Nebraska Sex Offender Treatment Program

Norfolk Regional Center

Mission: Providing Sex Offender treatment to prepare for community reintegration while maintaining public safety.

Vision: Helping people rebuild their lives with no more victims.

02-07-2020

Lincoln Regional Center

Table of Contents

HISTORY OF SEX OFFENDER TREATMENT IN NEBRASKA

The Nebraska Legislature first enacted a treatment provision for sex offenders in 1949 with the passage of a Sexual Psychopath Law. The law provided for civil commitment of these individuals and treatment consisted of generic mental health interventions of the time.

Sexual Sociopath Law

In 1971, the Legislature replaced the Sexual Psychopath Law with a Sexual Sociopath Law. Along with the civil commitment provision, the Sexual Sociopath law required mandatory hearings for persons convicted of more than one sexual offense. The law also provided for indefinite sentencing in which a sexual sociopath could be held until he was no longer considered to be a sexual sociopath.

Mentally Disordered Sex Offender Law

In 1979, the Legislature replaced the Sexual Sociopath Law with the Mentally Disordered Sex Offender Law. Under the Mentally Disordered Sex Offender Law, special provisions were applied only after a person was convicted of a felony sexual assault. The law required an evaluation by a mental health professional to determine whether the individual was a Mentally Disordered Sex Offender. A report of the evaluation was sent to the sentencing court. If the court determined the individual to be a Mentally Disordered Sex Offender and that the individual had a treatable disorder, the individual was sent to the Lincoln Regional Center to receive treatment. The law provided for a mandatory Mental Health Board hearing at the end of the individual's sentence. It was shortly after the passage of this law that the Lincoln Regional Center began to develop a sex offender specific treatment program.

Convicted Sex Offender Law

In 1991, the Legislature replaced the Mentally Disordered Sex Offender Law with the Convicted Sex Offender Law. This legislation states that any individual convicted of a felony sexual assault and sentenced to the Department of Corrections facility, has the option to request that an evaluation be conducted by the Lincoln Regional Center to determine if the individual is a suitable treatment candidate. If the individual is found to be a suitable candidate, he is placed on a waiting list and admitted to the Lincoln Regional Center's Sex Offender Services when space is available.

LB 1199

In 2006, the Nebraska Legislature passed a package of sex offender provisions that altered the civil commitment procedure for sex offenders who are approaching the end of their prison terms. Legislative Bill 1199 (LB 1199)[1] amended Nebraska's criminal code by redefining sexual offenses perpetrated against children, increased the penalty for a second conviction or failure to comply with sex offender registration rules, expanded the list of offenses for which an offender would need to register according to Nebraska's Sex Offender Registration Act; extended the post-release supervision of certain classes of sex offenders; and enabled municipalities to impose residency restrictions on sex offenders. LB 1199 also created a new civil commitment procedure for sex offenders called "the Sex Offender Civil Commitment Act" Neb. Rev. Stat. §71-1201.

Sex Offender Commitment Act

Nebraska's Sex Offender Commitment Act Neb. Rev. Stat. §71-1201 through §71-1228 intends "to provide for the court-ordered treatment of sex offenders who have completed their sentences but continue to pose a threat of harm to others. A "dangerous sex offender" is defined as:
(a) a person who suffers from a mental illness which makes the person likely to engage in repeat acts of sexual violence, who has been convicted of one or more sex offenses, and who is substantially unable to control his or her criminal behavior or (b) a person with a personality disorder which makes the person likely to engage in repeat acts of sexual violence, who has been convicted of two or more sex offenses, and who is substantially unable to control his or her criminal behavior Neb. Rev. Stat. § 83-174-.01

Neb. Rev. Stat. § 83-174 through § 83-174.03 and Neb. Rev. Stat. § 71-1201 through § 71-1228 identify the procedures by which a person may be committed under the Sex Offender Commitment Act. These include:

(1) "any person who believes that another person is a dangerous sex offender may communicate such belief to the county attorney" Neb. Rev. Stat. §71-1205.

(2) A mental health board shall be notified in writing of the release by the treatment facility of any individual committed by the mental health board. Such notice shall immediately be forwarded to the county attorney. The mental health board shall, upon the motion of the county attorney, or may upon its own motion, conduct a hearing to determine whether the individual is a dangerous sex offender and consequently not a proper subject for release. Neb. Rev. Stat. §71-1221.

(3) "an agency with jurisdiction over a person who is required to register as a sex offender must notify the county attorney, among others, at least ninety days before that person's release from incarceration or civil commitment or the termination of that person's probation or parole supervision" Neb. Rev. Stat. § 83-174.

(4) "the Department of Corrections shall order an evaluation…by a mental health professional to determine whether or not the individual is a dangerous sex offender". ... "… the department shall send written notice to the Attorney General, the county attorney…" Neb. Rev. Stat. §83-174.02.

