

**Standards of Sex Offender Management
ALASKA DEPT OF CORRECTIONS**

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1.000 INTRODUCTION

The Standards of Sex Offender Management were developed to insure a uniform and professional approach to the management of sex offenders under the jurisdiction of the Department of Corrections for the State of Alaska. The Standards have been established as part of DOC's effort to develop and improve assessment and management of sex offenders within the State of Alaska. They provide standards for sex offender programs irregardless of the setting in which they occur. The Standards apply to all Approved Providers, Contractors and agencies regardless of their profit or non-profit status. All such persons and/or agencies that provide services to sex offenders are expected to conform to the Standards as outlined in this manual or the most current revision of the Standards. Services which do not conform to the Standards will not be reimbursed under contract. Sex offenders who are involved in sex offender programs that are out of compliance with these Standards may not receive credit from DOC for their sex offender programming.

1.100 History of the Standards of sex offender management

In 1988 a sex offender planning committee was established by DOC. In March of 1989 the committee met and, at the suggestion of the Department, agreed to establish statewide Standards for the operation of the sex offender management programs (SOMP's). A consultant was hired in August of 1989 to assist in the development of an earlier version of this manual. The manual was revised in 1994. The present manual is the second revision. These Standards will undergo periodic revision as needed.

All Approved Providers, including Contractors are required to operate within the guidelines and context of the most current statement of Standards.

1.200 History of Sex Offender Programs in Alaska

Sex offender programs have been developed, over a number of years, by the Alaska Department of Corrections along a continuum of care in a number of regions throughout the State. The first program was established in 1979 at Lemon Creek Correctional Center (LCCC), Juneau, Alaska. The program was funded via a small Law Enforcement Administration Act (L.E.A.A.) grant of approximately \$18,000.00 and worked with 10 and later 15 sex offenders, at any given time. The program received L.E.A.A. moneys for two years and was then funded by the Department of Corrections for another one and a half years.

A second institutional program was developed in 1981 at Fairbanks Correctional Center (FCC) and housed 32 inmates in a milieu program setting. This program was closed in 1992. The make-up of the FCC population was largely unsentenced felons (60%) and misdemeanants (15%). Thus when the institution reached population caps there was a natural tendency to transfer program participants rather than short term prisoners or those who would need to be available for court. This created an atmosphere of instability for the program participants and the program itself. The Department followed the recommendations of a special task force and closed the program, transferring continuing participants to other institutional programs. Community based programs for sex offenders continued in the Fairbanks area.

A third institutional program was established in 1982 at Hiland Mountain Correctional Center (HMCC) in Eagle River just outside of Anchorage. This program housed approximately 100 sex offenders in a milieu setting. Seventy of these were involved in intensive treatment programming and 30 were involved in pre-treatment programming/screening and pre-release services. The program moved to Meadow Creek Correctional Center (MCCC) in 1998 due to the need to create a facility for female offenders at HMCC. The MCCC program housed 78 pretreatment and treatment beds. This program used specially trained correctional officers as wing counselors. The wing counselors worked as part of a team alongside professionally trained therapists and other professional staff to provide an intensive therapeutic environment. The program was closed in 2002 because of funding issues. The DOC began to focus on treatment delivery in the community.

The program at LCCC was re-established in 1985 and was revised in 1989 and again in 1992, 2003, and 2004. The earlier revisions to the program established it as a pre-treatment facility rather than a full treatment program. This was an attempt to establish a continuum of care rather than attempt to duplicate the program at MCCC. LCCC did not have the staff and resources to duplicate the milieu approach that was possible at MCCC. The LCCC program was revamped as an assessment facility after the MCCC program was closed in 2003. The focus was on assessing sex offenders prior to their release into the community so that probation/parole and community providers would have necessary information to manage these offenders. The program also provided preliminary education about sexual offending to program participants. This proved an inefficient method for conducting assessment because of travel costs incurred in moving offenders to the Juneau facility. The program was closed in 2004 and individual contractors were hired instead to conduct assessments at several facilities. This allowed for a greater number of sex offenders to receive comprehensive risk assessments prior to their release from prison. The program was re-opened as a milieu treatment program in 2010.

In 2002 DOC began consultations with experts from Colorado. This culminated in a pilot project that incorporated polygraph testing with treatment and supervision. The project was initiated in Anchorage in 2006. The program included 25 to 30 offenders who had been released into the community. These offenders had in depth risk assessments conducted prior to their release. Initial results revealed many more victims than previously known for these offenders. Results also revealed new information about the age range of victims, the gender of victims, and their relationship to the offender.

In 2008 DOC established a sex offender program in a Community Residential Center (CRC) in Bethel, Alaska to serve sex offenders from the Yukon-Kuskokwim Delta area. The program is a treatment milieu and can provide assessment and treatment services to offenders on furlough and probation/parole. Offenders from outlying villages may volunteer to reside at the CRC to complete sex offender treatment ordered by the court or the Parole Board. The program was developed with intensive involvement and input from a number of interested community persons and groups. Input from these parties was invaluable in creating a program that is culturally relevant and appropriate for offenders in the region. The program has openings for 19 sex offenders. A community-based sex offender program was also established in Bethel to serve offenders who are able to reside in Bethel. The community program may also serve as a transitional program for offenders released from the CRC sex offender program and preparing to return to their villages.

DOC has plans to re-establish institutional sex offender programming in other correctional institutions in Alaska.

Community based programs for sex offenders are provided in several areas. There are currently 63 openings available for community based treatment in Anchorage, 10 in Fairbanks, 15 in Juneau and 8 each in Kenai and Ketchikan, and 10 in Bethel. Efforts are currently underway to establish community programs in other areas as resources allow. The Department is committed to community management programs for sex offenders and continues to strive for the development of these programs.

In addition to sex offender management programs funded by the Alaska Department of Corrections there are other providers approved by DOC who offer sex offender programs for private pay. A current list of providers is available from the Criminal Justice Planner for Offender Programs.

A timeline of significant events in sex offender management and treatment is given in Appendix A.

1.300 Purpose of the Standards

The purpose of these Standards is to provide *minimum* requirements for provision of services by any approved provider to sex offenders who are in the custody of, or under supervision by, the Alaska Department of Corrections. The Standards apply to any approved provider regardless of whether they have a contract with DOC or are reimbursed for their services by the offender or other parties.

The Standards provide guidelines for assessment and treatment of sex offenders under the jurisdiction of the Department of Corrections. The services shall include, as resources allow, sex offender evaluation, treatment, transition planning, aftercare and other community based programming, and follow-up. Such programming shall be designed to assist sex offenders in becoming law-abiding and self sufficient, contributing members of the community.

These Standards serve a variety of functions. They have been established to:

- Provide minimum standards to insure professionalism among those individuals working with the SOMP and thereby increase professional performance and increase public safety
- Recognize and define sex offender programs in DOC
- Provide statewide consistency in SOMP programming
- Provide ease of transfer of offenders between programs
- Maintain efficiency in operation
- Decrease the potential for legal suits by providing a framework within which DOC and its Approved Providers can operate in a legally responsible fashion
- Clarify the role of DOC and its contractors and other Approved Providers in relation to operation of these programs
- Define the scope of work to be provided under SOMP contracts
- Clarify DOC's position on the treatment and supervision of sex offenders
- Allow for the uniform collection of data for purposes of research and determining overall program outcome

1.400 Terminology. There are a number of terms in this document that are used in the fields of corrections and mental health in general, and in the field of sexual offender programming in particular. A glossary of terms developed by the Center of Sex Offender Management (CSOM) is given in Appendix B. The reader is referred to that glossary for a definition of terms.

Note: It is acknowledged that both males and females commit sexual crimes and that both male and female sexual offenders enter the criminal justice system and DOC. However, in order to increase the readability of this document, and because the majority of offenders receiving sex offender treatment are male, the terms man, men, he, him, his, will be used to refer to all sex offender offenders regardless of gender.

2.000 OVERVIEW

DOC's Mission Statement: *working together to protect the public from sexual violence*

The Alaska Department of Corrections (DOC) provides a variety of services to sex offenders. The ultimate goal of the Department is the safety, well-being and protection of the citizens of Alaska. The development and operation of sex offender programming contributes to this commitment by offering services which increase community safety while preventing future crimes and potential victims of crime.

DOC is committed to providing a comprehensive system of sex offender assessment, treatment, and community management for convicted sexual offenders committed to DOC. In achieving this mission, DOC will strive to provide the highest quality of care available to those individuals under the supervision of corrections who request, or who are ordered, to participate in a DOC sex offender management program.

2.100 Philosophy of Management and Rehabilitation

DOC operates SOMP's based upon the premise that sex offenders can change their behavior but that this process is complex and difficult. Sex offender treatment is a specialty area within the field of forensic psychology. Sex offender treatment specialists teach sex offenders self-management skills that are directly related to their pattern(s) of sexual offending. Not all therapy or counseling can be considered sex offender treatment. For example, pastoral counseling, counseling for sexual addiction, and growth and development counseling are not sex offender treatment and these forms of counseling are not an appropriate substitute for the rehabilitation of sexual offenders. Sex offender programming strives to teach offenders internal management techniques so they have the tools to manage their own behavior. The underlying personality structure of the offender is robust and resistive to change, so teaching management strategies is a difficult and lengthy process. The programs also work with other correctional personnel to design external management strategies that are fitted to individual offenders and provide a structure around each offender to improve community safety. It is the expectation of sex offender treatment that sex offenders learn to self-manage their behavior and risk factors. If offenders reliably and consistently use self-control techniques, external management may be relaxed in some cases. However, DOC believes that SOMP's can significantly lower but not completely eliminate the sex offender's risk to the community. Offenders in program are encouraged to look at recovery as a lifelong process in which they are responsible for engaging in ongoing individualized maintenance programs in their communities. It is also recognized that some sex offenders are not amenable to SOMP's because of attitudes, behaviors or other characteristics that interfere with the goals of the program. These offenders are unlikely to internalize the principles of the program designed to reduce reoffense risk and must be closely managed using strong external means, i.e. intensive supervision.

Since sex offenders may be at different levels of readiness for rehabilitation, various types of programs may be developed that are designed to assist offenders as they move through the correctional system. These programs will be designed to provide maximum security to the public.

DOC's approach to sex offenders is one of clinically oriented management. This approach holds that the more educated Approved Providers and supervisory officers become about the offender's pattern(s) of abuse and relapse, the more effectively they can provide appropriate management of the offender. Even in those cases where offenders' amenability to programming is questionable Approved Providers and supervisory officers

can improve their management of these offenders and reduce the probability of re-offenses by being educated as to the circumstances under which each offender is likely to relapse. DOC maintains that the best approach to sex offender management requires diligent assessment and a coordinated application of management strategies.

2.200 Guiding Principles

The DOC philosophy of sex offender management incorporates the following five guiding principles:

1. Community Safety
2. Victim Orientation
3. Offender Accountability
4. Structure and Consistency
5. Collaboration and Teamwork

2.210 Community Safety

- **Community safety is paramount.** The protection of the community and the prevention of further victims is the primary goal of DOC
- **Sex offenders are dangerous.** When a sexual assault occurs there is always a victim. Victims of sexual assault are usually the most vulnerable members of our society, i.e. children and women. Both the literature and clinical experience suggest that sexual assault can have devastating effects on the lives of victims and their families. There are many forms of sexual offending. Offenders may have more than one pattern of sexual 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. Untreated sex offenders also commonly 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 stages of development. Therefore, it is difficult to predict with high accuracy 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 long term monitoring to minimize the risk.
- **The sex offender needs to learn internal mechanisms to control his own behavior.** Sexual offending is a behavioral disorder which cannot be “cured”. The term “sexual offender” is not a clinical term, but rather a legal one. Sexual offenses are defined by law and may or may not be associated with clinical diagnoses. Sexual offenders may or may not have the characteristics of sexual deviance which are described as paraphilias. Some sex offenders may have diagnoses such as mental disorders, organic disorders, or substance abuse problems. Many sex offenders do not have these conditions. Even when sex offenders have a diagnosable medical or psychiatric condition this does not account for their sexual offending, although it may complicate their treatment and management. Many offenders can learn to manage their sexual offending behaviors and decrease their risk of re-offense. Sex offenders choose sexually

abusive behavior patterns rather than more adaptive coping responses. Sexual abuse results from a series of decisions made by the offender. These decisions can be changed by the offender and, therefore, sexually abusive behavior can be controlled. This requires that sex offenders accept and utilize constructive feedback offered them in program. Such behavioral management should not, however, be considered a "cure," as successful programming cannot permanently eliminate the risk that sex offenders may return to dysfunctional and deviant patterns and repeat their offenses. The term "treatment" as it relates to sexual offending and other behavioral disorders differs significantly in connotation from the term as it is used in certain medical situations. In the medical field some diseases can be cured through the application of medication or through surgery. In these cases the etiology of the disease may stem from an alien body such as a virus or bacteria or may be the result of an injury to an organ or biological structure. Medical procedures can sometimes completely resolve these issues and return the patient to his or her pre-morbid condition. Some diseases, for example diabetes, can not be cured but can be successfully controlled through diet and medication. In a similar manner, sex offenders have a disorder that needs to be controlled. External control is provided by society when individuals fail to control their own harmful urges. Sexual offending stems from dysfunctional and destructive patterns of thinking and behaving endogenous to the individual. The assaultive behavior patterns are not coming from an external and alien source but from the dysfunctional personality constructs of the individual himself. In sex offender programming the "treatment" is an attempt to give the individual some tools to recognize and alter his dysfunctional patterns. He is taught tools to self manage his behavior. He must choose to use these tools in order to avoid future offending. There is no guarantee that the offender will learn the tools offered or make the choice to use what he has learned. However, offenders who are exposed to sex offender programming have a better chance of learning and using self management techniques than those who have no such training. External controls must remain in place until there is consistent evidence that the offender has learned and is applying internal controls.

- **Sex offenders are intrinsically motivated in destructive ways.** Sex offenders are not without motivation. The goals for which they strive, however, are typically self serving and destructive to themselves and others. They are self-oriented rather than other-oriented. Untreated, their efforts are directed towards maintaining unhealthy ways of thinking and behaving. There may be little or no intrinsic motivation to alter the patterns which lead them to offend. The sex offender's chronic patterns of thinking, perceiving, and behaving lead to maladaptive patterns of adjustment. The patterns are self maintained and resistant to change. They may cause the individual little anxiety and are said to be "ego-syntonic." That is; they fit comfortably with the person's values and are incorporated into the individual's self-concept or personal identity. These patterns involve criminal behavior that is harmful to other persons and to society as a whole. These unhealthy patterns must be identified and addressed in sex offender programming. This typically decreases comfort levels of the offender, at least temporarily. When maladaptive personality patterns are confronted the offender may resist the feedback in an attempt to maintain his dysfunctional self concept

and reduce the stress of facing these problems. Sex offender therapists must focus on what will make the sex offender safer and more functional in the community, not just what will make him feel better. In any rehabilitation program it is important to understand the personality patterns of the person being treated. Diagnostic evaluation is essential to identifying the maladaptive patterns which are the targets of treatment. Sex offenders have thinking errors that facilitate offending behavior. Ingrained patterns of behavior are tactics that aid the offender in carrying out his offense cycle or patterns. Sex offenders must learn to identify and correct these patterns if they are to avoid relapse. This concept has important implications for rehabilitation and is essential to any program that hopes to provide successful programming to sex offenders. Because ingrained patterns of behavior are resistant to change it is important to establish greater external control and structure when working with sex offenders until internalized control has been consistently demonstrated.

- **Assessment and evaluation of sex offenders is an on-going process. Progress in treatment and level of risk are not constant over time.** The effective assessment and evaluation of sexual offenders is best seen as a process. In Alaska many sex offenders are assessed prior to their release from prison. Assessment of sex offenders' risk and amenability to management should not, however, end at this point. Subsequent assessments must occur on an ongoing basis. Assessment and evaluation should be an ongoing practice in any sex offender program. In the management 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 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.

2.220 Victim Orientation

- **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 to the offender management and treatment process. 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.
- **You don't know the offender until you know the offense from the victim's perspective.** Offenders strive to maintain an image of social propriety. In many respects they may appear as normal well adjusted citizens. They tend to distort the facts of the assault and to shift responsibility for their actions in order to protect their self-image. Many offenders live a dual life. They present with an air of conformity and hide their acting out behavior. They may go to great extent to convince others around them that they are incapable of committing acts of sexual assault. They often present to evaluators and to probation/parole officers as well functioning people. It is critical for those working with sex offenders to have

collateral information, including reports from the victim about the nature and extent of the sexual offending, to obtain an accurate picture of the offender's actions and deviancy.

- **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.
- **Victim involvement must be empowering not re-traumatizing.** When a victim reports a sexual assault they typically have to recount their story to a number of people. Victims may first report to a family member, friend, victim advocate, or others. They then have to repeat their story to police. If they have not been in counseling before, they now have to repeat their story to a counselor. If the case is prosecuted they have to repeat their story to prosecutors. If the case goes to trial they have to testify in court and be cross-examined by the offender's defense attorney. Each time the victim repeats their story they may re-experience the trauma of the assault. Every effort should be made to minimize trauma to the victim by not having them repeat their story unnecessarily.
- **Victims must be allowed to determine their level of involvement in the process.** Victims should have control over how much involvement they have in the judicial system. Their wishes should be respected regardless of what they choose to do.
- **Victims are entitled to notification when offenders are about to be released from prison.** The Alaska constitution guarantees victims the right of notification. DOC Policy and Procedure 1206.01 states that victims may choose to be notified about an offender's pending release from prison. They may also choose to be notified when an offender is being considered for furlough or discretionary parole. They may be notified whenever an offender is going to a lower form of custody. In addition they may choose to be notified when an offender has violated his conditions of probation or parole. If the offender violates his conditions of probation the District Attorney's office notifies the victim. If the offender violated his conditions of parole the victim is notified by DOC. Professionals also have a duty to warn the victim if there is information to suggest the offender is an imminent threat to the victim.
- **Victims should be contacted through appropriate channels.** It is always preferable for there to be a central contact person for the victim. This would typically be someone in their support circle such as a parent, victim advocate,

counselor etc. When there is a need for information from the victim or a need to pass information on to the victim, it is in the victim's best interest to have the support person act as an intermediary for contact. This protects the victim from unwanted contact but gives them the option to speak directly with others if they so choose. In cases when victims must be contacted directly, DOC staff and Approved Providers shall be respectful of victim wishes regarding contact and not attempt to influence their decision.

2.230 Offender Accountability

- **Sex offenders are completely responsible for their behaviors.** Programming must continue to focus on the offender taking responsibility for his behaviors. This includes taking responsibility for, and learning from, the negative consequences that resulted from the offense(s). Sex offense specific programming must continue to focus on the offender taking responsibility for his behavior. He must see how his behavior was self-directed and maintained, sometimes through great effort, rather than being a sudden impulsive act carried out without forethought. They are also responsible for actively working on correcting and coping with patterns and problems that contributed to their offending behavior.
- **Program participants are responsible for active participation in their program.** DOC is committed to providing programming in the most effective and efficient manner. The goals of program must be wholly related to factors that are related to sexual offense patterns. The Department monitors the progress of participants to insure that unmotivated offenders are not allowed to continue in program thereby taking up valuable treatment resources and denying motivated offenders the opportunity for participation.
- **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 which 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. This includes polygraph assessment which is required by statute of all sex offenders under the supervision of DOC.

2.240 Structure and Consistency

- **Sex offender programming requires structure and consistency.** Sex offender programming is goal oriented. Many of the goals are common to all those in program and some are individualized. Programs must be structured and organized such that certain activities can occur which will force the offender to focus on certain issues or problems which require work. The activities of a rehabilitation program are not haphazard but are purposely intended to focus the offender's attention on some things and not on others. The more that is known about the offender's thinking errors, grooming patterns, assault cycles, patterns of relating to others, and other essential elements of his personality patterns the greater the chance that professionals will be able to appropriately evaluate him and develop a successful management protocol. Structure facilitates goal achievement. The

most intense form of structure occurs in a milieu program where an offender's activities can be monitored and directed on an ongoing basis. All DOC programs shall contain structure to the degree possible in which to evaluate, and better manage the offender. Activities of the programs shall be organized towards the goals intended. Consistency is critical to the rehabilitation process. Progress is not made with sex offenders through sudden insight followed by rapid and remarkable change. Rather, progress is the slow result of hard work on the part of the offender and the consistent application of principles by program staff. Consistency within and between programs is also essential. The goals of programming will be focused on issues specific to sexual offending and specific goals will be outlined in an Offender Treatment Plan

- **Dangerous and dysfunctional attitudes and behaviors will be consistently confronted in an appropriate and respectful manner.** Sex offenders have developed chronic patterns of maladaptive behavior and thinking that are self-serving and robust in their resistance to change. Furthermore, sex offenders typically distort the meaning of things in their world in a way which will endorse their patterns of thinking and behaving. This then allows them to continue these patterns without feeling discomfort. These distortions must be confronted and efforts made to help the offender modify them. *Confrontation is the presentation of information which challenges the person's distorted view and paves the way for the correction of that view.* Confrontation *does not* involve intentionally demeaning or humiliating comments, the intention of which is to induce shame. Confrontations should be made in a matter-of-fact manner, free from negative emotional tone. DOC programs, contractors and other Approved Providers will refrain from tactics which are intended to induce a sense of humiliation and/or shame but will strive consistently to confront the distorted perceptions of the offender. Likewise DOC Approved Providers will not endorse or encourage humiliation tactics on the part of program participants engaged in confronting a fellow participant. DOC staff and Approved Providers will attempt to train offenders in the appropriate manner of delivering feedback.
- **Sex offender assessment, management, 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, management, and behavioral monitoring of sex offenders should not discriminate based on race, religion, gender, sexual orientation, disability or socioeconomic status. Sex offenders meeting the criteria for admission into SOMPs will be given equal opportunity to participate in DOC sex offender programming. Sex offenders must be treated with dignity and respect by all members of the team who are managing the offender regardless of the nature of the offender's crimes or conduct. Providers of services to sexual offenders shall be bound by their professional ethics at all times.

2.250 Collaboration and Teamwork

- **Sexual offending occurs in secret. Sex offenders must waive confidentiality for evaluation, treatment, supervision, and case management purposes.** All members of the Management Team must have access to the same relevant information. Sex offenses are committed in secret, and all forms of secrecy potentially undermine the rehabilitation of sex offenders and threaten public

safety. The more information the Management Team has about the offender's patterns of thinking, feeling and relating the more able they are to develop effective management strategies. Offenders typically conceal information about themselves as a means of perpetuating sexually deviant behavior. Offenders are expected to share information about their inner thoughts, fantasies, emotions and behavior patterns with group members. They are also expected to share information about each other that is relevant to rehabilitation. Collaterals will also provide information, not because it is being kept secret by the offender, but because the offender doesn't understand the significance of the information to his offense chain and to his rehabilitation. Offenders are expected to sign confidentiality waivers so that information can be freely shared between management staff. This open channel of communication differs from typical therapeutic practice but is critical in the rehabilitation of sexual offending. The limits of confidentiality shall be explained to offenders prior to program entry. There are limitations to the release of sensitive clinical information. Clinical information will be shared only with persons that are responsible for the rehabilitation and management of the offender. Some information, such as psychological test data, is appropriate only for individuals trained to interpret such data. As such, there may be restrictions on the type of information provided based upon the qualifications of the individual requesting such information. Psychologists will release test data and information in accordance with the ethical standards of the American Psychological Association.

- **Standards and guidelines for assessment, management, and behavioral monitoring of sex offenders will be most effective if the entirety of the criminal justice and social services systems apply the same principles and work together.** DOC realizes that setting standards for sex offender providers alone will not significantly improve public safety. In addition, the process by which sex offenders are assessed and managed by a variety of state agencies and the judicial system should be coordinated and improved.
- **The management of sex offenders requires a coordinated team response.** All DOC contractors and other Approved Providers must be willing to communicate, coordinate and cooperate with DOC staff. All relevant individuals and agencies must cooperate in planning containment strategies of sex offenders for the following reasons:
 1. Sex offenders should not be in the community without comprehensive programming, supervision, and behavioral monitoring
 2. Each discipline brings to the team specialized knowledge and expertise
 3. Open professional communication confronts sex offenders' tendencies to exhibit secretive, manipulative and denying behaviors, and
 4. 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 managing the sex offender.

- **Successful management of sex offenders is enhanced by the positive cooperation of family, friends, employers and members of the community who have influence in sex offenders' lives.** Sexual issues are often not talked about freely in families, communities and other settings. In fact, there is often a tendency to avoid and deny that sex offenses have occurred. Successful management of sex offenders involves an open dialogue about this subject and a willingness to hold sex offenders accountable for their behavior. Safety-Nets shall be developed for sex offenders whenever possible following the Standards given in this document.

2.300 Management and the Use of Polygraph Testing

DOC began to incorporate the polygraph into sex offender management in 2003 after consultation with experts from the state of Colorado. DOC uses a three pronged approach that incorporates specific sex offender assessment and treatment strategies, specific sex offender supervision strategies, and polygraph assessment. The goal is to contain sexual aggression through careful assessment, management, and rehabilitative efforts thereby increasing public safety. DOC has had specialized sex offender supervision, assessment, and rehabilitation services for a number of years. However, polygraph services had not been available until 2006 when a pilot project was initiated in the Anchorage area. The 2006 legislature passed legislation requiring polygraph assessment of all sex offenders beginning in July 2007. DOC has been mandated to implement the use of polygraph assessment to enhance the management and rehabilitation of all sex offenders throughout Alaska.

It is well known in the field of sexual aggression that sexual offenders are often secretive about their past history of sexual offending. The information on record about sexual offenders is typically the tip of the ice berg with respect to the scope, duration, and intensity of the offenders' sexual offense history. Polygraph assessment often reveals a much more extensive history of sexual offending than that revealed by the offender. Offenders who are involved in rehabilitation programs may reveal more extensive sexual offending over the course of their programming but this may take months or years of involvement in program to uncover. Even those offenders who are actively involved in programming may not reveal the full extent and complete nature of their sexual offense history. Polygraph assessment is an efficient and effective way to assess the full extent of offenders' sexually deviant behavior. Offenders may not only reveal a longer history of sexual offending with many more victims than formerly identified, but they may also reveal offending against other age, gender, and relationship groups than formerly known. This is important because supervision staff need to know the potential victim groups that need to be protected from the offenders. Polygraph assessment may also reveal elements of force that are used by the offender and give a more accurate assessment of the potential for danger presented by individual offenders. The polygraph also assists in helping the offender work through denial more quickly and allowing the therapists to know the extent of any acting out or high risk behavior engaged in by the offender while under supervision. The polygraph assists supervision staff by evaluating the offenders' cooperation with conditions of probation/parole. Specific issue polygraphs and ongoing

monitoring polygraphs increase the effectiveness of supervision by providing knowledge to probation/parole officers about potential violations. Offenders often state that the polygraph helps them contain their high risk behavior because they know it will be detected upon testing.

2.400 Cognitive Behavioral Treatment and Relapse Prevention

Cognitive behavioral treatment is a technique that teaches offenders to recognize patterns of feelings, thoughts, and behaviors that precede a relapse pattern. It requires that offenders work intensively on their personal assault cycles and patterns so that they can recognize signs and triggers to a potential reoffense. The purpose of cognitive-behavioral treatment is to teach offenders to become aware of their pre-relapse signs and to initiate corrective responses so that they can maintain self-control over their urges to reoffend.

The affective, cognitive, and behavioral patterns referred to above are not accidental or transient. Sexual offenders typically have ingrained patterns of thinking, feeling, and behaving that are dysfunctional. The particular personality patterns displayed may differ from offender to offender but they are persistent within each offender and lead the offender on a destructive path of behavior that may eventually end in sexual violence. Offenders are expected to learn to recognize their patterns and correct for them. Feelings may be a trigger for an offense but they are not the *reason* for the offense. Offenders need to learn to identify feelings as a signal to engage in protective behaviors and not use feelings to rationalize offending. Sex offenders have cognitive distortions or thinking errors that are used to rationalize offending and to energize them into reoffense patterns. Sex offender programming is designed to identify these patterns and teach the offender to correct them with healthy thinking that is less self-centered and that takes into account the rights and needs of others. Programming is designed to help the offender recognize and incorporate the rights and needs of others into his decision making. Programming also identifies dysfunctional behavior patterns that allow the offender to avoid responsibility for his behavior and continue to engage in unhealthy interpersonal behaviors. The treatment programming for sexual offending is a long term process, typically taking several years and involving a coordinated effort between program and supervision staff. Sex offenders must make a commitment to abstain from participating in future deviant sexual behavior. The offender must learn new behaviors to substitute for the old and destructive ones they have engaged in previously. Abstinence from sexually deviant, criminal, and other abusive and destructive behavior is promoted as the primary goal for all sex offenders who enter program.

2.500 Supervision of Sexual Offenders. Specific procedures for supervision of sex offenders are given in the Standard Operating Procedures for Supervision by the Division of Probation and Parole. Information from assessment and treatment shall be incorporated into the supervision plans for sexual offenders. Approved Providers shall give regular input to supervision staff and conduct ongoing consultation as needed to assist the supervising officers manage their caseload of sexual offenders.

3.000 QUALIFICATION OF PROVIDERS

The Department has established minimum standards for providers who offer services to sex offenders under the jurisdiction of DOC. DOC has established an Approved Provider Level System which approves clinicians at different service levels according to their training and experience. For treatment providers, the levels include Sex Offender Treatment Supervisor, Full service provider, and Partial service provider. DOC also approves individuals in pre and post graduate training programs to provide services under supervision. Polygraph examiner levels include Full Operating level and Associate Level. Plethysmograph examiners may be approved at Full Operating Level Treatment Provider and/or Full Operating Level Evaluator. All contract staff and Approved Providers must meet the minimum standards set forth in this document. Furthermore, special conditions and/or restrictions may be placed upon providers whose qualifications to provide specific services are limited by lack of experience. Individual professionals and staff working with sex offenders under the jurisdiction of Corrections must meet the minimum qualifications and follow specific conditions and restrictions as determined by DOC. Additionally, they must meet all applicable State and Federal licensure requirements and restrictions. Providers must be licensed in their respective clinical fields. The exception to this policy is DOC personnel who as a part of their job responsibilities are required to participate in the overall supervision and/or delivery of services to the sex offender population.

3.100 Ethics/Professional Conduct

DOC is committed to providing safe and effective programming to offenders under its supervision. The ultimate goal of rehabilitation and management is to reduce the incidence of sexual aggression. Appropriate programming enhances the safety and protection of the public. Approved Providers must be committed to the welfare of the offenders, their family members, victims, and the community as a whole. Ethical principles set guidelines for professional behavior and conduct that reflect high standards of integrity and competence. This protects the public, preserves public trust, and ultimately advances the fight against sexual aggression.

Approved Providers are licensed in one of several mental health professions in Alaska. Each of these professions has a code of conduct that its licensed members must follow. Most mental health professionals also must adhere to a code of ethics developed by national associations in their respective fields. The Association for Treatment of Sexual Abusers (ATSA) has ethical standards for those who practice in this field. In addition, State and Federal laws govern the conduct of mental health professionals. Approved Providers are responsible for familiarizing themselves with ATSA Standards and Guidelines. Approved Providers are also responsible for familiarizing themselves with the ethical guidelines of their respective licensing boards and professional organizations. All treatment providers, polygraph examiners, and plethysmograph/Abel assessment providers shall follow the ethical guidelines of their respective practice, follow the ATSA code of ethics as well as follow all State and Federal laws governing mental health professionals.

3.200 Department Approval of Treatment Providers

All individuals who wish to provide assessment and treatment services to sex offenders under the jurisdiction of DOC must be Approved Providers as determined by Approved Provider Regulations. *Approval as a provider is required of anyone wishing to assess or treat sex offenders in DOC's jurisdiction regardless of whether there is a charge for services and regardless of who pays for the services.* The approved provider process is a systematic review and approval process which has been established by the DOC to insure that sex offenders who are under the Department's jurisdiction are seen by professionals whose philosophy and methods of treatment are commensurate with the Department's Standards of sex offender management. Sex offenders with probation/parole requirements to obtain sex offender treatment are required to see a DOC Approved Provider. All Approved Providers must be licensed by the State of Alaska in their respective fields of practice unless they are involved in a DOC approved pre-graduate or post-graduate sex offender internship program. DOC encourages advanced graduate students at the Masters and Doctoral levels, who have completed their basic class work and practicum training, to obtain supervised experience in the area of sex offender assessment and treatment. The goal of the internship programs is to allow qualified individuals to gain basic knowledge and skills in the area of sex offender assessment, treatment, and management. Supervised experience will help individuals to eventually qualify as DOC approved providers and to provide sex offender services in an ethical and professional manner to a culturally diverse population of sex offenders.

Applications from providers will be reviewed by a Sex Offender Approved Provider Committee appointed by the Department. The approval process is outlined in DOC regulations.

DOC does not approve agencies but only individuals as Approved Providers. There is no "agency umbrella" for approval as a DOC provider. All agency staff persons who work with DOC offenders must undergo the review and approval process. Agencies may not substitute non-Approved Providers for staff persons who have been approved.

DOC does not consider itself to be a governing agency as to licensure or competence of professionals in their respective fields of training and expertise. The Department reserves the right, however, to maintain a list of Approved Providers that sex offenders under their jurisdiction must select from when participating in institutional or community based treatment programs for sex offenders. Approved Providers delivering sex offender treatment services may be added and deleted from the list of Approved Providers based on compliance or lack of compliance with the treatment provider regulations including these Standards.

3.210 Levels of Approval for Treatment Providers

Providers may be approved to provide assessment and treatment services to sex offenders at one of the following five levels:

1. Sex Offender Treatment Supervisor
2. Level I - Full Service Provider
3. Level II – Partial Service Provider
4. Sex Offender Intern – Post-Graduate Level
5. Sex Offender Intern – Pre-Graduate Level

Sex offender treatment supervisors may engage in the full spectrum of assessment and treatment services and may also supervise other DOC Approved Providers. Level I

providers are approved to provide a full range of clinical services to sexual offenders. Less experienced Level I providers may be required to maintain clinical supervision from an approved sex offender treatment supervisor. Level II providers may provide specific services to sexual offenders at the discretion of DOC and an approved sex offender treatment supervisor. All Level II providers are required to receive supervision by a Sex Offender Treatment Supervisor. Pre-Graduate interns must have completed the necessary course work at their college or university to be approved for an internship. They must work under the direct on-site supervision of a Sex Offender Treatment Supervisor. Post-Graduate interns must also work under the supervision of a Sex Offender Treatment Supervisor and may not conduct individual, group, or family therapy sessions independently until approved by the Sex Offender Treatment Supervisor.

The requirements for approval at each level are given in Appendix C.

3.211 Restrictions for all Provider Categories:

All new providers are required to obtain clinical supervision for at least the first year that they provide services to offenders supervised by, or in the custody of the Alaska DOC.

The Department, upon recommendation by the Approved Provider Committee, may elect to impose limits upon the services provided to offenders in custody by any approved provider. Some examples of limitations placed upon providers include:

- May not conduct assessments unless under direct supervision of a Sex Offender Treatment Supervisor.
- Services provided will be on a case review basis and approved by DOC, (e.g., may only treat clients with a previous history of treatment in a DOC program, may only treat low risk offenders).
- All clinical reports must be reviewed and signed by a Sex Offender Treatment Supervisor.
- May not conduct psychological testing if not licensed to do so in this state.

3.212 Movement Between Levels

Movement between levels of approved provider status must be recommended by a Sex Offender Treatment Supervisor and reviewed and approved by DOC Offender Programs. Level I providers may request to be trained as a Sex Offender Treatment Supervisor. Level I providers interested in providing supervision must be trained and supervised by an approved Sex Offender Treatment Supervisor.

3.213 Supervision Guidelines for Approved Providers.

DOC requires that some providers receive supervision from a Sex Offender Treatment Supervisor. The purpose of supervision is to provide guidance and training to less experienced providers, to assure compliance with the DOC treatment model, and to improve the quality and consistency of treatment.

3.214 Amount of Supervision Required.

The amount and type of supervision required will vary according to the experience and training of the supervisee as well as the number and complexity of the cases being treated. The minimum standards for supervision time are as follows:

- One hour every two weeks for every 10 offenders or more on a case load
- One hour every month for case loads less than 10
- Interns must work one hour per week with their approved supervisor

These are minimum standards. Sex Offender Treatment Supervisors shall require more supervision time at their discretion should the circumstances in their opinion warrant it for any reason. The method of supervision can include a variety of techniques in addition to face-to-face supervision meetings, such as taped sessions, supervisor sitting in on sessions, use of forms developed by the supervisor, etc.

Supervision shall be required until such time as the Sex Offender Approved Provider Committee recommends, and the Department agrees, that supervision is no longer necessary.

3.215 Supervision Plans.

All Approved Providers who require supervision shall file a Supervision Plan with the Criminal Justice Planner for Offender Programs prior to the start of any treatment of DOC offenders. The Supervision Plan shall address the frequency, method, and mode of supervision. The plan shall specify any special conditions required (e.g. additional training), and/or any and all prohibitions.

3.216 Guidelines for Supervision and the Evaluation of Provider Performance.

Sex Offender Treatment Supervisors shall be required to provide evaluations of Approved Providers under their supervision on a schedule established when the individual is approved. Appendix D provides a sample evaluation form.

3.217 Notification, Suspension, and Termination

Contractors and other Approved Providers are obligated to notify DOC the next working day if:

1. They are being investigated for malpractice and/or ethical violations by a licensing board or professional organization such as APA, ACSW, etc.

or

2. They are named as a party in any civil or criminal litigation relating to their professional activities.

Contractors and Approved Providers may be temporarily suspended from delivery of sex offender treatment services if either item 1 or 2 applies.

Contractors are subject to termination and Approved Providers may be removed from the approved provider list if they are found civilly or criminally responsible in the circumstances related in items 1 or 2.

3.218 Continued Placement on the Approved Provider List. All Approved Providers must apply for continued placement on the Provider List every 3 years by the date provided by the Approved Provider Committee. Additionally, the provider must abide by Alaska Administrative Code 22AAC30.070 Renewal process.

(a) To renew provider approval under this chapter, an approved provider must apply for renewal of approval no later than 60 days before the end of the provider's current approval period by submitting an application for renewal to the Sex Offender Treatment Committee on a form provided by the department.

(b) For a provider's approval to be renewed, the provider must

(1) have a current professional license, in good standing, as described in 22AAC30.030(b);

(2) be a good moral character;

(3) have obtained, within the proceeding three years, 20 hours of continuing education in the treatment of sex offender that

(A) was sponsored or conducted by the Association for the Treatment of Sexual Abusers;

(B) fulfills a continuing education requirement imposed by the board that licenses the provider as a psychiatrist, psychologist, psychological associate, social worker, marital and family therapist, or professional counselor; or

(C) has been approved by the department as being substantially equivalent to the continuing education described in (A) or (B) of this paragraph:

(4) agree to abide by the standards set out in 22AAC30.200 in providing sex offender treatment to a sex offender who is under the department's jurisdiction; and

(5) provide a reference, on a form provided by the department, from the supervising full-service-level approved provider if the applying provider's current approval is conditioned under 22AAC30.040 on that supervision.

(c) A renewal application must include

(1) the provider's name, business mailing address, and telephone number;

(2) verification from the relevant Alaska licensing board that the provider has a current professional license, as described in (b)(1) of this section, in good standing;

(3) documentation verifying that the provider has obtained the continuing education required by (b)(3) of this section;

(4) the reference described in (b)(5) of this section, signed by the supervising full-service-level provider, if the reference is required under (b)(5) of this section;

(5) all information not previously provided to the department regarding the provider's criminal history; and

(6) information not previously provided to the department regarding any investigations of the provider within the past three years for possible professional license violations.

(d) A renewed provider approval lapses three years from the date of renewal.

3.219 Complaints Against an Approved Provider

Per Alaska Administrative Code 22AAC30.110, the following shall be followed if the Approved Provider Committee receives a complaint against an approved sex offender treatment provider.

(a) A person, including an employee of the department, may bring a complaint against an approved provider, alleging a violation of a requirement for provider approval under this chapter, a violation of a supervision condition placed on the approval as described in 22 AAC 30.040, or a violation of a standard of care in 22 AAC 30.200 by submitting the complaint in writing to the Sex Offender Treatment Committee. The committee shall open a complaint file and review the complaint. Upon completion of initial review of the complaint, the committee shall prepare for the complaint file a report regarding the complaint, including the committee's conclusion as to whether there is probable cause to believe that a violation has occurred. In the report, the committee may recommend that the department suspend the provider's approval under this chapter until the complaint is resolved, in order to prevent an undue risk of harm to the public. The committee shall forward the complaint file to the department.

(b) If, after review of the complaint file, the department determines that probable cause does not exist to believe that a violation has occurred, the department will furnish a written report of the complaint to the provider who is the subject of the complaint, setting out the reasons for the determination, and will place a copy of the report in the complaint file.

