Standards of Sex Offender Management
ALASKA DEPT OF CORRECTIONS

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1.000 INTRODUCTION

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

1.100 History of the Standards of sex offender management

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

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

1.200 History of Sex Offender Programs in Alaska

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

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

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

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

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

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

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

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

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

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

1.300 Purpose of the Standards

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

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

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

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

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

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

2.000 OVERVIEW

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

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

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

2.100 Philosophy of Management and Rehabilitation

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

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

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

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

2.200 Guiding Principles

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

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

2.210 Community Safety

- **Community safety is paramount.** The protection of the community and the prevention of further victims is the primary goal of DOC

- **Sex offenders are dangerous.** When a sexual assault occurs there is always a victim. Victims of sexual assault are usually the most vulnerable members of our society, i.e. children and women. Both the literature and clinical experience suggest that sexual assault can have devastating effects on the lives of victims and their families. There are many forms of sexual offending. Offenders may have more than one pattern of sexual offending behavior and often have multiple victims. The propensity for such behavior is often present long before it is detected. It is the nature of the disorder that sex offenders' behaviors are inherently covert, deceptive, and secretive. Untreated sex offenders also commonly exhibit varying degrees of denial about the facts, severity and/or frequency of their offenses. Prediction of the risk of re-offense for sex offenders is in the early stages of development. Therefore, it is difficult to predict with high accuracy the likelihood of re-offense or future victim selection. Some offenders may be too dangerous to be placed in the community and other offenders may pose enough risk to the community to require long term monitoring to minimize the risk.

- **The sex offender needs to learn internal mechanisms to control his own behavior.** Sexual offending is a behavioral disorder which cannot be "cured". The term "sexual offender" is not a clinical term, but rather a legal one. Sexual offenses are defined by law and may or may not be associated with clinical diagnoses. Sexual offenders may or may not have the characteristics of sexual deviance which are described as paraphilias. Some sex offenders may have diagnoses such as mental disorders, organic disorders, or substance abuse problems. Many sex offenders do not have these conditions. Even when sex offenders have a diagnosable medical or psychiatric condition this does not account for their sexual offending, although it may complicate their treatment and management. Many offenders can learn to manage their sexual offending behaviors and decrease their risk of re-offense. Sex offenders choose sexually

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

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

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

- **Assessment and evaluation of sex offenders is an on-going process. Progress in treatment and level of risk are not constant over time.** The effective assessment and evaluation of sexual offenders is best seen as a process. In Alaska many sex offenders are assessed prior to their release from prison. Assessment of sex offenders' risk and amenability to management should not, however, end at this point. Subsequent assessments must occur on an ongoing basis. Assessment and evaluation should be an ongoing practice in any sex offender program. In the management of sex offenders there will be measurable degrees of progress or lack of progress. Because of the cyclical nature of offense patterns and fluctuating life stresses, sex offenders' levels of risk are constantly in flux. Success in the management of sex offenders cannot be assumed to be permanent. For these reasons, monitoring of risk must be a continuing process as long as sex offenders are under criminal justice supervision. Moreover, the end of the period of court supervision should not necessarily be seen as the end of dangerousness.

2.220 Victim Orientation

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

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

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

- **When a child is sexually abused within the family, the child's individual need for safety, protection, developmental growth and psychological well-being outweighs any parental or family interests.** All aspects of the community response and intervention system to child sexual abuse should be designed to promote the best interests of children rather than focusing primarily on the interests of adults. This includes the child's right not to live with a sex offender, even if that offender is a parent. In most cases, the offender should be moved or inconvenienced to achieve the lack of contact, rather than further disrupting the life of the child victim.

- **Victim involvement must be empowering not re-traumatizing.** When a victim reports a sexual assault they typically have to recount their story to a number of people. Victims may first report to a family member, friend, victim advocate, or others. They then have to repeat their story to police. If they have not been in counseling before, they now have to repeat their story to a counselor. If the case is prosecuted they have to repeat their story to prosecutors. If the case goes to trial they have to testify in court and be cross-examined by the offender's defense attorney. Each time the victim repeats their story they may re-experience the trauma of the assault. Every effort should be made to minimize trauma to the victim by not having them repeat their story unnecessarily.

- **Victims must be allowed to determine their level of involvement in the process.** Victims should have control over how much involvement they have in the judicial system. Their wishes should be respected regardless of what they choose to do.