According the Neb. Rev. Statute §71-1209, "The state has the burden to prove by clear and convincing evidence that (a) the subject is a dangerous sex offender and (b) neither voluntary hospitalization nor other treatment alternatives less restrictive of the subject's liberty than inpatient or outpatient treatment ordered by the mental health board are available or would suffice to prevent the harm described in subdivision (1) of section 83-174.01." The Mental Health Board can reach one of several conclusions. If the board determines that the subject does not fit the definition of a dangerous sex offender, then the subject is unconditionally discharged. If the board concludes that the subject fits the definition of a dangerous sex offender but that "voluntary hospitalization or other treatment alternatives less restrictive of the subject's liberty than treatment ordered by the mental health board" are both sufficient and available, then the subject may be unconditionally discharged, or the board may suspend proceedings for up to ninety days to allow the subject time to enroll in voluntary treatment. If the board finds that the subject is a dangerous sex offender and that less restrictive treatment options are not possible, the board can order the subject to receive inpatient or outpatient treatment.

Subjects remanded to receive treatment are assigned a treatment plan Neb. Rev. Stat. §71-1215. Their treatment progress must be communicated to the Mental Health Board every ninety days during the first year of their treatment, and every six months during each subsequent year of their treatment Neb. Rev. Stat. §71-1216. At the time that each report is filed, the subject may request for a review hearing to occur before the respective Mental Health Board, and may also request to be discharged Neb. Rev. Stat. §71-1219.

For clarification relative to Mental Health Board creation and function in Nebraska:

Each Nebraska judicial district has its own Mental Health Board, created by a respective district judge, who carries out functions as specified by the Nebraska Mental Health Commitment Act. Each board consists of a licensed attorney (who chairs the board), along with any two individuals who must come from different listed categories of mental health professionals and/or be "a layperson with a demonstrated interest in mental health and substance dependency issues" Neb. Rev. Stat., § 71-915.

Assault on Healthcare Professionals Offenses

In 2011, legislative bills were passed creating offenses related to assaulting healthcare professionals. These are related to physical assaults and use of bodily fluids.

Neb. Rev. Stat. §**28-929. Assault on an officer or a health care professional in the first degree; penalty.**

(1) A person commits the offense of assault on an officer or a health care professional in the first degree if:

(a) He or she intentionally or knowingly causes serious bodily injury:

(i) To a peace officer, a probation officer, or an employee of the Department of Correctional Services;

(ii) To an employee of the Department of Health and Human Services if the person committing the offense is committed as a dangerous sex offender under the Sex Offender Commitment Act; or

(iii) To a health care professional; and

(b) The offense is committed while such officer or employee is engaged in the performance of his or her official duties or while the health care professional is on duty at a hospital or a health clinic.

(2) Assault on an officer or a health care professional in the first degree shall be a Class ID felony.

28-930. Assault on an officer or a health care professional in the second degree; penalty.

(1) A person commits the offense of assault on an officer or a health care professional in the second degree if:

(a) He or she:

(i) Intentionally or knowingly causes bodily injury with a dangerous instrument:

(A) To a peace officer, a probation officer, or an employee of the Department of Correctional Services;

(B) To an employee of the Department of Health and Human Services if the person committing the offense is committed as a dangerous sex offender under the Sex Offender Commitment Act; or

(C) To a health care professional; or

(ii) Recklessly causes bodily injury with a dangerous instrument:

(A) To a peace officer, a probation officer, or an employee of the Department of Correctional Services;

(B) To an employee of the Department of Health and Human Services if the person committing the offense is committed as a dangerous sex offender under the Sex Offender Commitment Act; or

(C) To a health care professional; and

(b) The offense is committed while such officer or employee is engaged in the performance of his or her official duties or while the health care professional is on duty at a hospital or a health clinic.

(2) Assault on an officer or a health care professional in the second degree shall be a Class II felony.

28-934. Assault with a bodily fluid against a public safety officer; penalty; order to collect evidence.

(1) Any person who knowingly and intentionally strikes any public safety officer with any bodily fluid is guilty of assault with a bodily fluid against a public safety officer.

(2) Except as provided in subsection (3) of this section, assault with a bodily fluid against a public safety officer is a Class I misdemeanor.

(3) Assault with a bodily fluid against a public safety officer is a Class IIIA felony if the person committing the offense strikes with a bodily fluid the eyes, mouth, or skin of a public safety officer and knew the source of the bodily fluid was infected with the human immunodeficiency virus, hepatitis B, or hepatitis C at the time the offense was committed.

(4) Upon a showing of probable cause by affidavit to a judge of this state that an offense as defined in subsection (1) of this section has been committed and that identifies the probable source of the bodily fluid or bodily fluids used to commit the offense, the judge shall grant an order or issue a search warrant authorizing the collection of any evidence, including any bodily fluid or medical records or the performance of any medical or scientific testing or analysis, that may assist with the determination of

whether or not the person committing the offense or the person from whom the person committing the offense obtained the bodily fluid or bodily fluids is infected with the human immunodeficiency virus, hepatitis B, or hepatitis C.

(5) As used in this section:

(a) Bodily fluid means any naturally produced secretion or waste product generated by the human body and shall include, but not be limited to, any quantity of human blood, urine, saliva, mucus, vomitus, seminal fluid, or feces; and

(b) Public safety officer includes any of the following persons who are engaged in the performance of their official duties at the time of the offense: A peace officer; a probation officer; an employee of a county, city, or village jail; an employee of the Department of Correctional Services; an employee of the secure youth confinement facility operated by the Department of Correctional Services, if the person committing the offense is committed to such facility; an employee of the Youth Rehabilitation and Treatment Center-Geneva or the Youth Rehabilitation and Treatment Center-Kearney; or an employee of the Department of Health and Human Services if the person committing the offense is committed as a dangerous sex offender under the Sex Offender Commitment Act.