(c) If, after review of the complaint file, the department determines that there is probable cause to believe that a violation has occurred, the department will notify the provider who is the subject of the complaint of the allegations contained in the complaint, and will furnish the provider with a response form. The department will return the complaint file to the committee and direct the committee to investigate the allegations in the complaint.

(d) If the department directs the committee to conduct an investigation as described in (c) of this section and the department concludes that suspension of the provider's approval pending resolution of the complaint is necessary to prevent an undue risk of harm to the public, the department will notify the provider that the department intends to suspend the provider's approval under this chapter pending resolution of the complaint and that the provider may contest the suspension determination by providing to the department,

within three days after the date of the notification under this subsection, a written statement as to why suspension is not necessary to prevent an undue risk of harm to the public. The department will consider the provider's statement, make a final determination as to whether the provider's approval under this chapter should be suspended pending resolution of the complaint, and will notify the provider of that final determination. If the department's final determination is that the provider's approval under this chapter should be suspended, the suspension takes effect upon the provider's receipt of notification of that final determination.

(e) Within 14 days after the date of the notification of allegations under (c) of this section, the provider shall submit to the committee, on the response form furnished by the department, a sworn statement in response to the allegations in the complaint. The provider shall cooperate with the investigation of the complaint by providing to the committee any documents or information requested by the committee. The provider's failure to respond to the allegations or to cooperate with the committee's investigation as required by this subsection may result in revocation of the provider's approval. The committee shall place in the complaint file the provider's response statement, any other documents or information provided to the committee under this subsection, and any other material considered by the committee in its investigation.

(f) Upon completion of its investigation, the committee shall prepare for the complaint file a report of the results of the committee's investigation and a recommendation for department action regarding the complaint, and shall forward the complaint file to the department. The committee's recommendation may be that the department

(1) take no action;

(2) continue the provider's approval under this chapter with conditions designed to correct the violation, if the committee considers the violation to be a minor one that does not create an undue risk to the public and is amenable to correction within a specified period of time; or

(3) revoke the provider's approval under this chapter.

(g) If, after review of the complaint file, including the committee's report and recommendation under (f) of this section, the department decides to

(1) take no action on the complaint, the department will notify the provider of the decision, will furnish the provider with a written report of the decision and will retain a copy of the notification and report in the complaint file;

(2) continue the provider's approval under this chapter with specified conditions designed to correct the violation, the department will notify the provider of the continued approval and conditions, will furnish the provider with a written report of the decision, including a statement of the reasons for the conditions, and will retain a copy of the notification and report in the complaint file;

(3) revoke the provider's approval under this chapter, the department will notify the provider of the revocation decision, will furnish the provider with a written report of the decision, including a written statement of the reasons for revocation and instructions for requesting a review of the decision, and will retain a copy of the notification and report in the complaint file.

(h) A provider who receives notification of a decision under (g)(2) or (3) of this section has 30 days from the date of the notification to request review of the decision in the manner described in 22 AAC 30.060(a) . If the provider timely requests review as provided in this subsection, the department's review of the decision will be conducted as described in 22 AAC 30.060. If a timely request for review is not received as provided in this subsection, the revocation or the placement of conditions takes effect on the 31st day after the date of the notification of the decision under (g) of this section.

(i) After resolution of a complaint under this section, the department will inform the complainant of the disposition of the complaint.

(j) In this section, "violation" means a violation of a requirement for provider approval under this chapter, a violation of a supervision condition placed on the approval as described in 22 AAC 30.040, or a violation of a standard of care in 22 AAC 30.200.

3.300 Department Approval of Polygraph Examiners

3.310 Levels of Approval

DOC approves polygraph examiners at the following two levels;

1. Full Operating Level
2. Associate Level.

An examiner at the Full Operating Level may conduct polygraph assessments of offenders without supervision. Associate Level examiners have less experience and may not have a baccalaureate degree. They are required to have supervision by an examiner at the Full Operating Level.

The requirements for each are given in Appendix E.

3.320 Continued Placement on the Approved Provider List at Full Operating Level:

Clinical polygraph examiners at the Full Operating Level must apply for continued placement on the Provider List every 3 years by the date provided by the Approved Provider Committee. Requirements are as follows:

1. The polygraph examiner must demonstrate continued compliance with these Standards;
2. Full Operating Level Clinical polygraph examiners shall complete a minimum of forty (40) hours of continuing education every three years in order to maintain proficiency in the field of polygraph testing and to remain current on any developments in the assessment, treatment, and monitoring of adult sex offenders. Up to ten (10) hours of this training may be indirectly related to sex offender

- assessment/treatment/management. It is incumbent on the trainee to demonstrate relevance to sex offender issues if the training is indirectly related to sex offender assessment/treatment/management. The remaining thirty (30) hours must be directly related to sex offender assessment/ treatment/ management.
3. Shall conduct a minimum of 100 post-conviction sex offense polygraph examinations in the 3-year listing period;
 4. Provide satisfactory references as requested by DOC. DOC may also solicit such additional references as necessary to determine compliance with the Standards, including, but not limited to other members of the community supervision team;
 5. Submit documentation that the examiner has engaged in periodic peer review by other clinical polygraph examiners listed at the Full Operating Level operating separately from the examiner's agency. Peer review must be conducted biannually at a minimum;
 6. The individual shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment;
 7. Submit to a current background check and be fingerprinted;
 8. Report any practice that is in significant conflict with the Standards;
 9. Comply with all other requirements outlined in American Polygraph Association guidelines and DOC policy.

3.330 Continued Placement on the Approved Provider List as an Associate Level Examiner: Clinical polygraph examiners at the Associate Level must apply for continued placement on the Provider List every 3 years by the date provided by the board. Requirements are as follows:

1. The polygraph examiner must demonstrate continued compliance with these Standards;
2. The applicant shall have completed all training as outlined in these Standards;
3. Conduct a minimum of 75 clinical polygraph examinations in the 3 year listing period;
4. Provide satisfactory references as requested by DOC. DOC may also solicit such additional references as necessary to determine compliance with the Standards, including, but not limited to other members of the community supervision team;
5. Submit documentation that the examiner has engaged in periodic peer review by other clinical polygraph examiners listed at the Full Operating Level operating separately from the examiner's agency. Peer review must be conducted biannually at a minimum;
6. The individual shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment;
7. Submit to a current background check and be fingerprinted;
8. Report any practice that is in significant conflict with the Standards;
9. Comply with all other requirements outlined in American Polygraph Association guidelines and DOC policy.

3.340 Professional Supervision: A supervision agreement shall be signed by both the polygraph examiner and his/her supervisor. The supervision agreement should specify such things as the frequency and length of supervision, type of supervision, and it shall specify accumulated supervision hours.

Supervision must be a minimum of thirty (30) minutes for each of the 100 sex offense polygraphs for a total minimum of fifty (50) face-to-face supervision hours provided by the Full Operating Level clinical polygraph examiner.

The components of supervision include, but are not limited to:

- Preparation for a polygraph examination
- Review/live observation of an examination
- Review of video and/or audio tapes of an examination
- Review of other data collected during an examination

3.350 Movement to Full Operating Level: Associate Level clinical polygraph examiners wanting to move to Full Operating Level status must complete and submit documentation of:

- Obtaining a baccalaureate degree;
- The individual shall have conducted at least 200 criminal specific-issue examinations including post conviction sexual history, maintenance and monitoring exams;
- A letter from his/her supervisor indicating the applicant's readiness to move to Full Operating Level status, including documentation of having completed the professional supervision components;

3.400 Plethysmograph Examiner:

3.410 Levels of Approval

A Plethysmograph Examiner may be approved at the following two levels:

1. Full Operating Level Treatment Provider
2. Full Operating Level Evaluator

Both Full Operating Level Treatment Providers and Evaluators may conduct plethysmograph assessments. In addition a Full Level Treatment Provider may conduct aversive conditioning or other forms of sexual deviancy re-conditioning. The requirements for plethysmograph examiners are given in Appendix F.

Plethysmograph examiners at both levels will be required to prepare and submit reports of their assessment to include an interpretation of the data.

3.420 Continued Placement on the Provider List: Plethysmograph Examiners must apply for continued placement on the Provider List every 3 years by the date provided by DOC. The application will be considered as a part of the application to continue placement on the List as a Full Operating Level Treatment Provider and/or Full

Operating Level Evaluator, since placement on the List as a Full Operating Level Treatment Provider and/or Full Operating Level Evaluator is a requirement of all Plethysmograph Examiners.

Documentation of continued administration of plethysmograph examinations will be required. Additionally, DOC may request a review of reports or program materials specific to plethysmography or evidence of a portion of the continuing education hours addressing plethysmograph examinations.

3.421 Stimulus materials. Plethysmograph examiners shall be aware of, and comply with, all applicable federal and state legislation regarding the possession of sexually explicit materials.

Examiners shall use appropriate stimulus items to evaluate the sexual interests of clinical concern. If permitted, visual stimuli for testing of sexual interest in children should include pictures depicting males and females of different ages and different stages of physical development from very young infants and toddlers to physically mature adults. Neutral stimuli should be included to evaluate the validity of the assessment.

Audio-taped stimuli may also be used to assess sexual interest in children. These stimuli shall clearly specify the age and sex of the depicted individuals. Examiners should use audiotapes describing consensual sex, rape, and sadistic violence when evaluating sexual arousal to non-consenting sex and eroticized aggression. Neutral, nonsexual interactions should also be included. Stimuli may depict males and females as well as adults and children.

At a minimum, examiners shall have at least two examples of each stimulus category. Stimulus items should be of good quality without distracting elements.

3.500 Abel Assessment Examiner:

3.510 Levels of Approval

Providers may be approved at the following two levels:

1. Full Operating Level Treatment Provider
2. Full Operating Level Evaluator

Full operating Level Treatment Providers have more experience and do not require supervision. Full Operating Level Evaluators have less experience and shall be required to be supervised by a Full Operating Level Treatment Provider until the supervisor recommends that supervision is no longer required.

Full Operating Level Treatment Provider and/or Full Operating Level Evaluator under these Standards, have a baccalaureate degree from a four-year college or university and demonstrate that he or she had been trained and licensed as a site to utilize the instrument.

3.520 Continued Placement on the Provider List: Abel Assessment Examiners must apply for placement on the Provider List every 3 years by the date provided by the Board. The application will be considered as a part of the application to continue placement on the List as a Full Operating Level Treatment Provider and/or Full Operating Level Evaluator, since placement on the List as a Full Operating Level Treatment Provider and/or Full Operating Level Evaluator is a requirement of all Abel Assessment Examiners.

Documentation of continued administration of the Abel Assessment will be required. Additionally, DOC may request a review of reports or program materials specific to Abel Assessment administration or evidence of a portion of the continuing education hours addressing use of the Abel Assessment.

3.600 Exclusions. DOC reserves the right to deny placement on the Provider List to any applicant to be a treatment provider, evaluator, clinical polygraph examiner or plethysmograph/Abel Assessment examiner under these Standards. Reasons for denial include but are not limited to:

- A. The DOC determines that the applicant does not demonstrate the qualifications required by these Standards;
- B. The DOC determines that the applicant is not in compliance with the Standards of practice outlined in these Standards;
- C. The applicant fails to provide the necessary materials for application as outlined in the application materials and the administrative policies and procedures;
- D. The applicant has been convicted or received a deferred judgment for any criminal offense;
- E. The applicant has been found to engage in unethical behavior by any licensing or certifying body or has had a license or certification revoked, canceled, suspended or been placed on probationary status by any professional oversight body;
- F. The applicant is addicted to or dependent on alcohol or any habit forming drug as defined or is a habitual user of any controlled substance or any alcoholic beverage;
- G. The applicant has a physical or mental disability which renders the applicant unable to treat clients with reasonable skill and safety or which may endanger the health or safety of persons under the individual's care;
- H. The Board determines that the results of the background investigation, the references given or any other aspect of the application process are unsatisfactory.

4.000 STANDARDS OF PRACTICE FOR SEXUAL OFFENDER ASSESSMENT**4.100 Psychological/Risk Assessment**

4.110 General Considerations: The assessment process for sexual offenders is designed to evaluate the offender with respect to major problems, issues, and patterns across his life span so that programming can be focused specifically upon the areas that contributed to sexual offending. A comprehensive assessment allows treatment and management personnel to conceptualize the sexual offense(s) in the greater context of the offender's life. It also allows for rehabilitation and supervision to be focused on the specific needs and problems of the offender so that the risk of harm to society can hopefully be reduced. Evaluators have an ethical responsibility to conduct evaluations in a comprehensive and factual manner regardless of the offender's status within the criminal justice system. The following are general points of consideration:

- Assessment and evaluation are ongoing processes and should continue through each transition of supervision and treatment. Re-evaluation by community supervision team members should occur on a regular basis to ensure recognition of changing levels of risk.
- The evaluator shall obtain the informed assent of the offender for the evaluation, by advising the offender of the assessment and evaluation methods to be used, the purpose of the evaluation, and to whom the information will be provided. The evaluator shall explain to the offender about the role the evaluator fills with regard to the offender, DOC, the court, and the parole board. The evaluator shall explain the limits of confidentiality and the obligations regarding mandatory reporting of child abuse and other reporting obligations. The offender shall be warned that if he gives specific names, location, dates *or other identifying information* of other offenses not previously reported to authorities that these will be reported and he may be prosecuted for a new offense.”
- The evaluator shall be sensitive to any cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues, or disabilities that become known during the evaluation.

4.120 Corroboration of Self-report: Some information will come directly from interviews with the offender. This includes the offender's version of the offense and his report of any past sexually deviant behavior. In addition the clinician must collect general information about the offender's past adjustment across a number of areas including family, social, and sexual history. Also a clinical assessment is obtained to determine past and present psychiatric/psychological problems.

Sex offenders are secretive about their past behavior and adjustment. This perspective allows them to feel less anxiety about past maladaptive attitudes, emotions and behaviors, and therefore skews information that they report. They use defense mechanisms to deny, minimize, rationalize and blame others for their actions. There may also be information that is not known by the offender. Therefore, information they provide may be inaccurate

and/or missing. They typically present information that will place them in a good light and ignore or minimize their problems. For this reason collateral information must be obtained to derive a true picture of the offender's life adjustment. Evaluators must review available records to get an accurate picture of the offender.

4.121 Types and Sources of Corroborating Information:

4.130 Record review The following records should be reviewed prior to meeting with the offender.

1. Indictments
2. Pre-Sentence Report(s)
3. Sentencing Document(s)
4. Probation/Parole Conditions
5. Reports of Parole/Probation Violations
6. Police Reports
7. Victim Statements
8. Prior Psychological/Psychiatric Reports
9. Prior Treatment Records/Risk Assessments
10. Institutional Records
11. Juvenile Records

4.140 Other sources of information: Interviews with relatives, spouses, victim(s), and other significant persons in the offender's life are also helpful when possible and when these can be conducted without harm to these parties.

4.150 Offender Interviews: Offender interviews may occur over a period of time when the assessment is performed while the offender is engaged in a rehabilitation program. At other times the interview may occur as part of a pre-sentence assessment, an assessment prior to placement in program, or prior to release from custody. In these cases the interview may be conducted in one or a few meetings over a short period of time. Assessments will not be conducted prior to trial and/or conviction. Sex offender assessments cannot determine a person's guilt or innocence. To conduct an evaluation prior to the determination of guilt could mislead the court into believing that mental health professionals can determine if an individual committed a specific act. The sex offender evaluator cannot replace the trier of fact. To conduct a pre-trial assessment would constitute an ethical violation.

In all assessment situations or circumstances, an attempt is made to gather information directly from the offender regarding the specifics of the offense as well as social, family and sexual history. The examiner is hoping to gather not only "facts" about the offender's life and view about the offense, but also, to gain insight into how the offender conceptualizes the offense and various aspects of his history. Therefore, the examiner notes the offender's approach to the interview, his use of defenses, his attitude about the offense, his attitude towards treatment and his ability to handle confrontation, his interpersonal style, and his general personality patterns.

4.151 Pre-interview preparation: It is always preferable to read all available collateral material prior to interviewing the offender. *The evaluator shall clarify confidentiality issues before the interview begins and obtain informed assent in writing.* They shall also ask for the offender's understanding of why he's there to determine his level of comprehension about the assessment and correct any misconceptions. The evaluator should explain their credentials and expertise and let the offender know that they have read all the materials provided describing the victim(s), witness, and police accounts of the event(s). They should also encourage the offender to be completely open and honest. It may be helpful to do some preparation work regarding defensiveness with the offender explaining normal defense mechanisms and emphasizing the importance of him giving accurate information.

Techniques for reducing defenses include:

- Asking him to provide information about his own defenses and how you would recognize when he is feeling self-protective or challenged.
- Developing a "yes set,"
- Going slowly to first obtain information prior to the assault,
- Using progressive questioning, paradoxical techniques, and repeating questions later in the interview should you encounter resistance or denial.

The clinical interview must cover the following areas:

1. The instant offense
2. Prior sexual offending and other criminal history
3. Social/family history
4. Developmental history
5. Sexual history
6. Mental/behavioral status examination

See Appendix G for interview guidelines for obtaining specific information regarding the instant offense, sexual history, and social/family history.

4.160 Psychological Testing: A variety of psychological testing may be performed depending on potential issues in each case. The particular tests will vary depending on the particular clinician and his or her experience and training with particular instruments. Psychological testing may be used to assess functioning in the following areas:

- Intellectual Functioning
- Academic Achievement Testing (Reading level, mathematical ability, etc.)
- Neuropsychological Functioning
- Character/Personality Pathology
- Mental Illness
- Self-Concept/Self-Esteem
- Drug/Alcohol Use/Abuse
- Sexual History

- Attitudes/Cognition
- Risk Assessment

Whenever possible and appropriate, evaluators shall use instruments that have specific relevance to evaluating sex offenders and instruments with documented reliability and validity. They should also use at least one validated risk assessment instrument that was normed on a population most similar to the offender being evaluated. When the norm population differs significantly from the offender, this should be mentioned.

4.170 Assessment of Risk

Sex offenders pose a risk to the community. The crimes committed by these offenders are crimes against people rather than property. The typical ways of judging risk for non-sex offenders are not accurate predictors of risk for the sex offender. Sex offenders pose a risk to a vulnerable part of society, most typically women and children. Sex offenders commonly appear to be well adjusted members of society. Their “normal” or well-adjusted appearance often causes people to underestimate their risk to society. It is generally recognized by experts in the field that specific risk assessment is needed for sex offenders. Although risk assessment is far from an exact science certain guidelines are generally recognized as important considerations in judging the danger these offenders pose to public safety. It is also important to remember that risk is not a stable characteristic, but can change over time. While some risk factors are constants, such as a history of violence, others are fluid, such as compliance with treatment or supervision. Therefore, it is essential that risk be reassessed as changes in offender behavior and attitude are apparent. While all sex offenders will have some of these factors, high risk offenders will generally have more factors or more serious ones.

Sex offenders are a heterogeneous group. They vary in the level of risk they pose to the community. The risk assessment process is an attempt to differentiate levels of risk as well as focus attention on relevant variables that may affect judgments about treatment and supervision. It should be kept in mind that in some cases one or a few very serious factors will be enough to judge an offender as high risk.

In recent years several researchers have developed risk assessment screening tools that help to quantify risk prediction. While some risk assessment tools that have been developed are helpful in predicting risk of re-offense, they do not usually address all the factors that may be pertinent to an individual offender’s community management. This is because factors are removed from a scale if they are not significantly correlated with re-offense rates for the entire sample of sex offenders in the study. This is done so that the scale will achieve statistically significant predictive validity. Removed factors, however, may predict re-offense for particular individuals or classes of individuals. For example, sadistic offenders re-offend at high rates. However, since they are a relatively uncommon class of sex offenders (approximately 5%), sexual arousal to hurting the victim does not usually improve statistical prediction for sex offenders as a whole. This is only because these individuals make up such a small percentage of the total number of offenders included in a particular study. Logic and clinical experience dictate, however, that these offenders should be supervised closely. It is therefore helpful to use

statistically validated risk scales in combination with a more individualized assessment of risk factors. It is important to keep in mind that, although it is important to determine which offenders pose the greatest long term risk of re-offense, it is equally important to understand which factors are relevant to managing the risk of all offenders in the community.

In estimating risk, Approved Providers and supervisory officers are interested in two areas of assessment. They want to know how likely it will be that a particular offender will repeat criminal behavior (recidivism), and how much harm this behavior will cause (dangerousness). These factors may operate somewhat independently as some offenders may have a high probability of re-offense with a low likelihood of harm, e.g. obscene phone callers, while others may have a high probability of harm to a victim even though the probability of a re-offense may not be judged to be high. Therefore factors must be considered that help predict recidivism potential as well as factors that help determine dangerousness when estimating risk to the public. Most risk assessment tools that have been developed focus primarily upon risk of recidivism rather than dangerousness. Evaluators also need to estimate the harm an offender may inflict upon future victims should he reoffend. One assumption is that future harm may likely be as serious as past harm inflicted by the offender. In some cases there may be evidence of escalating violence and an upward adjustment to risk of harm may be indicated in these situations. There are several rating scales for estimating dangerousness. These are given in Appendix H.

Approved Providers and DOC staff are required to formulate an assessment of risk, estimating both risk of reoffense and risk of harm to future victims. Several actuarial tools are available for judging risk of reoffense. Approved Providers are encouraged to obtain training in the use of these and other risk assessment tools.

Risk assessment shall be conducted on all sex offenders that are in program. Evaluators shall estimate to the best of their ability the risk offenders under their care pose to the community. All available records shall be reviewed prior to assessment. It is the joint responsibility of the approved provider and DOC staff to gather all information which is available and may contribute to the assessment of risk. Risk assessments should be conducted using input from both program and supervision staff. Whenever possible, assessments should be conducted in a group setting with as many members of the Case Management Team present as possible. (See Sections 8.200 and 8.210)

4.180 Report of Evaluation: Evaluators shall prepare a report summarizing their findings and recommendations. They shall list the documents reviewed and the methods employed in the assessment. They shall summarize their findings in the following areas:

- Demographic information
- PSI and offender versions of the instant offense
- Sexual history information
- Social/Family history information
- Mental Status Examination results
- Psychological Testing Results
- Risk Assessment

Evaluators will also make recommendations or findings regarding:

- Amenability for treatment
- Recommendations regarding offense-specific treatment
- Treatment for co-existing conditions
- Need for further assessment
- Need for medical/pharmacological treatment if indicated
- Housing recommendations

4.190 Other Considerations:

Evaluators have an ethical responsibility to conduct evaluation procedures in a manner that ensures the integrity of testing data, the humane and ethical treatment of the offender, and compliance with the mental health statutes. Evaluators should use testing instruments in accordance with their qualifications and experience. Un-interpreted raw data from any type of testing should never be released to those not qualified to interpret that data.

Any required evaluation areas that have not been addressed or any required evaluation procedures that have not been performed, shall be specifically noted. In addition, the evaluator must state the limitations the absence of the required evaluation areas or procedures causes to the evaluation results, conclusions or recommendations. When there is insufficient information to evaluate one of the required areas, then no conclusions shall be drawn nor recommendations made concerning that required area.

Evaluation instruments and processes will be subject to change as more is learned in this area. As culturally sensitive tests become available, these should be used in place of other tests when appropriate. Because measures of risk are imperfect at this time, evaluation and assessment must be done by collecting information through a variety of methods. Evaluation and assessment therefore currently involve the integration of physiological, psychological, historical, cultural, and demographic information to adequately assess a sex offender's level of risk and amenability to treatment. When the evaluator is in doubt, s/he should err on the side of protecting community safety in drawing conclusions and making recommendations.

4.200 Standards of Practice for Polygraph Assessment

4.210 Equipment. Polygraph examiners shall use a computerized polygraph system or a late model (1980's to present) state-of-the-art, four or five channel polygraph instrument that will simultaneously record the physiological phenomena of abdominal and thoracic respiration, galvanic skin response, and the cardiovascular system.

If the examiner employs a computerized polygraph system, recognized scoring software must be used (e.g. the Johns Hopkins Applied Physics Laboratory scoring algorithm). Computerized charts must also be independently hand scored by the examiner.

4.220 Examination Length. The duration of each examination (including the pre-test, in-test, and post-test phases) shall be scheduled for a minimum of 90 minutes. Time begins when the examinee enters the examination room with the examiner and ends when the examinee departs after the conclusion of the polygraph examination.

4.230 Design of Test Questions. In order to design an effective polygraph examination and adhere to standardized and recognized procedures the relevant test questions should be limited to no more than four (4) and shall:

- Be simple, direct and as short as possible
- Not include legal terminology that allows for examinee rationalization and utilization of other defense mechanisms
- Not include mental state or motivation terminology
- The meaning of each question must be clear and not allow for multiple interpretations
- Each question shall contain reference to only one issue under investigation
- Never presuppose knowledge on the part of the examinee
- Use language easily understood by the examinee and all terms used by the examiner should be fully explained to the examinee
- Be easily answered yes or no
- Avoid the use of any emotionally laden terminology (such as rape, molest, murder, etcetera) and use language that is behaviorally descriptive

4.240 Examination Procedures. Examiners shall use a recognized Comparison Question Technique (CQT).

Examiners shall adhere to the established ethics, standards, and practices of the American Polygraph Association (APA). In addition, clinical polygraph examiners shall demonstrate competency according to professional standards and conduct all polygraph examinations in a manner that is consistent with the reasonably accepted standard of practice in the clinical polygraph examination community.

Examiners shall use the following specific procedures during the administration of each examination:

- A. The examinee shall agree in writing or on video tape to a standard waiver/release statement. The language of the statement should be agreed upon prior to the polygraph examination with the therapist, probation/parole officer, case manager, or prison treatment provider;
- B. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual polygraph examination;
- C. The testing process shall be completely explained to the examinee, including an explanation of the instrumentation used and causes of general nervous tension;
- E. Examiners shall review and explain all test questions to the examinee. Examinees must demonstrate that they comprehend the meaning of each question;
- F. Surprise or trick questions are forbidden during the administration of primary test charts;
- G. All test questions must be formulated to allow only Yes or No answers;
- H. An optional acquaintance/practice test may be run;

- I. A minimum of three primary test charts shall be administered on the primary issue(s);
- J. Test results shall be reviewed with the examinee;
- K. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination.

Videotaping of polygraph examinations is required. Video tapes of the entire examination shall be maintained for a minimum of three years from the date of the examination.

4.250 Peer Review. Examiners shall use a DOC approved quality control assurance process that allows for periodic independent review of all documentation, polygraph charts, and reports. The review should cover the quality assurance protocol given in Appendix I for post conviction sex offender polygraph testing.

4.260 Reporting. Examiners shall issue a written report. The report must include factual, impartial, and objective accounts of the pertinent information developed during the examination, including statements made by the subject. The information in the report must not be biased, or falsified in any way. The examiner's professional conclusion shall be based on the analysis of the polygraph chart readings and the information obtained during the examination process. All polygraph examination written reports must include the following:

- Date of test or evaluation
- Name of person requesting exam
- Name of examinee
- Location and supervision status of examinee in the criminal justice system (incarcerated offender, offender on probation/parole, etc.)
- Reason for examination
- Date of last clinical examination
- Examination questions and answers
- Any additional information deemed relevant by the polygraph examiner (e.g. examinees' demeanor)
- Reasons for inability to complete exam, information from examinee outside the exam, etc.
- Results of pre-test and post-test examination, including answers or other relevant information provided by the examinee.

4.300 Standards of Practice for Plethysmograph Assessment. Plethysmograph testing is intended for use in treatment. It is not intended for use in a court of law to determine the guilt or innocence of an individual. As in other assessment procedures, it cannot determine if an individual committed a specific act.

4.310 Examination Procedures. A plethysmograph examiner shall adhere to the "Guidelines for the Use of the Penile Plethysmograph," published by the Association for the Treatment of Sexual Abusers, ATSA Practitioner's Handbook and shall demonstrate competency according to professional standards and conduct plethysmograph examinations in a manner that is consistent with the reasonably accepted standard of practice in the plethysmograph examination community.

Plethysmograph examiners shall adhere to the following specific procedures during the administration of each examination:

1. The examiner shall obtain the informed assent of the offender for the plethysmograph examination, and shall inform an offender of the examination methods, how the information will be used, and to whom it will be given. The examiner shall also inform the offender about the nature of the evaluator's relationship with the offender and with the court. The examiner shall respect an offender's right to be fully informed about the examination procedures, and results of the examination should be shared with the offender and any questions clarified;
2. The examinee shall also sign a standard waiver/release of information statement. The language of the statement should be coordinated prior to the plethysmograph examination with the therapist, probation/parole officer, case manager, or prison treatment provider;
3. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual plethysmograph examination;
4. The testing process shall be completely explained to the examinee, including an explanation of the instrumentation used and causes of general nervous tension;
5. Test results shall be reviewed with the examinee;
6. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination.

Plethysmograph examinations should never be used in isolation. The results must be utilized in conjunction with other evaluative measures or as a part of a treatment program to effectively assess risk.

4.320 Stimulus Materials. See Section 3.421

4.330 Reporting. The plethysmograph examiner shall prepare a written report of findings summarizing the results of testing. Reports must include the following:

- Date of test or evaluation
- Name of person requesting exam
- Name of examinee
- Location and supervision status of examinee in the criminal justice system (incarcerated offender, offender on probation/parole, etc.)
- Type of examination (e.g., initial assessment, follow-up assessment, aversive conditioning session)
- Date of last clinical examination
- A description of the type of stimuli and method of presentation

- Any additional information deemed relevant by the plethysmograph examiner (e.g. examinees' demeanor)
- Reasons for inability to complete exam if relevant
- Results of the examination, including deviant and non-deviant arousal patterns and/or ability to control deviant arousal

4.400 Standards of Practice for Abel Assessment. Abel assessment is intended for use in treatment. It is not intended for use in a court of law to determine the guilt or innocence of an individual. As in other assessment procedures, it cannot determine if an individual committed a specific act.

4.410 Examination Procedures. An Abel assessment examiner shall adhere to the guidelines for administration and interpretation that were recommended by the licensed trainers of the instrument. They shall demonstrate competency in the administration of the instrument and in the interpretation of data stemming from the examination. They shall follow guidelines consistent with the reasonably accepted standards of practice in the Abel assessment examination community.

Abel assessment examiners shall adhere to the following specific procedures during the administration of each examination:

1. The examiner shall obtain the informed assent of the offender for the Abel assessment examination, and shall inform an offender of the examination methods, how the information will be used, and to whom it will be given. The examiner shall also inform the offender about the nature of the evaluator's relationship with the offender and with the court. The examiner shall respect an offender's right to be fully informed about the examination procedures, and results of the examination should be shared with the offender and any questions clarified;
2. The examinee shall also sign a standard waiver/release of information statement. The language of the statement shall be coordinated prior to the examination with the therapist, probation/parole officer, case manager, or prison treatment provider;
3. The examiner shall elicit relevant historical information from the examinee prior to administering the actual examination;
4. Test results shall be reviewed with the examinee;
5. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination.

Abel assessment examinations should never be used in isolation. The results must be utilized in conjunction with other evaluative measures or as a part of a treatment program to effectively assess risk.

4.420 Reporting. The Abel assessment examiner shall prepare a written report of findings summarizing the results of testing. Reports must include the following:

- Date of test or evaluation
- Name of person requesting exam
- Name of examinee
- Location and supervision status of examinee in the criminal justice system (incarcerated offender, offender on probation/parole, etc.)
- Type of examination (e.g., initial assessment, follow-up assessment).
- Date of last clinical examination
- A description of the type of stimuli presented
- Any additional information deemed relevant by the plethysmograph examiner (e.g. examinees' demeanor)
- Reasons for inability to complete exam if relevant
- Results of the examination, including deviant and non-deviant interest patterns.

5.000 STANDARDS OF PRACTICE FOR SEXUAL OFFENSE SPECIFIC TREATMENT

5.100 Sex Offender Program Referral Process

Community program referrals will be coordinated by individual area Probation & Parole Offices and Institutional program referrals will be coordinated by Institutional Probation Officers. Some treatment providers are under contract with DOC and others are not. Offenders in the community who can pay for their own sex offender programming may enter programming with Approved Providers in private practice but the Supervising Officer must approve the particular approved provider that the offender selects making sure the provider is the most appropriate choice for that offender.

Offenders who cannot pay for services will be referred to a contract provider. When a contract provider has a vacancy, the Probation & Parole Officer or the Institutional Probation Officer will refer the next sex offender eligible for program to the contractor providing treatment.

Furlougees will be referred to community sex offender programs by the institutional furlough officer who will coordinate with Probation & Parole.

All sex offenders referred to a DOC contract program must be admitted into the program provided there is an opening available and the offender meets the eligibility and amenability requirements. Clinicians shall give input as to the appropriateness of referrals into their program. They shall use their clinical judgment to advise DOC as to the appropriateness of the referral. An offender may be judged as inappropriate for a particular program for a number of reasons. For example, the clinician may determine the offender is too high risk to be treated in the community and that community treatment may actually increase his risk. They may also determine that the offender is likely to be disruptive to their program. The clinician may indicate that they don't have the specialty skills to deal with the problems presented by the offender. The clinician shall provide an explanation in writing when offenders are not accepted into the program.

The Probation & Parole Contract Action Officer will monitor the available community openings. The Institutional Probation officer at the program site will monitor available openings in the institutional program. Sex offenders with the least amount of time left on probation/parole will be given a priority for admission into the community program. Offenders with the closest Projected Release Date or Parole Eligibility Date will be given preference in institutional programs.

On occasion, Approved Providers may find themselves in conflict with providing services to a particular offender. In such cases, Approved Providers may refuse to accept an offender prior to program admission or after program admission. These cases will be reviewed by the field probation/parole officer or, if need be, by the Criminal Justice Planner for Offender Programs prior to finalization of such decisions. Such decisions and their rationale shall be documented in the Management Team Report.

5.200 Program Eligibility Criteria

All furlougees, parolees, and probationers will be referred for assessment and/or programming by the Probation & Parole Office. In order to establish uniform criteria for eligibility into any of the SOMP's, DOC has adopted the following *minimum* mandatory criteria for acceptance:

- a. The offender has engaged in sexual offending behavior and has been convicted of such or is willing to acknowledge that he has engaged in sexually assaultive behavior (see note on denial below). In **most** cases there must be an identified victim or victims as well as victim version(s) of the offense(s) to which the offender can be held accountable. In some cases this may require that the court clarify that there was an identified victim, and specify the sexually assaultive behavior that was tied to the offense of record, whether or not the conviction is for a sexual offense as defined by Alaska Statutes. However, in some cases there may not be a specific victim identified and/or a victim version of the offense such as child pornography cases in which a specific victim cannot be identified or cases of bestiality in which there is no victim version of the offense. Nevertheless, these offenders may be judged to be in need of sex offender treatment.
- b. The offender requests to participate in the program and completes an application form which is acceptable to the Case Management Team.
- c. The offender must be sentenced. Unsentenced sex offenders, or offenders who are appealing their conviction for a sexual offense, are not eligible for participation in sex offender treatment programs. Offenders who are unsentenced or appealing their convictions have an investment in presenting themselves in the best possible light. They are aggressive in the pursuit of their defense and are motivated to protect themselves. This results in a high probability of denial, minimization, justification, blaming and other forms of psychological self-defense. While this may make sense within the framework of a legal proceeding, it is counterproductive in assessment and rehabilitation. Indeed one of the first tasks a sex offender must accomplish is to overcome the tendency to deny or minimize his actions. Therefore, putting an offender in program while he is engaged in continuing legal proceedings creates a psychological bind for the offender in which he either has to jeopardize his legal defense by being open during programming or conceal information in order to protect his legal defense. If an offender lies to his therapist and/or his therapy group during his legal proceedings it will be more difficult for him to retract his false statements later. In fact, cognitive dissonance theory (Festinger, 1957, 1964) predicts that he may come to believe his self-pronounced falsehoods. One therefore runs the risk of complicating this offender's rehabilitation by involving him in the rehabilitation process prior to sentencing and/or appeal proceedings. In a sense this may make him more difficult to reach therapeutically and less amenable to rehabilitation in the long run. Offenders who are appealing their sentence rather than their conviction are eligible for programming. However, if results of a sentence appeal/modification would result in the offender not meeting the time eligibility requirements of a given program, the appeal must first be ruled on by the court before the offender is considered for placement in that program.
- d. Offenders who deny their offense may be admitted into the program provisionally at the discretion of the approved provider but will have six months to resolve their denial issues. They will be required to pass a specific issue polygraph on the instant offense within the six month time period. Failure to do so is grounds for removal from the treatment program.
- e. Interpretive assistance will be provided to offenders for whom English is a second language as necessary and within available resources.
- g. The offender did not engage in sadistic/ritualistic behaviors with his victim(s).

- h. The offender is not actively psychotic or suffering from any disabling major mental disorder(s) with active symptoms so severe as to preclude him from program benefit. Offenders with such symptoms should receive medical attention and reapply after their condition has stabilized.
- i. The offender does not suffer from a documented severe medical condition that precludes him from participating in the program.

5.300 Amenability to Treatment

Successful rehabilitation is not possible unless certain basic criteria are met by the offender. For example, the offender must have sufficient time remaining on his sentence or supervision to participate meaningfully in program. Offenders who meet the basic requirements are said to be eligible for sex offender programming. Once eligibility has been determined (see above section on eligibility requirements) an offender may begin the process of evaluation for sex offender program services. ***Just because an offender is eligible for sex offender programming does not mean that he is amenable to the rehabilitation process that is available.***

Amenability assessment is a process that begins when the offender undergoes a risk assessment or first enters sex offender programming. Amenability to treatment is determined through clinical interviews, various forms of psychological assessment and through the process of actual involvement in program. Amenability is typically determined within the first 90 days of programming. In order for an offender to benefit from programming he will require certain abilities and attitudes and have to meet certain other requirements. Some of these are described in the eligibility requirements. Beyond this the offender will need to demonstrate other attitudes and behaviors. These include:

- A willingness to lower his self-protective defenses in order to explore the process of how he offends. This means he must acknowledge responsibility for offenses for which he was convicted and be willing to describe in detail his thinking, emotions and behaviors prior to, during, and after the offense(s). He must be willing to discuss personal history that may be relevant to understanding the offense pattern(s). Clinical staff shall determine on an individual basis whether an offender has a sufficient level of disclosure and acceptance of responsibility to be amenable to the rehabilitation process. Offenders are required to work on disclosure and responsibility issues as they progress in program or face program removal.
- A willingness to follow institutional rules (for incarcerated offenders) as well as the conditions of probation/parole
- A willingness to change maladaptive behavior patterns within himself rather than try to change others and/or the environment
- A willingness to accept corrective feedback and constructive criticism from others and a willingness to make an active attempt to incorporate this feedback into his daily life
- A willingness to give feedback to others in a constructive fashion
- A willingness to demonstrate appropriate control over the expression of anger and refrain from aggressive or destructive behavior

- A willingness to enter and actively participate in group therapy and to remain actively involved with the group process
- A willingness to apply the principles learned in program to daily life rather than rote memorization and verbalization of concepts.
- A willingness to participate in all assessment procedures and techniques including polygraph testing and phallometric assessment.
- A willingness to attend all classes, groups, individual and/or joint counseling sessions, and complete all assignments and follow all other recommendations of the Management Team
- A willingness to abide by all prohibitions and restrictions ordered or recommended by the court and/or the Management Team.

Within a few months offenders should show substantial efforts towards achieving the qualities outlined above. Once in program they will need to continue their efforts along these lines or face program removal. A determination of amenability to rehabilitation can usually be made within a few months from the time the offender enters a program. Providers will make a determination of each offender's amenability. This will be clearly documented in the clinical record. In some cases an offender may be removed from program and required to complete remedial or adjunct program work. This could include substance abuse treatment, a denier's group or other forms of programming. Staff will make a clinical decision regarding amenability to treatment and recommend the specific site of programming if appropriate.

Offenders who are judged to be unamenable to treatment may reapply for admission at a later time, but will be required to demonstrate that they have changed attitudes and behavior patterns counter-productive to rehabilitation. In cases when the court has ordered participation in sex offender treatment a petition to revoke probation/parole will be filed by the institutional or field probation officer whenever an offender with such an order has been removed for cause from program or found unamenable to treatment. In these cases procedures shall be followed as outlined in Policy and Procedure 811.16.

5.400 Program Descriptions

Each contractor providing sex offender services for DOC shall be required to develop and maintain an up-to-date written program description. The program description will describe the purpose, philosophy, and program services, and should be developed in conjunction with DOC staff. The program description shall be approved by the Criminal Justice Planner for Programs, or designee, prior to publication and distribution. The SOMP must operate according to this program description.

The program description shall be written in such a fashion as to be understood by program participants and shall be made available to them.

