06 Domestic Violence Offender Treatment

I. ***Group Therapy:*** In-person group therapy is the preferred and expected modality in which domestic violence offender treatment should occur. Group therapy promotes development of pro-social skills, provides positive peer support and is used for group process. Other treatment modalities such as individual, psycho-educational, and other adjunct options may be appropriate for goal-oriented purposes. The specific client needs and the purpose of alternative modalities shall be determined by the Approved Provider. Changes in modality shall be documented in the client's treatment plan and reviewed during each Treatment Plan Review.

A. In-person group sessions shall:

i. **BE FACILITATED BY A DVOMB APPROVED PROVIDER AT THE RATE OF TIME AND RATIO OF CLIENTS LISTED IN THE TABLE BELOW:**

GROUP SIZE	NUMBER OF CLIENTS	GROUP DURATION	NUMBER OF PROVIDERS
Small	1-2	1 HOUR	1
Medium	3-12	1.5 HOURS	1 - 2
Large	13-16	2 HOURS	2

LARGE group sessions shall be co-facilitated by one Approved Provider and one co-facilitator who is another individual listed on the DVOMB Approved Provider List or a Mental health professional listed with the Colorado Department of Regulatory Agencies (DORA) ***WHO UNDERSTANDS AND SUPPORTS THE OVERALL GOALS OF OFFENDER TREATMENT. CO-FACILITATION CAN BE DONE BY INTERNS WHO ARE LISTED AS AN ASSOCIATE LEVEL CANDIDATE.*** **CO-FACILITATION CAN BE DONE BY INTERNS WHO ARE LISTED AS AN ASSOCIATE LEVEL CANDIATE. THE APPROVED PROVIDER SHALL DOCUMENT ANY CO-FACILITATORS DURING ~~LARGE~~ GROUP SESSIONS. APPROVED PROVIDERS SHALL NOT EXCEED GROUP SIZE MAXIMUMS WITHOUT THE PRIOR APPROVAL FROM THE APPLICATION REVIEW COMMITTEE THROUGH A VARIANCE REQUEST.**

Discussion Point*: The preferred group size generally ranges from 8 to 12 clients. In addition to these Standards and Guidelines, it is the responsibility and expectation that Approved Providers set group size based on their experience, training, facilitation skills, and requirements from DORA.*

ii. Prioritize in-person services prior to the use of teletherapy in accordance with Standard 5.05 (IV) and Appendix I.

iii. Differ based on function such as educationally focused or a combination of education and therapy, or skills-based group. Approved Providers are not required to create three distinctly different groups but may create a combination of modalities.

iv. Be separated by specific offending populations **(E.G., FEMALE AND LGBTQ+ OFFENDING POPULATIONS)** and should continuously assess the need for the

appropriate placement in treatment.

v. Be content and gender specific.

vi. Be specific to sexual orientation and gender identity (Refer to Appendix B).

Discussion Point: For many individuals, gender identity and gender expression are non-binary and can lie on a spectrum. Allowing transgender individuals to participate in a group with peers that identify as the same sex as they do may have a greater potential for the successful completion of treatment. Placement of individuals that do not fall within the binary model of gender should be based on the best environment for the client and that which has all clients' best interests in mind.

B. Approved Providers should:

i. Monitor and control groups to minimize exposure to negative peer modeling and harmful behaviors and to provide for the safety of all group members. Not only are the dynamics multifaceted in group therapy, the safety of group members is of concern.

Discussion Point: *Attempt to provide treatment with co-facilitators of diverse sexual orientation, gender expression, and culture to the best of their abilities. The intensity of these groups requires a strong team approach to model healthy interpersonal relationship dynamics and communication.*

ii. When determining group size, an Approved Provider should continually assess individual client needs and group dynamics to ensure the best size for healthy group functioning. The therapeutic benefit and group cohesion decrease substantially when the group size becomes large enough for clients to disengage. People with additional needs, may need a smaller group to effectively progress through treatment. Approved providers should consider client needs in determining the gender of the providers who are co-facilitating group sessions.

II. ***Individual Treatment:*** Individual treatment (50-minute minimum) may be utilized on a case by case basis appropriate for treatment, such as crisis intervention, initial stabilization, or to address severe denial. If individual treatment is the only form of treatment, it shall be for specific **AND DOCUMENTED** reasons documented by the Approved Provider and in consultation with the MTT consultation notes in the offender's case file.

