

SAN DIEGO COUNTY SEX OFFENDER ADULT TREATMENT STANDARDS

Version 2.0

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**** Please note that Version 2.0 of these Standards include revisions approved the the San Diego Sex Offender Mangement Council in October 2005.**

SECTION 1: OVERVIEW

Introduction

In 2000, the San Diego County Probation Department received a grant from the Center for Sex Offender Management (CSOM) and the Violence Against Women Office. This grant allowed representatives from the entire county to collect research and make recommendations that would improve all aspects of sex offender management.

One of the recommendations made by the CSOM Planning Team was the development of Standards for the assessment and treatment of sex offenders. These Standards, however, would need to integrate with a coordinated system of sex offender management adopted by San Diego County. The System, known as the *Containment Model*, is based on the belief that offenders cannot necessarily be “cured,” but can be treated and monitored in a manner that enhances the safety of the community and protects victims. To be effective, a *Containment* approach must include interagency and interdisciplinary teamwork.

These Standards are based on the national best practices known today. They are the product of both research as well as input from local, experienced professionals in the field of sex offender management.

The Standards are not intended for the treatment of sexually abusive children and adolescents. Although there are many similarities in the behavior and treatment of adults and children, there are also a number of important differences that make assessment and treatment different for the two populations.

The management and treatment of sex offenders is a specialized and developing field, and the modification of these Standards will be necessary as new research and published findings emerge. A process for the review of the Standards will be addressed within the body of this document to insure that San Diego remains current with processes and procedures that contribute to safer communities.

San Diego County owes a great deal of gratitude to the state of Colorado, who shared their Standards with us and allowed us to model our Standards on the product of their hard work.

Declaration of Principles

These Standards, which apply to the management of adult sexual offenders under the jurisdiction of the criminal justice system, are guidelines designed to establish a basis for systematic management and treatment of these offenders. While we acknowledge that many sex offenders cannot be “cured” we also recognize that the criminal sexual behaviors of many offenders can be managed.

The combination of comprehensive sex offender treatment and carefully structured and monitored behavioral supervision conditions can assist many sex offenders as they develop internal controls for their behaviors.

Because this population requires a specialized approach that addresses the changes in attitudes and behaviors and also provides the necessary external controls, a coordinated system for the management and treatment “contains” the offender and enhances the safety of the community and the protection of victims. To be effective, a “containment approach” which includes interagency and interdisciplinary teamwork is essential.

To this end, the San Diego County Sex Offender Management Council and these Standards subscribe to the following principles:

Principle 1: Sexual offending is a behavioral disorder that in many cases may not be “cured”:

Principle 2: Sexual offenses are defined by law and may or may not be associated with or accompanied by the characteristics of sexual deviance, some which are described as paraphilias. Some sex offenders also have coexisting conditions such as mental disorders, organic disorders, or substance abuse problems.

Principle 3: Many offenders can learn through treatment to manage their sexual offending behaviors and decrease their risk of re-offense. Such behavioral management should not, however, be considered a “cure,” and successful treatment cannot permanently eliminate the risk that sex offenders may repeat their offenses.

Principle 4: Sex offenders present a danger in our communities:

- When sexual assault occurs there is always a victim. Both the literature and clinical experience suggest that sexual assault can have long lasting effects on the lives of victims and their families.
- There are many forms of sexual offending and offenders may have more than one pattern of offending behavior and often have multiple victims. The propensity for such behavior is often present long before it is detected. It is the nature of the disorder that sex offenders’ behaviors are inherently covert, deceptive, and secretive, and sex offenders often exhibit varying degrees of denial about the facts, severity, and or frequency of their offenses.
- Prediction of the risk of re-offense for sex offenders is in the early stage of development, therefore, it is difficult to predict the likelihood of re-offense or future victim selection.

- Some offenders may be too dangerous to be placed in the community and other offenders may pose enough risk to the community to require extended long-term monitoring to minimize the risk.

Principle 5: Community safety is paramount:

- The highest priority of these Standards and guidelines is community safety.

Principle 6: Assessment and evaluation of sex offenders is an on-going process.

- Progress in treatment and level of risk are not constant over time:
- Ideally, all sex offenders should be assessed and referred for a mental health sex offense-specific evaluation prior to the pre-sentence investigation conducted by the Probation Department. If this cannot take place, an evaluation should be completed by each treatment provider prior to the commencement of treatment.
- Assessment of sex offenders' risk and amenability to treatment should not, however, end at this point. Subsequent assessments must occur at both the entry and exit points of all sentencing options. In addition, assessment and evaluation should be an ongoing practice in any program providing treatment for sex offenders.
- In the management and treatment of sex offenders there will be measurable degrees of progress or lack of progress. Because of the cyclical nature of offense patterns and fluctuating life stresses, sex offenders' levels of risk are constantly in flux. Success in the management and treatment of sex offenders cannot be assumed to be permanent. For these reasons, monitoring of risk must be a continuing process as long as sex offenders are under criminal justice supervision. Moreover, the end of the period of court supervision should not necessarily be seen as the end of dangerousness.

Principle 7: Assignment to community supervision is a privilege, and sex offenders must be completely accountable for their behaviors:

- Sex offenders on community supervision must agree to intensive and sometimes intrusive accountability measures that enable them to remain in the community rather than in prison. Offenders carry the responsibility to learn and demonstrate the importance of accountability, and to earn the right to remain under community supervision.

Principle 8: Sex offenders must waive confidentiality for evaluation, treatment, supervision and case management information sharing:

- All members of the team managing and treating each offender must have access to the same relevant information. Sex offenses are often committed in secret, and all forms of secrecy potentially undermine the rehabilitation of sex offenders and therefore threaten public safety.

Principle 9: Victims have a right to safety and self-determination:

- Victims have the right to determine the extent to which they will be informed of an offender's status in the criminal justice system and the extent to which they will provide input through appropriate channels. In the case of adolescent or child victims, custodial adults and/or guardian ad litem act on behalf of the child to exercise this right, in the best interest of the victim.

Principle 10: When a child is sexually abused within the family, the child's individual need for safety, protection, developmental growth and psychological well-being outweighs any parental or family interests:

- All aspects of the community response and intervention system to child sexual abuse should be designed to promote the best interests of children rather than focusing primarily on the interests of adults. This includes the child's right not to live with a sex offender, even if that offender is a parent. In most cases, the offender should be moved or inconvenienced to achieve the lack of contact, rather than further disrupting the life of the child victim.

Principle 11: A continuum of sex offender management and treatment options should be available in each community in the county:

- Many sex offenders can be managed in the community. It is in the best interest of public safety for each community to have a continuum of sex offender management and treatment options. Such a continuum should provide for an increase or decrease in the intensity of treatment and monitoring based on offenders' changing risk factors, treatment needs, and compliance with supervision conditions.

Principle 12: Standards and guidelines for assessment, evaluation, treatment and behavioral monitoring of sex offenders will be most effective if the criminal justice and social services systems, not just sex offender treatment providers, apply the same principles and work together.