- **Victims are entitled to notification when offenders are about to be released from prison.** The Alaska constitution guarantees victims the right of notification. DOC Policy and Procedure 1206.01 states that victims may choose to be notified about an offender's pending release from prison. They may also choose to be notified when an offender is being considered for furlough or discretionary parole. They may be notified whenever an offender is going to a lower form of custody. In addition they may choose to be notified when an offender has violated his conditions of probation or parole. If the offender violates his conditions of probation the District Attorney's office notifies the victim. If the offender violated his conditions of parole the victim is notified by DOC. Professionals also have a duty to warn the victim if there is information to suggest the offender is an imminent threat to the victim.

- **Victims should be contacted through appropriate channels.** It is always preferable for there to be a central contact person for the victim. This would typically be someone in their support circle such as a parent, victim advocate,

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

2.230 Offender Accountability

- **Sex offenders are completely responsible for their behaviors**. Programming must continue to focus on the offender taking responsibility for his behaviors. This includes taking responsibility for, and learning from, the negative consequences that resulted from the offense(s). Sex offense specific programming must continue to focus on the offender taking responsibility for his behavior. He must see how his behavior was self-directed and maintained, sometimes through great effort, rather than being a sudden impulsive act carried out without forethought. They are also responsible for actively working on correcting and coping with patterns and problems that contributed to their offending behavior.

- **Program participants are responsible for active participation in their program.** DOC is committed to providing programming in the most effective and efficient manner. The goals of program must be wholly related to factors that are related to sexual offense patterns. The Department monitors the progress of participants to insure that unmotivated offenders are not allowed to continue in program thereby taking up valuable treatment resources and denying motivated offenders the opportunity for participation.

- **Assignment to community supervision is a privilege, and sex offenders must be completely accountable for their behaviors.** Sex offenders on community supervision must agree to intensive and sometimes intrusive accountability measures which enable them to remain in the community rather than in prison. Offenders carry the responsibility to learn and demonstrate the importance of accountability, and to earn the right to remain under community supervision. This includes polygraph assessment which is required by statute of all sex offenders under the supervision of DOC.

2.240 Structure and Consistency

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

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

- **Dangerous and dysfunctional attitudes and behaviors will be consistently confronted in an appropriate and respectful manner.** Sex offenders have developed chronic patterns of maladaptive behavior and thinking that are self-serving and robust in their resistance to change. Furthermore, sex offenders typically distort the meaning of things in their world in a way which will endorse their patterns of thinking and behaving. This then allows them to continue these patterns without feeling discomfort. These distortions must be confronted and efforts made to help the offender modify them. ***Confrontation is the presentation of information which challenges the person's distorted view and paves the way for the correction of that view.*** Confrontation ***does not*** involve intentionally demeaning or humiliating comments, the intention of which is to induce shame. Confrontations should be made in a matter-of-fact manner, free from negative emotional tone. DOC programs, contractors and other Approved Providers will refrain from tactics which are intended to induce a sense of humiliation and/or shame but will strive consistently to confront the distorted perceptions of the offender. Likewise DOC Approved Providers will not endorse or encourage humiliation tactics on the part of program participants engaged in confronting a fellow participant. DOC staff and Approved Providers will attempt to train offenders in the appropriate manner of delivering feedback.

- **Sex offender assessment, management, and behavioral monitoring should be non-discriminatory and humane, and bound by the rules of ethics and law.** Individuals and agencies carrying out the assessment, management, and behavioral monitoring of sex offenders should not discriminate based on race, religion, gender, sexual orientation, disability or socioeconomic status. Sex offenders meeting the criteria for admission into SOMPs will be given equal opportunity to participate in DOC sex offender programming. Sex offenders must be treated with dignity and respect by all members of the team who are managing the offender regardless of the nature of the offender's crimes or conduct. Providers of services to sexual offenders shall be bound by their professional ethics at all times.

2.250 Collaboration and Teamwork

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

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

- **Standards and guidelines for assessment, management, and behavioral monitoring of sex offenders will be most effective if the entirety of the criminal justice and social services systems apply the same principles and work together.** DOC realizes that setting standards for sex offender providers alone will not significantly improve public safety. In addition, the process by which sex offenders are assessed and managed by a variety of state agencies and the judicial system should be coordinated and improved.