---

[1] Nebraska Legislative Bill 1199, 99th Leg., 2d Sess. 57 – 82, 57-87 (2006).

MISSION AND TREATMENT PHILOSOPHY

The Nebraska Health and Human Service Sex Offender Treatment Program provides treatment to adults characterized as sexually dangerous individuals that have been adjudicated under the Nebraska Convicted Sex Offender Act or have been committed to inpatient treatment by a county Mental Health Board for treatment of a paraphilia. The Program is evidence based and utilizes research to guide treatment programming. A primary assumption is that human behavior, including sexual behavior, is learned and treatment of sexual deviance and paraphilias requires the learning of responsible social and sexual behavior to substitute for the harmful behavior leading to sexual offenses. The Nebraska Sex Offender Treatment Program is focused on the reduction of dangerousness and risk of reoffense for patients involved in treatment.

Upon entering the Program at Norfolk Regional Center (NRC), the patient receives a comprehensive psychological and psychiatric evaluation including a risk assessment for violence, reoffense, and self harm. After orientation to the Program, patients are involved in therapeutic groups designed to address such areas as problem-solving skills, emotional regulation problems, basic educational skill deficits, and criminal thinking. The patients are introduced to the Therapeutic Community and are expected to play a supportive role in helping others in the Program as well as themselves.

Patients participate in an intensive group therapy three times a week as well as individual therapy that is focused on building motivation for change. Many patients entering the Program are resentful of authority and mental health board commitment believing that they have paid their debt to society and will not offend again. Part of early treatment is to help the offender recognize their risk factors and develop attitudes supportive of treatment. Patients with substance abuse problems may participate in a nine month chemical dependency group as well as AA and NA.

When patients successfully achieve treatment targets (see the guidelines for Advancement in Treatment below) at NRC, they are eligible to be transferred to the Lincoln Regional Center (LRC). At LRC, patients continue to gain awareness of cognitive distortions which enable sexually deviant behavior to occur, and internalize changes to eliminate these distortions. Understanding of the precursors to sexual assaults and developing relapse prevention skills, including awareness and understanding of the impact of their sexually assaultive behaviors on their victims are a focus of treatment.

The Program at both sites focuses on reducing deviant sexual attractions, arousals, and fantasies, and developing and maintaining appropriate sexual attractions. A multidisciplinary Treatment Team utilizes a variety of individual and group interventions in a positive Therapeutic Community to achieve treatment goals and specific individual patient goals. Treatment is also individualized to the unique bio-psycho-social needs of each patient. Progress evaluations are conducted by the Treatment Team on a regular basis, and patients are provided feedback regarding their progress and areas of continued concern.

When patients successfully achieve the next set of treatment targets, they are eligible to be transferred to the Transition Program. This program is also located at LRC. At this point in treatment, patients have gained the coping skills and behaviors necessary to begin the process of successful and safe re-integration into the community. This reintegration is carefully monitored to insure that patients are using the skills they learned in treatment to keep themselves and the community safe. An aftercare plan

is developed and implemented to provide ongoing support and monitoring once patients are discharged. When Transition goals are successfully achieved, patients are discharged back into the community to continue with their aftercare treatment which was established while in the Transition Program.

The Program uses a cognitive behavioral team approach to rehabilitation. A strong Therapeutic Community provides an atmosphere conducive to changing deviant patterns of thinking and behaving. The Program offers a high level of structure, supervision and therapeutic intensity. Patients participate in approximately thirty hours of therapeutic activity per week. Patients advance in treatment by moving various Progress Levels, with treatment typically lasting from 18 months to 4 years. The length of treatment depends on each patient's motivation to change. However, patients who have difficulty internalizing what they have learned remain in treatment until the Treatment Team believes they are able to safely rejoin the community. Convicted Sex Offenders (CSOs) either return to the correctional facility to complete their sentence or are paroled to LRC for a gradual, carefully monitored transition into the community. Mental Health Board committed patients pass through the Transition Program and are gradually reintegrated into society.

TREATMENT GOALS

1. Gain an understanding of the pattern of thoughts, feelings, and behaviors that are related to acting out in a sexually deviant manner.
2. Take responsibility for harmful/criminal behavior and demonstrate consistent motivation for making productive changes.
3. Learn the negative consequences of sexual assault on victims, family and community, and the concept of empathy.
4. Participate in groups and complete assignments to increase knowledge of intimacy, communication, and social skills.
5. Reduce/control deviant arousal and inappropriate sexual urges and behaviors.
6. Learn relapse prevention strategies.
7. Learn about a balanced lifestyle through leisure, educational, and occupational activities and problems associated with substance abuse.

ADVANCEMENT IN TREATMENT

The following treatment goals are necessary for advancement but may not be sufficient. Please see your Treatment Plan for your individualized plan.

