



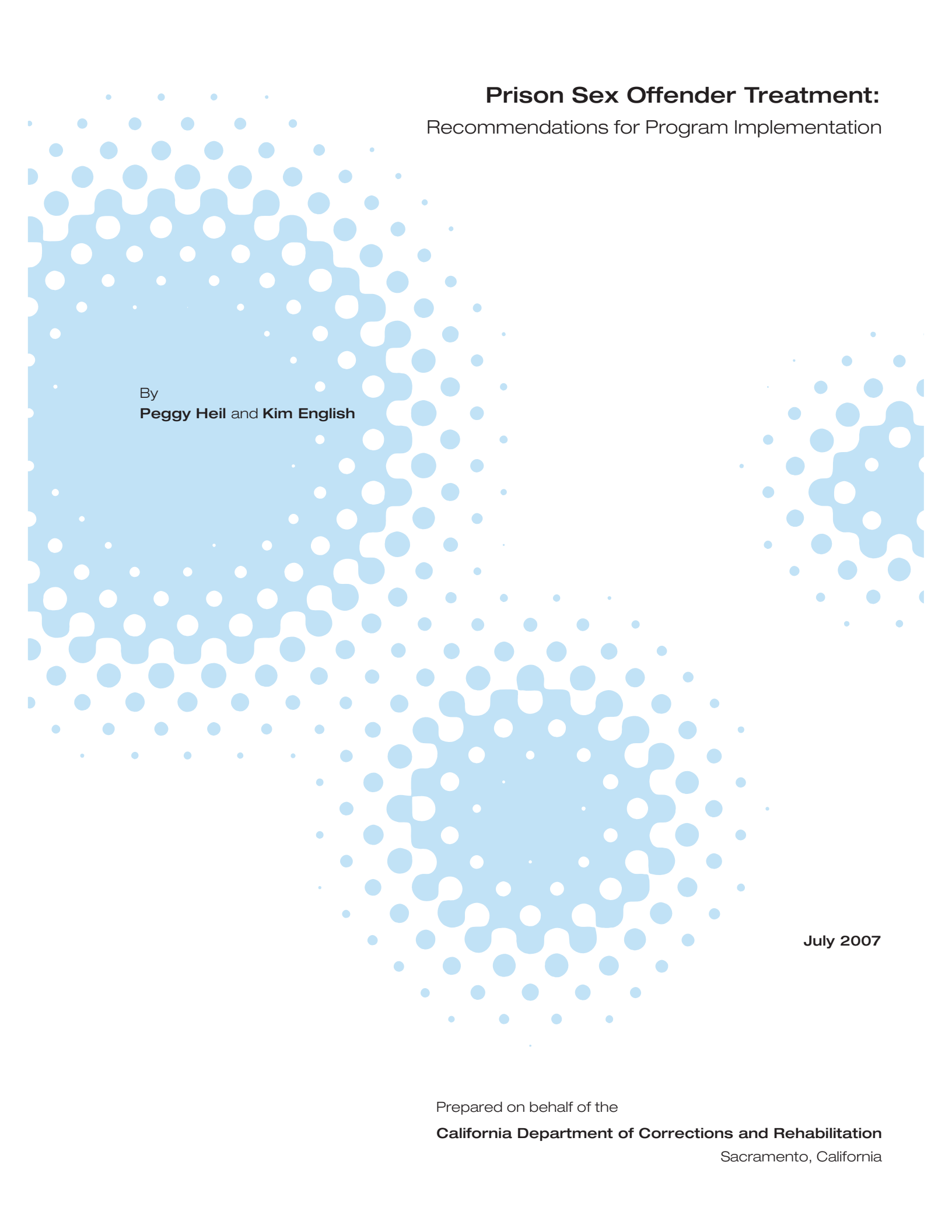
# **Prison Sex Offender Treatment:** Recommendations for Program Implementation

**July 2007**

Prepared on behalf of the

**California Department of Corrections and Rehabilitation**

Sacramento, California



# Prison Sex Offender Treatment: Recommendations for Program Implementation

By  
**Peggy Heil and Kim English**

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# Section one: The larger context of treatment and organizational change

## Preface

Sexual offenses cause tremendous harm to the lives of victims, the victims' families and our communities. We recommend that the California Department of Corrections and Rehabilitation implement the "containment approach" for managing sex offenders in prison and on parole. The containment approach is a comprehensive strategy that prioritizes victim protection and community safety.

Prison treatment for sex offenders can be an effective component of the containment approach. Intense prison treatment can reduce recidivism and enhance community safety. It can also reduce the substantial costs (emotional and financial) associated with recidivism. Miller, Cohen and Wiersema (1996)<sup>1</sup> estimated that *child sexual abuse crimes* costs victims and society \$99,000 per victimization, and estimated \$87,000 per *rape/sexual assault victimization*. These costs are estimated to be \$140,531 and \$123,497 in 2007 dollars. Ninety-percent of the costs are associated with significant reduction in the quality of life for victims of these crimes.<sup>2</sup>

Quantifying the costs of sexual victimization seems to trivialize it nonetheless. As Miller et al. (1996:14) state, "pain, suffering, and reduced quality of life do not have a market price and cannot be bought and sold." Certainly victims would pay dearly to avoid them, as would their families and members of the community.

The following report details a prison sex offender treatment program plan that is designed to reduce recidivism and avoid the costs and immeasurable harm of sex crime victimization. It provides evidence-based sex offender treatment and management recommendations to increase community safety and decrease new sex crimes by known offenders.

<sup>1</sup> See Miller, T.R., Cohen, M.A. and Wiersema, B. (1996). *Victim Costs and Consequences: A New Look*. A final summary report presented to the National Institute of Justice, U.S. Department of Justice. Washington, D.C. NCJ155282.

<sup>2</sup> The complex estimates include tangible and intangible losses to the victim, plus costs associated with the criminal justice system, victim services, incarceration of the offender, and "second generation costs" associated with future victims of crimes associated with earlier victims.

## Introduction

### PURPOSE OF THIS REPORT

The California Department of Corrections and Rehabilitation (CDCR) requested a document that describes an empirically based prison sex offender treatment program and provides recommendations for the development and implementation of such a program in the California prison system. Program recommendations are drawn from research and clinical experience. Where possible, materials from other programs are included in appendices to facilitate implementation.

### VALUE OF TREATMENT

As states face the cost of burgeoning prison populations, along with the public's fear of sexual offenders, the use of sex offender treatment as a primary management and containment tool has become commonplace in jurisdictions across the United States.

Fortunately, a plethora of research studies over the past 20 years is guiding most programming, and there is a general consensus among sex offender management professionals about "best practices" for this population. When this information is combined with the "what works in corrections" literature describing evidence-based practices that reduce recidivism, a solid framework is available for developing and implementing a state-of-the-art prison treatment program. However, prison treatment will be more effective if it is followed by community-based containment services, including supervision, treatment, and polygraph testing.

### RECIDIVISM REDUCTION

While the efficacy of sex offender treatment remains a debated topic, many studies show that treatment participation is correlated with lower officially recorded recidivism rates.<sup>3</sup> Studies of programs using cognitive-behavioral

<sup>3</sup> Hanson, K. R., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L. and Seto, M. C. (2002). First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders. *Sexual Abuse: A Journal of Research and Treatment*, Vol.14, No. 2, 169-194. This meta-analytic review examined the effectiveness of psychological treatment for sex offenders by summarizing data from 43 studies (combined n = 9,454). Averaged across all studies, the sexual offense recidivism rate was lower for the treatment groups (12.3%) than the comparison groups (16.8%, 38 studies) and the same was found with general recidivism (treatment 27.9%, comparison 39.2%, 30 studies). Current treatments (cognitive-behavioral, k = 13; systemic, k = 2) were associated with reductions in both sexual recidivism (from 17.4 to 9.9%) and general recidivism (from 51 to 32%). Older forms of treatment (operating prior to 1980) appeared to have little effect.

treatment techniques have found recidivism reductions of 30-50 percent. This reduction translates into victimizations prevented, criminal justice expenditures avoided, and crime-free living on the part of many offenders. Clearly, sex offender treatment can be an effective offender management tool and crime prevention strategy. Thus, treatment is a sound, fiscally responsible public policy.

Many treatment effectiveness studies, however, only briefly describe the content of the program and the services delivered. In many cases, the population of program participants is only minimally described. Even fewer studies include information on the extent to which the program is actually delivered as planned. This lack of programmatic detail translates into a significant unknown in terms of understanding *how* a specific program or treatment reduces recidivism.

## RECIDIVISM REDUCTION IN COLORADO

The only prison sex offender treatment program that has undergone a comprehensive evaluation that both detailed services delivered and participant outcomes is the sex offender treatment program at the Colorado Department of Corrections (CDOC), founded by the first author in 1984 and evaluated by the second author in 2003.<sup>4</sup> Since the authors of this report work for separate state departments, the evaluation was undertaken by researchers who had no stake in the outcome.

The 2003 evaluation found that CDOC treatment participants were significantly less likely to be rearrested for a violent crime upon release from prison, and the treatment effect remained for nearly 7 years, the duration of the follow-up. The study was generously funded by the U.S. Department of Justice, Bureau of Justice Assistance, and allowed for extensive data collection and descriptions of the services delivered.<sup>5</sup>

Further, the first author implemented a strong research component to continuously study and improve program

activities. The unique knowledge generated about the CDOC program from its internal research operation provides additional empirical guidance for implementation of a similar program at CDCR.<sup>6</sup> It also reflects the necessity of such research to the treatment model so that service delivery remains consistent and excellent. The value of prison treatment as a public safety tool was established by the Colorado evaluation, described in Section One, and effective replication of the program in California will require similarly rigorous research-oriented program monitoring and quality assurance efforts. Recommendations to this effect begin in Section Three.

Because of the relative plethora of research on the Colorado Department of Corrections sex offender treatment program,<sup>7</sup> the authors use this program as a model that would meet the objectives of the CDCR for an empirically-based program that reduces recidivism.

## NATIONAL OVERVIEW

To provide a context for the recommendations presented here, this report includes a review of existing in-prison treatment programs based on two national surveys conducted in 2000 and 2006 along with more detailed information on seven prison programs (South Dakota, Vermont, Texas, New Hampshire, Washington State, Minnesota, and Alaska). A review of the Colorado program follows. Data from these programs are provided when available.

## AUDIENCE

This report was developed for multiple audiences and includes a broad range of information, from “what are other states doing?” (a common question from legislators)

<sup>4</sup> Lowden, K., Hetz, N., Harrison, L., Patrick, D., English, K., and Pasini-Hill, D. (2003). *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders: A Report of Findings*. Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety. Denver, Colorado.

<sup>5</sup> Researchers observed 67 therapy groups (two researchers in each group using structured observation instruments), conducted 18 staff interviews and 7 inmate focus groups, and hand-collected information from 578 case files. For a copy of the full report, go to <http://dcj.state.co.us/ors/pdf/docs/WebTCpart1.pdf> and <http://dcj.state.co.us/ors/pdf/docs/WebTC%20part%202.pdf>.

<sup>6</sup> For example, see Heil, P., Ahlmeyer, S., & Simons, D. (2003). Crossover sexual offenses. *Sexual Abuse: A Journal of Research and Treatment*, 15(4), 221-236; Heil, P., Simons, D., Ahlmeyer, S. (2003). *Impact of incentives and therapist attitudes on polygraph results*. Presentation at the Association for the Treatment of Sexual Abusers, 22nd Annual Research and Treatment Conference. St. Louis, Missouri; Ahlmeyer, S., Heil, P., McKee, B., & English, K. (2000). The impact of polygraphy on admissions of victims and offenses in adult sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 12, 123-138; Simons, D., Heil, P., English, K. (2004). *Utilizing polygraph as a risk prediction/treatment progress assessment tool*. Presentation at the Association for the Treatment of Sexual Abusers, 23rd Annual Research and Treatment Conference. Albuquerque, N.M.

<sup>7</sup> Lowden, K., Hetz, N., Harrison, L., Patrick, D., English, K., and Pasini-Hill, D. (2003). *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders: A Report of Findings*. Office of Research and Statistics, Division of Criminal Justice., Colorado Department of Public Safety. Denver, Colorado.

to details about important treatment staff characteristics. As such, some sections may be more relevant to certain readers than other sections. Overall, the intent is to provide a model for a public safety oriented, in-prison sex offender treatment program that is grounded in support from the professional literature on sex offender treatment and management. This information is integrated with the “what works to reduce recidivism” scientific literature that has proliferated in the past two decades. The report also includes a short discussion of organizational change since implementation will require focus and commitment by CDRC administrators. In the end, we hope this document provides a “how to” along with a “why to” strategy for the implementation of a very specific program. The documents in the appendices may be useful to the program director and staff as implementation proceeds.

#### ORGANIZATION OF THIS REPORT

This report is organized as follows:

##### **Section One** provides

- An overview of in-prison sex offender programs across the nation,
- A summary of programs with positive outcomes,
- A special focus on the Colorado prison program,
- A review of the findings from the final evaluation study of the Atascadero sex offender treatment program,
- A brief overview of evidence-based practices for correctional programming, and
- A brief discussion of organizational change.

##### **Section Two** provides

- A description of the containment approach,
- A focus on the use of the post-conviction polygraph examination,
- And a review of the effectiveness of the containment approach in several jurisdictions.

**Section Three** provides specific guidance for the development and implementation of a CDCR prison sex offender treatment program. It also briefly addresses continuing the containment approach through supervision in the community. The section contains the following subsections:

- Designing the program for effectiveness
- Target population
- Program structure
- Description of treatment stages
- Treatment location (facility selection)
- Community containment
- Quality control and program evaluation
- Program staffing

**Section Four** presents a preliminary cost analysis associated with prison treatment and recidivism reduction.

**Section Five** is a simple list of 14 implementation steps.

**Section Six** contains appendices to this report. Some of the appendices contain supporting documentation; others contain sample forms and policies that CDCR officials can use when developing the California program.



## Summary of U.S. prison-based sex offender treatment programs

### COLORADO DEPARTMENT OF CORRECTIONS SURVEY: 2000, 2006.

In 2000, the Colorado Department of Corrections (CDOC) conducted a national survey of in-prison sex offender treatment programs. Parts of the survey were updated in 2002 and 2006.<sup>8</sup> While all of the information may not be current, it is clear that the majority of prison systems in the U.S. have implemented treatment programs for sex offenders. Overall, the information provides an important national context for the CDCR undertaking.

***Although it is estimated that more than 300,000 sex offenders are incarcerated in state or federal prisons, it appears fewer than 480 therapists nationwide are working with this population, according to survey findings.***

### SIGNIFICANT VARIATION

Of 49 responding states and the Federal Bureau of Prisons, 44 of these systems had sex offender treatment programs in 2006. The survey revealed significant variation in the operation of sex offender treatment programs. The number of inmates participating in programs ranged from 20 in Alabama to 1,000 in Michigan and 2,000 in Pennsylvania.

### NUMBER OF THERAPISTS

A telling measure of institutional commitment may be the number of program therapists, which ranged from 2 in Louisiana and Rhode Island to 65 in Texas, with 26 institutions reporting fewer than 10 therapists. Although it is estimated that more than 300,000 sex offenders are incarcerated in state or federal prisons, it appears fewer than 480 therapists nationwide are working with this population, according to the survey findings.

<sup>8</sup> Lins, Richard G. (2006). *The 2006 50 State Survey of Sex Offender Prison Programs*. Colorado Department of Corrections, Colorado Springs, CO; West, M., Hromas, C. S., and Wenger, P. (2000). *State Sex Offender Treatment Programs, 50-state survey*. Colorado Department of Corrections, Colorado Springs, CO.

### PROGRAM DURATION

Program length varied considerably, from 6 months (Georgia) to 48 months (Maine). Only seven institutional programs were 24 months or longer; another 3 reported open-ended completion times. It is likely that many prison sex offender treatment programs lack the duration necessary to assist offenders make long lasting changes. The Colorado evaluation of the CDOC program found longer time in intense treatment was correlated with reduced recidivism.

***Prison inmate policies are frequently modified for sex offender program participants to ensure consistency with treatment objectives.***

### VISITATION WITH CHILDREN

Prison inmate policies are frequently modified for sex offender program participants to ensure consistency with treatment objectives. Twenty-five of the 45 institutions surveyed disallow visitation with children for inmates convicted of sexual assault against a child.

Research using guaranteed confidentiality, anonymous survey, or polygraph testing indicates that the majority of convicted sex offenders “crossover” in the age, gender and relationship of their victims,<sup>9</sup> meaning that few sex offenders “specialize” and most have histories of assaulting multiple types of victims. The most progressive policy would be to disallow all sex offenders from having contact with children unless a comprehensive evaluation indicates that they pose a low risk to children. Contact may place a child at risk of being abused and increase the likelihood

<sup>9</sup> Heil, P., Ahlmeyer, S., & Simons, D. (2003). Crossover sexual offenses. *Sexual Abuse: A Journal of Research and Treatment*, 15(4), 221-236; Ahlmeyer, S., Heil, P., McKee, B., & English, K. (2000). The impact of polygraphy on admissions of victims and offenses in adult sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 12, 123-138; Abel, G. G., Becker, J.V. Cunningham-Rathner, J., Mittelman, M.S., & Rouleau, J.L. (1988). Multiple paraphilic diagnoses among sex offenders. *Bulletin of the American Academy of Psychiatry and the Law*, 16, 153-168; English, K., Jones, L., Pasini-Hill, D., Patrick, D., & Cooley-Towell, S. (2000). *The value of polygraph testing in sex offender management*. Final research report submitted to the National Institute of Justice for grant number D97LBVX0034. Denver, CO: Colorado Division of Criminal Justice, Office of Research and Statistics; O'Connell, M. A. (1998). *Using polygraph testing to assess deviant sexual history of sex offenders* (Doctoral dissertation, University of Washington, 1998). *Dissertation Abstracts International*, 49, MI 48106; Grubin, D., Madsen, L., Parsons, S., Sosnowski, D., Warberg, B., (2004). A prospective study of the impact of polygraphy on high-risk behaviors in adult sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 16(3), 209-222; Weinrott, M.R. & Saylor, M. (1991). Self-report of crimes committed by sex offenders. *Journal of Interpersonal Violence*, 6, 286-300.

that an offender will engage in sexual fantasies involving children.<sup>10</sup> Yet only 11 states restrict visitation of sex offenders whose conviction crime did not involve children. See Section Three, *Facility policies that promote a treatment environment*, and Appendix 1 for more information.

#### PORNOGRAPHY

Twenty-six of the survey respondents reported that all prisoners were restricted from viewing pornography, but only eight of the 19 states that allowed pornography among the general population disallowed its use by those in sex offender treatment. Pornography encourages the objectification of others, and since this is an issue in sex offender treatment and criminal thinking generally, it is an important issue for prison administrators to address. See Section Three, *Facility policies that promote a treatment environment*, for more information.

#### INCENTIVES

Because change is difficult for everyone, and sex offender treatment requires considerable effort on the part of the inmate, treatment incentives are an important aspect of program management. Nineteen states awarded earned time based on treatment participation. Of the 26 states with post-release supervision, 14 used treatment participation as a criterion for recommending the inmate for release. Only 14 used treatment participation as a progressive custody classification for moves to a less restrictive facility.

Among the states participating in the survey, only Colorado used all three incentives inquired about: earned time, parole recommendations, and progressive moves. However, depending on the corrections system, only some of these options were available. Iowa, Kansas, Nebraska, New Mexico, North Dakota, and South Dakota implemented two of the three incentives.

#### STATEWIDE STANDARDS

In 2006, seven respondents reported that sex offender treatment was guided by statewide standards: Colorado, Georgia, Iowa, Kentucky, Louisiana, Tennessee, and Virginia.

<sup>10</sup> Heil, P. (1999). *Contact with children in the prison visiting room*. Colorado Department of Corrections, Colorado Springs, CO, as cited in the Colorado Sex Offender Management Board *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (rev 2003), Colorado Department of Public Safety, Denver, CO; Davis, G., Williams, L., and Yokley, J. (1996). *Deviant fantasies and masturbation in sex offenders with and without contact with children*. Paper presented at the 15th Annual Conference of the Association for the Treatment Sexual Abusers.

***Given the recommended practices regarding use of the polygraph, it appears from the survey data that most prisons using the polygraph did so in a minimal fashion, suggesting that it was significantly underused in the prison setting.***

#### ASSESSMENT TOOLS

Eight of the states and the Federal Bureau of Prisons (BOP) used the penile plethysmograph,<sup>11</sup> 6 states and the BOP used the Abel Assessment,<sup>12</sup> and 13 states and the BOP used the polygraph as assessment and monitoring tools. These are commonly used tools in the sex offender treatment community. However, the extent to which the polygraph was used became clearer when one of the surveys indicated that most of the programs used the polygraph less than once per year. Eight reported that it was used only once during treatment; two reported that it was used “rarely” or on less than 10 percent of program participants. Only Colorado and Delaware had integrated polygraph testing into the program as recommended by experts, with Colorado using it every four months, and Delaware using every six months.<sup>13</sup> It appears from the survey data that most prisons using the polygraph did so in a minimal fashion, suggesting that it was significantly underused in the prison setting.

#### IDENTIFICATION OF TREATMENT POPULATION

The most significant reform in sex offender management has been in the area of the identification of sex offenders. Today, it is rare to classify sex offenders solely based on their conviction crime. Sex crimes are difficult to investigate

<sup>11</sup> The penile plethysmograph is a phallometric measure of sexual arousal.

<sup>12</sup> The Able Assessment of Sexual Interest is visual reaction time measure of sexual interest.

<sup>13</sup> English, K., Pullen, S., and Jones, L. (1996). *Managing adult sex offenders: A containment approach*. Lexington, KY: American Probation and Parole Association; Simons, D., Heil, P., English, K. (2004). *Utilizing polygraph as a risk prediction/treatment progress assessment tool*. Presentation at the Association for the Treatment of Sexual Abusers, 23rd Annual Research and Treatment Conference. Albuquerque, N.M.; Hindman, J. & Peters, J. (2001). Polygraph testing leads to better understanding adult and juvenile sex offenders. *Federal Probation*, 65(3); Heil, P., Ahlmeyer, S., & Simons, D. (2003). Crossover sexual offenses. *Sexual Abuse: A Journal of Research and Treatment*, 15(4), 221-236; Colorado Sex Offender Management Board *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders* (rev 2003), Colorado Department of Public Safety, Denver, CO.

and prosecute since the victim is often a child or a close acquaintance or both; therefore, offenders are frequently convicted on other charges such as burglary, murder or contributing to the delinquency of a minor. Current practice is to look at the facts associated with current and past crimes to identify the actual sex offender population.

***The most common method of prioritizing offenders for treatment was time to release.***

Not surprisingly, then, the 2006 survey of prison treatment programs found that only eight states identified sex offenders for treatment based on their conviction crime alone. Thirty states included the factual basis of the conviction crime as a criterion for treatment, and 33 states included past convictions in the identification of eligible offenders. Ten states included juvenile adjudications, and 12 states included misdemeanor sex crimes. Only eight states included the common institutional sex crime of exposure;<sup>14</sup> this is unfortunate since research on sex offenders at the Colorado Department of Corrections found these offenders to be especially dangerous upon release.<sup>15</sup>

Only seven respondents (Federal Bureau of Prisons, Colorado, Kansas, Louisiana, Michigan, Pennsylvania, and Virginia) included all of the following as a basis for identifying an offender as eligible for sex offender treatment: factual basis of a sex crime, current or past felony or misdemeanor conviction for a sex crime, and juvenile adjudication for a sex offense.

