WEST VIRGINIA
SECRETARY OF STATE
NATALIE E. TENNANT
ADMINISTRATIVE LAW DIVISION

Form #7

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2010 JUN 30 PM 4:09

OFFICE WEST VIRGINIA
SECRETARY OF STATE

Effective Date

NOTICE OF AN EMERGENCY RULE

AGENCY: WVDHHR/ Bureau for Behavioral Health and Health Facilities TITLE NUMBER: 64

CITE AUTHORITY: W.Va. Code 62-12-2(e) and 62-12-26(e)

EMERGENCY AMENDMENT TO AN EXISTING RULE: YES ___ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: ___

TITLE OF RULE BEING AMENDED: ___

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 87

TITLE OF RULE BEING PROPOSED: Sex Offender Treatment Program Certification

THE ABOVE RULE IS BEING FILED AS AN EMERGENCY RULE TO BECOME EFFECTIVE AFTER APPROVAL BY SECRETARY OF STATE OR 42ND DAY AFTER FILING, WHICHEVER OCCURS FIRST.

THE FACTS AND CIRCUMSTANCES CONSTITUTING THE EMERGENCY ARE AS FOLLOWS:

Patsy A. Hardy
Authorized Signature

Use additional sheets if necessary

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Sex Offender Treatment Program Certification

Type of Rule: X Legislative ___ Interpretive ___ Procedural

Agency: Health and Human Resources

Address: 1900 Kanawha Blvd. East
Bldg. 3, Room 206
Charleston, WV 25305

Phone Number: (304) 558-1555 Email: craig.a.richards@wv.gov

Fiscal Note Summary

Summarize in a clear and concise manner what effect this measure will have on costs and revenues of state government.

This rule establishes general standards and procedures for the certification of sex offender treatment services and programs and certification and training of persons who engage in activities related to sex offender treatment. This bill would necessitate the hiring of a contract Psychologist to fulfill this role. Currently, there are 28 forensic sexual offenders under the authority of the Secretary of the DHHR with varying jurisdictions. The current patient load could be expected to yield an approximate need of 13 licensed sex offender treatment programs throughout the state in order to establish appropriate accessibility from each of the Comprehensive Behavioral Health Center's catchment area. This number could be expected to change based on number of patients seeking the required treatment.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

Effect of Proposal	Fiscal Year		
	2010 Increase/Decrease (use"-")	2011 Increase/Decrease (use"-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	0	202,145	194,645
Personal Services		148,145	148,145
Current Expenses		46,500	46,500
Repairs and Alterations			
Equipment		7,500	
Other			
2. Estimated Total Revenues		11,050	11,050

3. Explanation of above estimates (including long-range effect):

Please include any increase or decrease in fees in your estimated total revenues.

The total estimated annual revenues to the Bureau are based upon the license fee of $850 per year multiplied by the number of licensed programs anticipated. Should the need for additional progrmas arise, the revenue would increase by $850 per year for each new license issued.cost to the Bureau for Behavioral Health and Health Facilities of $9,600 is based upon an estimated 240 hours of service at a rate of $40/hour for a Psychologist trained in the assessment of sex offenders.

The total (first year) cost to the Bureau for Behavioral Health and Health Facilities of $202,145 is based upon the following:
Personal services costs totaling $94,445 are broken down as follows: 1 HHR Specialist Sr. at $37,000, 1 HHR Specialist at $31,720, and 1 Office Assistant III at $25,725 for a total of $94,445.
Benefits totaling $53,700 are broken down as follows: admin. fees and health insurance - $23,502 ($7,834/FTE * 3 FTE), FICA and PERS - $23,281 (24.65% of personal services), Workers Compensation - $1,889 (2.00% of personal services) and OPEB - $5,029 ($139.69/mo/FTE).

Current expenses totaling $46,500 are broken down as follows: $32,500 to implement a license application review protocol to ensure that applications are appropriate for award and to implement a compliance review process of all licensed programs throughout the state (includes staff travel, lodging, and meals); $7,500 for travel for the Program Director/Coordinator (to attend meetings with providers); $1,500 for travel and training for one Office Assistant; and, $5,000 for travel and other expenses for DUI providers for planning and training (minimum of semi-annual meetings).

Equipment costs (for the first year) totaling $7,500 are broken down as follows: computers, phones, etc. for an HHR Specialist Sr., an HHR Specialist and one staff.

Memorandum

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

License fees and review procedures would have to be developed and integrated into the BHHF operations and as such, fiscal estimates are ased solely on anticiapted costs and revenues.

Date	Agency	Authorized Representative
	Department of Health and Human Resources	Patsy A. Hardy

Cabinet Secretary

Brief Summarv of the Rule

This Proposed rule, §64-87 Sex Offender Treatment Program Certification incorporates the amendments required by the passage of W. Va. Code §§62-12-2(e) and 26(e) implementing certification of Sex Offender Treatment Programs. This rule is promulgated as Legislative Rule $64-87, as mandated by the passage of the W .Va. Code §§62-12-2 and 26.

Statement of Circumstances Requiring the Proposed Rule

The circumstances that require this rule is W. Va. Code §§ 62-12-2(e) and 26(e), which were enacted by the legislature in 2006, charging DHHR to develop qualifications for sex offender programs. This rule sets forth the requirements for sex offender programs to be certified in the state of West Virginia for the protection of West Virginia residents and to ensure that sex offenders receive proper treatment. This rule is promulgated as mandated by the passage of the W.Va. Code §§62-12-2(e) and 26(e).

EMERGENCY RULE QUESTIONNAIRE

DATE: June 30, 2010

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM:(*Agency Name, Address & Phone No.*) Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350, Charleston WV 25301, 304-558-0562

EMERGENCY RULE TITLE: Sex Offender Treatment Program Certification

1. Date of filing 06/30/2010

2. Statutory authority for promulgating emergency rule:

   W.Va. Code 62-12-2(e) and W.Va. Code 62-12-26(e)

3. Date of filing of proposed legislative rule: 6/30/2010

4. Does the emergency rule adopt new language or does it amend or appeal a current legislative rule? No

5. Has the same or similar emergency rule previously been filed and expired?

   No

6. State, with particularity, those facts and circumstances which make the emergency rule necessary for the **immediate** preservation of public peace, health, safety or welfare.

   This rule sets for the requirements for sex offender programs to be certified in the State of West Virginia for the protection of West Virginia residents and to ensure that sex offenders receive proper treatment. This rule is promulgated as mandated by the passage of the W.Va. Code 62-12-2 and 26

7. If the emergency rule was promulgated in order to comply with a time limit established by the Code or federal statute or regulation, cite the Code provision, federal statute or regulation and time limit established therein.

W.Va. Code 62-12-26(e). The rule was to promulgated by September 30, 2006

8. State, with particularity, those facts and circumstances which make the emergency rule necessary to prevent substantial harm to the public interest.

