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# Domestic Violence Treatment Best Practices for Civil Clients

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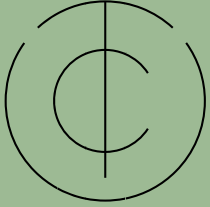
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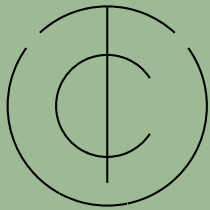


## Introduction

Often when treatment services between civil and criminal worlds collide, many professionals are left feeling stuck considering and questioning the parameters under which they are required to operate. Which guidelines do you follow? Who needs what pieces of information? Who oversees the work to be done? This experience is common when the civil department of human services system intertwines with a commonly-provided-service for clients with criminal convictions. Case in point: domestic violence (DV) treatment for child welfare involved parents.

As a treatment provider who first gained experience in the civil system that is child welfare (aka social services aka human services aka whatever your state/city/town calls these powers that be), I provided various services ranging from therapeutic supervised visitation to intensive family therapy to home-based interventions. Since I was trained in working with civil clients before completing training to work with criminal justice involved clients, the crossover into providing domestic violence treatment for both civil and criminally involved clients simultaneously lacked intimidation. For those on the other side of the discussion, having first only worked with criminal justice involved clients mandated to receive treatment, the treatment experience with civil clients is identified as containing more reticence, hesitancy, and concern. Let me address some of your possible uncertainty and apprehension.

If you are not trained in domestic violence and are reading this as a beginning part of your journey, welcome! Domestic violence dynamics can be so very nuanced, and I commend you on doing research, reading, and seeking education instead of jumping into the field as a provider defenseless against the DV subtleties of significance.



## Civil Client or Criminal Justice Client?

What are best practice ways to provide domestic violence treatment to civil, often mandated, child welfare involved caregivers? Glad you asked! First let us clarify that the subsequent discussions in this e-book are relevant to adults suspected of or arrested for - but not convicted of – domestic violence, and subsequently (or concurrently) involved in a founded or voluntary Dependency and Neglect (D&N) child welfare case. A D&N case does not involve criminal prosecution of parents. These parents are instead held responsible for behavior, substance, and other treatment changes to benefit the children’s safety and best interest.

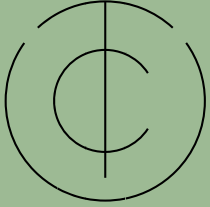
In the state of Colorado, D&N cases are founded when the attorney for the county or city has proven by a preponderance of the evidence the child or children were abused or neglected by the parent(s). A preponderance of the evidence is the burden of proof in D&N cases, which is 51%. This is different than “clear and convincing evidence” and “beyond a reasonable doubt” which you may be more familiar with. Preponderance of the evidence is barely more than half, so take note of this.

Further clarity on civil versus criminal justice differentiation: *(Note: Crime arrests and convictions may include a range of charge types (e.g., assault, harassment, stalking, etc.) with different crime enhancers that could indicate a domestic violence crime, but for the purposes of this section, the general term “DV” will be used for brevity of examples.)*

- Arrested for DV, charges dismissed, child welfare involved family = civil system involved client
- Suspected DV in home, child welfare involved family = civil system involved client
- Arrested for DV, convicted of DV, on probation, child welfare involved family = criminal justice and civil systems involved client
- Arrested for DV, convicted of DV, on probation = criminal justice involved client

## Treatment Independence

The beauty of being a treatment provider who contracts with social services is the child welfare system professionals may often default to your knowledge and expertise in treating the person. To be contracted with social services, you likely have evidenced your expert best practices to reduce risk, decrease violence, and increase protective parenting capacity. Yes, there are best practices around collaborating and consulting with a multidisciplinary treatment team when it comes to risk to victims and children of domestic violence. Yes, there are competencies that should be of focus to help reduce risk to the victim, the family, and the community. And, yes, in some instances (depending on state or governance of the practice or service) you may not be



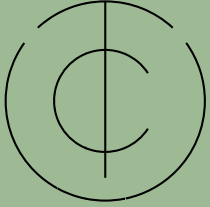
required to adhere to the guidelines by an agency that regulates and oversees the provision of those services for individual with criminal convictions. For me, this is where the independence lies. I get to more closely tailor my domestic violence treatment methods to address the concerns identified by child welfare as well as my own expert assessment of the client based on domestic violence dynamics. While remaining within the best practice guidelines that I operate under with convicted offenders\*, I get more professional freedom to do what work I determine the most pressing and prominent of needs for the civil client. How great is this!?! I absolutely love it. I get to provide treatment and therapy with less cooks in the kitchen. I still carry the same risk of grievance as I do with any therapy services I provide (for those who may worry about the risk of less oversight). The work is no less expert, just more directly determined by me and not by guidelines I am required to operate under when working with criminally convicted clients.

## Who is Involved?

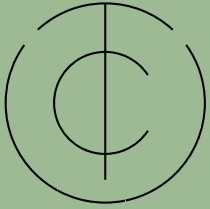
If you choose to expand into providing domestic violence treatment for child welfare involved clients, who are the players? Again, glad you asked! Such good questions!

Let's run through some of the possible players and process types when working with social services (*Note: Names/Titles may be different in your local area*):

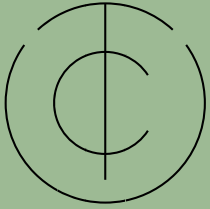
- Judge/Magistrate: Judicial officer who makes decisions based on legal parameters, can act as the judge and jury when a client chooses to not have a jury trial when Dependency & Neglect (D&N) is alleged.
- Caseworker: Primary staff who works the case and puts the pieces together, includes intensive case management and communication to inform the Judge/Magistrate of updates or changes.
- Caseworker Supervisor: Staff who oversees a group of Caseworkers and their caseloads. Has previously been a case carrying Caseworker.
- Referral Professional/Service Navigator: Staff who manages/oversees/assigns service referrals to external (or sometimes internal) treatment agencies.
- Guardian ad Litem (GAL) for the child(ren): Attorney who legally represents the best interest of the child.
- Guardian ad Litem (GAL) for the parent/caregiver: Attorney whose responsibilities to the parent are to ensure they understand the process and possible consequences as a result of the case. Informs parents through the court process and proceedings. Appointed when there is a concern about the parent's ability to understand the legal or court process.



