STATE OF RHODE ISLAND
DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

TO: **Interested Parties**

FROM: **Trista Piccola, Director**
Department of Children, Youth and Families

DATE: **July 30, 2018**

SUBJECT: **Repeal of Sexual Abuse Treatment for DCYF Involved Youth Practice Standards**

In accordance with the Administrative Procedures Act, the Department is advertising for promulgation the following proposed DCYF rule and associate repeals.

It is within the RI Department of Health's (DOH) authority to license/regulate clinicians of various professions to treat sexual abuse and trauma. In addition to licensure from the DOH, provider's must comply with Medicaid's provider manual. The Department will be issuing practice guidance for provider's who treat DCYF involved youth for sexual abuse.

The proposed rule is accessible on the DCYF website (http://www.dcyf.ri.gov) and through the RI Secretary of State's Proposed Rules and Regulations Database Search (http://sos.ri.gov/ProposedRules/).

RHODE ISLAND GOVERNMENT REGISTER
PUBLIC NOTICE OF PROPOSED RULEMAKING

AGENCY: Department of Children, Youth and Families
DIVISION: Sexual Abuse Treatment for DCYF Involved Youth Practice Standards
RULE IDENTIFIER: ERLID # 7678
REGULATION TITLE: Sexual Abuse Treatment for DCYF Involved Youth Practice Standards
RULEMAKING ACTION: Repeal
Direct Final: N/A
TYPE OF FILING: Proposed repeal

TIMETABLE FOR ACTION ON THE PROPOSED RULE: Public comment will end on **August 31, 2018.**

SUMMARY OF PROPOSED RULE: This rule is being repealed and will be replaced by DCYF Guidelines.

COMMENTS INVITED:
All interested parties are invited to submit written or oral comments concerning the proposed regulations by **August 31, 2018** to the address listed below.

ADDRESSES FOR PUBLIC COMMENT SUBMISSIONS:

All written comments or objections should be sent to, Sarah St. Jacques, DCYF Policy Office, Rhode Island Department of Children, Youth and Families
Mailing Address: DCYF, 3rd Floor, 101 Friendship Street, Providence, RI 02903
Email Address: Sarah.StJacques@dcyf.ri.gov

WHERE COMMENTS MAY BE INSPECTED:
Mailing Address: DCYF, 3rd Floor, 101 Friendship Street, Providence, RI 02903

PUBLIC HEARING INFORMATION:
If a public hearing is requested, the place of the public hearing is accessible to individuals who are handicapped. If communication assistance (readers/ interpreters/captioners) is needed, or any other accommodation to ensure equal participation, please call (401) 462-6266 or RI Relay 711 at

least three (3) business days prior to the meeting so arrangements can be made to provide such assistance at no cost to the person requesting.

ALTERNATIVE PUBLIC HEARING TEXT:
In accordance with R.I. Gen. Laws § 42-35-2.8, an oral hearing will be granted if requested by twenty-five (25) persons, by an agency or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within ten (10) days of this notice.

FOR FUTHER INFORMATION CONTACT:
Sarah St. Jacques, DCYF Policy Office, Rhode Island Department of Children, Youth and Families, 3rd Floor, 101 Friendship Street, Providence, RI 02903 or Sarah.StJacques@dcyf.ri.gov

SUPPLEMENTARY INFORMATION:
Regulatory Analysis Summary and Supporting Documentation:
There are no new societal costs and benefits in the adoption of this rule.

Authority for This Rulemaking: R.I. Gen. Laws Chapters 42-72-4

Regulatory Findings:
In the development of the proposed regulation, consideration was given to: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small business. No alternative approach, duplication, or overlap was identified based upon available information.

RHODE ISLAND
DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES



Sexual Abuse Treatment for DCYF Involved Youth

Practice Standards

April 28, 2014

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SECTION ONE - GENERAL PROVISIONS

I. Statement of Intent

The Rhode Island Department of Children, Youth and Families (hereinafter, the Department) has partnered with families and stakeholders, including private treatment agencies and victim advocates, to develop and implement a comprehensive management program for youth involved with the Department who have exhibited sexually abusive behaviors or have been affected by sexual abuse. This rule establishes practice standards to assist sexual abuse treatment providers in assessment, evaluation and implementation of services and supports and delineates requirements for the education and training of treatment providers.

The Department does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, handicap or socio-economic status. The prohibition against discriminatory practices extends to the agencies, organizations and institutions that contract with the Department.

II. Legal Basis

Rhode Island General Law (RIGL)

- RIGL 40-11, Abused and Neglected Children
- RIGL 14-1, Proceedings in Family Court
- RIGL 42-72-2, Declaration of Policy (DCYF)
- RIGL 42-72-5, Power and Scope of Activities (DCYF)
- RIGL 42-72-5.2, Development of a Continuum of Children's Behavioral Health Programs (DCYF)
- RIGL 11-37.1-3, Sexual Offender Registration and Community Notification

Federal Law

- Adam Walsh Child Protection and Safety Act of 2006 (PL 109-248)

III. Definitions

Aftercare - Support services, commencing while youth is in treatment, that continue subsequent to discharge.