NRC to LRC

Treatment Goals:

1. Patient has acknowledged that a problem exists concerning his sexual behavior.
2. Patient accepts responsibility for his sexual deviancy by not projecting blame and/or presenting self as powerless to control his behaviors.
3. Patient has consistently complied with Program rules and regulations.
4. Patient has identified behaviors that need to be changed.
5. Patient has set treatment goals and has developed plans to obtain those goals.
6. Patient consistently interacts with the unit staff members in socially appropriate ways.
7. Therapeutic Recreation requirements are consistently met.
8. Patient has consistently participated in all assigned therapy groups and classes.

9. Patient has displayed the ability to accept feedback constructively without being argumentative and/or defensive.
10. Patient is able to describe some of the negative/harmful consequences his behaviors have had on his victim and others.

Professional staff will rate patients on significant goal areas and on overall treatment participation. Level of advancement is made when scores reflect established criteria of treatment progress.

Advancement to Transition Program

Treatment Goals:

1. Patient is able to verbalize in detail the negative/harmful consequences his behaviors have had on his victim and others.
2. Patient is able to identify his assault pattern and cognitive distortions and has begun to verbalize how to interrupt the pattern.
3. Patient can verbalize deviant attractions, arousals and fantasies and has begun to verbalize how to manage and control them.
4. Patient has displayed leadership by confronting inappropriate behaviors in others, practicing healthier behaviors, and by assisting in Community projects.
5. Patient can verbalize some high-risk situations, behaviors, and thinking.

Professional staff members will rate patients on significant goal areas and on overall treatment participation. Level of advancement is made when scores reflect established criteria of treatment progress

LRC to NRC

When a patient has demonstrated a pattern of treatment inconsistency such that the team perceives he is unwilling to meet his master treatment plan objectives, consideration should be given to referring the patient to NRC. Such a transfer will be evaluated when two or more of the following occurs with limited or no improvement in other areas:

1. Patient has been demonstrating sexually inappropriate behavior with peers and/or staff members and has consistently not responded despite change in treatment interventions.
2. Patient behavior has resulted in inconsistent scores and fluctuations to level IV or V over the last year.
3. Patient continues to be resistive to change and is failing to progress even with changes in treatment approach/interventions.
4. Patient displays an unwillingness to accept feedback constructively and is argumentative and/or defensive.
5. Patient refuses to attend and participate in assigned therapy groups or if he attends is often disruptive to the group process, is superficial or non-participatory.
6. Patient consistently fails to comply with program rules and regulations.

A staffing will be completed to allow the patient's treatment team to make recommendations regarding appropriateness of transfer to NRC.

TREATMENT APPROACHES

A variety of treatment modalities are used in the Program to assist individuals in reaching the treatment goals. The program is a Therapeutic Community, using engagement, motivational interviewing, cognitive-behavioral, and relapse prevention approaches. Individual therapy, group therapy, occupational therapy, therapeutic recreation, adult basic education, skills-building groups, a Level system, dietary services, medical/dental services, and medication management are all offered through the Program.

Modified Programs designed to assist meeting individual therapeutic needs are offered. LRC has a Female Program to best meet the specific needs of this population. NRC Skill Building and LRC Life Skills are programs for males who have learning disabilities, experience psychotic episodes, or have other cognitive limitations. Please refer to each manual for specific information about these Programs.

Treatment Activities

Orientation
Orientation is designed to familiarize and educate new patients to the expectations and goals of the treatment program.

Individual Therapy
Individual therapy allows patients the opportunity to discuss and process motivation and impediments to treatment with a trained therapist, in order to focus on the identified treatment goals.

Sex Offender Group
This group facilitates interactive communication for the patient to gain awareness of deviant sexual thinking and behavior and to develop coping skills to manage sexual deviancy.

Relapse Prevention I
Teaches interventions and coping skills to reduce the risk of relapse.

Relapse Prevention II
Focuses on coping skills and application of interventions learned in Relapse Prevention I in preparation for discharge and reoffense prevention.

Relapse Prevention III
Focuses on application of interventions in the Transition Program as patients increase community involvement.

Community Living Skills
This group focuses on communication and coping skills related to day-to-day stressors. Discussion is limited to developing support, conflict resolution and learning how to effectively give and receive feedback to create a Therapeutic Community.

Patient Hour
Gives patients the opportunity to discuss treatment related issues and allow him/her to practice giving and receiving feedback.

Community Activities
Patients are expected to participate in pro-social activities to learn empathy, social skills, and problem-solving, communication and assertiveness skills. These activities include self-directed leisure such as crafts and table games as well as patient and staff 1:1s.

Arousal Reconditioning
Focuses on education and skill building to decrease deviant sexual arousals and to increase non-deviant (appropriate) sexual arousals in order to reduce risk of reoffense.

Didactic Skill-Training and Adjunct Therapy Groups (This is not an exhaustive list)
Anger Management
Assertiveness Training
DBT
Human Sexuality Education
Problem-Solving
Relationship/Intimacy Group
Substance Abuse Education and Group
Therapeutic Movie Group
Thoughts and Feelings
Trauma/Grief Group
Understanding Emotions
Victimization Group

Other Treatment Modalities
Therapeutic Recreation
Occupational Therapy

Written Exercises
Autobiography
Sexual history time-line
Sexual assault time-line
Sexual assault cycle
General cycle
Sexual assault cycle with interventions
Victim empathy exercises I, II, III, IV
Masturbation monitoring worksheet
Lapse log
Relapse Chain

<u>Audio/Video Taping</u>
Group therapy and individual sessions may be audio or video taped to assist patients in making therapeutic progress. These tapes will be used solely in the Sex Offender Treatment Program and will not be displayed outside the program without written consent from every patient involved in the group or session. Cameras may also be used to monitor the units as a safety and security measure and shared with legal authorities if possible criminal behaviors are noted.