- **The management of sex offenders requires a coordinated team response.** All DOC contractors and other Approved Providers must be willing to communicate, coordinate and cooperate with DOC staff. All relevant individuals and agencies must cooperate in planning containment strategies of sex offenders for the following reasons:

1. Sex offenders should not be in the community without comprehensive programming, supervision, and behavioral monitoring

2. Each discipline brings to the team specialized knowledge and expertise

3. Open professional communication confronts sex offenders' tendencies to exhibit secretive, manipulative and denying behaviors, and

4. Information provided by each member of an offender Case Management Team contributes to a more thorough understanding of the offender's risk factors and needs, and to the development of a comprehensive approach to managing the sex offender.

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

2.300 Management and the Use of Polygraph Testing

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

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

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

2.400 Cognitive Behavioral Treatment and Relapse Prevention

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

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

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

3.000 QUALIFICATION OF PROVIDERS

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

3.100 Ethics/Professional Conduct

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

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

3.200 Department Approval of Treatment Providers

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

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

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

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

3.210 Levels of Approval for Treatment Providers

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

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

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

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

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

3.211 Restrictions for all Provider Categories:

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

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

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

3.212 Movement Between Levels

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

3.213 Supervision Guidelines for Approved Providers.

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

3.214 Amount of Supervision Required.

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

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

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

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

3.215 Supervision Plans.

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

3.216 Guidelines for Supervision and the Evaluation of Provider Performance.

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

3.217 Notification, Suspension, and Termination

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

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

or

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

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

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

3.218 Continued Placement on the Approved Provider List. All Approved Providers must apply for continued placement on the Provider List every 3 years by the date provided by the Approved Provider Committee. Additionally, the provider must abide by Alaska Administrative Code 22AAC30.070 Renewal process.
(a) To renew provider approval under this chapter, an approved provider must apply for renewal of approval no later than 60 days before the end of the provider's current approval period by submitting an application for renewal to the Sex Offender Treatment Committee on a form provided by the department.

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

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

(2) be a good moral character;

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

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

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

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

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

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

(c) A renewal application must include

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

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

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

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

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

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

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

3.219 Complaints Against an Approved Provider

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

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

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

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

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

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

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

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

(1) take no action;

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

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

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

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

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

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

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

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

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

3.300 Department Approval of Polygraph Examiners
3.310 Levels of Approval

DOC approves polygraph examiners at the following two levels;

1. Full Operating Level
2. Associate Level.

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

The requirements for each are given in Appendix E.

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

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

assessment/treatment/management. It is incumbent on the trainee to demonstrate relevance to sex offender issues if the training is indirectly related to sex offender assessment/treatment/management. The remaining thirty (30) hours must be directly related to sex offender assessment/ treatment/ management.

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

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

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

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

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

The components of supervision include, but are not limited to:
- Preparation for a polygraph examination
- Review/live observation of an examination
- Review of video and/or audio tapes of an examination
- Review of other data collected during an examination

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

3.400 Plethysmograph Examiner:

3.410 Levels of Approval
A Plethysmograph Examiner may be approved at the following two levels:
1. Full Operating Level Treatment Provider
2. Full Operating Level Evaluator

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

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

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

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

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

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

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

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

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

3.500 Abel Assessment Examiner:

3.510 Levels of Approval

Providers may be approved at the following two levels:

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

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

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

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

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

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

A. The DOC determines that the applicant does not demonstrate the qualifications required by these Standards;

B. The DOC determines that the applicant is not in compliance with the Standards of practice outlined in these Standards;

C. The applicant fails to provide the necessary materials for application as outlined in the application materials and the administrative policies and procedures;

D. The applicant has been convicted or received a deferred judgment for any criminal offense;

E. The applicant has been found to engage in unethical behavior by any licensing or certifying body or has had a license or certification revoked, canceled, suspended or been placed on probationary status by any professional oversight body;

F. The applicant is addicted to or dependent on alcohol or any habit forming drug as defined or is a habitual user of any controlled substance or any alcoholic beverage;

G. The applicant has a physical or mental disability which renders the applicant unable to treat clients with reasonable skill and safety or which may endanger the health or safety of persons under the individual's care;

H. The Board determines that the results of the background investigation, the references given or any other aspect of the application process are unsatisfactory.

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

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

- Assessment and evaluation are ongoing processes and should continue through each transition of supervision and treatment. Re-evaluation by community supervision team members should occur on a regular basis to ensure recognition of changing levels of risk.