III. ***Teletherapy:*** In some cases, teletherapy may be an appropriate modality to meet the needs of the client. The provision of services via teletherapy is considered to be a privilege that is intended to promote risk-reduction strategies, engagement in the therapeutic process for the client, and the promotes the best interest of victim safety.

A. The provision of teletherapy services to individuals subject to the DVOMB Standards and Guidelines shall only be conducted by a DVOMB Approved Provider who has met the criteria established by Section 9.08 and who is listed as being Telehealth Approved. Online programs or individuals who are not listed on the DVOMB Approved Provider List do not meet the requirements set forth in 16-11.8-104, C.R.S.

B. Approved Providers who are listed as Teletherapy Approved shall:

i. Follow all DVOMB Standards and Guidelines and ethical codes of conduct in the same manner as is expected during face-to-face or in-person sessions.

ii. Establish policies that ensure that teletherapy is driven by the individual risk, need, and responsivity factors of the client, victim safety considerations, and continuity of care allowing for both teletherapy and in-person services.

iii. Have a dedicated workspace that is free from distractions and ensures confidentiality.

iv. **FACILITATE VIRTUAL GROUP SESSIONS AT THE RATE OF TIME AND RATIO OF CLIENTS LISTED IN THE TABLE BELOW:**

GROUP SIZE	NUMBER OF CLIENTS	GROUP DURATION	NUMBER OF PROVIDERS
Small	1-2	1 HOUR	1
Medium	3-10	1.5 HOURS	1 - 2
Large	11-12	2 HOURS	1 - 2

THE APPROVED PROVIDER SHALL DOCUMENT ANY CO-FACILITATORS FOR ~~LARGE~~ GROUP SESSIONS. APPROVED PROVIDERS SHALL NOT EXCEED VIRTUAL GROUP SIZE OF MORE THAN 12 CLIENTS PER GROUP.

DISCUSSION POINT: WHEN FACILITATING LARGE GROUP SESSIONS VIA TELETHERAPY, CAREFUL CONSIDERATION SHOULD BE GIVEN TO THE LEVEL OF RISK, GROUP COMPOSITION, CLIENT DYNAMICS, AND THE ABILITIES OF THE PROVIDER. PROVIDERS SHOULD BE MINDFUL OF THE CHALLENGES THAT COME WITH A LARGE GROUP FORMAT, INCLUDING MAINTAINING ENGAGEMENT, MANAGING RISK FACTORS, MONITORING BODY LANGUAGE, AND ENSURING THAT ADMINISTRATIVE TASKS DO NOT INTERFERE WITH EFFECTIVE FACILITATION. LARGE GROUP SESSIONS REGULARLY SHOULD BE CO-FACILITATION BY ANOTHER INDIVIDUAL LISTED ON THE DVOMB APPROVED PROVIDER LIST OR A MENTAL HEALTH PROFESSIONAL LISTED WITH THE COLORADO DEPARTMENT OF REGULATORY AGENCIES (DORA) WHO UNDERSTANDS AND SUPPORTS THE OVERALL GOALS OF OFFENDER TREATMENT. CO-FACILITATION CAN BE DONE BY INTERNS WHO ARE LISTED AS AN ASSOCIATE LEVEL CANDIDATE. PROPER DOCUMENTATION OF CO-FACILITATORS IS NECESSARY TO ENSURE ACCOUNTABILITY AND OVERSIGHT.

v. **HAVE THE HIPAA REQUIRED EQUIPMENT, HARDWARE (E.G., MONITORS, CAMERA, MICROPHONE, ETC.), ~~AND~~ SOFTWARE AND KNOWLEDGE TO FACILITATE SERVICES.**

DISCUSSION POINT: APPROVED PROVIDERS MUST IMPLEMENT BEST PRACTICES TO ENSURE SECURE, EFFECTIVE, AND SEAMLESS SERVICE DELIVERY. THIS INCLUDES USING HIPAA-COMPLIANT PLATFORMS, MAINTAINING UPDATED COMPUTER SYSTEMS AND SOFTWARE, AND SAFEGUARDING CLIENT

CONFIDENTIALITY THROUGH ENCRYPTED COMMUNICATIONS AND SECURE DATA STORAGE. REGULAR SYSTEM UPDATES, STRONG PASSWORD MANAGEMENT, AND RELIABLE BACKUP PROCEDURES ARE ESSENTIAL TO PREVENT TECHNICAL DISRUPTIONS AND PROTECT SENSITIVE INFORMATION. ADDITIONALLY, PRACTITIONERS SHOULD ESTABLISH CLEAR PROTOCOLS FOR ADDRESSING CONNECTIVITY ISSUES, EMERGENCY SITUATIONS, AND CLIENT ACCESSIBILITY CONCERNS. PROVIDERS ARE RECOMMENDED TO ARRANGE THEIR WORKSTATION THAT ALLOWS FOR ALL CLIENTS TO BE VISIBLE (I.E., GALLERY VIEW) WHICH MAY REQUIRE MORE THAN ONE MONITOR.