5.500 Confidentiality

An approved provider shall obtain signed waivers of confidentiality based on the informed assent of the offender. If an offender has more than one therapist or treatment provider, the waiver of confidentiality shall extend to all therapists treating the offender. The waiver of confidentiality shall extend to the supervising officer and all members of the management team and, if applicable, to the Office of Children's Services and other individuals or agencies responsible for the supervision of the offender.

Waivers of confidentiality should 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 programming and (2) information about risk, threats, and/or possible escalation of violence.

A provider shall notify all clients of the limits of confidentiality imposed on therapists by the mandatory reporting law.

A 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 confidential.

When indicated and consistent with the informed assent of an offender, a provider shall obtain a waiver of confidentiality in order to communicate with the victim's therapist, Guardian ad Litem, custodial parent, guardian, caseworker or other professional involved in making decisions regarding reunification of the family or an offender's contact with past or potential child victim(s).

A provider shall obtain specific releases which waive confidentiality for communications with other parties in addition to those described in this standard.

Waivers of confidentiality will be required of the sex offender by the (1) conditions of probation, parole, and/or furlough and 2) the treatment provider-client contract. Notwithstanding such waivers of confidentiality, Approved Providers shall safeguard the confidentiality of client information from those for whom waivers of confidentiality have not been obtained.

5.600 DOC Contract Payment for Services

Reimbursement for DOC paid clinical services is accomplished through contracts between the service provider and DOC. Levels of reimbursement are clearly stated in the contract agreements.

Services for sex offenders in community sex offender programming must be provided on a prioritized basis. Contact the CJP for offender programs to obtain a copy of the current reimbursement policy and practices. Reimbursement for services is defined in each contract.

5.610 Offender Payment for Services

The supervising officer shall determine each offender's ability to pay for sex offender programming. To the extent that offenders can afford their own rehabilitation they shall be required to pay for it.

Under some circumstances, an approved provider, probation officer or other member of the Management Team may suggest services be provided that are beyond what DOC subsidizes. Offenders may therefore be asked to pay for these services. Any such services that are added to an offender's management plan must be reviewed by the case Management Team. These services must be written into the management plan and the plan approved and signed by all members of the Case Management Team including the P.O. and the offender. The plan must be reviewed and approved by DOC. ***Approved Providers must obtain DOC approval in advance before requiring an offender to participate in extra services for which he will be responsible for payment.***

In the event that the services are required but the offender is unable to afford the costs, the contractor may request that DOC provide funding for the services needed. These requests will be reviewed by the Criminal Justice Planner for Offender Programs. A request for payment of additional services must be made in writing to the Criminal Justice Planner for Offender Programs. A rationale must be provided to DOC as to why additional services are necessary. Extra services are approved on a case by case basis and not unilaterally. Additionally, the Probation Officer must determine that the offender can not afford the services without causing undue hardship on himself and/or his family. In some cases reimbursement for needed services may be denied due to limitations in funding.

An offender may not be discharged from program by a contractor for non-compliance with a plan for additional services that has not been approved by DOC.

5.700 Approved Provider-Client Contract

An approved provider shall develop and utilize a written contract with each sex offender (hereafter called "client" in this section of the Standards) prior to the commencement of programming. The contract shall define the specific responsibilities of both the provider and the client.

The contract shall explain the responsibility of an approved provider to:

- Define and provide timely statements of the costs of assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations;
- Describe the waivers of confidentiality which will be required for a provider to provide programming to the client for his/her sexual offending behavior; describe the various parties with whom information will be shared during programming; describe the time limits on the waivers of confidentiality; and describe the procedures necessary for the client to revoke the waiver;
- Describe the right of the client to refuse programming and/or to refuse to waive confidentiality, and describe the risks and potential outcomes of that decision;

- Describe the type, frequency, and requirements of the program and outline how the duration of programming will be determined, and;
- Describe the limits of confidentiality imposed on therapists by the mandatory reporting law.

The contract shall explain any responsibilities of a client (as applicable) to:

- Pay for the cost of programming for him or herself, and his or her family, if applicable;
- Pay for the cost of assessment and treatment for the victim(s) and their family(ies), when ordered by the court, including all medical and psychological tests, physiological testing, and consultation;
- Inform the client's family and support system of details of past offenses which are relevant to ensuring help and protection for past victims and/or relevant to the relapse prevention plan. Clinical judgment should be exercised in determining what information is provided to children;
- Actively involve relevant family and support system, as indicated in the relapse prevention plan.
- Notify the approved provider of any changes or events in the lives of the client and members of the client's family or support system;
- Participate in polygraph testing as required in the Standards and Guidelines and, if indicated, plethysmograph testing;
- Assent to be tested for sexually transmitted diseases and HIV, and assent for the results of such testing to be released to the victim by the appropriate person, and;
- Comply with the limitations and restrictions placed on the behavior of the client, as described in the terms and conditions of probation, parole, or furlough and/or in the contract between the provider and the client.

The contract shall also, (as applicable):

Provide instructions and describe limitations regarding the client's contact with victims, secondary victims, and children;

- Describe limitations or prohibitions on the use or viewing of sexually explicit or violent material;
- Describe the responsibility of the client to protect community safety by avoiding risky, aggressive, or re-offending behavior, by avoiding high risk situations, and by reporting any such forbidden behavior to the provider and the supervising officer as soon as possible;
- Describe limitations or prohibitions on the use of alcohol or drugs not specifically prescribed by medical staff, and;
- Describe limitations or prohibitions on employment or recreation.

5.800 Sex Offender Specific Programming.

A provider who treats sex offenders under the jurisdiction of the criminal justice system must use sex offense-specific programming (See Definition Section). They must be approved by DOC at Level 2, Level 1, or Supervisor Level.

A provider shall employ methods that are supported by current professional research and practice. Modes of therapy may include intake/assessment, psychological testing, physiological testing, polygraph assessment, individual, group, and family therapy, educational classes, behavioral therapy, and medication for reduction of sexual drive.

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

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

The content of offense-specific programming for sex offenders shall be designed to:

- Reduce offenders' denial and defensiveness;
- Decrease and/or manage 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 that may lead to a reoffense. These may include sexual and non-sexual risk factors;
- Teach offenders self-management methods to avoid a sexual re-offense;
- Identify and address the offenders' thoughts, emotions, and behaviors that facilitate sexual re-offenses or other victimizing or assaultive behaviors;
- Identify and teach the offender to correct cognitive distortions;
- Teach offenders to recognize their dysfunctional personality patterns and the core schema or belief systems underlying those patterns and teach offenders methods to correct for these patterns;
- 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 victims;

- 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 the victim, and promoting emotional restitution for the victim(s). This is not a letter of apology;
- Identify and treat the effects of trauma and past victimizations on 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. The timing of trauma work with offenders must be carefully considered by the Case Management Team. If the trauma work triggers diminished responsibility for offending behavior it shall be terminated and not resumed until these issues are successfully resolved;
- 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 treatment referrals, as indicated, for offenders with co-existing medical, pharmacological, mental, substance abuse and/or domestic violence issues, or other disabilities;
- Maintain communication with other significant persons in offenders' support systems when indicated, and to the extent possible, to 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, and;
- Identify and address issues of anger, power, and control.

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

5.810 SOMP Assessment and Program Components

The following services may be offered in SOMP's. Some services may be encouraged in DOC contract programs but not reimbursed due to funding restrictions. All Contractors must adhere to their contract with regard to reimbursable services.

5.811 Intake/Assessment

Each program participant will participate in clinical interviews to collect information germane to risk assessment, risk management, and amenability to rehabilitation. This may include social/family history, sexual history, mental status examinations, and other areas as deemed important by program staff such as crisis evaluations. Some information may already be available in a DOC risk assessment and will not need to be repeated.

5.812 Psychological Testing

Most sex offenders will have had a risk assessment prior to their release from prison. These assessments may include psychological testing. Psychological testing may be performed on offenders entering a SOMP if the testing required has not been previously performed or if it is outdated. Psychological evaluations may be conducted only by a licensed psychologist or psychological associate.

5.813 Physiological Assessment

Physiological assessment of sexual interest and arousal patterns will be encouraged for all offenders participating in an SOMP. This service may be performed only by those with documented experience and training. Before an offender participates in a physiological assessment, he must read and sign a Physiological Assessment Consent Form (Appendix J).

5.814 Polygraph Assessment

Beginning July 1, 2007 all sex offenders are required to submit to polygraph assessment. Offenders who deny all or part of their instant offense as described in the Presentence Investigation, charging documents, or police reports will be subject to a specific issue polygraph exam to resolve conflicts in the official and offender versions of the offense. They will have 180 days to pass this polygraph assessment or face program removal. All sex offenders must also pass a sexual history polygraph prior to being successfully discharged from program. They are also subject to monitoring polygraphs every 6 months or at the discretion of the supervising officer.

5.815 Sex Offender Management Plan: A provider shall develop a written management plan based on the needs and risks identified in current and past assessments/evaluations of the offender. The individualized management plan will be composed of specific goals determined by the Management Team to be appropriate to the offender in program. Offenders will only be required to complete goals that are relevant to their case as determined by the Management Team. The management plan may be revised during the offender's involvement in program and as additional information becomes available about the offender's issues and relapse process. The management plan shall:

- Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and/or unwanted contact with the offender
- Be individualized to meet the unique needs of the offender
- Identify the issues to be addressed, including multi-generational issues if indicated, the planned intervention strategies, and the goals of programming
- Define expectations of the offender, his/her family (when possible), and support systems
- Address the issue of ongoing victim input

5.816 Group Counseling Sessions

There are several advantages to group therapy (with the group comprised only of sex offenders) that have caused it to become the preferred method of sex offense-specific programming. When more experienced and advanced offenders discuss their offense patterns, less experienced and more defensive sex offenders may become desensitized to

the anxiety of admitting to their crimes. Feedback from peers is oftentimes easier for group members to accept. Sex offenders understand the behavior patterns involved in sexual offending and can therefore recognize these patterns in other offenders and make appropriate observations and interventions. Offenders learn from each other in group, making treatment progress more rapid and more efficient.

At a minimum, any method of programming used must conform to the Standards for content of treatment (see below) and must contribute to behavioral monitoring of sex offenders. The sole use of individual therapy is not recommended with sex offenders, and shall be avoided except when geographical--specifically rural--or disability limitations dictate its use. Family therapy is used as necessary and appropriate as determined by the Case Management Team. The use of male and female co-therapists in group therapy is highly recommended and may be required by the supervising agency. Group therapy may need to be supplemented by treatment for drug/alcohol abuse, marital/family therapy, individual counseling and individual crisis intervention. However, group sex-offense specific programming should remain the primary modality utilized with sex offenders. The ratio of therapists to sex offenders in a treatment group shall not exceed 1:10. Treatment group size shall not exceed 12 sex offenders. It is understood that the occasional illness or absence of a co-therapist may occur, which will cause the treatment group to exceed this ratio. It is also understood that a particular program may be structured in such a way that specific didactic modules of psycho-educational information are presented to larger groups of sex offenders at one time. Such psycho-educational information is a component of, but not a substitute for sex offense-specific programming. These circumstances constitute occasional exceptions to the standard described above. The test for compliance with this standard will be the regularity with which the ratio of therapists to sex offenders is congruent with the ratio given above. DOC believes that the rehabilitation of sex offenders is sufficiently complex and the likelihood of re-offense sufficiently high that the client to therapist ratio and group size should be fairly small. . A minimum of 1 group per week in community programs must be provided. Institutional programs may have more frequent group therapy sessions. Exceptions to this configuration must be approved by DOC in advance.

5.817 Individual Counseling Sessions

Individual therapy is an adjunct to group therapy and focuses on specific individual tasks the offender needs to work on outside the group. This may include behavioral therapy, work on personal victimization issues, and other issues deemed appropriate by the Case Management Team. Offenders that are judged to be amenable to rehabilitation are eligible for individual counseling. Offenders must receive at least one hour of individual counseling per month by contract personnel until this is judged to be no longer necessary by the Case Management Team. Individual counseling sessions are defined as one to one counseling sessions with the program participant and contract staff or other approved provider.

5.818 Family Counseling Sessions

Family therapy may be recommended if appropriate as determined by the Case Management Team. Family counseling sessions may occur in the context of individual family sessions or family group sessions. Involvement of children in family sessions should be restricted to individual family sessions and should be infrequent. The impact of

family therapy on victims and other family members will be assessed prior to the initiation of family treatment (see Chapter on Victim Issues).

5.819 Education Classes

Educational classes may occur within the context of the therapy groups or larger classes within community programs. Educational classes may be co-taught by the approved provider and the supervising probation officer. Education classes may include orientation groups, high risk management groups, denier groups, and groups focused on other specific topics relevant to relapse prevention.

5.820 Behavioral Therapy

All offenders in SOMP's, participating in behavioral therapies, will sign an informed consent form (Appendix K) prior to engaging in behavioral therapy. Behavioral therapy shall be conducted in strict adherence to ethical and professional standards. Behavioral therapy will not be used as a form of punishment. Providers of this service must have documented training and experience.

5.821 Medication Therapy for Reduction of Sexual Drive

Anti-androgen therapy (AAT) or other medication used to reduce sexual drive shall only occur under the supervision of a licensed medical doctor. Any program participant participating in such therapy will be required to sign an informed consent (Appendix L) prior to the first administration of the drug. This therapy will not be used for experimental purposes or as a form of punishment. The use of this therapy method is determined on a case by case basis.

5.822 Non-Standard Practices.

DOC generally expects that staff, Contractors and other Approved providers will follow the standard practices and procedures of their respective professions when providing rehabilitation services to sex offenders. There may, however, be occasions when Contractors and other Approved Providers may choose to employ a practice which is not standard in their field. An example is a therapist who wishes to provide therapy via telephone to an offender in a remote area of the State.

Whenever a therapist wishes to use a non-standard practice, this practice must first be approved by the Approved Supervisor, if there is one, and then by DOC. A written explanation of the procedure to be used along with the rationale for its use should be sent to the Criminal Justice Planner for Offender Programs. A copy of the offender's Management Plan signed by the Approved Supervisor and other members of the Case Management Team should accompany the written explanation of the proposed non-standard practice. Approval from DOC must precede implementation of the procedure.

5.900 Special Needs Populations

Rehabilitation must be tailored to a variety of groups that may have special needs by virtue of their gender, cultural differences, physical and mental disabilities, or other factors that require specialized services.

5.910 Alaska Native Sex Offenders

Alaska Natives constitute approximately 17% of the State's population and approximately 34% of the population of incarcerated felons. Alaska Native sex offenders who are non-English speaking or for whom English is a second language will receive assistance when necessary.

In recognizing the specific cultural differences of Alaska Natives and their respective customs, DOC will make every effort within existing resources to assure that these cultural differences and customs are recognized and respected by DOC and contractor personnel. DOC will encourage Approved Providers providing sex offender rehabilitation services to be sensitive to Alaska Native Cultural issues and will arrange periodic education of personnel working with the SOMPs in regard to Alaska Native culture when resources allow.

Elders and other Alaska Natives will be encouraged to work with the sex offender programs when appropriate and coordinated with program staff. Modifications to the rehabilitation process which incorporate traditional values, traditional healing methods and other techniques which enhance the rehabilitation of native persons are encouraged but must be consistent with the DOC treatment model.

5.920 Developmentally Disabled Sex Offenders

Some sex offenders within DOC institutions are developmentally disabled or learning impaired. The Department recognizes that these individuals require specialized programming that is consistent with the standards and needs of the population. Such programming will be offered as appropriate and available within existing resources.

Some Approved Providers may be specialized in working with individuals who have developmental disabilities or learning impairments. Offenders should be referred to these providers whenever possible.

5.930 Other Disabled Sex Offenders

DOC recognizes that sex offenders receiving rehabilitation services may occasionally have physical disabilities, e.g. hearing or vision impairments, which will require some adjustment(s) be made in service delivery. Reasonable accommodations will be made to allow for these adjustments in service provision unless it would result in a fundamental alteration of the program or undue financial and administrative burden.

5.940 Female Sex Offenders

It recognizes that some female sex offenders charged with sexual offenses will need to receive rehabilitation services which are separate from those offered to the male sex offenders, in that they can not be served within the same physical setting or therapy groups.

Female sex offenders who are identified within the correctional system and request sex offender programming, will be referred to appropriate institutional staff or sex offender Approved Providers in the community. Individual and/or group services will be provided to these women separate from the male offender groups.

6.000 EVALUATION OF PROGRESS IN TREATMENT

6.100 Completion of Court-Ordered Treatment

Completion of programming ordered by the court should be understood as the cessation of court-ordered, offense-specific programming, not the end of offenders' rehabilitative needs or the elimination of risk to the community. If risk increases, programming may be reinstated. The sex offender's community supervision team shall consult about the completion of programming. This decision shall come after the evaluation and assessment, management plan, course of program sequence, and the minimum of a non-deceptive disclosure (sexual history) polygraph examination and two or more consecutive non-deceptive maintenance polygraph examinations. The maintenance polygraph examinations shall test the offender's compliance with court rules, supervision conditions, program contract provisions (including complete abstinence from grooming of victims) and full, voluntary compliance with all conditions required to prevent re-offending behavior. These two or more non-deceptive polygraph examinations must be those most recent prior to termination of programming. (See definitions for non-deceptive polygraph examination results.) A failed polygraph examination may not be used as the sole reason to deny successful completion of program. The team should carefully consider termination of programming based on maintaining community safety. Offenders who pose an ongoing threat to the community, even while demonstrating progress in program, may require ongoing supervision and/or programming to manage their risk. Any exception made to any of the requirements for program completion must be made by a consensus of the Case Management Team. In this case, the team must document the reasons for the determination that program completion is appropriate without meeting all of the standard requirements and note the potential risk to the community.

To determine the recommendation for the successful completion of program, the provider shall:

- Assess actual changes in a client's potential to re-offend prior to recommending termination;
- Attempt to repeat, where indicated, those assessments that might show changes in a client;
- Assess and document how the goals of the management plan have been met, what actual changes in a client's re-offense potential have been accomplished, and what risk factors remain, particularly those affecting the emotional and physical safety of the victim(s);
- Seek input from others who are aware of a client's progress as part of the decision about whether to discharge the offender from program;
- Report to the supervising officer regarding a client's compliance with the program and recommend any modifications in conditions of community supervision.
- At the end of this reassessment process, inform the client regarding the recommendation to end court-ordered programming.

Prior to discontinuing offense-specific programming, a provider shall, in cooperation with the Case Management Team, develop an aftercare plan that includes ongoing behavioral monitoring, such as periodic polygraph examinations. Such monitoring is intended to motivate the offender to avoid high-risk behaviors that might be related to increased risk of re-offense.

6.200 Treatment Providers' Use of the Polygraph, Plethysmograph and Abel Assessment

A treatment provider may employ methods that integrate the results of plethysmography, the Abel Assessment or other physiological testing, as indicated. If plethysmography is used, the examiner must meet the standards for plethysmography as defined in the ATSA Practitioner's Handbook. If the Abel Assessment is used, the treatment provider or evaluator must be trained and licensed as a site to utilize the instrument.

It is recommended that a provider employ plethysmography as a means of gaining information regarding the sexual arousal patterns of sex offenders or the Abel Assessment as a means of gaining information regarding the sexual interest patterns of sex offenders.

Physiological data can be useful in assessing a client's progress in therapy. However, physiological assessment data of this type cannot be used as the sole basis for determining an offender's risk nor, for determining whether an individual has committed or is going to commit a specific deviant sexual act. Providers who utilize this data shall be aware of the limitations of plethysmography and the Abel Assessment and shall recognize that this physiological data is only meaningful within the context of a comprehensive evaluation and/or rehabilitation process.

In cooperation with the supervising officer, the provider shall employ methods that incorporate the results of polygraph examinations, including specific issue polygraphs, disclosure polygraphs, and maintenance polygraphs. Exceptions to the requirement for use of the polygraph may be made only by the Case Management Team.

The Case Management Team shall determine the frequency of polygraph examinations, and the results shall be reviewed by the team. The results of such polygraphs shall be used to identify issues to focus on in programming and for behavioral monitoring.

Because of the epidemic nature of sexual assault, there is a need for more and better methods to accurately assess, rehabilitate, and monitor sex offenders. Polygraph testing is an effective tool for informing the Case Management Team about the type and severity of abusive behavior patterns, and compliance with rehabilitation and supervision conditions, and can assist in suggesting necessary levels of supervision and rehabilitative programming. In addition, polygraph testing can improve outcomes by shortening the denial phase. It is recommended that polygraph exams occur at least every six months, and more frequently as necessary.

There are distinct clinical functions within the levels of Full Operating and Associate Level Providers. Refer to an earlier section of this document for specifics regarding these functions and qualifications.

6.300 Case Staffing/Case Management Team Meetings

Case staffing involves regularly scheduled face-to-face meetings with DOC and clinical staff for the purposes of case review/consultation regarding offenders in program and/or under supervision. For DOC contract billing purposes, these meetings are to be billed under Program Consultation. Case Management Team meetings must:

- a. Be held at least once per month for a maximum of two hours for every 10 sex offenders in the community program reviewed, and a minimum of one hour for every 10 Sex offenders reviewed.
- b. Determine the cases that are to be discussed during the case Management Team meeting. Cases should be prioritized whenever possible prior to the case staffing.
- c. Include case discussion on those sex offenders prioritized for case staffing, or additional times established for case discussion in a separate meeting.

Time restraints may require that cases to be staffed be prioritized according to the following criteria:

1. Cases in crisis, offenders showing lapse behavior or any cases where there is a concern about safety (e.g., high scores or IN scores on the Acute Dynamic risk assessment)
2. Cases going back to court for PTR
3. Cases being terminated from treatment
4. Cases that have been approved for victim contact or reunification efforts
5. Cases with medium-high or above Static 99/Static 2002R scores or high scores on another risk instrument
6. New cases and others who haven't been staffed within 6 months
7. Cases in which the offender is scheduled for a polygraph exam

The focus of case staffings is to:

1. Review and determine progress in program and supervision.
2. Establish, review and/or finalize program/case management plans.
3. Review the results of polygraph testing and set sanctions if appropriate
4. Review the results of plethysmograph testing, psychological testing, substance abuse evaluations and any other pertinent testing and modify program plans as necessary.
5. Determine program removal or suspension
6. Review discharge plans

7. Review offenders being considered for exceptions to established service levels
8. Establish or review risk ratings

All program consultation meetings will include the approved provider and DOC representatives and may include the following:

1. Individuals involved in the sex offender's community programming and/or supervision
2. Field Probation/Parole Officers
3. Any professional staff from community agencies working directly with the sex offender, the sex offender's family, the victim of the sex offender, etc.
4. Contract staff (maximum of two, without prior approval)
5. Other professionals as deemed appropriate or necessary
6. The sex offender may or may not be invited to the meeting at the discretion of the Case Management Team.

6.400 Program Removal

All program removals will be initially processed through the Field or Institutional Probation Officer. Consultation with Case Management Team members and other providers will be pursued prior to case staffings being conducted for program removal. Case Management Team meetings held for program removal should encourage the participation of as many members as possible.

There are a variety of reasons why an offender in an SOMP may need to be removed from the program. These include non-participation or non-cooperation with the rehabilitation process, violations of the conditions of probation or parole which signal the offender is not safe to be managed in the community, committing another offense, inability to benefit further from the treatment process and other possible reasons specific to individual cases. When Approved Providers are considering program removal they shall contact the appropriate Field or Institutional Probation Officer and arrange for a Case Management Team review as soon as possible. Concerns about community safety should be conveyed immediately. Except in urgent circumstances, offenders should be given an opportunity to comment on the reasons for the proposed removal prior to the final decision.

Offenders may be removed from program in several ways.

6.410 Offender requests removal: Some offenders leave program against the advice of their Case Management Team. Offenders who request removal should be required to spend some time reflecting upon their request prior to the request being honored. During this time they are required to meet with treatment and probation staff and other program participants to discuss their reasons for requesting discharge.

6.420 Administrative removal: Some offenders may be removed from program for administrative reasons without being judged non-compliant with their individualized management plan. These are "no-fault" removals. Examples include offenders with medical problems that interfere with their ability to focus on program and offenders who have legal issues that must be resolved before rehabilitation can go forward.

6.430 Case Management Team removals: Offenders who are not compliant with their individualized management plan may be removed by the Case Management Team after they have been given ample opportunity to address issues raised by the program staff. Offenders who are removed are given due process and this is documented in their clinical file.

At the time of removal the offender shall be given guidelines for re-entry to the program at a future time if this is appropriate.

When clinical staff members are considering removal they will schedule a Case Management Team meeting to discuss the reasons for the potential removal. The case Management Team shall outline steps the offender can take to avoid removal along with time lines for completion of the goals. At this time a date will be established for a follow-up case Management Team meeting in which the offender's progress towards meeting his goals will be assessed. At the follow-up case Management Team meeting the Case Management Team may decide to remove the offender from program or they may vote to continue him in program depending upon his compliance with the suggested corrections and his progress in meeting his goals. The Case Management Team's decision and the reasons for it will be recorded and placed in the offender's record. At the time of removal the offender is given the last Case Management Team vote sheet, along with guidelines for seeking reentry if this is appropriate.

6.500 Program Reentry

Offenders who have been removed from program may seek re-entry. Reentry options are summarized below.

Offenders who have been removed from program for any of the above reasons may seek reentry. Reentry is not, however, guaranteed but is at the discretion of the Case Management Team. The offender must complete an application for reentry in which he addresses the reasons for removal. These reasons are addressed in the last Case Management Team report in which the removal decision was made. The offender must present a plan for dealing with the reasons for removal that is acceptable to the Case Management Team. He must demonstrate that he understood the feedback that was given by the Case Management Team and that he understands the issues to be addressed and is committed to working on those issues. He must show that he is committed and motivated to change the behaviors that led to removal. His behavioral record since the time of removal must demonstrate this commitment. Offenders seeking re-entry shall meet the requirements for re-entry that were given them at the time of removal.

The Case Management Team will review the assignment and determine whether or not the offender has addressed the reasons for removal and the relevance of these issues to his individual management plan. The Case Management Team may require further information or clarification and may require additional assignments. If the team decides the offender is ready for reentry this will be encouraged as long as eligibility requirements are met

Offenders who are removed from sex offender treatment programs in the community frequently apply for entry into sex offender treatment with other providers. In many of these cases a Petition to Revoke Probation (PTRP) or a Parole Violation Report (PVR) has been filed or is in the process of being filed. Offenders may seek entry into another program to avoid the consequences of being removed from their prior program. At other times offenders may quit one program in an attempt to avoid some part of the program they do not wish to comply with. Offenders in these situations are "therapist shopping."

This behavior should not be encouraged. Approved providers should not accept offenders into their sex offender treatment program until the PTRP and PVR issues are resolved by the court or the Parole Board. Approved Providers shall not accept these offenders into treatment until they have received and reviewed all materials from the prior approved provider and the Probation/Parole officer. They should communicate and coordinate with the prior approved provider and the supervising officer before accepting the offender into their program. They shall also provide documentation about how their program/services will address the issues and needs of the offender that were a problem in the former program. This should be documented in the Intake Assessment.

No Reentry Options for Some Program Removals. Most offenders who are removed from Program or who quit program will be eligible for reentry. There will occasionally be offenders whose behavior was/is so serious that they will be removed with no reentry option. The behaviors of these offenders indicate a very high risk of injury to victims in the community, an ongoing risk of manipulation and assault upon others in program, and behavior that undermines the integrity of the program environment. These include offenders who 1) commit a new assault and/or who pose an ongoing risk of assault to others, 2) offenders who entered the SOMP but who concealed and/or later revealed information that was not in compliance with their eligibility requirements, and 3) offenders who exhibit a blatant disregard for probation/parole or institutional guidelines or undermine the program participation of other offenders.

Offenders who pose an extremely high risk of harm to victims and who are not responsive to treatment may actually become more dangerous if they continue in treatment and learn ways to manipulate treatment and supervision staff. They may learn more techniques for grooming future victims and may learn enough about sex offender treatment to convince some that they have benefited from treatment and are no longer dangerous. These offenders will best be dealt with from a purely management perspective.

6.600 Policy on Pornography.

Approved Providers shall not encourage or permit the use of pornography. Pornographic materials of various types are antecedent stimuli to deviant sexual fantasies for most sex offenders. Such materials are commonly part of a sex offender's grooming arsenal and assault cycle. Furthermore, pornography promotes attitudes of objectification, sexualization and degradation which further reinforce deviant sexual interests and sexual aggression. The possession and use of pornographic materials by sex offenders therefore is counterproductive to rehabilitation.

The possession and/or use of pornographic materials by sex offenders in DOC treatment programs are prohibited.

6.610 Definition of Pornography

Pornographic material is defined, for the purpose of this document, as any material which can reasonably be expected to trigger or encourage sexual fantasies and/or behaviors that are part of the offender's pattern of sexual aggression or which could encourage new forms of sexually deviant thoughts, feelings and/or behaviors. Pornography includes materials which invite the audience to view the person or persons as a sexual object without respect for the individual as a person. This includes traditional forms of pornography including "X-rated" materials and "soft pornographic" materials available at

news stands. Other materials which were not intended to invite sexualization of a person may also be subject to pornographic interpretation by the offender. In this case the offender may super-impose meaning on a depicted person even when this clearly was not the purpose or intent of the material to begin with. An example is the pedophile's pornographic use of photos of children in clothing catalogues.

The nature of the prohibited materials is determined on an individual basis as, for example, seemingly innocuous photos of children may be highly erotic to the pedophile but may cause no arousal to other types of sexual offenders.

The offender's Case Management Team will determine which materials are prohibited. The Case Management Team may consider various clinical materials in the file including but not limited to the offenders sexual assault history, other sexual history, plethysmograph data, polygraph data, and any other clinical data to aid them in making their determination.

The prohibition of pornography is intended for all sex offenders in DOC programs including those in community care programs.

The Case Management Team may apply a number of sanctions for the possession and/or use of pornography, up to and including program removal.

7.000 RECORDS AND REPORTING

Providers shall maintain clients' files in accordance with the professional standards of their individual disciplines and with Alaska state law on health care records. Client files shall:

- Document the goals of program, the methods used, the client's observed progress, or lack thereof, toward reaching the goals in the program records. Specific achievements, failed assignments, rule violations and consequences given should be recorded.
- Accurately reflect the client's progress, sessions attended, and changes in programming.

Providers must maintain minimum clinical and program data that will enable DOC to answer specific questions. DOC requires certain information from all Approved Providers in order to carry out evaluation and management functions and will provide parameters and/or forms for data collection on a regular basis. Approved Providers are required to complete appropriate forms in a timely fashion and submit them to DOC.

DOC is required to comply with State law regarding court ordered treatment. In order to do so, providers must supply DOC with reports of offender participation and progress. Each offender must have an individualized management plan and providers shall document offender compliance with the management plan and provide DOC with appropriate reports.

Sex offenders must demonstrate progress by satisfactorily meeting all program requirements of their individualized management plan and have such documented in their program file. Progress towards meeting goals must be documented in the offender's program files. Whenever possible, standardized tests and measures should be used to evaluate change. As DOC establishes a list of specific measures to be used for offender and program evaluation, Approved Providers may be required to use these instruments.

7.100 Program Files.

Sex offender programs in correctional facilities and community settings shall maintain a program file on each sex offender who has received services. The contractor is the custodian of the program file, but the file is the property of DOC. Approved Providers may elect to keep a separate clinical file on program participants. The nature, organization, and content of separate contractor files are the business of the contractor establishing them.

The program file will include the following documents:

1. Pre-Sentence Investigation (PSI)
 - a. Criminal History
2. Intake and Assessment
 - a. Identifying Information
 - b. Social History
 - c. Sexual History
 - d. Plethysmograph and Polygraph Assessment (when available)
 - e. Previous Mental Health History (collateral contacts)
 - f. Psychological Assessment/Evaluation/Testing Results (when available)
 - g. Risk Assessment

3. Treatment Contract
4. Treatment Plan
5. Clinical Summaries/Progress Reports
6. Discharge Summaries
7. Releases of Information
8. Other Documents pertinent to treatment

Approved Providers who provide sex offender rehabilitation services will be required to submit monthly attendance records, quarterly progress reports (or more frequent at the request of the supervising officer) and discharge summaries when offenders are released from program or when their program involvement is terminated for any reason.

7.200 Program Evaluation

Evaluations are conducted for the purpose of ensuring that the SOMPs are operating within the guidelines established in the SOMP Standards of Sex Offender Management. Program evaluation will be used to insure quality, continuity, and consistency in the rehabilitation programming of sexual offenders under the jurisdiction of DOC. Contract compliance and program operation will be the central themes of program evaluations. Quality assurance and utilization review will also be considerations of the overall evaluation process.

DOC reserves the right to conduct an audit/evaluation whenever deemed necessary. The evaluation may be conducted by DOC personnel and/or by a privately contracted consultant with a demonstrated understanding and expertise in the area of sexual aggression and sex offender programming. Whenever possible, programs will be given advance notice of the intent to conduct a program evaluation.

Guidelines and evaluation criteria have been established for the evaluation of the Department's SOMP's and are contained in this manual as Appendix M. They are subject to change by addition, deletion, or modification at the discretion of the Department. Changes in the evaluation procedures may be requested by the contractor provided they are made in writing to the Department in advance of the evaluation. Changes in evaluation guidelines and criteria will be made available to the contractor as they are established.

7.400 Research

DOC personnel, Approved Providers and others may desire to conduct research on various aspects of sex offender rehabilitation as well as other subjects related to sexual aggression. Additionally, researchers have occasionally asked to conduct studies unrelated to sexual deviancy using participants in DOC sex offender programs.

DOC supports efforts to increase scientific knowledge in the field of sexual deviancy and other forms of criminal behavior. The Department recognizes, however, the importance of insuring that all research is conducted according to high ethical standards and that the rights and safety of offenders be protected along with insuring that research activities will not compromise the security and safety of correctional facilities and staff and of the community.

All research conducted in DOC facilities and/or using DOC offenders must first receive approval from a Human Subject and Research Approval Committee or reviewed by independent researchers. University researchers may submit their research proposal to the University's Human Subjects Committee for approval of methods with respect to

ethical considerations. All other researchers must provide documentation that their research proposal has been reviewed and approved by an independent and appropriate human research committee or other appropriate professionals.

All research must be conducted in accordance with Sections 6.06 through 6.26 of the Ethical Principles of Psychologists and Code of Conduct of the American Psychological Association. Once the research project has been approved by the Human Subjects Committee and all recommendations of the committee either carried out or made part of the research plan, the project must be approved by DOC. The procedure for obtaining approval is given in DOC Policy and Procedure 501.02. All research projects must comply with the provisions of this Departmental policy and procedure.

8.000 EXTERNAL MANAGEMENT OF SEX OFFENDERS - COORDINATION AND SUPERVISION ISSUES.

8.100 Standards of Practice for Supervising Sexual Offenders

The Division of Probation and Parole (DPP) has developed Standard Operating Procedures (SOP's) for probation/parole officers who supervise sex offenders on their case load. A copy of the SOP's can be provided by DPP.

8.200 Establishment of a Case Management Team.

As soon as possible after the conviction and referral of a sex offender to DPP, the supervising officer should form a Case Management 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 the sex offense-specific evaluation and pre-sentence investigation as a starting point for such decisions;

Although policy development is an important function, the primary purpose of the team is individual case management, not policy development.

Supervision and behavioral monitoring is a joint, cooperative responsibility of the supervising officer, the approved provider, and the polygraph examiner.

Each team, at a minimum, should consist of:

- The supervising officer,
- The offender's approved provider, and
- The polygraph examiner
- Adjunct treatment provider

Each team is formed around a particular offender and is flexible enough to include any individuals necessary to ensure the best approach to managing and treating the offender. Team membership may therefore change over time.

The team may include individuals who need to be involved at a particular stage of management or treatment (e.g., the victim's therapist or victim advocate). When the sexual offense is incest, the child protection worker is also a team member if the case is still open.

In rural areas, the team members may be the same for each offender. In more highly populated areas, there may be a cluster of teams that include various combinations of supervising officers, Approved Providers, and polygraph examiners.

The team is coordinated by the supervising officer, who determines:

- The members of the team and, beyond the required membership, who should attend any given meeting;
- The frequency of team meetings;

- The content of the meetings (with input from other team members);
- The types of information required to be released.

Team members should keep in mind the priorities of community safety and risk management when making decisions about the management and/or treatment of offenders.

8.210 Case Management Team Norms. The team should demonstrate the following behavioral norms:

- There is an ongoing and completely open flow of information among all members of the team;
- Each team member participates fully in the management of each offender;
- Team members 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.
- Team members should communicate frequently enough to manage sexual offenders effectively, with community safety as the highest priority.

Supervising officers are encouraged to periodically attend group and/or individual therapy sessions to monitor sex offenders under their supervision. Approved Providers are encouraged to allow attendance of supervising officers and prepare sex offenders in the group in advance for the attendance of a supervising officer. Preparation should include notification of the supervising officer's attendance and execution of appropriate waivers of confidentiality, if necessary. The visiting supervising officer shall be bound by the same confidentiality rules as the approved provider and should sign a statement to that effect. It is understood that Approved Providers may set reasonable limits on the number and timing of visits in order to minimize any disruption to the group process.

8.300 Supervising Officer's Role and Responsibilities in Team Management of Sex Offenders

The supervising officer shall refer sex offenders for evaluation and rehabilitation services only to Approved Providers who meet these Standards.

Supervising officers have a responsibility to ensure that the offender is engaged in appropriate rehabilitation with a provider who is listed in DOC'S Approved Provider List and that the rehabilitation program is consistent with DOC's Standards. It is the supervising officer's responsibility to refer to Approved Providers who will best meet the sex offenders' rehabilitation needs and the need for community safety.

The Supervising officer shall ensure that sex offenders sign releases for at least the following types of information:

- Releases of information to treatment providers, including information from any treatment program in which the offender participated at the Department of Corrections;
- Releases of information to Case Management Team members, including collateral information sources, as indicated, such as the child protection agency, the approved provider, the polygraph examiner, the victim's therapist, and any other professionals involved in the rehabilitation and management of the offender;
- Releases of information to the victim's therapist, the Guardian ad Litem, custodial parent, guardian, caseworker, or other involved professional, as indicated. Such information may be used in the victim's treatment and/or in making decisions regarding reunification of the family or the offender's contact with the victim.

The supervising officer, in cooperation with the approved provider and polygraph examiner, should utilize the results of periodic polygraph examinations for program and behavioral monitoring. Team members should provide input and information to the polygraph examiner regarding examination questions. The information provided by the team should include date and results of last polygraph examination.

Supervising officers have a responsibility to ensure that the offender receives polygraph examinations from a polygraph examiner who is listed on DOC's Provider List and that the examinations are consistent with DOC's Standards. It is the supervising officer's responsibility to refer to polygraph examiners who will best meet the sex offenders' rehabilitation needs and the need for community safety.

Exceptions to the requirement to use the polygraph shall be made only with the unanimous agreement of the Case Management Team and the reasons for the exception shall be recorded in the sex offender's file.

Although deceptive findings on a polygraph test are not in and of themselves a violation of probation or parole, they can be considered in determining the intensity and conditions of supervision. Pre-test and post-test admissions, however, may be used in a revocation hearing. An offender's failure to take a polygraph as directed should be considered a violation of probation and/or parole; Offenders can be required to complete a polygraph examination on their crime of conviction once all appeals of their conviction are exhausted. If they are appealing their sentence and not their conviction they can be required to complete a polygraph examination on the instant offense. **They cannot be required to answer polygraph questions on any unreported crime(s) that would give information such as victim names, dates of offenses, locations of offenses, and any other information that would incriminate them and could lead to their being prosecuted for a new offense. They may assert their Fifth Amendment rights if asked to give specific details of prior unreported offenses. They may be required to**

answer general questions regarding their prior sexual history as long as the information is not specific enough to implicate them in a new crime.

The supervising officer should require sex offenders to provide a copy of the written plan developed in program 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.

The supervising officer should require sex offenders to obtain the officer's written permission to change sex offender programs (refer to 6.500 for a discussion of changes in sex offender treatment providers).

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.

The supervising officer should require Approved Providers to keep written updates on sex offenders' status and progress in program. Progress reports should be submitted quarterly at a minimum or sooner at the request of the supervising officer.

The supervising officer should discuss with the approved provider, the victim's therapist, custodial parent or foster parent, and Guardian ad Litem specific plans for any and all contacts of an offender with a child victim and plans for family reunification.

The supervising officer should develop a supervision plan and contact standards based on a risk assessment of each sex offender, the sex offender's offending cycle, physiological monitoring results, polygraph results, and the offender's progress in program.

Recognizing that sex offenders present a high risk to community safety, probation/parole/officers should base their field work on the supervision plan, relapse prevention plan, and offense cycle/pattern of an offender.

The supervising officer should not request early termination of sex offenders from supervision.