THERAPEUTIC COMMUNITY

The therapeutic milieu for the Sex Offender Treatment Program is based on the "Therapeutic Community." The primary goal of a Therapeutic Community is to foster personal growth. This is accomplished by changing an individual's lifestyle through a Community of concerned people working together to help themselves and each other. It is expected that the patient(s) will take responsibility for their individual and collective behavior. Further, it is expected that the patient will integrate a concern and regard for others and a sense of responsibility to others as well as commitment to the Community. Community in this sense is defined as the Sex Offender Treatment Program at both of the Regional Centers and to society at large, once they are released.

The Therapeutic Community represents a structured environment with defined boundaries and expectations. It utilizes Community imposed sanctions and penalties as well as earned advancement of status with privileges as part of the growth process. Several modalities are used within the Program to help accomplish treatment goals.

Abuse/Neglect/Exploitation will not be tolerated. The program has a system that requires all employees to be trained and assessed for competency relative to prevention, intervention, reporting and documentation of any instance of abuse/neglect or exploitation. Patients have the right to receive treatment in a safe environment. Any allegations of abuse, neglect or exploitation shall be reported and documented and investigated. Internal investigations will occur in all cases, but based on the nature of the incident may also be investigated by outside entities such as state licensure or law enforcement. Allegations will be reviewed in the daily leadership huddle, monthly in administrative council and quarterly by the governing body. Investigation findings will also be reviewed by program leadership to evaluate any identified needs for changes in process, disciplinary action or policy changes.

BEHAVIORAL EXPECTATIONS

The Sex Offender Treatment Program uses a Baseline Sheet to monitor behaviors in the Therapeutic Community. This document is used by staff members to track appropriate and ineffective behaviors of the patients. It is used to provide verbal feedback to patients. The patient should discuss problem areas with staff members and peers as they occur, so that they become aware of their behavior. With increased self-awareness, the patient can eliminate negative behaviors and make positive changes.

General areas of expected behavior include refraining from aggressive, intimidating, and disruptive behavior; following rules; participating in therapeutic groups with relevant participation; accepting responsibility for actions; and, assisting in the Therapeutic Community.

QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRESS LEVEL SYSTEM/

Quality Assurance and Performance Improvement (QAPI) processes are established in the QAPI plan which is monitored by the QAPI Committee. The QAPI plan is inclusive of all systems of care, all departments, patients, and staff. The QAPI plan creates the framework in the organization that focuses on quality of care and safety, setting principles for assessing, analyzing, and tracking quality indicators of performance.

The Sex Offender Treatment Program at both NRC and LRC includes a Level System designed to reflect patients' progress in the program. The Program Leadership is responsible for the Progress Level System program. This system uses Goal Attainment Scores to track progress on the patient's treatment plan goals. The initial assessment is completed 40 days after admission and the score is updated at 60 day, except for those in transition who are scored every 90 days. As patients exhibit progress toward their therapy goals and display appropriate behaviors in the therapeutic community, they will advance in the level placement. Patients may regress in levels based on behavior or demonstration of high risk actions.

Although the Program is located on two sites, it is a continuous Program in which patients' advancement through the Level system is based on their progress. Patients may reach level IV at NRC which is consistent with level IV at LRC. The goals at the two locations are somewhat different as noted in the Advancement in Treatment section. In addition, the level of privileges are different based on progression in treatment.

PROGRAM COMMITTEES

When a patient is admitted, a Welcoming Committee composed of two or three patients meet with the newly admitted patient on the day they are admitted. The purpose of the Committee is to welcome new members to treatment and to explain the guidelines in each facility.

The Sponsorship Program pairs patients who have earned more advanced Levels with newly admitted patients for the first eight weeks following admission to the facility. The pairing is approved by the Treatment Team. The purpose of the Sponsorship Program is to identify an experienced peer for the newly admitted patient to interact with and obtain support from during their adjustment to treatment. The program also provides an opportunity for peers to gain experience talking about their problems and asking others for help. Sponsors develop leadership skills and provide input to staff members.

There is a Patient Representative who is elected by the Therapeutic Community and serves a six-month term. This individual facilitates the weekly Community Meetings and serves as a liaison between the Community and program staff members. The Patient Representative is elected from the more advanced Level patients.

The Formulation Committee (Patient Advisory Council PACat NRC) serves as a liaison between the Treatment Team and patient population. The Committee works with the Treatment Team, as the need arises, in dealing with rule violations, conflicts between patients, and other designated responsibilities requested by the Treatment Team. The Committee makes recommendations to the Treatment Team for problem resolution or Community activities. The Treatment Team makes final decisions after considering the recommendations submitted by the Committee. The Formulation Committee consists of 2- level IV's, 2- level V's and 2 level VI's one is the unit rep. At LRC, a patient cannot be eligible if he has been on the committee in the prior 6 months or has been on PS for the past 90 days.