The circumstances that require this rule is W.Va. Code 62-12-26(e), which was enacted by the legislature in 2006, charging DHHR to develop qualifications for sex offender programs. This rule sets forth the requirements for sex offender programs to be certified in the State of West Virginia for the protection of West Virginia residents and to ensure that sex offenders receive proper treatment. This rule is promulgated as mandated by the passage of the W.Va. Code 62-12-26(e).

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OFFICE WEST VIRGINIA
SECRETARY OF STATE

TITLE 64
LEGISLATIVE RULE
BUREAU FOR PUBLIC HEALTH
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

SERIES 87
SEX OFFENDER TREATMENT PROGRAM CERTIFICATION

§64-87-1. General.

1.1. Scope. -- This rule establishes general standards and procedures for the certification of sex offender treatment services and programs and certification and training of persons who engage in activities related to sex offender treatment. This rule should be used in conjunction with WV Code §§15-2C-2, 15-12-1 et. seq.; 15-13-1 et seq.; 61-8B-1; 61-8B-3; 62-11D-1; 62-11D-2; 62-12-2 and 62-12-26(c). The WV Code is available in public libraries and on the Legislature's webpage http://www.legis.state.wv.us/.

1.2. Authority. -- WV Code §§62-12-2(e) and 62-12-26(e).

1.3. Filing Date. --

1.4. Effective Date. --

1.5. Purpose. -- The purpose of this rule is to regulate the provision of sex offender treatment services for adults and juveniles through the formulation, and the regulation of standard applications and minimum certification of persons providing those services.

§64-87-2. Application and Enforcement.

2.1. Application. This rule applies to programs, as defined by this rule, that offer treatment services to sex offenders and training of persons who engage in activities related to sex offender treatment.

2.2. Applicability to Other Standards. When an individual receives care or treatment from a sex offenders treatment program, state and federal requirements, accreditation standards applicable to the program and the standards set forth in this rule apply. If there is a conflict between requirements, the more stringent standard applies.

2.3. Exceptions.

2.3.a. This rule does not apply to the following:

2.3.a.1. Entities operated by the federal government;

2.4.a.2. Information and referral services; and

2.4.a.3. A private practice, as that term is defined in this rule.

§64-87-3. Definitions.

3.1. Administrator. -- The individual responsible for the day-to-day operation of the agency.

3.2. Agency. -- The legal entity that operates a certified program.

3.3. Aversive Conditioning. -- Behavioral techniques that involve pairing deviant sexual arousal with a noxious stimulus in order to reduce or eliminate deviant sexual arousal.

3.4. Bureau. – The Bureau for Behavioral Health and Health Facilities in the State Department of Health and Human Resources.

3.5. Certified Individual. -- Except as used with certified polygraph analyst, an individual granted a certificate for completion of sex offender treatment training through a training program approved by the designated state oversight agency.

3.6. Certified Polygraph Analyst. -- A polygraph analyst meeting the definition of WV Code §62-11D-1.

3.7. Client. -- An individual receiving treatment or services in or from the program. Used interchangeably with adult sex offender and juvenile sex offender.

3.8. Collateral Psychosocial Interventions. -- Treatment interventions that are didactic/educational in nature and serve as collateral and supplementary interventions to sex offense specific treatment interventions.

3.9. Denial. -- The refusal or inability to acknowledge in whole or in part sexually deviant arousal, sexually deviant intent and/or sexually deviant behavior.

3.10. Designated State Oversight Agency. – The Bureau for Behavioral Health and Health Facilities is the Agency designated by the Secretary to provide regulatory oversight on behalf of the state of West Virginia; responsible for certifying, and monitoring sex offender treatment programs.

3.11. Deviant Sexual Arousal. -- A pattern of physiological sexual responses to inappropriate fantasies, thoughts, objects, animals and/or persons that may or may not precede a sexual act.

3.12. Discharge. -- The termination of a client's affiliation with the program.

3.13. Discharge Planning. -- The organized process of identifying the approximate length of stay and the criteria for exit of a client from the current service.

3.14. Empathy. -- The ability to identify and understand another person's feelings, situation, or ideas.

3.15. Grooming. -- The process of desensitizing and manipulating the victim(s) and/or others for the purpose of gaining an opportunity to commit a sexually deviant act and prevent disclosure.

3.16. Penile Plethysmograph or Vaginal Photoplethysmograph (PPG). -- A diagnostic method to assess sexual arousal by measuring the blood flow (tumescence) to the penis or vagina during the presentation of sexual stimuli in a controlled setting by providing the identification of a client's physiological arousal in response to sexual stimuli (audio/visual).

3.17. Plan. – A detailed formulation of a program of action.

3.18. Plan of Care. -- A written design

based upon the assessment of a client's sexual offenses that identifies problems, sets client goals and objectives and describes services, programs and activities required to support the achievement of the goals and objectives.

3.19. Plan of Correction. -- The written description of the actions the program intends to take to correct and prevent the reoccurrence of violations of rules and identified by the Bureau for Behavioral Health and Health Facilities during a survey or complaint investigation.

3.20. Policy. -- A statement of the principles that guide and govern the activities, procedures and operations of a program.

3.21. Primary Counselor. -- The individual designated by the program to serve as the client's counselor and advisor on a regular basis; a member of the client's interdisciplinary team.

3.22. Private Practice. -- The private office practice of one or more health professionals who practice a behavioral health profession and are licensed to practice in West Virginia pursuant to the provisions of chapter thirty of the WV Code.

3.23. Procedures. -- The methods by which policies are implemented.

3.24. Program. -- A system of services offered by an agency designed to address the treatment needs of sex offenders. To include a private practice as defined in this rule.

3.25. Program Coordinator. -- Designated staff member of the program responsible for the day-to-day operation of the program.

3.26. Quality Assurance. -- A method designed to objectively monitor and evaluate the quality and appropriateness of client services and identify methods to improve services and resolve problems.

3.27. Reoffense Prevention Plan. -- A multilevel plan that assists the client in developing strategies to address the risk factors or precursors that typically precede sex offenses.

3.28. Secretary. -- The Secretary of the West Virginia Department of Health and Human Resources or his or her designee.

3.29. Service. -- A functional division of a program; the delivery of care.

3.30. Sex Offender. -- An individual who comes to the attention of the program as a result of sexual behavior in violation of the code of West Virginia, federal law or the laws of another state.

3.31. Sex Offender Treatment. -- A long-term comprehensive set of planned clinical treatment experiences and interventions that directly relate to the client's own abuse or offending history, as well as his or her psychological and/or behavioral pathology that modify sexually deviant thoughts, fantasies and behaviors and that utilize specific strategies to promote change and to reduce the chance of re-offending.

3.32. Supervising Entity. -- The entity designated by the circuit court or the parole board to supervise the sex offender.

3.33. Variance. -- A formal agreement

between the bureau or designated oversight agency and the program that allows the program to comply with the intent of a regulatory requirement in a manner not permitted by the wording of the requirement; it may not be obtained based solely on the inability to achieve compliance.