On a regular basis, the supervising officer should review each offender's specific conditions of probation, parole, or furlough and assess the offender's compliance, needs, risk, and progress to determine the necessary level of supervision and the need for additional conditions.

If contact is allowed, the supervising officer should limit and control the offenders' authority to make decisions for minors or to discipline them.

If necessary and possible, the supervising officer should request an extension of supervision to allow an offender to complete sex offender programming.

The supervising officer should notify sex offenders that they must register with local law enforcement, in compliance with state sex offender registration laws.

The supervising officer should discuss program issues and progress with offenders during office visits and other contacts.

The supervising officer/agency should impose or request criminal justice sanctions for offenders' unsatisfactory termination from sex offender programming, including revocation of probation or parole.

The supervising officer should require sex offenders who are transferred from other states through an Interstate Compact Agreement to agree in advance to participate in offense-specific programming and specialized conditions of supervision contained in these Standards.

The supervising officer should not allow a sex offender who has been unsuccessfully discharged from a sex offender rehabilitation program to enter another program unless the new program and case management arrangement will provide *greater* behavioral monitoring and *increased* programming in the areas the sex offender "failed" in the previous program. The purpose of this standard is to discourage movement among treatment providers by offenders as a way of avoiding doing the work of therapy.

Supervising officers assessing or supervising sex offenders should successfully complete training programs specific to sex offenders. Such training shall include information on:

- Prevalence of sexual assault
- Offender characteristics
- Assessment/evaluation of sex offenders
- Current research
- Community management of sex offenders
- Interviewing skills
- Victim issues
- Sex offender rehabilitation
- Choosing evaluators and Approved Providers
- Relapse prevention
- Physiological procedures
- Determining progress
- Offender denial
- Special populations of sex offenders
- Cultural and ethnic awareness

It is also desirable for agency supervisors of officers managing sex offenders to complete such training.

On an annual basis, supervising officers should obtain continuing education/training specific to sex offenders.

The successful completion of training required in guidelines given above is necessary prior to the supervising officer attending any individual or group therapy sessions of sex offenders under his/her supervision.

8.400 Treatment Providers' Role and Responsibility in Team Management of Sex Offenders

An approved provider shall establish a cooperative professional relationship with the supervising officer of each offender and with other relevant supervising agencies.

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

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. Contractors and Approved Providers are required to notify the field P.O. within 24 hours of any information which indicates that an offender is a risk of re-offending. If the community offender is a furloughee, this notification will be made to the furlough officer. In cases where an offender commits a new offense, local and/or state law enforcement shall also be notified;

A provider shall report to the supervising officer any reduction in frequency or duration of contacts or any alteration in programming that constitutes a change in an offender's management plan. Any permanent reduction in duration or frequency of contacts or permanent alteration in programming shall be determined on an individual case basis by the provider and the supervising officer.

All Contractors and DOC Approved Providers who provide sexual offender programming in the community will be required to provide 1) monthly attendance reports to field P.O.'s in writing, and 2) quarterly progress reports (or more often at the request of the supervising officer) on each program participant. Progress reports shall document the offender's participation in treatment, increase in risk factors, changes in the treatment plan, and treatment progress. Reports shall be submitted in a timely fashion.

If a revocation of probation or parole is filed by the supervising officer, a provider shall furnish, when requested by the supervising officer, written information regarding the offender's progress in program. The information shall include: changes in the management plan, dates of attendance, treatment activities, the offender's relative progress and compliance in program, and any other material relevant to the court or the parole board at the hearing. The approved provider shall be willing to testify in Court if necessary. Payment for expert witness testimony shall be reimbursed by the individual or agency that requests and/or summons the approved provider to testify in Court. Providers who are called as factual witnesses in a sexual offender case shall not give expert opinions. If an expert opinion is requested the provider shall ask the Court to review his or her credentials and experience and determine if they qualify as an expert witness in the particular case before the Court.

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.

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

8.500 Polygraphers' Role and Responsibility in Team Management of Sex Offenders

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

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, no longer than two (2) weeks post testing.

Attendance at team meetings shall be on an as-needed basis. At the discretion of the supervising officer, the polygraph examiner may be required to attend only those meetings preceding and/or following an offender's polygraph examination, but the examiner is nonetheless an important member of the team.

8.600 SOMP Case Review Team

The individual rehabilitation programs for sex offenders are subjected to oversight by the offender's Case Management Team. Program reviews occur periodically and case records are reviewed at random during these reviews to assess the quality of record keeping as well as program planning. Individual case reviews are also requested from time to time to address specific issues and complaints regarding sex offenders who have been removed from their program or denied admission or re-admission. There are also requests for review due to concerns regarding the specifics of a particular offender's program. These requests may come from the offender himself or from others such as family, attorneys, legislators or others who have an interest in the offender's rehabilitation.

A SOMP case review team may be convened for the purpose of conducting these individual case reviews. Case review by the Case Review Team is not intended as a regular review process but rather as a process for exceptional cases and situations that warrant special attention.

The Case Review Team may also conduct inquiries into sexual re-offenses in an attempt to obtain information regarding the offense that might help correctional and program staff to recognize pre-relapse signs and prevent future occurrences of re-offending.

8.610 Case Review Team Personnel: The review team is composed of several members who have expertise in the rehabilitation and management of sex offenders. Minimally, the case review team shall be composed of the Criminal Justice Planner for Offender Programs, the Statewide Consultant for Sex Offender Programs, and clinical and correctional staff responsible for the management of the case.

8.620 Case Review Process: The review process will always involve a thorough review of the offender's institutional and/or probation/parole record, as well as his or her program record. In addition the team may request interviews with the offender,

Approved Providers, correctional staff, family members and others who may provide input about the offender.

8.700. Safety-Net Team Standards

Sex offenders are typically secretive about the behaviors and thought processes which lead to relapse. Any successful approach to rehabilitation must involve supervision and monitoring as well as other more traditional therapeutic measures. An offender's chances of successfully maintaining a non-assaultive life style in the community can be significantly increased if those individuals in a position to observe the offender are well educated about offenders' high risk signs and their relapse process. The safety-net is a group of natural helpers that can alert professionals who are working with the offender of potential pre-relapse indicators so that intervention can occur more rapidly.

The safety-net is a small group of individuals (typically three to five) who are in a position to observe the day to day behaviors of the offender. Safety-net members are trained to recognize pre-relapse signs and to report such signs to various members of the Case Management Team including therapists and probation officers. Safety-net team members may include family, employers, clergy, friends and others who have frequent contact with the offender. They are trained to be "experts" in the relapse process of the particular offender they are helping.

The primary purpose of the safety-net is to aid in the supervision and management of the offender by acting as an "early-warning" system. The safety-net aids the probation officer by providing information which will allow the supervising officer to take corrective measures when an offender slips into a pre-relapse cycle.

The following Standards shall be followed in creating a safety-net:

1. All sex offenders in Community SOMP's shall have a safety-net.
2. The minimum size for a safety-net is three persons. There is no maximum size but a safety-net would typically include three to five persons.
3. At least two members of the Safety-net must be persons outside the offender's immediate family.
4. Persons on the offender's Case Management Team can also be members of the Safety-net but the Safety-net can not be entirely made up of Case Management Team members.
5. The composition of the Safety-net should be representative of the offender's environments in the community. That is, any location in which the offender spends significant time should be represented by a Safety-net person from that environment. Examples of such environments include home, work, religious environments, cultural groups, adjunct treatment groups such as AA, etc.
6. Safety-net members must be consistently available to observe the offender. Frequent or prolonged absences may disqualify an individual from being part of the Safety-net.

7. All Safety-net members shall be non-paid volunteers. Safety-net members may not accept payment in any form from offenders or others for their involvement in the Safety-net.
8. All Safety-net members must undergo training conducted by the approved provider and the supervising officer.
9. Objectivity and a willingness to report pre-relapse signs are an essential characteristic of a good Safety-net member. Safety-net members must be selected with these traits in mind. Those members who are reluctant to report or who are non-objective observers are subject to removal from the Safety-net.
10. The Field Probation/parole Officer is in charge of the safety-net team and shall give approval for all Safety-net members. Safety net members may be contacted by the approved provider and/or the supervising officer to gather information regarding the offender. After the offender completes treatment it is the responsibility of the supervising officer to contact the safety-net team members.
11. The removal of a Safety-net member may be recommended by the Management Team or the Field Probation Officer, but the final decision to remove a member is made by the Field Probation Officer. All removals are subject to review by the Criminal Justice Planner for Offender Programs.

8.800 Violations of Conditions of Probation/Parole (Technical Violations)

When the Safety-net concept works as intended, a number of violations of the conditions of probation/parole may be reported. These may vary in seriousness and present different degrees of potential risk to the community. It is DOC's hope that offenders may be maintained safely in the community and the Department recognizes the importance of dealing with technical violations quickly and appropriately. Guidelines for Handling Violations of Conditions of Probation/Parole are provided in Appendix N. These guidelines assist the Field Probation Officer in evaluating the offender's potential danger to the community and in determining the appropriateness of various sanctions. These sanctions range from verbal and written warnings to recommendations for re-incarceration. A number of therapeutic interventions lie in between these extremes.

The supervision of the sex offender is an essential part of the offender's programming. All Contractors and other Approved Providers must report condition violations to the Field Probation Officer as soon as possible after becoming aware of such violations.

9.000 VICTIM ISSUES

9.100 The Role of Victims/Survivors in Sex Offender Treatment

DOC recognizes that the behavior of sex offenders can be extremely damaging to victims and that their crimes can have a long-term impact on victims' lives. Moreover, the level of violence and coercion involved in the offense does not necessarily determine the degree of trauma experienced by the victim.

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

In Alaska victims may state whether they wish to be notified about any changes in the offender's status in the criminal justice system. In certain situations, the Case Management Team may communicate with a victim's therapist or a designated victim advocate. Further, if a victim is willing, s/he may be contacted for information during the pre-sentence investigation, in order to include additional victim impact information in the investigation report.

Professionals in the criminal justice, evaluation, and treatment systems should 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, Approved Providers and supervisors to develop management plans and supervision conditions that may prevent or detect future offenses. Oftentimes the victim's information about an offense can be obtained through a third party such as a victim therapist, a family member, or other persons close to the victim. It is often preferable to obtain information indirectly so as not to re-traumatize the victim. Some victims may wish to give their input directly, however. Supervising officers and Approved Providers must use extreme sensitivity in contacting and talking to survivors of sexual abuse so as not to re-traumatize them. At all times a victim's right to not discuss the offense, the impact of the offense, or other aspects of his/her involvement with the offender shall be respected.

9.200 Victim Contact

Warning: Child Protective Statutes in Alaska (AS 11.51.100) prevent certain offenders from having contact with minors. Approved Providers must check with the Office of Adult Probation prior to recommending or initiating any contact between the offender and minor children to establish that contact is authorized. The Department of Law has advised DOC as to the application of AS 11.51.100 to probationers and parolees. Approved Providers should make every effort to insure that they are operating in a manner consistent with advice from the Attorney General's Office.

The primary mission of DOC is to protect the public. It is therefore essential that all DOC staff, Contractors and other Approved Providers hold the best interest of victims in mind when working with sex offenders. The safety and well being of victims and potential victims must be considered as the highest priority. Safety in this context means both physical and psychological safety. DOC staff and other providers of service to sex offenders must consider the best interest of victims when making decisions regarding the rehabilitation and management of sex offenders. Decisions about victim/potential victim

contact must be made conservatively. Research indicates that most sex offenders have a more extensive history of sexual offending including multiple victim and offense types than is indicated in criminal justice records. The offense(s) for which an offender was convicted is not a reliable indicator of all victims who may be at risk. As offenders participate successfully in rehabilitation programs more information is gathered and a more accurate estimate of risk may be forthcoming. Ongoing risk assessment is critical so that decisions made by the team that could affect victim safety are made with the most accurate information available. In making decisions about victim contact the following standards shall be followed:

- Contact between offenders and victims or potential victims will not occur until there has been consultation with, and approval by, all appropriate parties. This includes the offender's approved provider and the provider's clinical supervisor if one is required, the supervising probation officer, the victim, the victim's therapist, the victim's parent or guardian, and the victim's advocate or Guardian ad Litem. This applies to direct and/or indirect contact. Contact is intended to refer to any form of interaction including:
 1. Physical contact, face to face, or any verbal contact;
 2. Being in a residence with a child or victim;
 3. Being in a vehicle with a child or victim;
 4. Visitation of any kind;
 5. Correspondence (both written and electronic), telephone contact (including messages left on a voice mail or answering machines), gifts, or communication through third parties;
 6. Entering the premises, traveling past or loitering near the child or victim's residence, school, day care, or place of employment;
 7. Frequenting places used primarily by children, as determined by the Community Supervision Team.

Prohibition of contact does not impact an offender's responsibility to pay child support. This applies to contact in a prison or in a community setting.

- Case Management Teams should plan for changes in risk level and recognize that offenders will always present with some level of risk for sexual re-offending. Progress in program may not be consistent over time. The team should also consider that changes in child development characteristics or adult victim characteristics may affect offenders' risk level. Approval of situations that involve contact with children under the age of eighteen shall be continually reviewed and changed by the Case Management Team based on current risk.
- In the event that there is a court order prohibiting contact between the offender and the victim or potential victims, this order will be followed unless altered by the court or, if so indicated, by the supervising probation officer.
- All contacts between sex offenders and victims or potential victims must be approved by the supervising probation officer
- All non-authorized contact with victims and potential victims will be reported immediately to the supervising probation officer

- All guidelines for family clarification as described below will be followed by DOC staff and other providers of services to sex offenders

In order to maintain program integrity, Approved Providers and evaluators who receive referrals for offenders in circumstances which conflict with these Standards should refuse to accept or continue to work with offenders who do not agree to comply with the requirements in the Standards regarding restricted contact. The referral source should be informed in writing of the reasons for the refusal and of the possible risk to the involved children or victims.

During any time that an offender is not in program, the supervising officer should maximize the use of surveillance, monitoring and containment methods including more frequent use of polygraphs. The supervising officer may obtain additional information during this period of time which should be brought back to the court for additional guidance and/or sentencing conditions.

9.210 Exclusionary Criteria

Due to extreme risk, when any of the following are present, the Case Management Team shall ensure that the offender is **not** considered for any type of contact with children.

A clinical diagnosis by an approved evaluator or treatment provider of:

- Pedophilia (Exclusive Type, per DSM IV-TR or later DSM versions), i.e. attracted only to children)
- Psychopathy or Mental Abnormality per the Psychopathy Checklist-Revised (PCL-R) or per the MCMI III (85 or more on each of the following scales: Narcissistic, Antisocial and Paranoid)
- Sexual sadism, as defined in the DSM IV-TR or later revision of this manual

9.300 Victim and Family Clarification/Resolution

Sexual assault is like a ripple in a pond. It affects many persons other than the offender and the immediate victim. Immediate and extended family are also affected by the offender's behavior and are among the many secondary victims. In cases of intra-familial child abuse the impact on family is especially significant. The purpose of victim and family clarification is to give primary and secondary victims the opportunity to convey to the offender how they have been harmed by the offense and to re-establish boundaries. Clarification sessions also establish that the offender is fully responsible for the offense and clarify, to the family members, details of the offense and grooming patterns. Clarification sessions may help to relieve denial and minimization among family members, relieve family members of perceived responsibility and facilitate their healing process, and educate family as to potential relapse patterns so they may function, if desired, as appropriate safety-net members. Victims may also challenge information provided by the offender and offer program staff information that may help in the offender's rehabilitation.

There may also be occasions when family clarification meetings are appropriate even though none of the family members were victimized by the offender. For example, it is common for an offender to request that he be allowed to live with a new partner and her children. The children may or may not be the same gender or in the age range of prior victims. In such cases, clarification sessions may help establish appropriate boundaries, educate the family as to warning signs of potential relapse, establish contacts for reporting and set up other protections for the family.

Clarification sessions may include couples counseling, counseling with other family dyads and counseling with the entire family as deemed necessary and appropriate.

Family re-unification is not the purpose of family clarification. Guidelines for family re-unification are given in the next section. The following guidelines are to be followed for victim/family clarification sessions.

- There shall be no direct or indirect contact between offenders and their victims until this is approved by the DOC Approved Clinical Supervisor (if there is one) and the supervising PO. Permission from the sentencing court and/or parole board will be obtained prior to contact in cases where the court or parole board prohibits contact.
- Confidentiality will be maintained for both the offender and the victim(s).
- The Approved Provider will establish through contact with the victim and/or family members that contact with the offender is desired.
- The Approved Provider will establish that both the offender, victim and family members are psychologically prepared for the clarification session(s). Contact will be made with the victim's and/or family members therapist(s), if such exist, to determine that all parties are suitably prepared for the clarification session(s) and that such sessions are beneficial to the victim and family members. The Approved Provider will also establish that such therapists will be available to their clients after the clarification sessions for de-briefing.
- The Approved Provider will inquire of the victim and family members if they desire other persons including victim and/or other therapists to be present during the session(s) for purposes of support.
- The Approved Provider shall clarify to all parties involved that the purpose of the clarification session is not to re-establish the relationship or re-unite the family.
- The Approved Provider shall conduct the session in a structured manner and call an immediate halt to the session if it should become inappropriate or potentially damaging to the victim or family members.
- The Approved Provider will make every effort to communicate and coordinate with other therapists involved with the victim or family to determine the impact of the session(s) upon the victim and family members and readjust plans for further meetings accordingly.
- The victim's wish to end a clarification session and/or the clarification process itself shall be respected at all times.

9.400 Family Reunification

Many families who are victims of intra-familial child abuse do not re-unite. This is an appropriate resolution for many families. Family re-unification may be desired by some families and may or may not be appropriate depending on a number of factors. ***Family reunification is not appropriate in all cases even if desired by the offender and all family members.*** Approved Providers must determine the appropriateness of family reunification prior to initiating the process. Decisions about the appropriateness of family re-unification are based first and foremost on safety issues. Approved Providers must follow the guidelines listed below before re-unification is attempted.

- Prior to initiating the family reunification process, approval must be obtained from the DOC Approved Supervisor (if one exists), the supervising PO, the victim's guardian or custodial parent, and the victim's therapist (if one exists). Conditions of probation/parole must be modified by the Court and/or parole board when necessary.
- Victim and Family Clarification sessions must be successfully completed prior to initiating family re-unification.
- The Approved Provider shall determine that the non-offending parent or parental guardian can appropriately protect the child from future sexual assaults. In determining this, contact with the victim(s) and non-offending parent's therapist and social worker may be required.
- The Approved Provider shall determine that the re-unification plan adequately provides for the safety of the victim(s). This shall be determined through consultation with the treatment supervisor (if there is one), the supervising probation officer, the guardian or custodial parent, the victim's therapist (if there is one), the Guardian ad Litem (if there is one), and any others that are in a position to evaluate safety of the victim.
- All parties must agree that re-unification is appropriate, desired, and in the victim's best interest.
- A trained safety-net must be in place. The non-offending parent or custodial guardian must be a trained member of the safety-net.
- When appropriate the victim(s) must be trained to recognize and report pre-relapse behaviors. In cases where this is not appropriate (e.g. extremely young victims or victims with severe cognitive impairments) other family members will be trained.
- There shall be a written re-unification plan. This shall include a list of pre-relapse signs and prohibited behaviors along with the names and phone numbers of persons to notify in case high risk behaviors occur. The plan shall also indicate a graduated schedule of direct contact that provides adequate opportunity to evaluate the safety of the re-unification process. Violations of the plan by the offender or non-offending parent shall result in immediate cessation of contact between the offender and the victim(s).
- The Approved Provider shall make periodic contact with safety-net members to determine if pre-relapse behaviors are occurring in or outside of the home.
- All contact between the offender and the victim or potential victims shall be supervised until all parties agree this is no longer necessary.

APPENDIX A

Significant Events in Sex Offender Treatment & Management in Alaska

- 1979 A pilot sex offender program, funded by an LEAA grant, opens at Lemon Creek Correctional Center
- 1980 Alaska initiates presumptive sentencing for Class A, B and C felonies (2nd offense)
- 1981 An institutional sex offender treatment program is established at Fairbanks Correctional Center . A community aftercare program is established in Fairbanks
- 1982 The Lemon Creek program closes.
A pilot program is established at Hiland Mountain Correctional Center.
Alaska moves Class A felonies to unclassified status and initiates presumptive sentencing for a first offense of Sexual Assault and Sexual Assault of a Minor
- 1984 A community aftercare program is established in Anchorage
The HMCC SOTP expands
- 1985 Plethysmograph assessment and behavioral treatment begin at HMCC
The LCCC program reopens
A community aftercare program is established in Juneau
- 1986 Social Skills Program established at Hiland Mountain for lower functioning individuals
Pre-program (pre-treatment) wing is established at Hiland Mountain
- 1989 Standards for provision of sex offender treatment developed in Alaska (second in U.S.)
LCCC SOMP is revised
- 1990 DOC sponsors statewide training for probation officers
- 1991 DOC hires NIC national experts to evaluate Alaska's sex offenders programs
DOC sponsors training in Relapse Prevention for treatment providers
- 1992 Based on recommendations of NIC evaluators, DOC hires statewide clinical consultant
The LCCC SOMP is reorganized into a pre-treatment program
The Fairbanks institutional program is closed
Community treatment openings in Fairbanks are increased

- A community treatment program is established in Ketchikan
An Approved Provider process is established and DOC begins contracting with individual Approved Providers rather than agencies
- 1993 A community treatment program is established in Kenai
A Safety Net Training Manual is written under an NIC grant
- 1994 DOC sponsors a training workshop for treatment providers
Began developing/training safety net teams in communities
Standards of sex offender management for provision of treatment services are revised
- 1995 Ketchikan treatment provider established safety net program in Metlakatla
A community treatment program is established in Bethel
- 1996 Recidivism study on participants of main institutional programs
- 1997 Sex Offender Working Group established
Clinical consultant and CJP began providing risk assessment training to Probation Officers
- 1998 Main institutional program revised and moved to Meadow Creek
Bethel program closed due to loss of contract therapists
Interagency Sex Offender Working Group established
- 1999 Risk study is conducted, including review of institutional program by two outside consultants
- 2001 Process for establishing regulations for sex offender treatment providers began;
Static 99 & SONAR training held and participation in standardization study Began
- 2002 High Risk Management Program developed in Juneau. Consultations regarding the containment approach begin with Colorado experts.
- 2002 SOMP at MCCC closes and the Pre-Treatment/Pre-Release Program at LCCC is revised and shortened so that a greater number of offenders can be assessed. The LCCC program provides focused risk assessment and risk management services to offenders prior to release
- 2003 The LCCC program closes and Contractors are hired to conduct assessments at individual facilities. As a result the number of assessments conducted increases.

Standards of Sex Offender Management

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2006 A pilot containment project begins and the first group of sex offenders undergo polygraph testing.

The Alaska State Legislature passes legislation requiring polygraph testing on all sex offenders by 2007.

2008 CRC and community sex offender treatment programs are established in Bethel for sex offenders from the Yukon-Kuskikwim Delta area.

2010 The LCCC sex offender management program re-opens

2011 The Standards of sex offender management are revised.

APPENDIX B

Glossary of Terms Used in the Management and Treatment of Sexual Offenders

Abstinence: The decision to refrain from taking part in a self-prohibited behavior. For sex offenders, abstinence is marked by refraining from engaging in behaviors that are associated with their offense patterns and not dwelling on deviant fantasies and thoughts.

Abstinence Violation Effect (AVE): A term used to describe high risk factors and a variety of changes in beliefs and behaviors that can result from engaging in lapses. Among the components of the AVE are: a sense that treatment was a failure; a belief that the lapse is a result of being weak-willed and unable to create personal change; a failure to anticipate that lapses will occur; and recalling only the positive aspects of the abusive behavior (also referred to as the Problem of Immediate Gratification). When sex offenders are not prepared to cope with the AVE, the likelihood of relapse increases. The AVE is experienced most strongly when clients believe that lapses should never occur.

Abel Assessment for Sexual Interest: A psychological test giving an objective measurement of deviant sexual interests. This is a computer driven test that gives the operator an objective reaction time measure of deviant sexual interests. Offenders who participate in an Abel Assessment complete a 30-minute computerized test showing 160 slides of clothed adults, teens, and children. Objective reaction time measuring 22 sexual areas are compared using “z scores” and self report. A 60-minute paper and pencil questionnaire is coupled with the computerized test to provide extensive details of the offender’s history of interest, degree of control, accusations, and other information. The Abel test assesses most dangerous clients, least dangerous clients, and clients most likely to commit a sex crime.

Access to the Community: Refers to a sex offenders’ ability to leave the physical confines of a residential program (with or without permission) and enter the community for any purpose and under any level of supervision or under no supervision.

Access to Potential Victims: Any time a sex offender is alone with a potential victim the sex offender is considered to have access to a potential victim, and the potential victim is considered at risk.

Actuarial Risk Assessment: A risk assessment based upon risk factors which have been researched and demonstrated to be statistically significant in the prediction of re-offense or dangerousness.

Adaptive Coping Response (ACR): A change in thoughts, feelings, and/or behaviors that helps sex offenders deal with risk factors and reduces the risk of lapse. Adaptive coping responses help sex offenders avoid re-offending (relapse), and may be general in nature (e.g., talking with a friend who is upset, hurt, or angry) or specific to certain situations (e.g., avoiding children or refraining from masturbation to deviant fantasies). General coping responses improve the quality of life. These responses include: effectively managing stress and anger; improving skill and ability to relate with others; changing life in ways which do not support sexually abusive behavior; learning to relax; and increasing knowledge, skills and ability to solve problems.

Specific coping responses deal with lapses and identified risk factors. These include: avoiding triggers to behavior (stimulus control); avoiding high risk factors; escaping from risk factors; developing specific coping methods for a particular problem and using them when the problem occurs; changing the way one thinks; learning ways to reduce the impact of the AVE; developing lapse contracts; setting positive approach goals; and using other methods of dealing with problems when they arise.

Adjudication: The process of rendering a judicial decision as to whether the facts alleged in a petition or other pleading are true; an adjudicatory hearing is that court proceeding in which it is determined whether the allegations of the petition are supported by legally-admissible evidence.

Admission Criteria: The specific characteristics and level of risk which can be treated and managed safely and effectively in a treatment program.

Adolescent/Juvenile Sexual Abuser: A person, legally or legislatively defined by the criminal or juvenile code of each state, with a history of sexually abusing other persons.

Aftercare: The portion of treatment that occurs after formal termination or graduation from the primary treatment program. Aftercare is provided either by the primary treatment provider or by community resources that are overseen and/or contracted by the primary treatment provider.

Aftercare Plan: The plan created by the primary treatment staff, family, other support systems, and the sex offender which includes the development of daily living skills, a focus on community reintegration while residing in a less structured/restrictive environment, a relapse prevention component, an emphasis on healthy living and competency building, and an identified system of positive support.

Aggravating Circumstances: Conditions that intensify the seriousness of the sex offense. Conditions may include age and gender of the victim, reduced physical and/or mental capacity of the victim, the level of cruelty used to perpetrate the offense, the presence of a weapon during the commission of the offense, denial of responsibility, multiple victims, degree of planning before the offense, history of related conduct on the part of the offender, and/or the use of a position of status or trust to perpetrate the offense.

Alford Plea: An Alford Plea allows the offender to admit that there is enough evidence to convict him or her at trial without admitting to the offense of record. This type of plea often precludes treatment since it is difficult to treat someone who has not admitted responsibility for the offense.

Anaphrodisiac: A drug or medicine that reduces sexual desire.

Androgen: A steroid hormone producing masculine sex characteristics and having an influence on body and bone growth and on the sex drive.

Anti-androgen: A substance that blocks the production of male hormones.

Aphrodisiac: Anything that stimulates sexual desire or arousal.

Assault Cycle: The sex offenders' pattern of abusing that includes triggers, feelings, behaviors, cognitive distortions, planning, etc. Methods of addressing the assault cycle may include charting, the use of a psycho educational curriculum, individual teaching/therapy, etc.

Assessment: See Phases of Assessment.

Autoerotic: Self-stimulation; frequently equated with masturbation.

Aversive Conditioning: A behavioral technique designed to reduce deviant sexual arousal by exposing the client to a stimulus which arouses him/her and then introducing an unpleasant smell or physical sensation.

Boredom Tapes: A behavioral technique wherein the client masturbates alone while talking into a tape recorder about the sexual fantasies he is using to achieve sexual arousal.

Castration: Removal of sex glands—the testicles in men and the ovaries in women. Chemical castration refers to the use of medications to inhibit the production of hormones in the sex glands.

Chaperone: This is a person who has been approved by a supervising officer to supervise contact between a person at risk (generally a minor or developmentally disabled person) and an offender.

Child Pornography: Any audio, visual, or written material that depicts children engaging in sexual activities or behaviors, or images that emphasize genitalia and suggest sexual interest or availability.

Civil Commitment: The confinement and treatment of sex offenders who are especially likely to reoffend in sexually violent ways following the completion of their prison sentence. Commitment is court ordered and indeterminate.

Clarification: This procedure requires the sex offender to write a letter to the victim, in an effort to relieve the victim of any responsibility for the sexual abuse and clarify what occurred in language the victim can understand. Clarification is permitted only after the offender and victim have adequately demonstrated progress in their respective therapy programs. This is a supervised process by the offender and victim's treatment provider and sometimes the supervision officer. This procedure is a pre-requisite for re-unification to occur. In cases where the victim is not in therapy, the offender may still write a letter and the letter is kept in the offender's treatment file. This process varies, but usually requires the offender to accomplish the following tasks:

- Verbalize full responsibility for his sexual deviancy and for making the victim endure the abuse;
- State why he chose the victim and how he misused those qualities to abuse him/her;
- Acknowledge "grooming" behavior which;
- Affected family relationships;
- Isolated the victim;
- Created confusion or guilt for the victim;
- Manipulated the victim into compliance; and
- Convinced the victim to keep the abuse secret.
- Support the victim's decision to report abuse and take responsibility for making the victim endure the legal process;
- Acknowledge deviancy as a life-long process and describe what the offender is doing to manage it; and
- Make no request for forgiveness and ask no questions of the victim.

Clinical Polygraph: A diagnostic instrument and procedure designed to assist in the treatment and supervision of sex offenders by detecting deception or verifying truth of statements by persons under supervision or treatment. The polygraph can assess reports relating to behavior. The three types of polygraph examinations that are typically administered to sex offenders are:

- Sexual History Disclosure Test: Refers to verification of completeness of the offender's disclosure of his/her entire sexual history, generally through the completion of a comprehensive sexual history questionnaire.
- Instant Offense Disclosure Test: Refers to testing the accuracy of the offender's report of his/her behavior in a particular sex offense, usually the most recent offense related to his/her being criminally charged.
- Maintenance/Monitoring Test: Refers to testing the verification of the offender's report of compliance with supervision rules and restrictions.

Clinical Support: Clinical support refers to participants in an aftercare group or receipt of individual therapeutic support.

Cognition: Refers to the mental processes such as thinking, visualizing, and memory functions that are created over time based on experience, value development and education.

Cognitive Distortion (CD): A thinking error or irrational thought that sex offenders use to justify their behavior or to allow themselves to experience abusive emotions without attempting to change them. Cognitive distortions are ways sex offenders go about making excuses for justifying and minimizing their sexually abusive behavior. In essence, these are self-generated excuses for taking part in one's relapse patterns. These thoughts distort reality.

Cognitive Restructuring: A treatment technique wherein the client is made aware of distorted thinking styles and attitudes that support sexual offending and/or other problem behaviors and is encouraged to change those cognitions through confrontation and rebuttal.

Coitus: Sexual intercourse between a male and female, in which the male penis is inserted into the female vagina.

Collaboration: A mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. This type of relationship developed between supervising officers, treatment providers, polygraph examiners, victim advocates, prosecution and the defense bar has been credited with the success of effective sex offender management. This type of relationship includes a commitment to:

- Mutual relationships and goals;
- A jointly developed structure and shared responsibility;
- Mutual authority and accountability; and
- Sharing of resources and rewards.

Collateral Contacts: The sharing and use of information regarding a sex offender among law enforcement, probation/parole officers, treatment providers, employers, family members, and friends of the offender to enhance the effectiveness and quality of community supervision.

Community Justice: A proactive systems approach which emphasizes community partnerships and crime prevention. Principles of Community Justice include:

- The community (including individual victims and offenders) is the ultimate customer, as well as a partner, of the justice system;
- Partnerships for action, among justice components and citizens, strive for community safety and well being;
- The community is the preferred source of problem solving as its citizens work to prevent victimization, provide conflict resolution, and maintain peace; and
- Crime is confronted by addressing social disorder, criminal activities and behavior, and by holding offenders accountable to victims and the community.

Community Notification Laws: Laws which allow or mandate that law enforcement, criminal justice, or corrections agencies give citizens access to relevant information about certain convicted sex offenders living in their communities (see Megan's Law).

Community Supervision: Day to day casework by a supervision officer that centers around the officer's monitoring of the offender's compliance to conditions of supervision, as well as the offender's relationship and/or status with his/her family, employers, friends and treatment provider. From these sources, the officer obtains information about the sex offender's compliance with conditions of community supervision, participation in treatment and risk of reoffense, and assists the offender in behavior modification and restoration to the victim and community. Types of community supervision include:

- *Bond supervision (also called "Pre-Trial Supervision"):* Supervision of an accused person who has been taken into custody and is allowed to be free with conditions of release before and during formal trial proceedings.
- *Parole supervision:* The monitoring of parolees' compliance with the conditions of his/her parole.
- *Probation supervision:* The monitoring of the probationers compliance with the conditions of probation (community supervision) and providing of services to offenders to promote law abiding behavior. General goals of community supervision include (American Probation and Parole Association, 1995):
 - Protection of the community and enhancement of public safety through supervision of offenders and enforcement of the conditions of community supervision;
 - Provision of opportunities to offenders which can assist them in becoming and remaining law-abiding citizens; and

- Provision of accurate and relevant information to the courts to improve the ability to arrive at rational sentencing decisions.

Conditions of Community Supervision: Requirements prescribed by the court as part of the sentence to assist the offender to lead a law-abiding life. Failure to observe these rules may lead to a revocation of community supervision, or graduated sanctions by the court. Examples of special conditions of community supervision for sex offenders are noted below:

- Enter, actively participate, and successfully complete a court recognized sex offender treatment program as directed by your supervising officer, within 30 days of the date of this order;
- No contact with the victim (or victim's family) without written permission from your supervising officer;
- Pay for victim counseling costs as directed by the supervising officer;
- Submit at your expense to polygraph and plethysmograph testing as directed by your supervising officer; and
- Do not possess any sexually explicit materials.

Contact: As a special condition of supervision or as a treatment rule, a sex offender is typically prohibited from contact with his/her victim or potential victims. Contact has several meanings noted below:

- Actual physical touching;
- Association or relationship: taking any action which furthers a relationship with a minor, such as writing letters, sending messages, buying presents, etc.; or
- Communication in any form is contact (including contact through a third party). This includes verbal communication, such as talking, and/or written communication such as letters or electronic mail. This also includes non-verbal communication, such as body language (waving, gesturing) and facial expressions, such as winking.

Contact with Prior Victims or Perpetrators: This includes written, verbal or physical interaction, and third party contact with any person whom a sex offender sexually abused or who committed a sexual offense against the sex offender.

Containment Approach: A model approach for the management of adult sex offenders (English, et al. 1996). This is conceptualized as having five parts:

1. A philosophy that values public safety, victim protection, and reparation for victims as the paramount objectives of sex offender management;
2. Implementation strategies that rely on agency coordination, multi-disciplinary partnerships, and job specialization;
3. A containment approach that seeks to hold sex offenders accountable through the combined use of both the offenders' internal controls and external criminal justice control measures, and the use of the polygraph to monitor internal controls and compliance with external controls;
4. Development and implementation of informed public policies to create and support consistent practices; and
5. Quality control mechanisms, including program monitoring and evaluation, that ensure prescribed policies and practices are delivered as planned.

Conviction: The judgment of a court, based on the verdict of guilty, the verdict of a judicial officer, or the guilty plea of the defendant that the defendant is guilty of the offense.

Copulation: Sexual intercourse; coitus.

Covert Sensitization: A behavioral technique in which a deviant fantasy is paired with an unpleasant one.

Crossover: A sexual behavior pattern which reveals that a sex offender is aroused or acting out to sexual interests in addition to the offenses of record or conviction.

Cruising: The active seeking out of a victim for purposes of engaging in deviant sexual activity.

Culpability: While the term guilty implies responsibility for a crime or at the least, grave error or misdoing, culpability implies a lower threshold of guilt. Culpability connotes malfeasance or errors of ignorance, omission, or negligence. Criminal justice practitioners and treatment providers use an assessment that includes a detailed examination of abusive behavior and criminal histories to determine culpability in sex offenses.

Denial: A psychological defense mechanism in which the offender may act shocked or indignant over the allegations of sexual abuse. Seven types of denial have been identified (Freeman-Longo and Blanchard, 1998):

1. *Denial of facts:* The offender may claim that the victim is lying or remembering incorrectly;
2. *Denial of awareness:* The offender may claim that s/he experienced a blackout caused by alcohol or drugs and cannot remember;
3. *Denial of impact:* Refers to the minimization of harm to the victim;
4. *Denial of responsibility:* The offender may blame the victim or a medical condition in order to reduce or avoid accepting responsibility;
5. *Denial of grooming:* The offender may claim that he did not plan for the offense to occur;
6. *Denial of sexual intent:* The offender may claim that s/he was attempting to educate the victim about his/her body, or that the victim bumped into the offender. In this type of denial, the offender tries to make the offense appear non-sexual; and
7. *Denial of denial:* The offender appears to be disgusted by what has occurred in hopes others would believe s/he was not capable of committing such a crime.

Detumescence: The process of a fully or partially erect penis losing erection and becoming flaccid resulting from drainage of blood from the erectile tissue in the penis. This usually occurs because the man is no longer aroused by the erotic stimulus that previously caused the man's penis to become erect.

Deviant Arousal: The sexual arousal to paraphilic behaviors. Deviant arousal is a sex offender's pattern of being sexually aroused to deviant sexual themes. Not all sex offenders have deviant arousal patterns. The most common method of assessing deviant arousal is through phallometric assessment conducted by a trained and qualified sexual abuse treatment specialist.

Disinhibitors: Internal or external motivators (stimuli) which decrease reservations or prohibitions against engaging in sexual activities. An example of an internal disinhibitor is a cognitive distortion (e.g., "that 8 year old is coming on to me," or "she said no, but she really wants to have sex with me"). Alcohol and drug use are examples of external disinhibitors.

Disposition: A final settlement of criminal charges.

Drug Testing: A chemical analysis of one or more body substances to determine the presence or absence of drugs or drug metabolites.

DSM-IV/ICD-10: The DSM-IV is an abbreviation for the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition and the ICD-10 is an abbreviation for the International Classification of Diseases, Tenth Edition. These are compendia of diagnoses and their definitions that are utilized universally in psychiatry and related professions.

Egosyntonic: Congruent with an individual's self image or values.

Egodystonic: Disruptive to an individual's self-image or values.

Electronic Monitoring: An automated method of determining compliance with community supervision restrictions through the use of electronic devices. There are three main types of electronic monitoring utilizing different technologies (Crowe, 1998):

1. *Continuous Signaling Technology:* The offender wears a transmitting device that emits a continuous coded radio signal. A receiver-dialer is located in the offender's home and is attached to the telephone. The receiver detects the transmitter's signals and conveys a message via telephone report to the central computer when it either stops receiving the message or the signal resumes again.
2. *Programmed Contact Technology:* This form of monitoring uses a computer to generate either random or scheduled telephone calls to offenders during the hours the offender should be at

his/her residence. The offender must answer the phone, and verify his/her presence at home by either having the offender transmit a special beeping code from a special watch attached to the offender's wrist, or through the use of voice or visual verification technology.

3. Global Positioning Technology (GPS): This technology is presently under development and is being used on a limited basis. The technology can monitor an offender's whereabouts at any time and place. A computer is programmed with the places offenders should be at specific times and any areas that are off limits to the offender (e.g., playgrounds and parks). The offender wears a transmitting device that sends signals through a satellite to a computer, indicating the offender's whereabouts.

Empathy: A capacity for participating in the feelings and ideas of another.

Evaluation: The application of criteria and the forming of judgments; an examination of psychological, behavioral, and/or social information and documentation produced by an assessment (sex offender assessments precede sex offender evaluations). The purpose of an evaluation is to formulate an opinion regarding a sex offender's amenability to treatment, risk/dangerousness, and other factors in order to facilitate case management.

Exclusion Criteria: The specific offender characteristics and level of risk which cannot be treated and managed safely and effectively in a treatment program.

External, Supervisory Dimension (ESD): The dimension of relapse prevention that enhances the ability of probation/parole officers and significant others (e.g., employer, family members, and friends) to monitor a sex offender's offense precursors.

