APPENDICES

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.

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 from 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-IO: 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 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 devise 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.
Hervey 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 highrisk 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 described 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

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 <u>adult</u> 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 Supervision 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

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

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

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

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. Deterring 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 known 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).

Erotocized 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.

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.

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 lease 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.

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

Name	Position	Interview Date	Time
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		

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name:_____ Date_____

Interviewer(s)_____

_

_____

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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?

POSITION SPECIFIC QUESTIONS-PROGRAM STAFF

A. **Administrative/Clinical Director**

INTERVIEW GUIDELINES-SUGGESTED QUESTIONS

Name:_____ Date_____

Interviewer(s)_____

_

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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.

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)_____

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_____

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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?

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)_____

****

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

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

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

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).

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 ffenders._____

_____

_

Post Session Interview:

Therapist(s) Comments:_____

_____

_____

Offenders Comments:_____

_____

_____

Was the session representative?_____

_____

_____

Evaluator(s) Summary and Comments._____

_____

_____

_____

_____

_____

_____

_____

Evaluator Signature_____

Evaluator Signature_____

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_____
_____
_

Post Session Interview:

Therapist Comments:_____
_____
_

Offender Comments:_____
_____
_

Was the session Representative?
_____
_____
_

Evaluator(s) Summary and Comments:_____
_____
_____
_____
_____
_____

Evaluator
Signature_____

Evaluator
Signature_____

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_____

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_____

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:_____

_____

_

Evaluator(s) Summary and Comments_____

Evaluator Signature_____

Evaluator Signature_____

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

Post Session Interview:

Instructor Comments_____
_____
_

Class Comments
_____
_____
_

Was the session representative?_____
_____
_

Evaluator(s) Summary and Comments_____
_____
_____
_____
_____
___

Evaluator Signature_____

Evaluator Signature
_____

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_____
_____
_

Post Session Interview:

Therapist/Technician Comments:_____

_____

_

Offender Comments:_____

_____

_

Was the session representative?_____

_____

_

Evaluator(s) summary and Comments_____

_____

_____

_____

_____

_____

Evaluator Signature_____

Evaluator Signature_____

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?_____

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)

	Present	Completed	Not Comp.	N/A
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

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 severity		moderate severity		high 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:

_____

_____

_____

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_____

_____