- Respondent Parent Counsel (RPC): Attorney to the parent/caregiver. Advocates for the parent’s rights at each stage of the D&N proceedings.
- County Attorney/City Attorney: Attorney who represents the caseworker from the department of human services and is responsible for initiating the D&N case with the court.
- Court Appointed Special Advocate (CASA): Trained volunteer advocate participating in efforts for the child(ren)’s best interests.
- Special Respondent: Volunteering parties to the case; can be family members, neighbors, psychological parents, family mentor, or others. Person is actively involved in the case and added as a party to the case for the Court to be able to make any orders regarding participation in the case.
- Utilization Management: Person or department who oversees the use of agency resources.
- Core Service Director (various titles): One of the people in charge of your contract, negotiations, questions, language, etc.
- Permanency Roundtable (PRT): Court process involving the young adult in determining the goals going forward in the case.
- Permanency Audit: State hired agent(s) who audit cases and ensures the human service system is following guidelines and timelines according to the law when a youth has been in out of home placement for more than one (1) year.
- Foster Parent(s): Paid caregivers who accept the housing and care duties and schedule of a child or sibling children. Can be legal risk (foster to adopt) or providing temporary care as foster parents.
- Kinship Placement: Paid or unpaid caregivers related or closely connected to the biological/psychological caregiver who accept the housing and care duties and schedule of a child or sibling children.
- Group Home Providers: Including managers, line staff, and other people hired in each home.
- Various External Service Providers:
  - Therapists (mental health, OT, ST, PT, etc.)
  - Treatment Providers
    - DV, SUD, etc.
  - Victim Services



- Visitation Supervisors
- Mentors
- Psychologists
- Case Managers
- Probation Officers
- Parole Officers
- Service Coordinators
- Teachers
- Case Aids
- Hospitals (doctors, treatment teams, specialists)
- Jails/Prisons
- Veteran’s Administration (VA)
- Division of Vocational Rehabilitation (DVR)
- Community Support Agencies
- Day Programs
- Residential Treatment Centers
  - Qualified Therapeutic Residential Treatment Centers
  - Farm and Wildlife Treatment Centers
  - Specialized Residential
  - Others
- Halfway Houses
- Work-Release Programs
- More, more, and more



## Who Do You Answer To?

When you have a contract relationship with human services, who do you answer to, and subsequently, owe information to?

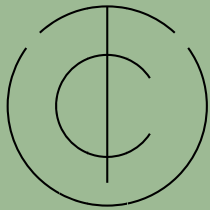
An unfavorable, although entirely true, conversation is the one where providers acknowledge they have two clients with every client they work with. One client is the person who pays for the service: the county or system. The other client is the client you are providing the service to. THE client.

As a clinician and contracted provider, our responsibilities to the county are to collaboratively develop a treatment plan and subsequently provide culturally competent services to the individual client or family that address clinical issues, child protection and/or delinquency concerns. Additionally, responsibilities involve communication with the Caseworker such as unsuccessful attempts at reaching the client, new concerns of child abuse or neglect, a gap in treatment, or other significant events or changes affecting or influencing recommendations around the needs of the family, parent, or children. Potential testimony is also a responsibility.

As a provider of services to the individual or family client, our responsibilities include providing any variety of ethical and culturally competent treatment or support services that address protective parenting capacity, reduction of risk, and addressing barriers to ongoing stability through creating compensatory strategies and training for the client to strengthen likelihood for sustained maintenance of custody of the children through safe and stable parenting.

How does a clinician navigate the conflict of interest with having two (2) clients simultaneously who may have different end goals incompatible with one another? Wait, is there a conflict of interest? Yes and no. Yes, because the system paying you or referring you clients to assess and treat may be arguing in court the parent is not fit and wants you to testify to those sentiments. If you disagree and feel the client/caregiver is making progress and you provide information that is favorable for the client/caregiver, you may feel like you are biting the hand that feeds you by disagreeing with the position of the county or system. On the other side of it, if your assessment is that the parent is unable to make the needed gains in a reasonable amount of time, and need to testify to such information, that is a different layer of internal conflict. Essentially you are, at times or many times, needing to report negative things about your client. Feels a bit “ick,” however, the foundation of child welfare and the laws this system is governed by is for the best interest of the children, so for me, the ‘ick’ is a bit less. More on this later.

Now onto the reasons why serving these two clients/parties is not a conflict of interest. The service you are providing the human service system is therapeutic and/or support services to the client in efforts to reunify the family back together or maintain permanency with the family. Information given to the human service system commonly is a monthly report, your attendance and discussion at meetings when invited, court testimony



(when subpoenaed), and emails and phone calls when progress updates are needed in between reports or if something significant happens. While that sounds like a lot of things, they are not owed your agreement with their assessment. They are owed communication to best keep the Court informed so laws and regulations are followed, and appropriate planning is done for the purposes of child safety and protection.

This is the beauty of the work.

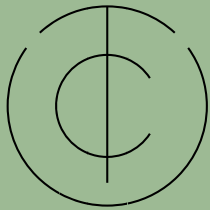
When working within these different systems and professionals, the various teams of people respect the differences of opinions, assessments, and even testimony. Each person has their roles and goals. They sometimes align and they sometimes do not. Thank goodness for relative checks and balances via multiple professionals across various systems with different training backgrounds coming together to work with one (1) family system to avoid the sinkhole that is Group Think\*\*.