- Setting Standards for sex offender treatment providers alone will not significantly improve public safety. The *process* by which sex offenders are assessed, treated, and managed by the criminal justice and social services systems should be coordinated and improved.

Principle 13: The management of sex offenders requires a coordinated team response:

All relevant agencies must cooperate in planning treatment and containment strategies of sex offenders for the following reasons:

- Sex offenders should not be in the community without comprehensive evaluation, treatment, supervision, and behavioral monitoring;
- Each discipline brings to the team specialized knowledge and expertise;
- Open professional communication confronts sex offenders' tendencies to exhibit secretive, manipulative and denying behaviors;
- Information provided by each member of an offender case management team contributes to a more thorough understanding of the offender's risk factors and needs, and to the development of a comprehensive approach to treating and managing the sex offender.

Principle 14: Sex offender assessment, evaluation, treatment and behavioral monitoring should be non-discriminatory and humane, and bound by the rules of ethics and law:

- Individuals and agencies carrying out the assessment, evaluation, treatment and behavioral monitoring of sex offenders should not discriminate based on race, religion, gender, sexual orientation, disability or socioeconomic status. Sex offenders must be treated with dignity and respect by all members of the team who are managing and treating the offender regardless of the nature of the offender's crimes or criminal conduct.

Principle 15: Successful treatment and management of sex offenders is enhanced by the positive cooperation of family, friends, employers and members of the community who have positive influence in the offenders' lives:

- Sexual issues are often not discussed in families, communities or other settings. In fact, there is often a tendency to avoid and deny that sex offenses have occurred. Successful management and treatment of sex offenders involves an open dialogue about this subject and a willingness to hold sex offenders accountable for their behavior.

Principle 16: By addressing the criminogenic needs of offenders it is more likely that offenders will avoid behaviors and life style decisions that bring them back before the criminal justice system:

- Identified risk factors, sometimes unrelated to offense-specific risk factors, should be assessed and targeted in treatment and supervision case plans. Assisting sex offenders in addressing these needs will help them reduce their risk to recidivate.

SECTION 2: ESTABLISHMENT OF AN INTERAGENCY COMMUNITY SUPERVISION TEAM

As soon as possible after the conviction and referral of a sex offender to probation or parole, the supervising officer should convene a team to manage the offender during his/her term of supervision.

The purpose of the team is to staff cases, share information, and make informed decisions related to risk assessment, treatment, behavioral monitoring, and management of each offender. The team should use a mental health sex offense-specific evaluation, an assessment of risk and criminogenic needs, and the pre-sentence investigation report as starting points for such decisions.

STANDARD 1: Supervision and behavioral monitoring is a joint, cooperative responsibility of the supervising officer, the treatment provider, and the polygraph examiner.

Each team, at a minimum, should consist of:

- The supervision officer
- The offender's treatment provider
- The polygraph examiner
- The victim advocate

Each team may find that from time to time it is beneficial to include other individuals who can help with information sharing and decision-making. At those times, the team should include the victim's therapist, child protection worker, or other individuals associated with the offender.

The team is coordinated by the Supervision Officer who determines:

- The members of the team beyond the required membership
- The frequency of team meetings
- The content of the meetings, with input from other team members

The team should demonstrate the following:

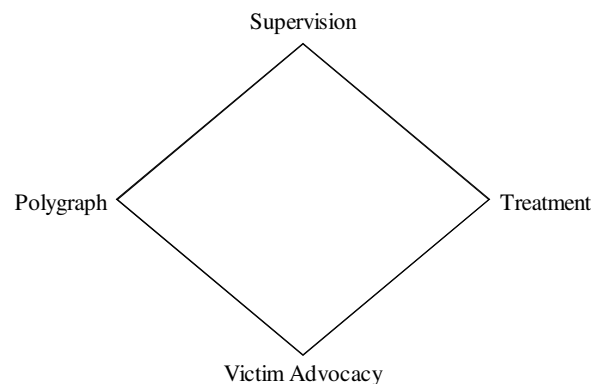
- Meetings should take place in person whenever possible, but telephonic meetings and electronic meetings can also be held;
- An ongoing flow of information among all members of the team (pursuant to signed waivers of confidentiality obtained from the offender);
- Team members will settle among themselves conflicts and differences of opinion that might make them less effective in presenting a unified response. The final authority rests with the supervising officer;

- Team members are committed to the team approach and seek assistance with conflicts or alignment issues that occur;
- Communicate frequently enough to manage and treat sexual offenders effectively, with community safety as the highest priority.

The Containment Model

The Containment Model is a method of case processing and case management that focuses on holding offenders accountable for past and present behaviors, while providing the offender an opportunity to develop the tools necessary to avoid re-offense. This system requires that “the justice system (court) must identify and implement limitations or barriers to foreseeable high-risk behavior in order to provide the highest level of public safety and offender accountability. This is accomplished with the use, monitoring and enforcement of specialized conditions of supervision.” (Bullens, ed. 2002) Coupled with this element of external control, these offenders must also be required to participate in specialized treatment focused on the identification of high-risk situations and behaviors and the development of an appropriate relapse prevention plan. The offender’s activities and compliance are then monitored routinely with the use of polygraph examinations to verify the offender’s compliance to both supervision and treatment goals, in addition to reducing the offender’s denial mechanisms. This model requires that professionals working with sex offenders collaborate at all stages of the case management system to ensure that decisions are appropriate, informed and victim focused, “what is best for the victim”. The focus on accountability also extends beyond the offender, to those professionals responsible for supervision, treatment, polygraph and others monitoring—“containment” tools. Thus, the containment model focuses on “containing” offenders in a tight supervision and treatment network with active monitoring and enforcement of rules and expectations.

CONTAINMENT MODEL



Responsibilities of the Supervising Officer for the Team

- STANDARD 2:** The supervising officer shall refer sex offenders for evaluation and treatment only to treatment providers who meet these Standards and to Polygraph examiners who have a contract with the County.
- STANDARD 3:** The supervising officer should ensure that sex offenders sign releases for at least the following types of information:
- Releases of information for all members of the management team
 - Releases of information for all relevant collateral information sources
- STANDARD 4:** The supervision officer, in cooperation with the treatment provider and polygraph examiner, should utilize the results of periodic polygraph examinations for treatment and behavioral monitoring. Team members should provide input and information to the polygraph examiner regarding examination questions.
- STANDARD 5:** The supervision officer should require sex offenders to provide a copy of the written plan developed in treatment for preventing a relapse, signed by the offender and the therapist, as soon as it is available. The supervising officer should utilize the relapse prevention plan in monitoring offenders' behavior.
- STANDARD 6:** The supervising officer should require sex offenders to obtain the officer's written permission to change treatment programs.
- STANDARD 7:** The supervising officer should ensure maximum behavioral monitoring and supervision for offenders in denial. The officer should use supervision tools that place limitations on offenders' use of free time and mobility and emphasize community safety and containment of offenders.
- STANDARD 8:** The supervising officer should require treatment providers to keep ongoing written case notes on sex offenders' status and progress in treatment and written progress reports each 90 days.
- STANDARD 9:** The supervising officer should discuss with the treatment provider, the victim's therapist, custodial parent or foster parents, and guardian ad litem specific plans for any and all

contacts of an offender with a child victim and plans for family reunification.