False Remorse: An insincere attempt by the offender to show s/he feels sorry for the abuse s/he has committed. The false remorse is usually self-pity or self-disgust.

False Resolve: An insincere effort on the part of an offender to make promises to him/her self never to abuse again.

Family Reconciliation: The therapeutic process that ends with a resolution of problems and conflict areas that prevent a family from having a healthy, non-abusive relationship. Family reconciliation must take place before family reunification can occur. Reconciliation may take place without reunification, although reunification should not occur without reconciliation.

Family Reunification: This is the joining again of the family unit as part of a sex offender's treatment plan. It is a step-by-step process with achievable goals and objectives.

Gender Role: The pattern of behaviors and attitudes considered appropriate for a male or a female in a given culture.

Graduation or Discharge Readiness: Documented evidence of a sex offender's accomplishment of treatment goals outlined in an individual treatment plan. Sex offender progress that leads to graduation or discharge readiness may include, but is not limited to:

- A decrease in the offender's risk/dangerousness to the community;
- Aftercare planning;
- A community reintegration plan;
- The ability to recognize and alter thinking errors and to intervene in the assault cycle;
- The ability to develop and use relapse prevention plans;
- Knowledge of healthy sexuality and safe sex practices;
- Improved social skills;
- Vocational and recreational planning; and
- A commitment to attend aftercare support groups.

Grooming: The process of manipulation often utilized by child molesters, intended to reduce a victim's or potential victim's resistance to sexual abuse. Typical grooming activities include gaining the child victim's trust or gradually escalating boundary violations of the child's body in order to desensitize the victim to further abuse.

High Risk Factors (HRF): A set of internal motivations or external situations/events that threaten a sex offender’s sense of self-control and increase the risk of having a lapse or relapse. High risk factors usually follow seemingly unimportant decisions (SUDs).

Homogeneous: Similar in significant characteristics that relate to treatment and living needs (e.g., age, cognitive ability, type of sexual offending behavior, mental health diagnosis, etc.).

Incest: Sexual relations between close relatives, such as father and daughter, mother and son, sister and brother. This also includes other relatives, step children, and children of common-law marriages.

Index Offense: The most recent offense known to authorities.

Individual Treatment Plan: A document outlining the essential treatment issues which must be addressed by the sex offender. Treatment plans often consist of core problem areas to be addressed in treatment such as cognitive restructuring, emotional development, social and interpersonal skills enhancement, lowering of deviant sexual arousal, anger management, empathy development, understanding of the sexual abuse cycle, and the formulation and implementation of a relapse prevention plan. These plans include the:

- Problem to be addressed;
- Proposed treatment;
- Treatment goal;
- Responsible staff; and
- Time frame to meet goals.

Internal, Self-Management Dimension (ISD): The aspect of relapse prevention that allows a sex offender to recognize and control offense precursors.

Intake Procedure: The process of admission/reception into a treatment program.

Intrusive: The degree to which a treatment/reception technique invades the usual physical and/or psychological privacy and/or functioning of a sex offender in order to address specific components of sexually aggressive behavior. Because sex offender treatment is usually involuntary/mandatory, all abuse specific treatment may be considered intrusive and may require informed consent. The use of phallometric measurement, pharmacological agents, and treatment modalities involving physical contact are generally deemed to be the most intrusive treatment methods. Treatment providers who use the most intrusive treatment methods should consider requiring a separate statement of informed consent for each method. Audio recording of masturbation satiation exercises and verbal confrontations that violate normal body space boundaries are examples of intrusive treatment techniques. Abusive techniques such as shaming, verbal abuse, and name calling are not commonly used or accepted intrusive treatment techniques. Intrusive is also used in sex offender management to describe the degree of intrusiveness or violation of the victim by the sex offender. This is often categorized along a continuum from relatively low intrusiveness offenses, such as obscene phone calling or exhibitionism, to high intrusiveness offenses, such as forced intercourse with a minor by a parent.

Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act:

Enacted in 1994, this federal mandate requires states to establish stringent registration programs for sex offenders—including lifelong registration for offenders classified as “sexual predators” by September 1997 (see Sex Offender Registration).

Justification: A psychological defense mechanism by an offender in which s/he attempts to use reasoning to explain offending behavior.

Lapse: An emotion, fantasy, thought, or behavior that is part of a sex offender’s cycle and relapse pattern. Lapses are not sex offenses. They are precursors or risk factors for sex offenses. Lapses are not failures and are often considered as valuable learning experiences.

Lapse Contract: A contract signed by the sex offender, his/her therapist, and/or probation/parole officer that describes the extent to which the sex offender is permitted to lapse. Effective lapse contracts include clauses that require sex offenders to delay engaging in the lapse, permit only one instance of the lapse, require that the sex offender immediately report the lapse to the therapist and/or the probation/parole officer, and receive some penalty for the lapse behavior (e.g., a curfew, a driving restriction, house arrest, etc.).

Less Restrictive: The result of changing the environment in which a sex offender lives by decreasing security offered by the physical structure (e.g., increased number of roommates), reducing the level/intensity of supervision, allowing greater access to unsupervised leisure time activities, and permitting community or family visits. A less restrictive environment is usually the result of significant treatment progress or compliance with the treatment program and environment.

Level of Risk: The degree of dangerousness a sex offender is believed to pose to potential victims or the community at large. The likelihood or potential for a sex offender to re-offend is determined by a professional who is trained or qualified to assess sex offender risk.

Level of Service Inventory-Revised (LSI-R): A risk assessment tool designed to assess re-offense risk and treatment needs among the general criminal population. This tool utilizes a 54 item scale scored “yes” or “no” or a “0-3” rating by clinical staff or case managers (Andrews and Bonta, 1995). This instrument has not been validated for a sex offender population.

Maladaptive Coping Response (MCR): An apparent effort to deal with a risk factor or lapse that actually enables the sex offender to get closer to relapse (e.g., an angry rapist who decides to take a drive and picks up a female hitch-hiker, or a child molester who knows that he has a problem with alcohol and decides to have a drink because he is upset).

Masochism: A sexual deviation in which an individual derives sexual gratification from having pain, suffering and/or humiliation inflicted on him/her.

Masturbation: Self-stimulation of the genitals; autoeroticism.

Megan’s Law: The first amendment to the Jacob Wetterling Crimes Against Children and Sexually Violent Offenders Act. This was passed in October 1996 and requires states to allow public access to information about sex offenders in the community. This federal mandate was named after Megan Kanka, a seven-year-old girl who was raped and murdered by a twice-convicted child molester in her New Jersey neighborhood (see Community Notification).

Minimization: An attempt by the offender to downplay the extent of abuse.

Minnesota Sex Offender Screening Tool—Revised (MnSOST-R): A risk assessment tool commonly used for screening adult sex offenders for civil commitment and community notification. This tool has 16 items scored by clinical staff or case managers using a weighted scoring key.

Mitigating Circumstances: Conditions that may modify the seriousness of a sex offense. Conditions may include the offender participating in the offense under coercion or duress; a lack of sufficient capacity on the part of the sex offender for judgment due to physical or mental impairment; or sincere remorse and a course of action undertaken to demonstrate restitution, responsibility, and culpability.

Multi-Cultural Issues: Any difference that exists between the language, customs, beliefs, and values among various racial, ethnic, or religious groups.

Multi-Disciplinary Team: A variety of professionals (e.g., psychologists, psychiatrists, clinical social workers, educators, medical personnel, recreational staff, paraprofessionals, criminal justice personnel, volunteers, and victim advocates) working together to evaluate, monitor, and treat sex offenders.

Narcissism: Excessive self-love; self-centeredness, beliefs that the individual is overly “special,” often resulting in the individual’s belief that rules, requirements and laws that apply to others should not apply to him/her. Also, sexual excitement through admiration of one’s own body.

Nolo Contendere: A plea in criminal prosecution that, without admitting guilt, leads to conviction but does not prevent denying the truth of the charges in a collateral proceeding. A defendant may plead nolo contendere only with the consent of the court after the judge has obtained a factual basis. A plea of nolo contendere cannot be considered an admission of guilt in civil court proceedings.

Obscene: A legal finding that a specific depiction, typically sexually explicit, is so abhorrent to a community's standards of acceptability that it is an exception to the First Amendment's free speech protections and is therefore illegal to possess or distribute. Examples of obscene materials include depictions of children engaged in sexual behavior.

Obsession: A neurosis characterized by the persistent recurrence of some irrational thought or idea or by an attachment to or fixation on a particular individual or object.

Orgasmic Reconditioning: A behavioral technique designed to reduce inappropriate sexual arousal by having the client masturbate to deviant sexual fantasies until the moment of ejaculation, at which time the deviant sexual theme is switched to a more appropriate sexual fantasy.

Outcome Data: Data that demonstrates clear, relevant, and undisputed information regarding the effect of supervision and/or treatment on sex offender recidivism rates.

Pam Lychner Act: Passed in 1996, this federal amendment to the Jacob Wetterling Act requires the U.S. Department of Justice to establish a National Sex Offender Registry (NSOR) to facilitate state-to-state tracking of sex offenders and lifetime registration and 90-day address verification requirements on violent and habitual sex offenders. This act also requires the Federal Bureau of Investigations (FBI) to handle sex offender registration and notification in states unable to maintain "minimally sufficient" programs on their own.

Paraphilia: A psychosexual disorder. Recurrent, intense, sexually arousing fantasies, urges, and/or thoughts that usually involve humans, but may also include non-human objects. Suffering of one's self or partner, children, or non-consenting persons is common. A deviation in normal sexual interests and behavior that may include:

- *Bestiality (Zoophilia):* Sexual interest or arousal to animals.
- *Coprophilia:* Sexual interest or arousal to feces.
- *Exhibitionism:* Exposing one's genitalia to others for purposes of sexual arousal.
- *Frotteurism:* Touching or rubbing against a non-consenting person.
- *Fetishism:* Use of nonliving objects (e.g., shoes, undergarments, etc.) for sexual arousal that often involves masturbation.
- *Hebophilia:* Sexual interest in, or arousal to, teens/post-pubescent children.
- *Klismophilia:* Sexual arousal from enemas.
- *Necrophilia:* Sexual interest in, or arousal to, corpses.
- *Pedophilia:* The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for pedophilia are as follows:

1. Over a period of at least 6 months, recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a pre-pubescent child or children (generally age 13 years or younger);
2. The fantasies, sexual urges, or behaviors cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
3. The person is at least 16 years old and at least 5 years older than the child or children in the first criterion (this does not include an individual in late adolescence who is involved in an ongoing sexual relationship with a 12 or 13 year old).

- *Pederast:* Sexual interest in, or arousal to, adolescents.
- *Sexual Masochism:* Sexual arousal/excitement from being humiliated, beaten, bound, or made to suffer.
- *Sexual Sadism:* Sexual arousal/excitement from psychological or physical suffering of another.

- *Telephone Scatologia*: Engaging in uninvited, sexually explicit talk with another person via the telephone. This is often referred to as “obscene phone calling.”
- *Transsexual*: A person who has undergone a surgical sexual/gender change.
- *Transvestic Fetishism*: The wearing of clothing articles and especially undergarments for persons of the opposite sex. This is often referred to as “cross dressing.”
- *Voyeurism*: Observing unsuspecting individuals, usually strangers, who are naked, in the act of dressing or undressing, or engaging in sexual activities.

Parole: A method of prisoner release on the basis of individual response and progress within the correction institution, providing the necessary controls and guidance while serving the remainder of their sentences within the free community.

Pathology: Structural and functional deviations from the norm that constitute disease or psychological malfunctioning.

Pedophile: An individual who turns to prepubescent children for sexual gratification. (The DSM-IV criteria for pedophilia is noted under pedophilia.) There are several typologies of pedophiles, including:

- *Fixated Pedophile*: An individual who is sexually attracted to children and lacks psychosexual maturity.
- *Regressed Pedophile*: Most commonly describes a sex offender who has a primary adult sexual orientation but under stress engages in sexual activities with underage persons.

Phallometry (Phallometric Assessment or Penile Plethysmography): A device used to measure sexual arousal to both appropriate (age appropriate and consenting) and deviant sexual stimulus material. Stimuli can be either audio, visual, or a combination.

Phases of Assessment: An assessment is the process of collecting and analyzing information about an offender so that appropriate decisions can be made regarding sentencing, supervision, and treatment. An assessment does not and cannot determine guilt or innocence, and it cannot be used to determine whether an individual fits the “profile” of an offender who will commit future offenses. Assessments lay the groundwork for conducting an evaluation.

There are several phases and types of sex offender assessments. These include the following:

- *Investigative Assessment*: An investigative assessment is generally completed by a team that includes law enforcement personnel, a prosecuting attorney, and a child protective services staff member. The purpose of this assessment is to gather as much information as possible regarding the modus operandi of a sexual abuser and to corroborate evidence regarding the crime scene and how the abuse occurred.
- *Risk Assessment*: A risk assessment considers the nature, extent, and seriousness of an offender’s sexually abusive behavior; the degree of threat the offender presents to the community or victim; and the general dangerousness of the offender in any particular setting. It determines specifically and in detail the appropriate setting, the intensity of intervention, and the level of supervision needed by a particular sex offender. A risk assessment is required prior to admission to any program for sex offenders, and is conducted on an ongoing basis after admission.
- *Treatment Planning Assessment*: The purpose of a treatment planning assessment is to identify specific problem areas, strengths and weaknesses, skills, knowledge, and the precedents and antecedents of the sexually abusive behavior. The assessment includes consideration of thinking, affect, behavior, organicity of behavioral and cognitive issues, psychiatric disorders, addictions, and family functioning.
- *Clinical Assessment*: A clinical assessment is necessary for treatment planning. It helps determine the problem areas that need to be addressed in treatment as well as the types and modalities of treatment most suitable to treat the sex offender.
- *Formal and Informal Assessments of Progress in Treatment*: Formal and informal assessments of progress in treatment are used to determine sex offender progress in treatment. They are typically done using prepost testing of information learned, direct observation and evaluation of the skills the sex offender has acquired, and the extent of his/her behavioral change.

- *Graduation or Discharge Readiness Assessment:* A graduation or discharge readiness assessment is used to determine if a sex offender has successfully completed treatment. The sex offender's skills, knowledge, and abilities are evaluated based upon the treatment plan and other factors that were identified to determine the offender's progress.
- *Classification Assessment:* A classification assessment is conducted to determine the supervision classification status of a probationer or parolee who is a sex offender.
- *Outcome Evaluations:* Outcome evaluations are conducted after discharge from a program, typically by tracking all sex offenders to determine rates of recidivism/re-offense.

Plethysmograph: A device that measures erectile responses in males to both appropriate and inappropriate stimulus material (see Phallometry).

Polygraph: See Clinical Polygraph.

Pornography: The presentation of sexually arousing material in literature, art, motion pictures, or other means of communication or expression.

Positive Treatment Outcome: A treatment outcome that includes a significantly lower risk of the sex offender engaging in sexually abusive behavior as a result of attaining/developing a higher level of internal control. Positive treatment outcomes include a lack of recidivism; a dramatic decrease in behaviors, thoughts and attitudes associated with sexual offending; and other observable changes that indicate a significantly lower risk of re-offending.

Precocious Sexuality: Premature onset of sexual interest and behavior in children.

Precursors: A general term used to describe seemingly unimportant decisions (SUDs), maladaptive coping responses (MCRs), risk factors, lapses, and the abstinence violation effect (AVE). Precursors are events that occur prior to a sex offense.

- *Perpetuating Precursors:* Thoughts, feelings, and behaviors which are generally ongoing problems in the sex offender's life and often help maintain him/her in the pretend-normal phase of the cycle and trigger the relapse process (e.g., unresolved angers, alcohol and drug abuse, and low self-esteem). The pretendnormal phase of the deviant cycle for a sex offender is the phase in which the offender attempts to cover up his/her behavior by engaging in "normal daily routines" that do not include sexually deviant behavior.
- *Precipitating Precursors:* Thoughts, feelings, and events which generally began during the sex offender's childhood which influence the way he/she currently thinks, feels, and behaves (e.g., thoughts and feelings experienced today that are a result of abuse during childhood).
- *Predisposing Precursors:* Thoughts, feelings, and events which occur in the sex offender's life which trigger the deviant cycle and relapse process. These precursors are usually high risk factors and triggers which precede acting out (e.g., arguments with others, isolation, etc.).

Presentence Investigation Report: A court ordered report prepared by a supervision officer. This report includes information about an offender's index offense, criminal record, family and personal history, employment and financial history, substance abuse history, and prior periods of community supervision or incarceration. At the conclusion of the report, the officer assesses the information and often makes a dispositional recommendation to the court.

Probation: A court ordered disposition through which an adjudicated offender is placed under the control, supervision, and care of a probation field staff member in lieu of imprisonment, so long as the probationer (offender) meets certain standards of conduct.

Problem of Immediate Gratification (PIG Phenomenon): The PIG phenomenon is part of the Abstinence Violation Effect (AVE). It occurs when sex offenders selectively remember the positive sensations experienced during, or immediately after, past assaults, and forget the delayed negative consequences (e.g., guilt, loss of family and friends, loss of employment, newspaper and television coverage of arrest and conviction, incarceration, parole, etc.). Recalling only the immediate positive sensations from past assaults increases the likelihood of relapse. When sex offenders learn to counter the strength of the PIG phenomenon by focusing on the delayed negative effects of their acts (and the immediate and delayed harmful impacts on victims), the likelihood of relapse decreases.

Programmed Coping Responses: Coping responses and interventions that are well practiced by the offender so that they are used automatically when s/he is faced with a risk factor or high risk situation.

Progress in Treatment: Observable and measurable changes in behavior, thoughts, and attitudes which support treatment goals and healthy, non-abusive sexuality.

Promiscuous: Engaging in sexual intercourse with many persons.

Psychopath: A disorder characterized by many of the following: glibness and superficial charm; grandiosity; excessive need for stimulation/proneness for boredom; pathological lying; cunning and manipulative; lack of remorse or guilt; shallow affect; parasitic lifestyle; poor behavior controls; promiscuous sexual behavior and many short-term relationships; early behavioral problems; lack of realistic, long-term goals; impulsivity; irresponsibility; history of juvenile delinquency; likelihood of revocation on conditional release; and criminal versatility.

Hervy Cleckley (1982) developed the following three important points about psychopaths:

- Psychopaths have all of the outward appearances of normality—they do not hallucinate or have delusions and do not appear particularly encumbered by debilitating anxiety or guilt;
- Psychopaths appear unresponsive to social control; and
- Criminal behavior is not an essential characteristic.

Psychopathy Checklist—Revised: The clinical instrument to assess the degree to which an individual has characteristics of psychopathy. It is a 20-item instrument that is scored by the evaluator based on collateral information and typically an interview of the offender (Hare, 1991).

Psychopharmacology: The use of prescribed medications to alter behavior, affect, and/or the cognitive process.

Psychosexual Evaluation: A comprehensive evaluation of an alleged or convicted sex offender to determine the risk of recidivism, dangerousness, and necessary treatment. A psychosexual evaluation usually includes psychological testing and detailed history taking with a focus on criminal, sexual, and family history. The evaluation may also include a phallometric assessment.

Puberty (or Pre-Pubescence): The stage in life at which a child's reproductive organs become functionally operative and secondary sexual characteristics develop.

Range of Clinical Needs: Clinical needs of sex offenders may include developmental, psychiatric, neuropsychological, cognitive, and psycho-social issues.

Rape: Forcible sexual penetration of a child or an adult (vaginal, oral, or anal) with a penis, finger, or object. Groth (1979) proposed three types of rapists:

1. *Anger Rapist:* A sex offender whose rape behavior is motivated primarily by a desire to release anger and hostility on his/her victims. Offender's mood is one of anger and depression.
2. *Power Rapist:* A sex offender whose primary motivation for raping others is to feel powerful and exercise control over victims. Offender's mood is one of anxiety.
3. *Ritualistic-Sadistic Rapist:* A sexual offender whose primary motivation for raping is the eroticized power or anger. If power is eroticized the victim is subjected to ritualistic acts, such as bondage. If anger is eroticized, the victim is subjected to torture and sexual abuse. Offender's mood is one of intense excitement and dissociation.

Rapid Risk Assessment for Sex Offense Recidivism (RRASOR): A risk assessment tool that assesses sexual re-offense risk among adult sex offenders at five and ten year follow-up periods. In this tool, four items are scored by clinical staff or case managers using a weighted scoring key (Hanson, 1997).

Recidivism: Commission of a crime after the individual has been criminally adjudicated for a previous crime; reoffense. In the broadest context, recidivism refers to the multiple occurrence of any of the following key events in the overall criminal justice process: commission of a crime whether or not followed by arrest, charge, conviction, sentencing, or incarceration.

Reintegration: Gradual re-acclimation or adjustment to a non-supervised, less structured environment featuring opportunities to demonstrate new social skills and responsible decision making in support of community and personal safety.

Relapse: A re-occurring sexually abusive behavior or sex offense.

Relapse Prevention: A multidimensional model incorporating cognitive and behavioral techniques to treat sexually abusive/aggressive behavior. See Appendix I for listings of relapse prevention specific terminology.

Release of Information: A signed document for purposes of sharing information between and among individuals involved in managing sex offenders (e.g., two-way information release between treatment providers and legal professionals includes the sharing of sex offender legal and treatment records and other information necessary for effective treatment, monitoring and supervision).

Restrictive: The degree to which a program places limitations or external controls on a sex offender's physical freedom, movement within a treatment facility, access to the community, or other basic privileges. Secure treatment units with perimeter security and individual rooms for sex offenders that are locked at night and/or prisons would be considered the most restrictive treatment settings. The use of locked seclusion rooms and policies forbidding supervised community outings for sex offenders would be considered very restrictive intervention techniques.

Restitution: A requirement by the court as a condition of community supervision that the offender replaces the loss caused by his/her offense through payment of damages in some form.

Restorative Justice: Focuses on the repair of the harm to the victim and the community, as well as the improvement of pro-social competencies of the offender, as a result of a damaging act.

Reunification: A gradual and well-supervised procedure in which a sex offender (generally an incest offender) is allowed to re-integrate back into the home where children are present. This takes place after the clarification process, through a major part of treatment, and provides a detailed plan for relapse prevention.

Risk Controls: External conditions placed on a sex offender to inhibit re-offense. Conditions may include levels of supervision, surveillance, custody, or security. In a correctional facility, these conditions generally are security and custody related. In a community setting, conditions are a part of supervision and are developed by the individual charged with overseeing the sex offender's placement in the community.

Risk Factors: A set of internal stimuli or external circumstances that threaten a sex offender's self-control and thus increases the risk of lapse or relapse. Characteristics that have been found through scientific study to be associated with increased likelihood of recidivism for known sex offenders. Risk factors are typically identified through risk assessment instruments. An example of a sex offender risk factor is a history of molesting boys.

Risk Level: The determination by evaluation of a sex offender's likelihood of reoffense, and if the offender reoffends, the extent to which the offense is likely to be traumatic to potential victims. Based on these determinations, the offender is assigned a risk level consistent with his/her relative threat to others. Sex offenders who exhibit fewer offenses, less violence, less denial, a willingness to engage in treatment, no/few collateral issues (e.g., substance abuse, cognitive deficits, learning disabilities, neurological deficits, and use of weapons) are considered lower risk than those whose profile reflects more offenses, greater violence, and so on. Risk level is changeable, depending on behaviors exhibited within a treatment program. Disclosures of additional, previously unknown offenses or behaviors may also alter the offender's assessed level of risk.

Risk Management: A term used to describe services provided by corrections personnel, treatment providers, community members, and others to manage risk presented by sex offenders. Risk management approaches include supervision and surveillance of sex offenders in a

community setting (risk control) and require sex offenders to participate in rehabilitative activities (risk reduction).

Risk Reduction: Activities designed to address the risk factors contributing to the sex offender's sexually deviant behaviors. These activities are rehabilitative in nature and provide the sex offender with the necessary knowledge, skills, and attitudes to reduce his/her likelihood of re-offense.

Sadism: The achievement of sexual gratification by inflicting physical or psychological pain and/or humiliation upon another.

Seemingly Unimportant Decisions (SUDs): Decisions sex offenders make that seem to them to have little bearing on whether a lapse or relapse will occur. SUDs actually allow sex offenders to get closer to high-risk factors that increase the probability of another offense (e.g., a pedophile who decides to go holiday shopping at a mall on a Saturday afternoon or decides to go to a Walt Disney movie on a Saturday afternoon is making a Seemingly Unimportant Decision--the certain presence of children in the mall or the inevitable presence of children at the theater creates a high-risk factor that may lead to lapse or relapse).

Selective Serotonin Reuptake Inhibitors (SSRIs): A class of antidepressant drugs, sometimes used in the treatment of sex offenders, that includes fluoxetine (Prozac), fluvoxamine, paroxetine and sertraline. SSRIs are mood stabilizers that can cause sexual dysfunction.

Self-Deprecation: Belittling or putting down oneself.

Sex Offender: The term most commonly used to define an individual who has been charged and convicted of illegal sexual behavior.

Sex Offender Registration: Sex offender registration laws require offenders to provide their addresses, and other identifying information, to a state agency or law enforcement agency for tracking purposes with the intent of increasing community protection. In some states, only adult sex offenders are required to register. In others, both adult and juvenile sexual offenders must register (see Jacob Wetterling Act).

Sexual Abuse Cycle: The pattern of specific thoughts, feelings, and behaviors which often lead up to and immediately follow the acting out of sexual deviance. This is also referred to as "offense cycle," or "cycle of offending."

Sexual Abuser: The term most commonly used to describe persons who engage in sexual behavior that is considered to be illegal (this term refers to individuals who may have been charged with a sex crime but have not been convicted).

Sexual Abuse Specific: A term used to imply that aspects of treatment, assessment, and programming are targeting sexually abusive behaviors and not generic problems. Sexual abuse specific treatment often includes limited confidentiality, involuntary client participation, and a dual responsibility for the therapist: meeting the offender's needs while protecting society).

Sexual Assault: Forced or manipulated unwanted sexual contact between two or more persons.

Sexual Contact: Physical or visual contact involving the genitals, language, or behaviors of a seductive or sexually provocative nature.

Sexual Deviancy: Sexual thoughts or behaviors that are considered abnormal, atypical or unusual. These can include non-criminal sexual thoughts and activities such as transvestitism (cross-dressing) or criminal behaviors, such as pedophilia.

Sexual Predator: A highly dangerous sex offender who suffers from a mental abnormality or personality disorder that makes him/her likely to engage in a predatory sexually violent offense.

Statement of Informed Consent: A clinical document that is signed by a sex offender which becomes part of the treatment record and may be admissible in court. It implies that the sex offender understands the benefits and risks of a particular treatment procedure and may voluntarily withdraw from the procedure without consequence. Informed consent is used with treatments such as behavioral therapy, phallometry, odor aversion, aversive conditioning techniques and chemotherapy treatments that may generate physical

discomfort or be intrusive to the human body. Informed consent is not used with sex offense specific treatments such as group and individual therapy, and educational classes.

Successful Completion: Indicates a sex offender can graduate from a program with a discharge statement stating that s/he has successfully demonstrated all skills and abilities required for safe release from the program.

Suppression: The later part of the sexual abuse cycle after the individual offends during which a conscientious effort is made to cover up and forget the abusive behavior.

Termination of Community Supervision: Community supervision usually ends in one of three ways:

- *Early Termination:* For good behavior and compliance with the conditions of probation, the court may reduce the period of supervision and terminate community supervision prior to the conclusion of the original term.
- *Expiration of Sentence/Term:* An offender completes the full probated or incarcerated sentence.
- *Revocation:* If the offender violates the terms of the community supervision, the court, following a revocation hearing, may suspend community supervision and sentence the offender to a term in jail or prison.

Thinking Error: See Cognitive Distortion.

Transducer: The gauge used to measure physiological changes in penile tumescence during a phallometric assessment. Also referred to as a “strain gauge.”

Treatment Contracts: A document explained to and signed by a sex offender, his/her therapist, his/her probation/parole officer, and others that includes:

- Program goals;
- Program progress expectations;
- Understanding and acceptance of program and facility (if applicable) rules;
- Agreement by the sex offender to take full responsibility for his/her offenses within a specific time frame;
- Acknowledgment of the need for future stipulations as more risks and needs are identified (e.g., triggers, patterns, etc.) and that privileges or restrictions may be adjusted as progress or risk factors change;
- Parental/family requirements to participate in sexual abuse specific family treatment and be financially responsible when necessary;
- Acknowledgment of consequences for breaking the treatment contract; and
- Incentives.

Treatment Models: Various treatment models are employed with sex offenders.

- *Bio-Medical Treatment Model:* The primary emphasis is on the medical model, and disease process, with a major focus on treatment with medication.
- *Central Treatment Model:* A multi-disciplinary approach to sex offender and sexual abuser treatment that includes all program components (e.g., clinical, residential, educational, etc.).
- *Cognitive/Behavioral Treatment Model:* A comprehensive, structured treatment approach based on sexual learning theory using cognitive restructuring methods and behavioral techniques. Behavioral methods are primarily directed at reducing arousal and increasing pro-social skills. The cognitive behavioral approach employs peer groups and educational classes, and uses a variety of counseling theories.
- *Family Systems Treatment Model:* The primary emphasis is on family therapy and the inclusion of family members in the treatment process. The approach employs a variety of counseling theories.
- *Psychoanalytic Treatment Model:* The primary emphasis is on client understanding of the psychodynamics of sexual offending, usually through individual treatment sessions using psychoanalytic principles.

- *Psycho-Socio Educational Treatment Model*: A structured program utilizing peer groups, educational classes, and social skills development. Although the approach does not use behavioral methods, it employs a variety of counseling theories.
- *Psychotherapeutic (Sexual Trauma) Treatment Model*: The primary emphasis is on individual and/or group therapy sessions addressing the sex offender's own history as a sexual abuse victim and the relationship of this abuse to the subsequent perpetration of others. The approach draws from a variety of counseling theories.
- *Relapse Prevention (RP) Treatment Model*: A three dimensional, multimodal approach specifically designed to help sex offenders maintain behavioral changes by anticipating and coping with the problem of relapse. Relapse Prevention: 1) teaches clients internal self-management skills; 2) plans for an external supervisory component; and 3) provides a framework within which a variety of behavioral, cognitive, educational, and skill training approaches are prescribed in order to teach the sex offender how to recognize and interrupt the chain of events leading to relapse. The focus of both assessment and treatment procedures is on the specification and modification of the steps in this chain, from broad lifestyle factors and cognitive distortions to more circumscribed skill deficits and deviant sexual arousal patterns. The focus is on the relapse process itself. (See Appendix I for a list of terms commonly used in the relapse prevention treatment models.)
- *Sexual Addiction Treatment Model*: A structured program using peer groups and an addiction model. This approach often includes 12-Step and sexual addiction groups.

Treatment Planning/Process Meeting: A face-to-face gathering of a multi-disciplinary team to discuss the results of initial evaluations and outline the individual treatment plan for a sex offender. The meeting generally focuses on specific developmental, vocational, educational and treatment needs; and housing and recreational placement.

Treatment Program or Facility: Any single program in which sex offenders routinely are grouped together for services. It may include residential, educational, and day treatment programs; or any similar service. A treatment program or facility is differentiated from an agency which may administer a number of different treatment facilities.

Treatment Progress: Gauges the offender's success in achieving the specific goals set out in the individual treatment plan. This includes, but is not limited to: demonstrating the ability to learn and use skills specific to controlling abusive behavior; identifying and confronting distorted thinking; understanding the assault cycle; accepting responsibility for abuse; and dealing with past trauma and/or concomitant psychological issues, including substance abuse/addiction.

Triggers: An external event that begins the abuse or acting out cycle (i.e., seeing a young child, watching people argue, etc.).

Victim Impact Statement: A statement taken while interviewing the victim during the course of the presentence investigation report, or at the time of pre-release. Its purpose is to discuss the impact of the sexual offense on the victim.

Victim-Stancing: The behavior of an individual who has been the perpetrator of victimization inaccurately portraying the real victim.

Violence Risk Appraisal Guide (VRAG): A risk assessment tool designed to assess sexual and nonsexual violence re-offense risk among adult male offenders. This tool has twelve items scored by clinical staff using a weighted scoring key (Quinsey, 1998).

APPENDIX C
ALASKA ADMINISTRATIVE CODE REGULATING SEX OFFENDER
TREATMENT PROVIDERS

Section

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22 AAC 30.010. Sex offender treatment committee

(a) The commissioner will establish a Sex Offender Treatment Committee for the purposes of

(1) assisting in developing a Sex Offender Treatment Standards of Care Manual for use by providers approved under this chapter;

(2) reviewing applications from individuals applying for approval, or renewal of approval, to provide sex offender treatment to offenders under the department's

jurisdiction and making recommendations to the department regarding the applications;
and

(3) reviewing and investigating complaints against approved providers and making recommendations to the department regarding disposition of the complaints.

(b) The committee will include

(1) the department employee with responsibility for oversight of the sex offender treatment program;

(2) one department employee representing the department's correctional facilities;

(3) two department employees representing the department's community corrections programs; and

(4) three public members, from different judicial districts in the state, who are licensed under AS 08 in a professional field listed in 22 AAC 30.030(b) (1) and who have experience in providing clinical services to sex offenders.

(c) The committee's members serve on the committee at the pleasure of the commissioner. The commissioner will designate one of the committee members to be the committee chairperson.

History: Eff. 11/2/2002, Register 164

Authority: AS 33.30.011

AS 33.30.021

AS 44.28.030

22 AAC 30.020. Provider approval

(a) An individual who wishes to provide sex offender treatment to a sex offender who is under the department's jurisdiction first must obtain, and then maintain, approval from the department under this chapter in order for the treated sex offender to be considered in compliance with a sex offender treatment requirement imposed by the court, the parole board, or the department. Department approval of such a provider is required regardless of who pays for the sex offender's treatment and regardless of whether the treatment takes place in a correctional facility or is community-based.

(b) An individual does not need approval under this chapter in order to provide a service that is not sex offender treatment, as defined in 22 AAC 30.900, to a sex offender who is under the department's jurisdiction.

History: Eff. 11/2/2002, Register 164

Authority: AS 33.30.011

AS 33.30.021

AS 44.28.030

22 AAC 30.030. Application process; qualifications

(a) An individual who wishes to become an approved sex offender treatment provider must apply to the department on a form provided by the department. Only an individual may be approved as a sex offender treatment provider.

(b) To become an approved provider under this chapter, an individual must

(1) have a current professional license, in good standing, issued under AS 08, as a psychiatrist, psychologist, psychological associate, social worker, marital and family therapist, or professional counselor;

(2) be of good moral character; and

(3) agree to abide by the standards set out in 22 AAC 30.200 in providing sex offender treatment to a sex offender who is under the department's jurisdiction.

(c) An application for provider approval must include

(1) the applicant's name, business mailing address, and telephone number;

(2) a statement of the applicant's educational degrees, the year they were obtained, and the institutions from which they were obtained;

(3) verification from the relevant Alaska licensing board that the applicant has a current professional license, as described in (b) of this section, in good standing;

(4) a history of the applicant's specialized training in the treatment of sex offenders;

(5) a history of the applicant's professional work experience;

(6) the applicant's complete criminal history, if any;

(7) information about any investigations of the applicant by any licensing authority in this or any other jurisdiction for possible professional license violations; and

(8) references from at least two individuals familiar with the applicant's professional training and experience.

(d) Except as provided in 22 AAC 30.100, initial department approval of a provider lapses three years from the date of the approval.

History: Eff. 11/2/2002, Register 164

Authority: AS 33.30.011

AS 33.30.021

AS 44.28.030

22 AAC 30.040. Provider levels; supervision condition

(a) The department will establish different provider levels, including a full-service level, and will approve a provider at a particular level based on the provider's education, training, experience, and professional license.

(b) Department approval of a provider at a provider level less than the full-service level will be conditioned on the requirement that, in providing sex offender treatment to a sex offender who is under the department's jurisdiction, that approved provider must be supervised by an approved full-service-level provider.

History: Eff. 11/2/2002, Register 164

Authority: AS 33.30.011

AS 33.30.021

AS 44.28.030

22 AAC 30.050. Application review; approval or denial; request for review of denial

(a) The Sex Offender Treatment Committee shall review an application for approval as a sex offender treatment provider and shall place in the applicant's file the committee's recommendation to the department regarding approval or denial of the application. The committee may recommend denial only if the committee determines that the applicant does not meet the requirements for approval in 22 AAC 30.030. If the committee recommends denial of an application, the committee's recommendation to the department must include a written statement of the committee's reasons for recommending denial. The committee shall forward the applicant's file to the department.

(b) After review of the application and the committee's recommendation, the department will approve or deny an application for provider approval and will notify the applicant of the decision. If the department denies the application, the department will furnish the applicant with a statement of its findings regarding the denial and with instructions for requesting a review of the denial under 22 AAC 30.060. Failure to timely request review

as provided in 22 AAC [30.060\(a\)](#) precludes further department consideration of the denial.

History: Eff. 11/2/2002, Register 164

Authority: [AS 33.30.011](#)

[AS 33.30.021](#)

[AS 44.28.030](#)

22 AAC 30.060. Review of denial

(a) An applicant whose application for provider approval was denied under 22 AAC [30.050](#) may request review of the denial by filing a request with the commissioner within 30 days after the date of the department's notification of denial under 22 AAC [30.050\(b\)](#). The request for review must contain a statement of why the department's decision should be changed and must indicate which department findings the applicant believes are in error.

(b) If the commissioner determines that the request for review demonstrates a genuine issue in contention, the commissioner will grant an administrative review. The commissioner's denial of a request for review is a final administrative decision for purposes of appeal to the superior court under the Alaska Rules of Appellate Procedure.

(c) If the request for review is granted, the commissioner will appoint a review officer to conduct the review. If the commissioner appoints a department employee as the review officer, the employee will not be a person who participated in the decision to deny the application.

(d) In conducting the review, the review officer may

(1) request additional information from the applicant if the review officer considers the information to be necessary to the review; and

(2) conduct an additional investigation if the review officer believes that the information to be obtained from the additional investigation is necessary to the review.

(e) All information resulting from the review officer's review will be retained in the applicant's file.

(f) Upon completion of the review, the review officer shall prepare a written report that summarizes the case and recommends a decision, and shall submit the report and the applicant's file to the commissioner. The commissioner will review the report and will issue a written decision that sets out the reasons for accepting or rejecting the review officer's recommendation. The review officer's report and a copy of the commissioner's

decision will be retained in the applicant's file. The commissioner's decision is a final administrative decision for purposes of appeal to the superior court under the Alaska Rules of Appellate Procedure.

(g) In a review under this section, the burden of proof is on the applicant to establish by a preponderance of the evidence that the applicant meets the department's requirements for provider approval under this chapter.

History: Eff. 11/2/2002, Register 164

Authority: [AS 33.30.011](#)

[AS 33.30.021](#)

[AS 44.28.030](#)

22 AAC 30.070. Renewal process; qualifications

(a) To renew provider approval under this chapter, an approved provider must apply for renewal of approval no later than 60 days before the end of the provider's current approval period by submitting an application for renewal to the Sex Offender Treatment Committee on a form provided by the department.

(b) For a provider's approval to be renewed, the provider must

(1) have a current professional license, in good standing, as described in 22 AAC [30.030\(b\)](#) ;

(2) be of good moral character;

(3) have obtained, within the preceding three years, 20 hours of continuing education in the treatment of sex offenders that

(A) was sponsored or conducted by the Association for the Treatment of Sexual Abusers;

(B) fulfills a continuing education requirement imposed by the board that licenses the provider as a psychiatrist, psychologist, psychological associate, social worker, marital and family therapist, or professional counselor; or

(C) has been approved by the department as being substantially equivalent to the continuing education described in (A) or (B) of this paragraph;

(4) agree to abide by the standards set out in 22 AAC [30.200](#) in providing sex offender treatment to a sex offender who is under the department's jurisdiction; and

(5) provide a reference, on a form provided by the department, from the supervising full-service-level approved provider if the applying provider's current approval is conditioned under 22 AAC [30.040](#) on that supervision.

(c) A renewal application must include

(1) the provider's name, business mailing address, and telephone number;

(2) verification from the relevant Alaska licensing board that the provider has a current professional license, as described in (b)(1) of this section, in good standing;

(3) documentation verifying that the provider has obtained the continuing education required by (b)(3) of this section;

(4) the reference described in (b)(5) of this section, signed by the supervising full-service-level provider, if the reference is required under (b)(5) of this section;

(5) all information not previously provided to the department regarding the provider's criminal history; and

(6) information not previously provided to the department regarding any investigations of the provider within the past three years for possible professional license violations.

(d) A renewed provider approval lapses three years from the date of renewal.