All members are elected by the Community and each member at LRC serves a six-month term. The Committee elects a Chairperson. All elected Committee members are subject to Treatment Team approval. The Formulation Committee Chairperson will present the voting results to the Treatment Team for final approval.

Each Formulation Member and Ward Representatives are voting members.
The Staff Liaisons work with the Formulation Committee to develop the slate of nominations made up for President and Secretary. Ward Representatives may not serve as President or Secretary of the Committee. The Formulation Committee President presents any voting results to the Staff Liaisons for final approval. The Secretary takes notes regarding peer rule violation meetings, and other written reports/requests submitted to the Staff Liaisons. The committee is also responsible for requesting and organizing order outs, cook outs, nacho dates and peer of the month nominations. The committee meets a minimum of 1 time a month

A Formulation Member or PAC is expected to be a role model to the Therapeutic Community. Thus, being placed on Ward Restriction results in losing the position. If during the course of a Formulation/PAC term, one is placed on Privilege Suspension twice during six-months, he is placed on probation to serve as a warning he needs to improve his behavior. If a member is placed on PS three times during a six-month period, he is removed from the Formulations/PAC Committee. Treatment Team may remove a person from being Formulation/PAC Member if they are no longer an acceptable role model. When the term has expired, all members/roles are expected to pass the Program Manual and any other material to the next elected patient and orient that person to the duties of being a Unit Representative, Formulation Member, President and/or Secretary.

There is no waiting period between serving as Ward Representative and/or Formulation Committee.

A **Ward Representative** serves as a liaison between the Therapeutic Community and program staff members. They are responsible for leading the weekly Community Meetings, gathering information for volunteer of the quarter, obtaining volunteers for the Card Committee and Welcome Committee, The Unit Representative is a voting member of the Formulation Committee. They will assist the formulations President in organizing cook outs, and order outs. They are to check in with team leaders weekly for any announcements that need to be made to the community

At LRC thee Ward Representative should be level VI unless a level VI is not available and not have been on privilege suspension for 3 months, approved by the Treatment Team and elected by the Therapeutic Community. They serve a six-month term.

When the Ward Representative's term has expired, he is expected to pass the Ward Representative Program Manual and information to the next elected Unit Representative and orient that person to the duties of being a Ward Representative.

A Ward Representative is expected to be a role model to the Therapeutic Community. Thus, being placed on Ward Restriction results in losing the position of Ward Representative. The Treatment Team may remove a person from being Unit Representative if they are no longer an acceptable role model.

The TV Committee aids direct care staff members in coordinating TV programming as well as evaluates the appropriateness of specific programs. The committee is made up of at least one patient from each Level. At LRC, chairperson is elected within the committee and all members serve a six-month term.

The Card Committee is a volunteer committee responsible for obtaining or making greeting cards to commemorate patients' birthdays and other occasions.

THE TREATMENT PLAN PROCESS

- The Treatment Team develops and implements a treatment plan and evaluates the effectiveness of the treatment plan for each patient. An initial treatment plan is developed within the first ten days following admission. It is then reviewed at least every 60 days thereafter.
- If there is a change in status or a significant treatment event, a Special Treatment Plan Review may be held at any time.
- Patients are given the opportunity to have guardians and family members participate in person or by phone in the treatment planning process.
- The Treatment Team is charged with the responsibility of coordinating discharge planning for each patient. It is expected that all male patients will progress through all NRC and LRC programming prior to discharge. However, the discharge plan for each patient will be reviewed as part of the treatment plan review and be updated as needed. The Treatment Team makes discharge recommendations to those responsible for a discharge placement. This may include mental health board, parole or other Department of Health and Human Services representatives. The Treatment Team anticipates which services may be needed by the patient upon discharge from the Program. The discharge plan includes recommendations for ongoing treatment, identification of formal and informal supports, issues related to financial responsibility (e.g. child support) and/or community safeguards for the patient, family and general public.
- In order to address ongoing treatment needs and requests, the Treatment Team meets at least weekly and more frequently when needed. Minutes are taken for Treatment Team meetings.

For those patients in the Transition Program

- The Treatment Team reviews requests for off ground activities for approval, including outside employment.
- Therapeutic passes will be approved through the Treatment Team meetings. The Treatment Team follows policies related to community safety when considering approval of a therapeutic pass. A patient must have an approved Safety Plan as part of the approval process.

TREATMENT STAFF

Although NRC and LRC have somewhat different management structures, the role remains the same. At NRC, a multidisciplinary council comprised of the Director of Psychology, Clinical Director, Facility Operating Officer, Director of Nursing, Clinical Program Manager, and Quality Assurance/Risk Management Manger is responsible for the overall administration and management of the Program. This includes responsibility for programming, clinical supervision, policy, procedure and regulation compliance. At LRC, members of the Sex Offender Treatment Program serve on committees that are part of the overall facility programming and policy decisions. A Clinical Psychologist serves as the Program Director and is responsible for the overall administration and management of the Program. This includes responsibility for programming, clinical supervision, policy, procedure and regulation compliance. The LRC Program Manager is responsible for the day-to-day operation of the Therapeutic Community and has responsibility for policy, procedure and regulation compliance specific to the day-to-day operations. This includes supervisory responsibility for the Team Leaders and other

personnel. Team Leaders supervise the Security Specialists and patients while managing the day-to-day operation of the units.