- STANDARD 10:** Recognizing that sex offenders present a high risk to community safety, probation and parole officers should base their fieldwork on the supervision plan, relapse prevention plan, and offense cycle of an offender.
- STANDARD 11:** The supervising officer should not request early termination of sex offenders from supervision.
- STANDARD 12:** On a regular basis, the supervising officer should review each offender's specific conditions of probation or parole and assess the offender's compliance, needs, risk, and progress to determine the necessary level of supervision and the need for additional conditions.
- STANDARD 13:** If contact with children is allowed, the supervising officer should limit and control the offenders' authority to make decisions for minors or to discipline them.
- STANDARD 14:** If necessary and possible, the supervising officer should request an extension of supervision to allow an offender to complete treatment.
- STANDARD 15:** The supervising officer should notify sex offenders that they must register with local law enforcement in compliance with PC 290.
- STANDARD 16:** The supervising officer should discuss treatment issues and progress with offenders during office visits and other contacts.
- STANDARD 17:** The supervising officer should impose or request criminal justice sanctions for offenders' unsatisfactory termination from sex offender treatment, such as revocation of probation or parole.
- STANDARD 18:** The supervising officer should require sex offenders who are transferred from other states through the Interstate Compact Agreement to agree in advance to participate in offense-specific treatment and specialized conditions of supervision contained in these Standards.
- STANDARD 19:** The supervising officer should not allow a sex offender who has been unsuccessfully discharged from a treatment

program to enter another program unless the new treatment program and case management arrangement will provide *greater* behavioral monitoring and *increased* treatment in the areas the sex offender “failed” in the previous program.

STANDARD 20: Supervising officers assessing or supervising sex offenders should successfully complete training programs specific to sex offenders and on an annual basis should obtain continuing education specific to sex offenders. Training should include the following:

- Prevalence of sexual assault
- Offender characteristics
- Assessment/evaluation of sex offenders and risks and needs
- Current research
- Community management of sex offenders
- Interviewing skills
- Victim issues
- Sex offender treatment
- Relapse prevention
- Physiological procedures
- Offender denial
- Special populations of sex offenders
- The use of polygraph examinations
- Computer use by sex offenders

Responsibilities of the Treatment Provider within the Team

A treatment provider shall establish a cooperative professional relationship with the supervising officer of each offender and with other relevant supervising agencies. This includes but may not be limited to the following:

STANDARD 21: A treatment provider **shall immediately** report to the supervising officer all violations of the provider/client contract, including those related to specific conditions of probation or parole;

STANDARD 22: A provider **shall immediately** report to the supervising officer evidence or likelihood of an offender’s increased risk of re-offending so that behavioral monitoring activities may be increased;

STANDARD 23: A provider shall report to the supervising officer any reduction in frequency or duration of contacts or any alteration in treatment modality that constitutes a change in

an offender's treatment plan. Any permanent reduction in duration or frequency of contacts or permanent alteration in treatment modality shall be determined on an individual case basis by the provider and the supervising officer;

STANDARD 24: On a timely basis, and no less than quarterly, a provider shall provide to the supervising officer written progress reports documenting offenders' attendance, participation in treatment, increase in risk factors, changes in the treatment plan, and treatment progress. Immediate notification is required if there is an increased risk or a violation (see STANDARD 22);

STANDARD 25: If the supervision officer files a revocation of probation or parole, a provider shall furnish, when requested by the supervising officer, written information regarding the offender's treatment progress. The information shall include: changes in the treatment plan, dates of attendance, treatment activities, the offender's relative progress and compliance in treatment, any other material relevant to the court at the hearing. The treatment provider shall be willing to testify in court if necessary.

STANDARD 26: A provider shall discuss with the supervising officer, the victim's therapist, custodial parent, foster parent and/or guardian ad litem specific plans for any and all contacts of the offender with the child victim and plans for family reunification.

STANDARD 27: A provider shall make recommendations to the supervising officer about visitation supervisors for an offender's contact with children, if such contact is allowed.

Responsibilities of the Polygraph Examiner within the Team

The polygraph examiner shall participate as a member of the post-conviction case management team established for each sex offender.

STANDARD 28: The polygraph examiner shall submit written reports to each member of the community supervision team for each polygraph exam. Reports shall be submitted in a timely manner.

Attendance at team meetings shall be on an as-needed basis. At the discretion of the supervising officer, the polygraph examiner may be invited to attend meetings preceding and/or following an offender's polygraph examination to

discuss offender's test results and the examiner's professional opinion, and to assist in strategies for intervention. The examiner should also be willing to provide various team members information about the role of polygraph testing in Containment and assist in ways this tool can be used more effectively. The examiner is an important member of the team.

The Role of the Victim Advocate in the Team

The behavior of sex offenders may be extremely damaging to victims and crimes can have long-term impact on victims' lives.

Victims' involvement in the criminal justice process can be either empowering or re-victimizing. These Standards are based on the premise that victims should have the option to decide their level of involvement in the process, especially after the offender has been convicted and sentenced.

STANDARD 29: Victims have a right to be informed of the following:

- The offender's status in the criminal justice system
- The offender's compliance with treatment and any changes in the offender's treatment status which may pose a risk to the victim

In certain situations, the interagency team may communicate with victims, victim's therapists, or victim advocates in order to provide relevant information to victims and to solicit information from victims who may be relevant to the treatment or supervision of the offender. Professionals in the criminal justice, evaluation, and treatment systems should therefore contact victims through appropriate channels to solicit their input, since victims may possess valuable information that is not available elsewhere. In particular, a victim's information about an offender's offense patterns can assist evaluators, treatment providers and supervisors to develop treatment plans and supervision conditions that may prevent or detect future offenses.

STANDARD 30: During the pre-sentence investigation, victims should be contacted to determine whether he or she is willing to provide information, in the form of a victim's statement, as part of the pre-sentence report.

Confidentiality

STANDARD 31: A treatment provider shall obtain signed waivers of confidentiality (signed releases of information) based on the informed consent of the offender. If an offender has more than one therapist or treatment provider, the waiver of confidentiality shall extend to all therapists and mental health professionals who are treating the offender. The waiver of

confidentiality shall extend to the supervising officer and to all members of the team (see STANDARD 1) and, to any and all individuals and/agencies responsible for the supervision of the offender.

- When indicated and consistent with the informed consent of the offender, the treatment provider shall obtain a waiver of confidentiality (signed releases of information) in order to communicate with the victim's therapist, guardian ad litem, custodial parent, guardian, pastor, caseworker and/or any and all professionals involved in making decisions regarding reunification of the family or an offender's contact with past or potential child victim (s).
- The treatment provider shall obtain specific releases that waive confidentiality for communications with other parties in addition to those described in this STANDARD.

Discussion: Waivers of confidentiality (signed releases of information) will be required of the sex offender by the (1) conditions of probation, parole, and/or community corrections, (2) the treatment provider-client contract.