Amenability to Treatment - A sincere willingness, even if minimal, to participate in treatment to address changes in thoughts, feelings and behaviors.

Assessment - Measurement used to test levels of functioning, including cognitive, neuropsychological, psychiatric, psychological, memory and learning, social and emotional, social stability, family dynamics, academic, vocational/career, sexual, accountability and sexual offense/abuse characteristics and risk factors.

Associate Level - Status approved by the Department that allows a provider to treat, under the supervision of a provider at the Qualified level, a youth who has committed a sexual offense or has exhibited sexually abusive behaviors.

Caregiver - Parent, guardian or other adult who has a custodial responsibility to care for the youth.

Child Abuse - Maltreatment of a child as defined by RIGL 40-11-2 and **DCYF Policy 500.0000: Reporting Child Abuse and/or Neglect**, **DCYF Policy 500.0050, Standards**

for Investigating Child Abuse and Neglect (CA/N) Reports (Levels 1, 2, 3) and DCYF Policy 500.0010, Criteria for a Child Protective Services Investigation.

Clarification - A treatment intervention where any points of confusion or concerns specifically related to the child's sexual abuse experience are processed, including any confusion regarding who was responsible for the abuse.

Community Supervision - Youth residing in any unlocked location (home, foster placement, residential placement) that is under the supervision of a multidisciplinary team and assigned to a probation or parole officer.

Contact - Any verbal, physical, written or electronic communication (direct or indirect) between an abuser and a victim or potential victim. **Purposeful**: a planned experience with an identified potential outcome. **Incidental**: unplanned or accidental or by chance.

Department Primary Worker - Probation Officer, Family Services Unit Social Worker or Clinical Social Worker employed by the Department of Children, Youth and Families.

Department - Rhode Island Department of Children, Youth and Families (DCYF) responsible for child welfare, children's behavioral health and juvenile correctional operations in the state.

Direct Clinical Contact - Includes intake, assessment, face-to-face therapy, case/ treatment staffing with the youth and family/caregiver, treatment plan review with the youth and family/caregiver, crisis management and milieu intervention.

Discharge - Release from treatment due to a variety of factors such as, but not limited to, court order, aging out of the youth system, moving out of the state's jurisdiction or successfully completing all elements of the sexual abuse treatment. Discharge may not be an indication of the end of the youth's management needs or the elimination of risk to the community.

Dynamic Risk Factors - Characteristics, variables or conditions that are subject to change and must be addressed in sexual abuse treatment and which, when successfully treated, are associated with lowered recidivism rates.

Evaluation - Review and analysis of various assessments and information that result in recommendations for treatment and supervision. Evaluation of those who have been sexually abused is abuse informed, but not exclusively abuse focused, encompassing the direct effect of the abuse as well as pre-existing and concurrent needs.

Informed Consent - Necessitates that the youth: (a) has the capacity to consent; (b) has been adequately informed of significant information concerning treatment processes and procedures; (c) has been adequately informed of potential risks and benefits of treatments for which generally recognized standards do not yet exist; (d) has freely and without undue influence expressed consent; and (e) has provided consent that is appropriately documented. When youth, due to age or mental status, are legally incapable of giving informed consent, therapists obtain informed permission from a legally authorized person.

Informed Supervision - Conscientious daily supervision of a youth by a responsible adult who:

- Is aware of the youth's history of sexually abusive behavior;
- Does not deny or minimize the youth's responsibility for or the seriousness of the sexually abusive behavior exhibited;
- Can recognize abusive behaviors in daily functioning;

- Is aware of the laws relevant to youth sexual behaviors;
- Is aware of the dynamic patterns and cycles associated with abusive behaviors and is able to recognize such patterns in daily functioning;
- Understands the conditions of community supervision and treatment;
- Can design, implement and monitor safety plans for daily activities;
- Is able to hold the youth accountable for behavior;
- Has the skill to intervene in and interrupt high risk patterns;
- Can share accurate observations of daily functioning; and
- Communicates regularly with members of the multidisciplinary team.

Intern - Status approved by the Department that allows an individual to treat, under the direct supervision and in the presence of a provider at the Qualified level, a youth who has committed a sexual offense or has exhibited sexually abusive behaviors.

Licensed Practitioner of the Healing Arts - Doctoral or masters level clinician independently licensed in the State of Rhode Island in the field of medicine, psychology, nursing, social work, mental health counseling or marriage and family counseling.