History: Eff. 11/2/2002, Register 164

Authority: [AS 33.30.011](#)

[AS 33.30.021](#)

[AS 44.28.030](#)

22 AAC 30.080. Renewal application review; approval or denial; request for review of denial

(a) Review of an application for renewal of provider approval by the Sex Offender Treatment Committee and the department, and approval or denial of the application, will be conducted in the manner provided in 22 AAC [30.050](#) for an application for initial provider approval.

(b) Review of denial of a renewal application may be requested as provided in 22 AAC [30.060\(a\)](#) . The review of a denial will be conducted as described in 22 AAC [30.060](#).

History: Eff. 11/2/2002, Register 164

Authority: AS 33.30.011

AS 33.30.021

AS 44.28.030

22 AAC 30.090. Transition: previously approved providers

(a) Notwithstanding the provisions of 22 AAC 30.020 - 22 AAC 30.060, an individual who, on 11/1/2002, had approval from the department to provide sex offender treatment to sex offenders who are under the department's jurisdiction is considered on 11/2/2002 to be an approved provider under this chapter.

(b) The individual's provider approval under (a) of this section lapses on 11/2/2003. To maintain provider approval under this chapter, the individual must, no later than 60 days before the lapse date of the individual's provider approval under this section, apply for renewal of provider approval under 22 AAC 30.070. The individual must meet the requirements of 22 AAC 30.070 in order to obtain renewal of approval.

History: Eff. 11/2/2002, Register 164

Authority: AS 33.30.011

AS 33.30.021

AS 44.28.030

22 AAC 30.100. Lapsed approval

(a) If an individual's provider approval under this chapter lapses, the individual may submit to the department, no later than 60 days after the approval lapsed, a request to submit a late renewal application. The request must state the reasons for late application. If the department determines that good cause exists to allow a late renewal application, the department will notify the individual that a late renewal application may be submitted and will be processed under 22 AAC 30.070 and 22 AAC 30.080. If the department determines that good cause does not exist to allow a late renewal application, the department will notify the individual of that determination and that the individual must instead follow the procedures in 22 AAC 30.030 for a new initial approval.

(b) An individual whose approval under this chapter has lapsed and who subsequently applies for a new initial approval under 22 AAC 30.030 must, in addition to meeting the requirements of 22 AAC 30.030, meet the continuing education requirement in 22 AAC 30.070(b) and must submit with the application under 22 AAC 30.030 documentation of having met that requirement.

History: Eff. 11/2/2002, Register 164

Authority: AS 33.30.011

AS 33.30.021

AS 44.28.030

22 AAC 30.110. Complaints; subsequent action against provider approval

(a) A person, including an employee of the department, may bring a complaint against an approved provider, alleging a violation of a requirement for provider approval under this chapter, a violation of a supervision condition placed on the approval as described in 22 AAC 30.040, or a violation of a standard of care in 22 AAC 30.200 by submitting the complaint in writing to the Sex Offender Treatment Committee. The committee shall open a complaint file and review the complaint. Upon completion of initial review of the complaint, the committee shall prepare for the complaint file a report regarding the complaint, including the committee's conclusion as to whether there is probable cause to believe that a violation has occurred. In the report, the committee may recommend that the department suspend the provider's approval under this chapter until the complaint is resolved, in order to prevent an undue risk of harm to the public. The committee shall forward the complaint file to the department.

(b) If, after review of the complaint file, the department determines that probable cause does not exist to believe that a violation has occurred, the department will furnish a written report of the complaint to the provider who is the subject of the complaint, setting out the reasons for the determination, and will place a copy of the report in the complaint file.

(c) If, after review of the complaint file, the department determines that there is probable cause to believe that a violation has occurred, the department will notify the provider who is the subject of the complaint of the allegations contained in the complaint, and will furnish the provider with a response form. The department will return the complaint file to the committee and direct the committee to investigate the allegations in the complaint.

(d) If the department directs the committee to conduct an investigation as described in (c) of this section and the department concludes that suspension of the provider's approval pending resolution of the complaint is necessary to prevent an undue risk of harm to the public, the department will notify the provider that the department intends to suspend the provider's approval under this chapter pending resolution of the complaint and that the provider may contest the suspension determination by providing to the department, within three days after the date of the notification under this subsection, a written statement as to why suspension is not necessary to prevent an undue risk of harm to the public. The department will consider the provider's statement, make a final determination as to whether the provider's approval under this chapter should be suspended pending resolution of the complaint, and will notify the provider of that final determination. If the department's final determination is that the provider's approval under this chapter should

be suspended, the suspension takes effect upon the provider's receipt of notification of that final determination.

(e) Within 14 days after the date of the notification of allegations under (c) of this section, the provider shall submit to the committee, on the response form furnished by the department, a sworn statement in response to the allegations in the complaint. The provider shall cooperate with the investigation of the complaint by providing to the committee any documents or information requested by the committee. The provider's failure to respond to the allegations or to cooperate with the committee's investigation as required by this subsection may result in revocation of the provider's approval. The committee shall place in the complaint file the provider's response statement, any other documents or information provided to the committee under this subsection, and any other material considered by the committee in its investigation.

(f) Upon completion of its investigation, the committee shall prepare for the complaint file a report of the results of the committee's investigation and a recommendation for department action regarding the complaint, and shall forward the complaint file to the department. The committee's recommendation may be that the department

(1) take no action;

(2) continue the provider's approval under this chapter with conditions designed to correct the violation, if the committee considers the violation to be a minor one that does not create an undue risk to the public and is amenable to correction within a specified period of time; or

(3) revoke the provider's approval under this chapter.

(g) If, after review of the complaint file, including the committee's report and recommendation under (f) of this section, the department decides to

(1) take no action on the complaint, the department will notify the provider of the decision, will furnish the provider with a written report of the decision and will retain a copy of the notification and report in the complaint file;

(2) continue the provider's approval under this chapter with specified conditions designed to correct the violation, the department will notify the provider of the continued approval and conditions, will furnish the provider with a written report of the decision, including a statement of the reasons for the conditions, and will retain a copy of the notification and report in the complaint file;

(3) revoke the provider's approval under this chapter, the department will notify the provider of the revocation decision, will furnish the provider with a written report of the decision, including a written statement of the reasons for revocation and instructions for requesting a review of the decision, and will retain a copy of the notification and report in the complaint file.

(h) A provider who receives notification of a decision under (g)(2) or (3) of this section has 30 days from the date of the notification to request review of the decision in the manner described in 22 AAC [30.060\(a\)](#) . If the provider timely requests review as provided in this subsection, the department's review of the decision will be conducted as described in 22 AAC [30.060](#). If a timely request for review is not received as provided in this subsection, the revocation or the placement of conditions takes effect on the 31st day after the date of the notification of the decision under (g) of this section.

(i) After resolution of a complaint under this section, the department will inform the complainant of the disposition of the complaint.

(j) In this section, "violation" means a violation of a requirement for provider approval under this chapter, a violation of a supervision condition placed on the approval as described in 22 AAC [30.040](#), or a violation of a standard of care in 22 AAC [30.200](#).

History: Eff. 11/2/2002, Register 164

Authority: [AS 33.30.011](#)

[AS 33.30.021](#)

[AS 44.28.030](#)

22 AAC 30.120. Summary suspension or revocation of provider approval

(a) Notwithstanding the procedures set out in 22 AAC [30.110](#), the department will summarily suspend or revoke a provider's approval as provided in this section.

(b) The department will summarily suspend a provider's approval under this chapter if the department determines that the provider's professional license issued in this or another jurisdiction has been suspended or determines that the provider has violated a condition placed on the approval under 22 AAC [30.110\(g\)](#) . The department will notify the provider of the suspension of provider approval under this section. Suspension of provider approval under this subsection takes effect on the date the provider is notified of the suspension. The provider may not apply for renewal of the approval, or apply for a new initial approval, under this chapter while the provider's approval is suspended under this section. If, before the lapse date of the provider's approval, the provider

(1) submits verification to the department that the provider's suspended professional license has been restored to good standing, or that the provider is in compliance with the relevant condition, as applicable, the department will lift the suspension of the provider's approval under this chapter;

(2) has not submitted verification to the department that the provider's suspended professional license has been restored to good standing or that the provider is in

compliance with the relevant condition, as applicable, the provider's approval under this chapter lapses.

(c) A provider whose professional license was suspended and whose approval under this chapter lapsed under (b)(2) of this section because that professional license had not been restored to good standing must comply with the procedures and requirements of 22 AAC [30.100](#) to obtain a subsequent approval under this chapter and must submit verification acceptable to the department that the provider's suspended professional license has been restored to good standing.

(d) The department will summarily revoke a provider's approval under this chapter if the department determines that the provider's professional license issued in this or another jurisdiction has been revoked. The department will notify the provider of the revocation. Revocation under this subsection takes effect on the date the provider is notified of the revocation.

(e) In this section, "professional license" means a license described in 22 AAC [30.030\(b\)](#) (1) or a license to practice in one of the fields listed in 22 AAC [30.030\(b\)](#) (1) issued by another licensing jurisdiction.

History: Eff. 11/2/2002, Register 164

Authority: [AS 33.30.011](#)

[AS 33.30.021](#)

[AS 44.28.030](#)

22 AAC 30.130. Revoked approval

If an individual's provider approval under this chapter is revoked under 22 AAC [30.110](#) or 22 AAC [30.120](#), the individual

(1) may not apply for a new initial approval under 22 AAC [30.030](#) sooner than two years after the effective date of the revocation;

(2) in applying for a new initial approval under 22 AAC [30.030](#) also must meet the continuing education requirement of 22 AAC [30.070\(b\)](#) and must submit documentation of meeting the requirement.

History: Eff. 11/2/2002, Register 164

Authority: [AS 33.30.011](#)

[AS 33.30.021](#)

AS 44.28.030

22 AAC 30.200. Standards of care

(a) An approved provider shall comply with the standards of care set out in this section in providing sex offender treatment to a sex offender who is under the department's jurisdiction.

(b) An approved provider may not

(1) allow personal feelings about a client or the client's crimes to interfere with the provider's professional judgment and objectivity, and shall make appropriate referrals to other professionals if the provider is unable to manage negative reactions to a client;

(2) discriminate based on age, gender, race, ethnicity, national origin, religion, sexual orientation, political affiliation, social or economic status, disability, or any basis proscribed by law;

(3) engage in behavior that is harassing, exploitative, or demeaning to a client;

(4) barter for services;

(5) advise or facilitate family reunification unless suitable measures have been taken to ensure the safety of, and appropriateness of reunification for, the client's victim;

(6) provide sex offender treatment to a sex offender who is under the department's jurisdiction if the provider has a pre-existing relationship with that person and that relationship could impair the provider's professional judgment;

(7) engage in a sexual relationship with a client or former client, regardless of whether payment was made for the sex offender treatment, and may not engage in a sexual relationship with a family member of a client or former client;

(8) engage in a business or social relationship with a client if that relationship could conflict with or compromise the primary professional relationship;

(9) disclose identifying information about a client during professional training or workshops; an audiotape or videotape to be used by the provider during training or a workshop must protect the identity of the client and may be used only after obtaining written informed consent from the client; or

(10) encourage or permit the use of pornography.

(c) An approved provider shall

(1) discuss fees to be charged for services before, or at the time of, the client's initial appointment, and shall inform the client before a change is made regarding fees that will be charged;

(2) at the time of the initial appointment, inform the client about the types of services to be provided, reasonable expectation of outcomes, alternatives to the type of services proposed, potential benefits and risks involved in the services, and the limits of privilege and confidentiality; if a client is incapable of consenting to services, the provider shall explain to the client the proposed assessments and treatments in a manner commensurate with the client's developmental and psychological capabilities and shall obtain a signed informed consent from the client's legal guardian;

(3) carry out professional duties regarding a client in a way that maximizes safety for the client's victims and potential victims;

(4) hold in confidence information provided by a client's victim, and not provide the information to others, including the client, without the written permission of the victim;

(5) comply with all state and federal reporting laws;

(6) advise each client as to the confidentiality of communications with the client, how confidentiality applies when multiple clients are members of the same family, and of statutory requirements for mandatory reporting;

(7) except when reporting is mandated by state statute, obtain a written waiver of confidentiality before releasing information about a client; the provider shall inform the client about the reasons for the release of information; and

(8) cease sex offender treatment for a client if

(A) the client also is receiving treatment from a provider who is not approved under this chapter;

(B) it is determined by another provider who is an approved full-service-level provider that that treatment is interfering with sex offender treatment with the approved provider; and

(C) the client does not cease treatment with the unapproved provider.

(d) Supervision arrangements between a supervising provider under 22 AAC [30.040](#) and a supervised provider must be agreed upon in writing before the supervised provider begins providing sex offender treatment to a client. The written document must specify the duties to be performed by the supervised provider, the scope and focus of the supervision, and the frequency and duration of supervision meetings.

(e) An approved provider who is supervising another approved provider under 22 AAC [30.040](#) may not delegate responsibilities to or advise professional activities for the supervised provider unless the supervising provider is confident that the responsibilities or activities are within the competencies of the supervised provider. In deciding whether to delegate or advise, the supervising provider shall consider the training, education, and experience of the supervised provider.

(f) A provider who is supervising another provider under 22 AAC [30.040](#) shall take the steps necessary to ensure that the supervised provider performs professional duties ethically, competently, and responsibly. A supervising provider shall review and co-sign all reports prepared by the supervised provider, to indicate either concurrence or nonconcurrence with the opinions, conclusions, and recommendations stated in the report.

(g) A provider who is supervising another provider under 22 AAC [30.040](#) may not engage in a sexual relationship with that provider.

(h) A provider whose approval is conditioned under 22 AAC [30.040](#) upon being supervised shall inform clients of the supervision, supply the name of the supervising provider, and explain the impact of the supervision on the confidentiality of communications with the client.

(i) In this section, "client" means a sex offender who is under the jurisdiction of the department and who is receiving, or will be receiving, sex offender treatment.

History: Eff. 11/2/2002, Register 164

Authority: [AS 33.30.011](#)

[AS 33.30.021](#)

[AS 44.28.030](#)

22 AAC 30.900. Definitions

In this chapter,

(1) "approved provider" means an individual who has received approval from the department under this chapter to provide sex offender treatment to sex offenders who are under the department's jurisdiction;

(2) "clinical services" means the application of assessment and psychotherapeutic techniques by an individual licensed under [AS 08](#) to practice in the field of psychiatry, psychology, social work, marital and family therapy, or professional counseling;

(3) "committee" means the Sex Offender Treatment Committee established under 22 AAC [30.010](#);

(4) "commissioner" means the commissioner of corrections;

(5) "department" means the Department of Corrections;

(6) "good moral character" means, based on consideration of all aspects of an individual's character, the absence of acts or conduct that would cause a reasonable person to have substantial doubts about the individual's honesty, fairness, and respect for the rights of others and for the laws of the state and the nation; the following are indicia of a lack of good moral character:

(A) illegal conduct;

(B) conduct involving moral turpitude, including dishonesty, fraud, deceit, or misrepresentation;

(C) intentional deception or fraud, or attempted deception or fraud, in an application, examination, or other document submitted to secure employment, eligibility for licensure, or certification;

(D) conduct that adversely reflects on a person's fitness to provide sex offender treatment, including intoxication while providing treatment and undue familiarity with a client, or with a sex offender, or correctional inmate, probationer, or parolee, with whom the provider has a professional relationship;

(7) "moral turpitude" means an act that

(A) is contrary to justice, honesty, principle, or good morals;

(B) violates the private and social duties that a person owes to another or to society in general; or

(C) is immoral in itself, regardless of illegality;

(8) "sex offender" means an individual who

(A) has been convicted of a sexual offense as defined in

(i) [AS 11.41.410](#) - 11.41.470, [AS 11.61.110](#) (a)(7), 11.61.120(a)(4) or (5), or 11.61.125; or

(ii) former [AS 11.15.120](#) , 11.15.134, 11.15.160, [AS 11.40.080](#) , 11.40.110, 11.40.130, or 11.40.200 - 11.40.420;

(B) has been convicted under a statute of another jurisdiction that is substantially similar to a statute listed in (A) of this paragraph; or

(C) acknowledges behavior that, if charged, would have been a crime under a statute listed in (A) of this paragraph;

(9) "sex offender treatment" means the provision of clinical services to a sex offender and includes assessment of the sex offender;

(10) "undue familiarity" means developing, or attempting to develop, an intimate, personal, or financial relationship with an individual, or otherwise failing to maintain an appropriate professional relationship with the individual.

History: Eff. 11/2/2002, Register 164

APPENDIX D

REQUIREMENTS FOR APPROVAL AS A DOC APPROVED SEX OFFENDER TREATMENT PROVIDER

Sex Offender Treatment Supervisor: Professionals meeting the requirements below may engage in supervision of other DOC Approved Providers.

REQUIREMENTS:

- Meets all requirements of Level I full service provider.
- Masters degree or Doctorate degree in the behavioral sciences and licensed by the State of Alaska in the graduate field of study.
- Experience in supervising other professionals who are treating sexual offenders.
- Clinical experience in treating, rapists, child molesters, and other paraphiliac disorders.
- Experience in working with residential treatment programs for sex offenders is desirable.
- Three years full time experience in the assessment and treatment of sexual offenders or 6000 documented hours of direct experience in the assessment and treatment of sexual offenders.
- Three years experience in working with Alaska DOC's sexual offender programs (or program(s) with a comparable philosophy and approach).

Level I - Full Service Provider: Approved to provide the full range of clinical services necessary in the treatment of sexual offenders. Less experienced full service providers may still be required to obtain clinical supervision.

REQUIREMENTS:

- Masters degree or Doctorate degree in behavioral sciences and licensed by the State of Alaska in the graduate field of study.
- One year full time experience in the assessment and treatment of sexual offenders or 2000 documented hours of direct experience in the assessment and treatment of sexual offenders.
- Clinical experience in treating adult rapists, child molesters, and other paraphiliac disorders.

Level II - Partial Service Provider: Approved to provide specific sex offender services at the discretion of DOC and a Sex Offender Treatment Supervisor. All Level II providers are required to receive supervision by a Sex Offender Treatment Supervisor no less than once every two weeks for a case load of 10 or more offenders and once per month for a case load of less than 10 offenders.

REQUIREMENTS:

- Masters degree or Doctorate degree in the behavioral sciences and licensed by the State of Alaska in the graduate field of study.

Sex Offender Intern Pre-Graduate Student: Individuals meeting the requirements below may perform specified duties with sexual offenders under the supervision of a Sex Offender Treatment Supervisor. Pre-Graduate Student Interns are in a transitional phase in which they are receiving specialized education and experience in preparation for eventually becoming approved providers.

REQUIREMENTS & DUTIES:

- The candidate must have a Bachelor's degree in the behavioral sciences.
- Candidates must be enrolled in a program of graduate study at a regionally accredited college or university and have satisfactorily completed the necessary course work to be approved for an internship under the guidelines of the department in which they are enrolled.
- They must be recommended for the internship by their university clinical supervisor and complete an application that must be approved by the Approved Provider Committee.
- They must complete a minimum of 80 hours of continuing education specifically in the area of assessment and treatment of sexual offending during the internship.
- They must work under the direct on-site supervision of a Sex Offender Treatment Supervisor. Areas of training and supervision during the internship shall include the following:

- Intake assessments
- Risk assessment
- Treatment planning
- Ongoing therapy
- Interagency coordination/cooperation
- Case reviews and treatment team meetings
- Safety-net development and training
- Community safety and issues related to recidivism
- Containment approach to sex offender management
- Individual and cross cultural differences
- Personality Disorders
- Review of relevant research and/or conducting research
- Report writing.

- Pre-graduate level interns must have a written supervision plan developed by the Sex Offender Treatment Supervisor in collaboration with the university clinical supervisor.
- Pre-graduate student interns may observe but not independently conduct individual, group, or family counseling.
- The Sex Offender Treatment Supervisor will read and co-sign all reports and assessments completed by pre-graduate student interns.
- The Sex Offender Treatment Supervisor will conduct ongoing assessments of the intern's progress in supervision. Areas of weakness will be noted and a plan for correction will be established. This may include additional continuing education and/or additional direct in-vivo supervision.
- The Sex Offender Treatment Supervisor will coordinate and collaborate with the intern's graduate clinical supervisor.
- The internship will continue for a minimum of one academic year or the equivalent of two semesters. The length of the internship may be extended upon the recommendation of the Treatment Supervisor and approval by the college or university clinical supervisor.
- All candidates for a Pre-graduate student internship must clear a background check and follow all DOC policies and procedures.

Sex Offender Intern – Post Graduate Level: Individuals who have completed graduate study in the behavioral sciences in either a Masters or Doctoral graduate program but have not yet obtained the necessary requirements for licensure in the State of Alaska, but are license eligible, may practice as an intern at the Post Graduate level.

REQUIREMENTS & DUTIES:

- The candidate must have a graduate degree in the behavioral sciences.
- They must have completed a pre-graduate internship or the equivalent.
- They must have filed an application for licensure in their respective field.
- They must work under the direct supervision of a Sex Offender Treatment Supervisor.
- Post-graduate level interns must have a written supervision plan developed by the Sex Offender Treatment Supervisor
- They may not conduct individual, group, and family therapy sessions independently unless approved by the Sex Offender Treatment Supervisor. The supervisor shall sit in on group, individual, and family counseling sessions at his or her discretion. Audio and/or video tapes of counseling sessions may be reviewed by the Sex Offender Treatment Supervisor in place of face to face supervision.
- The Sex Offender Treatment Supervisor will read and co-sign all reports and assessments completed by Post Graduate Level Interns.
- The Sex Offender Treatment Supervisor will conduct ongoing assessments of the intern's progress in supervision. Areas of weakness will be noted and a plan for correction will be established. This may include additional continuing education and/or additional direct in vivo supervision.

- The internship may continue until the candidate is licensed in the State of Alaska as a psychiatrist, psychologist, psychological associate, licensed clinical social worker, marriage and family counselor, or licensed professional counselor. At this time they may apply to become an Approved Provider with DOC.
- All candidates for a Post-graduate internship must clear a background check and follow all DOC policies and procedures.

APPENDIX E

SAMPLE EVALUATION FORM FOR APPROVED PROVIDERS UNDER SUPERVISION

Approved Provider Supervisor _____

Average Caseload _____ Current Caseload _____

Date of Evaluation _____ Approved Provider Level _____

List any restrictions or special requirements that are part of the Supervision Plan. _____

Have these restrictions been followed and/or have special requirements been met? Describe below. _____

PERFORMANCE STANDARDS

(Circle appropriate numbers below.)

A. Ability to function as a team member

1) Provides clinical structure for offenders

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

below standard standard above standard

2) Uses system intervention.

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

below standard standard above standard

3) Coordinates and consults with other staff and offenders in the program.

1 _____ 2 _____ 3 _____ 4 _____ 5 _____

below standard standard above standard

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- 4) Coordinates and consults with relevant staff and/or offenders outside the program.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

- 5) Provides direction to others (wing counselors, probation officers, other therapists etc.)

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

- 6) Participates in treatment teams.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

- 7) Participation in staff meetings.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

- 8) Knowledge of the Standards of Care, Policy and Procedures, Legislation and other relevant legal, institutional and Departmental structure.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

B. Quality of relationship with offenders.

- 1) Respect for the whole person.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

- 2) Diagnostic skills and impressions.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

- 3) Clinical comprehension of the sex offender.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

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- 4) Ability and flexibility in working with different types of sex offenders.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

- 5) Responsive to special needs populations.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

- 6) Multi-cultural awareness.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

C. Knowledge of the DOC treatment model.

- 1) Understanding of the DOC model.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

- 2) Provider's philosophy consistent with the DOC model.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

- 3) Ability to develop treatment plans.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

D. Application of the model/performance of specific skills.

- 1) Clinical judgment.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

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2) Group therapy skills.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

3) Individual therapy skills.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

4) Family therapy skills.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

5) Victim orientation.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

6) Behavioral interventions.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

7) Crisis intervention skills with mental health or behavioral crisis.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

8) Education of offenders.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

9) Documentation: Record keeping and reporting.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

E. Response to clinical supervision.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

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F. Independence of performance.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

G. Continuing education

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

H. Training of staff.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

I. Research and/or knowledge of current literature.

1 _____ 2 _____ 3 _____ 4 _____ 5

below standard standard above standard

J. Remediation

1) Areas of below standard performance.

2) Action Plans and Specific Time Frames

K. Other recommendations and comments.

Signature _____

APPENDIX F

QUALIFICATIONS FOR DOC APPROVED POLYGRAPHERS

Polygraph Examiner - Full Operating Level: Polygraph examiners who test adult sex offenders must meet the minimum standards as indicated by the American Polygraph Association as well as the requirements throughout these Standards.

Polygraph examiners who conduct examinations on adult sex offenders shall adhere to best practices as recommended within the polygraph profession.

To qualify at the Full Operating Level to perform examinations of adult sex offenders, an applicant must meet **all** the following criteria:

1. The individual shall have graduated from an accredited American Polygraph Association (APA) school and shall have a baccalaureate degree from a four year college or university;
2. The individual shall have conducted at least two hundred (200) criminal specific-issue examinations broken down into the following categories:
3. Of these 200 examinations, a minimum of half or one hundred (100) must be post-conviction sexual offender (adult or juvenile) polygraph examinations;
4. Of these 100 examinations, a minimum of half or fifty (50) must be post-conviction adult sexual offenders;
5. Of these 50 examinations, twenty (20) must be sexual history (see Note); twenty (20) must be maintenance/monitoring; and the remaining ten (10) may be from any or a combination of the three categories (specific issue, sexual history, maintenance/monitoring).

Note: A sexual history examination is identified by question areas that verify a subject's entire sexual history and may include documentation provided by the subject prior to the examination.

The individual shall have completed 64 hours of specialized clinical sex offender polygraph examiner training;

Following completion of the APA school curriculum the applicant shall have completed an APA approved forty hour training specific to post-conviction sexual offending which focuses on the areas of evaluation, assessment, treatment and behavioral monitoring and includes, but is not limited to the following:

- Pre-test interview procedures and formats
- Valid and reliable examination formats
- Post-test interview procedures and formats
- Reporting format (i.e., to whom, disclosure content, forms)
- Recognized and standardized polygraph procedures

- Administration of examinations in a manner consistent with these
- Standards
- Participation in sex offender community supervision teams
- Use of polygraph results in the treatment and supervision process
- Professional standards and conduct
- Expert witness qualifications and courtroom testimony
- Interrogation techniques
- Maintenance/monitoring examinations
- Periodic/compliance examinations

The applicant must **also** complete twenty-four (24) hours of specialized training in any of the following areas:

- Behavior and motivation of sex offenders
- Trauma factors associated with victims/survivors of sexual assault
- Overview of assessment and treatment modalities for sex offenders
- Sex offender denial

The aggregate of the required APA approved forty hour training specific to post-conviction sexual offending and the twenty-four (24) hours of specialized training make up the 64 hours of training post-graduation from an APA accredited polygraph school.

If an applicant wishes to substitute any training not listed here, it is incumbent on the applicant to write a justification demonstrating the relevance of the training to this standard.

In concert with the generally accepted standards of practice of the polygraph profession, the individual shall adhere to the Professional Code of Ethics (2001) published by the Association for the Treatment of Sexual Abusers (ATSA). The individual shall demonstrate competency according to the individual's respective professional standards and conduct all examinations in a manner that is consistent with the reasonably accepted standard of practice in the clinical polygraph examiner community;

Provide satisfactory references as requested by DOC. DOC may also solicit such additional references as necessary to determine compliance with the Standards. These references shall include, but not be limited to, other members of the community supervision team;

The individual shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment;

Submit to a current background check and be fingerprinted.

Polygraph Examiner - Associate Level: A clinical polygraph examiner at the Associate Level is an individual who otherwise meets the Standards for Full Operating Level but who does **not** have;

- A. A baccalaureate degree from a four year college or university and/or,
- B. Who has not yet completed two hundred (200) post-conviction polygraph examinations broken out into the following categories:
 - a. Of these 200 examinations, a minimum of half or one hundred (100) must be post-conviction sexual offender (adult or juvenile) polygraph examinations;
 - b. Of these 100 examinations, a minimum of half or fifty (50) must be post conviction adult sexual offenders;
 - c. Of these 50 examinations, twenty (20) must be sexual history (see Note); twenty (20) must be maintenance/monitoring; and the remaining ten (10) may be from any or a combination of the three categories (specific issue, sexual history, maintenance/ monitoring).
- C. The examiner shall obtain supervision from a clinical polygraph examiner at the Full Operating Level under these Standards for each remaining polygraph examination up to the completion of 200 polygraph exams. The supervision agreement must be in writing.
- D. All applicants must have an application on file with DOC that includes the supervision agreement. Supervision must continue for the entire time an examiner remains at the Associate Level.
- E. The supervisor of a clinical polygraph examiner shall review samples of the videotapes of clinical polygraphs and/or otherwise observe the examiner; and provide supervision and consultation on question formulation for clinical polygraph exams, report writing, and other issues related to the provision of polygraph testing of adult sexual offenders. Supervisors must review and sign off on each polygraph examination report completed by an Associate Level polygraph examiner under their supervision.
- F. If the Associate Level polygraph examiner has met all the requirements for Full Operating Level status except for obtaining a bachelor's degree, the supervision requirement that supervisors sign off on each exam may be waived by DOC if the following conditions are met:

The Associate Level polygraph examiner submits:

- Documentation that all other criteria for Full Operating Level status have been met
- Evidence of continuing work toward obtaining a B.A. degree with a proposed

- completion date.
- Evidence that the examiner is continuing to conduct clinical polygraph exams
 - A letter from the examiner's supervisor indicating their proficiency and their willingness to lower the intensity of supervision to one hour per month.
- G. The applicant shall have completed all training as outlined in these Standards;
- H. If an applicant wishes to substitute any training not listed here, it is incumbent on the applicant to write a justification demonstrating the relevance of the training to this standard;
- I. In concert with the generally accepted standards of practice of the polygraph profession, the individual shall adhere to the Professional Code of Ethics (2001) published by the Association for the Treatment of Sexual Abusers (ATSA). The individual shall demonstrate competency according to the individual's respective professional standards and conduct all examinations in a manner that is consistent with the reasonably accepted standard of practice in the clinical polygraph examiner community;
- J. Provide satisfactory references as requested by DOC. DOC may also solicit such additional references as necessary to determine compliance with the Standards. These references shall include, but not be limited to other members of the community supervision team;
- K. Submit documentation that the examiner has engaged in periodic peer review by other clinical polygraph examiners listed at the Full Operating Level operating separately from the examiner's agency. Peer review must be conducted bi-annually at a minimum;
- L. The individual shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior, or a felony that would bring into question the competence or integrity of the individual to provide sex offense specific treatment;
- M. Submit to a current background check and be fingerprinted.

APPENDIX G

QUALIFICATIONS FOR DOC APPROVED PLETHYSMOGRAPH AND ABEL ASSESSMENT PROVIDERS

Qualifications for Plethysmograph Assessment Providers:

Full Operating Level Treatment Provider and/or Full Operating Level Evaluator under these Standards, have a baccalaureate degree from a four year college or university, demonstrate that s/he has received credible training in the use of the plethysmograph and shall interpret plethysmograph test results.

At this time there is no certification or accreditation process for Plethysmograph Examiners. Those wishing to conduct exams should seek credible training from experienced examiners. Should a certification process be developed, these Standards will be revised to accommodate such a process.

A Plethysmograph Examiner shall interpret the results of the plethysmograph exam and write and sign off on reports.

A Plethysmograph Examiner or any person who administers the plethysmograph exam shall adhere to the “Guidelines for the Use of the Penile Plethysmograph,” published by the Association for the Treatment of Sexual Abusers (ATSA) Practitioner’s Handbook (1997) and shall demonstrate competency according to professional standards, and conduct plethysmograph examinations in a manner that is consistent with the reasonably accepted standard of practice in the plethysmograph examination community.

A Plethysmograph Examiner shall be proficient in the use of stimulus materials:

Determination of type of stimuli to be utilized for each assessment;

- Use of specialized stimuli;
- Familiarity with state and federal codes regulating possession, storage, use and transportation of pornographic materials.

Interpretation of data shall consider the following:

- A. Differential responses to various stimuli categories;
- B. Required minimum response levels;
- C. Maximum response; latency; area under the curve;
- D. Base rates for responses;
- E. Client’s self-estimates of response;
- F. Detecting faking/suppression attempts;
- G. Data validity/reliability.

A Plethysmograph Examiner shall have received the equipment manufacturer's training and/or other supervised training on equipment operation and shall be trained in:

- A. Types and selection of available gauges;
- B. Gauge size determination for each client.

A Plethysmograph Examiner shall be knowledgeable about and familiar with the uses of plethysmograph data for:

A. Assessment/evaluation:

- Assessing cross-over of deviant interests;
- Assessing reliability of self-report;
- Determining existence of deviant arousal;
- Determining baseline data for treatment of deviant arousal reduction/control.

B. Treatment:

- Providing objective measure of treatment progress in terms of deviant arousal;
- Providing recommendations based on knowledge of treatment methodologies.

C. Offenders in denial:

- Understanding limitations;
- Understanding proper/improper uses.

D. Validity/Reliability:

- Familiarity with current and historical research;
- Client's ability/potential to control arousal response during assessment;
- As a variable for recidivism prediction;
- Habituation as a potential contaminating factor.

APPENDIX H

ASSESSMENT GUIDELINES

Sexual Offense Interview Guideline

Psychodynamics of Offense:

- A. Offender version of offense: Allow the offender to tell his version of the incident. Pay attention to what he doesn't say as well as to what he does say. Note conflicts between the official version and offender version. Question him about the differences and record his responses.
- B. Sexual behavior during the offense: Describe the nature and extent of the abuse, once again determining conflicts between the official and offender versions.
- C. Pre-meditation: Determine the extent to which the offender thought about or planned the offense prior to acting-out. Obtain information about the grooming process. Note the conflicts between official and offender versions.
- D. Victim Characteristics: Note the age and gender of each victim. Note whether the offender over-estimates the age of child victims. Describe the relationship (stranger, acquaintance, relative etc.) between the offender and the victim(s). Ask the offender to describe the physical aspects and personality or temperament of each victim. If the victim(s) is known to the offender, determine the offender's feelings about the victim(s) prior to, during, and after the assault. Make note of any vulnerabilities of the victim(s).
- E. Assault Style: Note whether the assault was exploitive or forceful. Describe the nature and extent of force used. Determine if a weapon was involved. Try to determine if there was eroticized aggression. Note the type and extent of psychological pressure used. Note if kidnapping was involved. Note the length of the grooming cycle i.e., was it a gradual process of grooming or a sudden attack.
- F. Offender Affect: Determine the offender's emotions prior to, during, and after the assault.
- G. Sexual Fantasies: Ask the offender to describe his sexual fantasies prior to and during the assault. Determine his expectations regarding the victims' reactions. Also ask about the nature of other sexual fantasies in the offender's life. Ask about masturbatory fantasies and associated fantasies. Ask how often he masturbates. Ask about deviant sexual fantasies that are not acted out.
- H. Communication During Assault: Record the nature of any communication with the victim prior to, during, and after the assault.
- I. Disinhibiting Factors: Record the use of disinhibitors such as alcohol, drugs, and pornography. Also ask about disinhibiting thoughts (defenses, thinking errors). Determine the nature and extent of external as well as internal stresses.
- J. Detering Factors: Determine if the offender deterred himself from offending in the past. Ask him what caused him to stop noting internal and external inhibitors.
- K. Conflicts between Offender and Official Version of Offense: Summarize the conflicts between offender and victim versions.
- L. Acceptance of Responsibility for Offending: Describe the offender level of acceptance for the offense. Note the use of particular defense mechanisms. Note if

any denial is full or partial. List the offenders attempt to rationalize, minimize, or blame other persons or problems for the assault.

- M. Recidivism: Record the number of assaults against the victim(s) in the instant offense. Record the time period over which the offending took place. Record any history of prior sexual assault including allegations, charges, arrests, and convictions.
- N. Attitude Towards Treatment: Ask about the offender's position on treatment in general and sex offender treatment in particular. Determine the nature and extent of any resistance to treatment.

Social/Family History Interview Guideline

Social/Family History: The following areas in the offender's life should be addressed by reviewing the record and through interview with the offender. Note the age at which each significant event occurred. Try to gauge the offender's reaction to events in his life. How did they affect his thinking, emotions and actions? Be mindful of conflicts between the offender's account of his life and the account of others as noted in the records.

A. Childhood/Adolescent History – Family Structure:

1. Describe the family structure including parent(s)/step-parents in the home, siblings, others living in the home.
2. Did his biological parents raise the offender? If so until what age? How old was the offender when he left home? Under what conditions did he leave?
3. Relationship to family members – relationship to parents, stepparents, siblings, and significant others in the home. What was the offender's perceived role in the family?

B. Childhood/adolescent History - Problems in the family:

1. Note a history of medical, psychiatric (include substance abuse, behavior/criminal problems, financial problems and other stresses on the family.
2. What was/is the offender's attitude about these problems?
3. What was the relationship like between parents, stepparents, and significant others?
4. Was there domestic violence in the home?
5. How does the offender describe his caretakers and what is his view of his relationships with them?

C. Childhood/Adolescent History - Early adjustment:

1. Report medical/emotional/behavioral/cognitive problems and how the offender and others handled these in the household.
2. Note contact with authority figures including school officials and police.
3. Note and describe aggressive behavior to self or others. Document frequency and type of offenses as well as actions taken. What was, and is, the offender's attitude towards these behaviors?
4. Report diagnosis and treatment of cognitive, emotional or behavior problems in childhood.
5. Report the offender's academic performance, truancy problems, suspensions/expulsions, and attitude towards school.
6. Does the offender have a high school diploma or GED?
7. Report interpersonal adjustment. Were there significant peer problems? Did the offender have any close friends? How does he characterize the peer group he was involved with?
8. Describe any use of drugs or alcohol noting the types, frequency and patterns of use.

D. Childhood/Adolescent History - Discipline:

1. Note the use of corporal punishment and other discipline methods.
2. Report the presence and appropriateness of supervision by parents or others, and the offender's reaction to discipline and supervision.

3. Note if the offender was exposed to physical or emotional abuse (self or others).
- E. Childhood/Adolescent History - Moral Development:
1. Was there any religious or spiritual guidance in the offender's youth?
 2. Ask the offender what lessons, morals, or ideals his parents tried to teach him. Note what parental figures said as well as what they modeled.
 3. Were parental values conforming and constructive or anti-social? What was the offender's reaction to this influence?
 4. What values did he learn from other adults, his peer group, or from other sources such as the media?
 5. Did he develop his own set of values from experience? What were those values? What are his values at the present time; i.e. what principles does he now try to live by?
- F. Adult History - Education/work/military:
1. Report post-high school education or vocational training. What were his performance/grades? Does he have an advanced degree?
 2. List the number, types and length of employment.
 3. Report job performance and achievement in the work field.
 4. Was he ever terminated from employment? If so, report circumstances.
 5. Note the offender's reliability as an employee. Did he quit work impulsively and/or leave a job without another lined-up.
 6. Note frequency and length of unemployment periods.
 7. Has he ever collected unemployment or public assistance? If so, how many times, for how long, and at what ages?
 8. How did he support himself (money, food, and lodging) on the street if not through employment? Did he rely on others or engage in criminal activity for money.
 9. Does he have any plans for future employment or training? Are the plans realistic?
 10. What are his long-term career goals and what problems does he expect in achieving these goals?
 11. Has he ever "hit the road" with no plans? If so, when and for how long?
 12. When he works at something for a long time does he get bored?
 13. Did the offender serve in the military?
 14. Were there any disciplinary infractions in the military record?
 15. What was the type of discharge obtained?
 16. What was the offender's rank at the time of discharge? Was rank ever reduced during term of duty? If so for what reasons?
 17. Is the offender a combat veteran? If so did he see light, moderate, or heavy combat?
 18. Are there any medical or psychiatric problems that are service related?
- G. Adult History - Finances:
1. Determine how responsible the offender has been with money. Has he met his financial obligations or ignored them in favor of spending money frivolously?
 2. Determine if he has had loans and if he paid them back.
 3. Also determine if he has been required to pay child/spousal support and if he has met his obligations.

4. How is his credit rating?

H. Adult History - Medical/Psychiatric Health:

1. Does the offender have any serious medical or psychiatric problems? Include intellectual, neurological, and emotional/behavior problems. Report former diagnoses.
2. Has he ever attempted suicide? List age and method of suicide attempt. Was the attempt serious or just to get attention?
3. Does he have an adult history of psychiatric/psychological hospitalization/treatment? List psychiatric medications (past and current).
4. How did he respond to mental health treatment?
5. Has he been involved in any other form of treatment (sex offender, anger management or other treatment)? How did he respond to treatment?
6. What is his attitude towards treatment? Is he willing to participate in treatment programs in the future?
7. Does the offender feel he has an anger problem? Do others see him as being short tempered or explosive?
8. Does the offender feel guilty about anything in his life other than his crime(s)?
9. When was he the most depressed and the happiest in his life?
10. Has he ever lost someone close to him and how did he respond?
11. Is he satisfied with himself and his life so far? What improvements or changes does he feel he needs to make? Does he feel he has any attitude, emotional, or behavior problems?
12. How does he feel about himself? Ask him to name his greatest strengths and his greatest flaws.

