

SEX OFFENDER SUBCOMMITTEE MEETING of the JUSTICE BEHAVIORAL HEALTH COMMITTEE MINUTES

The Sex Offender Subcommittee of the Justice Behavioral Health Committee met on Tuesday, March 29, 2016 at Trabert hall, 2202 S. 11th Street, Lincoln, Nebraska. The focus of this group as a subcommittee is to:

1. Create minimum standards for Registered Service Providers for the provision of sex offender treatment services. Create minimum standards for staff for the provision of sex offender treatment services.
2. Identify best practices in sex offense treatment.
3. Create recommendations to support Registered Service Provider sustainability in working with the sex offender population. Include measures that address provider concerns regarding liability.
4. Create recommendations to increase state access to treatment services available. Explore additional accessibility of treatment for the sex offender population (i.e., telehealth, video conferencing).
5. Identify community supervision, case management standards that incorporate accountability measures, victim's safety, treatment and reintegration for sex offenders to reduce recidivism.

WELCOME & INTRODUCTIONS

Gene Cotter officiating. Gene announced Dr. Stephanie Bruhn for DCS and Todd Rosenthal from Parole had been granted permission to join our group and will be at future meetings.

APPROVAL OF MINUTES – No concerns or comments.

MEMBERSHIP

Members Present:

Gene Cotter
Roxanne Koenig
Michael Nehe
Denise Ahl
Nicholas Giles

Members Absent:

Linda Witmuss *
Lisa Sample
Alyssa Nelson*
Todd Rosenthal
Dr. Stephanie Bruhn
Bryan Crosby*

*indicates known absence

1. **MINUTES** – no changes

2. REVIEW OF FEEDBACK FROM JBHC ON QUALIFICATIONS GRID

Cotter presented the qualifications grid to the body of the Justice Behavioral Health Committee at a recent meeting and, with limited exceptions, JBHC indicated support for the work of the committee. However, the JBHC voiced concerns over the face-to-face clinical hour requirements listed in the "Start- 1st year" as it was felt this may be excessive and unattainable. It was suggested by JBHC an "immersion" program be explored as a possible way to assist prospective providers to perform these hours.

The group discussed this at length. It was felt important not all of the 50 hours be spent in "immersion," as a continuation of services over the course of time to allow for some continuity and on-going learning was critical. Having said that, the group discussed the possibility of at least a portion of these hours could be accomplished in this setting.

The subcommittee suggested 20-24 hours of the 50 required could be spent in an “immersion” type setting. Of this, the prospective provider would need to participate in/observe:

1. A clinical interview for a risk assessment
2. Multiple group sessions
3. Multiple individual sessions
4. Clinical staffing

Otherwise all else would remain the same. Cotter will update the grid and resubmit at the next JBHC meeting in June, 2016.

3. BEST PRACTICE STANDARDS IN SEX OFFENDER SUPERVISION

The group discussed present supervision practice standards generally in-place for the supervision of sex offenders and identified what was thought to be best practice standards for the case management of those convicted or with a history of sexual offending.

Recommended responsive case management standards are:

1. A comprehensive, collaborative, bio/psycho/sexual evaluation/risk assessment followed by any corresponding, relevant sex offender treatment programming, including applicable polygraph examinations, with engaged relationships between the treating professional, the assigned supervision entity, and other related individuals such as family members, sponsors or other relevant individuals.
2. Dynamic risk assessment through the use of a validated sex offender risk assessment tool such as the ACUTE not less than quarterly, with periodic more wide-ranging risk assessment on a validated sex offender risk assessment tool such as the STABLE once every six months.
 - a. Reassessment of risk will prompt update of treatment and case plans.
3. Frequent, as needed, home, field and neighborhood visits which include engagement with family members, employers and/or others supporting safety and the progress of the individual under supervision for the purpose of behavioral monitoring within the community.
4. Frequent searches of home, property and electronic equipment for the purposes of behavioral monitoring.
5. Victim contact.
 - a. When completing home, field and neighborhood visits and/or home, property and electronic equipment searches, special attention shall be paid to identification of future victims.
6. Cognitive programming upon completion of sex offender treatment or sooner in collaboration with the treatment provider.
7. Dosing of involvement in prosocial events outside of the home to avoid isolation.
8. Incorporation of other necessary tools such as chemical testing, GPS monitoring, etc. to monitor or addresses other areas of concern.

*** Through engaged, collaborative relationships between treatment professionals, supervision entities and other relevant and related individuals a Community Supervision Team is created and tasked with the joint case management of the case.

4. REVIEW AND DISCUSSION OF SEX OFFENDER EVALUATION CONTENT

The group ran out of time and did not get to this topic. I will be prioritized at the next meeting.

5. OTHER TOPICS OF CONVERSATION

It was suggested criminogenic CEU's or requirements be brought into alignment with education units that are approved by APA. At present, APA approves certain CEU's that probation does not. Further, it was asked that criminogenic CEU's come due in concert when a providers licensing is due.

6. **ADJOURNMENT** Next meeting – May 24, 2016 1:00-3:00 PM at Trabert Hall 2202 So. 11th, Fourth Floor Nebraska Room, Lincoln, NE 68502