- The evaluator shall obtain the informed assent of the offender for the evaluation, by advising the offender of the assessment and evaluation methods to be used, the purpose of the evaluation, and to whom the information will be provided. The evaluator shall explain to the offender about the role the evaluator fills with regard to the offender, DOC, the court, and the parole board. The evaluator shall explain the limits of confidentiality and the obligations regarding mandatory reporting of child abuse and other reporting obligations. The offender shall be warned that if he gives specific names, location, dates *or other identifying information* of other offenses not previously reported to authorities that these will be reported and he may be prosecuted for a new offense."

- The evaluator shall be sensitive to any cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues, or disabilities that become known during the evaluation.

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

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

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

4.121 Types and Sources of Corroborating Information:

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

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

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

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

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

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

Techniques for reducing defenses include:

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

<u>The clinical interview must cover the following areas:</u>

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

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

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

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

- Attitudes/Cognition
- Risk Assessment

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

4.170 Assessment of Risk

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

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

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

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

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

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

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

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

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

Evaluators will also make recommendations or findings regarding:

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

4.190 Other Considerations:

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

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

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

4.200 Standards of Practice for Polygraph Assessment

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

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

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

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

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

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

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

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

A. The examinee shall agree in writing or on video tape to a standard waiver/release statement. The language of the statement should be agreed upon prior to the polygraph examination with the therapist, probation/parole officer, case manager, or prison treatment provider;

B. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual polygraph examination;

C. The testing process shall be completely explained to the examinee, including an explanation of the instrumentation used and causes of general nervous tension;

E. Examiners shall review and explain all test questions to the examinee. Examinees must demonstrate that they comprehend the meaning of each question;

F. Surprise or trick questions are forbidden during the administration of primary test charts;

G. All test questions must be formulated to allow only Yes or No answers;

H. An optional acquaintance/practice test may be run;

I. A minimum of three primary test charts shall be administered on the primary issue(s);

J. Test results shall be reviewed with the examinee;

K. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination.

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

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

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

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

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

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

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

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

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

4.320 Stimulus Materials. See Section 3.421

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

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

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

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

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

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

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

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

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

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

5.000 STANDARDS OF PRACTICE FOR SEXUAL OFFENSE SPECIFIC TREATMENT

5.100 Sex Offender Program Referral Process

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

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

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

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

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

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

5.200 Program Eligibility Criteria

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

a. The offender has engaged in sexual offending behavior and has been convicted of such or is willing to acknowledge that he has engaged in sexually assaultive behavior (see note on denial below). In **most** cases there must be an identified victim or victims as well as victim version(s) of the offense(s) to which the offender can be held accountable. In some cases this may require that the court clarify that there was an identified victim, and specify the sexually assaultive behavior that was tied to the offense of record, whether or not the conviction is for a sexual offense as defined by Alaska Statutes. However, in some cases there may not be a specific victim identified and/or a victim version of the offense such as child pornography cases in which a specific victim cannot be identified or cases of bestiality in which there is no victim version of the offense. Nevertheless, these offenders may be judged to be in need of sex offender treatment.

b. The offender requests to participate in the program and completes an application form which is acceptable to the Case Management Team.

c. The offender must be sentenced. Unsentenced sex offenders, or offenders who are appealing their conviction for a sexual offense, are not eligible for participation in sex offender treatment programs. Offenders who are unsentenced or appealing their convictions have an investment in presenting themselves in the best possible light. They are aggressive in the pursuit of their defense and are motivated to protect themselves. This results in a high probability of denial, minimization, justification, blaming and other forms of psychological self-defense. While this may make sense within the framework of a legal proceeding, it is counterproductive in assessment and rehabilitation. Indeed one of the first tasks a sex offender must accomplish is to overcome the tendency to deny or minimize his actions. Therefore, putting an offender in program while he is engaged in continuing legal proceedings creates a psychological bind for the offender in which he either has to jeopardize his legal defense by being open during programming or conceal information in order to protect his legal defense. If an offender lies to his therapist and/or his therapy group during his legal proceedings it will be more difficult for him to retract his false statements later. In fact, cognitive dissonance theory (Festinger, 1957, 1964) predicts that he may come to believe his self-pronounced falsehoods. One therefore runs the risk of complicating this offender's rehabilitation by involving him in the rehabilitation process prior to sentencing and/or appeal proceedings. In a sense this may make him more difficult to reach therapeutically and less amenable to rehabilitation in the long run. Offenders who are appealing their sentence rather than their conviction are eligible for programming. However, if results of a sentence appeal/modification would result in the offender not meeting the time eligibility requirements of a given program, the appeal must first be ruled on by the court before the offender is considered for placement in that program.