Measurable Outcomes - Observable changes made by individuals or populations during or after participating in programming. Outcomes may relate to behavior, skills, knowledge, attitude, values, condition or other attributes.

Needs - Issues to be addressed therapeutically or by specific intervention through the treatment and supervision plan.

Non-Offending Parent/Caregiver - A caregiver of a child who has not sexually abused the child, including but not limited to the alleged offender's significant other, relative caregivers, foster parents and adoptive or birth parents.

Potential Victim - A person about whom the youth objectifies, fantasizes and/or makes plans to harm.

Provider List - Roster of individuals or agencies established by the Department who are approved to offer treatment to Department-

~~involved youth who have exhibited sexually abusive behaviors or have been affected by sexual abuse.~~

~~**Protective Factors** - Characteristics, variables or conditions present that enhance the likelihood of positive outcomes and lessen the likelihood of negative consequences from exposure to risk.~~

~~**Qualified Level** - Licensed Practitioner of the Healing Arts approved by the Department to offer sexual abuse treatment to Department-involved youth who have exhibited sexually abusive behaviors or have been affected by sexual abuse. A provider at the Qualified level may supervise an Associate or Intern level provider.~~

~~**Recidivism** - Return to sexually abusing behavior after some period of abstinence or restraint.~~

~~**Reunification** - The process and event resulting in a youth who was sexually abused residing in the same household where his or her abuser resides.~~

~~**Risk Factors** - Dynamic or static characteristics, factors, variables or conditions present that increase the likelihood of an adverse outcome.~~

Safety Planning - Recognition and acknowledgement of daily, circumstantial and dynamic risks and purposeful planning of preventive interventions which the youth can use to moderate risk in current situations.

Secondary Victim - A relative or other person closely involved with the primary victim who is impacted emotionally or physically by the trauma suffered by the primary victim.

Sexual Abuse - May encompass a range of behaviors including but not limited to; unwanted sexual language, text messages, peeping, exposure, frottage, sexual assault, aggravated sexual assault, attempted or completed rape. All of the behaviors can lead to harmful physical, mental and emotional health outcomes. Refer to **DCYF Policy 500.0050, Standards for Investigating Child Abuse and Neglect (CA/N) Reports (Levels 1, 2, 3)** and **DCYF Policy 500.0010, Criteria for a Child Protective Services Investigation**.

Sexual Abuse Evaluation (SAE) - Review and analysis of various assessments and information to develop recommendations for treatment and supervision. Evaluation of those who have been affected by sexual abuse is abuse informed, but not exclusively abuse focused, encompassing the direct effects of the abuse as well as pre-existing and concurrent needs.

Sexual Abuse Treatment for Youth Affected by Sexual Abuse - Specialized treatment interventions that directly address common psychological, emotional and behavioral effects of sexual abuse upon an individual, family and/or community.

Sexual Abuse Treatment for Youth Who Exhibit Sexually Abusive Behavior - Comprehensive set of planned therapeutic experiences and interventions to reduce the risk of further sexual offending or abusive behavior by the youth. Treatment focuses on the situations, thoughts, feelings and behaviors that have preceded and followed past sexual abusing cycles and promotes changes in each area relevant to the risk of continued sexual abusive or sexually deviant behaviors. Treatment is provided on the basis of individual assessment and evaluation and is designed to stop sexually abusive behavior while increasing the youth's ability to function as a healthy, pro-social member of the community. Progress in treatment is measured by the achievement of change rather than the passage of time. Treatment may include adjunct therapies to address the unique needs of the youth, but always includes offense and abuse specific services by approved sexual abuse treatment providers.

Sexual Abuse Treatment Provider - Also referred to as provider; an individual credentialed through the Department at the Qualified, Associate or Intern level to offer treatment and services to youth who have exhibited sexually abusive behaviors or have been affected by sexual abuse.

Therapeutic Care - Intervention and nurturance which address treatment goals to increase the youth's potential and competency for successful, normative functioning. Such care may be provided by a caregiver who is an active participant in the treatment process.

Therapeutic Caregiver - Individual responsible for implementing interventions to address goals to be accomplished in a therapeutic care setting.

Transition - Planned movement from one level of care to another.

Trauma - An event or situation that causes distress and/or disruption. Incidents of physical/emotional/sexual abuse, neglect, abandonment, witnessing violence and other experiences a person may view as life threatening. Often characterized by profound

powerlessness, intrusive memories, avoidance, hyper-arousal and hyper-sensitivity to stimuli associated to the traumatic event(s).

Youth - For the purposes of these standards, a youth refers to a person between birth and twenty-one years of age.

SECTION TWO – PROVIDER APPROVAL PROVISIONS

I. Application

A. A provider applying to offer sexual abuse treatment and service interventions for youth involved with the Department completes in the application in full and submits to the Department's Community Services and Behavioral Health division the application:

1. For approval as a sexual abuse treatment provider for DCYF Involved Youth who Exhibit Sexually Abusive Behavior, or
2. As a treatment provider for DCYF Youth Affected by Sexual Abuse.