***Few states rely only on the crime of conviction to identify offenders for treatment eligibility. Thirty states include the factual basis and 33 include past convictions for sex crimes.***

#### PRIORITIZATION FOR TREATMENT

According to the survey findings, the most common method of prioritizing offenders for treatment was an offender's

proximity to release from prison. Colorado, Hawaii, Idaho, Kansas, Kentucky, New Jersey, and Washington used this as the sole criterion. These states relied upon risk assessment scores: Connecticut, Delaware, Minnesota, New Mexico, South Carolina, South Dakota, Texas, West Virginia, and Wisconsin.<sup>16</sup>

#### INTENSE TREATMENT

Twenty of the states reported that sex offender programming included some form of residential milieu-oriented treatment. These are highly structured residential programs that integrate the inmates' community and work life to promote difficult behavior changes.

#### Snapshots of prison programs

The following descriptions of prison treatment programs provide additional programmatic detail and raise important policy issues. Ideally, this section would describe both the services delivered by program staff along with the recidivism findings, but both types of information are rarely available. Detailed outcome studies of prison programs in Vermont and Minnesota are presented below but services received by the treatment groups are minimally described. Likewise, detailed information is available on services delivered by the Texas Department of Corrections, but the program has not been evaluated. Thus, while available information varies significantly, snapshots of seven state prison treatment programs are provided below.

#### SOUTH DAKOTA

Inmates convicted of a current or past sex offense or who have a sex crime as the factual basis of their conviction crime are encouraged to take part in a Sex Offender Treatment Program (SOTP). Failure to take part or complete SOTP can negatively impact an inmate's parole and classification level. Those inmates who are terminated from or refuse treatment while in prison may have their visits restricted, may be classified to a higher level and may jeopardize their parole release.<sup>17</sup>

<sup>14</sup> The eight departments that included institutional exposure as a criterion for sex offender treatment were the following: Colorado, Kansas, Louisiana, Michigan, Rhode Island, Vermont, Virginia and the Federal Bureau of Prisons.

<sup>15</sup> English, K., and Heil, P. (2005). Prison rape: What we know today. *Corrections Compendium*. 30(5), 1-5, 42-43.

<sup>16</sup> Note that for all of the states in this list, the data were not available in the 2006 survey but rather were obtained from a brief 2002 survey executed by the same author as the 2006 study.

<sup>17</sup> South Dakota Department of Corrections at [http://www.state.sd.us/corrections/FAQ\\_Sex\\_Offenders.htm](http://www.state.sd.us/corrections/FAQ_Sex_Offenders.htm).

## VERMONT

The Vermont DOC recently (January 2006) expanded its treatment program for sex offenders. Like most modern correctional interventions, the treatment program uses a cognitive behavioral group treatment approach. Prison-based treatment takes place as the offender approaches re-entry to maximize the likelihood that the skills learned in treatment will be transferred and reinforced in the community. Follow-up community treatment is available to offenders on supervised released.

***Prison-based treatment takes place as the offender approaches re-entry to maximize the likelihood that the skills learned in prison treatment are transferred and reinforced in the community. Follow-up community treatment is available once offenders are released.***

Sex offenders entering the Vermont DOC receive an initial risk/needs assessment. The Vermont DOC relies primarily on the Static-99 risk tool which considers a variety of factors including prior sex offenses, prior sentencing dates, non-contact sexual offenses, nonsexual violence, the relationship of the victim to the offender, the gender of the victim, the age of offender, and the offender's cohabitation history. An offender who takes responsibility for his or her sexual offense and is determined to be at low risk on the Static-99 generally does not receive prison sex offender treatment. These inmates are generally released after serving the minimum sentence and receive sex offender treatment in the community. Inmates designated moderate to high risk will be required to complete the prison treatment program to be considered for release at their minimum sentence. Prison sex offender treatment is approximately 18 months to three years in duration and occurs toward the end of an offender's minimum release date.

***A study of the Vermont prison program showed that male sex offenders who completed treatment had a rate of reoffense six times lower than that of male offenders who did not complete treatment.***

Very high risk inmates are also required to complete a general violent offender program in prison. All sex offenders are released into community-based sex offender treatment. According to the most recent study, slightly more than half of incarcerated sex offenders enter sex offender treatment. Of those offenders, slightly more than half completed the treatment. In community programs, approximately 85 percent of offenders who enter sex offender treatment complete the treatment.<sup>18</sup>

One study found that those who completed treatment had fewer violent crimes than those with no treatment although the differences were modest. Upon return to the community, those inmates who completed prison treatment were more likely to receive correctional supervision and aftercare sex offender treatment. This is important because the longer a participant was in outpatient aftercare community treatment, the less likely he was to sexually reoffend. Conversely, sexual and violent recidivists were less likely to receive community supervision and engage in treatment.<sup>19</sup>

***The longer a participant was in outpatient aftercare community treatment in Vermont, the less likely he was to sexually reoffend upon release.***

## TEXAS

Because Texas has a large prison system akin to California's, it is instructive to review in greater detail the programming implemented there. Implementation problems faced by California officials will likely mirror those faced by their DOC counterparts in Texas.

The Sex Offender Treatment Program (SOTP) is a part of the Texas Department of Criminal Justice Rehabilitation Tier Programs. The program is an educational and psychological treatment program designed to interrupt cognitive and behavioral patterns that lead to sexual offending

<sup>18</sup> McGrath, R. J., Cumming, G., Livingston, J. A., Hoke, S. E. (2003). Outcome of a treatment program for adult sex offenders: From prison to community. *Journal of Interpersonal Violence*, 18(1), 3-17. Sexual recidivism rates for those who: Completed-treatment, 5.4 percent; Some treatment, 30.6 percent; No-treatment, 30.0 percent.

<sup>19</sup> Ibid.

and criminal behaviors. The design of the Sex Offender Treatment Program is based on the following assumptions:

- There is no known “cure” for sexual deviancy at this time.
- The sex offender remains vulnerable to his deviant sexual preference indefinitely.
- In some cases the offender can learn appropriate and necessary skills and tools to control his behavior if he is highly motivated and involved in an intense and specialized treatment program.
- Without specialized treatment participation during incarceration and follow-up community based programs, the prison experience may only increase the offender’s pathology.
- The development of sexual deviancy is complex and can only be understood within the context of each offender’s developmental years.
- Environmental, socio-cultural, experiential, interpersonal and biological factors all impact the psychosexual development of an individual.
- The individual person’s circumstances resulted in the development of a pattern of faulty, deviant, and criminal thinking that distorts his perceptions and feelings, leading to his deviant and destructive behavior.
- Effective treatment depends on extensive assessment and knowledge of an individual’s criminal history so that treatment strategies can be developed to address the needs of each offender.
- Effective treatment must be sufficient in duration to allow for mastery of appropriate behavioral and cognitive changes.<sup>20</sup>
- To enhance the probability that appropriate changes will continue beyond the incarceration experience, the individual must receive relapse prevention training before he is released from prison.
- The individual must continue relapse prevention training and treatment after his release, for an indefinite period of time.<sup>21</sup>

According to its web site,<sup>22</sup> the Texas sex offender program includes a modified therapeutic community with

behavior change linked to privileges. The TC is highly structured, and the program policies and procedures state that placement in the program phases is awarded based on behaviors, participation, and personal growth. The time spent in each level depends on individual progress. Levels are associated with privileges such as phone calls and commissary allowances.

### **TEXAS DOC**

#### ***Required SO Treatment Programs***

- *Orientation*
- *Group Counseling*
- *Individual Counseling*
- *Cognitive Training*
- *Relapse Prevention*

#### ***Need Based***

- *Family Counseling*

#### ***Optional***

- *AA/NA Sessions*
- *Education Program*
- *Alcohol/Drug Education*
- *Chaplaincy Program*

Level III is assigned when offenders first arrive on the Estelle Unit. To advance, offenders must complete two weeks of orientation, a Committing Offense Synopsis, and apply for membership into the therapeutic peer group. After completing Level III, an offender progresses to Level II. The time spent at this level is determined by the offender’s willingness to engage in the program. To complete Level II the offender must complete all three *Offense Cycle Worksheets* and the *Offense Cycle Summary* to the satisfaction of the treatment team and his peer group. The offender must also demonstrate diligent participation in the functions of the therapeutic community and positive interaction with peers. After all criteria are met in Level II, the offender may graduate to Level I if they are demonstrating consistent peer leadership qualities. To progress through Level I the offender must undertake victim empathy work, complete three traumatic experiences worksheets, a persons harmed worksheet, a victim empathy letter, victim losses worksheet, and transition to the relapse prevention phase.

Each phase of the program is located in different facility units. According to a very small sample of fewer than 50 offenders who entered Phase II, 36 percent returned

<sup>20</sup> Despite this point, the Texas sex offender program is time limited and programming for most offenders is, at most, between 12 and 24 months, according to the description of the program at <http://www.tdcj.state.tx.us/pgm&svcs/pgms&svcs-sexofftrpgm.htm>.

<sup>21</sup> Ibid.

<sup>22</sup> Ibid.



to Phase III; and 26 percent remained at Phase II. Staff reported that program integrity was compromised because of pressure to transfer inmates to Phase I to maximize bed space. Movement of offenders between the phases was further complicated by release dates, according to the information placed on the Internet by the Texas DOC.<sup>23</sup>

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#### NEW HAMPSHIRE

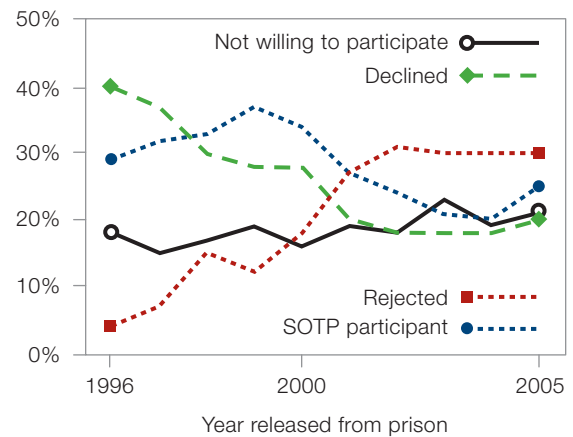
The state has two prison programs for sex offenders. The program for moderate- to high-risk offenders lasts 18 months. Approximately 85 men live in the same cellblock as part of a therapeutic community. The less intensive program targets lower risk sex offenders and provides group treatment twice per week. Sex offenders must complete the programs to be paroled. New Hampshire targets prisoners for programming at the end of their minimum release date. According to the 2006 survey discussed above, 85 percent of the participants complete the programs. Program participants are polygraphed once per year, but it appears there are no consequences for deceptive results since it is not used to assess treatment progress.

#### WASHINGTON STATE

The Washington State Department of Corrections (DOC) has operated a prison-based Sex Offender Treatment Program (SOTP) at the Twin Rivers Corrections Center since 1988. In 1996, the SOTP began using a combination of treatment techniques including group therapy, psycho-educational classes, behavioral treatment, and family involvement. Offenders selected for the prison treatment program must be convicted of a sex crime, admit their guilt, volunteer to participate, qualify for medium

or lower custody classification, and have at least one year remaining on their prison sentence. Additionally, since 2000, sex offenders assessed as having a high likelihood to reoffend, based on their criminal history, are prioritized for program entry. The SOTP uses three tools to determine risk for sexual reoffense: MnSOST-R, RRASOR, and Static 99. The length of treatment has decreased from two years in 1996 to approximately one year as of 2006.<sup>24</sup>

Figure 1.1. Trends in Washington state DOC treatment participation for sex offenders released from prison since 1996



#### Public policy may influence treatment participation.

The Washington State Institute for Public Policy evaluated the prison's sex offender treatment program. First researchers analyzed the characteristics of offenders served in the program and found changes in the level of participation, as reflected in the following figure displaying program participation rates between 1996 and 2006. In 1996, 40 percent declined to participate, 30 percent participated, 18 percent were not willing to participate, and less than 5 percent were rejected. In 2005, 20 percent declined to participate, 25 percent participated, 20 percent were not willing, and 30 percent were rejected. The researchers speculate that program participation patterns may be influenced by changes in laws and policies regarding sex offenders. For example, the full implementation of community notification laws (public release of information related to sex offenders leaving prison) may cause more sex offenders to

<sup>23</sup> From <http://www.tdcj.state.tx.us/pgm&svcs/pgms&svcs-sexofftrtpgm.htm>.

<sup>24</sup> Washington State Institute for Public Policy. (June 2006). *Sex offender sentencing in Washington State: Who participates in the prison treatment program?* Evergreen State College, Olympia, WA. Available at <http://www.wsipp.wa.gov/rptfiles/06-06-1204.pdf>.

seek treatment and, thus, potentially decrease their notification level. On the other hand, the law authorizing civil commitment of sexually violent offenders could motivate some sex offenders to decline participation because revelations during their treatment about additional victims or violence could later be used as reasons for the state to file a Sexually Violent Predator petition.

***The number of Washington State SOTP participants released from prison peaked at 192 in 2000; 131 SOTP participants were released in 2005. This is not inconsequential given the research that links treatment participation to lower recidivism rates. Public policy regarding sex offender management must be informed, comprehensive and integrated to maximize public safety.***

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In its 2006 evaluation, the Washington State Institute for Public Policy found that the SOTP group had a statistically significant *higher* felony sex recidivism rate (1.8 percent, or 12 crimes) than the comparison group (.06 percent, or 6 crimes). The comparison group represented those offenders who were *willing* to participate in treatment but did not. Further, the treatment group had a greater proportion of child sexual abusers (22 percent higher), and male-oriented child abusers have been found to have higher recidivism rates in the sex offender literatures.<sup>25</sup> Nevertheless, the researchers concluded that the program did not reduce recidivism.<sup>26</sup>

<sup>25</sup> Hanson, R. K and Morton-Bourgon, K. (2004). *Predictors of Sexual Recidivism: An Updated Meta-Analysis*. Public Works and Government Services Canada, Ontario. Available at [http://ww2.ps-sp.gc.ca/publications/corrections/pdf/200402\\_e.pdf](http://ww2.ps-sp.gc.ca/publications/corrections/pdf/200402_e.pdf).

<sup>26</sup> Baranoski, R. (2006). *Sex offender sentencing in Washington State: Does the prison treatment program reduce recidivism?* Washington State Institute for Public Policy, Olympia, WA. Available at <http://www.wsipp.wa.gov/rptfiles/06-06-1205.pdf>.

## MINNESOTA

In April 2007, researchers at the Minnesota Department of Corrections analyzed the impact of treatment and post-release supervision by studying 3,166 sex offenders released from prison between 1990 and 2002. The average follow-up period was 8.4 years, with a range of 3-16 years. Recidivism was measured three different ways (rearrest, reconviction, and reincarceration for a new crime) and distinguished by the type of felony or misdemeanor reoffense (sex offense, non-sex offense, any offense). After three years, seven percent of the 3,166 offenders had been rearrested for a sex offense, six percent reconvicted, and three percent reincarcerated.

By the end of the follow-up period (an average of 8.4 years for all 3,166 offenders), 12 percent had been rearrested for a sex offense, 10 percent were reconvicted, and seven percent were reincarcerated. Failure in prison-based sex offender treatment significantly increased the risk of a new sex crime. Supervised release and successful participation/completion of sex offender treatment each significantly reduced the risk of timing to a sexual reoffense.

The length and intensity of post-release supervision for sex offenders increased dramatically over the last decade. For example, the average length of post-release supervision for sex offenders released in 2002 was 63 months, which is 50 months greater than the average for 1990 releasees. Moreover, very few offenders were released to intensive supervision prior to 1997. In 2002, however, 53 percent of sex offenders were placed on intensive supervised release. Due largely to longer and more intense periods of post-release supervision, sex offenders have been returning to prison more frequently as technical violators. Indeed, during 2005, supervised release violators comprised 56 percent of sex offender admissions compared to only 11 percent during 1990.

***In Minnesota, greater intensity and length of supervision of sex offenders reduced recidivism; completion of prison treatment decreased sexual recidivism and delayed the time to reoffense.***

It is noteworthy that during the period that release supervision expanded, sexual recidivism declined substantially

since 1990, but especially since 1997. In 1990 the sexual recidivism rate was 19 percent (rearrested within three years) and in 2002 the rate was 3.8 percent.

#### ALASKA

The Alaska DOC, in conjunction with the University of Alaska Anchorage Justice Center, completed a study of sex offenders in the treatment program from January 1987 to August 1995.<sup>27</sup> The treatment group was compared with three other groups: (1) a motivated control group, (2) an unmotivated control group, and (3) a group of non-sex offenders. The study found the following:

1. A treatment effect was clearly demonstrated. Treated sex offenders lasted longer in the community before they re-offended than offenders in any of the comparison groups. Even under varied definitions of re-offense, the treatment group lasted longer without re-offense regardless of the definition applied (arrest, conviction, or return to prison).
2. Treatment at any level delayed length of time to new detected crime, but those who were in treatment longer tended to remain longer in the community without a re-offense.

Before it was disbanded in 2003, the multi-phase treatment program housed approximately 85 sex offenders in a therapeutic milieu setting. Seventy of the inmates were involved in intensive treatment programming while 15 were involved in pre-treatment and program screening. Services were provided by a unique blend of contract therapists and specially trained correctional officers.

***Those who completed all stages of treatment through the advanced stage had a zero reoffense rate for sexual reoffenses.***

The SOTP consisted of four program stages.

**Pretreatment:** The purpose of this stage was to provide assessment, orientation, education, challenge of offense denial, and clinical management. **Beginning Treatment:** This stage prepared offenders to give and receive feedback,

to use self-regulation and social skills, to assume responsibility for the current offense and how it affected the victim(s). It focused on the most immediate precursors to the sexual offense and assisted offenders in developing external management strategies. **Intermediate Treatment:** This stage addressed the earliest precursors to the offense and helped offenders develop the skills for self-management of all risk factors. In the Intermediate phase the focus was on the internalization of skills learned in the preceding phase. **Advanced Treatment:** This stage emphasized the application and generalization of skills to new situations.

Except for pretreatment, each stage lasted from six to 12 months. Duration in treatment depended on the offender's individual resources, problem areas, skills, motivation, and length of sentence. The sex offender population was recognized as diverse, allowing for different levels of outcome. The SOTP was **not** designed with the expectation that every sex offender would complete all stages of treatment since many offenders lacked the ability or the sentence length to complete each phase of the program. Regardless of which stage was reached, offenders were eligible for follow-up treatment in community programs.

#### SUMMARY OF STATE SNAPSHOTS

The review above is less than complete due to the lack of documentation of important information. Some programs have outcome data but no comprehensive program description, while others have program descriptions without outcome data. For that reason, we now turn to a brief overview of the Colorado Department of Corrections' Sex Offender Treatment and Management Program (SOTMP) for which details are available on both the program delivered and the outcome of treatment participants. The first author developed the program and directed it for 18 years; the second author evaluated it with a team of professional researchers.

<sup>27</sup> *Sex Offender Treatment Program: Initial Recidivism Study*. (August 15, 1996). Alaska Department of Corrections, Offenders Programs and the University of Alaska, Alaska Justice Statistical Analysis Unit Justice Center, Anchorage, AK.



## Program description and evaluation findings: Colorado Department of Corrections Sex Offender Treatment and Monitoring Program<sup>28</sup>

### COMPLETE DESCRIPTION PLUS OUTCOME DATA

This section thus far shows that few prison sex offender treatment programs have a thorough description of services delivered (and an objective, systematic assessment of services delivered) along with a detailed program outcome evaluation. The Colorado Department of Corrections program has both. For that reason, the program and the evaluation findings are summarized here. Since the outcomes were positive, the program will serve as the authors' model for implementing a prison sex offender treatment program in California.

### HISTORY

The Colorado DOC established the Sex Offender Treatment and Monitoring Program in 1984. It was designed with the understanding that most sex offenses are the sexual expression of aggression, not the aggressive expression of sexuality. In addition, sex offenses were seen as a symptom of multiple underlying problems in meeting life demands. The program initially had three phases: Basic group, Advanced Group, and Pre-Release Preparation.<sup>29</sup>

In the early stages of program development, clinical administrators visited Missouri, Nebraska, and Oregon to gain information from established treatment programs. Over the years, the program evolved considerably to reflect advances in the field of treatment and correctional management.

In 1992, the Colorado General Assembly specifically allocated funds to ensure sex offender treatment services continued in DOC and parole. In 1993, a 48-bed modified therapeutic community (TC) was opened to intensify and support the cognitive behavioral treatment components of the program. While designing the residential

component of the program, clinical staff and prison administrators visited sex offender treatment programs in Minnesota that operated within the context of therapeutic milieus. That same year, the program director hired a researcher to collect and analyze data to provide empirical feedback and guidance for program development and modification. The following year, after being presented with research findings regarding the impact of the use of the polygraph as a treatment tool, the General Assembly allocated additional funding to pay for polygraph examinations for inmates and parolees.

### MODIFIED TC

From the onset, the program was a modified TC. Specifically, some of the principles of substance abuse TC intervention were adapted to accommodate psychological issues related to sexual offending behavior. For example, traditional drug and alcohol TCs usually hire recovering addicts to work in the program. And, as participants progress in the program, they take on leadership roles whereby they may exert power over others with lower program status. However, because sex offender's abuse power in the commission of their crimes, the use of these program components would be non-therapeutic and potentially

*Therapeutic Communities have been a method of treatment for drug abuse and addiction for nearly 40 years. Many studies have found this approach to be an effective means of treatment for substance abusers, reducing both drug use and criminal recidivism (for example, Field, 1989; Inciardi et al., 1997; Prendergast, et al., 2001; Shapiro, 2001; Wexler, Falkin and Lipton, 1990; 1998). The most comprehensive study of the effects of TCs on rearrest for adult offenders concluded that these programs "do significantly reduce recidivism" (Lipton, Pearson, Cleland and Yee, 2002; P. Falkin, and D. S. Lipton, 1990). Further, the latter study found that those who received more treatment were more likely to avoid recidivism.*

*DeLeon (1995:1610) notes that treatment "is not provided but made available" to individuals who then must commit to the process of change in themselves and others. Lipton et al. (2002) note that recovery depends on positive and negative pressures to change, and remaining in treatment requires continued motivation to change. Changes in lifestyle and identity are learned in the community. The process begins in prison but must be continued in the community (Wexler, 2000; Lipton, et al., 2003).*

<sup>28</sup> Lowden, K., Hetz, N., Harrison, L., Patrick, D., English, K, and Pasini-Hill, D. (2003). *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders: A Report of Findings*. Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety, Denver, Colorado. For a copy of the full report, go to <http://dcj.state.co.us/ors/pdf/docs/WebTCpart1.pdf>.

<sup>29</sup> For a complete description, see the report by Lowden et al. (2003).

dangerous. Therefore, the focus in the Colorado TC for sex offenders is on the development and maintenance of egalitarian relationships. This is a key program difference between traditional TCs and the Sex Offender Treatment and Management Program (SOTMP).