For those of you considering additionally the conflict of treatment; the who needs what and the who wants what are continuous evolutions throughout the relationship and contractual work together, but you are only providing clinical treatment to one set of the parties. The child welfare system is requiring your work to be provided to the individual client and/or family with required communication to the human service system on those services, progresses, and barriers.

Jumping back to the original question, who are we owed information to? The answer is whoever the client has signed a release of information for, as it were. Primarily we need to get information to the county system because it needs to go in front of the judge or magistrate. We are purposely engaging in a court system in best interest of the child(ren). Restricting information ultimately puts the child at risk and the child is the nucleus of the child welfare purpose.

What if you do not have a contracted relationship with the county? In that case, release information according to your signed releases of information from the client. Your agency's purpose may not involve a child welfare focus, so you may not be inclined to provide information above and beyond dates of attendance and topics addressed.

Now let's break down the 'ick' I referenced previously. I develop the work that I do (and the work that my staff do) around the basic approach of transparency. When completing an intake, disclosure statement, and releases of information with a client, I give them the full run down: what my role is, what my goal is, what is asked of me by the county, what I may or may not be required to testify to, and what my expectations of the client are in our work together. If and when it comes time to testify, I meet with my clients ahead of time and tell them the questions I expect to be asked on the stand and the answers they will hear come from my mouth that day. I tell them that everyone, even the county, operates under the absolute best practice consideration that children thrive most often when living with safe and protective biological/psychological parents or family. I tell the



client the possible outcomes of the case, even though they may have heard the information already: remain at home, reunification, allocation of parental responsibility (APR) to another person, joint allocation of parental responsibility (for example, APR to one parent and an aunt together), relinquishment of parental rights, or termination of parental rights (TPR).

## Child Welfare Outcomes

From my therapeutic lens in working with child welfare involved clients, of those six (6) options listed in the previous section, seven (7) options are considered successful outcomes and four (4) of those options may be considered unsuccessful outcomes. That is not a typo. Let me explain.

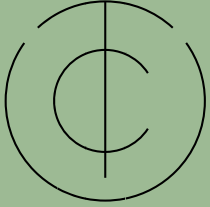
Children remaining at home while services are provided, and progress is documented is a great success #1. It is important to note compliance with services from the family are required. Without compliance and improvement in areas of identified need or risk, the case becomes a bit more complex during the involvement of the social service system.

Successful reunification after out of home placement is a successful case outcome #2.

Allocation of parental responsibility offers the parent(s) additional time to make progress and better strengthen areas of their lives to offer a safe and stable home through the obligation of time. Success #3. In Colorado, two (2) years must pass while the child(ren) are in the legal and physical care of another person or family member. The parents may be permitted parenting time which can be modified between the parties, but custody cannot be changed by the Court before two (2) years. After the designated time has lapsed, the parent(s) can petition the Court to regain custody and provide evidence of positive and protective parenting changes made and sustained. The petition to modify the custody order can be made by either of the parties and is done at the same place where APR is filed, generally the Domestic Relations District Court.

Joint APR is the same notion, but in efforts to achieve sole custody, and no longer to be shared with a family member. Success #4.

Relinquishment of parental rights can be successful because a parent recognizes they are not currently, or identify can likely never, create and maintain a safe and stable home for the child(ren). Relinquishment is the most complicated yet beautiful way of putting their child(ren)'s wellbeing first as a parent. Relinquishment requires a parent go through relinquishment counseling to ensure they know, understand, and uphold their decision without pressure or coercion from another party. It is saying, "I love my child above all else and want them to have the best opportunity I cannot provide." The awareness is unmatched. The ultimate parenting sacrifice is also the ultimate parenting perfection in that decision for the best interest of their children. Success #5.



Termination of parental rights is successful when a parent is deemed competent to confess the motion and subsequently agree with termination of their rights. Similar to relinquishment (which a parent with determined lack of, or concern of, competency is not given the rights to do), confessing the motion is waiting a bit longer to confess, or formally agree, with the motion of termination of parental rights. Written confession documents can be prepared by the Respondent Parent Counsel (RPC) and submitted to the Court. This parent is not required to complete relinquishment counseling. They are able to show up to their final court hearing, agree, wait for all parties to accept the agreement, and the decision will be finalized. Success #6.

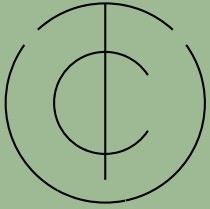
Termination of parental rights is also successful when a parent who is not competent to confess the motion, thus is prohibited from this practice, but outwardly agrees with the termination. The biggest barrier with this is often these clients may feel required to sit through the painful process of hearing all of the negative things about them to complete the court involved termination process, however, attendance is not mandatory for the parent. In these instances, this is Success #7.

Now we turn over the coin to discuss the unsuccessful nature of four (4) of the above-mentioned options. Allocation of Parental Responsibility can be unsuccessful for the parent(s) who disagree with the decision or with whom the child(ren) is placed with. The same information applies to joint APR. One example for this could be if joint APR is granted to a biological parent and a biological grandparent but the two (2) adults have a contentious relationship.

Relinquishment can be unsuccessful if there is coercion or pressure put on the parent from another party. An example of this is if a foster parent develops a close relationship with a parent and plants the seed of relinquishment and then waters it over the course of time through intentional dialogue leading to the parent believing relinquishment is the only option in the best interest of the child. This may lead to the parent withdrawing from their efforts in treatment and engagement in the child welfare treatment plan. Perhaps you are wondering, does this really happen? Unfortunately, yes. That can be a deeper conversation for another day.

Termination of parental rights is unsuccessful if the parent maintains the position against this decision, and is unable to connect the lack of safety, protective capacity, or ability to meet the child's basic needs as problematic.