B. The following information is included with the application:

1. Current resume;
2. Professional reference;
3. Clinical experience;
4. Professional supervision agreement;
5. Documentation of training; and
6. Documentation of active Rhode Island clinical license for Qualified Practitioner applicant.

II. Determination

A. Upon receipt of a completed application packet, the Department's Community Services and Behavioral Health division takes one of the following actions within thirty days:

1. Approves the applicant for placement on the provider list.
2. Denies the applicant for placement on the list and informs applicant of the reason for denial and the right to appeal in accordance with Section

IV. Appeal/Hearing, below.

B. If the applicant is approved and included on the provider list, he/she continues at that approval level in accordance with these

~~standards and submits required documentation biannually to the Department in accordance with Section III. Renewal of Approval below.~~

~~III. Renewal of Approval~~

~~A. The provider demonstrates continued compliance with these standards to maintain Department approval.~~

~~B. The provider at the Qualified level submits written documentation biannually to the Department's Community Services and Behavioral Health division that the following requirements have been completed within the past two years:~~

~~1. Rhode Island State License is current.~~

~~2. Twenty-four hours of training are completed as described below in Section Three, Provider Requirements, I. Qualifications and Training.~~

~~C. Associate and Intern level providers submit written documentation biannually to the Department's Community Services and Behavioral Health division reporting~~

progress toward the next approval level or submits an application for approval as a Qualified or Associate level treatment provider.

IV. Appeal/Hearing

A. Any applicant may appeal any action or decision of a Department staff person, supervisor or administrator that is adverse to the status as an applicant or approved provider.

B. All administrative hearings for appeals are held in accordance with **DCYF Policy 100.0055, Complaints and Hearings**.

SECTION THREE – PROVIDER REQUIREMENTS

I. Qualifications and Training

A. The provider adheres to the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care.

B. The Department recognizes three levels of qualification for providers:

1. Qualified
2. Associate
3. Intern

C. Provider at the Qualified level supervises providers at the Associate or Intern level.

D. The provider at any of the three levels of qualification meets the following criteria:

1. Does not have a conviction or a deferred judgment for any offense listed on the Department's Disqualifying Information Addendum. (Refer to **DCYF Policy 900.0040: Criminal Records Checks**).
2. Complies with generally accepted standards of practice of his or her mental health profession and the Professional Code of Ethics.

E. A provider approved at the Qualified level also meets the following criteria (in addition to criteria outlined in D above).

1. Is a Licensed Practitioner of the Healing Arts in accordance with Section One - General Provisions, III Definitions.
2. Is a certified Medicaid provider in Rhode Island.
3. Has completed, within the last five years, a minimum of one thousand supervised (by a provider at the Qualified level) hours of clinical experience.

a. Providers treating youth who exhibit sexually abusive behavior have clinical experience in the areas of assessment and treatment of

~~youth who commit sexual offenses, exhibit sexually abusive behavior or are affected by sexual abuse. At least half of these required hours are direct clinical contact.~~

~~b. Providers treating youth affected by sexual abuse have clinical experience in the areas of assessment and treatment of youth affected by sexual abuse. At least half of these required hours are direct clinical contact.~~

~~c. The provider may request credit for training outside of topic areas by submitting documentation to the Department's Community Services and Behavioral Health division demonstrating relevance.~~

~~d. The provider completes required continuing education credits.~~

4. Providers treating youth affected by sexual abuse complete within the last five years at least sixty hours of documented training to include:

a. Thirty hours of victim related topic areas.

b. Eighteen hours of general topic areas.

c. Twelve hours of sexual abuse specific training.

5. Providers treating youth who exhibit sexually abusive behavior complete within the last five years at least sixty hours of documented training to include:

a. Thirty hours of sexual abuse specific training.

b. Eighteen hours of general topic areas.

c. Twelve hours of victim related topic areas.

F. A provider approved at the Associate level also meets the following criteria (in addition to criteria outlined in D above):

1. Possesses, at minimum, a master's degree in a behavioral science;

2. Is working toward attaining the Qualified level; and

3. Treats the youth under the supervision of a provider at the Qualified level who is responsible for signing off on all documented work.

G. A provider approved at the Intern level also meets the following criteria (in addition to criteria outlined in D above):

1. Is enrolled in a master's or doctorate degree program from an accredited university in a behavioral science;

2. Treats the youth under the direct supervision of a provider at the Qualified level who is responsible for signing off on all documented work;

3. Participates in co-therapy with a provider at the Qualified level; and

4. Receives clinical supervision as determined by the provider at the Qualified level. Clinical supervision includes co-therapy and direct observation of the intern conducting the treatment.