#### PROGRAM DESCRIPTION

The goals of the SOTMP, according to material reviewed by the evaluation team, was:

To increase public safety by

1. Providing treatment to sex offenders who are motivated to change to a more appropriate lifestyle and eliminate sexually assaultive behaviors;
2. Developing increased information on specific offender's sex offending behaviors to contribute to more effective monitoring and early detection if the offender does reoffend;
3. Contributing to the general knowledge of sex offenders for prevention, treatment, management and detection efforts through research, community service projects and program evaluation.

Between April 1993 and March 2003, 723 inmates were admitted to the TC. Eighty-two were still active at the time of the evaluation. Many prison inmates in Colorado participate in Core Curriculum, a program that introduces inmates to basic mental health concepts and prepares them for more specific treatment later. This brief educational program is delivered to inmates in a 16 session group format. Participation in this program is a prerequisite to the sex offender program.

#### PHASE I

Participation in Phase I of the SOTMP requires the following of inmates:

- Admit that they committed a sex crime;
- See sex offending as a current problem;
- Be willing to discuss the crime and their problems in the context of treatment.

At the time of the program evaluation, adapted forms of Phase I were offered to inmates who were developmentally disabled, chronically mental ill, Spanish-speaking, and women. Phase I involved 2-hour group therapy sessions conducted by two specially trained clinicians. The groups

met 4 days per week for six months and followed a very specific education and cognitive-restructuring curriculum. At the end of each section, inmates were tested on the program content. Successful completion of Phase I was necessary for participation in Phase II, the TC.

***Phase I was not offered in all facilities, and inmate movement, along with variations in treatment motivation over time, likely affected program participation. Many of the inmates who eventually participated in Phase II spent, on average, one year in Phase I, even though it was a six-month program. For a variety of reasons (drop outs, terminations, lack of motivation) many of the offenders repeated Phase I before successfully completing it. In reality, then, many TC participants spent more than six months in Phase I.***

The program evaluation focused on Phase II, the TC. Nevertheless, in the course of the evaluation, some information was learned about Phase I. Among the most important findings were those related to duration of treatment participation. Analysis of Phase I completions and dropouts/terminations found that many if not most of those who completed Phase I dropped in and out of the program.<sup>30</sup> Phase I was not offered in all facilities, and inmate movement, along with variations in treatment motivation over time, likely affected program participation. Many of the inmates who eventually participated in Phase II spent, on average, one year in Phase I, even though it was a six-month program. In reality, then, many TC participants spent more than six months in Phase I.

#### PHASE II, THE TC

The evaluation study found that the TC program design, which was well documented in the TC handbook, its

<sup>30</sup> Many of the Phase I program entry/exit dates were missing in the DOC's management information system. Consequently, the data were too unreliable to include in anything more than a cursory review of duration in treatment. Nevertheless, a few trends appeared and were consistent with information obtained from program staff.

program plans, and its *Resource Guide*, described the program and expectations of the offender.<sup>31</sup> The modified TC housed inmates together, providing opportunities for them to work and live with others who were addressing on similar treatment issues. The TC was designed to address offenders' life skills and their understanding of the world, others, and themselves, and to help offenders develop socially appropriate responses to their problems. Treatment tools included relapse prevention plans, cognitive restructuring programming, and education and psychotherapy that focused on sexuality, denial and social skills. Because the program evaluation found that the TC was primarily implemented as planned,<sup>32</sup> the description that follows provides an overview of the program philosophy and methods that resulted in recidivism reduction.

*Sex offenders are comfortable operating in a power position. They evaluate relationships in terms of who has more power and how they can increase their power. They tend to have deficits in establishing mutually caring relationships on the basis of equality. We designed this TC to minimize opportunities for power or control over others and to maximize opportunities for equal peer relationships and responsibility for others. We also want to teach offenders how to respond appropriately to conflict. Therefore, we require offenders to use non-offensive language, a behavior that is usually allowed in drug and alcohol TC's "game." Further, we wanted to maximize peer monitoring instead of using hierarchical monitoring, and we wanted inmates to progress to higher treatment levels by assuming greater responsibility instead of greater power over other participants.<sup>33</sup>*

The TC targeted offenders who had successfully completed Phase I. To participate, inmates were required to be motivated to work toward eliminating sexual assault behavior and accept responsibility for changing their behavior.

***The program evaluation found that the TC was primarily implemented as planned. Deficits in the program could be linked to a reduction of resources due to state-wide budget shortfalls.***

The goals for Phase II of treatment were

1. Applying and incorporating the material learned in Phase I into his lifestyle.
2. Identifying and changing distorted thinking.
3. Preparing for living a responsible lifestyle in the community.
4. Realizing the importance of developing a balanced lifestyle and monitoring his thoughts and behaviors the rest of his life.
5. Identifying his relapse cycle and methods for intervention in the cycle.
6. Realizing the importance of sharing his relapse cycle and methods for intervention with significant others in his life.
7. Practicing and incorporating a model for solving problems.
8. Ongoing evaluation of the inmate and his problem areas.

Group therapy was the primary intervention. Sixteen types of groups were offered:

- Basic orientation training,
- Anger management,
- Concept group,
- Covert sensitization,
- Crossover/kitchen group (this group included inmates from the drug and alcohol TC to discuss issues that arose in their shared work environment),
- Cycle group,
- Integrated group (this group included inmates who were developmentally disabled and in Phase I of the program; while they were not part of the TC, they worked with Phase II members),
- Interpersonal communication skills,
- Journaling I,
- Journaling II,

<sup>31</sup> Program materials that documented the intervention objectives and expectations of participants were readily available to evaluators, and were the source of the descriptions provided here.

<sup>32</sup> Program deficits were identified and documented in the final evaluation report (Lowden et al, 2003) but the implementation weakness were primarily due to minimal staffing of the program. The program had lost 25 percent of its clinical staff in the preceding two years, along with training and contract funds as a result of state budget problems. Therapists literally ran across the prison yard to move from one group to the next, and the lack of adequate resources, including facility space, affected service delivery. Although some were weakened, all program components were in place except for a quality control process; an effort to implement a quality control component was interrupted by state budget cuts.

<sup>33</sup> Lowden, et al. (2003). Page 30.

- Personal change contract development,
- Probation group (for inmates who had been placed on probation for lack of progress),
- Rational office (this is a committee that determines consequences and learning experiences for program violations),
- Rational behavior therapy,
- Relapse prevention rehearsal, and
- Victim impact.

***Using structured instruments to document the interactions, researchers observed 67 groups and found that therapists emphasized inmates' behavior change rather than just verbalizing insight.***

The evaluation findings included data collected from six focus groups with inmates and one focus group with parole officers. While some inmates expressed concern about being a “snitch” or a “rat” in the TC and the danger this presented in the general population, other inmates did not agree. One inmate said, “I went from having a sick feeling in the pit of my stomach before I came over here thinking about...all the stuff I’d heard in GP about it being a snitch pad.... It’s [a place where we say] ‘oh, yeah, they rat each other out’.... Getting over here and seeing how it worked I came to believe it was a stroke of genius.” Another said, “You’ve got to break up the convict code to get out of that. People think it is still snitching and it’s really to be helping.”

Given that the evaluation found the TC services were delivered essentially as planned and intended, the outcome findings can be considered linked to the program.

## OUTCOME FINDINGS

Between April 1, 1993 and July 30, 2002, over 3,000 sex offenders were released from the Colorado DOC. Those in Phase I specialty programs (women, Spanish-speaking or inmates with developmental disabilities) were excluded from analysis since the number of cases was too small to analyze possible differences.

The largest group was the “no treatment” group, which comprised nearly 74 percent of the follow-up cohort. Over 500 inmates participated in Phase I and over 300 participated in Phase II. The number of inmates studied is shown in Table 1.1.

Table 1.1. Colorado TC evaluation study groups<sup>34</sup>

	Count	Percent
No treatment	2465	73.8%
Phase I	548	16.4%
Phase II	325	9.7%
Total	3338	100.0%

Efforts to develop matched comparison groups were confounded by a lack of data in the DOC’s data management system on criminal history variables. Only half of the cases included information that might be suitable to match cases on historical and service need variables. The groups were very well matched on prior felonies and prior incarcerations, with about 85 percent of each group serving their first prison sentence, but those in treatment were older.<sup>35</sup> The treatment groups were more likely to be: (1) white, (2) serving a longer sentence, and (3) serving time for a sex crime conviction (versus having a documented history of a sex crime while serving time for a non-sex crime conviction). Therefore, the treatment groups were likely less serious to some unknown extent compared to the no treatment group since being white and older are factors that tend to improve recidivism outcomes.

The outcome study involved two analyses. The first focused on the group of offenders released to parole to determine the proportion that was revoked back to prison. Those under parole supervision clearly have a different release situation compared to those who are discharged without parole, so parolees were analyzed separately.

<sup>34</sup> For details on variation across groups, please refer to Lowden et al., 2003.

<sup>35</sup> Average age was as follows: No treatment group, 36.0 years; Phase I, 37.1; Phase II, 38.5.

Table 1.2. Parole outcomes: Colorado SOTMP

		Completed	Revoked	Total
No treatment	n	685	625	<b>1310</b>
	%	52.3%	47.7%	<b>100.0%</b>
Phase I	n	112	48	<b>160</b>
	%	70.0%	30.0%	<b>100.0%</b>
Phase II	n	97	18	<b>115</b>
	%	84.3%	15.7%	<b>100.0%</b>
<b>Total</b>	n	<b>894</b>	<b>691</b>	<b>1585</b>
	%	<b>56.4%</b>	<b>43.6%</b>	<b>100.0%</b>

**Note:** Sex offenders placed on parole between April 1, 1993 and July 30, 2002. Difference is significant at  $p < .001$ .

**Source:** Lowden et al. (2003). *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders: A Report of Findings*. Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety, Denver, Colorado.

Treatment was significantly related to successful parole completion. Approximately half of the no treatment group completed parole compared to 70 percent of the Phase I group and 84 percent of the Phase II group.

Next, offenders who successfully completed parole and discharged their sentence were compared with those who discharged directly from prison. Figure 1.2 compares the violent crime outcomes of these offenders by treatment category. The value of treatment combined with parole supervision, polygraph testing, and sex offender treatment in the community is evident in the first year.

Table 1.3 shows that 55.3 percent of the no treatment group was rearrested within three years, compared to 42.8 percent for those in Phase I and 34.5 percent for those in Phase II.

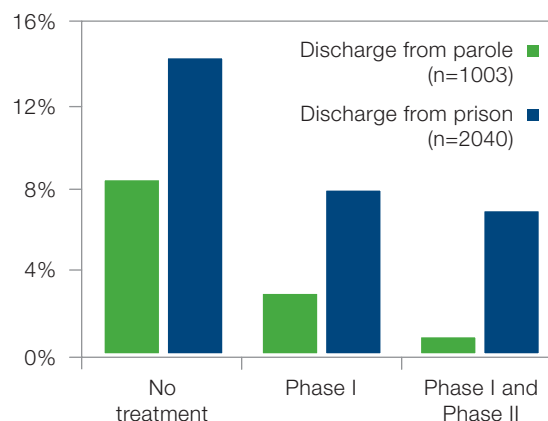
Figure 1.2. Colorado SOTMP: Violent rearrest 1-year post discharge from prison or parole<sup>36</sup>

Table 1.3. Any rearrest 3 years: Colorado SOTMP

		No arrest	New arrest	Total
No treatment	n	491	607	<b>1098</b>
	%	44.7%	55.3%	<b>100.0%</b>
Phase I	n	170	127	<b>297</b>
	%	57.2%	42.8%	<b>100.0%</b>
Phase II	n	78	41	<b>119</b>
	%	65.5%	34.5%	<b>100.0%</b>
<b>Total</b>	n	<b>739</b>	<b>775</b>	<b>1514</b>
	%	<b>48.8%</b>	<b>51.2%</b>	<b>100.0%</b>

**Note:** Sex offenders discharged from prison between April 1, 1993 and July 30, 2002 who had at least 3 years at-risk. Difference is significant at  $p < .001$ .

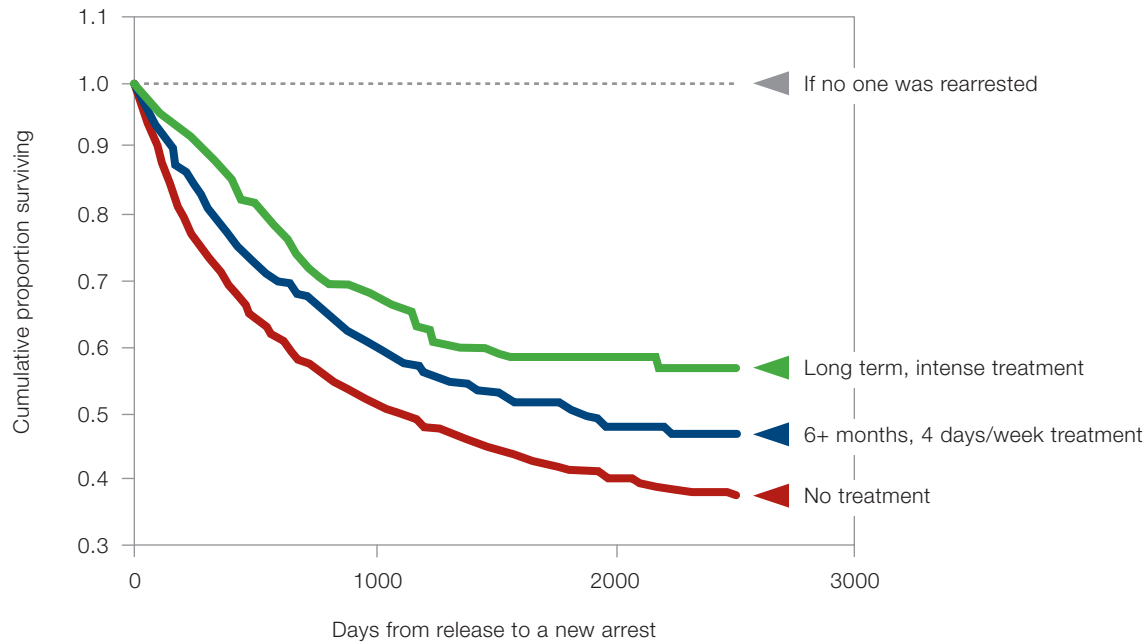
**Source:** Lowden et al. (2003). *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders: A Report of Findings*. Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety, Denver, Colorado.

Further, the average time to new arrest for the no treatment group was substantially shorter than the Phase I group, as was the time to new arrest for the Phase I group compared to the TC group (data not presented). As can be seen in Figure 1.3, survival analysis showed remarkable separation in the outcomes for the three groups on "any arrest" for nearly 8 years, the maximum amount of at-risk time studied. This suggests that the treatment effect lasted for the duration of the outcome time period.

<sup>36</sup> Lowden et al. (2003). Page 114, Table 17.



Figure 1.3. The proportion of cases **not** rearrested for a new crime during the study period, by treatment groups



**Note:** Significant at  $p < .001$ .

**Source:** Lowden et al., 2003.

Finally, analysis revealed that increasing time spent in the TC significantly decreased the risk of rearrest.<sup>37</sup> Specifically, each additional month spent in the TC increased the likelihood of success upon release by one percent—12 percent per year.

Other factors were positively correlated with new arrest including *not* being released to parole supervision. In sum, duration of intense TC participation and parole supervision were linked with lower recidivism rates.

#### STRENGTH OF THE STUDY

The treatment groups in this study contained everyone who participated in that phase of treatment for at least 30 days whether or not they dropped out or were terminated after 30 days. This method makes the findings more significant. That is, the evaluation of the SOTMP can be viewed with greater confidence because the problem inmates were not excluded from the analysis.

***The treatment groups in this study contained everyone who participated in that phase of treatment for at least 30 days whether or not they dropped out or were terminated after 30 days. This method makes the findings more significant. That is, the evaluation of the SOTMP can be viewed with greater confidence because the problem inmates were not excluded from the analysis.***

#### LIMITATIONS OF THE STUDY

The primary limitation of the study was the lack of equivalent study groups. The TC participants were more likely to be white and were older, on average, by over two years, compared to the no treatment group, and these factors are known to reduce the probability of recidivism. Also, the Phase 1 group was more likely (because of changes in the parole laws) to discharge their sentence from prison without serving time on parole.

<sup>37</sup> Using the Cox proportional hazards regression technique.

Another limitation is that the study followed a release cohort which, by the fact that the offenders are getting released, is inherently a less serious group.

Finally, arrest data is a more sensitive measure than filing charge or conviction. This is important with a criminal population that is rarely arrested (since few sexual assault victims report the crime). Yet, even arrest data are often incomplete, so this measure underestimates actual reoffense.

Despite the study limitations, this model—if carefully replicated and monitored for quality assurance—appears to hold promise for improving community safety.

### Atascadero: Program efficacy study

The most rigorously designed study of a cognitive-behavioral relapse prevention program found no difference in recidivism rates of treated and untreated offenders. The findings are particularly relevant to this report since the program operated at Atascadero State Hospital.<sup>38</sup>

The program operated between 1985 and 1995 and was considered state-of-the-art. The program consisted of Relapse Prevention (RP) groups three days a week in addition to specialty groups and individual appointments with therapists. Deviant sexual arousal was addressed with the techniques of orgasmic reconditioning or olfactory aversion.

Marques, Wiederanders, Day, Nelson and Ommeren (2005) compared outcomes of sex offenders engaged in RP<sup>39</sup> with those of two untreated control groups: treatment volunteers and treatment refusers.<sup>40</sup> The authors point out that the random assignment did not produce equivalent groups: the treated group had higher risk scores, a higher number of offenders previously committed for treatment as mentally disordered sex offenders

and a higher number of unmarried offenders.<sup>41</sup> Program participants, then, were probably more serious and more likely to reoffend than those in the control groups.<sup>42</sup>

### OUTCOME

Arrest data were obtained from the FBI and the California Department of Justice records. Reincarceration data were obtained from the California DOC.<sup>43</sup>

Sexual reoffense averaged 19-22 percent after eight years at risk. “When static risk was controlled for, the RP group appeared to have the lowest reoffense rate, but this difference did not approach [statistical] significance . . .” (Marques et al, 2005:94).

In comparison to the voluntary control group, the RP group had a lower percentage of crimes that were rated as severe on three of the four indicators, sexual penetration (15.3 percent compared to 33.3 percent), weapons (2 percent compared to 10 percent), and victim injury (7.6 percent vs. 14.6 percent).

Treatment dropouts had a shorter time to sexual reoffense. Early dropouts tended to reoffend within one year. Treatment dropouts were significantly younger than treatment completers. Reoffenses occurred steadily the first three years and almost leveled off after five years.

Offenders with less than one year treatment (due to termination or dropping out) had the highest rate of recidivism (35.7 percent after eight years at risk) while offenders who met treatment goals had the lowest recidivism (13.5 percent versus 27.2 percent), which approached significance. High-risk offenders who “got it” (according to program staff) reoffended at a significantly lower rate (10 percent). In particular, child molesters who were judged as “got it” in relationship to treatment goals had lower recidivism versus rapists.

<sup>38</sup> Marques, J., Wiederanders, M., Day, D., Nelson, C., and van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's sex offender treatment and evaluation project (SOTEP). *Sexual abuse: A Journal of Research and Treatment*, 17, 79-107.

<sup>39</sup> There were 259 men in the Relapse Prevention group; 55 withdrew consent before entering program, 204 were admitted to the program, and 167 completed their sentence in the program.

<sup>40</sup> There were 225 in the volunteer control group and 220 in the non-volunteer control group.

<sup>41</sup> Specifically, the RP group had higher average scores on the “Static-Lite” risk assessment scale (reduced version of the Static 99 that included: prior sex offenses, convictions for noncontact sex offenses, any unrelated victims, any stranger victims, any male victims, young and never married); 12.8 percent of the RP group had been previously committed for treatment as mentally disordered sex offender compared to 6.4 percent of the controls; and a higher percentage (66.3 percent) of the RP group was unmarried compared to the controls (58.7 percent).

<sup>42</sup> The study sample excluded incest offenders, offenders who perpetrated with another person (gang rape), those with more than two prior felony convictions prior to instant offense, offenders with psychotic or organic mental conditions, and those who had a record of severe management problems in prison.

<sup>43</sup> Sexual reoffenses included hands-on and hands-off offenses.

***High-risk offenders who “got it” (according to program staff) reoffended at a significantly lower rate (10 percent). In particular, child molesters who were judged as “got it” in relationship to treatment goals had lower recidivism versus rapists.***

RP participants who were intoxicated at the time of original offense had lower recidivism after treatment compared to a similar group that did not receive treatment. This is an interesting finding since participants with significant substance abuse histories had to participate in the substance abuse RP treatment component. It is possible that the additional treatment was valuable.

The researchers identified considerable problems with the proper implementation of the treatment program. Marques et al. (2005) note that the treatment program differed in some respects from most current treatment programs.

1. To reduce treatment attrition, offenders were not required to fully participate in the program.<sup>44</sup> Participants did not have to demonstrate motivation, fully engage in treatment or show improvement to stay in the program.
2. The only individuals terminated from the program were those that caused severe management problems in the hospital.
3. Treatment was time-limited, up to two years.
4. The offender's sentence determined program discharge and was unrelated to treatment progress or assessed risk.
5. The program did not include polygraph testing.
6. Upon release, offenders received one-year follow-up treatment in the community with twice a week individual or group sessions and standard (not intensive) parole supervision.
7. Therapists were encouraged but not required to communicate with parole officers.
8. Polygraph testing was not a component of the release program.

9. Additional surveillance, such as GPS monitoring, was not included in the release program.
10. Medications for deviant arousal were not included in the release program.
11. The release program did not include social or other supportive services.

The authors conclude:

Although it has not been rigorously tested, this “containment approach” (English, 1998) represents the current thinking in the field (Association for the Treatment of Sexual Abusers, (2004; California Coalition on Sexual Offending, 2001; Center for Sex Offender Management, 2000; Colorado Sex Offender Management Board, 1999). As we learned in interviews with our treatment failures, a number of RP participants were facing high-risk situations soon after entering the community (Marques et al., 2000). It is possible that added surveillance and teamwork could have prevented some of these early failures (Marques, 2005: 101-102).<sup>45</sup>

In the end, the efficacy of institutional treatment as it was applied in the Atascadero program remains uncertain. However, treatment in combination with additional program components, such as behavioral accountability and polygraph testing to obtain information on risk and behavioral change, and use of the containment approach upon release, have the potential to considerably improve outcomes.

## Evidence based correctional practices

Corrections and criminology research conducted over the past several decades provides substantial direction for implementing prison and community-based programs for criminal offenders. Criminologists have spanned the research-practice divide in the last fifteen years, and now leaders in corrections must take the information forward

<sup>44</sup> The reported drop-out/termination rate was only 18 percent, far below other programs that require accountability in the therapeutic approach.