3.34. Victim. -- An individual that is the target of a sex offender.

3.35. Victim Advocate. -- A person or agency acting on behalf of a victim to establish, expand, protect and enforce his or her human, legal and civil rights in a victim's best interest.

3.36. Waiver. -- A declaration that a certain rule is inapplicable in a particular circumstance.

§64-87-4. State Administrative Procedures.

4.1. General Certification Provisions.

4.1.a. All programs shall be operated by a state, county, city or other unit of government or have a business certificate or license from the Secretary of State, and are subject to standards contained within this rule.

4.1.b. Programs not operated by a unit of government shall be one or more of the following: a hospital licensed under "Hospital Licensure," 64CSR12; a behavioral health center licensed under "Behavioral Health Centers Licensure," 64CSR11; or a residential child care and treatment facility licensed under "Minimum Licensing Requirements for Residential Child Care and Treatment Facilities for Children and Transitioning Adults in West Virginia," 78CSR3; and are subject to standards contained within this rule in addition to relevant licensing requirements as specified by the Secretary.

4.1.c. Beginning January 1, 2011, before establishing, operating, maintaining or advertising a sex offender treatment program within the State of West Virginia, a program shall first obtain a certificate authorizing the operation from the Bureau.

4.1.d. The program shall meet the requirements of this rule in addition to any other applicable federal or state law and rule.

4.1.e. If the Bureau determines not to issue a certificate as applied for, the Bureau shall notify the applicant.

4.1.f. A certificate is valid for the program named in the application and is not transferable.

4.1.g. The program shall surrender an expired or otherwise invalid certificate to the Bureau upon written demand.

4.2. Certificate Application.

4.2.a. An application shall identify the service location(s) of the program and provide other information in accordance with forms provided by the designated state oversight agency.

4.2.b. A program shall submit an initial application to the Bureau not less than thirty days and not more than sixty days prior to the initiation of services.

4.2.c. A program shall submit a renewal application to the Bureau not less

than sixty days prior to the expiration of the current certificate.

4.2.d. A program shall submit an amended application to the Bureau not less than thirty days prior to a change if there is:

4.2.d.1. A change in the geographic location of a service or facility;

4.2.d.2. A change in bed capacity; or

4.2.d.3. A change in identifying information.

4.2.e. Except for applications from agencies operated by the state of West Virginia, a county, a city or other unit of government within West Virginia, applications for an initial, amended or renewal certificate shall be accompanied by a non-refundable certificate fee in the following amounts:

4.2.e.1. Initial and amendment license fees shall be set at $850, subject to subsequent adjustments according to increases in the consumer price index;

4.2.e.3. Renewal license fees shall be set at $850, plus $25 per licensed bed, subject to subsequent adjustments according to increases in the consumer price index if any; and

4.2.e.4. The annual fee shall be adjusted on June 1st of each year to correspond with increases in the consumer price index.

4.2.f. If the Bureau does not receive a complete application with required fee for a renewal license by the end of the licensure period, the existing certificate shall expire.

4.3. Issuance.

4.3.a. The Bureau shall make an inspection prior to the issuance of an initial, renewal or provisional certificate.

4.3.b. Following an application review and an onsite inspection or inspections with approval of subsequent plans of correction as needed, the Bureau shall, if there is substantial compliance with this rule, issue one of following:

4.3.b.1. An initial certificate valid for six months from the date of issuance shall be issued to programs establishing a new service found to be in substantial compliance on initial review with regard to policy, procedure, facility and recordkeeping regulations;

4.3.b.2. A provisional certificate shall be issued when a program seeks a renewal certificate and is not in substantial compliance with this rule but does not pose a significant risk to the rights, health and safety of a client. It expires not more than six months from date of issuance, unless the provisional recommendation is that of the state fire marshal; or

4.3.b.3. A renewal certificate shall be issued when a program is in substantial compliance with this rule and expires not more than one year from date of issuance.

4.3.c. The Secretary may make an inspection prior to the issuance of an amended certificate.

4.3.d. The Secretary may provide consultation to the agency in obtaining compliance with this rule.

4.4. Inspections.

4.4.a. To carry out the intent of this rule, the Bureau shall require inspections by authorized representatives.

4.4.b. Inspections shall include, but are not limited to:

4.4.b.1. Observation of the service delivery milieu;

4.4.b.2. Review of life safety and environment;

4.4.b.3. Review of clinical and administrative records; and

4.4.b.4. Interviews with clients, employees, staff and/or administrators.

4.4.c. If a certified program is accredited by an accreditation body, it shall supply copies of all relevant accreditation reports to the designated state oversight agency within ten days of receipt of the report.

4.4.d. The program shall comply with any request from the Bureau to have access to the program, staff, clients and records.

4.4.e. Within fifteen working days of completion of an inspection, the Bureau shall issue a report.

4.4.f. An onsite inspection is not always required for issuance of an amended certificate.

4.4.g. The program may contest any deficiency issued by the Bureau or designated state oversight agency. This disagreement must be supported by documentation or other credible evidence. An informal meeting may be held to resolve a dispute.

4.4.h. Requests for meetings must be filed in writing with supporting documentation. The Bureau reserves the right to determine if a meeting shall be held.

4.4.i. The agency may not use the informal dispute resolution process to delay the formal imposition of remedies.

4.5. Reports and Records.

4.5.a. The Bureau shall maintain a report of any inspection.

4.5.b. A report of an inspection shall specify the deficiency and the provision of the rule it violates and describe the precise data that supports the deficiency.

4.5.c. Information in reports or records is available to the public except:

4.5.c.2. Information required to be kept confidential by federal law as provided under the Privacy Rule of the federal Health Insurance Portability and Accountability Act of 1996; and

4.5.c.3. Information required to be kept confidential by state law as provided for in the "Behavioral Health Consumer Rights" rule, 64CSR74, §64-74-11.

4.5.d. A report of an inspection made public shall be made public when a plan of correction has been submitted to, or approved by the Bureau.

4.6. Plans of Correction.

4.6.a. Within ten working days after receipt of the inspection report, the program shall submit to the Bureau, for approval, a written plan to correct all deficiencies that are in violation of this rule, unless a variance is requested by the program and granted by the Bureau. The plan shall specify:

4.6.a.1. Any action taken or procedures proposed to correct the deficiencies and prevent their reoccurrence;

4.6.a.2. The date of completion of each action taken or to be taken; and

4.6.a.3. The signature of the administrator or his or her designee.

4.6.b. The Bureau shall approve, modify or reject the proposed plan of correction in writing. The program may make modifications to the plan at a later date in conjunction with the Bureau.

4.6.c. The Bureau shall in writing state the reasons for rejection or modification of any plan of correction.

4.6.d. Upon receipt of a rejection of a plan of correction, the program shall submit a revised plan of correction to the Bureau within ten working days from the date the program is notified of the rejection. The Bureau may issue a directed plan of correction if the revised plan submitted by the program is not approved.

4.6.e. The program shall immediately correct a violation that severely risks the health or safety of a client or other persons.