II. Required Notification

A. The provider notifies the Department's Community Services and Behavioral Health Division of any changes to contact information, treatment location and professional status or licensure.

B. The provider reports any known or suspected child abuse or neglect to the Department's Child Protective Services (CPS) Hotline in accordance with RIGL 40-11-3 and **DCYF Policy 500.0000, Reporting Child Abuse and/or Neglect**. Any person who has reasonable cause to know or suspect that any child has been abused and/or neglected or has been a victim of sexual abuse by a

~~parent, third party adult or another child reports that information to the CPS Hotline within twenty-four hours.~~

~~C. The provider immediately notifies the Department primary worker of:~~

~~1. Refusal by youth and/or caregiver to consent to treatment; or~~

~~2. Violations of the treatment contract including those related to child or community safety or Conditions of Probation; or~~

~~3. Reduction in frequency or duration of contacts or any alteration in treatment modality.~~

~~D. The Department's primary worker ensures that a youth adjudicated on a sexual offense registers with local law enforcement as required. The Department's primary worker verifies that registration has taken place.~~

E. If a violation of probation or revocation of Temporary Community Placement (TCP) is filed by the Department's primary worker, the provider testifies if necessary and furnishes, when requested, written information regarding the youth's treatment progress. This information includes:

1. Changes in the treatment plan;
2. Dates of attendance;
3. Treatment activities;
4. Youth's progress and compliance with treatment; and
5. Any material relevant to the court or revocation hearing.

F. The provider shares case information with collateral parties as needed and within the context of law and policy. (Refer to **DCYF Policy 100.0000, Confidentiality** and Section Three, Provider Requirements, III. Confidentiality, below.)

III. Confidentiality

A. The Department's primary worker ensures that the youth and the caregiver have signed the DCYF #007A, Authorization to Release Confidential Information and the DCYF #007B, Authorization to Obtain Confidential Information to ensure that the treatment provider and multidisciplinary team have all relevant information required for the assessment and evaluation, treatment and management of the youth. (Refer to **DCYF Policy 100.0000, Confidentiality** and **DCYF Policy 100.0005, Confidentiality: Access to Information Contained in Departmental Service Records**).

B. Sexual abuse treatment providers maintain confidential client records in accordance with *Health Insurance Portability and Accountability Act* of 1996 (*HIPAA*, Title II), Rhode Island law and the professional standards of the discipline regarding health care records.

C. The provider ensures that the youth and the caregiver understand the scope and limits of confidentiality.

SECTION FOUR – PROVISION OF SERVICES – DEPARTMENT INVOLVED YOUTH AFFECTED BY SEXUAL ABUSE

I. Sexual Abuse Evaluation (SAE)

A. Only providers certified by the Department and placed on the provider list conduct SAE's for youth in the care of the Department.

B. The provider obtains the informed consent of the parent/caregiver for the SAE.

1. Youth and parent/caregiver are informed of the SAE methods, how the information is used and to whom it may be released.

2. Provider ensures the youth is fully informed about the SAE procedures.

3. The non-offending parent/caregiver reviews the results of the SAE and/or is provided with a copy of the report.

C. SAEs serve to:

1. Assess the presence of sexual abuse and/or traumatic experience.

2. Determine the impact of abuse and/or trauma on the youth and their family/caregiver.

3. Assess youth's strengths, risks, needs and family dynamics.

4. Identify and document treatment and developmental needs.

5. Determine amenability or potential barriers to treatment.

6. Make recommendations for treatment and safety.

7. Assess safety of youth's present situation.

D. The provider is sensitive to any cultural, language, ethnic, developmental, sexual orientation, gender identity and expression, medical or educational issues that may arise during the SAE. The provider selects SAE procedures relevant to the individual circumstances of the youth and commensurate with the provider's level of training and expertise.

E. Due to the complexity of evaluating a youth who has been affected by sexual abuse, the provider utilizes instruments with:

1. Specific relevance to the evaluation of the individual youth.

2. Demonstrated reliability and validity (as supported by research in the mental health and youth sexual abuse treatment fields).

F. SAEs address strengths, risks and needs in the following areas:

1. Cognitive Functioning;
2. Personality, Mental Disorders and Mental Health;
3. Social/Developmental History;
4. Developmental Competence;
5. Individual Functioning;
6. Family Functioning;
7. Sexual History/Evaluation;
8. Assessment of Risk; and
9. Amenability to Treatment.

G. The provider utilizes the following resources to inform the SAE:

1. Department case files;
2. Police report;
3. Collateral information including the youth's treatment and sexual abuse history;
4. Structured clinical interviews and clinical mental status examination;
5. Family interviews; and
6. Observational assessment.