<sup>45</sup> Association for the Treatment of Sexual Abusers. (ATSA). (2004). *Practice guidelines for members of the Association for the Treatment of Sexual Abusers*. Beaverton, OR: Author; California Coalition on Sexual Offending. (2001). *Effective management of sex offenders residing in open communities*, available at [www.ccoso.org/papers/containment.html](http://www.ccoso.org/papers/containment.html); Center for Sex Offender Management. (2000). *The collaborative approach to sex offender management*. Available from [www.csom.org/pubs/collaboration.pdf](http://www.csom.org/pubs/collaboration.pdf); Colorado Sex Offender Management Board. (1999). *Standards and guidelines for the assessment, evaluation, treatment and behavioral monitoring of adult sex offenders*. Denver: Colorado Department of Public Safety; English, K. (1998). The containment approach: An aggressive strategy for the community management of adult sex offenders. *Psychology, Public Policy, and Law*, 4, 218-235.



and implement programs based on the principles of effective intervention. “What works in corrections” is not a program or a single intervention but rather a body of knowledge that is accessible to criminal justice professionals.<sup>46</sup>

The National Institute of Corrections (NIC) has been promoting the use of evidence-based practice for many years. The nine principles of evidence-based corrections are summarized on the NIC website.<sup>47</sup> These principles, along with additional discussion, are presented below.

1. **Assess offender risk/need levels** using actuarial instruments. Risk factors are both static (never changing) and dynamic (changing over time, or having the potential to change). Focus on criminogenic needs, that is, offender deficits that put him or her at-risk for continued criminal behavior.<sup>48</sup> For example, many studies show that specific offender deficits are associated with criminal activity, such as lack of employment, lack of education, lack of housing stability, substance abuse addition. Actuarial instruments are available which can assist in the identification of these areas of service needs. One of the most common of these is the Level of Service Inventory (LSI).<sup>49</sup> In a 1999 study, researchers found that 14 percent of the agencies surveyed in a national study were using the LSI-R with another 6 percent planning on implementing it in the near future.<sup>50</sup> It is used in jurisdictions across the U.S. and Canada, and has been the subject of a considerable amount of research. Systematically identifying and intervening

in the areas of criminogenic need is effective at reducing recidivism.

2. **Enhance offender motivation.** All humans must be motivated (rather than persuaded) to engage in a change effort. An essential principle of effective correctional intervention is recognizing that the treatment team plays an important role in this regard and must use proven motivation techniques. Motivational Interviewing, for example, is a specific approach to interacting with offenders in ways that tend to enhance and maintain interest in changing their behaviors.

***Research shows that targeting three or fewer criminogenic needs does **not** reduce recidivism. Targeting 4 to six needs (at a minimum) has been found to reduce recidivism by up to 31 percent.***

3. **Target interventions.** This requires the application of what was learned in the assessment process described in #1 above.<sup>51</sup> Research shows that targeting three or fewer criminogenic needs does *not* reduce recidivism. Targeting 4 to six needs (at a minimum) has been found to reduce recidivism by up to 31 percent. Correctional organizations have a long history of assessing inmates, for institutional management purposes if nothing else. But when it comes to using this information in the systematic application of program services, most corrections agencies fall short. Inmate files may have adequate information on the offender's deficits, but lack of staff training regarding case management, lack of services, inmate movement, lockdowns, and day-to-day prison operations often take priority over the delivery of services based on the offender's criminogenic needs. Targeting interventions requires clear leadership and management of the prison culture. Implementation methods include the following:

<sup>46</sup> Latessa, E. J. and Lowenkamp, C. (2006). What works in reducing recidivism? *University of St. Thomas Law Journal*, 521-535.

<sup>47</sup> Available at <http://www.nicic.org>.

<sup>48</sup> Criminogenic need refers to these attributes associated with criminal behavior and recidivism (Gendreau, and Andrews, 1990): (1) Anti-social attitudes, values, and beliefs (criminal thinking); (2) Pro-criminal associates and isolation from pro-social associates; (3) Particular temperament and behavioral characteristics (e.g., egocentrism); (4) Weak problem-solving and social skills; (5) Criminal history; (6) Negative family factors (i.e., abuse, unstructured or undisciplined environment, criminality in the family, substance abuse in the family); (7) Low levels of vocational and educational skills; (8) Substance abuse. The more factors present, the greater the risk for committing criminal acts.

<sup>49</sup> Andrews, D.A. and Bonta, J. L. (2003). *Level of Supervision Inventory-Revised*. U.S. Norms Manual Supplement. Multi Health Systems, Toronto. The LSI assesses the extent of need in the following areas: criminal history, education, employment, financial, family and marital relationships, residential accommodations, leisure and recreation activities, companions, alcohol and drug problems, emotional and personal problems, and pro-social attitudes and orientations.

<sup>50</sup> Jones, D., A., Johnson, S., Latessa, E. J., and Travis, L. F. (1999). *Case classification in community corrections: Preliminary findings from a national survey*. Topics in Community Corrections, National Institute of Corrections, U.S. Department of Justice, Washington, D.C.

<sup>51</sup> Latessa, E. J. and Lowenkamp, C. (2006). What works in reducing recidivism? *University of St. Thomas Law Journal*, 521-535.

- **Act on the risk principle.** This means prioritizing supervision and treatment resources for higher risk offenders. Some studies have shown that lower risk offenders have a high probability of successfully re-integrating into the community without intense prison programming.<sup>52</sup> They tend to have positive support groups and are not without resources. Placing these offenders in correctional programs tends to disrupt their pro-social networks and increase their likelihood of recidivism.
  - *Sex offenders are different.* The majority of known sex offenders in prison are high need/risk. Studies show that institutionalized adult sex offenders generally commit sex crimes for many years prior to getting caught,<sup>53</sup> meaning that abusive behavior is well-ingrained. Since victims seldom report the crime to law enforcement, many sex offenders have minimal criminal records and score low risk on actuarial scales. For sex offenders in prison, risk should be considered high, medium or unknown. Only polygraph assessments in treatment can verify when a sex offender is low risk. This is because the combination of treatment and polygraph exams elicits critical information about past sex crimes and victims that would otherwise remain hidden.
- **Act on the need principle.** The fundamental point of this principle is to provide services according to individual deficits—social skills, thinking errors, vocational training, leisure time monitoring, drug and alcohol treatment—when these are identified by the assessment in #1 above. Sex offenders, like other offenders, have significant deficits, and research shows they have additional treatment needs that require specialized interventions.
- **Implement the responsivity principle.** Inmates, like other humans, have different temperaments, learning styles, and motivation levels. These must be acknowledged and services must accommodate and consistently promote every individual's ability to participate in a program. This means gender and cultural differences must be accounted for. Many evidence-based programs have lower or no success with offenders of color, and women have very different service and program needs than men. Recidivism reduction requires developing interventions that are sensitive to the learning styles and psychological needs of program participants.
- **Ensure adequate program dose and duration.** Many efficacy studies have found that high-risk offenders should spend 40 to 70 percent of their time in highly structured activities and programming for 3 to 9 months prior to release.<sup>54</sup> However, these are minimum durations and are likely to be inadequate for both sex offender populations and serious drug addicts. Studies of both populations have found that duration and intensity are linked to positive outcomes. For both populations, the need for structured and accountable time throughout the day and week is likely higher than the average 40 to 70 percent found in studies of the general criminal population. The continuity of structure, treatment and accountability must follow both substance addicts and sex offenders into the community, and treatment should be delivered as a life-long plan for changing entrenched negative lifestyle behaviors.<sup>55</sup> The evidence indicates that incomplete or uncoordinated approaches can have negative effects and increase recidivism and victimization.<sup>56</sup>

<sup>52</sup> Andrews, D. A. and Bonta, J. (2003). *The psychology of criminal conduct*. Anderson Publishing Co., Cincinnati; Clear, T. R. "Objectives-Based Case Planning," *NIC, Monograph 1981*, Longmont, CO.; Currie, E. (1998). *Crime and punishment in America*. Metropolitan Books, New York; Palmer, T. (1995). "Programmatic and non-programmatic aspects of successful intervention: New directions for research," *Crime and Delinquency*, 41, 100-131.

<sup>53</sup> Ahlmeyer, S., Heil, P., McKee, B., & English, K. (2000). The impact of polygraphy on admissions of victims and offenses in adult sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 12, 123-138.

<sup>54</sup> Gendreau, P. and Goggin, C. (1995). "Principles of effective correctional programming with offenders," Center for Criminal Justice Studies and Department of Psychology, University of New Brunswick, New Brunswick; Palmer, T. (1995). "Programmatic and non-programmatic aspects of successful intervention: New directions for research," *Crime & Delinquency*, 41, 100-131; Higgins, H. and Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions*. Washington, D.C.: American Psychological Association.

<sup>55</sup> National Institute on Drug Abuse's *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research Based Guide*, available at [http://www.nida.nih.gov/PODAT\\_CJ/](http://www.nida.nih.gov/PODAT_CJ/) from the U.S. National Institutes of Health.

<sup>56</sup> Higgins, H. and Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions*. Washington, D.C.: American Psychological Association.

4. **Implement the treatment principle.** The treatment principle states that cognitive/behavioral treatment should be incorporated into all sentences and sanctions.<sup>57</sup> Treatment is action. First, it is centered on the *present* circumstances and risk factors that are responsible for the offender's behavior. Second, it is *action* oriented rather than talk oriented. Offenders do something about their difficulties rather than just talk about them. Third, clinicians *teach* offenders new, prosocial skills to replace the anti-social ones like stealing, cheating and lying, through modeling, practice, and reinforcement. Examples of behavioral programs include the following: structured social learning programs where new skills are taught, and behaviors and attitudes are consistently reinforced; cognitive behavioral programs that target attitudes, values, peers, substance abuse, anger, etc.; and family based interventions that train families on appropriate behavioral techniques. Interventions based on these approaches are very structured and emphasize the importance of modeling and behavioral rehearsal techniques that promote self-efficacy, challenge cognitive distortions, and assist offenders in developing good problem-solving and self-control skills. These strategies have been demonstrated to be effective in reducing recidivism.<sup>58</sup>
5. **Provide skill training for staff and monitor their delivery of services.** Evidence-based programming emphasizes cognitive-behavior strategies and is delivered by well-trained staff. Staff must coach offenders to learn new behavioral responses and thinking patterns; offenders must engage in role playing and staff must continually and consistently reinforce positive behavior change.
6. **Increase positive reinforcement.** Researchers have found that optimal behavior changes results when the ratio of reinforcements is four positive to every negative reinforcement.<sup>59</sup> While this principle should not interfere with the need for administrative responses to disciplinary violations, the principle is best applied with clear expectations for and descriptions of behavior compliance, and consequences for failing to meet expectations should be known to the offender as part of the programming activity. Clear rules and consistent consequences that allow offenders to make rewarding choices can be integrated into the overall treatment approach.<sup>60</sup>
7. **Engage ongoing support in natural communities.** For many years research has confirmed that placing offenders in poor environment and with anti-social peers increases recidivism. The prison-based drug and alcohol treatment communities show that the inmate code can be broken and replaced with a positive alternative and, in the process, teach offenders the skills they will need upon release. Likewise, parole supervision requires attending to the pro-social supports required by inmates to keep them sober and crime free. Building communities in prison and outside of prison for offenders who struggle to maintain personal change is a key responsibility of correctional administrators today. The National Institution of Corrections calls for this:  
  
*Realign and actively engage pro-social support for offenders in their communities for positive reinforcement of desired new behaviors.*<sup>61</sup>
8. **Measure relevant processes/practices.** An accurate and detailed documentation of case information and staff performance, along with a formal and valid mechanism for measuring outcomes, is the foundation of evidence-based practice. Quality control and program fidelity play a central and ongoing role to maximize service delivery. In a study at the Ohio DOC, programs that scored highest on program integrity measures reduced recidivism by 22 percent. Programs with low integrity increased recidivism.<sup>62</sup>

<sup>57</sup> Latessa, E.J. (no date). *From theory to practice: What works in reducing recidivism?* University of Cincinnati. Paper prepared for the Virginia Division of Criminal Justice Services. Available at <http://www.dcjs.virginia.gov/corrections/documents/theoryToPractice.pdf>.

<sup>58</sup> Excerpted from page 2, Latessa, E.J. (no date). *From theory to practice: What works in reducing recidivism?* University of Cincinnati. Paper prepared for the Virginia Division of Criminal Justice Services. Available at <http://www.dcjs.virginia.gov/corrections/documents/theoryToPractice.pdf>.

<sup>59</sup> Gendreau, P. and Goggin, C. (1995). *Principles of effective correctional programming with offender*. Unpublished manuscript, Center for Criminal Justice Studies and Department of Psychology, University of New Brunswick, New Brunswick.

<sup>60</sup> McGuire, J. (2001). "What works in correctional intervention? Evidence and practical implications," *Offender rehabilitation in practice: Implementing and evaluating effective program*; Higgins, S. T and Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions*. American Psychological Association.

<sup>61</sup> National Institute of Corrections, <http://nicic.org/ThePrinciplesofEffectiveInterventions>.

<sup>62</sup> Latessa, E. J. and Lowenkamp, C. (2006). What works in reducing recidivism? *University of St. Thomas Law Journal*, 521-535.

***In a study at the Ohio DOC, programs that scored highest on program integrity measures reduced recidivism by 22 percent. Programs with low integrity increased recidivism.***

9. **Provide measurement feedback.** Providing feedback builds accountability and maintains integrity, ultimately improving outcomes. Offenders need feedback on their behavior changes, and program staff need feedback on program integrity. It is important to reward positive behavior—of inmates succeeding in programs, and of staff delivering effective programming. Measurements that identify effective practices need, then, to be linked to resources, and resource decisions should be based on objective measurement.

### Implementing organizational change

Evidence-based principles provide a scientific basis for developing more effective services. Organizational development is required to successfully implement and maintain systemic change. Implementing evidence-based practices (EBP) require organizational administrators and leaders to redefine the organizational mission and develop explicit values that are consistent with the new direction. It is vital to expose staff to new ideas, and then to proactively build new knowledge and skills through a carefully planned training program. It is usually necessary to modify the infrastructure to support this new way of doing business—that is, a portion of the organization must be identified as having the authority and responsibility to move the new plan forward. Transforming organizational culture requires a consistent message from the organization leaders, followed by actions and resources that reinforce the message. The National Institute of Corrections offers technical assistance to correctional organizations to implement evidence-based policies and practices.<sup>63</sup>

NIC asked Ralph Serin, a respected researcher, to summarize this topic for correctional administrators. He makes a solid case for effective programming:

*Prison administrators then have two primary goals – safely operating their prisons and preparing inmates for safe release. Interestingly, these goals are empirically related in that poor institutional behavior is predictive of higher rates of post-release recidivism (French and Gendreau, 2003; Motiuk, 1991). Substantial published research across multiple countries and correctional agencies has also demonstrated that a primary method to reduce prison misconducts and recidivism is through effective correctional programming (Andrews, Zinger, Hoge, Bonta, Gendreau, and Cullen, 1990; French and Gendreau, 2003; Lösel, 1995; McGuire, 1995, 2002). This means that if prison administrators want to ensure safer institutions and communities, then they need to provide correctional programming opportunities consistent with evidence-based practice.<sup>64, 65</sup>*

***It is vital to expose staff to new ideas, and then to proactively build new knowledge and skills through a carefully planned training program.***

Cognitive-behavioral correctional programming reduces prison misconducts. French and Gendreau (2003) conducted a meta-analysis of 103 studies involving 21,000 inmates and found that correctional programs that met EBP criteria resulted in a 26 percent reduction in prison misconducts.

<sup>64</sup> French, S. & Gendreau, P. (2003). Safe and Humane Corrections Through Effective Treatment, Correctional Service of Canada, *Research Report 139*; Motiuk, L.L. (1991). *The Antecedents and Consequences of Prison Adjustment: A Systematic Assessment and Reassessment Approach*. Unpublished doctoral thesis. Ottawa: Carleton University, as cited in Serin, R. C. (2005). *Evidence-Based Practice: Principles for Enhancing Correctional Results in Prisons*, National Institute of Corrections, Washington, D.C.; Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, 28, 369-404; Lösel, F. (1995). The efficacy of correctional treatment: A review and synthesis of meta-evaluations. In J. McGuire (Ed.). *What Works: Reducing Reoffending. Guidelines from research and practice*. Chichester: Wiley; McGuire, J. (1995). *What Works: Reducing Re-offending. Guidelines from research and practice*. Chichester: Wiley; McGuire, J. (2002). Criminal sanctions versus psychologically-based interventions with offenders: a comparative empirical analysis. *Psychology, Crime and Law*, 8, 183-208.

<sup>65</sup> Serin, R. C. (2005). *Evidence-Based Practice: Principles for Enhancing Correctional Results in Prisons*, National Institute of Corrections, Washington, D.C. available at <http://nicic.org/Downloads/PDF/Library/021139.pdf>.

<sup>63</sup> For more information, contact NIC directly or explore their web site at NIC at <http://nicic.org/OrganizationalCommitment>.

***Transforming organizational culture requires a consistent message from the organization leaders, followed by actions and resources that reinforce the message.***

In some jurisdictions such as Canada, according to Serin, providing correctional programming to inmates is mandated by legislation and described in correctional policy. The primary goal of correctional programming is to reduce recidivism but there are other benefits for correctional agencies. These include:

- Population management (impacting the flow of inmates out)
- Institutional management (reducing rate and seriousness of institutional incidents)
- Increasing case-based knowledge for risk management (identifying factors for institutional and parole staff to monitor)
- Facilitating re-entry to the community (continuity of care)<sup>66</sup>

Serin summarizes the steps necessary to implement evidence-based programs:

- Systematic assessment of criminogenic needs and risk using standardized and validated procedures
- Address program design and implementation issues
- Consider staff selection & initial training
- Provide clinical supervision
- Develop standardized manuals
- Monitor service (doing what you say)
- Monitor change (is it working)
- Provide adequate dosage/ duration/ intensity of programming for the risk level of inmates
- Consider program intensity, sequencing, and dosage
- Monitor change and be dynamic to reflect change during incarceration or supervision
- Conduct evaluation to confirm effectiveness
- Provide ongoing staff training and professional development<sup>67</sup>

Florida's Department of Juvenile Justice recognizes the need for organizational change to implement effective interventions in corrections settings. It has tasked its executive staff with the responsibility for implementing a "quality improvement loop" that includes needs assessments, program design and implementation protocols, and program monitoring and evaluation to ensure management has the information necessary to implement periodic program adjustments that ensure "a safer Florida." Action plan tactics for this priority include:

- **Tactic 1:** Educate staff and stakeholders regarding the impact of implementation quality on outcomes and cost.
- **Tactic 2:** Develop and disseminate implementation guidelines and standards designed to ensure high quality treatment and services.
- **Tactic 3:** Provide advanced training for supervisory personnel, including monitoring tools.
- **Tactic 4:** Provide technical assistance and coaching services to programs that choose to implement evidence-based practices.
- **Tactic 5:** Provide a departmental quality assurance process that assesses implementation quality and treatment fidelity.
- **Tactic 6:** Target poorly performing programs for technical assistance, coaching or contract sanctions.<sup>68</sup>

In sum, many efforts are underway nationwide and resources, such as those offered by the National Institute of Corrections, may be available to assist in the organizational and cultural changes facing the California Department of Corrections and Rehabilitation as it moves forward its recidivism reduction initiatives.

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<sup>66</sup> Ibid, page 13.

<sup>67</sup> Ibid, page 14.

<sup>68</sup> Florida Department of Juvenile Justice Florida Comprehensive Accountability Report, accessed June 2007 at <http://www.djj.state.fl.us/OPA/2006car/1philosophy.pdf>.



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## Section two: The containment approach

### Introduction

#### CONTAINMENT APPROACH IN CALIFORNIA

Sex offender containment has been part of the statutory language in California for several years. In 2000, Assembly Bill 1300 was named the “Sex Offender Containment Act,” and provided mandatory parole for certain sex offenders along with intensive parole supervision.<sup>1</sup> In the declaration of the Act, the Legislature stated the following: “the containment approach emphasizes making the safety of the community and past sex crime victims a high priority, and calls for individualized case management of sex offenders that addresses the specific supervision, treatment, and controls needed to reintegrate them safely in the community.” More recently, Senate Bill 1128 was named the “Sex Offender Punishment, Control and Containment Act of 2006.”<sup>2</sup> In addition, in its August 15, 2006 report, the California High Risk Sex Offender Task Force recognized the “containment model” as an important component of a comprehensive plan to improve public safety.<sup>3</sup> Likewise, the High Risk Sex Offender and Sexually Violent Predator Task Force’s December 1, 2006 report recommends that the Department of Mental Health formally adopt a policy that commits to the containment model. Further, the California coalition on Sexual Offending (CCOSO) identified the containment approach in a April 15, 2001 position paper.<sup>4</sup>

This section focuses on the containment approach for two reasons: (1) this approach is widely recognized in California, and (2) the treatment program recommended in this document is grounded in the containment approach. This section begins with a full description of the containment approach. This is followed by a discussion of some common questions concerning the use of

the post-conviction polygraph examination. Finally, while the containment approach has not yet been subject to a comprehensive evaluation, the last part of this section will review relevant research from jurisdictions using the containment approach.

### The Containment Approach<sup>5</sup>

The Containment Approach, often referred to as the containment model or model process, is a very specific case management strategy imbedded in a five-part practice that was first documented by researchers following extensive field study in multiple states.<sup>6</sup> As recognized by the reports issued by the HRSO and HRSO/SVP Task Force, the containment approach operates in the context of multi-agency collaboration, explicit policies, and consistent practices that combine case evaluation and risk assessment, sex offender treatment, and intense community surveillance – all designed specifically to maximize public safety.

Five components were identified from comprehensive field research in dozens of jurisdictions across the country.<sup>7</sup> The containment approach consists of the following aspects:

1. A philosophy that values victim protection, public safety, and reparation for victims as the paramount objectives of sex offender management;
2. Implementation strategies that depend on agency coordination and multidisciplinary partnerships;
3. An individualized, case management and risk control approach to supervision and treatment;

<sup>5</sup> Parts of this discussion are excerpted with permission from: English, K. (2004). The Containment Approach to Managing Sex Offenders, *Seton Hall Law Review*, 34(4).

<sup>6</sup> English, K., Pullen, S., & Jones, L. (Eds.). (1996). *Managing adult sex offenders: A containment approach*. Lexington, KY: American Probation and Parole Association; English, K., Jones, L., Pasini-Hill, D., Patrick, D., and Cooley-Towell, S. (2000). *The value of polygraph testing in sex offender management*. Final research report submitted to the National Institute of Justice for grant number D97LBVX0034. Denver, CO; English, K. (1998). The containment approach: An aggressive strategy for the community management of adult sex offenders. *Psychology, Public Policy, and Law*, 4, 218-235; English, K., Jones, L., and Patrick, D. (2003). Risk management of adult sex offenders. In B. Winick and J. LaFond (Eds.), *Sexually Violent Offenders: Law and Policy in North America*, American Psychological Association, Hyattsville, MD; English, K., Jones, L., Patrick, D., and Pasini-Hill, D. (2003); Sex Offender Containment: Use of the Post-Conviction Polygraph. In R. A. Prentky, E. Janus, & M. Seto (Eds.), *Sexually Coercive Behavior: Understanding and Management*. New York: New York Academy of Sciences.

<sup>7</sup> Much of this research was funded by the National Institute of Justice, U.S. Department of Justice. The findings reported here represent the views of the authors and not the Department of Justice.