I. Adult History - Substance Abuse:

1. Determine whether the offender used alcohol or drugs. Assess the pattern of usage giving the ages that the offender used, the frequency and amount of each substance used. Determine the extent to which substance abuse interfered with the offender's life adjustment.
2. Was substance abuse involved in the commission of prior or present crimes? Include arrests for DUI.
3. Has there been a substance abuse assessment?
4. Did the offender experience symptoms of dependency?
5. What was the offender's behavior and emotional functioning when using?
6. Has he attended substance abuse treatment and if so did he successfully complete the program(s)?
7. Has the offender relapsed into substance abuse after treatment? When, how often, and for how long?
8. Does the offender feel he has a substance abuse problem? What is his current attitude towards and willingness to participate in substance abuse treatment/management (including UA's)?

J. Adult History - Criminal Behavior:

1. Report the offender's prior adult criminal record. List the number and types of offenses. Describe offenses that were not reported or charged. Note prior accusations, charges, arrests, and convictions for sexual and non-offenses. Include all aggressive behavior (sexual and non-sexual) towards peers, partners, children and others.
2. What is the offender's attitude towards these offenses?
3. Has he been incarcerated in the past? If so when and for how long?
4. Describe any discipline problems in prison.
5. Has he been on Probation/Parole in the past? Has he ever breached probation/parole? Did he successfully complete supervision? Describe any problems while under supervision.
6. Was he involved in treatment programs in prison or in the community? If so, did he successfully complete them?
7. Does the offender accept responsibility for the offense(s)?
8. What does he feel he could have done to avoid committing the offense(s)?
9. Does he regret any of his crimes?
10. Is he able to describe the effect of his crimes upon his victims?
11. Has he had contact with his victims?
12. Are any of his crimes impulsive or are they all planned?
13. How does he feel when committing his crimes?
14. Has he ever used aliases?
15. Has he ever committed crimes for which he wasn't caught?
16. Does the offender have a history of escapes, failure to appear, or jumping bail?

K. Adult History - Social/Interpersonal Adjustment:

1. Describe the offender's adult social relationships. Note the quantity and quality of the friendships. Does he have any close friends? What is the offender's definition of a close friend?
2. Describe any problems or strains in past and present friendships. Does he feel that he is treated fairly by others?
3. Has the offender associated with others involved in criminal activities? Are others involved in criminal activity with the offender?
4. What is the proportion of positive to negative influences in the offender's current life? How many constructive support persons are involved in the offender's life that are not being paid to associate with him?
5. What is the offender's current relationship like with his family of origin?

Sexual History Interview Guideline

Sexual History: The sexual history should follow a developmental sequence from birth through the present. Sexual experiences and practices, memories, fantasies and education regarding sex should be explored. Try to get an account of both normal and deviant sexual practices.

A. Childhood Sexuality:

1. What were the offender's parents and/or significant others attitudes and practices regarding sexuality? Was there nudity in the home, use of pornography, or openness regarding sexual practices?
2. How did the offender learn about sex (sex education by peers, parents, school officials or others)?
3. Ask about early memories, curiosities and experiences regarding sex. Explore the topic of sexual experiences during childhood including fantasies, crushes on other children or adults, and sexual abuse (by or to the offender).
4. Was there a normal latency period?
5. Was there early sexual play between the offender and siblings or other peers?
6. Was there exposure to pornography at an early age?
7. Did the offender engage in early sexual acting-out behavior? Describe the nature of this behavior.

B. Adolescent Sexuality:

1. When did the offender first openly express an interest in the opposite sex?
2. When did he begin dating or have his first girlfriend? What sexual activity was involved?
3. Describe the dating pattern. Note the number of dating partners he was involved with, the length of the relationships, and the sexual activity involved.
4. Did the offender have any same-sex partners?
5. When did the offender first begin to masturbate? Report the frequency of masturbation including use of pornography and sexual fantasies.
6. Describe any deviant sexual practices, fantasies and urges during childhood and adolescence.
7. What was the offender's attitude towards his dating partners?
8. Did he feel that he was in love?
9. Were there any serious rejections? How did the offender handle this?
10. Was there any violence in early sexual relationships?

C. Adult Sexuality/Bonding:

1. Describe the dating pattern during adult life. Note both heterosexual and homosexual relationships. How many sexual relationships has the offender had?
2. Has the offender ever been married? How many live-in relationships/marriages has the offender had? Note the length of each relationship.
3. If there have been a large number of relationships ask "Why so many?"
4. Ask the offender to describe his partners (at least the most recent or ones from the longest relationships).

5. Ask him to describe the relationship, discuss problems in the relationship (including violence), describe the sexual practices and problems, describe his partner, and discuss why the relationship ended.
6. Was there any sexual violence in any of the offender's relationships with partners?
7. Was the offender in love with any of his partners?
8. Has the offender ever been unfaithful to any of his partners?
9. Ask about the offender's relationship with any ex-partners. If there are problems in these relationships ask him to talk about the problems.
10. Does the offender have any children or stepchildren? What is his relationship like with his children? How often does he have contact with them? Ask the offender to give his children's birth dates and ages. Also ask him to tell you about each child, paying attention to whether he appears to know his children in an intimate fashion.
11. What discipline practices did the offender use with his children/stepchildren? Did he physically, sexually or emotionally abuse any of his children? Did he neglect his children?
12. Describe deviant sexual practices in the offender's life including rape, child sexual abuse, voyeurism, exhibitionism, obscene phone calling, toucherism/frotteurism, bestiality, and sadomasochistic activity. Get the details for each incident. Including, age and sex of victims, offender's age at the time of each offense, offender's relationship to the victim, frequency of assault, nature of assaultive behavior, grooming patterns, contributing factors, use of force, degree of pre-meditation, emotions preceding, during and following the assault, and the offender's acceptance of responsibility for each offense. Also ask about non-criminal paraphilias and sexual dysfunctions.

APPENDIX I

ASSESSMENT OF DANGEROUSNESS

Risk assessment of sexual aggressors has been the subject of considerable study in recent years. In estimating high risk we are interested in two things. We want to know how likely it will be that a particular offender will repeat criminal behavior (recidivism), and we also want to know how much harm this behavior will cause (dangerousness). These factors may operate somewhat independently as some offenders may have a high probability of re-offense with a low likelihood of harm, e.g. obscene phone callers, while others may have a high probability of harm to a victim even though the probability of a re-offense may not be judged to be high. Therefore, we must consider factors, which help us, predict recidivism potential as well as factors which help us determine dangerousness when we estimate risk to the public. Most risk assessment tools that have been developed focus primarily upon risk of recidivism rather than dangerousness. The following risk tool focuses on the harm an offender may inflict upon future victims should he reoffend. The assumption is that future harm may likely be as serious as past harm inflicted by the offender. In some cases there may be evidence of escalating violence and an adjustment to the risk may be indicated in these situations. This tool is intended for use along with recidivism risk tools such as the Static-99 and the Sonar (Hanson, 1999, Hanson & Harris, 2000). The Department of Justice developed a brief four-point scale for judging harm. This is also given below.

Probability of Harm Factors

The following factors are related to the degree of physical harm the offender has caused to the victim(s) during his assault(s). Rate any and all factors that apply.

Crimes of penetration: Code this factor for offenders who have penetrated their victims orally, vaginally or anally with any part of their body or with an object. Once again the offenses may or may not have resulted in a criminal charge or conviction.

History of Aggression: This factor should be marked if there is evidence in the record that the offender directed physical aggression towards another person in the past. The act may or may not have caused actual physical harm to another person but the act was clearly intended to do so. This includes domestic violence offenses, a history of brawling and aggression used in the commission of any criminal activity. The category does not include socially sanctioned violence such as tournament boxing, martial arts competition, violence performed in the course of duty as a soldier or police officer, or other aggressive activities deemed as acceptable by society. This factor is for coding of non-sexual aggression. Code aggression during sexual assault under “Use of force,” “Use of extreme Force,” or “Eroticized aggression.”

Threats of force or death: Code this factor when the offender has threatened the victim during the commission of a sexual assault, but not followed through with the threat. Do not code this factor for threats made against a victim outside of the assault itself unless

the threat relates directly to the sexual assault, such as threats of violence if the victim reports the crime.

HIV or other STD's: Offenders who have a current diagnosis of HIV or who have infected a victim with HIV or other STD in the past should be coded on this factor.

Continued assault in spite of high level of verbal or physical objection from victim:

Score this item when the offender does not halt the assault even though the victim struggles, pleads or clearly demonstrates fear or pain before or during the assault. Evidence of Eroticized aggression is not necessary to code this item. In fact, if evidence of such exists the offender should be coded for eroticized aggression instead. The offender may or may not be under the influence of alcohol or drugs.

Vulnerability of victims: This factor is coded if the offender has assaulted victims who are extremely vulnerable by virtue of their age (extremely young or old), inability to communicate, physical or mental impairment, or other factors which would impair the victim's ability to report the crime or defend themselves against the assault. Vulnerability due to victim age is a subjective judgment but children who have no expressive use of the English language certainly qualify. Also victims, who are intoxicated, mentally ill, developmentally disabled and victims who rely entirely on the offender for primary care all qualify. The offender's position of authority (e.g., as in the case of a parent, coach or teacher) is not in and of itself enough to justify coding this factor.

Use of force: Code this factor if force was used in the commission of any sexual crime committed by the offender. Force may have been used in order to subdue the victim or it may have been used to prevent the victim from reporting. The force, however, was related directly to the commission of the sexual assault. Aggression to the victim that is committed at other times is coded under History of Aggression. Force used in the context of eroticized aggression should be coded under that category.

Use of a weapon: The offender used a weapon to commit a sexual assault. This includes the use of a knife, gun, or any other instrument, other than his own person, which could potentially cause physical harm to the victim and/or create a sense of fear in the victim beyond that caused by the assault itself. This factor should be marked regardless of whether or not the weapon was actually used to inflict harm. It should also be checked even if the weapon was not used in every offense committed. Also, code this item if the offender led the victim to believe he had a weapon even if he didn't.

Use of extreme force: Score this factor if the offender has kidnapped his victim and/or if he has murdered or attempted to murder any of his victims during a sexual assault. Kidnapping a victim and taking them to a pre-selected place is a high risk factor for serial killers. If the offender used extreme force as a part of a pattern of eroticized aggression score both categories.

Research note: Offenders who use force in committing offenses are more likely to recidivate (Barbaree & Marshall, 1988; Gebhard, Gagnon, Pomeroy, & Christiansen, 1965; Maletsky, 1990).

Eroticized Aggression: Score when evidence indicates that harming the victim sexually arouses the offender. This information may come from verbal report by the offender and in some cases the victim, from physiological assessment, or from information gathered from the record. This might include indication that the offender did not obtain an erection until causing harm to the victim or that he intensified the assault after the victim demonstrated resistance or pain. Arousal to force or physical aggression during a plethysmograph assessment is evidence of eroticized aggression. Evidence in the record that the offender possessed a torture or rape kit indicates ritual offending and the likelihood of eroticized aggression. Sadistic offenders often practice many elements of their offense pattern on their current or past partners. Interviewing these individuals will frequently give important input into the arousal patterns of the sadistic offender. Sexual and violent recidivism was predicted by phallometric measures of arousal to non-sexual violence in 54 rapists (Rice, Harris, & Quinsey, 1989b). Several studies showed that offenders with eroticized aggression might be particularly prone to recidivate (Groth & Birnbaum, 1979; Hazelwood, Reboussin, & Warren, 1989; Rice, Harris, & Quinsey, 1989a).

Probability of Harm Factors

Crimes of penetration ____
History of aggression ____
Threats of force/death ____
HIV or other STD's ____
Continued assault in spite of high level of verbal or physical objection from victim ____
Vulnerability of victims ____
Use of force ____
Use of weapon ____
Use of extreme force ____
Eroticized aggression ____

Rate the offender from 1 to 5 based on the following criteria. The higher the number the higher the potential for harm. If an offender has any factor in a given category he is assigned the number equivalent to the highest category scored.

- | | | |
|--|--------------------------|---|
| 1. No use of force
No physical harm to victims
No penetration
No other factors scored | 2. Crimes of penetration | 3. History of Aggression
Threats of force/death
HIV or other STD's
Continued assault in spite of objection
Vulnerability of victims |
|--|--------------------------|---|

- 4. Use of force
Use of weapon
- 5. Use of extreme force
Eroticized aggression

Estimate of Current Risk to the Community:

Potential Harm to victims: _____ (Rate 1-5 using above guidelines)
Was there a pattern of escalating violence prior to arrest? ___ Yes ___ No

Department of Justice Harm Scale:

Rate the harm to the victim on a four point scale.

- Victim required no medical treatment = 0
- Victim treated and released = 1
- Victim hospitalized = 2
- Death of victim = 3

DOJ Score ____

Hanson & Harris Harm Scale

Rate most serious victim injury inflicted during a sexual offense (including index offence).

- Non-contact offenses only = 0
- Physical contact but no victim injury = 1
- Victim injury (e.g., cuts, bruises) but not life threatening; forcible confinement =2
- Life threatening victim injury (e.g., murder, attempted murder, manslaughter) =3

H&H Score ____

Describe the worst physical harm inflicted on victim(s) by the offender.

Comments:

AMM August 1, 2003

APPENDIX J

QUALITY ASSURANCE PROTOCOL FOR POLYGRAPH EXAMINERS

The following standards and procedures shall be employed in the use and the evaluation of polygraph procedures and results.

Information is released only to professionals:

Written polygraph reports and related work products shall be released only to members of the management team, the court, parole board, or other releasing agency, or other professionals at the discretion of the management team.

Communication with the examiner after testing:

Following the completion of the examination and post-test review, examiners shall not discuss the polygraph results with the offender, or the offender's family members, unless done in the context of a formal case staffing.

Quality Assurance:

Examiners shall seek peer review of at least two examinations per year using the protocol. Additional peer reviews may be requested by the management team. Quality assurance reviews shall consist of a systematic review of the examination report, test data, test questions, scored results, computer score (if available), audio/video recording, and collateral information. Documentation of six quality assurance peer reviews shall be submitted to DOC at the time of re-application. The purpose of the Quality Assurance Protocol shall be to facilitate a second professional opinion regarding a particular examination, to gain professional consensus when ever possible, and to formulate recommendations for the management team.

The Quality Assurance Protocol is intended to advise members of the management team on the polygraph test about the strengths and limitations of a particular test, and to provide examiners with a formal vehicle for gaining professional feedback and consensus. Quality assurance activities include: compliance with standards of practice, certification requirements, ongoing training, supervision and oversight, options for recourse in the event of identified problems, and program evaluation. Quality assurance activities take place at varying levels of formality, including informal data checks via audio/video recording, procedural or follow-up case staffing with the examiner, collaborative peer review, blind review, panel review, or referral to an outside agency for quality assurance review.

Initiating the quality assurance review:

With the exception of exams required for reapplication purposes, quality assurance reviews shall be initiated by a member of the management team. Quality assurance reviews may be initiated in response to a variety of circumstances, including but not limited to:

- A. A formal or informal complaint regarding non-compliance with these standards, or when critical decisions may be influenced by the information or results from the polygraph test.
- B. When separate examinations yield differing test results regarding the same issue(s) and/or time period. This review would then be completed by the two examiners whose examinations yielded differing results. The purpose of this review is to clarify the reasons for the differing test results and formulate a recommendation for the management team. If consensus cannot be reached, the team shall consult with a third, independent DOC approved full operating level polygraph examiner, agreed upon by both polygraph examiners, to review the conflicting information and offer an opinion regarding the issue. If differences in test results remain unresolved, both examinations shall be set aside and a new polygraph examination shall be conducted. Whenever consensus cannot be reached the management team must err on the side of community safety when considering their response.
- C. When an examiner determines the test subject has attempted to use manipulative techniques to alter the test results. The purpose of the review is to confirm the offender's use of manipulative techniques prior to the imposition of sanctions or consequences for non-cooperation. This review may not be necessary when the offender admits non-cooperation, explains his or her in-test behavior, and is forthcoming in discussing his or her knowledge of the polygraph technique. In these cases the test results may be regarded as inconclusive or unresolved until the issues are subject to re-examination.

Selection of the reviewing examiner:

When initiating a quality assurance review, the management team shall contact the original examiner and, together with the original examiner, select an independent, full operating level polygraph examiner to complete an objective peer review.

The reviewing examiner shall contact the original examiner with any questions and feedback, and shall complete the Quality Assurance Protocol and a Quality Assurance Summary Report together with the original examiner.

It should not be assumed that a reviewer or reviewers present more expertise than the original examiner. Studies have found that results obtained by original examiners have outperformed those of subsequent reviewers (National Academy of Sciences, 2003). Quality assurance reviews serve only to offer an additional professional opinion to further advise management team members regarding a polygraph test whose decisions may be affected by the information and results obtained.

Conclusions from the quality assurance review:

Management team members shall include a Quality Assurance Summary Report in the offender's treatment and supervision files. Quality assurance reviewers shall refrain from making global or generalized conclusions regarding an examiner's work or competence

(which cannot be done based upon a single examination). Unless an empirical flaw is identified, the reviewing examiner shall endorse the original examiner's reported results, and shall limit professional opinions to the following conclusions:

- A. Examination is supported – results shall be accepted;
- B. Examination is not supported – results shall be set aside;
- C. Examination is not supported but qualified by identifiable empirical limitations – results may be set aside or accepted with reasonable caution. Such qualifying limitations may include identifiable empirical limitations pertaining to offender suitability, data quality, and clarity of the issue(s) under investigation and are often noted by the original examiner in the examination report.

Setting aside an examination result does not include removal of the examination report from the offender's supervision and treatment files, but should include the addition of documentation regarding the management team's response.

The use of polygraph with special considerations:

The management team shall address any special considerations such as severe medical, psychiatric, or developmental conditions that may affect an offender's suitability for polygraph testing. When deciding whether to use polygraph testing with such offenders; the management team shall consider the probable benefits of testing, including improved decision making, deterrence of problem behavior, and the value of additional disclosed information that might otherwise not be obtained.

APPENDIX K
INFORMED CONSENT FOR PHYSIOLOGICAL ASSESSMENT

ALASKA DEPARTMENT OF CORRECTIONS
SEX OFFENDER TREATMENT PROGRAMS

CONSENT FORM - PHYSIOLOGICAL ASSESSMENT OF SEXUAL INTERESTS

I understand that I am being asked to participate in an assessment specifically to evaluate my sexual interests. I will be questioned regarding my history with specific details being asked about my sexual behavior.

My sexual interests will be measured by recording my erection response while I look at explicit sexual slides, videos, or listen to sexual material. This sexual material will be very explicit and will include non-deviant sexual behavior and deviant sexual behavior relating to my problems. While I observe or listen to these sexual materials, my erection will be measured by a small penile transducer, an apparatus that I place around my penis in the privacy of a laboratory. This device is thoroughly cleaned with an antiseptic to kill germs.

Because I may not have had my erection measures recorded before and because the investigators will know my erection responses, I may feel uncomfortable about such recording. I subsequently may feel anxious, uncomfortable, depressed, nervous, or angry.

My fears about sexual performance in the laboratory may cause me to have fears about my sexual performance outside of the laboratory after such measures are taken and I may develop difficulties getting an erection. I understand that if I have any side effects or unwanted reactions resulting from the procedures that I should discuss these reactions with my therapist as soon as possible. If my therapist is not available, I can discuss the matter with my wing counselor or ask for a referral to the mental health clinician. Offenders in community treatment programs may contact _____ when the therapist is not available.

The benefits of such an assessment are that it will be able to identify exactly which (if any) treatment is needed because of my sexual interest and arousal. The results of such an assessment will be communicated to me by my therapist.

If I have any questions about the assessment, I have discussed them to my satisfaction with the person in charge of my evaluation. My signature below indicates I have read and understood all of the above.

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Person in charge of my evaluation _____ Date
Program Participant _____ Witness

APPENDIX L

INFORMED CONSENT FOR BEHAVIORAL TREATMENT

**ALASKA DEPARTMENT OF CORRECTIONS
SEX OFFENDER TREATMENT PROGRAMS**

BEHAVIORAL TREATMENT OF SEXUAL DEVIANCY

I, _____ understand that I am asked to participate in treatment specifically designed to reduce my sexual arousal to deviant themes and/or increase my sexual arousal to non-deviant themes.

During treatment I may be shown explicit sexual slides and/or video tapes, asked to listen to explicit sexual tapes or asked to verbalize or imagine explicit sexual behavior as well as graphic consequences for engaging in such behavior. The sexual material will depict deviant sexual behavior as well as non-deviant sexual behavior relating to my problems. The material may also include aversive scenes and/or natural consequences to my deviant sexual arousal/interest(s). The aversive scenes/consequences are designed to decrease my interest in sexual deviancy. While I observe, listen to, or verbalize these sexual materials my erection responses may be monitored and/or measured by a penile transducer.

I understand that the behavioral treatment may include covert rehearsal, arousal conditioning procedures, noxious scenes, masturbatory procedures, and aversive conditioning (i.e. odor aversion or galvanic stimulation). The use of these procedures may pair deviant sexual material with aversive elements. I am aware that the use of behavioral treatment procedures may result in increased anxiety, and/or nausea. This anxiety may carry over to outside the laboratory and cause me to have fears about my sexual performance, and I may develop difficulty getting an erection. Also, because my therapists will know my erection responses I may feel anxious, uncomfortable, depressed, or angry. I understand if I have any side effects or unwanted reactions resulting from the procedures that I should discuss these reactions with my therapist as soon as possible. If my therapist is not available, I can discuss my concerns with my wing counselor, or ask for a referral to the mental health clinician. Offenders in community programs may contact _____ when the therapist is not available.

The benefits of behavioral treatment include increased control over my deviant sexual urges and/or increased arousal to appropriate sexual stimuli.

I understand that at this time my therapist is recommending that I engage in the following behavioral therapies:

My signature below indicates that I have read and understand all of the above information.

Program Participant _____ Date _____

Witness _____

APPENDIX M

INFORMED CONSENT FOR MEDICATION TREATMENT FOR REDUCTION OF SEXUAL DRIVE

ALASKA DEPARTMENT OF CORRECTIONS SEX OFFENDER TREATMENT PROGRAMS

REQUEST FOR ANTI-ANDROGEN TREATMENT

I, _____ understand that I am requesting anti-androgen treatment (MPA or Medroxy Progesterone Acetate) to be administered to me to assist in reducing my sexual arousal to and interest in deviant themes. I also understand that I may have already participated in methods of treatment designed to reduce my deviant sexual arousal, but that those methods have not sufficiently done so. It is because I still have significant deviant sexual arousal that I am requesting the use of anti-androgen treatment (AAT).

I understand that AAT is administered on a weekly basis by injection and that serum testosterone levels will be conducted before and periodically during use, as well as plethysmographic assessments. I further understand that additional lab work such as sperm morphology may be required prior to administration of AAT.

I understand that the dosage of MPA will be sufficient to reduce my testosterone level to my pre-pubertal level. During which time I may be participating in behavioral therapies to assist in reducing my deviant sexual arousal. Once my deviant sexual arousal is reduced to an insignificant level my weekly dosages of AAT will be reduced monthly until I am no longer taking it.

The benefits of treatment are that it may reduce my deviant sexual arousal and assist in overcoming my habitual pattern of sexual deviancy.

I understand potential side effects resulting from use of AAT may include, but are not limited to: weight gain, increased need for sleep, cold sweats, hot flashes, testicles may decrease in size, hyperglycemia, G.I. discomfort, hypertension, nightmares, elevated blood glucose, muscular pain, labored or difficult breathing, decreased sperm count, abnormal sperm, nervousness and upset stomach. I also understand that with use of AAT I may have difficulties obtaining erections and the overall desire to sexualize or fantasize may decrease. These side effects are temporary while receiving AAT and are reversible. I agree to report any side-effects to the prescribing physician.

At any stage of treatment I may withdraw my consent for AAT by submitting my withdrawal in writing to my therapist.

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In signing this I indicate I have read and understand the above.

Program Participant _____

Date _____

Therapist _____

Date _____

APPENDIX N

**GUIDELINES FOR PROGRAM EVALUATION
SEX OFFENDER PROGRAM EVALUATION
GUIDELINES FOR PROGRAM REVIEW**

Written by

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and

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for

State of Alaska
Department of Corrections

October 1994

**SEX OFFENDER PROGRAM EVALUATION:
GUIDELINES FOR PROGRAM REVIEW**

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INTRODUCTION AND OVERVIEW

The State of Alaska's Department of Corrections (DOC) provides assessment and treatment services to sex offenders across a continuum of care. There are several sex offender programs including two institutional programs and a number of community based programs. The Department strives to expand and improve services throughout the state within the constraints of funding. Evaluation of programs is essential to maintaining a high standard of care and to facilitate healthy program growth.

The purpose of the evaluation process is to examine program structure and procedure to determine areas of strength and weakness as well as to determine compliance with DOC's Standards of Care. The evaluation process can assist programs in reaching their goals and maintaining program excellence. Program evaluation, properly done, enhances training and program development.

Program evaluations are conducted by an evaluation team composed of the Criminal Justice Planner for the Division of Institutions and a private contractor. Other DOC personnel will assist as needed.

Program evaluations are conducted annually and are part of the routine activities of the Department. The Department may conduct program evaluations whenever deemed necessary and appropriate, however. Additionally, programs may request a DOC evaluation at any time in order to assist in identifying and/or helping to resolve problems in service delivery. Requests for site visits and information regarding program evaluation should be made to the criminal justice planner for the Division of Institutions.

The present guidelines are an attempt to create a tool for evaluation which will lead to a consistent and standardized evaluation process. The instrument itself will undergo evaluation through its use. The instrument will undergo development and revision as needed. The document is in a three-ring binder format to facilitate its use and to encourage the addition or replacement of materials as needed.

PREPARATION FOR THE EVALUATION

Program evaluations are typically anxiety producing for program staff. Adequate preparation will help to alleviate anxiety regarding the process and facilitate the evaluation process for evaluators.

Programs should be notified 30 days in advance of the site visit so as to have sufficient time to provide pre-visit materials and arrange for interviews.

Additionally, program evaluation procedures and guidelines should be made available to programs for review. Programs should be encouraged to "self-evaluate" using the same guidelines and procedures used by DOC several months prior to the formal DOC evaluation. When deficits are identified a plan for resolution can often be developed and initiated prior to the formal evaluation process. This puts the responsibility for evaluation upon the program itself and encourages self-imposed standards and a higher quality of care.

PRE-SITE VISIT ACTIVITIES

Pre-Evaluation Information/Materials. In order for a productive evaluation to be conducted certain materials must be submitted for review prior to the actual site visit. This will expedite the work to be done and facilitate the evaluation process. The following materials and pieces of information should be provided to the Criminal Justice Planner for the Division of Institutions at least 14 days prior to the site visit:

1. A written program description including a statement of program philosophy and admission standards.
2. A list of all services provided (assessment, group therapy, individual therapy etc.) and frequency of sessions.
3. A list of current staff including their professional degree, current licensure information and approved provider level.
4. A completed Offender Enrollment Form with all DOC participants listed.
5. The number of non-DOC sex offenders (private clients who have not gone through the court system or former DOC clients) currently enrolled in the program.
6. The names of any DOC sex offenders currently on a waiting list and the numbers of any non-DOC sex offenders currently on that list.
7. A list of all DOC program drop-outs during the contract period.
8. A list of all DOC program removals during the contract period.
9. A list of all offenders who were released as program complete during the contract period.

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OFFENDER ENROLLMENT FORM

Name Sex DL Off EC SN ED TP

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

Key:

Sex: M=male, F=Female
DL: DOC Level (I, II, III)
Off: Offense(s) (A=offense against adults, C=offense against children, B=offense against both adults and children)
EC: Ethnic Code (C=Caucasian, AN=Alaska native, B=black, H=Hispanic, A=Asian, O=other)
SN: Special Needs (Y=yes, N=no)
ED: Entry Date (Mo./Day/Year)
TP: Treatment Phase (PT=pretreatment, B=beginning, I=intermediate, A=advanced)

Pre-visit Arrangements. In addition to reviewing certain documents and examining information regarding program services, DOC staff will require the program to arrange for the scheduling of several interviews. Interviews typically will last between 30 and 60 minutes. It is the responsibility of the contractor to arrange for time in program staff scheduling to allow for the various interviews. In addition, the contractor must arrange for observation times so the various treatment components can be observed by members of the evaluation team.

The evaluator(s) will at a minimum observe the following activities:

1. One or more assessment sessions
2. One or more education classes
3. One or more individual therapy sessions
4. One or more group therapy sessions

Other activities which may be observed include:

1. One or more marriage or family counseling sessions
2. One or more behavioral treatment sessions
3. Other program activities including staff training, case staffing, treatment team meetings and other activities as deemed appropriate by DOC.

DOC will notify the contractor of the activities to be observed 14 days prior to the site visit. The contractor should notify the Criminal Justice Planner immediately if problems arise in scheduling.

Since a random sampling of records for each therapist will be evaluated during the site visit all records should be maintained in good order and be made available to the evaluator(s) during the site visit.

INTERVIEW GUIDELINES

Overview. An important source of information about program performance comes from interviewing key personnel. The purpose of the interviews is to gather information from a variety of perspectives regarding program performance. A list of suggested persons to interview is given in the Program Evaluation Interview Schedule. The schedule is intended as a guideline. The evaluation team may choose those individuals to interview which they feel will provide the most appropriate information regarding program performance.

The interview schedule should be completed two weeks prior to the site visit. Program staff will be consulted and in some cases will be required to arrange interview times.

The Interview Process. The type of information to be obtained will differ according to who is interviewed. A list of suggested questions for each interview is given in the following sections of this document. These questions are intended to be guidelines for interviewing. The particulars of a given program or situation may necessitate additional questions. The evaluator(s) should feel free to develop whatever questions they feel are necessary to properly and completely evaluate the program. Many of the questions are open-ended and are designed to allow the interviewee an opportunity to give their opinions and observations freely. The exception is the interview process for offenders which is more directive. The reasons for this are discussed below.

Interviewing Offenders. The guidelines for interviewing offenders attempt to derive some sense of where the offender is in the treatment process. In a sense these questions are intended to test the offender rather than gather offender opinions regarding program performance. For many offenders an opportunity to critique the program can lead to a "gripe session" and give a false sense of control over program staff. This could be disruptive to the program itself. Personal interviews of offenders should, therefore, avoid gathering critical information about the program or attending to the personal needs of the offender being interviewed. Any discussion of the particular aspects of their case should be avoided. Instead the interviewer should be concerned with determining the level of knowledge the offender has about his own offense cycle and the attitude he portrays about his crime. The sense one gets of the offender's level of advancement should bear some relationship to his level of achievement in the program. For example, while we might expect denial in a Phase I (pre-treatment) offender, we certainly would not expect this in an offender who is in the advanced phase of treatment.

The offender's critique of program activities is obtained via an anonymous questionnaire. This allows offenders to offer comments, criticisms and suggestions without reinforcing destructive attitudes and allowing offenders to manipulate the evaluation process.

PROGRAM EVALUATION INTERVIEW SCHEDULE

<u>Name</u>	<u>Position</u>	<u>Interview Date</u>	<u>Time</u>
-------------	-----------------	-----------------------	-------------

Program Staff

Admin/Clin Dir.

Clinical Supervisor

Psychologist

Therapist

Educator

CRC Staff

DOC Personnel

Prison Superintendent/
Asst. Super.

Institutional/Field P.O.

Program/Wing Counselor Supervisor

Correctional Officer

Work Supervisor

Program Participants

Offender

Spouses/Partners

Victims/Family

Community Persons

Board Members

Shelter Staff/Victim Advocates

Others

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INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date _____

Interviewer(s) _____

—

—

GENERAL QUESTIONS (FOR ALL INTERVIEWED EXCEPT OFFENDERS)

- 1) How long have you been associated with the program?
- 2) Describe your job, role or connection with the program?
- 3) In your opinion what are the program's strengths and weaknesses?
- 4) What problems have you encountered in the past year in your role with the program? How were these problems resolved? or What is the plan to resolve the problems?
- 5) Describe any staff problems. What is the staff morale?
- 6) What is your perception of the degree of cooperation/coordination between staff? What level of cooperation/coordination exists between staff and other professionals, paraprofessionals and/or non-professionals?
- 7) Describe any problems in service delivery.
- 8) What suggestions do you have to improve the program?
- 9) Do you feel the program is effective? Do you have an opinion about the quality of services being provided?
- 10) Does the program emphasize prison/community safety?
- 11) Does the staff behave in a professional manner?

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POSITION SPECIFIC QUESTIONS-PROGRAM STAFF

A. **Administrative/Clinical Director**

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date _____

Interviewer(s) _____

—

-
1. What is the history of the program? When was it established and how has it evolved?
 2. Describe the program's history with DOC.
 3. How has the program been funded over the years?
 4. What percent of the total current funding is from DOC?
 5. Have you had any difficulties complying with your DOC contract?
 6. Have there been any difficulties staying in compliance with the Standards of Care?
 7. Do you receive funding for sex offender programming from any other sources?
 8. How do you feel about the relationship between yourself/your agency and DOC.
 9. Are there agency/practice problems which potentially could effect the performance and/or stability of the sex offender program?
 10. What other sources of funding does the agency/practice receive?
 11. What other types of programs/services does the practice/agency provide?
 12. What are the agency's overall goals and priorities for the coming year? What are the goals/priorities for the sex offender program?

B. Clinical Supervisor

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

—

—

1. Describe the services that you supervise. How are they staffed?
2. How frequently do you meet with staff? Describe how supervision is conducted.
3. How often do you observe program activities?
4. Summarize any difficulties you have had supervising the staff.
5. How do you feel about the overall skill and quality of staff?
6. Do you have any concerns about staff's responsiveness to supervision and guidance?
7. Are supervision plans being followed?
8. Do you feel that there are cooperation/coordination problems between clinical and DOC management staff?
9. Are you aware of any deficits that are seriously jeopardizing the quality of treatment?
10. List and summarize the problems with the program from a clinical perspective.
11. Are there teamwork problems among staff?
12. List your priorities for staff training.
13. Are there any problems complying with the Standards of Care?
14. List any difficulties with record-keeping/documentation.
15. Discuss any plans to improve supervision in the coming year.

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16. Are the staff's relationships with inmates appropriate?

C. Psychologist

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

—

—

1. Describe the types of assessments performed.
2. Are there any difficulties performing assessments and evaluations?
3. Do you feel the results of examinations are incorporated into the treatment plan?
4. Are you lacking any materials in order to perform the necessary tests?
5. Do you feel you need further training/consultation to perform the necessary tasks of your job?

D. Therapist

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

—

—

1. Are you experiencing any difficulties in carrying out your work as a therapist?
2. Do you feel you are getting adequate supervision?
3. Are there any safety issues that are not being adequately addressed (safety to victims, therapists, offenders)?
4. What areas of continuing education and training do you feel need to be addressed?
5. Are there any changes to the therapy process and/or the program itself that you would like to see made?

E. Educator/Instructor

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

—

—

1. Do you feel you have the necessary materials and resources to carry out your job?
2. Do you feel the curriculum is adequate for the educational components you teach? Do you have any ideas for curriculum development?
3. Do you need additional training/consultation to carry out your work?
4. Do you feel the educational program is effective?

F. CRC Staff

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

—

—

1. Are there any management problems as a result of SOTP programming that need to be addressed?
2. Do you have any safety concerns?
3. Do you feel the SOTP treatment staff keeps you informed regarding participants?
4. Do you feel you need further training/consultation from the SOTP staff in order to be effective in your job?
5. Is the sex offender program consistent with/coordinated with other CRC programs?

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POSITION SPECIFIC QUESTIONS-DOC PERSONNEL

A. Prison Superintendent/Asst. Superintendent

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

—

—

1. Do program staff follow security regulations and/or other institutional regulations and procedures?
2. Are you kept informed about management and/or security issues promptly?
3. Are program staff willing to coordinate with correctional staff?
4. Are reports placed in inmates files in a timely fashion?
5. Are relationships with inmates appropriate?
6. Is the program in compliance with the contract and the Standards of Care?
7. Is information provided in reports sufficient to substantiate recommendations for important decisions such as the decision to remove an inmate from program?

B. Institutional/Field Probation Officer

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

—

—

1. Are you kept informed about the offender's progress in treatment on a regular basis?
2. Are you consulted for input regarding offenders' behavior outside of treatment?
3. Do staff anticipate problems and consult with you beforehand or do they react to problems after they occur?
4. Do you feel that the program has a team approach and that you are a part of that team?
5. Do you receive required reports? Are they complete?
6. Are relevant institutional staff at treatment team meetings?

C. Program/Wing Counselor Supervisor

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) : _____

1. Describe the services you supervise and/or the administrative duties you have.
2. Have you had any difficulties carrying out these duties?
3. How frequently do you meet with staff?
4. How often do you observe program activities?
5. Summarize any difficulties you have supervising staff.
6. Do you have any concerns about the staff's responsiveness to supervision and guidance?
7. Do you feel there are cooperation/coordination problems between clinical and DOC management?
8. Have there been any problems with contractors meeting contract agreements?
9. What has been the quality of services provided?
10. Are you aware of any deficits that are seriously jeopardizing the quality of treatment?
11. Are there teamwork problems among staff?
12. Are there any problems complying with the standards of care?
13. Are the staff's relationships with inmates appropriate?
14. What are the program's goals and priorities for the coming year?
15. Have there been any problems interfacing with other programs?
16. Do you feel your relationship with prison administration and central office staff has been cooperative and supportive?

D. Correctional Officer-Wing Counselor

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

—

—

1. Are you kept informed about treatment activities when you are not co-facilitating?
2. Are you having any problems working with the therapist(s) or other program staff?
3. Do you feel that the program has a team approach and that you are a part of that team?
4. Do you feel you are getting the necessary guidance and supervision from the therapist?
5. Are conflicts between yourself and your co-therapist resolved in a satisfactory manner?
6. Do you feel that your input is accepted and valued by other treatment staff?
7. What types of training or continuing education do you feel you need to do your job more effectively?

E. Work Supervisor

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date _____

Interviewers (s) : _____

1. Are there any particular problems that sex offender programming causes to the work programs you supervise?
2. Are you consulted for input about offenders' attitudes on the job?
3. Do you see a relationship between progress in treatment and work performance?
4. Do you report job problems to treatment staff?
5. Do you think program staff value the goals you're working towards in your position?

F. Mental Health Clinician

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s): _____

1. Are there any coordination/cooperation problems between you and the SOTP staff?
2. What is your opinion of the level of expertise among the SOTP staff?
3. Describe any problem with record-keeping/documentation. Is there a flow of information between yourself and SOTP staff?
4. Do you get appropriate referrals? Are the referrals made in a timely manner?
5. Are you consulted for input about program participants?
6. Are you included in treatment team meetings?
7. Are the relationships between SOTP staff and inmates appropriate?

PROGRAM PARTICIPANTS

A. **Offenders**

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

1. How long have you been in treatment? What phase of treatment are you in?
2. How do you feel about your involvement in the program? How consistent has your effort been and how hard are you working?
3. Describe the changes you've made since joining the program.
4. Are the various aspects of treatment, e.g. group and individual therapy, behavior treatment, education, assignments etc., helping you to reach your treatment goals? Are you getting everything out of treatment that you could be?
5. What are your high risk factors?
6. Describe your predominant thinking errors.
7. What are your main stumbling blocks to change? What are you currently working on?
8. What has the program helped you understand about your relapse process?
9. What is your opinion of your risk to the community?
10. Do you feel you have contributed anything to the program?
11. What aspect of yourself do you think your group and/or your therapist has had the hardest time dealing with?
12. What is your biggest regret? Why?
13. What worries you the most about yourself?
14. How do you rate your risk of committing a sexual offense in the future? Circle one.

LOW 1 2 3 4 5 HIGH

B. Spouses/Partners

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Intra-Family Abuse ___ Extra-Family Abuse ___

Interviewer(s) _____

—

1. What involvement have you had in the program? What services are you receiving?
2. Do you have your own therapist?
3. Has the program been helpful? How?
4. Can you describe the main things you've learned about the offense and about relapse?
5. Do you have any safety concerns?
6. Have you seen any changes in your spouse/partner? Describe.
7. What areas do you feel still need work?
8. Have you had any problems working with program staff?
9. Do you feel that your needs and/or the needs of your children have been put first by staff?
10. What will you do if you sense that your partner is on the verge of a reoffense?
11. Who do you regard as your main support person(s) when you have questions and/or concerns regarding potential relapse?
12. Do you have any suggestions about how the program could help you and your family more effectively?
13. How do you rate the offender's risk of committing a sexual offense in the future? Circle one.