H. The provider makes written recommendations of clinical impressions, findings and observations.

II. Treatment for Youth Affected by Sexual Abuse

A. Treatment is designed to maximize measurable outcomes regarding:

1. Safety;
2. Reducing the risk of further victimization;
3. Individual and family empowerment;
4. Reduction of trauma symptoms;
5. Healthy sexual development;
6. Overall health and development;
7. Healthy interpersonal relationships;
8. Internalized effects of the abuse; and
9. Emotion regulation.

B. Treatment plans include individualized goals and interventions to improve functioning. Relevant outcomes include, but are not limited to, the Youth:

1. Demonstrates a decrease in trauma-related symptoms.
2. Demonstrates pro-social relationship skills and is able to establish closeness, trust and assess trustworthiness of others.
3. Has improved positive self-image.

4. Is able to relax, play and celebrate positive experiences.

5. Has identified family and community support systems.

6. Has an adaptive sense of purpose and future.

7. Demonstrates ability to carry out personal safety plan.

C. The provider develops a written, individualized treatment plan consistent with the Department's service plan and based on the SAE and/or assessment of the youth and his/her current environment. The plan addresses, but is not limited to, safety planning, symptom reduction and management and increasing overall health. Refer also to **DCYF Policy 700.0075: Comprehensive Assessment and Service Planning**.

D. The treatment plan is reviewed on a quarterly basis or more frequently if necessary.

E. Treatment plans designate measurable outcomes that indicate successful completion of treatment. Successful completion of treatment is not measured solely in terms of time in treatment.

F. Caregiver responsibilities are included as part of the treatment plan. The Department's primary worker supports cooperation and participation by the youth's family in treatment.

G. The provider utilizes developmentally appropriate evaluation, treatment and interventions.

H. Providers share concerning behavioral observations relevant to the youth's and/ or youth's family functioning and information regarding participation in treatment immediately with the Department's primary worker.

I. The provider submits progress reports documenting youth's attendance, participation in treatment, changes in the treatment plan and treatment progress monthly to the Department's primary worker.

J. Acceptable modalities of sexual abuse treatment include, but are not limited to:

1. Individual therapy;

2. Group therapy;

3. Family therapy;

4. Self-help or time-limited treatments may be used as adjuncts to enhance Individual, Group and/or Family therapy.

K. Providers continue to advocate for treatment until the outcomes in the individual treatment plan are achieved.

L. When a specific type of intervention is contra-indicated, the issue is documented and alternative interventions are listed. If the intervention becomes viable, the treatment plan is amended accordingly.

M. Providers maintain client files in accordance with the professional standards of the discipline and with Rhode Island state law on health care records. Client files include, but are not limited to:

1. Evaluations, assessments and treatment plans;
2. Documentation of treatment goals and interventions;
3. Documentation of progress toward measurable outcomes;
4. Critical incidents occurring during treatment;
5. Impediments to success or lack of resources and systemic response;

6. Level of participation by youth, family and/or support system;

7. Discharge criteria, safety plan and recommendations for aftercare;

8. Availability of family and community resources to support aftercare;

9. Documentation of session notes; and

10. All documentation requiring signature.

III. Team Approach to Treatment

A. Treatment decisions for a youth affected by sexual abuse are made in a coordinated manner with the youth's treatment provider, family and Department's primary worker. In some instances, an expanded team is utilized for the SAE, assessment, treatment and care of the youth.

1. Expanded team members may include the caregiver, extended family members, clinical professionals, school personnel, family court and legal advocates, faith-based affiliations, victim advocates and other identified informal and formal supports.

2. If such supports are utilized, necessary confidentiality agreements are documented in the youth's case file.

B. The Department's primary worker collaborates with the team to discuss and approve changes in treatment providers or placements.

IV. Reunification with Non-Offending Parent/Caregiver

A. If reunification is considered for youth removed from his/her family, the Department's primary worker seeks out the recommendation of the youth's sexual abuse treatment provider regarding reunification planning.

B. Family reunification can be a long-term process and never takes precedence over the safety of the youth affected by sexual abuse.

C. Reunification is only considered when the following is accomplished:

1. The youth has made significant progress toward treatment goals.

2. The non-offending parent/caregiver has made significant progress toward treatment goals.

3. The non-offending parent/caregiver has the ability to set age-appropriate boundaries and limits.

4. The non-offending parent/caregiver has actively participated in the youth's sexual abuse treatment, which includes, but is not limited to:

a. Safety Planning
b. Impact of Sexual Abuse
c. Grief and Loss
d. Caregiver Consistency
e. Supervision
f. Facts about Sexual Abuse
g. Signs and Symptoms of Sexual Abuse
h. Parenting Strategies specific to Survivors of Sexual Abuse
i. Systemic Issues (Courts/DCYF)
j. Information related to sex offenders

5. The non-offending parent/caregiver has demonstrated the ability to:

a. Initiate consistent communication with the youth regarding their safety.
b. Believe the abuse occurred, has received support and education and accepts that potential exists for future abuse.