4.6.f. The Bureau shall determine if corrections have been made.

4.7. Waiver and Variance.

4.7.a. The Secretary may grant a waiver or variance to a provision of this rule as long as:

4.7.a.1. Its application clearly would be impractical and alternate arrangements serve the best interest of quality of care and are not detrimental to the health, well-being or safety of the client, the victim or the community; and

4.7.a.2. The waiver or variance is written, approved by the Secretary and reviewed with each certificate renewal by the designated state oversight agency.

4.7.b. No waiver shall be granted for an issue involving the health or safety of a client, a victim or the community or that violates any state or federal statute.

4.8. Certificate Denial, or Decrease in Census.

4.8.a. The Bureau may deny the program's application for certification or certificate renewal if:

4.8.a.1. The Bureau makes a determination that fraud or other illegal action has been committed;

4.8.a.2. The program has violated federal, state or local law relating to building, health, fire protection, safety, sanitation or zoning;

4.8.a.3. The program's practices jeopardize the health, safety, welfare or clinical treatment of a client, victim or the community;

4.8.a.4. The program fails or refuses to submit reports or make records available as requested by the Bureau; or

4.8.a.5. The program refuses to provide access to its location or records when requested by the Bureau.

4.9. Administrative Due Process.

4.9.a. Any agency aggrieved by an order or other action by the Secretary based on this rule may request in writing a hearing by the Secretary in accordance with the Division of Health rule, "Rules of Procedure for Contested Case Hearings and Declaratory Rulings," 64CSR1, a copy of which may be obtained from the Secretary of State.

§64-87-5. Staffing.

5.1. Program Coordinator.

5.1.a. Each program shall have a designated program coordinator.

5.1.b. The program coordinator is responsible for:

5.1.b.1. Administration and supervision of all treatment services; and

5.1.b.2. Ensuring that the program conforms with all applicable local, state and federal regulations and rules regarding sex offender treatment.

5.1.c. The coordinator shall meet the minimum qualifications which include:

5.1.c.1. A physician licensed to practice medicine in the State of West Virginia with a valid board certification in psychiatry; or

5.1.c.2. A master's level clinical professional who is licensed as a psychologist, or clinical social worker, including licensed graduate social worker, licensed clinical social worker, and licensed independent clinical social worker; or

5.1.c.3. A counselor who is licensed in West Virginia.

5.1.d. The coordinator shall have at least four years documented clinical experience in the areas of assessment and treatment of sex offenders obtained within the past seven years specific to the target population of juveniles or adults.

5.2. Treatment Staff.

5.2.a. The program shall assign a primary counselor to each client.

5.2.a.1. For community-based programs, the counselor shall have a master's degree or higher and be licensed or license eligible/under supervision as a physician, counselor, psychologist, social worker or other health professional field or be certified.

5.2.a.2. For correctional programs that are institutional, the counselor shall meet the requirements under 5.2.a.1. above or shall have a bachelor's degree or higher in counseling, psychology, social work or other health professional field and be under the supervision of a master's level person meeting the requirements of 5.2.c.

5.2.b. Ratios of primary counselor to persons served shall be adequate to provide services in conformance with the standards of practice provided in Section 9 of this rule.

5.2.c. The program shall provide direct supervision for counselors by a master's level or above clinical professional who is licensed, certified, or license eligible and under supervision of a psychiatrist, counselor psychologist, clinical social worker or other health professional and who has three year's direct experience in the field of sex offender treatment as indicated below.

5.2.c.1. Counselors with less than three years experience in sex offender treatment shall receive at least one hour of supervision for every twenty hours of direct service.

5.2.c.2. Bachelor level counselors with more than three years experience in sex offender treatment shall receive at least one hour of supervision for every forty hours of direct service.

5.2.c.3. Master's level counselors with more than three years experience in sex offender treatment are not required to have direct clinical supervision.

5.2.c.4. Supervision may be group in nature, but must consist of case consultation and discussion and/or clinical training rather than administrative oversight. The program coordinator is responsible for documentation of supervision, which shall be available for review at all times.

5.2.d. Newly employed counselors without experience in a sex offender treatment program and other non-physician clinical staff without experience in a sex offender treatment program prior to the independent performance of clinical activities shall receive initial training lasting at least twenty hours and consisting of, at a minimum, the following:

5.2.d.1. Sex offender treatment overview;

5.2.d.2. Program policy and procedure;

5.2.d.3. Cultural sensitivity as necessary and appropriate;

5.2.d.4. Current strategies for identifying and treating sex offenders;

5.2.d.5. Identification of co-occurring mental health or developmental disorders;

5.2.d.6. Risk assessment;

5.2.d.7. Understanding sex offender deception; and

5.2.d.8. Other clinical issues as appropriate for the population served.

5.2.e. The program may document that experienced counselors newly

employed from other sex offender treatment programs are exempted from mandatory initial training by the Secretary.

5.2.f. Counselors with less than one year of full time experience in the field of sex offender treatment shall accompany an experienced counselor during the performance of a clinical activity for a minimum of two weeks before seeing persons served without immediate and constant supervision.

5.2.g. The primary counselor is responsible for developing and implementing the client's plan of care, in coordination with other members of the treatment team. The plan of care shall address the social, environmental, psychological and familial issues related to the individual's maladaptive patterns of sexual behavior and other high risk and/or destructive behaviors. The counselor is responsible for assisting the client to alter life styles and patterns of behavior in order to improve the individual's ability to function adaptively in his or her family and community.

5.2.h. The program shall have counselors available qualified to deal with issues such as domestic violence, substance abuse and anger management.

5.2.i. Policies shall ensure that gender specific groups will be available to all clients, as clinically indicated.

5.3. Assessment Staff.

5.3.a. Staff completing sex offender-specific assessments must, at a minimum, have a bachelor's degree in counseling, psychology, social work, other health-related field or criminal justice.

5.3.a.1. The program must provide or document that the individual has received specific training in the purpose and administration of any assessment to be administered.

5.3.a.2. Supervision must be provided by a qualified person holding a master's degree and meeting the requirements for a primary counselor.

5.3.b. Any individual who interprets the results of the sex offense-specific assessments should have a master's degree, appropriate experience and training, and be licensed and/or certified in a behavioral health field.

5.4. Psycho-Education Staff.

5.4.a. Any staff providing collateral psychosocial interventions must, at a minimum, have a bachelor's degree or higher in one of the following fields: counseling, social work, psychology, a health-related field or criminal justice.

5.4.a.1. The program must document that the staff has the appropriate experience and provide, or document, that the staff has received specific training on the interventions being provided.

5.4.a.2. Supervision must be provided by an appropriately trained and experienced professional holding a master's degree or above and meeting the requirements for a primary counselor.

5.4.b. Any individual using a workbook-specific curriculum must have, at a minimum, a bachelor's degree and be

working under the supervision of an appropriately trained and experienced professional with a master's degree and meeting the requirements for a primary counselor.