<sup>1</sup> Assembly Bill 1300 (2000), Chapter 142, amending Sections 3000 and 3000.1 of, to add and repeal Article 1.5 (commencing with Section 3005) Chapter 8 of Title 1 of Part 3 of, the state Penal Code.

<sup>2</sup> Senate Bill 1128, Chapter 337, Statutes of 2006.

<sup>3</sup> California High Risk Sex Offender Task Force. August 15, 2006. *Report to the Governor and the Legislature*. Author.

<sup>4</sup> California Coalition on Sexual Offending. (2001). *Effective Management of Sex Offenders Residing in Open Communities*. Available at <http://www.ccoso.org/papers/containment.html>.



4. Consistent multi-agency policies and protocols; and
5. Quality control mechanisms, including program monitoring and evaluation.

#### VICTIM-CENTERED PHILOSOPHY

“What’s best for the victim and the community?” This question lies at the crux of the containment approach. This aspect is based on an explicit philosophy that defines victim protection and community safety as primary objectives of sex offender management. Research on the effects of sexual assault on victims confirms that the consequences of this crime are often brutal and long-lasting (see Wyatt and Powell, 1988).<sup>8</sup> Because most sexual assaults occur in the context of a relationship established and manipulated over time, the victim is often confused and made by the perpetrator to feel responsible. Experts on sexual abuse explain that this violation of a trusting relationship causes great confusion and nearly unbearable trauma to the victim (Herman, 1992). Summit (1988:55) points to the psychological damage inherent in the full range of sexually abusive behaviors when he emphasizes not just rape but touching: “Sexual touching, so often trivialized by words such as fondling or molestation (annoyance), is only the physical expression of a climate of invasion, isolation and abandonment.” A victim-centered philosophy, then, assumes that every sexual assault, from a violent stranger-rape to voyeurism by a family member, represents a significant act resulting in fear and a sense of betrayal. The victim’s need for safety and empowerment thus becomes a priority in the management of the offender’s case.

If the societal or criminal justice system response to an attack is to place the victim at fault, the trauma is magnified and recovery may be delayed (Hindman, 1988). Explaining that sexual abuse is a complex process rather than an act or series of acts, Finkelhor (1988:77-78) notes, “Clinicians have often observed that the harm of some sexual abuse experiences lies less in the actual sexual contact than in the process of disclosure or even in the process of intervention.” Understanding this point is vital for professionals interested in implementing the containment approach. The power and authority of police

officers, lawyers, judges, and social workers can weigh as heavily on the victim as on the perpetrator.

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For example, even well intentioned community notification laws may have a devastating effect on the victim if the perpetrator is a family member. Recognizing this, an Oregon statute explicitly directed probation and parole officers to develop and implement the notification plan on a case-by-case basis to guard against re-victimization of family members. This process required the officer understand the full impact of notification and other policies on the victims of sex crimes. In an effective containment approach, the healthy recovery of the victim and the well-being of the community guide policy development, program implementation, and the actions of professionals working with both sexual assault victims and perpetrators.

***New information about the offender’s risk to reoffend is revealed in the first months and years of supervision, so intervention strategies and policies must encourage an elastic response to risk.***

Adopting a victim-centered philosophy sometimes requires a significant shift in management values, as every case management decision will require considering the risk the offender presents to past and potential victims. Probation and parole agencies may be challenged to dissolve usual job and agency boundaries so that risk management decisions can be made quickly and in an

<sup>8</sup> Sexual assault victims, compared to non-rape victims, are at significantly higher risk to abuse alcohol and drugs, to suffer from depression, anxiety, nightmares and social isolation, and to attempt suicide.

ongoing fashion. New information about the offender's risk to reoffend is revealed in the first months and years of supervision, so intervention strategies and policies must encourage an elastic response to risk. Although most sex offenders do not have an extensive arrest or conviction record, research indicates that many sex offenders have a long history of hurting many types of victims (Ahlmeyer, et al., 2000).<sup>9</sup> The lack of officially recorded contacts with the criminal justice system can cloud risk assessments conducted with actuarial scales since these usually depend on past (documented) criminal history to predict future criminal behavior.

#### MULTI-DISCIPLINARY COLLABORATION

The containment model for managing sex offenders in the community calls for the creation of intra-agency, interagency, and interdisciplinary teams. These teams can overcome the fragmentation that usually results from the multi-layered nature of the criminal justice system. These teams are valuable for several reasons:

- They vastly improve communication among the agencies involved;
- They allow for quicker and less intrusive responses to victims (Epstein and Langenbahn, 1994);<sup>10</sup>
- They promote the exchange of expertise and ideas;
- They facilitate the sharing of information about specific cases;
- They increase team members' understanding of what everyone on the team needs to do his/her job well; and
- Perhaps most importantly, they foster a unified and comprehensive approach to the management of sex offenders.<sup>11</sup>

Collaborating agencies include sex offender treatment programs, law enforcement, probation, parole, schools, social services, rape crisis centers, hospitals, prisons, polygraph examiners, researchers and victim advocate organizations. In a call to collaborate across disciplines and within communities for the purpose of addressing

the epidemic of sexual assault, the American Medical Association (1995) added the following to the list above: attorneys, emergency room staff, universities, and victim's assistance centers.

Interagency and multi-disciplinary collaboration can occur in many ways. In Colorado, for example, a state-level Sex Offender Management Board with multi-disciplinary membership is defined in legislation and meets monthly. The Board has issued guidelines for the evaluation, treatment, and behavioral monitoring of adult sex offenders, including sex offenders with developmental disabilities. It also developed release criteria for sex offenders serving lifetime probation or parole sentences, a sentencing strategy undertaken in lieu of civil commitment. In Oregon, a quarterly meeting is held for all the probation and parole officers from across the state who specialize in the supervision of adult sex offenders. In Ohio, a parole officer took it upon herself to meet her colleagues working in the local police department's sex crime unit, and they subsequently worked together to solve cases. The California Coalition on Sexual Offending is another example of a well coordinated effort to provide state-of-the-art information and clinical expertise to its membership and state policy makers. California's newly mandated state Sex Offender Management Board will serve as an expert policy forum that will promote best practices consistently implemented across many local jurisdictions.

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<sup>9</sup> Ahlmeyer, S., Heil, P., McKee, B. and English, K. (2000). The impact of polygraphy on admissions of victims and offenses in adult sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 12, 123-138.

<sup>10</sup> Epstein, J., & Langenbahn, S. (1994). *The Criminal Justice System and Community Response to Rape*. Washington DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

<sup>11</sup> English, Pullen and Jones (1996).

It is important to remember, however, that frequently, line staff initially forges these types of relationships, with one committed professional seeking out the expertise of another. Regular meetings and communication ensue. These small acts of collaboration are changing the way this work gets done in many jurisdictions across the country. Since the

***In the end, the day-to-day management of sex offenders rests with therapists and supervising officers who communicate and collaborate in the containment of each offender. This multidisciplinary collaboration is at the core of public safety; it requires and deserves significant support from policy makers and the public.***

management of sex offenders has become so high-profile, these small but vital acts of collaboration are often overshadowed by broad scale policy directives such as Jessica's Law. But, in the end, the day-to-day management of sex offenders rests with therapists and supervising officers who communicate and collaborate in the containment of each offender. This multidisciplinary collaboration is at the core of public safety; it requires and deserves significant support from policy makers and the public.

#### CONTAINMENT-FOCUSED RISK MANAGEMENT

Case processing and case management in a containment approach must be tailored to the individual sex offender and his or her deviant sexual history. The approach depends on obtaining and sharing key pieces of information about the abuser. Professionals must be prepared to consistently respond to that information in order to minimize the offender's access to victims and high-risk situations. Most jurisdictions consider community supervision to be a privilege, and a condition of this privilege in the context of sex offender containment is the offender's waiver of confidentiality. The waiver allows the sharing of important information about risk and treatment progress (or lack thereof) with the judge, probation and parole

***To manage risk effectively, the team needs to know much more: information about the offender's preferred victim types, sexual assault history (including age of onset), the frequency and extent of deviant sexual arousal and behaviors, and events, behaviors or emotional states that are precursors to reoffense.***

officer, offender, and family members or significant others (sometimes including the victim's therapist).

When a sex offender first begins to serve a sentence of probation, prison or parole, sources of information about the offender are usually limited to police reports, the pre-sentence investigation, sometimes a psychosexual evaluation or risk assessment, and some criminal history information.<sup>12</sup> To manage risk effectively, the team needs to know much more: information about the offender's preferred victim types, sexual assault history (including age of onset), the frequency and extent of deviant sexual arousal and behaviors, and events, behaviors or emotional states that are precursors to reoffense. Most offenders have more victims, more types of victims, and committed more sex crimes than the crime of conviction and the offender's self-report would suggest.

***Crucial information about a sex offender's modus operandi will be obtained though sex offense-specific treatment, validated and expanded by post-conviction polygraph examinations performed by specially trained examiners. Like urinalysis testing with drug offenders, the polygraph examination is a tool to gauge an offender's progress and compliance with treatment and supervision expectations.***

Additional crucial information about a sex offender's *modus operandi* will be obtained though sex offense-specific treatment, validated and expanded by post-conviction polygraph examinations performed by specially trained examiners. Like urinalysis testing with drug offenders, the polygraph examination is a tool to gauge an offender's progress and compliance with treatment and supervision expectations. Many offenders report a lengthy existence of secretive assaultive behaviors, and the use of the post-conviction polygraph exam assists

<sup>12</sup> Information on parolees may be even less available, if the conviction records and prison records do not accompany the offender's release onto parole. When offenders are released on parole, information on prison treatment and behavior, as well as information on the crime of conviction, must accompany the offender's movement into the community.

them in making the transition to honesty.<sup>13</sup> Its use should be officially required by criminal justice system (in the form of treatment and supervision conditions) whose representatives can issue consequences for noncooperation.

The key to the MO is the requirement that the offender discloses the details of a lifetime of sexual obsessions and abuse history. Early in the treatment process, the offender will be assigned the job of writing a sex history log detailing all sexual activity, consenting and non-consenting, a description of the victim (age, gender, relationship to offender), and the circumstances surrounding the assault. In this exercise, the offender reveals the lifestyle he or she has carefully designed to deceive others and promote deviant sexual activity, including methods of victim selection and efforts to keep the abuse a secret. The information is verified using a polygraph examination, and deceptive findings on the exam lead to a variety of consequences for the offender, most commonly payment for a subsequent examination. This information, not readily disclosed by the perpetrator, will be used to manage current and future risk and also to assure that the offender receives treatment that is appropriately directed at real patterns of behavior.

There are three anchors in containment focused risk management: 1) supervision, 2) therapy and 3) polygraph examinations. Each benefits from the distinct function of the others. “The criminal justice supervision activity is informed and improved by the information obtained in sex-offender-specific therapy, and therapy is informed and improved by the information obtained during well-conducted post-conviction polygraph examinations” (English, 1998:225). The offender must perceive each as separate anchors yet aligned with the other. Each of these three components is discussed below:

1. **Criminal justice supervision.** First and foremost, sexual assault is a crime that gives the criminal justice system jurisdiction over convicted sex offenders. The entire team is empowered primarily by the authority of the criminal justice system, which can exercise its containment powers in a number of ways, including: specialized terms and conditions for supervision, lengthy probation and parole sentences, restrictions on high-risk behaviors, restrictions on contact with children,

random home visits, urinalysis testing, electronic monitoring, and verified law enforcement registration.

The criminal justice system can also invoke consequences against the offender for non-participation in treatment, violation of supervision conditions, and/or behaviors that represents a risk to any potential victim. Consequences for failure to follow the directives of treatment and supervision can take a variety of forms. At a minimum, surveillance can be increased (house arrest, electronic monitoring, additional home visits by the supervising officer, requirements to phone the officer or others with location information, for example) and orders for additional treatment sessions (with a corresponding increase in treatment fees assessed against the offender) can be imposed. Intermediate sanctions include community service activities, short-term jail sentences, or placement in a halfway house for sex offenders. At the extreme end of the sanction continuum is revocation of the community sentence and placement in prison.<sup>14</sup> The anticipation of these potential consequences provides incentives for an offender to participate actively in treatment, obtain regular polygraph examinations, and comply with conditions of supervision.

***Not surprisingly, sanctions must be invoked immediately to encourage compliance. Many treatment providers and polygraph examiners have reported that without the leverage of the criminal justice system’s consequences for non-compliance, they could not work with sex offenders.***

Not surprisingly, sanctions must be invoked immediately to encourage compliance. Many treatment providers and polygraph examiners have reported that without the leverage of the criminal justice system’s consequences for noncompliance, they could not work with sex offenders. Change is difficult. When the offender engages in a long-term process to change a lifetime of behaviors and fantasies that have been

<sup>13</sup> English, K., and Heil, P. (2006). The need for complete information leads to the polygraph examination. In A. Schlank (Ed.), *The Sexual Predator, Vol. III*. Kingston, NJ: Civic Research Institute.

<sup>14</sup> Prison sentences are not the end of risk management concerns. Most prisoners eventually are released into the community, and prison treatment can enhance community safety when the offender is released.



self-gratifying and exciting, we expect this effort to ebb at times. The dangerousness presented by an offender's inconsistent effort to change is obvious, and is intolerable in terms of public safety. The availability of a variety of consequences invoked quickly, then, is a vital and ongoing aspect of risk management. Without consistent pressure on the offender to adhere to the behavioral expectations detailed in the conditions of supervision and treatment contract, community safety must depend on the offender's good will. According to trauma expert Dr. Judith Herman of Harvard (1992:188), "Vigorous enforcement of existing criminal laws prohibiting sexual assault might be expected to have some preventive effect since both the compulsive and opportunistic offenders are keenly sensitive to external controls."<sup>15</sup> Vigorous enforcement translates into supervision and surveillance strategies that are customized to each offender's individual assault patterns. Once these patterns are known, the officer can design specific restrictions in terms of employment (e.g. working around children), limit leisure time activities (e.g. cruising the streets in an automobile), monitor the offender's telephone bills for use of 900 numbers;<sup>16</sup> restrict the offender's use of alcohol and drugs; and/or confiscate items used to entice children (toys and video games, kittens or puppies) or stimulate deviant fantasies.

Pithers' (1990:334)<sup>17</sup> description of the assault pattern is a reminder of the need to be alert to what may, at first, appear to be accidental or occasional victim access: "Many aggressors, seeking to minimize their responsibility for offenses, would also have us believe their behaviors are the product of irresistible impulses overwhelming their self-control....In reality, many offenders carefully plan offenses so that they appear to occur without forethought." Hudson, Ward and McCormack (1999:179)<sup>18</sup> stated that

"[M]uch of the optimism that has pervaded the treatment of sexual offenders in the last 15 years has come from the notion that the processes that these men follow are comprehensible and, therefore, under ideal circumstances, at least controllable." To this end, they describe three potential types of planning in the "seduction process" (page 783): covert planning, explicit planning, and chance contact.

This very attention to planning increases the likelihood of detection once case managers have complete information about the offender. Equipped with such information, the criminal justice agent is well positioned to identify precursor behaviors that can be managed by applying appropriate restrictions.

***The intensity of supervision required of the probation or parole officer is significant, and collaboration with other professionals takes time and care. Case-specific supervision requires planning, documentation, and on-site meetings with the offender at home and work.***

The intensity of supervision required of the probation or parole officer is significant, and collaboration with other professionals takes time and care. Case-specific supervision requires planning, documentation, and on-site meetings with the offender at home and work. Often, safety considerations require that fieldwork be conducted in teams of two officers. Ongoing training is also necessary to keep professionals at the top of their game. Probation and parole officers should have caseloads limited to 20 or 25 sex offenders, and they should have flexibility in work hours to monitor the offender's activities at night and on weekends. Halfway houses with 24-hour monitoring of the facility and the offender's location should be available in all jurisdictions so that a safe residential option is available to criminal justice officials managing these cases. Criminal justice policymakers must explore the reallocation of resources if they intend to take the leadership role necessary to implement a containment approach.

<sup>15</sup> Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.

<sup>16</sup> Sometimes sex offenders generate telephone bills in the thousands of dollars by using 900 numbers. While this is not a crime, for sexual abusers, compulsive phone calls represents out-of-control behavior, a likely prelude to more dangerous acts. Also, the additional financial burden creates a level of stress that may seduce the offender into psychologically escaping into an assaultive fantasy—the first step in the next assault.

<sup>17</sup> Pithers, W.D. (1990). Relapse prevention with sexual aggressors: A method for maintaining therapeutic gain and enhancing external supervision. In W.L. Marshall, D.R. Laws, & H.E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theories, and treatment of the offender*. New York: Plenum Press.

<sup>18</sup> Hudson, S.M., Ward, T. and McCormack. (1999). Offense Pathways in Sexual Offenders. *Journal of Interpersonal Violence*, 14(8), 779-798.

2. **Sex offense-specific treatment.** Sex offender treatment targets the thoughts, feelings, denial, minimizations, motivations, justifications, and lifelong behaviors and thought patterns that are, in fact, fused to the sexual assault itself. The supervising officer works closely with the treatment provider to learn the offender's long-term patterns that *precede* actual assaults. This vital information, necessary for risk management, but historically outside the scope of criminal justice system intervention, is the stuff of therapy.

Sex-offense-specific treatment of offenders differs from traditional therapy in a number of important aspects.<sup>19</sup> First, in sex-offense-specific treatment, the therapist best cares for the client by not accepting the client's description of his or her sexual past as complete or even true. In addition, the therapist's primary commitment is to the community at large; public safety is paramount.<sup>20</sup> The focus of treatment is on assaultive behavior that harms others: substance abuse, the offender's abusive childhood, and the feelings the offender has toward therapy are secondary (although still important) concerns that the therapist must manage. The offender's manipulation and rationalizations that precede the assault are considered part of the crime, not an explanation for the assault. Treatment providers help the offender to disclose the full extent of his or her deviant sexual history. Holding on to these powerful secrets is not therapeutic and, if allowed by the therapist, may perpetuate the secrecy at the core of the offender's lifestyle.

Sex offense-specific treatment occurs primarily in group therapy settings. Working in a group, therapists are less likely to succumb to the subtle manipulations that offenders have perfected over a lifetime. A group of offenders, coached by the therapist, can often recognize and confront others' familiar manipulations. Descriptions of cognitive distortions and psychological defense mechanisms, the step-by-step sexual assault cycle that clients use to set up opportunities to assault

victims, and the development of a concrete prevention plan are the material of treatment.

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One essential role of treatment in the containment approach is to obtain the details needed by criminal justice officials to develop risk management plans as well as to assist sex offenders in developing internal controls over their offending behaviors. Offenders are expected to assume full responsibility for the damage they inflict and to take measures to prevent future abusive behaviors. The threat of criminal justice consequences helps motivate these non-voluntary clients to engage fully in treatment.

3. **Post-conviction polygraphs.** The post-conviction polygraph examination is the third element of the containment strategy. The polygraph examination strengthens sex offender treatment and supervision by verifying the accuracy and completeness of self-reported sexual history information gained in treatment and by periodically monitoring the offender's compliance with criminal justice and treatment conditions. It is important to select an examiner who specializes in this type of exam. This use of the polygraph, while non-traditional, is not uncommon. Our 1998 telephone survey of a nationally representative sample of more than six hundred probation and parole supervisors across the nation found that the post-conviction polygraph was used in jurisdictions in 30 states.

Sex offense-specific treatment, criminal justice supervision, and post-conviction polygraphs have a synergistic effect on each other. The threat of the polygraph increases the scope and accuracy of the sexual history information obtained by the treatment provider. Conversely, the polygraph examiner uses the information obtained in treatment and supervision

<sup>19</sup> In fact, many sex offender treatment professionals do not refer to this intervention as *therapy*, since it differs significantly from what they were taught in graduate school. Rather, it is typically referred to simply as sex offense-specific treatment.

<sup>20</sup> "Public safety is paramount" is one of a dozen guiding principals that introduce the *Colorado Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders*. This publication is available from the Colorado Division of Criminal Justice, 700 Kipling, Denver, Colorado, 80215.

to design test questions that verify the accuracy of the information. The criminal justice supervisor uses this information to manage risk and the therapist uses the information to design a meaningful treatment plan that is informed by the full scope and variety of the offender's sexual deviancy.

***Sex offense-specific treatment, criminal justice supervision, and post-conviction polygraphs have a synergistic effect on each other. The criminal justice supervisor uses this information to manage risk and the therapist uses the information to design a meaningful treatment plan that is informed by the full scope and variety of the offender's sexual deviancy.***

Studies of sex offenders' self-reports of sex crimes reveal that most offenders have engaged in a considerable number of lifetime sexual assaults. Abel and his colleagues<sup>21</sup> studied 561 men seeking voluntary treatment. The researchers found the ratio of arrest to self-reported (anonymous) sex crime was approximately 1:30 for those who engaged in rape and child molesting, and 1:150 for exhibitionists and voyeurism. Further, Abel et al., (1998) also found that exhibitionists were highly likely to engage in additional sexually assaultive behaviors: "46 percent reported nonfamilial female pedophilia, 22 percent reported male nonincestuous pedophilia, 22 percent reported female incestuous pedophilia and 25 percent reported rape" (Abel et al, 1988:163). A more recent study of 180 convicted adult sex offenders' self-reports of sex crimes obtained in conjunction with the polygraph examination found the following:<sup>22</sup>

- 56.5 percent of the 23 offenders who assaulted boys ages five and younger also assaulted girls in the same age category and 26.0 percent of this group reported assaulting adult women.
- 64.3 percent of 28 offenders who disclosed assaulting boys 6 to 9 years of age reported assaulting girls in the same age category; 39.3 percent reported assaulting adult women.
- 80 cases were convicted of incest but 104 admitted family victims. Of the 104, 34.8 percent self-reported assaulting strangers and 56.7 percent said they also had victimized another from "a position of trust." Two-thirds (64.4 percent) disclosed assaulting victims outside the family.

The point here is not that many sex offenders "cross-over" from one category of victim to another, since this phenomenon has been understood for many years. Rather, the assault history of each offender must be understood so that the duration, frequency, and variety of dangerous behavior is fully known by those who intend to provide treatment and supervision. Studies of cohorts of sex offenders can be used by those without the benefit of the polygraph examination to generalize the possibility for crossover. For example, among the incest perpetrators discussed above, two-thirds reported assaulting victims outside the family. For professionals managing incest perpetrators, this is a reasonable generalization. Since only one-third of the offenders in the English et al. (2003) study were found non-deceptive on the polygraph exam, it is likely that the extent of crossover found in that sample remains an underestimate.

***The assault history of each offender must be understood so that the duration, frequency, and variety of dangerous behavior is fully known by those who intend to provide treatment and supervision.***

The polygraph must be used in conjunction with sex offense-specific treatment. These two components, acting together and consistently supported by criminal justice supervision and consequences for noncompliance, provide a powerful incentive for an

<sup>21</sup> Abel, G., Becker, J., Cunningham-Rathner, J., Mittelman, M., & Rouleau, J. (1988). Multiple paraphilic diagnoses among sex offenders. *Bulletin of the American Academy of Psychiatry and the Law*, 15(2): 153-168; Abel, G., Becker, J., Mittelman, M., Cunningham-Rathner, J., Rouleau, J., & Murphy, W. (1987). Self-reported sex crimes of non-incarcerated paraphiliacs. *Journal of Interpersonal Violence* 2(1). Abel, G., Becker, J., Mittelman, M., Cunningham-Rathner, J., Rouleau, J., & Murphy, W. (1987). Self-reported sex crimes of nonincarcerated paraphiliacs. *Journal of Interpersonal Violence* 2(1).