It is important to state there are elements to each of these scenarios that were not discussed in detail above. The information was provided briefly for general purposes of understanding possible outcomes. Each process is unique, personal, and complicated. There is adjudication. There are appeals. There are contested hearings. There are emergency hearings. There are petitions filed. There is a lot happening over the course of a child welfare case.



## Best Practices

For domestic violence treatment providers, the foundation of DV services is reduction of risk. Reduction of risk to the victim, reduction of risk to children, reduction of risk to the community. In the state I practice, treatment is focused on reduction of risk based on assessment of gains in identified competencies: accountability, elimination of abusive behavior, development of empathy, identification of personal patterns of power and control, participation and cooperation, and others. With criminal justice involved clients, the clinician needs to assess all of the competencies required by the governing board. With civilly involved clients, I assess on the wider variety of competencies mentioned, yes, but I have more independence to incorporate and address child protective concerns as it relates to domestic violence, impacts, trauma, and power and control behaviors in family systems.

The thing of it is, we all misuse power and control from time to time. Think about it. From barking at another driver on the road, to throwing your hands up in frustration indicating intense emotion in front of children, to sighing loudly in a grocery store check-out line to notify or “encourage” the person in front of you to scan their items quicker, to justifying and shifting blame during conversations with a loved one to avoid discomfort. Power and control misuse is in our lives and all around us.

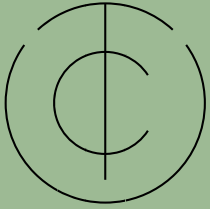
Civilly involved clients are this interesting mid-level group of clients who have transitioned into court conversations but not into criminal convictions. The domestic violence focused clinical and support work done with this population can be categorized as the current steps into preventative services for these post-court notified but pre (or never)-criminally charged clients. That is something to take note of! The child welfare system is investing their time, efforts, and fiscal dollars to recommend and refer clients to DV treatment providers who address power and control in the home and family unit. This is an impactful move that surpasses individual therapy, family therapy, mentorship, home based services, or other offerings to families involved in the child welfare system. Domestic violence treatment for civil clients reaches into community safety and reduction of risk to the community and that, my reading learners, is beyond impactful practice. It is the mark of best practice. And I’m here for it!

## Can I cover all domestic violence dynamics needed with civil clients?

The simple answer is ‘no.’ But let us not lead with simple answers. Let’s dive into the deep end. First, there are timelines that need adherence to.

### *The Clock*

- Families with children under age six (6) = one (1) year timeline to establish and decide permanency. This may be called Expedited Permanency Planning (EPP).



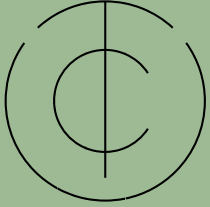
- Families with children over age six (6) = a little longer than one (1) year, much longer, incredibly longer, not longer at all. Time remains of the essence and each circumstance is unique.
- When case begins with child(ren) remaining at home and a subsequent removal happens, the legal timeline begins at removal.

*For example:*

If a child is under a certain age upon removal from the home, some laws state that the child needs to be in a permanent placement within twelve (12) months of the case being opened whether that is reunified with the parent or in another home permanently. So, if on month four (4) of that case, the county identifies concerns of domestic violence and sends a referral for the client to complete a domestic violence evaluation, that is another month passed in coordinating that. Then perhaps the client is recommended to enroll in domestic violence treatment so that is now month five of coordination. Next, it may take the client four (4) to twelve weeks (12) to buy into the treatment program (e.g. “I don’t have a DV charge so I shouldn’t even be here.”) so that is months six (6) through eight (8). So now we have a solid four (4) months to do the start, middle, and end of domestic violence treatment with the client fully invested. Four (4) months is not very long to treat domestic violence. You may have even chuckled when considering the amount of therapeutic effort needed to put in during that short amount of time. However, four (4) months is a lot longer than zero (0) months.

On the other hand, consider how four (4) months may not be that daunting in a case, for example, where the county identifies the predominant concern of yelling and name calling in the home (with the argument from the client that the children are \*ahem\* in the other room and do not know what is being said). I can get a lot done from a foundational standpoint with this, plus have time to expand into addressing other elements such as impact of trauma on children, emotional abuse, relationship rules, gender roles, family roles, empathy, and scheduled relationship check-ins. By the end of four (4) months, in this case scenario, I will have addressed the county concerns, my assessed concerns, and beyond in treatment to reduce risk, increase protective parenting capacity, and strengthen the family system (whether the romantic partners remain together). So short timelines are not always defeat.

Now let’s consider a client who both the county and the therapist have identified as having chronic behaviors of abuse under that same timeline. Or perhaps a client who refuses to disclose or engage and the county (who is one of your clients, remember?) asks for them to have chance after chance to avoid an unsuccessful discharge because they are “doing so well with other parts of their treatment plan.” The simple answer to this is, you adapt. For the client with chronic concerns of power and control and abusive behaviors, you can attest that the person has not made the gains in treatment in the timeline provided due to x, y, and z. The judge (if providing this information during testimony) may ask the magic question, “How much longer does the client need in treatment?” – which, I rarely will answer with a quantifiable response. But the good news with this question is



that it indicates consideration of an extension, which is exactly what the client in concern needs to do more of the work.

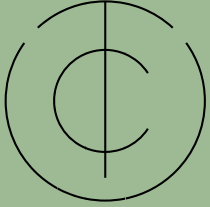
In the latter scenario, you do the best with what you have. In this instance, I would likely say, here are my concerns, this is the risk, and my final report for the client upon case closure with the county will identify this client did not complete treatment successfully and my recommendations for continuing requirements will be provided. What the county does with the information is out of your control. You have identified risk, barriers, successes, and recommendations moving forward. Your liability has been tended to. You provided the referred service for the referred purpose based on the assessment from the client and yourself. That is best practice.