STANDARD 32: Notwithstanding such waivers of confidentiality (signed releases of information), treatment providers shall safeguard the confidentiality of client information from those for whom waivers of confidentiality have not been obtained.

STANDARD 33: Waivers of confidentiality (signed releases of information) shall also extend to the victim, or custodial parent or guardian ad litem, of a child victim, particularly with regard to (1) the offender's compliance with treatment and (2) information about risk, threats and/or possible escalation of violence.

STANDARD 34: The treatment provider shall notify all clients of the limits of confidentiality imposed on therapists by the mandatory reporting law.

- The treatment provider shall ensure that an offender understands the scope and limits of confidentiality in the context of his/her particular situation, including the collection of collateral information, which may or may not be treated as confidential. This will be done by a signed document that states that the offender has understanding of the scope and limits of confidentiality.

Clinical Staffings

A Clinical Staffing is a strategy used by the supervision and treatment team to evaluate an offender's progress and set individualized goals for an offender. This is a formal meeting among the treatment provider, probation officer, sex offender and the sex offender's significant other—or other support person identified by the offender. Other professionals, such as the polygraph examiner, the victim's treatment provider, or family treatment provider may also be included in this meeting. A written report outlining the date, persons present, discussion and agreed upon action plan is created to document this meeting.

STANDARD 35: Treatment Providers shall make themselves available for a Clinical Staffing at the request of any treatment team partner—including the offender. A Clinical Staffing shall be implemented with all high risk offenders and those seeking reunification, when the team determines it is necessary. Typically, the offender is charged a rate comparable to an individual or couples fee by the treatment provider.

A general outline of the Clinical Staffing procedure is as follows:

- All parties introduce themselves
- Treatment provider/Director clarifies the purpose of the staffing
- Offender is asked to report the details of the offense leading to probation (discrepancies are addressed, as are new information identified by the significant other)
- Review of assessments, Abel Screen, Polygraph tests, etc.
- Review of general compliance/attitudes/system support networks
- Goals and Next Steps (identified as a group) with Deadlines identified
- Identification of Consequences if next steps are completed, or not completed in the specified manner (this is both rewards and sanctions)
- Written report prepared and signed by all parties
- Copies of the formal report are distributed (Treatment Provider retains master copy)

Special considerations in scheduling Clinical Staffings include:

- Require offender to pre-pay for the staffing—this will allow all parties to focus exclusively on the goals of the staffing
- Offender must identify a significant other—if married or dating, this must be the spouse or girlfriend, otherwise treatment provider will assist offender in identifying someone appropriate to attend.

The formal report of the Clinical Staffing is an official progress report in the file. All parties of the team should support the expressed case management plan identified in the formal report for the offender.

SECTION 3: QUALIFICATIONS FOR TREATMENT PROVIDERS

Levels of Providers

Licensed Group Treatment Provider—Full Operating Level

STANDARD 36: A treatment provider at the full operating level may treat sex offenders without supervision and may supervise a treatment provider at the associate level. To qualify to provide sex offender treatment at the full operating level, an individual must meet all the following criteria:

- 1) The individual shall have attained the underlying credential of licensure and be in good standing as a physician, psychologist, clinical social worker, or marriage and family therapist;
- 2) The individual shall have completed, within the last five years, a minimum of 3000 hours of clinical experience, specifically in the area of treatment of sex offenders, at least half of which shall have been face-to-face therapy with adult or juvenile convicted sex offenders. Such clinical experience may have been obtained while seeking licensure or after obtaining licensure; however, if it was obtained in part or in full after licensure, it is subject to the same requirements for supervision as required for treatment providers under these Standards;
- 3) The individual shall have had at least 40 hours of documented training specifically related to the evaluation and treatment methods described in these Standards, and including training in the area of victimology, within the last five years. The individual must demonstrate a balanced training history, having covered a wide or varied range of training topics. The training must directly relate to sex offender assessment/treatment/management and may include, but is not limited to:
 - Statistics of offense/victimization rates
 - Typologies
 - Sex offender assessment
 - Sex offender evaluation
 - Sex offender treatment techniques, including:
 - Evaluating and reducing denial
 - Behavioral treatment techniques
 - Cognitive behavioral techniques
 - Relapse prevention
 - Empathy training
 - Offender/offense characteristics
 - Sex offender risk
 - Physiological techniques, including:

- Polygraph
- Plethysmograph
- Abel Screen
- Victim issues
- Family reunification/visitations
- Legal issues regarding sex offenders
- Special sex offender populations, including:
 - Sadists
 - Developmentally disabled
 - Compulsive
 - Juvenile
 - Female
- Pharmacotherapy with sex offenders
- Impact of sex offenders
- Assessing treatment progress
- Secondary and vicarious trauma
- Anger management
- Sex education
- Supervision techniques with sex offenders
- Philosophy & Principles of the Sex Offender Management Council
- Group therapy dynamics

4) In concert with the generally accepted Standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abuse (ATSA), demonstrate competency according to the individual's respective professional Standards, and shall conduct all treatment in a manner that is consistent with the reasonably accepted STANDARD of practice in the sex offender treatment community.

Licensed Group Treatment Provider—Associate Level

STANDARD 37: A treatment provider at the Associate Level may treat sex offenders under the supervision of a treatment provider approved at the Full Operating Level under these Standards. To qualify to provide sex offender treatment that the Associate Level, an individual must meet all of the following criteria:

- 1) The individual shall have a Master's degree or above in a behavioral science and either (a) be a licensed provider who does not yet have sufficient experience and training to meet the level of a Full Operating Level Provider, or (b) meet the requirements of Registered Intern

(Licensed Clinical Social Worker, Marriage and Family Therapist or Psychology Intern).

- 2) The individual shall have completed within the past five (5) years a minimum of 500 hours of supervised clinical experience specifically in the area of treatment of sex offenders. At least half (250) of these hours must be in face-to-face therapy work with convicted adult or juvenile sex offenders. In addition, at least 160 of these face-to-face hours must have been in co-therapy, in the same room, with a treatment provider registered at the Full Operating Level.
- 3) Prior to commencing their clinical work, associates must complete 21 hours of balanced training as identified previously. The balance of the 19 hours must be completed within two years.
- 4) Associates must complete 72 hours of co-therapy with a full operating provider over a minimum of 6 months to be able to run sex offender groups on their own.
- 5) The individual must have received at least 50 hours of face-to-face clinical supervision by a treatment provider at the full operating level. The supervision must be reasonably distributed over the time in which the above clinical experience was being obtained (approximately 1 hour of supervision for each 10 hours of group supervision per week).
- 6) In concert with the generally accepted Standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abuse (ATSA), demonstrate competency according to the individual's respective professional Standards, and shall conduct all treatment in a manner that is consistent with the reasonably accepted STANDARD of practice in the sex offender treatment community.