<sup>22</sup> English, K., Jones, L., Patrick, D., and Pasini-Hill, D. (2003). Sex Offender Containment: Use of the Post-Conviction Polygraph (with. In R. A. Prentky, E. Janus, & M. Seto (Eds.), *Sexually Coercive Behavior: Understanding and Management*. New York: New York Academy of Sciences.

offender to be truthful and to refrain from behavior for which he or she will likely be caught. Without the use of the polygraph examination process, the information necessary to manage the risk of offenders is incomplete, and the offender's risk to the community remains uncertain.

The use of the post conviction polygraph is best described as a process because it requires the collaborative efforts of the examiner, the therapist, and the criminal justice supervisor. The examiner must understand the case and be prepared for the test by conferring with the therapist and the case manager. The examiner remains completely neutral, that is, with no vested interest in the outcome of the exam. This role differs from the other two professionals in the team. The therapist may hope that the offender has revealed all during group treatment, and the supervising officer may be continually suspicious. The polygraph examiner focuses on the technical and physiological requirements of the exam itself, the threats to validity, careful construction of questions, a methodical execution of the pretest (where every question is reviewed with the offender), the test itself (measuring heart rate, blood pressure, respiration, and perspiration), and the post-test (review of test results with the offender). Communication among the supervising officer, the treatment provider and the polygraph examiner is absolutely key to the successful implementation of this management tool. Lack of communication, or too much focus on "passing the polygraph" rather than being honest and trustworthy, will eventually undermine the use of the this containment strategy.

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## INFORMED AND CONSISTENT PUBLIC POLICIES

The fourth component of a sex offender containment approach requires local criminal justice practitioners to develop public policies at all levels of government that institutionalize and codify the containment approach. These policies should be based on research, should hold offenders accountable and, to be effectively implemented in the field, must empower those who work closely with these cases. Policies must define and structure the discretion authorities need to manage each offender individually. Criminal justice practitioners must also codify local and agreed-upon practices that support a victim-oriented approach to sex offender risk management. According to English, et al., (1996), written guidelines for the uniform processing of sex assault cases should include, at a minimum, the following:

- The acceptance or rejection of plea agreements in cases of sexual assault;
- The weight given in sentencing to an offender's denial of the crime;
- The use of polygraph information;
- Family reunification assessment protocols;
- Presentence investigation report information;
- Failure to progress in treatment;
- Revocation procedures;
- Third party liability/duty to warn potential victims;
- Employment restrictions for sex offenders under criminal justice supervision;
- Length of community supervision (i.e., lifetime).

Two important reasons for clearly stating policies include (1) the offender deserves to know what is expected of him or her and what to expect from the criminal justice/mental health system, and these clear expectations will help keep the focus on the offender "working his program" rather than complaining about the system, and (2) some policies undermine sex offender containment and minimize the seriousness of the crime. Policies that undermine sex offender containment include allowing plea bargains to lesser charges, to non-sex crimes, or to misdemeanor sex crimes *when the evidence exists to fully prosecute the case*. Lowering the charge, granting diversion, or issuing a deferred judgment at best facilitates the minimization of the case to the offender ("it wasn't that bad, I won't do it again") and the victim ("I'm not important to the court")



and, at worse, eliminates the sexual assault history in the official record. Prosecutors and judges who specialize in sex crimes and receive regular training from national entities understand the power of therapeutic jurisprudence. Aiding in the minimization process will ultimately make it harder for the offender to begin and sustain the lifelong changes required to ensure public safety, and it can add to the victim's distress.

***The goal is to go the “extra mile” to obtain detailed information from the offender since sex crimes occur in secret and few victims report the crime.***

Clear, consistent, and documented agreements on sex offender policies, combined with the cooperation of agencies responsible for managing sex offenders, then, are essential to enable the containment process outlined here to proceed. Written procedures and protocols should describe how and when team interactions occur. The range of activities that require such documentation is quite large, but primary among them is the need for open communication and information sharing at all stages of the process of managing sex offenders in the community.

#### QUALITY CONTROL

The containment approach requires broad discretion on the part of the criminal justice system professionals, treatment providers, polygraph examiners, and others collaborating to protect public safety. This discretion allows for quick responses to the ongoing assessment of risk and progress, and it recognizes that these cases often involve complicated relationships between the perpetrator and the victim. Such discretion must be systematically monitored to ensure fairness and justice. For this reason, quality control is fundamental to the administration of any sex offender management program, project, or system-wide process. Quality control activities should include, at a minimum:

- Monthly, multi-agency case review meetings to ensure that prescribed policies and practices are implemented as planned;
- The requirement of annual training on the topics of sexual assault, conflict resolution, teaming, victimization,

trauma, family reunification, treatment efficacy, and research related to each of these;

- Policies and practices that recognize the impact of working with this population so professionals are encouraged to change jobs if necessary, job share, take vacations, and otherwise maintain a healthy lifestyle;
- Developing and tracking performance measures associated with the policies and procedures specified in the jurisdiction;
- Videotaping of all polygraph examinations to avoid recanted statements and to facilitate periodic review of examinations (including chart reviews) by a quality control team, and
- The collection of case data describing the characteristics of offenders who fail in treatment or commit new sex crimes so gaps in containment can be identified and closed.

Sexual abuse cases are difficult to manage, and offenders attempt to manipulate the management system just as they did their victim(s). Containment professionals can burn out, get soft, miss “red flags,” become cynical, and otherwise become ineffective. Empathy toward victims and repeated exposure to traumatic material can also result in *compassion fatigue*.<sup>23</sup> Police, firefighters, and other emergency workers report that they are most vulnerable to compassion fatigue when dealing with the pain of children.<sup>24</sup> In addition, “trauma is contagious” (Herman, 1992:380).<sup>25</sup> Compassion fatigue, a near certainty in this work, presents a significant threat to the quality of the program, and the well-being of the dedicated professionals who are working to make our world safer.

Working together as a team is the first line of defense against this common phenomenon. Honest communication among team members is the first step in developing a continuum of quality control mechanisms. The next step is a process that brings together agency administrators

<sup>23</sup> Figley, C.R. (Ed.) (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel; Figley, C.R. (Ed.). (1985). *Trauma and its Wake*. New York: Brunner/Mazel; Stamm, B.H. (Ed.). (1995). *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators*, Sidran Press, Lutherville, Maryland.

<sup>24</sup> Beaton, R. and Murphy, S.A. (1995). Working people in crisis: Research implications. In C.R. Figley (Ed.), *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner/Mazel.

<sup>25</sup> Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377-391.

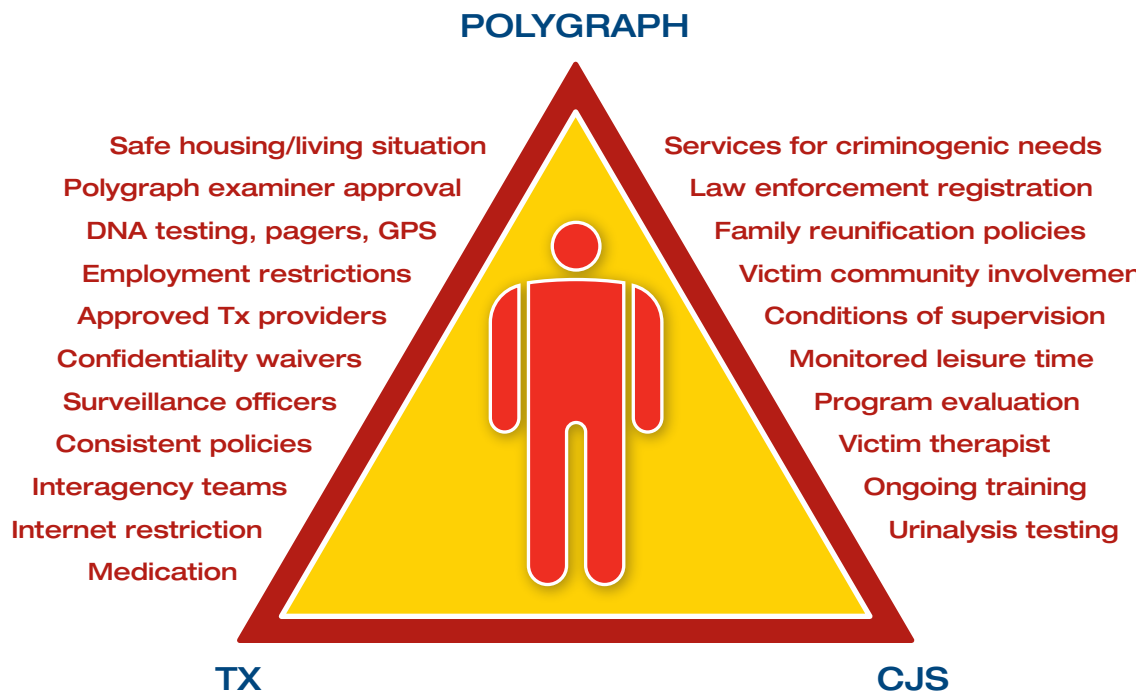
who actively support the protocols and stand behind the staff that enforce the protocols and make difficult decisions in the field. Ongoing training, flexible hours, a supportive environment, and safe working conditions are important ways that administrators can help fight compassion fatigue.

A final aspect of quality control consists of clearly defined and agreed-upon measures of success. It is challenging to identify measures of detection, detention, and revocation that target offenders *before* the commission of a new assault. Addressing these issues requires the allocation of resources for monitoring and evaluation. Indeed, resource allocation is a key component of quality control.

## CONCLUSION

The five-part containment model process for managing adult sex offenders summarized here establishes a framework within which agencies and communities can develop specific practices to promote public safety and victim protection. Just as the containment triangle itself must be tailored to the individual characteristics of the sex offender, so should the method of implementing this model process vary based on the context and needs of each community.

Figure 2.1. The containment triangle



Since polygraph testing tends to increase disclosures of sex crimes,<sup>31</sup> the CDCR should structure testing procedures with these court decisions in mind. Increased disclosures could increase the offender's chance of being determined a Sexually Violent Predator and civilly committed, increasing the period of incarceration unless some agreements can be worked out with the Department of Mental Health. On the other hand, progress in treatment, including a non-deceptive sexual history polygraph, might be a mitigating factor that reduces an offender's chance of being designated a SVP. The SVP decision in Wisconsin, for example, includes consideration of the inmate's actuarial risk level and whether the inmate completed prison treatment, which includes polygraph testing.

The use of information disclosed in the course of treatment for SVP consideration would, of course, be a serious disincentive to prison treatment participation. Clarifying how this information will be used outside of the treatment setting is critical to ensuring the program will not fail for lack of participation. CDCR might explore whether SVP determinations could be strictly based on official record data rather than treatment record data. Otherwise, offenders participating and progressing in treatment will have a higher probability of being civilly committed when, in fact, they would be complying with prison treatment expectations.

***The use of information disclosed in the course of treatment for California SVP consideration would, of course, be a serious disincentive to prison treatment participation. Clarifying how this information will be used outside of the treatment setting is critical to ensuring the CDCR program will not fail for lack of participation.***

## ACCURACY

The polygraph detects anxiety that, theoretically, is associated with fear of detection. The computer algorithm used to establish deception parameters in polygraph software, developed by Johns Hopkins University, gives more than 50 percent of the score's weight to sweating on the fingertips. Langleben at the University of Pennsylvania has been studying lying since 2000 using data generated from a functional-MRI scanner and has found that the sweat response is consistent with deception-generated changes in the back parietal cortex, providing the first empirically-based link to polygraph theory.<sup>32</sup>

***If an offender scores deceptive on a multiple issue test, there should be a follow-up exam. The focus of the follow-up test should be narrowed to the single issue of most concern. This second single-issue test will have a higher accuracy rate. Having greater specificity, the single-issue test can better distinguish the true positives from the false positives.***

According to the National Research Council (NRC),<sup>33</sup> the most researched and accurate type of polygraph test has a single-incident focus, that is, the test is limited to one specific event. The NCR identified the median accuracy rate of this test at 89 percent. However, a post-conviction polygraph test of a sex offender is rarely limited to one specific incident. Instead, it usually involves three or four questions addressing behavior within a specified time frame. This is a multiple issue test.

Such a multiple issue test is considered less accurate than a single issue exam and is somewhat comparable to an employment "screening test" although these tests are less focused than post-conviction exams. The average accuracy rate for a well-executed screening test is 80 percent (Krapohl, Senter, and Stern, 2005). However, the overall accuracy of polygraph testing can be increased by applying

<sup>31</sup> Heil, P., Ahlmeyer, S., & Simons, D. (2003). Crossover sexual offense. *Sexual Abuse: A Journal of Research and Treatment*, 15(4), 221-236; English, K., Jones, L., Patrick D., and Pasini-Hill, D. (2003); Sexual offender containment: use of the postconviction polygraph. In R. A. Prentky, E. Janus, & M. Seto (Eds.), *Sexually Coercive Behavior: Understanding and Management*. New York: New York Academy of Sciences; Ahlmeyer, S., Heil, P., McKee, B. & English, K. (2000). The impact of polygraphy on admissions of victims and offenses of adult sex offenses. *Sexual Abuse: A Journal of Research and Treatment* 12,123-138.

<sup>32</sup> Henig, R. M. "Looking for the Lie." *The New York Times Magazine*, February 6, 2006.

<sup>33</sup> National Academy of Sciences (2003). *The polygraph and lie detection*. Washington, D.C.: National Academies Press.

## The post-conviction polygraph examination of sex offenders

Many sex offenders have a propensity to engage in secretive and manipulative behaviors. Often, these behaviors are essential aspects of the sexually abusive lifestyles that facilitate the commission of sex crimes. The polygraph examination is a useful tool for sex offender management professionals seeking to provide appropriate treatment for clients with secretive and manipulative behaviors.

***The most controversial aspect of the containment approach is the use of the post-conviction polygraph exam conducted by examiners who are specially trained.***

The most controversial aspect of the containment approach is the use of the post-conviction polygraph exam conducted by examiners who are specially trained. It was the subject of a National Institute of Justice research study<sup>26</sup> and certainly many court cases.<sup>27</sup> Two common concerns – self-incrimination and accuracy – are important to understanding how the polygraph is used in sex offender management. These are discussed below.

### SELF-INCRIMINATION

Legal scholars Winick and La Fond (2003), concerned about Fifth Amendment guarantees against self-incrimination, refer to *Minnesota v. Murphy* (1984)<sup>28</sup> in which the U.S. Supreme Court upheld the use of the power of the state to compel answers to incriminating questions without violating an individual's Fifth Amendment rights. Although this case did not involve the use of the polygraph, Winick and La Fond (2003) argue that it would apply equally if the offender agreed to submit to polygraph testing as a condition of prison treatment and parole. Likewise, *McKune v. Lyle* (2002)<sup>29</sup> found that an agreement to participate in treatment that included polygraph testing at the Kansas Department of Corrections

***McKune v. Lyle (2002) found that an agreement to participate in treatment that included polygraph testing at the Kansas Department of Corrections did not result in compulsory self-incrimination.***

did not result in compulsory self-incrimination. In addition, refusal to respond to the polygraph examiner's questions after agreeing to do so, by agreeing to participate in treatment, is admissible in a hearing to determine if the offender's supervision should be revoked: "While the offender could invoke his Fifth Amendment privilege to refuse to answer a particular question in a polygraph examination, if his refusal to respond is itself a violation of an agreed-upon condition of release, his invocation of the privilege can serve as a basis for revoking his probation or parole" (Winick and La Fond: 2003: 317).

***In Lile v. McKune, the Supreme Court determined that a reduction in privileges and reassignment to maximum security from medium were not severe enough to compel self-incrimination.***

However, the CDRC resides in the jurisdiction of the Ninth Circuit Court. In *United States v. Antelope* (2005), the Ninth Circuit Court of Appeals reversed a district court ruling.<sup>30</sup> The court determined that Antelope's supervised release could not be revoked after he invoked his Fifth Amendment rights in connection with required participation in a treatment program that included completing a full sexual history disclosure with polygraph testing. However, in *Lile v. McKune* (2002), the Supreme Court determined that a reduction in privileges and reassignment to maximum security from medium were not severe enough to compel self-incrimination. Consequently, the Kansas Department of Corrections could use incentive levels to encourage participation in sex offender treatment that included sexual history disclosure with polygraph testing.

<sup>26</sup> English et al., 2000.

<sup>27</sup> For a review, see Winick, B. and LaFond, J. (Eds.) (2003). *Sexually Violent Offenders: Law and Policy in North America*. American Psychological Association, Hyattsville, MD.

<sup>28</sup> *Minnesota v. Murphy*, 465 U.S. 420 (1984).

<sup>29</sup> *McKune v. Lyle* (2002) 23 Kan. App. 2d 1029, 1032, 940 P.2d 78 (1997).

<sup>30</sup> *United States v. Antelope*, 395 F.3d 1128, 1132 (9th Cir. 2005).

a “successive hurdles” approach.<sup>34</sup> That is, if an offender scores deceptive on a multiple issue test, there should be a follow-up exam. The focus of the follow-up test should be narrowed to the single issue of most concern. This second single-issue test will have a higher accuracy rate and, having greater specificity, the single-issue test can better distinguish the true positives from the false positives.

The polygraph does compare favorably in terms of accuracy to many other instruments that are currently used with sex offenders. It is well established that actuarial risk instruments are an important component of sex offender management. However, LaFond and Winick (2004: 1177) state, “. . . actuarial risk assessment can identify a group of sex offenders who will sexually reoffend at a rate that can conservatively be estimated at 50 percent and could reasonably be estimated at 70 percent to 80 percent. Even if this high accuracy is achieved, predictions will have a false positive rate of from twenty percent to fifty percent.” Because actuarial assessments cannot be repeated, as polygraphs can, these tests may have a lower accuracy rate than polygraph testing.

#### CONSEQUENCES IMPROVE ACCURACY

An underlying theory of polygraph testing is that the subject must have something at stake for the test to register a physiological response. In post-conviction testing, the offender must fear detection (Kircher et al., 1988).<sup>35</sup> Heil, Simons and Ahlmeyer (2003)<sup>36</sup> found use of a consequences matrix that provided a range of negative and positive consequences for polygraph results increased the proportion of offenders scoring nondeceptive on polygraph exams. The study found that when offenders knew that the polygraph results would be related to consequences, they were significantly more likely to provide accurate information in response to polygraph questions. Before use of the matrix, only nine percent of the tests were scored nondeceptive. After full implementation, 55 percent of the tests were scored nondeceptive, and the non-deceptive rate climbed to 67 percent when all therapists in the program supported its use.

#### WHY USE THE POLYGRAPH?

Official record data are woefully inadequate when it comes to reflecting an offender’s sex crime history: Heil and colleagues found a ratio of 100 self-reported sex crimes for every crime recorded in official records.<sup>37</sup> Clearly, more accurate information about frequency, duration and intensity of an offender’s criminal history will lead to better treatment plans and supervision strategies. In 1988, Abel and his colleagues interviewed paraphiliacs under conditions of guaranteed confidentiality and found that only 3.3 percent of the paraphiliacs’ self-admitted hands-on sex offenses, such as rape and child molestation, resulted in an arrest. Less than one percent (0.7%) of hands-off sex offenses, such as exhibitionism and voyeurism, resulted in the offender’s arrest.<sup>38</sup>

***According to more than two-thirds of the respondents in the second national telephone survey of probation and parole officers, the polygraph led to better management and supervision of offenders.***

Usually complete information is not available from the offender since generally sex offenders are not forthcoming with their deviant pasts. Many sex offenders have a propensity to engage in secretive and manipulative behaviors. Often, these behaviors are essential aspects of the sexually abusive lifestyles that facilitate the commission of sex crimes. According to more than two-thirds of the respondents in the second national telephone survey of probation and parole officers, the polygraph led to better management and supervision of offenders.<sup>39</sup> In the same survey, officers also reported that they could better monitor the offender’s behavior, exercise more control in the supervision process, and were more confident that the risk of the offender was being accurately assessed. The

<sup>34</sup> Cronbach, L. J. and Meehl, P.E. (1955). Construct validity in psychological tests. *Psychological Bulletin*, 52, 281-302.

<sup>35</sup> Kircher, J.C., Raskin, D.C. (1988). Human versus computerized evaluations of polygraph data in a laboratory setting. *Journal of Applied Psychology*, 73(2):291-302.

<sup>36</sup> Heil, P., Ahlmeyer, S., & Simons, D. (2003). Crossover sexual offenses. *Sexual Abuse: A Journal of Research and Treatment*. 15(4), 221-236.

<sup>37</sup> Heil, P. Ahlmeyer, S., McCullar, B. and McKee, B. (2002). Integration of Polygraph Testing with Sexual Offenders in the Colorado Department of Corrections, *Polygraph*, 29 (1), 26-35.

<sup>38</sup> Abel, G., Becker, J., Cunningham-Rathner, J., Mittelman, M., & Rouleau, J (1988). Multiple paraphilic diagnoses among sex offenders. *Bull Am Acad Psychiatry Law*, 15(2): 153-168.

<sup>39</sup> English, K., Jones, L., Pasini-Hill, D., Patrick, D., & Cooley-Towell, S. (2000). *The value of polygraph testing in sex offender management*. Final research report submitted to the National Institute of Justice for grant number D97LBVX0034. Denver, CO: Colorado Division of Criminal Justice, Office of Research and Statistics.



polygraph provided information that allowed a quicker response to situations, and could lead to “stepped-up” supervision or additional restrictions, if necessary. Many respondents noted that anticipation of the polygraph had a positive influence on the offender’s behavior. Finally, the polygraph was seen as a useful tool to verify compliance with conditions of probation or parole.<sup>40</sup>

Quantitative studies have also found that polygraph testing in combination with treatment provides significantly more information about sex offenders compared to treatment alone, and this information can be incorporated into treatment and supervision plans.<sup>41</sup> Offenders reveal more extensive sexually deviant histories than are typically disclosed in treatment settings without polygraph testing.

#### ARE OFFENDERS EXAGGERATING?

If so, they are doing it across multiple samples and methods of data collection (See Appendix 2). Polygraph-generated information is quite similar to self-report data obtained using federal Certificates of Confidentiality<sup>42</sup> and anonymous questionnaires.<sup>43</sup> These studies found an under-identification of prior sex offenses in official records; diverse sex offense behaviors; an earlier age of onset of sexually deviant behaviors; a ten to 16 year detection lag-time between the initiation of sex offending and identification as a sex offender in the criminal justice system; and persistent risk, suggesting that offending appears to be well established in the individual’s lifestyle.

<sup>40</sup> Ibid.