5.5. Employees and contracted staff providing direct care to sex offenders shall be twenty-one years of age or older and capable of performing the duties assigned.

§64-87-6. Staff Training and Credentialing.

6.1. Each program shall ensure that:

6.1.a. Counselors and other licensed or certified care providers maintain their current license and comply with the credentialing requirements of their own professions;

6.1.b. All clinical staff receive initial education specific to treatment of sex offenders;

6.1.c. All clinical staff receive twenty continuing education units annually; and

6.1.d. Detailed job descriptions are developed for credentialed and non-credentialed staff that clearly define the qualifications and competencies required to provide specific services.

§64-87-7. Client Records.

7.1. All records shall be maintained for a minimum of five years from the time that the documented treatment is provided, except for juvenile sex offender records which must be maintained for five years after the client reaches age eighteen. Records may be stored in an electronic format as long as they are easily retrieved.

7.2. Client records are confidential and shall be updated in a timely manner.

7.3. Entries shall be legible and organized in an effective manner, allowing easily retrieved materials.

7.4. Program procedures shall ensure security of all records including electronic records, if any.

7.5. Individual records shall contain:

7.5.a. Identifying and basic demographic data and the results of the screening process;

7.5.b. An initial assessment report;

7.5.c. A biopsychosocial history or update completed within thirty days of the client's admission to the program;

7.5.d. Medical reports including results of the physical examination, past medical history, family medical history, laboratory reports and progress notes;

7.5.e. Dated case entries of all significant contacts with clients, including a record of each counseling session in chronological order;

7.5.f. Dates and results of case conferences for clients;

7.5.g. The initial plan of care;

7.5.h. Any amendments to the initial plan of care;

7.5.i. Reviews of the initial plan of care;

7.5.j. The long-term plan of care;

7.5.k. Any amendments to long-term plan of care;

7.5.l. Reviews of the long-term plan of care;

7.5.m. Documentation that services listed in the plan are available and have been provided or offered;

7.5.n. A written report of the process and factors considered in decisions impacting client treatment or any other significant change in treatment, both positive and negative;

7.5.o. A record of correspondence with the client, family members and other individuals and a record of each referral for services and its results;

7.5.p. Documentation that the client was provided with a copy of the program's rules and regulations and a copy of the client's rights and responsibilities and that these items were discussed with her or him;

7.5.q. Consent forms, releases of information, etc.; and

7.5.r. A closing summary, including reasons for discharge and any referral. In the case of death, the cause of death shall be documented.

7.6. The program shall have a written policy on confidentiality of client records.

7.6.a. The policy shall specify the conditions under which client records and information can be released without written authorization from the client.

7.6.b. The policy shall include release of client records to the supervising entity without written authorization from the client or the client's legal guardian.

7.6.c. The client shall be informed of this policy, and this shall be documented in the case file.

§64-87-8. Client Services Standards - General.

8.1. Applicability.

8.1.a. General client services standards apply to all certified programs.

8.2. Program Description.

8.2.a. Each program shall have a written description that shall include:

8.2.a.1. A description of the population to be served;

8.2.a.2. A description of the types of services offered;

8.2.a.3. A statement recognizing that the protection of the community is the highest priority of treatment and if treatment needs and community safety conflict, community safety takes priority; and

8.2.a.4. Exclusion criteria.

8.2.b. The program shall admit only those clients whose service needs are consistent with its service description, to whom services are available, and for which staffing levels and types meet the needs of

the clients to be served.

8.2.c. The program shall admit only clients whose identified needs can be met by the program.

8.3. Client Screening.

8.3.a. The program shall maintain written documentation of each screening performed, including:

8.3.a.1. The date of initial contact;

8.3.a.2. The name, age and gender of the individual;

8.3.a.3. The individual's address and phone number, if applicable;

8.3.a.4. Presenting needs or situation to include psychiatric and medical problems, current medications and history of medical care;

8.3.a.5. The name of the screening employee or independent health contractor;

8.3.a.6. The method of screening;

8.3.a.7. The screening recommendation; and

8.3.a.8. Disposition of individual referral.

8.3.b. If the individual is admitted, the screening documentation shall be included in the client's record.

8.4. Client Admission.

8.4.a. A client or his or her legal representative shall sign a written consent for the program's services prior to treatment unless otherwise indicated by the W.Va. code. This shall include a signed acknowledgement of limited confidentiality to allow all members of the treatment team to freely share information between those charged with managing the supervision and treatment of the client.

8.4.b. Upon admission, the client or his or her legal representative shall sign verification that he or she was informed in writing of his or her rights and responsibilities.

8.4.c. Upon admission, the client or his or her legal representative shall sign verification that he or she was informed in writing that he or she may contact the Bureau for Behavioral Health and Health Facilities or if his or her legal representative if unsatisfied with any aspect of the client's treatment they may do the same. This information shall include the address, phone number and fax number for the contact.

8.4.d. The program shall have a formal intake process that assesses a client using its criteria for admission and only admits a client who meets those criteria.

8.4.e. Intake documentation shall include all relevant preliminary screening and diagnostic, social, medical and legal information, and shall be signed and dated by the person completing the intake.

8.5. Client Discharge.

8.5.a. Discharge planning shall be

based on court order and/or client needs with the court order taking precedence.

8.5.b. A written discharge summary shall be entered in a client's record within thirty days of discharge and include:

8.5.b.1. The reasons for discharge;

8.5.b.2. The client's status and condition at discharge;

8.5.b.3. A final evaluation summary of the client's progress toward the goals set in the plan of care;

8.5.b.4. A plan developed in conjunction with the client, when available, for care after discharge and for follow-up; and

8.5.b.5. The signature of the staff completing the summary.

8.6. Quality Assurance.

8.6.a. The program shall have and implement a quality assurance program that evaluates the effectiveness of the services provided by the program.

§64-87-9. Principles of Practice.

9.1. State Principles of Practice.

9.1.a. Interventions shall be designed to assist the individual to effectively manage thoughts, feelings, attitudes and behaviors associated with his or her risk to reoffend. Structured, cognitive behavioral skills-oriented treatment programs shall target specific criminogenic needs to reduce re-offense rates. Interventions utilized in the assessment and treatment of sex offenders and juvenile sex offenders shall be empirically validated and generally accepted by professionals in this field.

9.1.b. Programs shall utilize the following principles when providing sex offender assessment and treatment:

9.1.b.1. Be committed to community protection and safety and be aware of any professional and legal obligations regarding a duty to protect or warn;

9.1.b.2. Not make statements that a client is no longer at any risk to reoffend sexually;

9.1.b.3. Act in the best interests of society, the victim and the client; and

9.1.b.4. Hold voluntary and mandated clients to the same standards of compliance.

9.1.c. Programs shall have the following written policies:

9.1.c.1. Restraint policies that permit restraint for the protection of clients, others they may harm or prevention of property destruction. Restraint policies should define the method of restraint;

9.1.c.2. Policies requiring the collaboration and coordination with all agencies involved with the client including probation/parole, law enforcement, etc.; and

9.1.c.3. A policy on biomedical approaches which mandates that use of

psychopharmacological agents shall never be the only method of treatment. Physical or chemical castration shall be utilized only as an adjunct to treatment and not in lieu of treatment.