vi. Maintain an option for in-person services for the clients because some clients may transition from teletherapy to in-person services or vice versa. **TELETHERAPY MAY BE AN OPTION AFTER THE CLIENT ESTABLISHES A THERAPEUTIC RELATIONSHIP IN TREATMENT, HAS STABLE MENTAL HEALTH, AND SHOWS PROGRESS TOWARD TREATMENT GOALS.**

vii. Provide **IN-PERSON** services to clients who work or reside with accessibility to their program, unless the Provider is unable to provide services based on a language barrier or other appropriateness criteria listed in Appendix I.

DISCUSSION POINT: REFERRING AGENTS AND SUPERVISING OFFICERS SHOULD AVOID CIRCUMSTANCES WHERE CLIENTS ARE RECEIVING SERVICES FROM APPROVED PROVIDERS OUTSIDE OF THE JURISDICTION IN WHICH THE CLIENT IS BEING SUPERVISED. OUTSOURCING REFERRALS CAN NEGATIVELY IMPACT CLIENTS WHO REQUIRE IN-PERSON SERVICES AT SOME POINT IN TREATMENT. THIS PRACTICE OF OUTSOURCING REFERRALS CAN EFFECTIVELY UNDERMINE THE VIABILITY OF LOCAL PROGRAMS, POSE RISKS TO VICTIM SAFETY, AND RESTRICT CONTINUITY OF CARE.

viii. Not engage in non-session related tasks or activities while conducting teletherapy sessions (e.g. driving, recreation activities, tending to others, tending to non-session related work, etc.).

ix. Not include other individuals, other than co-therapists or approved MTT members, during teletherapy sessions.

x. **ENSURE THE USE OF MULTI-MEDIA (E.G. PRE-RECORDED VIDEOS, AUDIO, ETC.) IS RELEVANT, APPROPRIATE, AND SUPPORTIVE OF THE TOPICS, CURRICULUM, AND/OR APPLICATION OF THE CORE COMPETENCIES. MULTI-MEDIA SHALL NOT REPLACE TREATMENT NOR BE USED IN A MANNER INCONSISTENT WITH GENERAL MENTAL HEALTH ETHICS AND BEST PRACTICES.**

DISCUSSION POINT: AT TIMES, A VIDEO OR AUDIO CLIP (E.G., 10 TO 15 MINUTES) CAN AID IN TEACHING AND DEMONSTRATING DIFFERENT CORE COMPETENCIES WITH CLIENTS. THE USE OF THESE TYPES OF MULTI-MEDIA SHOULD BE CAREFULLY AND INTENTIONALLY INTEGRATED AS PART OF LESSON PLANNING.

C. **CLIENTS REFERRED FOR DOMESTIC VIOLENCE OFFENDER TREATMENT SHALL NOT BE NOT ELIGIBLE FOR TELETHERAPY DURING THEIR FIRST TREATMENT PLAN REVIEW IF THEY PRESENT WITH ANY TWO OF THE FOLLOWING RISK FACTORS IDENTIFIED ON THE DVRNA:**

i. **PRIOR CONVICTION OF DOMESTIC VIOLENCE (A1).**

ii. **SUBSTANCE ABUSE/DEPENDENCE (B1) OR ILLEGAL DRUG USE (B3)**

iii. **IN NEED OF MENTAL HEALTH EVALUATION (C7)**

iv. **OFFENDER WAS ON COMMUNITY SUPERVISION AT THE TIME OF THE OFFENSE (F1)**

v. **EXPLICIT DOMESTIC VIOLENCE ATTITUDES (J1)**

vi. **ANY PRIOR DOMESTIC VIOLENCE OFFENDER TREATMENT (K)**

THE MTT MAY DEVIATE FROM THESE EXCLUSIONARY CRITERIA IN STANDARD 5.05 (IV)(C) IF AN APPROVED PROVIDER RECOMMENDS A CLINICAL OVERRIDE FOR A CLIENT AND THERE IS MTT CONSENSUS. THE MTT SHALL NOT RECOMMEND THE USE OF TELETHERAPY SOLELY AS A RESULT OF CONVENIENCE OR PREFERENCE OF THE APPROVED PROVIDER OR THE CLIENT. THE MTT CONSENSUS SHALL DOCUMENT AGREEMENT THAT:

I. **THE CLINICAL RATIONALE FOR ATTENDING TELETHERAPY EXCEEDS OR OUTWEIGHS THE BENEFITS OF IN-PERSON SERVICES;**

AND

II. **THE CLIENTS' ABILITY TO ATTEND IN-PERSON SERVICES IS NOT VIABLE;**

AND

III. **THE CLIENT'S INDIVIDUAL RISK FACTORS AND THE VICTIM'S SAFETY ARE NOT COMPROMISED THROUGH TELETHERAPY MODALITIES.**

D. **ANY CLIENT WHO IS SENTENCED TO UNSUPERVISED PROBATION OR COURT MONITORING SHALL NOT BE ELIGIBLE FOR TELETHERAPY SERVICES FOR DURING THE DURATION OF THEIR TREATMENT. PLEASE REFERENCE SECTION 5.02 REGARDING THE MULTI-DISCIPLINARY TREATMENT TEAM (MTT).**

E. The Approved Provider in consultation with the MTT, shall determine **IF AND** when the client is appropriate for in-person or teletherapy services using the appropriateness criteria outlined in Appendix I. **A MIXTURE OF IN-PERSON GROUP THERAPY AND TELETHERAPY CAN ENHANCE CLIENT ENGAGEMENT IN TREATMENT.** If considering the use of teletherapy the provider shall:

i. Assess the appropriateness and readiness of a client for teletherapy services and determine if there are any concerns that would impact the client's level of engagement or ability to attend teletherapy sessions (e.g. compliance concerns, specific responsivity issues, ongoing substance misuse, or any victim safety concerns etc.).

ii. Have an established therapeutic relationship with the client, or clients for group therapy, prior to considering the use of teletherapy.

iii. Determine if the client's progress in treatment can appropriately be assessed via teletherapy (e.g., body language, etc.).

iv. **DOCUMENT THE REASON TELETHERAPY IS BEING UTILIZED (E.G., DISTANCE OF CLIENT TO SERVICES, MEDICAL RISKS OR CONDITIONS, LACK OF RESOURCES TO SUPPORT IN PERSON THERAPY, COMMUNITY RISK, ETC.)**

v. Collaborate and consult with the MTT regarding the clinician's recommendation/decision for teletherapy.

vi. Document the clinical rationale of the supporting reasons why a client should receive in-person, teletherapy, or a combination of both modalities.

F. For clients who are eligible and determined to be appropriate for teletherapy, Approved Provider shall:

i. **NOTIFY THE MTT WHEN THERE IS A VIOLATION OF THE TREATMENT CONTRACT AND TO CONSIDER THE SEVERITY OF THE VIOLATION, VICTIM SAFETY, THE CLIENT'S PROGRESS TOWARD THE CORE COMPETENCIES, AND GENERAL RISK-RELATED BEHAVIOR IN DETERMINING IF THE CLIENT NEEDS TO ATTEND IN-PERSON SESSIONS.**

ii. **ESTABLISH SAFETY PLAN OR PROCESS FOR IDENTIFYING CLIENT LOCATION IN THE EVENT OF AN EMERGENCY (E.G. ASKING CLIENT FOR THEIR LOCATION IN THE GROUP CHAT, ETC).**

iii. Check in with the client at each treatment plan review to determine if teletherapy is a suitable approach for the client to meet the goals identified in their treatment plan and if any adjustments are needed. This can be adjusted anytime based on clinical indicators that suggest teletherapy is contra-indicated.

iv. Notify the MTT if there are issues regarding participation, limitations, and how the rationale for teletherapy services may impact other activities of the client (e.g. if teletherapy is being provided due to a community safety risk such as a pandemic, other community access/activities should be reviewed by the team).

v. Require any additional monitoring of the client based on the Provider's ability to assess the client's individual risk factors and victim safety concerns.

vi. Transition the client from teletherapy if they are no longer appropriate, in violation of the treatment contract, failing to progress, or disengaging from treatment. In such cases, the client shall either return to in-person services or be discharged in accordance with Section 5.09.

***Discussion Point**: Approved Providers may offer an initial orientation for the client to understand and become familiarized with using a virtual platform. When using a hybrid approach with clients attending both face-to-face and virtually, it is considered a best practice for the Approved Provider to use technology that provides for the monitoring of participants in both formats.*