<sup>41</sup> Ahlmeyer, S., Heil, P., McKee, B., & English, K. (2000). The impact of polygraphy on admissions of victims and offenses in adult sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 12, 123-138; Heil, P., Ahlmeyer, S., & Simons, D. (2003). Crossover sexual offenses. *Sexual Abuse: A Journal of Research and Treatment*, 15(4), 221-23; English, K., Jones, L., Patrick, D. and Pasini-Hill, D. (2003). Sexual Offender Containment, Use of the Postconviction Polygraph. *Annals of New York Academy of Sciences*, 989: 411-427; Hindman, J. & Peters, J. (2001). Polygraph testing leads to better understanding adult and juvenile sex offenders. *Federal Probation*, 65(3); Emerick, R. L., & Dutton, W.A. (1993). The effect of polygraphy on the self-report of adolescent sex offenders: Implications for risk assessment. *Annals of Sex Research*, 6, 84-103; O’Connell, M. A. (1998). Using polygraph testing to assess deviant sexual history of sex offenders (Doctoral dissertation, University of Washington, 1998). *Dissertation Abstracts International*, 49, MI 48106.

<sup>42</sup> Abel G. G., Becker, J.V. Cunningham-Rathner, J., Mittleman, M., and Rouleau, J. (1988). Multiple paraphilic diagnoses among sex offenders. *Bulletin of American Academy of Psychiatry and Law*, 16, 153-168; Weinrott, M. R., & Saylor, M. (1991). Self-report of crimes committed by sex offenders. *Journal of Interpersonal Violence*, 6, 286-300.

<sup>43</sup> Freeman-Longo, R.E. (1985). *Incidence of self-reported sex crimes among incarcerated rapists and child molesters*. Unpublished manuscript, Correctional Treatment Program, Oregon State Hospital.

#### MONITORING OFFENDERS

Polygraph testing also is used with sex offenders to monitor an offender’s progress in treatment and current behavior. An offender may understand the material presented in treatment, but choose not to apply it, making it difficult to determine whether he is incorporating treatment skills into his lifestyle. Monitoring polygraph testing provides a useful tool to monitor these changes. Questions can focus on whether the offender is having unauthorized contact with children, masturbating to thoughts of a child, or engaging in other high-risk behaviors. Such information allows professionals to intervene before a new sex offense is committed. However, when new crimes are not prevented, monitoring polygraph exams can also be used as a tool to detect additional offenses, allowing supervising officers to quickly initiate an investigation that might stop further offenses.

***Polygraph testing also is used with sex offenders to monitor an offender’s progress in treatment and current behavior.***

#### A DETERRENT TO HIGH-RISK BEHAVIORS

There is an accumulating body of evidence to indicate that polygraphy also functions as a deterrent to high-risk behaviors. Slightly more than half of the offenders in Harrison & Kirkpatrick’s (2000)<sup>44</sup> anonymous survey reported that polygraph testing decreased their grooming and masturbation behaviors. Twenty-seven percent reported decreased sexual touching of children as a result of polygraph testing. Grubin and colleagues<sup>45</sup> also found polygraph testing to have a deterrent effect on high-risk behaviors in a sample of sex offenders voluntarily participating in polygraph exams. The average number of high-risk behaviors reported by sex offenders significantly decreased between the first polygraph test and the second, suggesting that polygraphy was effective in decreasing these behaviors. At the same time, disclosures of high-risk

<sup>44</sup> Harrison, J. S., Kirkpatrick, B. (2000). Polygraph testing and behavioral change with sex offenders in an outpatient setting: an exploratory study. *Polygraph*, 29(1), 20-25.

<sup>45</sup> Grubin, D., Madsen, L., Parsons, S., Sosnowski, D., Warber, B., (2004). A prospective study of the impact of polygraphy on high-risk behaviors in adult sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, 16(3), 209-222.



behaviors to treatment providers and supervising officers increased. Abrams and Ogard (1986)<sup>46</sup> also studied the deterrent effect of polygraph testing on a general population of probationers and determined that 69 percent of offenders who received polygraph testing along with supervision successfully completed probation as opposed to only 26 percent of offenders who received supervision alone.

***There is an accumulating body of evidence to indicate that polygraphy also functions as a deterrent to high-risk behaviors.***

#### IDENTIFYING RISK FACTORS

Using the polygraph with sex offenders provides important information to supplement criminal justice records, as it can verify the accuracy of offenders' self-reported sexual histories and their compliance with supervision rules. This information can be used to assess individual risk factors. Several of the sexual recidivism risk factors identified in Hanson and Morton-Bourgon's 2004<sup>47</sup> meta-analysis can be further clarified through polygraph testing, including whether an offenders has a sexual preoccupation (through knowledge of the frequency of sexual behaviors), has violated supervision rules, or has a history involving use of force in sex offenses. Risk is ongoing, and research information is limited in terms of assessing factors that change over time, and in a moment. The polygraph examination can focus on relevant—historical and recent—factors that indicate risk behaviors and situations that might otherwise be overlooked.

***The polygraph examination can focus on relevant—historical and recent—factors that indicate risk behaviors and situations that might otherwise be overlooked.***

#### SUMMARY

For all of these reasons, the use of the polygraph as a tool in sex offender management continues to grow. For example, the Alaska Legislature recently passed legislation requiring that all convicted sex offenders on probation and parole receive polygraph testing and treatment.

#### Effectiveness of the containment model

Although the containment approach has not been formally evaluated, several studies have been completed that show promising results.

#### MASSACHUSETTS

A preliminary study of the containment approach in Framingham, Massachusetts produced positive results. Of the 152 sex offenders managed under containment between 1996 and 2005, 15 were still actively under parole supervision, 81 had successfully completed supervision and 58 had returned to custody. Perhaps most importantly, only eight offenders had been arrested for new crimes, none of which were for sex offenses.<sup>48</sup>

***Of the 152 sex offenders in the Massachusetts program since 1995, only 8 offenders had been rearrested for new crimes, none of which were for sex crimes.***

#### OREGON

A study of the Jackson County probation and parole program also found support for the containment approach.<sup>49</sup> Comparing outcome data on offenders in the Jackson County program with a comparison group from nearby county, researchers found that offenders who stayed in treatment for at least one year were 40 percent less likely than those in the comparison group to be convicted of a new felony. The Jackson County probation/parole pro-

<sup>46</sup> Abrams, S., and Ogard, E. (1986). Polygraph Surveillance of Probationers, *Polygraph*, 15, 174-182.

<sup>47</sup> Hanson, K., & Morton-Bourgon, K. (2004-02). *Predictors of Sexual Recidivism: An Updated Meta-Analysis*. Ottawa, Ontario, Canada: Public Safety and Emergency Preparedness Canada. Public Works and Government Services Canada. (Cat. No: PS3-1/2004-2E-PDF, ISBN: 0-662-36397-3).

<sup>48</sup> Walsh, M. (2005). *Overview of the IPSO program—Intensive Parole for Sex Offenders—in Framingham Massachusetts*. Presentation by the parole board chair to the National Governor's Association policy meeting on sexual offenders. November 15, 2005. San Francisco, CA.

<sup>49</sup> England, K. A., Olsen, S., Zakrajsek, T. Murray, P. and Ireson, R. (2001). Cognitive/behavioral treatment for sexual offenders: An examination of recidivism, *Sexual Abuse: A Journal of Treatment and Practice*, 13, No. 4, 223-231.

gram dates back to 1980 and was featured in English et al. (1996).

## ARIZONA

The Maricopa County (Arizona) Adult Probation Department has been using the containment approach since 1986. An evaluation of the program involving 419 probationers with an average 36-month follow-up period found 2.2 percent of the offenders were arrested for a new sexual offense and 13.1 percent were arrested for a new criminal offense.<sup>50</sup> This appears to compare favorably to the Hanson et al. (2002)<sup>51</sup> meta-analysis of studies that used re-arrest or re-conviction as outcomes. Hanson et al. (2002) found a sexual recidivism rate of 12.3 percent and a criminal recidivism rate of 27.9 percent over a median 46-month follow-up period. The Losel and Schmucker (2005)<sup>52</sup> meta-analysis found average sexual recidivism rates of 11.1 percent and criminal recidivism rates of 22.4 percent for treated offenders over an average five-year follow-up. Although the median follow-up period in the Hanson et al. meta-analysis and the average follow-up in the Losel and Schmucker (2005) meta-analysis were longer than the average follow-up period in the Hepburn and Griffin (2002) study, the findings in Maricopa County are much lower.

## VIRGINIA

The Virginia Department of Corrections has undertaken a preliminary study of the containment model, which is implemented in some counties and not others. Sex offenders in the containment model had significantly fewer arrests and convictions compared to sex offenders in standard probation offices. In addition, containment model participants were cited for more technical violations but were not revoked as often as those in the non-containment group. The research also found that polygraph exams, intensive supervision, and offense-specific treatment each contributed to lower recidivism rates; the strongest (negative) relationship was between treatment and recidivism.<sup>53</sup>

## COLORADO

A 2004 study of the living arrangements of 130 sex offenders in Colorado during the first 15 months of supervision<sup>54</sup> found that 41 percent of problematic behaviors was discovered by the offender's disclosure during a polygraph examination or treatment, or detection by the supervising probation officer. Note that this sample consists of serious offenders: 60 percent of the offend-

Table 2.1. Comparison of recidivism studies with Maricopa County's Containment Program

Measure	Hanson et al. (2002) Meta-analysis of 43 studies	Losel et al. (2005) Meta-analysis of 69 studies	Hepburn & Griffin (2002) Maricopa County Containment Approach Study
Follow-up period	Median of 3.8 years	Average of 5 years	Average of 3 years
Recidivism definition	Mixed – arrest or conviction	Mixed – lapse behavior to incarceration	Arrest
Criminal recidivism	27.9%	22.4%	13.1%
Sexual recidivism	12.3%	11.1%	2.2%

<sup>50</sup> Hepburn, J., and Griffin, M. (2002). *An analysis of risk factors contributing to the recidivism of sex offenders on probation*. Report Submitted to the Maricopa Count Adult Probation Department and the National Institute of Justice.

<sup>51</sup> Hanson, R. K., Gordon, A., Harris, A., Marques, J., Murphy, W., Quinsey, V., and Seto, M. (2002). First report of the collaborative outcome data project on the effectiveness of psychological treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment* 14(2), 169-194.

<sup>52</sup> Losel, F., and Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, 1, 117-146.

<sup>53</sup> Personal communication with Allison Stone.

<sup>54</sup> Colorado Division of Criminal Justice (2004). *Report on safety issues raised by living arrangements for and location of sex offenders in the community*. Colorado Division of Criminal Justice, Department of Public Safety. Denver, Colorado, available at [http://dcj.state.co.us/odvsom/sex\\_offender/SO\\_Pdfs/FullSLAFinal01.pdf](http://dcj.state.co.us/odvsom/sex_offender/SO_Pdfs/FullSLAFinal01.pdf).

ers in this study were high risk, and another 32 percent were medium risk. Urinalysis testing, treatment absences and failure to appear at scheduled appointments with the supervising officer accounted for another 27 percent of violations.<sup>55</sup> Fifteen offenders in this study (11.5 percent) were arrested for new hands-off sex crimes (voyeurism, indecent exposure) in the 15 months of study. No hands-on sex offenses were detected during the study. Of the 15 new crimes, 11 (73 percent) were self-reported during the polygraph examination; two crimes were reported to the probation officer by fellow group members; one offender self-reported to his therapist; and one was detected by law enforcement. Clearly, the use of the polygraph examination, combined with treatment and close monitoring resulted in obtaining information that would otherwise remain unknown.

Additionally, researchers evaluated the sex offender treatment program at the Colorado Department of Corrections, discussed previously in this report.<sup>56</sup> This program employed intense treatment with polygraph testing in the institution and, when paroled, the offenders participated in treatment, supervision and polygraph testing in the community. Researchers found that 84 percent of the offenders who participated in the therapeutic community component of sex offender treatment in the institution successfully completed parole versus only 52 percent of the offenders who had not participated in institutional treatment. By the third year following parole discharge, 21 percent of the offenders who had participated in institutional treatment had been arrested for any crime versus 42 percent of the offenders who had not participated in treatment.

## ILLINOIS

A study of probation sex offender programs in several counties in Illinois that were implementing the containment approach concluded the following:

...all specialized probation programs should be based on the **containment approach** and should include

(a) at least three unannounced random field visits per offender every month, (b) a full-disclosure polygraph and a maintenance polygraph exam every six months, and (c) a tight partnership between probation officers and treatment providers that includes probation officers appearing at random times at the treatment site to check on offenders' attendance.<sup>57</sup>

## SUMMARY

In sum, in the containment approach is victim-safety focused, multi-agency, and collaborative. It is founded on the expertise of those developing policy and managing caseloads. The supervising officer often goes beyond the boundaries of his or her job description. Since the officer represents the criminal justice agency responsible for the offender, he or she generally convenes the case management team. Supervising officers depend on a variety of information tools including "collateral contacts" (with an offender's family members, employer, and victim therapist, for example), home visits, surveillance officers, electronic monitoring and urinalysis testing for drug use. While polygraph testing is one technology in a varied set of tools that are used to improve the management of sex offenders, the integration of polygraph testing with treatment and supervision—never as a tool on its own—remains at the core of the case management component of the containment approach.

***A study of sex offender programs in several Illinois counties concluded "...all specialized probation programs should be based on the containment approach...." (Stalans, 2004).***

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## Section three: Building a CDCR sex offender treatment program

### Introduction

Section Three begins with a description of the fundamental link between sex offender treatment and public safety. It is crucial that the program maintain a public safety/victim-centered orientation. The program implemented by the CDCR should occur within the larger framework of the containment approach, described in Section Two.

This discussion is followed by specific direction regarding the implementation of a prison program in California including a description of community transition and community based containment services.

### Designing the program for effectiveness

#### HOW DOES TREATMENT PROMOTE PUBLIC SAFETY?

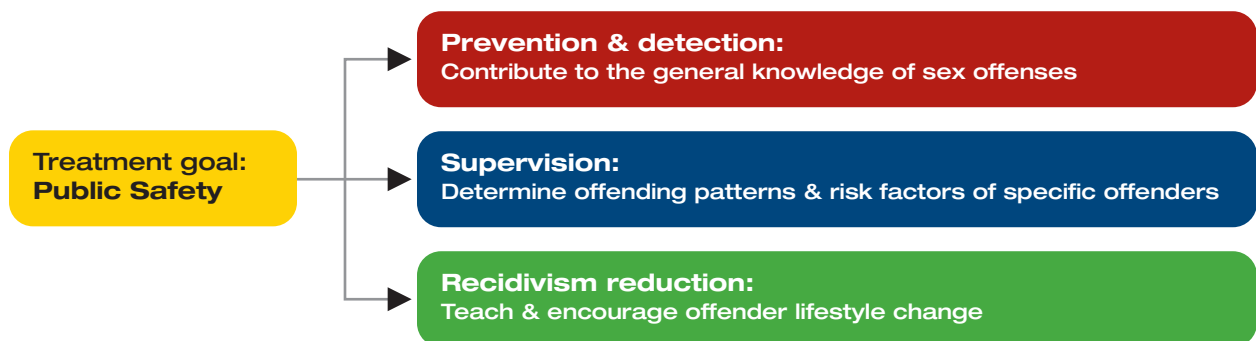
Treatment can be an effective component of public safety by contributing to sexual assault prevention and recidivism reduction, as displayed in Figure 3.1. First, the general knowledge gained from working with sexual offenders can contribute to sexual assault prevention and detection efforts. Further, treatment participants can con-

tribute to the general sexual assault knowledge through community service projects in which they disclose methods they used to set up offenses. For example, inmates in treatment in Colorado wrote a paper for school administrators entitled “A Guide for Teachers: Possible Indicators of Child Sexual Abuse and Things You Can Do.”<sup>1</sup> Inmates can also participate in research projects.

Second, treatment increases information on individual-level risk factors. This knowledge can be shared with correctional officers and, upon release, parole officers, thus contributing to individualized conditions of community supervision that address the offender’s specific risk factors. This information is also helpful in developing relevant supervision and surveillance plans for the offender in the community and designing pertinent polygraph monitoring questions that target high-risk behaviors.

Third, treatment can help offenders develop realistic relapse prevention (RP) plans as well as teach offenders how to eliminate problematic behaviors and replace them with pro-social skills. The structure and accountability of treatment and supervision encourages offenders to implement lifestyle changes. If treatment and supervision are of sufficient duration, some offenders will experience the long-term benefits of their new lifestyle and internalize the changes. However, for offenders that are not persuaded to implement lifestyle changes, treatment can reveal ongoing high-risk behaviors. Thus, officials can respond to problems early on, implementing additional accountability measures before the inmate or parolee reoffends.

Figure 3.1. Treatment is a component of public safety



<sup>1</sup> Colorado Department of Corrections. (2002). *Sex offenders: Myths, facts and treatment—A community outreach project and resource guide*. Sex Offender Treatment and Monitoring Program. Canon City, CO: Author.

To positively impact public safety, the treatment program should not operate in isolation. Collaboration with professionals who are involved in other aspects of sexual assault prevention is critical. At a minimum, these other agencies include law enforcement, victim organizations and, in the case of CDCR, correctional staff.

**Law enforcement collaboration.** Several potential benefits occur when treatment staff and parole officers develop collaborative relationships with sex crime investigators. Few professionals know the offender as well as the treatment provider; as such, they may have information that can help solve crimes. Conversely, law enforcement agencies have investigation reports that detail information about the offender's crime. This information can be invaluable to treatment providers. Further, when exceptionally dangerous offenders release, program staff can alert law enforcement about the offender's presence in the community.<sup>2</sup>

Once offenders transition to the community, parole officers should arrange regular meetings with law enforcement representatives in the region. Parole officers can brief sex crime investigators on the modus operandi of parolees who reside or work in their jurisdiction, while sex crime investigators can present information on unsolved sex crimes. This type of exchange can lead to enhanced public safety. Crimes committed by parolees can be solved more quickly and opportunities for additional victimizations can be interrupted. Moreover, for some offenders, law enforcement knowledge of their presence in the community can serve as a deterrent to reoffense.

**Victim services collaboration.** Developing a strong relationship with the victim service providers in the area is also critical. Knowledge can be exchanged between the two groups, creating a broader perspective of specific cases and sexual crimes in general. Further, victim therapists and offender therapists/parole officers can jointly evaluate decisions regarding family contact when the victim is a relative. Joint decisions can also be made when victims request contact for clarification or restorative justice purposes. Finally, another important benefit of a collaborative relationship is the opportunity for training. Victim providers can train therapists and parole officers on victim

impact and issues. Offender therapists and parole officers can share information on treatment and supervision expectations and general knowledge of offenders.

While the confidentiality of victims should always be guarded, many programs inform offenders that their treatment progress and status will be shared with victims upon request. This provision should be documented in offender treatment contracts. Victims may also have information that is relevant to offender treatment. When there is a strong collaborative relationship, victims can more easily share important safety information. For example, some offenders continue to harass their victims even while incarcerated. Many times victims may only reveal this information to their therapist. If the criminal justice system obtains this information, additional steps can be jointly planned to protect the victim. There are many ways in which a strong collaborative relationship can enhance both the safety and recovery of victims and the effectiveness of offender treatment and supervision.

**Correctional operations collaboration.** Prison sex offender treatment services require close coordination with correctional operations. The quality of the program can be significantly enhanced or sabotaged by the correctional staff's view of the program. Correctional staff support of the program provides a coordinated and consistent message to offenders, and this strengthens the effectiveness of the program. Also, treatment can assist in the management of a prison by keeping offenders occupied in non-criminal activities and by promoting personal responsibility and accountability. Ideally, the clinical and correctional staff would both take ownership in the program. Therefore, we suggest including a union representative in planning efforts to implement a CDCR sex offender treatment program.

## RISK REDUCTION, NOT CURE

The containment approach is premised on the idea that risk can be managed but not eliminated. Many sex offenders have committed multiple sexual offenses over the course of years prior to coming to the attention of authorities and treatment providers. As a result, the behaviors and thoughts associated with sex offending are usually well-ingrained by the time the criminal justice system and treatment providers intervene to try to stop the behavior. Given the seriousness of the problem, intensive long-term treatment is generally required. Treatment can help offenders learn how to manage sexual offending

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<sup>2</sup> Treatment providers cannot disclose confidential information obtained during the course of treatment unless there is (1) a duty to warn, (2) a mandatory reporting requirement as defined in state statute (i.e., child abuse), and (3) an informed consent (which is sometimes included in the treatment contract) or a release of information form signed by the offender as part of treatment program participation.

urges and decrease their risk of re-offense. However, the offender will always be capable of repeating the behavior.

***The containment approach is premised on the idea that risk can be managed but not eliminated.***

#### RECOMMENDED TREATMENT MODALITY

**Cognitive-behavioral.** Since cognitive-behavioral treatment within a containment approach appears to be one of the most promising methods of sex offender treatment, we recommend that the CDCR adopt this approach. This recommendation is consistent with position papers by the California Coalition on Sex Offenders,<sup>3</sup> and the treatment program operated by the California Sex Offender Civil Commitment Program. Further, the High Risk Sex Offender Task Force and the Expert Panel also have strongly recommended the use of cognitive-behavioral treatment.<sup>4</sup> As was reported by the Expert Panel, other state prison systems, such as those in Kansas and Pennsylvania, operate a variety of cognitive programs for inmates. The literature on evidence-based practices indicates that structured cognitive-behavioral group programs can reduce recidivism.<sup>5</sup> This approach involves educating offenders about the role cognitions play in the development and maintenance of abusive behavior, interventions to identify distortions, strategies geared to dispute distortions and replace them with more rational and realistic thoughts.<sup>6</sup>

**Relapse prevention.** Further, we recommend that the offense specific treatment program include a relapse prevention component, making the program compatible with

the California Sex Offender Civil Commitment Program. Relapse prevention (RP) is a model where offenders identify thoughts and behaviors before, during and after their crimes, and develop very specific intervention plans that address pre-cursor thoughts and behaviors to avert a new offense. It is based on the notion that relapse is a process that can be interrupted. Sex offenders can learn that their abusive pattern is like a train and they can get off and reverse course.<sup>7</sup> There are several recent variations that expand on relapse prevention concepts. These variations have common elements. They help offenders understand their individual pathways to assault and, based on that understanding, develop a broad, responsible life plan along with very specific safety plans. Input from other group members and the therapists aid offenders in developing, refining and practicing these plans. Other names for this overall strategy include “good lives model,” “pathways,” and “self-regulation model.”<sup>8</sup>

***Researchers found that training significant others on the relapse prevention model and identifying the offense chain were found to be more important than booster sessions or coping skills. This meta-analysis still found risk, criminogenic need and responsivity to be the strongest elements in recidivism reduction.***

Although the Atascadero cognitive-behavioral relapse prevention program did not produce favorable results (see Section One), a meta-analysis of 40 relapse prevention

<sup>3</sup> California Coalition on Sex Offenders. (2002). *Guidelines for outpatient treatment for adult sexual offenders*. Retrieved May 2007, from <http://www.ccoso.org/papers/adulttreatment.pdf>

<sup>4</sup> California High Risk Sex Offender Task Force. August 15, 2006. *Report to the Governor and the Legislature*. Sacramento, CA: Author; Expert Panel on Adult Offender and Recidivism Reduction Programming. (2007). *Report to the California State Legislature: A Roadmap for Effective Offender Programming in California*. Sacramento, CA: California Department of Corrections and Rehabilitation.

<sup>5</sup> Wilson, D., Bouffard, L. A., and MacKenzie, D.L. (2005). A quantitative review of structured, group-oriented, cognitive-behavioral programs for offenders. *Criminal Justice and Behavior*, 32(2), 172-204.