9.1.d. Programs that provide services to women or developmentally disabled clients shall modify the program to address the needs of the clients served.

9.1.e. Programs shall be familiar with the criminal and/or juvenile justice system, depending upon client population served, and the applicable confidentiality laws concerning sex offenders.

9.2. General Assessment Standards (Adults and Juveniles).

9.2.a. The assessment shall focus on the strengths, risks and needs of the client, and identifying factors from social and sexual history that may contribute to sexual deviance. Assessments shall provide the basis for the development of comprehensive plans of care and shall provide recommendations regarding the intensity of intervention, specific treatment protocol needed, amenability to treatment, as well as the identified risk the adult sex offender and/or the juvenile sex offender present to the community and the community's ability to manage that risk.

9.2.b. Program staff shall refrain from assessment protocols outside the scope and recognized boundaries of the staff competencies.

9.2.c. In preparing assessments of adult sex offenders and juvenile sex offenders, programs shall:

9.2.c.1. Be culturally sensitive, fair and impartial, providing objective and accurate data;

9.2.c.2. Respond only to referral questions that fall within the program staff's expertise and present level of knowledge;

9.2.c.3. Be respectful of the client's right to be informed of the reasons for the assessment, the interpretation of data, the basis for recommendations and conclusions;

9.2.c.4. Have knowledge of the client's legal status;

9.2.c.5. Understand the limitations of a client's self-report and make all possible efforts to verify the information provided by the client;

9.2.c.6. Use assessment procedures and techniques sufficient to respond to the presenting issues and provide appropriate substantiation for the resulting conclusions and recommendations;

9.2.c.7. Acknowledge if an assessment consisted of only a clinical review without client contact;

9.2.c.8. Provide clients, in writing, informed consent, statement of disclosures, releases and/or exceptions to confidentiality, and employ verbal explanations for clients who do not meet the reading or comprehension level required; and

9.2.c.9. Thoroughly review all available written documentation and

collateral interviews.

9.2.d. Programs shall subscribe and adhere to the following tenets regarding the client assessment:

9.2.d.1. If a client does not meet the reading or comprehension level required by an assessment instrument, arrangements for using a standardized approved auditory (taped or read) version of the test instrument shall be made to the extent such versions are available.

9.2.d.2. The clinical interview shall incorporate sufficient discussion necessary to augment, clarify and explore the information obtained from the review of collateral materials and contacts and other components of the assessment;

9.2.d.3. Programs shall make every effort to obtain the official offense report to compare the degree of similarity or disparity between the client's and the victim's statements;

9.2.d.4. Assessment of treatment needs shall identify strengths and weaknesses in the individual's psycho-sexual functioning for the purpose of directing treatment efforts to the appropriate areas;

9.2.d.5. When formulating recommendations, community safety and the degree to which a client and the community is capable and willing to manage risk shall be considered;

9.2.d.6. Based on the assessment protocol, if a significant amount of time has lapsed between the time of the assessment and when the client is accepted into a program, an assessment update shall be required;

9.2.d.7. An assessment update shall collect current data upon which the original plan of care can either be confirmed or amended; and

9.2.d.8. Programs shall make an effort to recommend the most appropriate treatment available and objectively state the level of risk management regardless of whether existing limited resources preclude or other circumstances adequate or appropriate services.

9.3. Assessment Standards for Adult Sex Offenders.

9.3.a. Programs shall assess all clients and develop a plan of care for each client.

9.3.b. A comprehensive assessment shall be completed within thirty days of a client being accepted into the treatment phase of the program. The assessment of adult sex offenders shall include:

9.3.b.1. Mental status examination;

9.3.b.2. Clinical interview;

9.3.b.3. Sex offense behaviors;

9.3.b.4. Recommendations for case management, treatment planning and further assessments;

9.3.b.5. Personality assessment, as appropriate; and

9.3.b.6. Intellectual assessment,

as appropriate.

9.3.c. Efforts shall be made to acquire the following information gathered in the assessment process, as appropriate:

9.3.c.1. Psychiatric history;

9.3.c.2. Medical history of head injuries, physical abnormalities, enuresis, encopresis, current use of medication, allergies, accidents, operations and major medical illnesses;

9.3.c.3. Self-destructive behaviors, self-mutilation and suicide attempts;

9.3.c.4. Psychopathology and personality characteristics;

9.3.c.5. Family history and marital/relationship history;

9.3.c.6. History of physical, emotional and/or sexual victimization;

9.3.c.7. Education and occupation history;

9.3.c.8. Criminal history;

9.3.c.9. History of violence and aggression including use of weapons;

9.3.c.10. History of truancy, fire-setting and abuse of animals;

9.3.c.11. Interpersonal relationships, both past and current;

9.3.c.12. Cognitive distortions;

9.3.c.13. Social competence;

9.3.c.14. Impulse control;

9.3.c.15. Substance abuse;

9.3.c.16. Official report regarding the instant sex offense;

9.3.c.17. Denial, minimization and inability to accept responsibility;

9.3.c.18. Sexual history including sexual development, adolescent sexuality and experimentation, dating history, intimate sexual contacts, gender identity issues, adult sexual practices, masturbatory practices, sexual dysfunction, fantasy content and sexual functioning; and

9.3.c.19. Sex offense behavior, including description of offense behaviors, number of victims, gender and age of victims, frequency and duration of abusive sexual contact, victim selection, access, grooming behaviors, use of threats, coercion or bribes to maintain victim silence, degree of force used before, during and/or after offense and deviant arousal patterns.

9.4. Treatment Standards for Adult Sex Offenders.

9.4.a. Programs shall adhere to the following standards when providing treatment to an adult sex offender:

9.4.a.1. Cognitive-behavioral approaches shall be utilized in sex offender treatment groups;

9.4.a.2. Treatment groups for non-developmentally disabled adults shall not be less than sixty minutes in length with

no more than twelve clients per group or fifteen, if there are two counselors;

9.4.a.3. Individual therapy, self-help groups, drug intervention, or other therapies shall be used primarily as adjuncts to more comprehensive sex offender treatment;

9.4.a.4. A written individualized plan of care shall identify the needs, issues, intervention strategies and goals of treatment and shall be prepared for each client within seven days of beginning treatment. Plans of care should be updated at least every six months;

9.4.a.5. Progress, or lack of progress, shall to be based on clearly specified objective criteria, refusal or failure to attend or participate in treatment, failing to abide by the client's plan of care and/or contracts, or any disclosures regarding violations of supervision, shall be clearly documented in treatment records. Programs shall provide and communicate this information to the appropriate supervising agency or pursuant to the court order;