D. Family reunification does not indicate completion of treatment, as needs may arise during the process that require changes to treatment plan goals.

E. Reunification of the youth with the family only occurs after the caregiver demonstrates the ability to provide protection and support and addresses the needs and risks of the youth.

V. Contact with the Abuser

A. The provider discusses with the Department's primary worker, the abuser's therapist and custodial parent if contact and/or family reunification with the abuser has been identified to be in the best interest of the youth affected by sexual abuse.

B. When considered, the provider ensures that contact is victim-centered, based on the victim's need and the clarification process has occurred.

C. Contact includes verbal or non-verbal communication that may be indirect or direct between the youth and the abuser. Contact is initiated through the clarification process.

D. The clarification process is lengthy and serves to benefit the youth. The abuser completes written work that may progress to verbal contact prior to, or in lieu of, face-to-face contact.

E. Clarification and contact procedures are developed in collaboration with the youth, non-offending parent/caregiver, youth's sexual abuse treatment provider, the Department's primary worker and the abuser's therapist, who:

1. Collaborate with the abuser's therapist or advocate, guardian, custodial parent, foster parent and guardian ad litem in making decisions regarding communication, visits and reunification in accordance with any court orders.

2. Support the youth's wishes regarding contact to the extent that it is consistent with the youth's safety and well-being.

F. If contact is approved, the process is supervised and monitored; it includes:

1. Safety plans that have mechanisms in place to inform involved parties and specifically the Department's primary worker of concerns during contact.

2. An assessment of the youth's emotional and physical safety on a continuing basis; contact is terminated immediately if any aspect of safety is jeopardized.

~~VI. Reunification with the Abuser~~

~~A. Reunification of a youth affected by sexual abuse and the abuser is considered only if all the elements of Reunification with the Non-Offending Parent (Section IV) and Contact with the Abuser (Section V) are met and it is deemed to be in the best interest of the youth.~~

~~B. Evaluation and treatment for the youth, family and abuser is essential.~~

~~Reunification is agreed upon by all parties prior to starting the reunification process. Some families may never move beyond supervised or unsupervised visitation; for other families reunification includes the goal of having the youth and abuser reunified and living in the same household.~~

1. Reunification occurs when the youth, abuser and family are assessed and deemed ready to undergo the reunification process.

2. Reunification occurs when all youth are safe and protected both emotionally and physically.

C. Family reunification does not indicate completion of treatment as needs may arise during the process that requires changes to treatment plan goals.

VII. Discharge from Treatment

A. Prior to discharge from treatment, victim safety is coordinated in conjunction with the youth's parent/caregiver, provider, the Department's primary worker and any other resource providers, as necessary.

B. Discharge documentation addresses and includes:

1. The reasons for discharge;

2. Accomplishment of the goals identified in the treatment plan;

3. Accomplishment of the treatment outcomes;

4. Any rationale for a revised plan;

5. Completed written safety plan; and

6. A treatment summary with aftercare plan recommendations, when indicated.

SECTION FIVE - PROVISION OF SERVICES – DEPARTMENT INVOLVED YOUTH WHO EXHIBIT SEXUALLY ABUSIVE BEHAVIOR

I. Pre-sentence Investigation (PSI)

A. Youth who sexually abuse or exhibit sexually abusive behaviors that are court involved are the subject of a Pre-Sentence Investigation (PSI), which includes a sexual offense specific evaluation. The PSI provides the court with verified and relevant information, which is considered during sentencing.

B. Based on the information gathered, the sexual offense evaluation establishes a baseline regarding the youth's risk factors, amenability to treatment and treatment needs and suitability for community supervision.

II. Multidisciplinary Team

A. A multidisciplinary team is convened for the assessment and evaluation, treatment, care and supervision of the youth.

B. Team members may include the youth, caregiver, extended family members, the Department's primary worker, treatment provider, clinical professionals, school personnel, Family Court and legal advocates, law enforcement, faith-based affiliations, peers, therapists, coaches, employers, advocates and other identified informal and formal supports.

C. Informed supervision and behavioral monitoring are the collaborative and cooperative responsibilities of the multidisciplinary team. The team shares information related to risk assessment, treatment and behavioral monitoring. Team decisions are based on individual assessment and evaluation.

D. Each team is formed around a particular youth and is flexible to include any individual necessary to ensure the best approach to managing and treating the youth.

E. Permanent reduction in duration or frequency of contact or permanent alteration in treatment modality is determined on an individual case basis by the provider and the multidisciplinary team.

III. Assessment and Evaluation

A. Only providers at the Qualified level certified by the Department and placed on the provider list conduct sexual abuse assessments and evaluations for youth in the care of the Department.

B. Comprehensive sexual abuse assessment and evaluation is completed for an adjudicated youth who has committed a sexual offense.