Licensed Individual Treatment Provider—Full Operating Level

STANDARD 38: A treatment provider at the Individual Level may be able to treat sex offenders and must meet all of the following criteria:

- 1) The individual shall have attained the underlying credential of licensure and be in good standing as a physician, psychologist, clinical social worker, or marriage and family therapist.
- 2) The individual shall have completed within the past five (5) years a minimum of 200 hours of clinical experience specifically in the area of evaluation and treatment of sex offenders. At least half (100) of these

hours must be in face-to-face therapy with convicted adult or juvenile sex offenders or perform three months of co-therapy and receiving supervision with a fully operational treatment provider.

- 3) The individual must have had at least 40 hours of balanced documented training specifically related to evaluation and treatment methods of sex offenders.
- 4) In concert with the generally accepted Standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abuse (ATSA), demonstrate competency according to the individual's respective professional Standards, and shall conduct all treatment in a manner that is consistent with the reasonably accepted STANDARD of practice in the sex offender treatment community.

Licensed Individual Treatment Provider—Associate Level

STANDARD 39: A treatment provider at the individual associate level may treat sex offenders under the supervision of a treatment provider approved at the Individual Full Operating Level under these Standards. To qualify to provide sex offender treatment at the associate level, an individual must meet all of the following criteria:

- 1) The individual shall have a Master's degree or above in a behavioral science and either (a) be a licensed provider who does not yet have sufficient experience and training to meet the level of a Full Operating Level Provider, or (b) meet the requirements of Registered Intern (Licensed Clinical Social Worker, Marriage and Family Therapist or Psychology Intern).
- 2) The individual shall have completed within the past five (5) years a minimum of 100 hours of face-to-face or group therapy hours or 350 total hours with 100 hours of the 350 hours obtained post Master's degree.
- 3) Prior to commencing their clinical work, associates must complete 21 hours of balanced training as identified previously. The balance of the 19 hours must be completed within two years.
- 4) Associate interns must be supervised on a weekly basis with supervision to include videotape review of associate face-to-face client contact;
- 5) In concert with the generally accepted Standards of practice of the individual's mental health profession, the individual shall adhere to the

Code of Ethics published by the Association for the Treatment of Sexual Abuse (ATSA), demonstrate competency according to the individual's respective professional Standards, and shall conduct all treatment in a manner that is consistent with the reasonably accepted STANDARD of practice in the sex offender treatment community.

Continued Placement on the Provider List

Continued Placement as a Licensed Group Treatment Provider on the Provider List

STANDARD 40: Treatment providers must apply for continued placement of the List every 3 years by the date provided by the Sex Offender Management Council, or the designated certification agency. Requirements are as follows:

- 1) The treatment provider must demonstrate continued compliance with the Standards and Guidelines.
- 2) The individual shall accumulate a minimum of 600 hours of clinical experience every three years, 300 hours of which shall be face-to-face therapy with adult or juvenile convicted sex offenders.
- 3) Treatment providers shall complete a minimum of 40 hours of continuing education every three years in order to maintain a proficiency in the field of sex offender treatment and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Up to 10 hours of this training may be indirectly related to sex offender assessment/treatment/management.
- 4) Provide satisfactory references as requested by the certification agency. The certification agency may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the case management team.
- 5) Submit to a current background check.
- 6) Report any of your own practices that may be in significant conflict with the Standards and request a time limited waiver of the Standards with reasons to justify the waiver.
- 7) Comply with all of the requirements outlined in these STANDARDS.

Continued Placement as a Licensed Individual Treatment Provider on the Provider List

STANDARD 41: A treatment provider at the Individual level must apply for continued placement on the List every 3 years by the date provided by the Council, or the designated certification agency. Requirements are as follows:

- 1) The individual must demonstrate continued compliance with the Standards and Guidelines.
- 2) The individual shall accumulate a minimum of 300 hours of clinical experience every three years, 150 hours of which shall be face-to-face therapy with adult or juvenile convicted sex offenders.
- 3) Treatment providers shall complete a minimum of 40 hours of continuing education within the past five years of application and every three years in order to maintain a proficiency in the field of sex offender treatment and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Up to 10 hours of this training may be indirectly related to sex offender assessment/treatment/management.
- 4) Provide satisfactory references as requested by the certification agency. The certification agency may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the case management team.
- 5) Submit to a current background check.
- 6) Report any of your own practices that may be in significant conflict with the Standards and request a time limited waiver of the Standards with reasons to justify the waiver.
- 7) Comply with all of the requirements outlined in these STANDARDS.

SECTION 4: STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS

Sex Offense Specific Treatment

STANDARD 42: Sex Offense-specific Treatment must be provided by a treatment provider registered at the full operating level or the associate level under these Standards.

Intake Risk Assessment

STANDARD 43: At the onset of treatment, all sex offenders shall undergo an intake and risk assessment. This shall include:

- Admission of Offenses
- Accountability
- Cooperation
- Offense History and Victim Choice
- Sexual deviancy and arousal patterns
- Social intent
- Lifestyle characteristics
- Psychopathy
- Developmental markers
- Substance abuse and other addictive patterns
- Criminal history
- Prior treatment history
- Social support system
- Overall control and intervention
- Motivation for treatment and recovery
- Self-structure
- Disowning beliefs

STANDARD 44: At the onset of treatment, the provider shall receive a copy of the following documents, if available, from the supervising agency:

- Psychological evaluations (note: in most cases this evaluation must be obtained directly from the prior evaluator)
- Police and/or probation reports
- Sex history tests
- Victim evaluation reports
- Child Protective Services
- Department of Social Services reports
- Condition of probation orders

- Polygraph results

STANDARD 45: A provider who treats sex offenders under the jurisdiction of the criminal justice system must use sex offense-specific treatment.

Treatment Plans

STANDARD 46: A provider shall develop a written treatment plan based on the needs and risk assessment functions identified on Risk Assessment and on current and past assessments/evaluations of the offender.

The treatment plan shall:

- Be individualized to meet the unique needs of the offender.
- Identify the issues to be addressed, including multi-generational issues in indicated, the planned intervention strategies, and the goals of treatment.
- Address the issue of ongoing victim input.
- Address the issues of victims and families.
- If necessary, be supplemented by treatment for drug/alcohol abuse, marital therapy and individual crisis intervention.

Treatment Group Design and Size

A provider shall employ treatment methods that are supported by current professional research and practice:

STANDARD 47: Group therapy (with the group comprised only of sex offenders) is the preferred method of sex offense-specific treatment, unless when otherwise determined by the treatment provider. At a minimum, any method of psychological treatment used must conform to the Standards for content of treatment and must contribute to behavioral monitoring of sex offenders.

STANDARD 48: The use of co-therapists in a group may be recommended by the treating agency.

STANDARD 49: The treatment group size shall not exceed 12 sex offenders.

STANDARD 50: The provider shall employ treatment methods that give priority to the safety of an offender's victim(s) and the safety of potential victims and the community.

STANDARD 51: The provider shall employ treatment methods that are based on recognition of a need for long-term, comprehensive, offense-specific treatment for sex offenders. Self-help or time-limited treatments shall be used only as adjuncts to long-term, comprehensive treatment.