### **How does a clinician not violate trust with the client?**

This one can be tricky because clients enrolled in domestic violence treatment are often guarded, wondering what we are going to do with the information they disclose. Are they going to get in more trouble? Are they going to get arrested? Are they going to jail? Many unknowns may be circling in their heads.

Clinically, I can do a lot more with a client who discloses than a client who does not. I can provide greater depth of treatment resulting in more treatment progress with a client who discloses than a client who does not. Clients sign a disclosure statement identifying explicitly (and then reviewed with the provider directly again) that their treatment is confidential except in some circumstances: releases of information signed or current threats to hurt themselves or someone else, as two (2) examples. Also, to consider, mandated reporters are often not required to report past abuse on other adults not considered “at risk”. So, to identify it clearly – our job as domestic violence treatment providers is to not criminalize people for their past behaviors. Our job is to treat the person in front of us based on the reported behaviors by others, the client’s identified uses of abuse, and integrate that with our assessment of their needs.

Further, upon beginning treatment, I discuss with the client my role, the county’s role, and the expectation on both of us working together. I transparently tell the client the information that will be shared with the county each month we are working together through a written monthly report, as well as email and phone communication. I offer to review my monthly report with the client through a virtual screen share or in person in the office. We discuss any concerns, questions, or comments so the client is again reinforced we are a team working together through their personal patterns of violence to strengthen and increase safety in relationships. Domestic violence treatment providers working with civil clients are not providing treatment in efforts to get the client in trouble. We are providing treatment to increase safety and reduce risk, subsequently reducing further difficulties for the clients. In essence, this is the best way to remind clients that you are working together toward this common goal which subsequently strengthens their chances for reunification with their children.



## Are civil clients going to incriminate themselves?

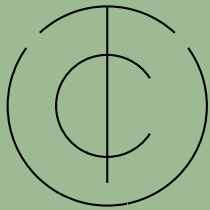
An important thing for multidisciplinary team members to know is that a civil client participating in domestic violence treatment is in no way an admission of guilt to a crime. As a mandated reporter, I am obligated to report concerns of neglect, abuse, or harm on certain populations. As a mandated reported, I am not required to report on past abuse of another adult (an at-risk adult is a different requirement). When your client inevitably discloses behaviors of violence and abuse, want to know what I do with it? I thank them for disclosing and I get to work. My job is to reduce risk, not create risk by sounding an alarm and notifying everyone of their admissions. That is entirely counter to the work and should never be expected of a DV treatment provider working with civil clients. If a client's accountability is not sacred in a domestic violence treatment room than treatment is seemingly worthless.

In my monthly reports, I write about treatment gains, treatment barriers, increases or changes in accountability, and any recommendations moving forward. That still clearly represents an update of the client given to the professionals who receive that document. That still clearly identifies successes, concerns, and plans for next steps. I would not be doing this work if it meant people engaging in treatment are required to incriminate themselves. Instead, they are receiving privacy, safety, support, pressure, and progress to reduce risk of harming others.

Lastly, civil clients who are enrolled in and are actively participating in domestic violence treatment can be categorized into prevention efforts from criminally charged domestic violence crimes. This is a significant win for the criminal justice system, incarcerating systems, families, and the community (also consider taxpayer dollars). Domestic violence treatment provided to civil clients could be one of the most underutilized services that makes a lasting impact on safety in the home. Spread. The. Word.

## What if a client will not sign a release of information?

This one is not as tricky as it seems. For the county contracts that my agency holds, the contract documents explicitly state that if referred a client using county funding, certain client information must be provided to the county. My hands are tied in that way. However, I also have an open conversation with the client about the potential consequences of not being able to share any of the progress the client is making with the county because of a refusal to sign a release of information. I explain how it would slow any progression toward reunification if the only information the county had was attended dates (which are required to provide for reimbursement of services) and the Court could not bear witness to information that spoke to the county treatment plan requirements of the client. I have been providing services to civil clients involved with the department of human services for twelve (12) years. I have had two (2) clients refuse to sign an ROI up to this



point – TWO - and both of those clients changed their minds when they recognized the stagnation it created in their cases. It benefits all parties for communication to occur. There is no manipulation in this piece. We need to communicate with one another.

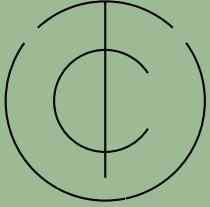
Also, clients who sign ROIs do believe that positive information will be reported back because they have the level of investment to attend services, do the work, and reunify. In my experience, if civil clients are not going to follow through with investing in DV treatment at any point, they likely do not attend the intake, or make it very complicated to schedule one. If clients do not believe in themselves to make improvement or deny improvements to be had, they are less inclined to sign ROIs. In these instances, there is also some work and rapport efforts to be done with the client. Spend time with them to support their understanding in the purposes of signing a release of information. What are the concerns with signing one? Are they clear they can revoke permissions? Find out where their reticence originates. Lack of communication with the county about their own efforts forward does far more harm than good. Be an ear of understanding and a voice of clarity to help them feel certain on the purpose and process. For a future discussion, there exists an argument of competency for some clients when signing ROIs, and that will be addressed in a later writing.

## Now the How

Up to this point, have you wondered why I have not given explicit instruction on how to provide domestic treatment TO civil clients receiving DV treatment via a social service system contract? The answer can be explained like this: You already have the answer. As a clinician trained in domestic violence, you possess the expertise and knowledge to work with people who use power and control to abuse others. You know how to write treatment goals and treatment plans. You know the best work is done with a multidisciplinary treatment team, open communication and connections with other professionals who serve different roles in the client's life for the function of best developing and supporting a plan of action that highlights the most urgent and critical needs for treatment progress. The learning edge is conquered when the clinician understands the delicacies amongst the criminal and civil systems and feels confident to balance the requirements and nuances of both to provide best practice treatment.