A multidisciplinary team approach is utilized throughout the Sex Offender Treatment Program. The goal is to address the multi-faceted needs of the patients in a comprehensive, interactive manner to increase treatment progress and to decrease patient risk for reoffense. The Sex Offender Treatment Program has a clinical team led by the psychiatrist and psychologist that addresses sex offender specific clinical, programming and Therapeutic Community decisions. There are professional staff members who are the core clinical team which consists of psychiatrist, psychologists, licensed mental health practitioners , social workers, nurses, therapeutic recreation and medical physicians and/or physician assistants. Security Specialists serve as the direct care staff members and are an integral part of the treatment process. The Human Services Treatment Specialists (HSTS) staff members manage the treatment plans to facilitate treatment planning, review and updates at LRC and at NRC they provide skills building groups.

Below is a listing of the disciplines with a brief review of their roles:

The Mental Health Security Specialist II (MHSSIIS) are staff at least 19 years who provide the day-to-day supervision of the patients to increase the safety, security, management of the patients and to assist with treatment compliance. At LRC, the MHSSIIs also serve as medication aides thus must complete the 8 hour medication aide class, be observed by a nurse to assess competency annually and have an active Med Aide certificate to complete this aspect of the MHSSII responsibilities.

The LRC Mental Health Security Unit Supervisors (aka Team Leaders) are staff at least 19 years with coursework/training in human services, social/behavioral sciences, mental health care or related field OR experience providing direct care services to patients with mental illness or other disability. Experience leading, coordinating, directing, monitoring and/or supervising others. The team leaders under limited supervision, oversees operations of a mental health security unit through supervision of Mental Health Security Specialist staff and under the guidance of professional nursing and medical staff; ensures assigned unit is in compliance with applicable State and federal regulations; Performs specialized sub-professional care for patients; performs related work as assigned.

The Program Manager who has at least a Bachelor's degree, experience with sex offenders and mentally ill individuals and supervisory experience. They are responsible for direction of the Clinical Program in an institutional setting including coordination and implementation of treatment team decisions as well as supervision of core personnel.

The Human Services Treatment Specialists (HSTS) are staff with a Bachelor's degree in a human services field such as psychology, sociology, special education, counseling, human development, education or speech communication AND experience working with, and applying treatment and habilitation programs for persons with intellectual or other developmental disabilities and/or mental illness. Equivalent education and/or experience may substitute for the educational requirement on a year-for-year basis. This individual manages the treatment plans to facilitate treatment planning, review and updates and may facilitate psychoeducational groups.

The LRC Activity Specialists must have post high school coursework with an emphasis in recreation management, music, recreation therapy, occupational therapy, vocational rehabilitation or related field or

experience in planning, coordinating, or directing activity or therapy services. They provide work skills training, work related groups and supervision of patients employed in on campus positions. Therapeutic Recreation personnel facilitate therapeutic recreational activities and groups to assist patients in developing healthy leisure activities and better understand the importance of a balanced lifestyle.

Nurses include LPNs and RNs must hold a current Nebraska nursing license or Nurse Licensure Compact to practice in order to provide the first line provision of medical care through medication delivery, assessment and treatment of less serious problems and coordination, referral and consultation with physicians and psychiatrists for more serious problems and implementation of medical treatment orders. An RN must participate in treatment planning and reviews.

Associate Director of Nursing (ADON), is required to be licensed as a nurse and have at least one year experience supervising others. The ADON provides oversight of the medication aide training, nurse competency assessment, responds to medication errors and is involved in maintaining compliance with medication processes in line with state and federal licensure and accreditation standards.

Licensed Mental Health Practitioners (LMHP) must meet Nebraska licensure requirements as an LMHP, provisionally licensed mental health practitioner (PLMHP) and facilitate group and individual therapy as well as to provide input into patient treatment plan needs.

Occupational Therapist(s), who is licensed to practice as an Occupational Therapist, facilitates group and individual therapy, occupational therapy assessments to provide input into patient treatment plans and needs. (contracted at NRC)

Social Workers, who are either fully licensed or provisionally licensed as social workers, facilitate group and individual therapy, provide input into treatment plans, develop psychosocial assessment, continually address discharge needs and support systems, and maintain communication with family and community based resources. They are considered core team members and attend treatment planning meetings.

Psychologist(s) has to be fully licensed as a clinical psychologist to complete admission evaluations and risk assessments as well as facilitate groups and conduct individual therapy. They participate in treatment planning including discharge decisions.

The Psychiatrist(s) has an active medical license to practice psychiatry and provides overall direction of the medical aspects of programming not only psychotropic medications, but treatment planning, assessment at admission and discharge and ongoing psychiatric services to meet the patient needs.

Other disciplines contribute as needed or on a regular basis to provide the support and day-to-day operation of the treatment programs. This includes housekeeping, dietary, barbers, transport personnel, facility maintenance, compliance specialist, response team and administrative support personnel.

At LRC, there are a minimum of 13 direct care staff (MHSSIIs & Team Leaders) on each first and second shift and a minimum of 9 on 3rd shift. There are 5 team leaders across 3 shifts and 2 floors. One LMHP supervisor provides clinical services as well as clinical supervision to 7 LMHPs. There are 3 social workers and one occupational therapist who provide services to the program. Currently, there are

4 ½ activity specialists who provide therapeutic recreation and patient employment opportunities/training. There is one full time psychologist and part-time contract psychiatrist. There is a nurse available on all shifts and usually at least one nurse assigned on each shift. There is one program manager and an ADON.