Treatment Curriculum

STANDARD 52: The content of offense-specific treatment for sex offenders shall be designed to:

- Reduce offenders' deviant sexual urges and recurrent deviant fantasies.
- Educate offenders (and individuals who are identified as the offenders' support systems) about the potential for re-offending and an offender's specific risk factors.
- Teach offenders self-management methods to avoid a sexual re-offense.
- Identify and treat the offenders' thoughts, emotions and behaviors that facilitate sexual re-offenses or other victimizing or assaultive behaviors.
- Identify and correct offenders' cognitive distortions.
- Educate offenders about non-abusive, adaptive, legal, and pro-social sexual functioning.
- Educate offenders about the impact of sexual offending upon victims, their families, and the community.
- Provide offenders with an environment that encourages the development of empathic skills needed to achieve sensitivity and empathy for their own victim(s).
- Provide offenders with guidance to prepare, when applicable, written explanation or clarification for the victim(s) that meets the goals of: establishing full perpetrator responsibility, empowering their victim(s), and promoting emotional restitution for their victim(s).
- Identify and treat offenders' personality traits and deficits that are related to their potential for re-offending.

- Identify and treat the effects of trauma and past victimizations of offenders as factors in their potential for re-offending. (It is essential that offenders be prevented from assuming a victim stance in order to diminish responsibility for their actions.
- Identify and decrease offenders' deficits in social and relationship skills, where applicable.
- Require offenders to develop a written relapse prevention plan for preventing a re-offense; the plan should identify antecedent thoughts, feelings, circumstances, and behaviors associated with sexual offenses.
- Provide referrals and collaborate with adjunct treatment providers in the community on an ongoing basis throughout treatment for offenders with co-existing medical, pharmacological, mental, substance abuse and/or domestic violence issues, or other disabilities.
- Maintain communication with significant persons in offenders' support systems when indicated, and to the extent possible, assist in meeting treatment goals.
- Evaluate cultural, language, developmental disabilities, sexual orientation and/or gender factors that may require special treatment arrangements.
- Identify and address issues of gender role socialization.
- Identify and treat issues of anger, power and control.

Discussion: The provision of educational and support service to the families of sex offenders enhances the possibility of meeting treatment, supervision and community safety goals.

Sex Offender Treatment Provider Collaboration

Treatment providers shall not exist in isolation.

STANDARD 53: Treatment providers should seek opportunities to network with other providers about current and evolving interventions and research.

STANDARD 54: It is the responsibility of the program to obtain the information and implementation changes as necessary they shall maintain cooperative working relationships with other providers and the criminal justice programs. Treatment providers must keep available a list of treatments that the provider as well as referrals to other programs.

Interprogram Transition and Communication

STANDARD 55: When clients move from one treatment program to another, a cooperative effort shall be made on the part of each provider to assist in effecting the client's transfer. In creating procedures to guide client transfers, the primary goal will be to encourage the clients' personal responsibility to their victims and to the court that has ordered them into counseling. Additional goals are to discourage manipulation of the criminal justice system by clients, and to prevent the loss of therapeutic/educational benefits that may be caused by "program hopping".

The following procedures shall be used to assure uniform treatment of transferring clients:

- At the time of the initial interview, all clients shall be asked if they have attended another program previously. *If a client admits to having attended a different program at either the intake or at any time during their program, the client shall be required to sign a release authorizing contact between the two programs.*
- Depending on individual program policies, intake providers may complete the enrollment process, but keep the client from attending sessions or not issue credit for sessions attended, until pertinent information has been exchanged between programs (e.g., reason(s) for termination, unpaid balance, non-compliance with previous program, etc.). The client shall be informed that contact with, and arrangements for payment of any outstanding balance to, the previous provider will be required before he/she may enroll in the current program.

STANDARD 56: A program's request for information from another program shall be made using the INTERPROGRAM COMMUNICATION FORM.

STANDARD 57: Attendance information will be documented and made available to the receiving program utilizing the INTERPROGRAM COMMUNICATION FORM.

STANDARD 58: The provider receiving the INTERPROGRAM COMMUNICATION FORM will complete it and respond to the requesting provider within three (3) business days.

Crisis Response Plans

STANDARD 59: Within the client contract, treatment providers must provide a crisis response plan for clients who are unable to cope or are

a danger to self or others. Treatment providers shall also be knowledgeable about community resources and will make this information available to clients as needed. If a crisis response plan is implemented, there must be coordination with the probation department as soon as possible.

Treatment Admission and Reporting

STANDARD 60: Treatment providers must provide admission to therapy within 21 days of contact by a client.

- If this condition cannot be met, the treatment provider will be required to notify the original referral source as to the reason for the delay or refer the client to another treatment provider. If a client is deemed inappropriate or unsuitable for the program, the treatment provider must notify the referral source within three (3) business days.

STANDARD 61: Treatment providers must report to the referral agent a minimum of one time every 90 days or at times stipulated by the Court regarding clients' progress using the appropriate reporting form. (See Appendix).

Treatment Violations and Termination

STANDARD 62: Treatment providers shall document in writing all violations of the client contract. This documentation shall be provided to the proper referring agency within three (3) business days utilizing the SEXUAL OFFENDER TREATMENT PROGRAM REPORT form. (See Appendix). Following termination, a new court order or written referral from the Probation Department, or other referring source, will be required prior to re-admission into the treatment program.

Indigent or "Reduced Fee" Clients

STANDARD 63: All treatment providers shall accept indigent clients. All clients should pay some fee for therapeutic reasons. Referrals of indigent clients shall be made to all certified treatment programs. (An indigent client or a "Special Fee" client shall be defined as a perpetrator applying for program treatments who does not have a current ability to pay the full program fee.) The agency will determine the perpetrator's ability to pay by obtaining a financial statement and applying

indigency or "Special Fee" guidelines. Refer to Appendix for criteria for "Special Fee" consideration.

- STANDARD 64:** All treatment providers shall accept a minimum of one "Indigent fee" client per group or 10% of total number of group participants.
- STANDARD 65:** Special fee or reduced fees will be granted in ninety (90) day increments. Clients may re-apply and be extended for continued "Special Fee" consideration if they continue to establish proof of need. It shall be the client's responsibility to contact the appropriate person at each program to make the necessary arrangements.
- STANDARD 66:** Fees for eligible indigent clients will be reduced to \$5.00 per session. Eligible clients will be allowed to enroll in the program for one-half (½) of the program's normal enrollment fee, providing there are "Indigent Fee" slots available.
- STANDARD 67:** An updated log of clients on indigent status will be maintained and made available to the certification representative upon request.

Treatment Client Files

- STANDARD 68:** Providers shall maintain clients' files in accordance with the professional Standards of their individual disciplines and with California state law on health care records. Client files shall:
- Document the goals of treatment, the methods used, the client's observed progress, or lack thereof, toward reaching the goals in the treatment records. Specific achievements, failed assignments, rule violations and consequences given should be recorded.
 - Accurately reflect the client's treatment progress, sessions attended, and changes in treatment;
 - Have ongoing assignment of risk.
- STANDARD 69:** Treatment providers shall maintain a contact log in each client's individual case file documenting a record of all phone calls, communications, violations, collateral contacts with other relevant involved professionals, including the Court,

Probation, Attorneys, CSB, other involved therapists. (Refer to Appendix for Standardized form)

STANDARD 70: Treatment providers must label case notes and contact logs in such a way that the certification representative can monitor the charts with ease. A Chart Order Checklist must be provided to the certification representative upon applying for re-certification of their program.