d. Offenders who deny their offense may be admitted into the program provisionally at the discretion of the approved provider but will have six months to resolve their denial issues. They will be required to pass a specific issue polygraph on the instant offense within the six month time period. Failure to do so is grounds for removal from the treatment program.

e. Interpretive assistance will be provided to offenders for whom English is a second language as necessary and within available resources.

g. The offender did not engage in sadistic/ritualistic behaviors with his victim(s).

h. The offender is not actively psychotic or suffering from any disabling major mental disorder(s) with active symptoms so severe as to preclude him from program benefit. Offenders with such symptoms should receive medical attention and reapply after their condition has stabilized.

i. The offender does not suffer from a documented severe medical condition that precludes him from participating in the program.

5.300 Amenability to Treatment

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

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

- A willingness to lower his self-protective defenses in order to explore the process of how he offends. This means he must acknowledge responsibility for offenses for which he was convicted and be willing to describe in detail his thinking, emotions and behaviors prior to, during, and after the offense(s). He must be willing to discuss personal history that may be relevant to understanding the offense pattern(s). Clinical staff shall determine on an individual basis whether an offender has a sufficient level of disclosure and acceptance of responsibility to be amenable to the rehabilitation process. Offenders are required to work on disclosure and responsibility issues as they progress in program or face program removal.

- A willingness to follow institutional rules (for incarcerated offenders) as well as the conditions of probation/parole

- A willingness to change maladaptive behavior patterns within himself rather than try to change others and/or the environment

- A willingness to accept corrective feedback and constructive criticism from others and a willingness to make an active attempt to incorporate this feedback into his daily life

- A willingness to give feedback to others in a constructive fashion

- A willingness to demonstrate appropriate control over the expression of anger and refrain from aggressive or destructive behavior

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

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

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

5.400 Program Descriptions

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

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

5.500 Confidentiality

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

Waivers of confidentiality should also extend to the victim, or custodial parent or Guardian ad Litem of a child victim, particularly with regard to (1) the offender's compliance with programming and (2) information about risk, threats, and/or possible escalation of violence.

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

A provider shall ensure that an offender understands the scope and limits of confidentiality in the context of his/her particular situation, including the collection of collateral information, which may or may not be confidential.

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

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

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

5.600 DOC Contract Payment for Services

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

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

5.610 Offender Payment for Services

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

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

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

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

5.700 Approved Provider-Client Contract

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

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

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

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

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

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

The contract shall also, (as applicable):

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

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

5.800 Sex Offender Specific Programming.

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

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

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

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

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

- Reduce offenders' denial and defensiveness;
- Decrease and/or manage offenders' deviant sexual urges and recurrent deviant fantasies;
- Educate offenders (and individuals who are identified as the offenders' support systems) about the potential for re-offending and an offender's specific risk factors that may lead to a reoffense. These may include sexual and non-sexual risk factors;
- Teach offenders self-management methods to avoid a sexual re-offense;
- Identify and address the offenders' thoughts, emotions, and behaviors that facilitate sexual re-offenses or other victimizing or assaultive behaviors;
- Identify and teach the offender to correct cognitive distortions;
- Teach offenders to recognize their dysfunctional personality patterns and the core schema or belief systems underlying those patterns and teach offenders methods to correct for these patterns;
- Educate offenders about non-abusive, adaptive, legal, and pro-social sexual functioning;
- Educate offenders about the impact of sexual offending upon victims, their families, and the community;
- Provide offenders with an environment that encourages the development of empathic skills needed to achieve sensitivity and empathy for victims;