For the clinicians in the beginning part of your domestic violence treatment training journey, it is imperative to give yourself grace. Do not let overwhelm consume you. Applaud your efforts for doing research, reading, and seeking education continuously to best understand the dynamics under which and for whom you will be providing treatment.

If you are looking for more direct and explicit instruction with how to provide treatment that meets a client or family's learning needs, stay connected for a following piece on just this.



## What about the research?

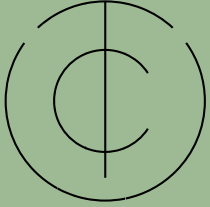
This question always gives me a bit of a giggle. I specialize in providing treatment to clients with nontraditional learning needs, clients with intellectual disabilities, developmental disabilities, learning disabilities, clients on the autism spectrum, clients with acquired or traumatic brain injuries, clients who have not had success with previous providers, or clients who have been identified as “difficult to serve.” Research for this particular population is a drought indeed. Disability with mental health as one (1) conversation is not prominent research. Disability with victimization is more common research. Offending clients with disabilities is not common research. ‘Disability’ used to be a reason permitted for evaluators to cite when determining if clients were unable or unfit to participate in domestic violence treatment. Untrained evaluators on disabilities were allowed to check this box. My skin crawls just typing those sentences. Can you imagine being told you are unteachable or untreatable because you have a disability? Beyond oppressive and exclusionary. It is entirely maddening. So, I worked to put a stop to that nonsense in my state and continue my loud dialogue on this problematic issue for those who missed the update or cannot hear me in the back.

There is research that shows low level offenders are influenced negatively by and learn from higher risk offenders. However, there lacks research that speaks to impacts and outcomes of civil clients and criminal justice involved clients with various disabilities being placed into the same treatment group together. Both groups are mandated – one through criminal court and one through their D&N case. My data is connected and collected through outcomes, treatment gains, and final parenting determinations for civil clients. And goodness those numbers look good up to this point. Also, there lacks research that speaks to impacts and outcomes of civil clients and criminal clients (with or without disabilities) being placed into the same *virtual* treatment groups. Something to ponder.

## What do you do with civil clients who are resistive or lack engagement in treatment?

First, let’s consider the use of the word “resistive.” Are they resistive because they lack accountability, lack understanding, or something else? Parse that out first before proceeding with the word ‘resistive’ to describe a client. Since 2017, I have only identified four (4) clients participating in DV treatment who were best appropriately called resistive. A measly number of four (4). That is quite extraordinary. There were many, many others who were navigating a concoction of unidentified learning disabilities, mental health needs, resource droughts, extensive trauma, and/or carrying repeat encounters of systemic racism, oppressive practices, and lack of equity and diversity experiences that displayed itself in behaviors clinicians often fell back on calling “resistive.” It should be rare for you to quickly identify a client as resistive. Rare.

Consider clients from this perspective:



A client who misses groups may be disorganized, not resistive.

A client who zones out during groups may have slower receptive processing skills and the brain is spending that time putting the information together, not ignoring the information. They are tuned in, not tuned out.

A client who declines reading something aloud in group may not defiant but have undiagnosed dyslexia.

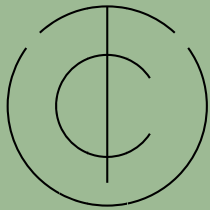
A client who uses loud volume of voice in group may be using this tool to hope you ask less of them so you do not discover they cannot cognitively keep up with the pace of the conversation. They are not aggressive, they are likely using a strategy than has shown previous success in protecting themselves from being exposed as struggling.

A client who briefly turns their camera off during an intense part of the group discussion, may be feeling triggered, or shedding a tear when they were raised with beatings if they showed emotion. They are not being careless. They are being careful.

There is so much more to the client experience than identifying them as resistive and swiftly escorting them out of the space. Amenability to treatment should not be decided definitively in the early assessment or early treatment part of their experience in most cases. There is often fear, shame, and confusion around the first few months of being on probation, parole, or involved in a dependency and neglect case. Hitting the gavel down to end their treatment too early can be a death sentence for some – victims and offenders alike.

So, what should one do with civil clients who lack engagement in treatment? Spend time with them. Build stronger rapport. Partner them up with a veteran group member during one-on-one activities. During small group work, place them strategically with members who have: insert therapeutic reason here (e.g., similar experience, work in a profession the client aspires to become a part of, a peer who has confronted the client before and it went well, etc.). There are ways in which we provide treatment that go beyond the materials needed to discuss. We are treating people. Provide people treatment.

Another element to consider is the experience of trauma or other significant experiences. I have had one (1) client in the history of providing domestic violence treatment who did not have significant experiences of either trauma, transitions, disabilities, or victimization in their lives. ONE (1). Be curious for this knowledge as it will help you determine a more informed course of treatment action for each client. Tunnel vision treatment is not best practice treatment. You must adapt and meet the needs of each client even in a group setting. If you struggle to do this, reach out to your clinical supervisor, a supervision support group, or colleagues you trust. Group treatment is managing multiple things at once, not doing one thing and assuming it will work for all. “Resistance” is not clear cut, it is a spectrum of elements to consider. Do some considering.