STANDARD 71: Treatment providers shall read and sign, under penalty of perjury, an acknowledgement stating that they will abide by these STANDARDS.

Contact with a Victim’s Treatment Provider

STANDARD 72: If a victim of a perpetrator is also attending counseling, treatment providers, with the victim's written authorization, shall consider any information provided by the victim's therapist as it relates to the perpetrator. *Obtaining this information is highly recommended within the ethical guidelines of confidentiality.*

Victim Safety

STANDARD 73: Treatment providers shall make a reasonable effort to ensure that victims' safety is never compromised. If the victim contacts the provider at any time during the sex offender treatment program, that information is not confidential and the victim must be informed of these limits of confidentiality at the onset of the conversation.

Family Reunification

STANDARD 74: The family reunification process should follow the procedures and protocols outlined in the CCOSO “Position Paper for Family Resolution”—Draft 7/1/02. (See Appendix)

SECTION 5: TREATMENT APPROACHES

Group Treatment

STANDARD 75: San Diego Standards are requiring group treatment as the treatment modality for sex offenders. San Diego Standards acknowledge possible exceptions noted below:

- Treatment providers, through their respective agencies, may decide whether groups will be open or closed in structure. The groups may range from a minimum of 3 to a maximum of 12 clients in attendance in any particular treatment group. Any exceptions to the group size require submittal of written request for a waiver to the Treatment Evaluation and Monitoring Committee.

Special Population

Certain clients may be inappropriate for group treatment due to the disruptive behaviors of inability to benefit from such a modality.

STANDARD 76: After initial assessment, or at any time during the treatment intervention, it becomes apparent that the client is inappropriate for group, if it is determined that an alternative treatment is therefore appropriate, the Treatment Provider shall notify the Court/Referring Agency of the alternative treatment modality. Examples may include, but are not limited to:

- A person who is actively psychotic in behavior
- A person who is neuro-psychologically impaired
- A person who has a personality disorder characterized by disruptive behavior, anger, impulsivity or hostility
- A person who is developmentally delayed
- A person who is psychopathic

STANDARD 77: Sex offenders who have been evaluated and/or have been determined to be psychopathic should be treated individually; should never be in a program which includes empathy training; or should not be treated at all. At the point that this is determined, they should be referred back to Probation.

Female Offenders

STANDARD 78: Due to their significant victimization issues, female sex offenders should be placed in a same gender group. In the absence of an available group, it is recommended that female sex offenders be treated in individual therapy.

Substance Abuse

A client's violent behavior cannot be successfully treated without also treating his/her substance abuse issues.

STANDARD 79: If the initial intake evaluation or at any time during the intervention, drug and/or alcohol abuse or dependence is indicated this should be addressed at the onset of the treatment or immediately after discovering the problem. The Court/referring agency will be notified of all recommended participation in substance abuse treatment, utilizing the Standardized Progress Report Form. Clients who fail to comply with the recommended substance abuse treatment will be reported back to the Court/referring agency utilizing the Standardized Substance Abuse Assessment/Recommendation Form.

STANDARD 80: Treatment programs will specifically evaluate for drug/alcohol abuse or dependence at intake, utilizing an established assessment instrument. Persons who administer and interpret this assessment instrument shall have adequate training to perform this task. Invasive drug/alcohol assessment procedures, such as urine testing, shall not be conducted without a court order. Results of this assessment will be recorded on the Substance Abuse Assessment Information-Results-Recommendations form (See Appendix).

STANDARD 81: Referrals to other agencies for specialized treatment intervention techniques must be initiated when the evaluation indicates drug or alcohol abuse or dependency. N.A. or A.A. attendance, or similar drug programs may be recommended to provide adequate treatment in such cases. Failure to voluntarily agree to and comply with these recommendations will be reported to the original referring agent with the recommendation that the adjunctive substance abuse treatment be included in the order.

STANDARD 82: The drug or alcohol provider and Sex Offender Treatment Provider must be willing to enter into a cooperative exchange of information.

STANDARD 83: Admission or re-admission into the Sex Offender treatment intervention program may be contingent on the following:

- Court order for adjunctive substance abuse treatment
- Consultation with adjunctive substance abuse treatment
- Compliance with treatment recommendations

STANDARD 84: When preparing each client's treatment plan, the Sex Offender Treatment Provider will take into consideration any substance abuse treatment plans provided by the Court's Substance Abuse Assessment Unit, when made available.

Pharmacological Agents

Evaluation for and use of pharmacological agents are useful and necessary for some sexual offenders. Anti-androgens, antidepressants and other pharmacological agents may, in fact, offer the client greater control over deviant fantasies and compulsive behavior. With this added control, a sex offender may be able to more effectively benefit from cognitive-behavioral methods of treatment. (ATSA standards, 1997)

STANDARD 85: If an offender is determined to present a high risk to re-offend, such agents should be considered.

STANDARD 86: Candidates may be those who exhibit predatory, violent sexual behaviors or those who have experienced multiple treatment failures and/or those who report compulsive fantasies with a proven inability to control their arousal.

STANDARD 87: Use of pharmacological agents, if not a component of a comprehensive sexual deviance treatment plan, is not recommended.

STANDARD 88: Pharmacological agents are not appropriate for use with all sex offenders. They pose considerable risk and should only be used with ongoing medical supervision.

Inappropriate Interventions

STANDARD 89: Any treatment approach or practice that blames or intimidates the victim or places the victim in a position of danger is not appropriate.

STANDARD 90: Any treatment technique that increase the risk to the victim, such as ventilation techniques that encourage or include aggression are not appropriate.

Treatment Protocol

STANDARD 91: The Sex Offender Treatment Provider, in conjunction with Probation, will be considered to be the lead therapist who will provide the treatment plan. All other treating professionals will concur with the treatment plan. If there is a discrepancy, the treatment plan that the Sex Offender Treatment Provider has written will take precedence.

STANDARD 92: Two therapists, working independently on sex offender issues is contraindicated.

Treatment Compliance

STANDARD 93: If the offender refuses to follow the Treatment Contract and/or recommendation of the Treatment Program, he may be dismissed from the Treatment Program and referred back to Probation.

- Offenders may be absent from their treatment program for a maximum of six times per year, if six absences are reached, the provider must staff the case and include the Probation Officer in the staffing.

SECTION 6: SEX OFFENDER POLYGRAPH STANDARDS

Examiner Qualifications

STANDARD 94: A minimum of 40 hours of post-conviction specialized instruction, beyond the basic polygraph examiner training course requirements, shall be a requisite of those who practice sexual offender testing.