- Provide offenders with guidance to prepare, when applicable, written explanation or clarification for the victim(s) that meets the goals of: establishing full perpetrator responsibility, empowering the victim, and promoting emotional restitution for the victim(s). This is not a letter of apology;
- Identify and treat the effects of trauma and past victimizations on offenders as factors in their potential for re-offending. It is essential that offenders be prevented from assuming a victim stance in order to diminish responsibility for their actions. The timing of trauma work with offenders must be carefully considered by the Case Management Team. If the trauma work triggers diminished responsibility for offending behavior it shall be terminated and not resumed until these issues are successfully resolved;
- Identify and decrease offenders' deficits in social and relationship skills, where applicable;
- Require offenders to develop a written relapse prevention plan for preventing a re-offense; the plan should identify antecedent thoughts, feelings, circumstances, and behaviors associated with sexual offenses;
- Provide treatment referrals, as indicated, for offenders with co-existing medical, pharmacological, mental, substance abuse and/or domestic violence issues, or other disabilities;
- Maintain communication with other significant persons in offenders' support systems when indicated, and to the extent possible, to assist in meeting treatment goals;
- Evaluate cultural, language, developmental disabilities, sexual orientation and/or gender factors that may require special treatment arrangements;
- Identify and address issues of gender role socialization, and;
- Identify and address issues of anger, power, and control.

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

5.810 SOMP Assessment and Program Components

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

5.811 Intake/Assessment

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

5.812 Psychological Testing

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

5.813 Physiological Assessment

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

5.814 Polygraph Assessment

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

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

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

5.816 Group Counseling Sessions

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

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

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

5.817 Individual Counseling Sessions

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

5.818 Family Counseling Sessions

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

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

5.819 Education Classes

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

5.820 Behavioral Therapy

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

5.821 Medication Therapy for Reduction of Sexual Drive

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

5.822 Non-Standard Practices.

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

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

5.900 Special Needs Populations

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

5.910 Alaska Native Sex Offenders

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

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

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

5.920 Developmentally Disabled Sex Offenders

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

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

5.930 Other Disabled Sex Offenders

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

5.940 Female Sex Offenders

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

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

6.000 EVALUATION OF PROGRESS IN TREATMENT

6.100 Completion of Court-Ordered Treatment

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

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

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

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

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

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

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

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

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

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

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

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

6.300 Case Staffing/Case Management Team Meetings

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

a. Be held at least once per month for a maximum of two hours for every 10 sex offenders in the community program reviewed, and a minimum of one hour for every 10 Sex offenders reviewed.

b. Determine the cases that are to be discussed during the case Management Team meeting. Cases should be prioritized whenever possible prior to the case staffing.

c. Include case discussion on those sex offenders prioritized for case staffing, or additional times established for case discussion in a separate meeting.

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

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

The focus of case staffings is to:

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

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

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

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

6.400 Program Removal

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

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

Offenders may be removed from program in several ways.

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

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

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

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

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

6.500 Program Reentry

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

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

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

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

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

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

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

6.600 Policy on Pornography.

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

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

6.610 Definition of Pornography

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

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

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

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

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

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

7.000 RECORDS AND REPORTING

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

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

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

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

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

7.100 Program Files.

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

The program file will include the following documents:

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

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

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

7.200 Program Evaluation

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

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

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

7.400 Research

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

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

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

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

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

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

8.100 Standards of Practice for Supervising Sexual Offenders

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

8.200 Establishment of a Case Management Team.

As soon as possible after the conviction and referral of a sex offender to DPP, the supervising officer should form a Case Management Team to manage the offender during his/her term of supervision:

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

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

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

Each team, at a minimum, should consist of:

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

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

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

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

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

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

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

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

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

- There is an ongoing and completely open flow of information among all members of the team;
- Each team member participates fully in the management of each offender;
- Team members settle among themselves conflicts and differences of opinion that might make them less effective in presenting a unified response. The final authority rests with the supervising officer;
- Team members are committed to the team approach and seek assistance with conflicts or alignment issues that occur.
- Team members should communicate frequently enough to manage sexual offenders effectively, with community safety as the highest priority.

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

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

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

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

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

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

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

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

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

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

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

The supervising officer should require sex offenders to provide a copy of the written plan developed in program for preventing a relapse, signed by the offender and the therapist, as soon as it is available. The supervising officer should utilize the relapse prevention plan in monitoring offenders' behavior.