9.4.a.6. Progress in treatment shall be based on specific, measurable objectives, with observable changes, the demonstrated ability to apply changes in relevant situations and comply with supervision requirements clearly documented. These changes shall be demonstrated by an increased understanding by the client of his/her own deviant behavior, understanding of current and sex offense sequence, increase in pro-social behaviors, compliance with supervision, increase in support systems and victim empathy;

9.4.a.7. Monthly treatment progress reports shall be distributed to the supervising agency, as appropriate. Discharge reports shall be issued according to the supervising agency policy or pursuant to the court order;

9.4.a.8. When a client has attained the goals outlined in the individualized plan of care, there should be a gradual and commensurate adjustment of interventions documented in an updated plan of care;

9.4.a.9. A program may refuse to treat a client;

9.4.a.10. A program shall have referred the client to a more comprehensive treatment program and/or to the judicial system when the program determines that a client is not making the necessary progress in treatment to reduce the client's risk to the community;

9.4.a.11. A program may decide to decline further involvement with a client who refuses to address any critical aspect of treatment;

9.4.a.12. A program shall immediately notify the appropriate authority when a client refuses or fails to comply with court-ordered treatment or probation or parole-ordered treatment;

9.4.a.13. Some degree of denial shall not preclude a client from entering treatment, although the degree of denial may be a factor in identifying the most appropriate form and location of treatment;

9.4.a.14. Modifications in

treatment and in expectations for treatment outcomes may be required in instances of persistent denial;

9.4.a.15. A program shall not rely exclusively on self-report by the client to assess progress or compliance with treatment requirements and/or conditions of probation, parole or supervised release. Programs shall rely on multiple sources of information, which may include information from collateral contacts, physiological methods, or other research-based sexual interest assessments;

9.4.a.16. Physiological methods or measures of sexual interest assessment shall not replace other forms of monitoring but may improve accuracy when combined with active surveillance, collateral verifications, and self-report. Penile plethysmograph or vaginal photoplethysmograph (PPG) assessments in West Virginia shall be conducted under the direction of a qualified practitioner; and

9.4.a.17. Polygraph examinations shall only be/administered by a certified polygraph analyst. It is primarily the program's responsibility for preparing the client for any polygraph. Sexual history polygraphs shall include all aspects of a client's sexual behaviors and a victim's list that occurred prior to the offense of conviction. Programs shall obtain the official offense report and shall ensure the polygraph examiner has the official offense report in order to administer the offense polygraph examination;

9.4.a.18. Informed consent shall be obtained prior to engaging clients in aversive conditioning;

9.4.a.19. Programs shall communicate and exchange information with the child protective services, child care licensing and with appropriate agencies regarding the safety of a child or children in the primary residence in which a sex offender resides;

9.4.a.20. The safety of children takes precedence and the highest priority shall be given to the rights, well-being and safety of children when making decisions about contact between the client and children. Supervised visits may be considered if:

9.4.a.20.A. It is determined that sufficient safeguards exist to protect the child(ren);

9.4.a.20.B. It does not impede the sex offender's progress in treatment; and

9.4.a.20.C. If it is compliant with the conditions of probation, parole or supervised release;

9.4.a.21. If possible, treatment referrals should be offered to the non-offending partners and children in cases where a parent or legal guardian has been removed;

9.4.a.22. Family support and participation in the treatment of the adult sex offender should be included when applicable and appropriate. Sexual assault victims or vulnerable children shall be excluded until such time as joint therapy is determined to be appropriate; and

9.4.a.23. The program shall make every effort to collaborate with the

victim's therapist in making decisions regarding communication, visits and reunification. Contact shall be arranged in a manner that places child/victim safety first.

9.5. Assessment Standards for Juvenile Sex Offenders.

9.5.a. The assessment of juvenile sex offenders shall include:

9.5.a.1. The assessment shall focus on strengths, risks and needs of the juvenile sex offender and shall identify factors from social and sexual history which may contribute to sexual deviance and minimize the likelihood that the individual will engage in delinquent or abusive behavior;

9.5.a.2. Assessments shall form the basis or foundation of a comprehensive plan of care and recommendations regarding the intensity of intervention, specific treatment protocol needed and amenability to treatment, as well as the identified risk the juvenile with sexual behavioral problems presents to the community;

9.5.a.3. A comprehensive evaluation and assessment of juvenile sex offenders shall be an ongoing and continuing process;

9.5.a.4. The assessment shall be age appropriate;

9.5.a.5. The assessment shall be sensitive to any cultural, language, ethnic, developmental, sexual orientation, gender, medical and/or educational issues that may arise during the assessment;

9.5.a.6. The assessment shall be developmentally appropriate which includes social, cognitive and educational levels, as well as measures specifically designed for youth; and

9.5.a.7. A comprehensive assessment shall be completed within thirty days of a client being accepted into treatment program.

9.5.b. A reasonable effort should be made to secure the following information gathered in the assessment process:

9.5.b.1. Intellectual and cognitive functioning;

9.5.b.2. Mental status psychiatric history/hospitalization;

9.5.b.3. Medical history;

9.5.b.4. Self-destructive behaviors including self-mutilation and suicide attempts;

9.5.b.5. Description of the family origin, family history and relationship history, including exposure to domestic violence;

9.5.b.6. Juvenile history;

9.5.b.7. Sex offender registration status;

9.5.b.8. History of violence and aggression;

9.5.b.9. History of school truancy, fire-setting, abuse of animals and running away;

9.5.b.10. Cognitive distortions;

9.5.b.11. Impulse control;

9.5.b.12. History of physical, emotional and/or sexual victimization;

9.5.b.13. Social and educational competence;

9.5.b.14. Sexual education, knowledge and information;

9.5.b.15. Strengths and assets, family support and pro-social activities;

9.5.b.16. Substance use or abuse;

9.5.b.17. Official reports regarding sex offense;

9.5.b.18. Sexual history including sexual development, sexuality and experimentation, gender identity issues, masturbatory practices and fantasy content; and

9.5.b.19. Sex offense behavior, including a description of the offense behaviors, number of victims, gender and age of victims, frequency and duration of sexual contact, victim selection, access, grooming behaviors, use of threats, coercion or bribes to maintain victim silence, degree of force used before, during and/or after the sexual behavior and sexually deviant arousal patterns.

9.5.c. If phallometric assessment or aversive treatment techniques are utilized with persons seventeen years of age or younger, informed consent for such assessment and treatment shall be obtained from the juvenile sex offender and written consent for such assessment and treatment shall be obtained from the juvenile's parents or legal guardians. The procedures shall be reviewed and approved by the multidisciplinary professionals or institutional advisory group. Stimuli shall be specific for use with adolescents.

9.5.d. Individuals that are pre-pubescent or under the age of thirteen shall not undergo phallometric assessment or aversive treatment except in rare cases, which shall be reviewed and approved by the multidisciplinary professionals or institutional advisory group.