MEDICAL SERVICES and EMERGENCY CARE AND TREATMENT

At LRC, Licensed Independent Practitioners (LIP) who are licensed to provide medical care, are available as needed to evaluate patient complaints and provide treatment or referral as necessary to meet patient medical needs. Coverage at NRC is through Physician Assistant(s) consistent with practice guidelines.

It is the policy of both LRC and NRC to provide all patients with comprehensive health care services. Transfer agreements have been entered into with local hospitals, which are all accredited by the Joint Commission on Accreditation of Healthcare Organizations. In addition, community LIPs representing all specialties are available to provide required health care beyond the capabilities of LRC after evaluation by the LRC/NRC LIP and with written order.

Staff are trained and competency assessed for knowledge and ability to respond to emergency situations to include medical, conflict resolution (Handle with Care program), self-harm, suicide prevention, and weather.

TRANSFER AND DISCHARGE POLICIES AND PROCEDURES

TRANSFER

Patients involved in sex offender treatment at the Lincoln and Norfolk Regional Centers are routinely assessed by a multidisciplinary team. A patient moves through different treatment Progress Levels when the overall review of their treatment progress justifies advancement in the Program. The following steps are taken prior to making transfer decisions:

1. Patients who have shown treatment progress as reflected by their Goal Attainment Scales (GASs) scores are the focus of a transfer/discharge Staffing Meeting. All disciplines involved with the patient's treatment provide written documentation of the patient's progress as well as each discipline's recommendation and rationale for or against transfer to the next phase of treatment.
2. All disciplines are notified of the time and location of the transfer/discharge Staffing Meetings by the Administrated Assistant and/or support staff members one week prior to the meeting. All staff members are expected to review the patient's medical record and confer with their colleagues prior to writing their report and recommendations.
3. Additionally, staff members are expected to be aware of situations where transferring a patient to the next phase of treatment would be contraindicated. One example would be patients whose cognitive functioning is such that they could not function safely in a community setting and thus, would not benefit from the services provided in the Transition Program. In such cases, discharge from inpatient treatment directly to a structured environment may be the more appropriate option. The rationale for such a decision must be reflected on the Transfer/Discharge

Recommendation form (see Appendix G). Furthermore, if such a decision is considered, the Chief Executive Officer's office will be notified of this decision.

4. Based upon the discussion and documentation presented at the transfer/discharge Staffing Meeting, the Medical Director will either write the order to transfer the patient or provide his/her rationale for not transferring the patient to the Transition Program. The Medical Director's decision will be documented on the Transfer/Discharge Recommendation form.

FEMALE PATIENTS (only at LRC)

The female patients reside in the same location throughout their hospitalization but functionally still progress through treatment similar to the programming for male patients. Once they have achieved established treatment goals and a Staffing Meeting is completed in which the Treatment Team consensus is supportive of transition opportunities, the patient will be allowed to participate in Transition activities e.g., supervised and unsupervised outings, off grounds employment, etc.

DISCHARGES

Patients residing in the Transition Program who have exhibited the ability to obtain and maintain employment, found appropriate housing, are receiving mental health services in the community, and have shown financial responsibility are considered for discharge. The following procedures are followed prior to making discharge decisions:

Patients who have maintained their GAS scores and who have obtained and retained employment, found acceptable housing, shown financial responsibility, and have arranged for mental health services from a qualified provider will be the focus of a transfer/discharge Staffing Meetings. All disciplines involved with the patient's treatment will provide written documentation of the patient's progress as well as each discipline's recommendation and rationale for or against discharge into the community.

All disciplines will be notified of the time and location of the transfer/discharge meeting by the Administrated Assistant and/or support staff one week prior to the meeting. Staff members are expected to review the patient's chart and confer with their colleagues prior to writing their report and recommendations.

An evaluation of the risk of reoffense will be completed by the program psychologist or the psychology extern prior to the Staffing Meeting and the results of this evaluation along with recommendations for managing risk in the community will be available for review at the Staffing Meetings.

An Administrative Assistant and/or support staff members must be present at Staffing Meetings and is charged with recording each discipline's report onto the Transfer/Discharge Recommendation Form (Appendix G) along with signatures of all staff members present at the time of the meeting. Based upon the discussion and documentation presented at the transfer/discharge Staffing Meetings, the program Medical Director will either write the order to discharge the patient or provide his/her rationale for retaining the patient for further evaluation and/or treatment. As with all other disciplines, the Medical Director's report will be reflected on the Transfer/Discharge Recommendation form. After completion of the form, which will include the signatures of all staff members present at the Staffing Meetings, the Transfer/Discharge Recommendation form will be included in each patient's permanent medical record.

Patients with medical needs or a disability that require a more supervised or structured environment will also have a Staffing Meeting. However, an appropriate living arraignment or facility must be identified and all available services clearly delineated prior to Staffing Meetings. The Sex Offender Treatment Program must receive verification in writing from the agency, group home, facility, etc. that is willing to provide the service and/or care prior to making a discharge decision.