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

The supervising officer should ensure maximum behavioral monitoring and supervision for offenders in denial. The officer should use supervision tools that place limitations on offenders' use of free time and mobility and emphasize community safety and containment of offenders.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A provider shall immediately report to the supervising officer evidence or likelihood of an offender's increased risk of re-offending so that behavioral monitoring activities may be increased. Contractors and Approved Providers are required to notify the field P.O. within 24 hours of any information which indicates that an offender is a risk of re-offending. If the community offender is a furloughee, this notification will be made to the furlough officer. In cases where an offender commits a new offense, local and/or state law enforcement shall also be notified;

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

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

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

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

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

8.500 Polygraphers' Role and Responsibility in Team Management of Sex Offenders The polygraph examiner shall participate as a member of the post-conviction case Management Team established for each sex offender.

The polygraph examiner shall submit written reports to each member of the community supervision team for each polygraph exam. Reports shall be submitted in a timely manner, no longer than two (2) weeks post testing.

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

8.600 SOMP Case Review Team

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

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

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

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

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

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

8.700. Safety-Net Team Standards

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

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

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

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

1. All sex offenders in Community SOMP's shall have a safety-net.

2. The minimum size for a safety-net is three persons. There is no maximum size but a safety-net would typically include three to five persons.

3. At least two members of the Safety-net must be persons outside the offender's immediate family.

4. Persons on the offender's Case Management Team can also be members of the Safety-net but the Safety-net can not be entirely made up of Case Management Team members.

5. The composition of the Safety-net should be representative of the offender's environments in the community. That is, any location in which the offender spends significant time should be represented by a Safety-net person from that environment. Examples of such environments include home, work, religious environments, cultural groups, adjunct treatment groups such as AA, etc.

6. Safety-net members must be consistently available to observe the offender. Frequent or prolonged absences may disqualify an individual from being part of the Safety-net.

7. All Safety-net members shall be non-paid volunteers. Safety-net members may not accept payment in any form from offenders or others for their involvement in the Safety-net.

8. All Safety-net members must undergo training conducted by the approved provider and the supervising officer.

9. Objectivity and a willingness to report pre-relapse signs are an essential characteristic of a good Safety-net member. Safety-net members must be selected with these traits in mind. Those members who are reluctant to report or who are non-objective observers are subject to removal from the Safety-net.

10. The Field Probation/parole Officer is in charge of the safety-net team and shall give approval for all Safety-net members. Safety net members may be contacted by the approved provider and/or the supervising officer to gather information regarding the offender. After the offender completes treatment it is the responsibility of the supervising officer to contact the safety-net team members.

11. The removal of a Safety-net member may be recommended by the Management Team or the Field Probation Officer, but the final decision to remove a member is made by the Field Probation Officer. All removals are subject to review by the Criminal Justice Planner for Offender Programs.

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

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

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

9.000 VICTIM ISSUES

9.100 The Role of Victims/Survivors in Sex Offender Treatment

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

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

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

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

9.200 Victim Contact

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

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

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

- Contact between offenders and victims or potential victims will not occur until there has been consultation with, and approval by, all appropriate parties. This includes the offender's approved provider and the provider's clinical supervisor if one is required, the supervising probation officer, the victim, the victim's therapist, the victim's parent or guardian, and the victim's advocate or Guardian ad Litem. This applies to direct and/or indirect contact. Contact is intended to refer to any form of interaction including:

    1. Physical contact, face to face, or any verbal contact;
    2. Being in a residence with a child or victim;
    3. Being in a vehicle with a child or victim;
    4. Visitation of any kind;
    5. Correspondence (both written and electronic), telephone contact (including messages left on a voice mail or answering machines), gifts, or communication through third parties;
    6. Entering the premises, traveling past or loitering near the child or victim's residence, school, day care, or place of employment;
    7. Frequenting places used primarily by children, as determined by the Community Supervision Team.

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

- Case Management Teams should plan for changes in risk level and recognize that offenders will always present with some level of risk for sexual re-offending. Progress in program may not be consistent over time. The team should also consider that changes in child development characteristics or adult victim characteristics may affect offenders' risk level. Approval of situations that involve contact with children under the age of eighteen shall be continually reviewed and changed by the Case Management Team based on current risk.

- In the event that there is a court order prohibiting contact between the offender and the victim or potential victims, this order will be followed unless altered by the court or, if so indicated, by the supervising probation officer.

- All contacts between sex offenders and victims or potential victims must be approved by the supervising probation officer

- All non-authorized contact with victims and potential victims will be reported immediately to the supervising probation officer

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

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

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

9.210 Exclusionary Criteria

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

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

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

9.300 Victim and Family Clarification/Resolution

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

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

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

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

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

9.400 Family Reunification

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

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