9.5.e. Collateral Information. The treatment provider shall review written documentation and collateral interviews, if available. The review should involve collecting information from all available and relevant sources concerning the juvenile and the victim(s), including:

9.5.e.1. Parent(s), guardian(s), or custodian(s);

9.5.e.2. Sibling(s);

9.5.e.3. Victim(s) statement(s);

9.5.e.4. School records;

9.5.e.5. Child protective services;

9.5.e.6. Previous treatment providers;

9.5.e.7. Mental health professionals;

9.5.e.8. Law enforcement;

9.5.e.9. The following information should be obtained from the supervising agency, if possible:

9.5.e.9.A. Court order or judgment;

9.5.e.9.B. Victim(s) information;

9.5.e.9.C. Juvenile risk assessment;

9.5.e.9.D. Data collection form; and

9.5.e.9.E. Official offense report.

9.5.f. Risk Assessments. The estimate of risk shall be a combination of the clinical interview and the assessment instruments. Risk assessments specific to juveniles shall be utilized and are available in the public domain.

9.5.g. Substance Abuse Assessment. Programs shall use a valid and reliable assessment tool to screen for substance abuse.

9.5.h. Polygraphs. The program is primarily responsible for preparing the juvenile for any polygraph. If polygraphs are utilized, the program shall:

9.5.h.1. Obtain the official offense report prior to administering the polygraph;

9.5.h.2. Include all aspects of a client's sexual behaviors and a victim's list for the sexual history polygraph;

9.5.h.3. Have a policy for informed consent; and

9.5.h.4. Ensure that the polygraph examiner is a certified polygraph analyst.

9.5.i. Assessment Recommendations. The following issues shall be addressed when formulating recommendations:

9.5.i.1. The strengths, risks, needs and the degree to which a juvenile is capable and willing to manage risk; and

9.5.i.2. Co-morbidity, placement, education/vocational needs, parent or guardian and family issues, substance abuse issues and supervision.

9.6. Treatment Standards for Juvenile Sex Offenders.

9.6.a. Treatment shall incorporate both cognitive/behavioral and reoffense prevention plans to reduce recidivism. A multifaceted program shall be age and developmentally appropriate and may include, but is not limited to the following:

9.6.a.1. Group and individual cognitive behavioral treatment; females shall not be treated in the same groups with male juveniles;

9.6.a.2. Sex offense sequence;

9.6.a.3. Reoffense prevention plans;

9.6.a.4. Family therapy;

9.6.a.5. Victim empathy;

9.6.a.6. Adjunct therapy may include substance abuse treatment, anger and stress management, conflict resolution, sex education, social competence/life skills, clarifying, values, trauma resolution, problem solving, impulse control and interpersonal communication;

9.6.a.7. Multisystemic therapy;

9.6.a.8. Psychopharmacological approaches;

9.6.a.9. Polygraphs; and

9.6.a.10. Visual reaction time or plethysmographs.

9.6.b. The treatment program for juveniles shall include a comprehensive individualized assessment, progressive levels of treatment, reoffense prevention plans, and for youth in residential treatment, transition into the community and aftercare.

9.6.c. Treating juveniles shall be part of a multidisciplinary collaborative approach that includes but is not limited to the juvenile, treatment provider, and as applicable the following: juvenile probation officer, the family, guardian, custodian, school officials, law enforcement, juvenile detention officers, institutional staff, mental health case workers, polygraph examiners, child protective services, victim advocates and the victim's therapist.

9.6.d. Programs shall focus on the juvenile's existing strengths and positive support system to promote pro-social behaviors and facilitate change.

9.6.e. Treatment referrals should be offered to the parent(s), guardian(s), or custodian(s) and sibling(s) of the juvenile where a juvenile has been removed.

9.6.f. Programs shall utilize developmentally appropriate treatment strategies for juveniles with intellectual and cognitive impairments.

9.6.g. Risk management strategies may address the needs underlying the juvenile's behavior, and may include, but are not limited to, safety plans, avoidance of high risk factors, impulse control, polygraphs and sex education.

9.6.h. The primary goals of treatment shall be to assist juveniles in gaining control over their sexual behavior problems, enhancing the juveniles' overall functioning, increasing their pro-social interactions, preventing further victimization, halting development of additional psychosexual problems and developing age-appropriate relationships.

9.6.i. If treatment groups are utilized for non-developmentally disabled juvenile sex offenders, groups shall have no more than twelve clients per group or fifteen clients per group with two counselors.

9.6.j. If treatment groups are utilized for developmentally disabled juveniles, groups shall have no more than eight clients per group.

9.6.k. Individual therapy, self-help groups, drug intervention, or other therapies shall be used primarily as adjuncts to a comprehensive sex offender treatment program.

9.6.l. A written individualized plan of care shall identify the needs, issues, intervention strategies and goals of treatment and shall be prepared for each client within thirty days of beginning treatment. Plans of care should be updated every six months.

9.6.m. Progress, or lack of progress, shall be based on clearly specified objective criteria, refusal or failure to attend or participate in treatment, failing to abide by the client's plans of care and/or contracts, or any disclosures regarding violations of supervision shall be clearly documented in treatment records. This information shall be provided and communicated to the appropriate supervising officer in the justice system according to the referring agency's policy or pursuant to the court order.

9.6.n. Monthly treatment progress reports shall be distributed to the supervision officer, referring agency and/or the court. Discharge reports shall be issued according to the referring agency policy or pursuant to the court order.

9.6.o. When a juvenile has attained the goals outlined in the juvenile's individualized plan of care, there should be a gradual and commensurate adjustment of interventions.

9.6.p. Some degree of denial shall not preclude a client from entering treatment, although the degree of denial shall be a factor in identifying the most appropriate form and location of treatment.

9.6.q. Modifications in treatment and in expectations for treatment outcomes may be required in instances of persistent denial.

9.6.r. Clients who remain in significant denial and/or are extremely resistant to treatment after the finite period of extension determined by the treatment provider and supervision team should be reassessed for appropriate placement in alternative treatment and/or interventions.

9.6.s. Programs shall communicate and exchange information with child protective services, child care licensing and with appropriate agencies regarding the safety of a child or children in the primary residence in which a juvenile resides.

9.6.t. The safety of children/victims takes precedence and the highest priority shall be given to the rights, well-being and safety of children when making decisions about contact between the juvenile sex offender and children. If the juvenile sex offender has a history of sexual arousal to reported fantasies of sexual contact with children of a particular age/gender group, supervised visits may be considered if:

9.6.t.1. It is compliant with the court mandated conditions;

9.6.t.2. It is determined that sufficient safeguards exist including but not limited to safety plans approved by the program and supervision agency;

9.6.t.3. It does not impede the juvenile's progress in treatment; and

9.6.t.4. The parent(s), guardian(s), or custodian(s) have demonstrated the ability and willingness to supervise the juvenile effectively and ensure the safety of other children in the

home.

9.6.u. The program shall make every effort to collaborate with the victim's therapist in making decisions regarding communication, visits and reunification. Contact shall be arranged in a manner that ensures the child/victim safety first.

9.6.v. If reunification is planned, there shall be provisions for monitoring behavior and reporting rule violations.