## How do I, myself, provide DV treatment to civil clients?

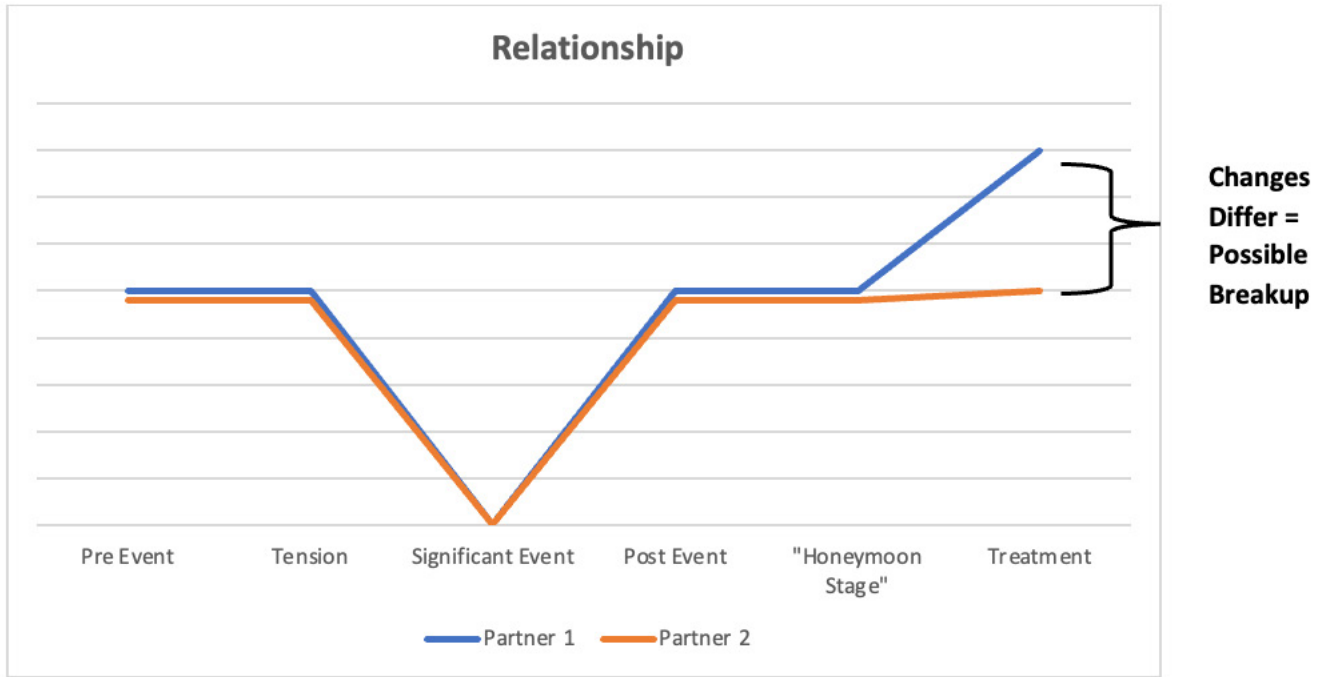
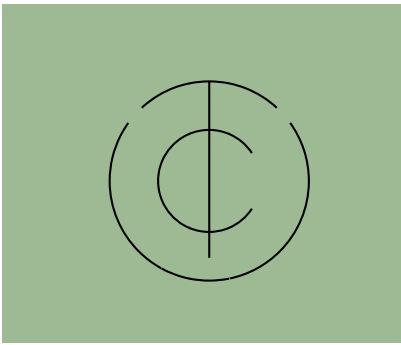
I openly told a professional who is part of an overseeing organization of my DV work that I only plan about 50% of my treatment sessions for domestic violence before stepping foot into my groups. This person responded less than enthused with my confession. However, it is the truth of how I provide my best practice. Fifty percent is preparation and the other fifty percent of my treatment efforts I decide in the beginning moments of group based on my assessment of the room, each person's nonverbal cues or direct identification of their needs that day, and – quite frankly – my belief in myself as a brilliant clinician to take the group where they need to go clinically to make treatment gains. I love this work and have been blessed with the skill of thinking on my feet and wordsmithing a conversation to be inclusive of group needs, competencies in focus, all the while addressing behaviors of abuse that clients speak openly about engaging in. It is a beautiful process.

The most I need walking into a group is remembering the competency I chose as the topic of the month and a refreshing review of my notes from the previous weeks, so I keep the momentum moving forward. My clients do not need to understand, memorize, and digest theories to progress. They are often not going to benefit from abstract psychological notions. Heck, half the time abstract concepts may even lose my attention.

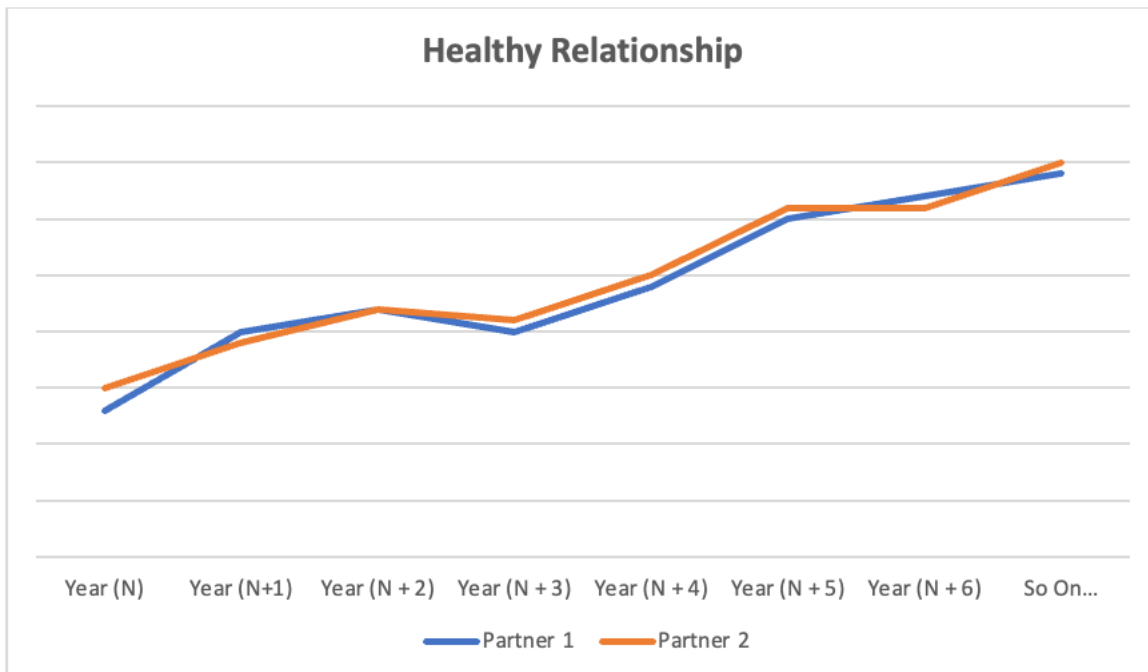
Domestic violence clients need tangible information that relates directly to their experiences, culture, and systems, so they have the highest chance of being able to transfer the information taught in treatment across environments. Clinicians are steered away from providing domestic violence treatment to high conflict clients in their home environment, for sound reasons. Therefore, clients do not have the opportunity to practice those skills learned in treatment directly in their home environment with the clinician present to reinforce, redirect, or reframe. In a reductionistic sense, we just “hope for the best” regarding client effort of using skills, reasoning, and behaviors relative to their interactions once they leave our office or sign out of our virtual treatment room.