1 _____ 2 _____ 3 _____ 4 _____ 5

LOW

HIGH

C. Victims/Other Family

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Intra-Family Abuse ___ Extra-Family Abuse ___

Interviewer(s) _____

1. What involvement have you had with the program?
What services have you received?
2. Do you have your own therapist?
3. Has the treatment helped you with your problems?
4. Do you feel that the program staff are concerned about your safety? If something were to start to happen again would you feel safe to tell?
5. What are the best and worst things about the program?
6. Have you felt comfortable/safe enough to share your feelings and problems with your therapist?
7. Is there anything happening in treatment that is a problem for you?
8. Is there anything that is not happening that should be?
9. Do you feel you have enough privacy in your home? Do people respect your privacy/boundaries?
10. How do you rate the offender's risk of committing a sexual offense in the future? Circle one.

1 _____ 2 _____ 3 _____ 4 _____ 5

LOW

HIGH

D. Program Drop-Outs

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____
—

1. How long did you participate in the program?
2. What phase of treatment were you in when you dropped out?
3. Give the main reason for dropping out.
4. What other factors effected your decision (i.e., wanting to be at another institution or location, wanting more time to work etc.)?
5. Do you feel you got anything out of the program?
6. What did you learn about your offense pattern?
7. Do you think you would want to participate again in the future?
8. How do you rate your risk of committing a sexual offense in the future? Circle one.

1 _____ 2 _____ 3 _____ 4 _____ 5
LOW HIGH

COMMUNITY PERSONS

A. **Board Members**

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

1. Describe any agency problems which could be effecting the program? What are the plans for resolution?
2. Are there any upcoming changes that could potentially effect the operation of the program?
3. What are the plans and goals for the agency's future? What are the priorities for the coming year?
4. What are your impressions of the degree of cooperation between the agency and DOC?

B. Shelter Staff/Victim Advocates/Victim Therapists

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name: _____ Date: _____

Interviewer(s) _____

1. What involvement have you had with the program?
2. What is your impression of the program?
3. Is the program's philosophy and methods consistent with victim protection and community safety?
4. Do you have any concerns about quality of treatment?
5. Has the program been open and receptive to your input?
6. Has program staff coordinated with shelter staff in providing services to victims and other family?
7. Have shelter staff been included in safety-net training with the victim/family?
8. Are you getting enough information to assist you in making decisions about victim safety?
9. Is there anything from the victim's standpoint that needs to happen in therapy that has not yet taken place?
10. Do you feel the victim feels safe/comfortable enough to make his/her needs/concerns known to the program staff?
11. Was the victim's therapist contacted before the offender had any contact with the victim?
12. What other recommendations do you have to improve services to the victim/family?

SEX OFFENDER TREATMENT SURVEY

General Instructions. The purpose of this survey is to give program participants an opportunity to share their opinions about the Sex Offender Program. The survey is anonymous and you are **NOT** to put your name on the questionnaire. Program staff will be given feedback about the findings from the survey. These findings will be summarized as a group. No ones' individual answers can be identified so please be open and honest in your responses. After you complete your survey, place it in the envelop provided and seal it. Please answer all questions. Thank you for your input.

SEX OFFENDER TREATMENT SURVEY

INSTRUCTIONS

- Do not put your name on this survey.
- Do not ask other individuals to help you complete the survey. If you have difficulty reading, you may ask for help from a wing counselor or other treatment staff.

Please read each statement carefully and put a check mark next to the answer you select.

1. I am:
 single
 married
 divorced
 widower

2. I am in Phase ____ of treatment. (**I** = Pre-Treatment, **II** = Beginning Treatment, **III** = Intermediate Treatment, **IV** = Advanced Treatment)

3. My therapist is: (check both if appropriate)
 male
 female

4. In my opinion, the one most important part of treatment is: (Please check one only)
 Problem-Solving
 Assertiveness
 Social Skills
 Empathy
 Relapse Prevention
 Anger Management
 Other (specify) _____

5. In the past, I have had a problem with alcohol or drugs.
 True
 False

6. The use/abuse of alcohol or drugs was involved in my sex offense.
- True
 False
7. How would you rate your wing counselor/therapist's presentation of the materials?
- very helpful
 mostly helpful
 somewhat helpful
 not helpful
8. If you are not currently in treatment specify the reason.
- I successfully completed the program.
 I was removed because of a conduct violation I received.
 I was removed for lack of motivation/participation; for example, absences.
 I was removed due to failure to understand or apply the concepts.
 I quit or refused to participate.
 Other reason (please explain) _____
9. The duration of treatment in the sex offender program is:
- too long
 too short
 just about right
10. Which Educational Components have you completed? (please check all that apply)
- Anger Management
 Relapse Prevention
 Values Clarification
 Empathy Training
 Assertiveness Training
 Substance Abuse Education
 Sexual Education
 Social Skills Training
 Other (specify) _____

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On the following questions, please circle the one word or phrase that expresses your point of view: (Double answers will not be counted)

11. Relapse Prevention was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree NeutralDisagree Strongly disagree

12. Empathy Training was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree NeutralDisagree Strongly disagree

13. Anger Management was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree NeutralDisagree Strongly disagree

14. Social Skills Training was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree NeutralDisagree Strongly disagree

15. Values Clarification was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree Neutral Disagree Strongly disagree

16. Assertiveness Training was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree Neutral Disagree Strongly disagree

17. Substance Abuse Education was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree Neutral Disagree Strongly disagree

18. Sexual Education was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree Neutral Disagree Strongly disagree

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19. The learning aids such as written handouts, audio-visual tapes, and films were helpful in treatment.

Strongly agree Agree NeutralDisagree Strongly disagree

20. The concepts of the program are valuable while still living in prison.

Strongly agree Agree NeutralDisagree Strongly disagree

21. The concepts of the program will help me when I return home.

Strongly agree Agree NeutralDisagree Strongly disagree

22. Treatment does, in fact, help you change your thinking and behavior.

Strongly agree Agree NeutralDisagree Strongly disagree

23. There is a possibility that I will re-offend.

Strongly agree Agree NeutralDisagree Strongly disagree

24. I still think irrationally at times.

Strongly agree Agree NeutralDisagree Strongly disagree

25. A person's thinking can control what he feels and does.

Strongly agree Agree NeutralDisagree Strongly disagree

26. Sex Offender Treatment is a needed and useful program in the Department of Corrections.

Strongly agree Agree NeutralDisagree Strongly disagree

27. Applying what I learned in treatment works for me.

Strongly agree Agree NeutralDisagree Strongly disagree

28. Being responsible is the key to staying out of prison.

Strongly agree Agree NeutralDisagree Strongly disagree

29. I think that treatment was successful in helping me to understand and change my behavior.

Strongly agree Agree NeutralDisagree Strongly disagree

30. I believe that my therapist was professional and treated me with respect.

Strongly agree Agree NeutralDisagree Strongly disagree

31. The therapist was fair and consistent with all group members.

Strongly agree Agree NeutralDisagree Strongly disagree

32. I believe my wing counselor was professional and treated me with respect.

Strongly agree Agree NeutralDisagree Strongly disagree

33. My wing counselor was fair and consistent with all group members.

Strongly agree Agree NeutralDisagree Strongly disagree

34. The materials (charts, principles, etc.) were presented in a way that I could understand them and use them.

Strongly agree Agree Neutral Disagree Strongly disagree

35. Do you have any suggestions that might be given to your therapist or wing counselor?

36. In your opinion, what can be done to improve the effectiveness of the Sex Offender Treatment Program?

SEX OFFENDER PRE-TREATMENT SURVEY

General Instructions. The purpose of this survey is to give program participants an opportunity to share their opinions about the Sex Offender Pre-Treatment Program. The survey is anonymous and you are **NOT** to put your name on the questionnaire. Program staff will be given feedback about the findings from the survey. These findings will be summarized as a group. No ones' individual answers can be identified so please be open and honest in your responses. After you complete your survey, place it in the envelope provided and seal it. Please answer all questions. Thank you for your input.

SEX OFFENDER PRE-TREATMENT SURVEY

INSTRUCTIONS

- Do not put your name on this survey.
- Do not ask other individuals to help you complete the survey. If you have difficulty reading, you may ask for help from a wing counselor or other treatment staff.

Please read each statement carefully and put a check mark next to the answer you select.

1. I am:
 - single
 - married
 - divorced
 - widower

2. I have been in Pre-Treatment for:
 - 1-30 days
 - 30-90 days
 - 90-180 days
 - over 180 days

3. My therapist is: (check both if appropriate)
 - male
 - female

4. In the past, I have had a problem with alcohol or drugs.
- True
 False
5. The use/abuse of alcohol or drugs was involved in my sex offense.
- True
 False
6. How would you rate your wing counselor/therapist's presentation of the materials?
- very helpful
 mostly helpful
 somewhat helpful
 not helpful
7. The duration of treatment in the sex offender Pre-Treatment program is:
- too long
 too short
 just about right
8. Which Educational Components have you completed? (please check all that apply)
- Orientation
 Anger Management
 Relapse Prevention
 Values Clarification
 Empathy Training
 Assertiveness Training
 Substance Abuse Education
 Sexual Education
 Social Skills Training
 Other (specify) _____

On the following questions, please circle the one word or phrase that expresses your point of view: (Double answers will not be counted)

9. Relapse Prevention was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree NeutralDisagree Strongly disagree

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10. Empathy Training was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree NeutralDisagree Strongly disagree

11. Anger Management was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree NeutralDisagree Strongly disagree

12. Social Skills Training was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree NeutralDisagree Strongly disagree

13. Values Clarification was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree Neutral Disagree Strongly disagree

14. Assertiveness Training was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree Neutral Disagree Strongly disagree

15. Substance Abuse Education was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree Neutral Disagree Strongly disagree

16. Sexual Education was a valuable part of the program. (Answer only if you attended this part.)

Strongly agree Agree Neutral Disagree Strongly disagree

17. The learning aids such as written handouts, audio-visual tapes, and films were helpful in treatment.

Strongly agree Agree NeutralDisagree Strongly disagree

18. The Pre-Treatment program has helped me understand what treatment is all about.

Strongly agree Agree NeutralDisagree Strongly disagree

19. I am better able to discuss my crimes than I ever was before.

Strongly agree Agree NeutralDisagree Strongly disagree

20. The Pre-Treatment program has helped me to better understand what my problems are.

Strongly agree Agree NeutralDisagree Strongly disagree

21. The Pre-Treatment program has helped me change my thinking and behavior.

Strongly agree Agree NeutralDisagree Strongly disagree

22. I think sex offender treatment will be the right program for me.

Strongly agree Agree NeutralDisagree Strongly disagree

23. Honesty about oneself is necessary before a person can really change.

Strongly agree Agree NeutralDisagree Strongly disagree

24. I believe the Pre-Treatment program has prepared me or will prepare me for treatment.

Strongly agree Agree NeutralDisagree Strongly disagree

25. The concepts of the program are valuable while still living in prison.

Strongly agree Agree NeutralDisagree Strongly disagree

26. The concepts of the program will help me when I return home.

Strongly agree Agree NeutralDisagree Strongly disagree

27. There is a possibility that I will re-offend.

Strongly agree Agree NeutralDisagree Strongly disagree

28. I still think irrationally at times.

Strongly agree Agree NeutralDisagree Strongly disagree

29. A person's thinking can control what he feels and does.

Strongly agree Agree NeutralDisagree Strongly disagree

Standards of Sex Offender Management

30. Sex Offender Pre-Treatment is a needed and useful program in the Department of Corrections.

Strongly agree Agree NeutralDisagree Strongly disagree

31. Applying what I learned in Pre-Treatment works for me.

Strongly agree Agree NeutralDisagree Strongly disagree

32. Being responsible is the key to staying out of prison.

Strongly agree Agree NeutralDisagree Strongly disagree

33. I believe that my therapist was professional and treated me with respect.

Strongly agree Agree NeutralDisagree Strongly disagree

34. The therapist was fair and consistent with all program participants.

Strongly agree Agree NeutralDisagree Strongly disagree

35. I believe my wing counselor was professional and treated me with respect.

Strongly agree Agree NeutralDisagree Strongly disagree

36. My wing counselor was fair and consistent with all program participants.

Strongly agree Agree NeutralDisagree Strongly disagree

37. The materials (charts, principles, etc.) were presented in a way that I could understand them and use them.

Strongly agree Agree Neutral Disagree Strongly disagree

38. Do you have any suggestions that might be given to your therapist or wing counselor?

39. In your opinion, what can be done to improve the effectiveness of the Sex Offender Pre-Treatment Program?

GUIDELINES FOR OBSERVATION OF PROGRAM ACTIVITIES

Overview. It is important for evaluators to actually observe the various aspects of the treatment process in order to get a first hand sense of how services are being delivered. The observation process is a subjective one, however, in the following section suggestions are made about what to look for in the various program components. It is not possible to observe evidence of all factors in any one session and this should not be implied from the list. Also there may be other important factors which are observed but are not on the list. These comments should be recorded as well. The lists are not exhaustive. The evaluators should attempt to record specific examples, whenever possible, of behaviors and interactions upon which their conclusions and judgments are based.

The Observation Process. Program participants should be informed prior to the site visit that observations will be made of the various treatment components. Participants should be informed that the purpose of the observation is to gather first hand information about how treatment is conducted. Therefore, treatment activities should be conducted normally as if the observer were not present. It should be made clear that the purpose of observation is not to field complaints about the program or to help offenders with problems related to their particular situations. The demeanor of the evaluator(s) should be one of quiet observation. Observers should not become actively involved in the ongoing process. A few minutes should be allowed at the end of the activity for the evaluator(s) to gather the participants' and therapists' perspective about the representativeness of the session. Also if the evaluator(s) wish to clarify anything about what went on during the session they can do it at this time.

Because of standardized testing procedures observation of certain psychological tests is not possible without invalidating the test itself. If necessary information about the test process for these procedures can be obtained through interview of the psychologist, treatment supervisor or participant(s).

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GUIDELINES FOR OBSERVATION OF GROUP THERAPY

Program Site _____ Date of Observation _____

Program Evaluator(s) _____

Type of Group _____

Therapists _____

Number of Group Participants _____

Evaluators should observe and comment upon the following areas of therapist and group performance.

1. Use of RP principles in group: _____

—

2. Ability of therapist to use relevant interventions. _____

—

3. Ability of therapist to maintain therapeutic control.

4. Ability to deliver feedback appropriately. _____

—

5. Attempts to involve all group members. _____

—

6. Ability to provide structure, focus and avoid getting sidetracked. _____

—

7. Ability to identify issues relevant to individual goals and/or treatment plans. _____

—

8. Shows respect for offenders. _____

—

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Post Session Interview:

Therapist(s) Comments: _____

—

Offenders Comments: _____

—

Was the session representative? _____

—

Evaluator(s) Summary and Comments. _____

—

Evaluator Signature _____

Evaluator Signature _____

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GUIDELINES FOR OBSERVATION OF INDIVIDUAL THERAPY

Program Site _____ Date of Observation _____

Program Evaluator(s) _____

Therapist _____

—

Evaluators should observe and comment upon the following areas of therapist performance:

1. Familiarity with the offender's case i.e., personality issues, case, treatment plan _____

—

2. Ability to provide focus for the session consistent with the treatment plan _____

—

3. Ability to make appropriate interventions during the session _____

—

4. Possession of necessary skills to carry out specific procedures e.g. role playing, cognitive sensitization, thought stopping etc. _____

—

5. Ability to focus on relevant aspects of the therapist/client relationship when appropriate _____

—

6. Ability to give appropriate feedback _____

—

7. Appropriate use of RP principles _____

—

8. Ability to maintain therapeutic control of the session _____

—

9. Appropriateness of homework assignments _____

10. Shows respect for offender _____

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Post Session Interview:

Therapist Comments: _____

—

Offender Comments: _____

—

Was the session Representative?

—

Evaluator(s) Summary and Comments: _____

Evaluator
Signature _____

Evaluator
Signature _____

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GUIDELINES FOR OBSERVATION OF FAMILY/MARITAL THERAPY

Program Site _____ Date of Observation _____

Program Evaluator(s) _____

Type of Therapy _____

Therapists _____

—

Number Family Members Present _____

Evaluators should observe and comment upon the following areas of therapist performance:

1. Ability to understand the following aspects of the family/marital system:

a) Communication patterns _____

b) Cooperation patterns _____

c) Decision making patterns _____

d) Hierarchies of power _____

e) Individual roles _____

f) How needs are met _____

G) Problem solving strategies _____

2. Ability to make appropriate interventions _____

—

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3. Attempts to help the family focus on relevant issues _____

4. Application of RP principles in the therapy session _____

—

5. Open and appropriate discussion of abuse and safety issues _____

—

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6. Ability to make victim issues/needs paramount in the session _____

—

7. Ability to focus on the healthy needs of the family as opposed to putting the offender's needs first _____

—

8. Ability to recognize the offender's manipulations and make appropriate interventions _____

—

9. Ability to facilitate discussion in the family so relevant issues emerge _____

—

10. Ability to deal with the offender's attempts to control the family and/or session _____

—

11. Ability to give appropriate feedback _____

—

12. Willingness to treat all family members with respect _____

—

13. Ability to help the family reframe issues when appropriate _____

—

14. Ability to provide positive support and focus _____

—

15. Understanding of individuality and awareness of boundary issues _____

Post Session Interview:

Therapist's Comments: _____

—

Family's Comments:-

-

Was the session representative: _____

-

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Evaluator(s) Summary and Comments _____

Evaluator Signature _____

Evaluator Signature _____

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GUIDELINES FOR OBSERVATION OF EDUCATION CLASS

Program Site _____ Date of Observation _____

Program Evaluator(s) _____

Class Topic _____

Instructor(s) _____

Number of Class Participants _____

Evaluators should observe and comment upon the following areas of Instructor performance:

1. Ability to cover material relevant to the topic area

2. Ability to explain concepts clearly _____

3. Ability to answer questions effectively

4. Ability to maintain control of the class _____

5. Ability to maintain focus, provide structure, and avoid
being sidetracked _____

6. Ability to use learning aids (assignments, videos,
etc.) appropriate to the topic _____

7. Ability to relate material to individual cases _____

8. Ability to generate discussion when appropriate _____

9. Willingness to be respectful to participants _____

-
-
10. Ability to deal with inappropriate or disruptive behavior effectively
-
-
-

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Post Session Interview:

Instructor Comments _____

—

Class Comments

—

Was the session representative? _____

—

Evaluator(s) Summary and Comments _____

—

Evaluator Signature _____

Evaluator Signature

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GUIDELINES FOR OBSERVATION OF BEHAVIORAL ASSESSMENT/TREATMENT

Program Site _____ Date of Observation _____

Program Evaluator(s) _____

Type of Session _____

Therapist/Technician _____

—

Evaluators should observe and comment upon the following areas of therapist/technician performance:

1) Ability to use accepted procedures for assessment/treatment

2) Ability to follow standardized procedures _____

—

3) Conducts pre-treatment/pre-assessment briefing _____

4) Ability to explain procedures _____

—

5) Ability to adequately answer offender's questions _____

—

6) Knowledge regarding methods and procedures used _____

—

7) Willingness to treat offenders with respect _____

—

8) Conducts debriefing session _____

—

9) Attempts to identify problems, concerns, or side effects which may have resulted from the procedures _____

—

10) Uses proper informed consent forms and releases _____

—

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Post Session Interview:

Therapist/Technician Comments: _____

—

Offender Comments: _____

—

Was the session representative? _____

—

Evaluator(s) summary and Comments _____

Evaluator Signature _____

Evaluator Signature _____

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GUIDELINES FOR OBSERVATION OF PSYCHOLOGICAL ASSESSMENT

Program Site _____ Date of Observation _____

Program Evaluator(s) _____

Type of Assessment _____

Psychologist _____

—

Evaluators should observe and comment upon the following areas of psychologist performance:

1. Appropriateness of setting in which tests are administered _____

2. Appropriateness of tests chosen _____

—

3. Use of standardized procedures _____

—

4. Knowledge of tests given _____

—

5. Ability to deal with offender's questions and/or problems which occur during the course of testing _____

—

6. Arrangements made for review of results _____

—

7. Knowledge of scoring and interpretation of tests administered _____

—

Post Session Interview:

Psychologist Comments _____

—

Offender Comments _____

—

Was the session representative? _____

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—
Evaluator(s) Summary and Comments _____

—
Evaluator Signature _____

Evaluator Signature _____

RECORD REVIEW PROCESS

Overview. Proper documentation of an offender's progress through the program is essential to evaluating participant advancement as well as being able to make important decisions regarding amenability to treatment, risk of reoffense, readiness for parole etc. The maintenance of good records is particularly important in cases where offenders move from one program site to another or when therapists change.

The focus of record review will be upon the completeness, accuracy and timeliness of required reports and forms. As such, the evaluators will be examining these forms using the Record Review Checklist as a guideline.

Process of Review. It is usually not possible to examine all records of current program participants. A sampling of records, therefore, must suffice especially if there is more than one therapist in a program. Inquiries about how the records are maintained and by whom is important as well as if the program has its own record review process. Records should be sampled such that some records from each primary therapist are examined. The particular records selected should be determined by the evaluator(s) at the time of review. The number of records sampled depends upon the number of therapists and the size of the program. Reviews should take approximately 30 minutes a file. Three to five files should give a representative sample of file quality. The files should be picked randomly without prior review. The evaluator(s) should keep track of the number of files reviewed for each therapist.

RECORD REVIEW CHECKLIST

Name of Offender _____ Phase __

Therapist _____ Date of Review _

Program Site _____

Evaluator(s) - _____

A. Quantitative Checks (Check those that apply)

	<u>Present</u>	<u>Completed</u>	<u>Not Comp.</u>	<u>N/A</u>
Intake Sheet	_____	_____	_____	_____
Psychological Eval.	_____	_____	_____	_____
Social History	_____	_____	_____	_____
Sexual History	_____	_____	_____	_____
Pre-Sentence Report	_____	_____	_____	_____
Police Report (may be in PSI)	_____	_____	_____	_____
Victim Statements (may be in PSI)	_____	_____	_____	_____
Progress Reports	_____	_____	_____	_____
Discharge Summary	_____	_____	_____	_____
Treatment Team Sum.	_____	_____	_____	_____
Treatment Plan	_____	_____	_____	_____
Treatment Overview	_____	_____	_____	_____

Number of documents expected to be present in record _____

Number of documents present and completed

Percent Complete

B. Quality Checks:

Do the reports contain relevant information about the offender's participation? _____

Is the background of the case adequately summarized in the reports? Has there been a thorough assessment? _____

Are the goals in the Treatment Plan consistent with the psychological evaluation and other assessment data? _____

—

—

Do identified problems have a written treatment strategy (e.g. specific therapy group, educational class, assignments etc.)? _____

—

How appropriate are the recommendations made by the treatment team with respect to restrictions and prohibitions? Are these recommendations tied to the offenders high risk factors?—

—

—

Are treatment team meetings held in a timely fashion? _____

—

What is the average time between treatment team meetings for this offender? _____

Is there documentation in the record of safety issues and concerns and measures taken when appropriate? _____

—

Is there documentation of referrals for adjunct assessment/treatment when appropriate? _____

Is there documentation of collateral contacts/coordination efforts? _____

—

PROGRAM EVALUATION REPORT OUTLINE

I. Identifying Information

Name of Program:

Type of Program:

Dates of Evaluation:

Evaluators:

II. Brief History and Description of Program

Describe how and when the program was established. Discuss the evolution of the program, its profit or non-profit status, its history of funding and its history with DOC. Describe any problems which have existed over the years and how these problems were addressed.

III. Offender Population Served

Summarize data noting problem areas and offer recommendations. Examine the following:

1. Numbers: (total number in program, monthly average, percent of total openings filled, waiting list)
2. Offense Categories: (total numbers and percentages by current offense, numbers of offenders with multiple paraphilias)
3. DOC Level: (total numbers/percentages by Level, total number/percent of non-DOC clients)
4. Special Populations: (numbers/percent of female offenders, minority offenders, handicapped, etc.)

IV. Admission Standards

Standards given in program description should be consistent with the standards of care. Admission practices should follow the description given.

V. Staffing Patterns

Describe the numbers, professional degrees, licensing and approved provider level of program staff. Also report sex ratios for DOC and contract staff as well as numbers of minority staff. Summarize and focus on specific deficits, offer recommendations, examine clinical supervisor ratings and evaluations when available.

VI. Description of Services

Summarize strengths and weaknesses and offer recommendations in areas given below:

1. Modes of Assessment: (psychological, psychiatric, plethysmograph, polygraph, treatment team ratings of progress etc.)
2. Mode(s) of Therapy: (individual, group, family/marital)
3. Modes of Education: (list specific educational topics/modules)
4. Frequency of Services: (frequency by wk. or mo. for each mode)
5. Staff: (numbers and qualifications of staff per mode)

VII. Direct Observation

Summarize observations for the following areas using guidelines for observation:

1. Assessment Sessions Observed: (give number by type i.e. intake, Psychological testing, Plethysmograph etc., dates observed)
2. Therapy Sessions Observed: (give number x mode, dates observed)
3. Educational Sessions Observed: (give number by topic and dates observed)

VIII. Individual Interviews

Summarize data in the areas given below:

A. Interviews:

1. Program Staff: (list names, positions, dates of interview)
2. DOC Personnel: (list names, positions, dates of interview)
3. Program Participants: (list numbers/percentage by offense category, dates of interview)
4. Others: (community members, board members, family of offenders, etc., dates of interview)

- B. Questionnaires: (anonymous client Questionnaires- numbers given and percentage completed summarize results giving statistical means, medians, and/or other relevant statistics, give ratings x offense and ratings x treatment phase when appropriate)

IX. Records Review

Summarize findings as to quantity and quality issues:

1. Numbers Reviewed: (random sample of records x therapist)
2. Quantity Checks: (numbers/percentages of records missing reports or other relevant materials)
3. Quality Checks: (examine records sampled for the following:)
 - a. Completeness of Reports/Information:
 - b. Appropriateness of Information provided:
 - c. Appropriateness of Treatment Plan:
 - d. Appropriateness of Recommendations:
 - e. Documentation of Safety Issues/Measures:
 - f. Documentation of Referrals for Adjunct Treatment/Assessment:
 - g. Documentation of Collateral Contacts/Coordination Efforts:

X. Offender Progress

The following data should be determined:

1. Drop-Out Rate/Program Removals: Determine the rate for the past year, since the last evaluation, or for however long the program has operated as deemed appropriate; give discharge rates as well as reasons for discharge.
2. Level of Advancement: Determine the number and percentage of offenders at each phase of treatment.
3. Time in Treatment: Determine the average amount of time offenders spend in each treatment phase, the average total treatment time, and the number/percent of offenders completing each treatment phase.

XI. Specific Compliance Issues

1. Written Program Description: As per the Standards this should be available for offenders and other interested parties-check for accuracy.
2. Program Admissions: Check against the Standards for general eligibility requirements and also, check for compliance with approval for funding x Level.
3. Treatment Philosophy: Program should be consistent with DOC philosophy, observation of treatment activities should reflect written statement of philosophy.
4. Treatment Approach: Check for compliance in following areas:
 - a) Assessment Process (appropriateness, timeliness, thoroughness)
 - b) Phases of Treatment (appropriateness of work to phase)
 - c) Modalities of Treatment (appropriateness of modalities to client need)
 - d) RP Principles (appropriate use and emphasis)
 - e) Treatment Techniques (appropriateness, skill level)
 - f) Family Reunification Work (appropriateness, safety measures taken, victim focus)
 - g) Frequency and Duration of Treatment
5. Use of Forms: Check compliance with Standards for use of appropriate reporting forms, consent forms, release of information forms, etc.
6. Records Compliance: Based on information above determine compliance as per standards.
7. Program Supervision: Determine existence and appropriateness of supervision plan, examine evaluations of staff by supervisor, frequency of contact with supervisor etc.)
8. Contract Compliance: Are services being provided as per contract agreement?

XII. Summary of Findings

Summarize the findings above and note:

1. Program Strengths:
2. Program Weaknesses:

XIII. Recommendations

List all recommended remedies and if possible recommended time frames. Recommendations should be summarized under the following headings:

1. Treatment Issues
2. Staffing Issues
3. Training Issues
4. Data and Research Issues

Signature- Evaluator

Date

Signature- Evaluator

Date

Sopeval revised 10/94

APPENDIX O

GUIDELINES FOR HANDLING VIOLATIONS OF CONDITIONS OF PROBATION/PAROLE & DECISION GRID

SAFETY NET TEAMS

Guidelines for Handling Violations of Conditions of Parole/Probation (Technical Violations)

Introduction

During fiscal year 1993, the Alaska Department of Corrections was awarded federal assistance by the National Institute of Corrections to develop a sex offender support network training manual for non-professionals. The manual is designed to assist in the training of non-professionals and probation officers in working with and supervising sex offenders in community placement.

The project is a collaborative effort between DOC and the University of Alaska-Anchorage, the staff of whom developed a manual for training “safety-net members” in the community to recognize and report pre-relapse signs. The idea is to train persons close to offenders to recognize and report early warning signs of relapse and to, therefore, enhance the probability of successful community placement of probationers and parolees through early intervention strategies. After the manual was developed, a pilot project was conducted to test its use. Efforts are currently underway to further develop the use of the safety net concept, as well as the manual, in areas throughout the state.

Purpose of Guidelines

If the program functions as envisioned, a number of technical violations may be identified for some offenders. These guidelines are intended to assist probation officers in handling these situations consistently and appropriately. While the hope is that most offenders can be maintained successfully in the community, the primary concern of DOC is community safety. It is believed, however, that if precursors to new offenses are identified early in the relapse chain, successful interventions can often be made which will allow for the offender to safely continue community placement.

Responsibility for Enforcing Sanctions

The field probation officer is ultimately responsible for imposing and enforcing sanctions which are determined to be appropriate. The P.O. should rely upon input from all members of the treatment team whenever possible before making a final decision. Although the final decision normally rests with the probation officer, the following should be considered:

- 1) If the severity of the technical violation and the risk to the community is considered low and the P.O. recommends revocation/reincarceration, he/she should provide justification for the recommendation.

2) Conversely, if the severity of the technical violation and the risk to the community is high and the P.O. does not recommend revocation/reincarceration justification for this recommendation should be provided.

LINES OF ORGANIZATION AND SUPERVISION

The following defines the organization of the entire safety net of natural supporters.

Personnel

Responsibility

DOC Central Office

This is the upper management team in charge of developing and managing the supervision system of care.

Field Supervisor(s)

There may be one or more field managers who supervise on-line staff (probation officers).

Field Probation Officers

On-line workers, probation officers, who directly supervise offenders and make decisions and judgments that effect management and care of offenders.

Health Care Providers

Professional and para-professional treatment specialists who deliver direct services to offenders and input to the P.O.

Natural Helpers

Interested persons who have agreed to observe the offender's behavior and report potential pre-relapse signs including technical violations and high risk signs.

Guidelines for Handling Technical Violations

Any member of the safety net team may contact the probation officer to report a technical violation. This may include health care providers such as substance abuse counselors, mental health counselors, sex offender therapists etc. as well as non-health care safety net members, such as family , employers, village elders, clergy etc.

When a violation is reported, the P.O. has several options depending upon the seriousness of the violation, the probability of risk to the community, the availability of alternative methods of treatment intervention etc. It is the purpose of these guidelines to offer information to field probation officers which will assist them in making decisions when a technical violation occurs. The guidelines will also assist the Department in developing a consistent approach to handling technical violations which is in accord with overall departmental policy and philosophy.

The following factors should be considered by the P.O. before making a decision regarding a technical violation:

1) The Number of High Risk Factors Present.

The greater the number of high risk factors present, the closer an offender generally is to a relapse. For example, a rapist who is using alcohol or drugs as well as pornography is likely to be closer to a reoffense than if only one factor is present. Although any factor alone can signal a

reoffense, generally the greater the number of factors converging the higher the probability of an offense.

2) The Offender's Supervision History.

The P.O. should consider prior history of technical violations. Consider the seriousness of the violations as well as the offender's attempts to self-correct or respond to interventions by the P.O. Also consider the offender's attitude towards past and present violations. Does he recognize the seriousness and importance of the violation? What is his attitude towards the system? Is he angry, rebellious, blaming, superficially compliant or does he appear to have a true sense of his own risk to the community and a genuine interest in "getting back on track."? How willing is he to accept increased supervision and further therapeutic intervention?

3) The Relative Seriousness of the Infraction(s).

The probation officer should rate the violation(s) along a continuum of low to high seriousness. The seriousness should not only be rated according to legal standards but also for the proximity in the offense chain to the actual relapse behavior. For example, consider the following pattern: A child molester's assault cycle consists of a) going to a playground, b) flying a kite to attract children, c) talking to the child, d) inviting the child for ice cream, e) driving to a secluded spot, and f) fondling the child's genitals. Information that the offender has just purchased a kite may be less serious than if he had been seen having ice cream with a child.

4) The Offender's History of Dangerousness and Violence.

The P.O. should consider who the offender has been violent towards as well as the frequency and the form the violence has taken. Things to consider here include history of fighting/brawling, domestic violence towards women, children or both, use of weapons, etc.

5) Prior History of Victimizing.

The P.O. should consider the frequency of sexual assaults in the offender's past as well as the number of total victims. Look for a history of repetitive and/or compulsive assaults. Do not rely upon offender accounts alone. Use as much collateral information as is available.

6) The Offender's "Risk Score" on the Probation/Parole Score Sheet.

This should be examined in addition to any other specific estimates of dangerousness/risk as it is a broader estimate of risk than other more specific measures.

7) The Likely Form of Sexual Behavior Upon Reoffense.

When the probability of an offense is judged to be low, the probable harm caused by the offense should be considered and the risk considered higher under conditions of greater harm. For example, if an offender's risk of reoffense is considered low but his offense pattern includes penetration, the risk should be rated higher than if his offense pattern was to expose himself without direct contact with the victim.

8) The Victims at Risk.

The P.O. should consider the range of potential victims including their ages and gender(s), as well as their vulnerability. The greater the number of victims, the greater the risk as it is more difficult to isolate the offender from those he harms. Those offenders who abuse highly vulnerable victims such as mentally or physically handicapped, very young victims, elderly victims etc. pose a greater risk. The availability of victims should also be of prime concern.

9) The Appropriateness of the Support Network.

It is important to consider the objectivity and safety-mindedness of natural helpers on the safety net team as well as other support persons close to the offender. Are there signs of enabling behaviors, minimizing, denial, etc. on the part of support persons? Dangerousness increases to the extent that such tendencies exist. Also consider how likely it is that the support members will report pre-relapse signs. Finally, consider the number of support persons available, their frequency of contact with the offender, and their ability to directly observe behavior accurately.

10) The Mental State of the Offender.

It is important to consider the mental status of the offender in terms of contact with reality, emotional stability, behavioral impulsivity, cognitive ability, and substance abuse. It is most important to determine the degree to which such factors will effect the offender's ability to follow therapeutic and management sanctions aimed at reducing the probability of a reoffense. Mental health treatment providers, DOC approved sex offender therapists, substance abuse counselors and other therapeutic personnel can offer assistance in evaluating the offender's ability to comply with intervention strategies.

11) The Offender's Amenability to Treatment.

Generally Level I and Level II offenders are more amenable than Level III offenders. Input from the sex offender therapist (DOC Approved Provider) and other members of the treatment team is critical.

12) The Availability and Suitability of Alternatives.

The P.O. should consider the availability and suitability of alternatives to incarceration and the probability that these alternatives will be successful in stabilizing the offender and breaking the reoffense chain. For example, an offender who abuses under the influence of alcohol has recently broken his sobriety. Can he be placed in an alcohol treatment center? What is the likely effectiveness of this approach? Has the approach succeeded or failed in the past?

RED FLAGS FOR REVOCATION

The purpose of using the natural support "safety net" model is to prevent relapse and improve offender survivability in the community. Community safety remains the primary objective and should never be compromised. In certain situations revocation proceedings are unavoidable and necessary. These situations include the following:

- 1) A reoffense
- 2) An offender is in violation of a condition of probation/parole and has not responded to intervention for correction and remains in the relapse cycle.
- 3) An offender is in violation of a condition of probation/parole and the P.O., in consultation with the treatment team, has determined that necessary interventions are unavailable and that relapse is imminent.
- 4) An offender is in violation of a condition of probation/parole and the offender is unable to comply with the intervention strategies due to his mental state and mental health options (e.g., hospitalization) are unacceptable or less appropriate i.e., the offender requires residential sex offender treatment.
- 5) An offender is in violation of a condition of probation/parole and, in the judgment of the treatment team, the danger to the community is so high that the benefits of attempting to maintain the offender in the community are outweighed by the potential for harm.

PROCEDURES

- 1) When the Probation Officer receives a report of a technical violation s/he shall investigate the report by interviewing all relevant parties/witnesses as soon as is feasible.
- 2) Witnesses and other relevant parties should be interviewed before the interview of the offender is conducted unless, in the Probation Officer's judgment, postponing the interview of the offender would jeopardize community safety.
- 3) After determining all relevant facts and obtaining input from all relevant parties the Probation Officer shall determine what action to take. The P. O. should complete the Technical Violations Rating Form (attached), as this will assist in the decision making process.
- 4) Once a decision has been made regarding appropriate sanctions and/or revocation, this information shall be conveyed to the offender's treatment team members and when appropriate to other safety-net members including natural helpers.
- 5) If applicable, the Probation Officer shall file for revocation.
- 6) A copy of the Technical Violations Rating Form shall be sent to the Criminal Justice Planner in the Division of Institutions for purposes of data collection.

HIERARCHY OF SANCTIONS

Field probation officers have a range of options and sanctions they can apply to fit the needs of a variety of situations. These options are as follows:

1) Verbal Warning.

In some cases all that is necessary is to remind the offender of his probation\parole conditions or clarify the meaning or extent to which those conditions apply.

2) Written Warning.

It is frequently important to clarify conditions in writing and give written notice of warning as well as noting potential consequences for noncompliance.

3) Change of Conditions of Probation\Parole.

The field P.O. typically has the ability to apply special sanctions and conditions to improve management of the case when special conditions and needs apply. Thus when the P.O. becomes aware of factors which effect community safety that were not evident at the time conditions were set special instructions can be given to the offender. These should be in writing and sent to the offender as well as all members of the treatment team.

4) Outpatient Therapeutic Sanctions.

The P.O. in consultation with the treatment team may determine that additional outpatient therapeutic measures such as increased frequency of therapy sessions, AA meetings, or other treatments can reduce the risk of reoffense to safe levels.

5) Alternative Therapeutic Placements.

There are situations in which a P.O. in consultation with the treatment team may determine that a residential therapeutic setting, such as a substance abuse detox and/or treatment facility, psychiatric hospital or other therapeutic setting may be most appropriate in reducing risk to the community and stabilizing the offender. Placement in a residential facility can only occur

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through court or parole board order unless the offender is willing to enter the facility on a voluntary basis.

6) Alternative Correctional Placement.

Placement in a CRC or other closely monitored supervision may at times be deemed a safe and appropriate alternative to reincarceration in prison. Placement at a CRC can only occur when an appropriate order exists. Under certain conditions and if the sentencing order allows the P.O. may place the offender under House Arrest employing electronic monitoring to manage the offender's movements in the community.

7) Reincarceration.

If other measures are thought to be inadequate to protect the community and stabilize the offender the P.O. should file a petition to revoke probation\parole and seek reincarceration.

TECHNICAL VIOLATIONS RATING FORM

Field Probation Officers Rating Sheet

Describe the violation in detail:

Rate the following 12 factors using a scale of 1 to 5 as shown below:

1	2	3	4	5
low		moderate		high
severity		severity		severity

- _____ Number of high risk factors present.
- _____ Offender's supervision history.
- _____ Relative seriousness of infraction(s).
- _____ Offender's history of dangerousness and violence.
- _____ Prior history of victimizing.
- _____ Offenders "Risk Score" on probation/parole score sheet.
- _____ Likely form of sexual behavior upon reoffence.
- _____ Victims at risk.
- _____ Appropriateness of support network.
- _____ Mental state of the offender.
- _____ Offender's amenability to treatment.
- _____ Availability and suitability of alternatives.

Comments:

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Average "severity" score. _____
Number of factors with five rating. _____
Number of factors with four or five rating. _____

Recommendations: _____

If revocation is being pursued check below all sanctions attempted prior to the recommendation for revocation.

- ___ Verbal warning(s)
- ___ Written warning(s)
- ___ Change of conditions of probation/parole
- ___ Outpatient therapeutics sanctions(s)
- ___ Alternative therapeutics placements(s)
- ___ Alternative correctional placements(s)
- ___ Prior revocation hearing(s)
- ___ Other _____