C. Comprehensive sexual abuse assessment and evaluation may be completed for a youth involved with the Department who has exhibited sexually abusive behavior, but has not been adjudicated for a sexual offense.

D. Assessments and evaluations are comprehensive and serve to:

1. Assess static and dynamic risk factors.
2. Provide written clinical assessment of a youth's strengths, risks and needs.
3. Identify and document treatment and developmental needs.
4. Determine amenability or potential barriers to treatment.
5. Make recommendations for the treatment, management and informed supervision of the youth.
6. Provide information which can help identify the type and intensity of community-based treatment or the need for a more restrictive setting.

E. Due to the complexity of evaluating a youth who has committed a sexual offense or exhibited sexually abusive behavior, the assessment must include, but is not limited to instruments that have:

1. Specific relevance to the evaluation of the individual youth.
2. Demonstrated reliability and validity (supported by research in the mental health and youth sexual abuse treatment fields).

F. Assessment and evaluation are ongoing processes that continue through each transition of informed supervision and treatment.

1. The youth's progress in treatment and compliance with supervision is assessed on an ongoing basis.

2. Risk and protective factors are assessed at transition points and include considerations of level of functioning, monitoring and follow-up.

3. Assessment is required prior to the youth's transition to another stage of treatment.

IV. Treatment Contract and Plan

A. The provider develops and utilizes a written treatment contract with the youth prior to the commencement of treatment.

1. The treatment contract addresses public safety and is consistent with provisions of the Department's service plan. Refer to **DCYF Policy** 700.0075: Comprehensive Assessment and Service Planning.

2. The treatment contract defines the specific responsibilities and rights of the provider and youth and is signed by the provider, caregiver and the youth.

B. The provider develops the written treatment plan based on the assessment and evaluation of the youth in partnership with the multidisciplinary team.

C. The treatment plan is reviewed quarterly or more frequently as determined by the multidisciplinary team. The frequency of review is documented in the plan.

V. Sexual Abuse Treatment

A. Sexual abuse treatment maximizes measurable outcomes and decreases the youth's dynamic risk factors.

B. Sexual abuse treatment methods and intervention strategies are based on the treatment plan developed in response to the youth's assessment and evaluation.

C. The provider utilizes developmentally appropriate assessments and evaluation, treatment and interventions.

D. Progress reports documenting a youth's attendance, participation in treatment, changes in risk factors, changes in the treatment plan and treatment progress are submitted monthly to the Department's primary worker.

VI. Informed Supervision

A. The primary caregiver of a youth who exhibits sexually abusive behavior is responsible to provide informed supervision. If the primary caregiver is unable or unwilling to perform this role, an informed supervisor can include an advocate, mentor, kin, spiritual leader, teacher, work manager, coach or an individual identified by the multidisciplinary team.

B. An Informed Supervision Agreement (DCYF Form #201) is signed by the informed supervisor and the Department's primary worker within the first twenty- four hours of placement and is kept in the youth's case record. This agreement establishes the required level of informed supervision.

C. A designated member of the multidisciplinary team meets with the informed supervisor within the first five days of community or residential supervision to discuss the elements of informed supervision.

VII. Therapeutic Care

A. Therapeutic care providers give corrective care and guidance beyond what is normally expected of a caregiver/informed supervisor to

assist the youth in addressing special needs or developmental deficits that impede successful functioning. Therapeutic care providers implement interventions to address treatment goals.

B. A therapeutic care provider seeking to work with a youth who has exhibited sexually abusive behavior does not have a conviction or a deferred judgment for any offense listed on the Department's Disqualifying Information Addendum. (Refer to **DCYF Policy 900.0040, Criminal Records Checks**).

VIII. Victim Clarification and Contact

A. The provider discusses with the Department's primary worker, the victim's therapist, custodial parent, foster parent, therapeutic caregiver or guardian ad litem specific plans for any and all contact of the youth with the victim and family reunification.

B. The victim clarification process is designed to primarily benefit the victim.

Through the process, the youth clarifies that the victim has no responsibility for the youth's behavior. Issues addressed include the damage done to the victim, family and secondary victim.

C. Department's primary worker discusses any plans for contact between the youth and the victim or potential victim with the multidisciplinary team, the victim's therapist/advocate and the youth's caregiver.

IX. Family Reunification

A. Reunification in a family that includes the victim must be agreed upon by the multidisciplinary team and the family prior to starting the reunification process.

B. Reunification occurs subsequent to assessment, evaluation and treatment of the victim, youth and family and only when all individuals are ready to begin the reunification process.

X. Discharge From Treatment

A. The multidisciplinary team considers victim and community safety before making a determination relating to discharge from treatment.

~~B.~~ ~~The reasons for discharge are documented by the multidisciplinary team noting any potential risk to the community and providing notification to any other necessary parties.~~