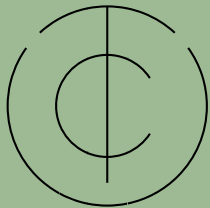
There is a lot at stake with this. That is why I purposely provide treatment in ways that reduce abstract methods or discussions. I provide visuals, often restate things multiple ways, use captions on videos, separate clients into small breakout rooms both with and without a clinician listening in, permit clients to use private chat or text my work phone during treatment, encourage writing notes, and various other multimodal efforts to ensure the information is “sticky,” accessible, and applicable to the clients I am treating.

One of my favorite visuals is one I created when I realized many clients asked for feedback or insight when they felt a separation and/or discord between their partner typically around months four (4) to six (6) in treatment. Instead of explaining an answer, I drew one. This small shift allowed the clients to actively see a separation of relationship through the use of a chart:



What we see often in healthy relationships is the continued evolution of change and growth, like below:





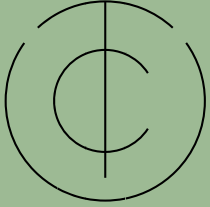
There are not areas without their events, difficulties, or conflict, but both parties commit and recommit to learning, growing, and accountability change efforts. When partners realize they are not dating the person they first met, but rather, they are dating the person in front of them today (experiences, changes, emergencies, pain, new traumas, and all), the commitment to ongoing efforts becomes a little bit easier. And the distinct difference between these charts is a mind-blowing “aha moment” for many in my treatment rooms.

Now you may be asking yourself, “Lindsey, how does this chart not slide an offending client into victim stance or victim blaming for the other person’s suspected lack of change or growth?” Simple. I am teaching clients to identify a gap. A distance. I am also teaching my clients to identify and accept the truth that we cannot control another person’s actions or efforts and subsequently, cannot expect someone to owe us something based on our efforts of change. The “it takes two” argument has little place in my treatment groups because our participation in the tennis match of conflict is our choice. We choose to hit the ball back. With the same process, we choose to make changes. Our changing does not require the other person to do so, and subsequently, the other person is maintaining their power with whatever their choice is. All my clients need to be clear on is if a gap in connection exists, they have now become cognizant of it and can address it with communication, a plan, a request for discussion, other solution, OR, they can see the gap as something to move on from instead of work through. This visual highlights the need for continued decisions, communication, and intentional action toward safety, security, and relationship health.

Another way I treat my clients is through my use of intentional and thoughtful self-disclosure. I provide examples, sometimes loosely, sometimes specifically, of behaviors of power and control I have engaged in, and this creates an evident shift in disclosures from the clients. They begin to lean more heavily into honesty and accountability with their past and present purposeful uses of power and control, and more readily step away from being covert and providing vague responses when asked to speak in group. It is an experience with clients that continues to give me goosebumps because I know, in those moments, risk to the victim, family, and community has reduced significantly. Once a person openly discusses their behaviors, they are more willing to receive feedback on those behaviors. Once a person recognizes and acknowledges their reasons for using abuse, they begin to challenge themselves and confront their faulty thoughts around their purposeful attempts of power and control. My self-disclosure is their permission slip to talk about their abuse. And they do.

## What Now?

Get started. Provider droughts are real. Clients, survivors, and communities need you. Children need you. Get trained. Do the work. Get more trained. Continue. Dive deep.



\*I felt it important to address the use of my wording choices in this document and in subsequent pieces of my writings. Problematic language may include terms that address the person by stigma, ailment, condition, disabilities, conviction, or other non-person-preferred or biased language. In using these words, we risk stigmatizing those we are trying to support, serve, or understand. However, there is a fundamental distinction on the use of specific language (e.g., convicted offenders) to support accessible and clear communication across systems and professional relationships. It is not in attempt to undermine the person or group’s individuality or personness, but rather maintaining accessibility of information to audiences and systems through shared term usage. It is evident that all people do not agree unanimously with terms for which to be called under certain categories they fall under for purposes of communication, outcomes, treatments, and beyond. This information is provided to you, the learner, to be informed that I use language mindfully and not carelessly, and for the foundational purposes of getting information across clearly with reduction of confusion of the message. I am a person-preferred language advocate and I want the messages I am speaking to be received with the intended meaning. To conclude this discussion, I, myself, am a learner, and will make mistakes along the way with personally planned and intentional efforts of reflection, repair, and improvement.

\*\*Group think is a phenomenon that occurs in groups of people. The outcome of a group agreement can be influenced by the faulty thinking that everyone is unanimously in agreement, the group is without any pressures or peer pressures, an “in members versus out members” indicating elite status of the group over others not a part of the group, the desire to minimize conflict internally in the group, and individual feelings behind acknowledging personal error or vulnerability during the group process which leads to a lack of correction of misinformation. These factors may ultimately result in the inability to consider alternate solutions or possibilities once decisions were perceived to be closing in on consensus.