Testing Environment

STANDARD 95: At a minimum, testing facilities will:

- Afford privacy and freedom from interruptions.
- Be free from visual distractions and noise problems.
- Have comfortable temperature and adequate ventilation.
- Have an area sufficient for testing.
- Support recording equipment (audio/video).

Test Specifications

STANDARD 96: The minimum pretest interview specifications are:

- Examinees must be advised of the purpose of the examination.
- Examinees must be advised that the examination is voluntary.
- Examinees must be advised that the examination can be terminated upon request.
- Examination must be conducted in a professional manner, and the examinee treated with respect and dignity.
- The pretest interview must be conducted in a non-accusatory manner.
- The examination must be conducted in compliance with governing local, state and federal regulations and laws, as well as APA STANDARD and principles of practice.
- Examiner must properly prepare for the pre-test interview. Preparation should include, at a minimum, a thorough review of the case facts and the information known about the examinee, and the goal of the examination.
- The examinee must agree upon the relevant test issues in advance of testing.
- Examiners must not display any type of bias, preconceptions, or pre-judgment of any examinee's innocence or guilt.
- Examiners must convey to examinees that test results will be based on the thorough analysis of the polygraph charts.
- Examiners must provide examinees with a sufficient explanation of the polygraph, included the physiological activity to be recorded.

- Examiners must provide examinees with a complete review of the testing procedures.
- Examiners must allow sufficient time for a thorough discussion of the test issues.
- Examiners must review all test questions with examinees prior to testing.
- Examiners must verify that examinees understand each question.
- Examiners must inform examinees of the need to cooperate during the examination.
- Examiners must satisfy the following administrative requirements:
 - Documenting that examinees were advised that the test is voluntary.
 - Verifying the identify of the examinee.
 - Obtaining information from the examinee about existing medical and physical conditions in order to assess fitness for testing.

STANDARD 97: The minimum in-test specifications are:

- Collection of test data must include, a permanent recording of the examinee’s respiratory, electrodermal, and cardiovascular activity.
- Physiological data will be continuously collected during each chart.
- Each single-issue examination shall employ a technique and format that has been validated through research.
- Reasonable deviations from formats validated by research are permitted, to the extent that an independent examiner/reviewer would concur that the research and field formats were not significantly dissimilar. Any deviations should be explained and justified by the examiner in writing where this test is subjected to an independent quality control.
- Test question pacing shall allow reasonable time for physiological recovery following response and/or distortion.
- Examiners shall conduct a sufficient number of charts, appropriate for testing technique.
- Examiners shall ensure that the physiological data collected are suitable for evaluation, and that each relevant question is asked on each of at least two separate charts.

STANDARD 98: The minimum post-test specifications are:

- The examinee should be advised of the test result.
- The examinee should be given an opportunity to provide an explanation for chart data resulting in inconclusive or deceptive test results.

STANDARD 99: If an examinee appears deceptive to one or more of the relevant issues, further testing, at a later date, may be required, depending on what new information is provided by the examinee explaining why he did not pass the question(s). If a follow-up examination is conducted to

resolve issues, that test will focus on a single issue or specific issue and will be in the format of a ZCT or validated question technique.

Quality Control

STANDARD 100: All polygraph examinations of sexual offenders submitted for quality control shall be recorded in their entirety. Video recording is the preferred medium, audio recording is sufficient to meet this STANDARD.

Polygraph File

STANDARD 101: All polygraph files will be maintained for a minimum period of one calendar year. Every file must include a minimum of the following information: name, date, location of examination, copy of consent forms, any completed pre-test questionnaires or examiner notes, copy of test questions, all case briefing materials, copy of charts, an examiner hand score sheet and the examiner's professional opinion.

STANDARD 102: All examination documentation shall list the amount of time that it took to conduct that examination. At a minimum, all post-conviction sexual offender examinations will be scheduled for a minimum of 90 minutes in duration.

Types of Polygraph Examination

There are five types of post-conviction polygraph testing. The following bulleted list explains the purposes for each type of referral and the accompanying information that must be provided by treatment providers to the polygraph examiner for the test to be administered:

- If the offender is minimizing or denying all or part of the offense for which s/he is now under court supervision, then request an **INSTANT OFFENSE-DISCLOSURE TEST**. This test is a specific issue test covering the details of the offense that resulted in the current probation. (NOTE: it is common for victims to under-report victimization; therefore, the offender may not be fully disclosing the details of the instant offense, even when s/he admits what is listed on the offense report). Offenders who deny all or part of their offense should be referred to this type of test prior to other types of polygraph referrals.
- If you want to verify the offender's compliance to conditions of probation and treatment rules, (such as, is the offender abstaining from alcohol and

drugs, has the offender had unsupervised contact with a child under 18 years old, contact with the victim, etc.) then you want a **MAINTENANCE EXAMINATION**. The relevant test questions focus on these probation violations, but not re-offense issues.

- If you want to verify an offender's self report of masturbatory behavior, sexual thoughts and/or arousal, or other specific *treatment issues*, then you want a **MAINTENANCE-SPECIFIC ISSUE EXAMINATION**.
- If you want to determine if an offender has sexually re-offended while under supervision (probation/parole), then request a **MONITORING EXAMINATION**. This specific examination covers sexual law violations only, not technical violations. However, compliance to conditions of probation is reviewed during the pre-test, much like during a Maintenance examination.
- *At the present time, the Probation Department will **not** be making referrals for **SEXUAL HISTORY-DISCLOSURE TESTS**. This type of test assists in both risk assessment and the identification of additional victims and paraphilias. It is used primarily for treatment purposes to verify the offender's report of sexual behaviors and activities PRIOR to the offense for which s/he is now under supervision. Treatment providers may refer for this type of polygraph as part of an assessment tool to verify the range and extent of the offender's deviant behaviors. Offenders who are in Court-ordered treatment programs may be asked to submit to this type (Sexual History—Disclosure test) of polygraph on a voluntary basis. Refusal to participate in a sex history polygraph does not constitute a violation of court ordered treatment. (See Appendix for Information that should be provided to offender's upon referral for this type of polygraph examination).*

Certain documents must be provided to the examiner in order for an examination to be conducted:

- **INSTANT OFFENSE-DISCLOSURE TEST:** A copy of the offense report and victim's statement (if available) are needed for this test.
- **MAINTENANCE EXAMINATION:** A copy of the conditions of court supervision (probation/parole), including any modifications, is needed for this test. If the request is for a specific issue treatment test covering sexually deviant thoughts/fantasies, it is recommended that the offender complete and submit an arousal log. When making this referral notify the examiner of specific issues to be addressed.
- **MONITORING EXAMINATION:** A copy of the conditions of court supervision and copy of the offense report are needed. This test focuses

on re-offending behaviors that have occurred during probation/parole.

SECTION 7: APPENDIX

INTERPROGRAM COMMUNICATION Form

SEXUAL OFFENDER TREATMENT PROGRAM REPORT form

Special Fee Form

Clinical Staffing Form

Progress Report

Substance Abuse Assessment/Recommendation Form

CCOSO "Position Paper for Family Resolution"

Special Notice for Sex History Polygraph Examination Referrals