<sup>6</sup> Murphy, W. D. (1990). Assessment and modification of cognitive distortions in offenders. In W.L. Marshall, D.R. Laws and H.E. Barbaree (Eds.), *Handbook of sexual assault: Issues, theory and treatment of the offender*, 331-342. New York: Plenum Press.

<sup>7</sup> Carich, M.S., Gray, A., Rombouts, S., Stone, M., Pithers, W. D. (2001). Relapse Prevention and the sexual assault cycle. In M.S. Carich and S.E. Mussack (Eds.), *Handbook for sexual abuser assessment and treatment*. Brandon, VT: Safer Society Press, 77-103.

<sup>8</sup> Ward, T. and Marshall, W. L. (2004). Good lives, aetiology and the rehabilitation of sex offenders: A bridging theory. *Journal of Sexual Aggression*, 10(2), 153-169; Ward, T. (2002). The management of risk and the design of good lives, *Australian Psychologist*, 37, 172 – 179; Ward, T. and Gannon, T. A. (2006). Rehabilitation, etiology, and self-regulation: The comprehensive good lives model of treatment for sexual offenders. *Aggression and Violent Behavior*, 11, 77-94; Bickley, J. A. and Beech, A.R. (2002). An Investigation of the Ward and Hudson Pathways Model of the Sexual Offense Process With Child Abusers, *Journal of Interpersonal Violence*, 17, 371-393; Webster, S. D. (2005). Pathways to sexual offense recidivism following treatment: An examination of the Ward and Hudson Self-Regulation Model of relapse. *Journal of Interpersonal Violence*, Vol. 20, 1175-1196; Ward, T., Hudson, S. M. and Keenan, T. (1998). A Self-Regulation Model of the Sexual Offense Process. *Sexual Abuse: A Journal of Research and Treatment*, 10, 141-157.

studies with offenders (not specific to sex offenders) found moderate reductions in recidivism (Dowden, Antonowicz, and Andrews, (2003). Researchers found that training significant others on the relapse prevention model and identifying the offense chain were found to be more important than booster sessions or coping skills. This meta-analysis still found risk, criminogenic need and responsivity to be the strongest elements in recidivism reduction.

**Group therapy.** Group therapy is generally recognized in the sex offender treatment literature as the preferred mode of treatment. Group therapy is beneficial for several reasons. Sex offenders have led secretive lifestyles, rarely developing genuine relationships with others. Instead they have presented a “pretends normal” front to others. While offenders may successfully hide behind this front in individual therapy, it is much more difficult to manipulate an entire group, especially one with other sex offenders. The group environment, then, provides an opportunity for therapists to observe the offender’s interactions with peers and address identified problems.

#### TREATMENT WITH ACCOUNTABILITY

Sex offense specific therapy differs from traditional treatment in that offenders are held accountable for their behaviors. It is not sufficient for offenders to gain insight into why they commit sex offenses. Just like any behavior that a person finds enjoyable, insight into the reason they began the behavior or an understanding of the detrimental nature of the behavior, does not necessarily result in discontinuation of the behavior. Take, for example, smoking or overeating. Individuals may continue the behavior

even with insight into the reasons they started the behavior and knowledge that the behavior is detrimental to their health. Therefore, in sex offender treatment, therapists develop methods of accountability to determine if their clients are actually applying what they are learning and refraining from high-risk behaviors.

***Just like any behavior that a person finds enjoyable, insight into the reason they began the behavior or an understanding of the detrimental nature of the behavior, does not necessarily result in discontinuation of the behavior.***

Collateral contacts with correctional staff and family members to check the offender’s behavior outside of group, as well as urinalysis and polygraph testing, are useful accountability measures. Collateral contacts (secondary sources) can reveal whether the offender is manipulating others, isolating, contacting their victim, or creating splits (conflicts) between people. Objective tests, for instance urinalysis and polygraph, indicate whether the offender is engaging in high-risk behaviors such as substance abuse, masturbating to thoughts of young children, and so on. These accountability measures help ensure that the offender is following through with change efforts instead of strictly relying on offender self-report in these areas. See *Training for Correctional Staff*, below, and *Using the Post Conviction Polygraph* in Section Two.

Table 3.1. Differences between traditional and sex offender treatment

Sex offense specific treatment	Traditional treatment
Non-trust basis - statements and behavior are externally verified	Accept client’s statements as truth
Client’s responsibility to change – the behavior is unacceptable	Client has the choice to change
Client has choices; consequences are based on their choices	Non-judgmental and supportive of client choices
There are consequences if directives are not followed	No consequences for choices
Primary focus is on current thoughts and behaviors that contribute to risk	Focus on insight regarding the past with the hope that awareness will change behavior
Limited confidentiality – Information is shared within the containment team	Complete confidentiality with exception of mandated reporting
Behavior change required	No change required

## THERAPEUTIC STYLE

There is a growing body of research on how the therapist's style affects treatment engagement and progress. The research on sex offenders and violent offenders is fairly consistent. Certain therapist characteristics promote treatment retention, engagement, and progress:

- Empathic and fair but firm,<sup>9</sup>
- Challenging, but not a confrontational therapeutic style,<sup>10</sup>
- Helpful and supportive, instilling a sense of hope and responsibility to the group, allowing feelings to be openly expressed, and conducting well-organized and well-led groups,<sup>11</sup>
- Empathic, warm and genuine, providing accountability with support, and instilling hope,<sup>12</sup> and
- Empathic, warm, rewarding progress and being directive.<sup>13</sup>

Research has determined certain therapeutic styles to be counterproductive:

- Inconsistency, defensiveness and confrontational style,<sup>14</sup>
- Aggressively confrontational,<sup>15</sup> and
- Overcontrolling.<sup>16</sup>

Sex offender therapists should receive training on these important therapeutic qualities. Program evaluation and quality assurance efforts could also focus on therapist style. These qualities are difficult to maintain over time with resistant clients,<sup>17</sup> providing another reason to help therapists effectively manage the impact of the job. Please see Appendix 20 for more information on how the job affects individual professionals and teams.

<sup>9</sup> Serin, R. (1994). *Treating Violent Offenders: A Review of Current Practices*. West Ottawa, Ontario: Research and Statistics Branch Correctional Service of Canada.

<sup>10</sup> Miller, W.R and Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behavior*. Guilford Press: New York, as cited in Serin 1994).

<sup>11</sup> Beech, A. R. and Fordham, A. S. (1997). Therapeutic climate of sex offender treatment programmes. *Sexual Abuse: A Journal of Research and Treatment*, 9(3), 219-237.

<sup>12</sup> Simons, D., Tyler, C., & Lins, R. (2006). *The influence of therapist characteristics on treatment progress*. Poster session at the Annual Conference for the Association for the Treatment of Sexual Abusers, Chicago, IL.

<sup>13</sup> Serran, G., Fernandez, Y., and Marshall, W.L. (2003). Process issues in treatment: Application to sexual offender programs. *Professional Psychology: Research and Practice*, 34(4), 368-374; Marshall, W.L. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment*, 17(2), 109-116.

<sup>14</sup> Simons, Tyler and Lins, (2006).

<sup>15</sup> Serran, Fernandez, and Marshall, (2003).

<sup>16</sup> Beech and Fordham, (1997).

<sup>17</sup> Serin, R. (1994). *Treating Violent Offenders: A Review of Current Practices*. West Ottawa, Ontario: Research and Statistics Branch Correctional Service of Canada.



## Target population

### DEFINITIONS

#### **Recommended for treatment –**

*Those offenders that CDCR defines as the target population of sex offenders that need treatment. These offenders should earn treatment incentives based on their compliance with the treatment recommendation.*

#### **Eligible for treatment participation –**

*The target population of offenders who are recommended for treatment and meet the participation requirements, i.e., they are within the time frame for treatment participation, admit they committed a sex offense, see it as a problem and agree to participate in treatment and sign the treatment contract.*

### TARGET POPULATION: IDENTIFYING INMATES RECOMMENDED FOR CDCR TREATMENT

The CDCR will need a system to identify the target population of inmates with sex offender treatment needs. Several categories of offenders would potentially benefit from participation in sex offender treatment. CDCR administrators need to decide on the type of offenders that will be recommended for treatment. “Recommended for treatment” refers to the target population.

This language—recommended for treatment—is the first step in making offenders responsible for their choices. Recommended for treatment means the Department has identified them as *needing* treatment. This designation, then, means that incentives (which should be developed by CDCR; see below) are now linked to the inmate’s decision to participate in the program. That is, incentives should be awarded based on the offender’s compliance with the treatment recommendation.

Since public safety is the overriding consideration, the following categories should be considered for possible treatment recommendations:

- In most corrections systems, offenders incarcerated on a **felony sex offense conviction** are recommended for treatment, although some systems further evaluate

offenders using actuarial risk instruments and only treat those that score out moderate or high risk.<sup>18</sup> While this is a common and scientifically based method of prioritizing treatment resources, it raises concerns about the accuracy of prediction for those identified as low risk. Since actuarial scales are based on official record data, and since most sex crimes are never reported, there is a realistic concern that those considered “low risk” are those who have selected victims who were unable to report the crimes to law enforcement. This potential fallibility of actuarial scales is a significant public safety concern.<sup>19</sup>

- Other DOCs extend treatment recommendations to offenders with **documented sex offending behavior** whether those offenses resulted in sexual offense convictions or other types of convictions. For example, an offender convicted of murder would be recommended for treatment if the official description of the crime included a rape.
- Several DOCs identify offenders with a documented history of sex offending behavior even if the offender’s current conviction does not contain any element of sexual offending behavior. These systems assume that an offender who continues to engage in criminal behavior might be at higher risk to repeat sexual offending behavior. Some of these prison systems apply additional criteria that filter out certain offenders with past offenses based on how many years ago the sexual offense was committed, whether the offender had a window of opportunity in the community to reoffend, and the number of prior sex offenses committed.
- Some DOCs provide treatment to offenders who commit **sexual offenses in prison** whether or not the offender has a history of sexual offending in the community. The rationale for treating this group of offenders involves both facility safety and community safety. Prison sex offenses create management problems and reduce facility safety for both inmates and staff. Further, there is evidence to suggest that prison sex

<sup>18</sup> As mentioned in Section One, only eight states in the 2006 survey of sex offender treatment in state correctional facilities (Lins, 2006) identified offenders for treatment based on the conviction crime alone.

<sup>19</sup> The authors have addressed this issue elsewhere. English, K., and Heil, P. (2006). The need for complete information leads to the polygraph examination. *The Sexual Predator, Vol. III*, (Anita Schlank, ed.), Kingston, NJ: Civic Research Institute. Also see Winick, B.J. and La Fond, J.Q. (2003). *Protecting society from sexually dangerous offenders: Law, Justice and Therapy*, Washington, D.C.: American Psychological Association. See also Section Two.

offenders are just as likely as convicted sex offenders to commit sex offenses and more likely to commit violent crimes when released back to the community.<sup>20</sup> This research finding corresponds with a substantial risk prediction literature that confirms that past criminal behavior (community or prison) is one of the strongest predictors of future behavior.<sup>21</sup>

***There is evidence to suggest that prison sex offenders are just as likely as convicted sex offenders to commit sex offenses and more likely to commit violent crimes when released back to the community.***

Prison sex crimes can include raping other inmates, and sexual offenses against staff and visitors. These include both hands-on and hands-off sex crimes such as indecent exposure, and sexual offenses committed against visitors.

**California developments.** Several recent developments in California provide guidance regarding the decision to treat specific groups of sex offenders. The judicial opinion in the *Freitag v. Ayers* (2006) Ninth Circuit Court of Appeals provides an argument for treating prison sexual offenders as a component of correcting hostile work environments that result from inmates' sexual harassment of staff.<sup>22</sup>

The August 15, 2006 California High Risk Sex Offender Task Force report made the following recommendation regarding institutional treatment: *All California inmates required to register as sex offender who are designated as HRSOs should be required to receive appropriate specialized sex offender treatment as warranted while incarcerated.*<sup>23</sup> Based on this report, there is substantial support to provide

treatment to designated high-risk offenders. Since there is already a process in place to conduct HRSO evaluations, it makes sense to recommend treatment for this identified high-risk group of offenders. Implementation of the HRSO evaluation at the point of intake would assist in this process.

However, it is likely that the HRSO process will not identify all sex offenders that pose a significant risk to public safety. Studies using guaranteed confidentiality, anonymous survey or polygraph testing reveal that the majority of sex offenders have undetected offenses and victims, indicating that assessments based on official record data can be unreliable and underestimate risk (see Appendix 1 for summary tables of relevant research). For this reason, we caution CDCR officials against over-relying on actuarial risk assessment tools to identify low risk sex offenders. Those scoring low risk may not have accumulated a sufficient *official* record to qualify as high risk on an actuarial scale.

***The HRSO process will probably not identify all sex offenders who pose a significant risk to public safety.***

Consequently, the CDCR should carefully consider the above categories and target resources to treat to as many sex offender groups as possible, including but not limited to HRSOs. This recommendation is consistent with the June 29, 2007 *Roadmap* report by the Expert Panel since recommendations 3 and 4 pertain to risk assessment and needs assessment, respectively.<sup>24</sup>

## TRACKING TREATMENT RECOMMENDATIONS

**Developing an electronic database.** It is important to develop an electronic database that tracks offenders who are (1) recommended for treatment, (2) meet participation criteria, and (3) need to be transferred to a treatment facility. Once CDRC determines the types of offenders that will be recommended for treatment, those offenders should be identified in the electronic database. Then, this system should “flag” inmates that need to be screened

<sup>20</sup> English, K., and Heil, P. (2005). Prison rape: What we know today. *Corrections Compendium*, 30(5), 1-5, 42-43.

<sup>21</sup> Hanson K. and Morton-Bourgon, K. (2004), *Predictors of Sexual Recidivism: An Updated Meta-Analysis*, Department of Public Safety and Emergency Preparedness, Canada; Hanson, R.K. and Morton-Bourgon, K. (2007). *Accuracy of recidivism risk assessments for sex offenders: A meta-analysis*. Office of Public Safety and Emergency Preparedness, Canada, available at [http://www.publicsafety.gc.ca/res/cor/rep/\\_fl/crp2007-01-en.pdf](http://www.publicsafety.gc.ca/res/cor/rep/_fl/crp2007-01-en.pdf).

<sup>22</sup> *Freitag v. Ayers*, 468 F.3d 528 (9th Cir. 2006).

<sup>23</sup> California High Risk Sex Offender Task Force. (January 25, 2007). *Report of Recommendations*, page 11. The description of the testimony and Task Force discussion that accompanies Recommendation 3 reads, in part, “Additional discussion included the concept of amending applicable statutes and regulations to deny in-custody credits to sex offenders who refuse to participate in treatment” (page 11).

<sup>24</sup> Expert Panel on Adult Offender and Recidivism Reduction Programming. (2007). *Report to the California State Legislature: A Roadmap for Effective Offender Programming in California*. Sacramento, CA: California Department of Corrections and Rehabilitation.

for treatment participation along with the details of the screening results. Finally, this system should identify inmates that need to be transferred to a prison where treatment is offered. Because some inmates have lengthy sentences, they may not need to be transferred to a treatment facility for several years. This electronic database should track those inmates who otherwise might get lost in the system due to the length of their sentence.

Treatment recommendations should be entered in a database that can be accessed by all relevant staff (i.e., case managers, program staff, classification staff, and parole officers). Additional treatment needs such as those related to hearing or visual impairment, developmental disability, serious mental illness, learning disabilities, or non-English speaking inmates, should also be documented in a system that will allow therapists to identify all offenders with a specified need. That way, therapists will be able to create special groups to accommodate these offenders.

#### **Developing a treatment recommendation protocol.**

Ideally, treatment recommendations should be determined when the offender enters the Department since offense information is generally available during the intake process. If this information is not available, an assigned position should gather criminal justice records from the court, district attorneys, probation and law enforcement agencies.

Once an identification process is established at intake, a secondary system should identify treatment recommendations for currently incarcerated inmates. After the backlog of inmates in the system has been identified, a process should continuously identify those inmates who acquire a treatment recommendation by committing a sex offense while incarcerated.

### **TREATMENT INCENTIVES**

**Mandatory versus voluntary participation.** While some sex offenders seek out treatment, many are not motivated to participate in treatment. There are a variety of reasons why sex offenders may be reluctant to pursue treatment and may deny their offenses, even when they have pled guilty to or been convicted of the crime: The offenses are shameful and generate social disapproval; support from family members and friends who believe in their innocence can be jeopardized; and their offenses are considered low status crimes in the prison culture, generating fear that disclosure will seriously endanger their safety.

***While some sex offenders seek out treatment, many are not motivated to participate in treatment.***

To encourage treatment, some criminal justice systems have mandated participation. Although inmates may be forced to sit in treatment groups, they cannot be forced to admit their offenses or benefit from treatment. In the Atascadero program (see Section One), to decrease program attrition, treatment participants did not have to be actively involved or progressing in the program.<sup>25</sup> When comparing the outcomes of treated versus untreated offenders, there were no significant differences. However, offenders that “got it” according to staff judgments, versus those that did not, had lower recidivism rates, implying that mandating offenders to sit in group will not reduce recidivism. Further, placing resistant group members in with motivated participants tends to inhibit offenders that are willing to work on their problems and admit their offenses. Frequently, the offender mandate turns into a therapist mandate to conduct groups with unmotivated and disruptive participants. For these reasons, mandated sex offender treatment is not recommended.

On the other hand, if treatment is strictly voluntary and not encouraged through incentives, few offenders will participate. It becomes incumbent upon the system to create incentives that make the choice to participate in treatment more desirable than denying the crime or refusing treatment. A public safety goal, then, is to encourage treatment participation.<sup>26</sup>

Leveraging incentives to encourage treatment participation has a long history in the drug abuse field, and most studies have found that individuals can benefit from compulsory treatment although dropout and retention rates

<sup>25</sup> Marques, J., Wiederanders, M., Day, D., Nelson, C., and van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's sex offender treatment and evaluation project (SOTEP). *Sexual abuse: A Journal of Research and Treatment*, 17, 79-107.

<sup>26</sup> As discussed in Section One, Lins' 2006 survey of prison sex offender treatment programs found that nineteen states awarded earned time based on treatment participation. Of the 26 states with post-release supervision, 14 used treatment participation as a criterion for recommending the inmate for release. Only 14 used treatment participation as a progressive custody classification and movement to a less restrictive facility. Among the states participating in the survey, only Colorado used all three incentives inquired about in the survey: good time, parole recommendations, and progressive moves.

***Mandated sex offender treatment is not recommended. On the other hand, if treatment is strictly voluntary and not encouraged through incentives, few offenders will participate. It becomes incumbent upon the system to create incentives that make the choice to participate in treatment more desirable than denying the crime or refusing treatment. A public safety goal, then, is to encourage treatment participation.***

are greatly affected by individual-level motivation.<sup>27</sup> The National Institute on Drug Abuse says this about compulsory treatment:

*Most studies suggest that outcomes for those who are legally pressured to enter treatment are as good as or better than outcomes for those who entered treatment without legal pressure. Those under legal pressure also tend to have higher attendance rates and to remain in treatment for longer periods, which can also have a positive impact on treatment outcomes.*<sup>28</sup>

Legal pressure is often applied through the application of incentives such as community supervision rather than

incarceration. Providing treatment incentives can be accomplished through legislation (such as discretionary parole) and department policy (such as granting privileges).

We recommend consideration of the following incentives for offenders who are in compliance with treatment recommendations:

- Housing in desirable living units that create a safe environment where they will be less likely to be harassed,
- Providing pay for participation in treatment,
- Qualifying treatment participants for higher paying jobs,
- Earning extra days off their sentence,
- Gaining extra privileges,
- Decreasing the probability of civil commitment,
- Ensuring vocational training to gain job skills to prepare for release,
- Family meetings with a program therapist,
- Participation in family/conjugal visits,
- Re-entry preparation (life skills training),
- Providing a sponsor or circle upon release<sup>29</sup>

***Within the California prison system, the most powerful incentive may be safety. Interviews with California sex offender parolees indicated that perhaps the most important incentive that CDCR could offer was safe housing.***

Within the California prison system, the most powerful incentive may be safety. Interviews with California sex offender parolees indicated that perhaps the most important incentive that CDCR could offer was safe housing. Sex offenders, particularly those with child victims, are vulnerable to violence from other inmates. Since treatment participation will “out” these offenders, it is critical that those who participate in sex offender treatment, whether they remain in the program or not, be permanently separated from the general population.

<sup>27</sup> Prochaska, J., and DiClemente, C. (1986). Toward a comprehensive model of change. In W. Miller and N. Heather (Eds.), *Treating addictive behaviors: Processes of change*, 3-27. New York: Plenum; Wild, T.C., Newton-Taylor, B., Ogborne, A., Mann, R., Erickson, P., and MacDonald, S. (2001). Attitudes toward compulsory substance abuse treatment: A comparison of the public, counselors', probationers' and judges' views. *Drugs: Education, Prevention and Policy*, 8(1), 33-45; Anderson, J.F. (2004). Concurrent disorders: From solitudes to similitude? *Visions: BC's Mental Health and Addictions Journal*, 2, 4-5; Anglin, D. (1988). The efficacy of civil commitment in treating narcotic addiction. In Leukefeld, D., Tims, F. (Eds.) *Compulsory treatment of drug abuse: Research and clinical practice*. Rockville, MD: National Institute on Drug Abuse, Division of Clinical Research; Porporino, F., Robinson, D., Millson, W. and Weekes, J. (2002). An outcome evaluation of prison-based treatment programming for substance abusers. *Substance Use and Misuse*, 37, 1047-2077; Lightfoot, L.O. (1999). Treating substance abuse and dependence in offenders: A review of methods and outcomes. In E.J. Latessa (Ed.), *Strategic solutions: The International Community Corrections Association examines substance abuse*. Lanham, MD: ACA Press. Ryan, R., Plant, R., and O'Malley, S. Initial motivations for alcohol treatment: relations with patient characteristics, treatment involvement and dropout. *Addictive Behaviors*, 20(3), 279-297; Knight, K., Hiller, M., Broome, K., and Simpson, D. (2000). Legal pressure, treatment readiness, and engagement in long-term residential programs. *Journal of Offender Rehabilitation*, 31(1/2), 101-115.

<sup>28</sup> National Institute on Drug Abuse. (N.D.) *Principles of Drug Abuse Treatment for Criminal Justice Populations*, available at [http://www.nida.nih.gov/PODAT\\_CJ/faqs/faqs1.html#5](http://www.nida.nih.gov/PODAT_CJ/faqs/faqs1.html#5).

<sup>29</sup> Circles of Support and Accountability refers to a small group of volunteers that meet with the offender on a daily basis, discussed later in this section. Please also see Appendix 10.

Some of the incentives listed above may require legislative support. For example, earning extra days off their sentence may require a statutory change while other incentives can be implemented through department policy and interagency collaborations.

We urge administrators to work with stakeholder groups to brainstorm potential incentives for treatment. At least two items on this list are consistent with the recommendations of others. The Little Hoover Commission's January 2007 report to Governor Schwarzenegger and the members of the legislature<sup>30</sup> recognized the need to implement incentives for program participation. The Commission made recommendations that merit consideration as sex offender treatment incentives. For example, the Commission recommended early release credits for education and job training program completion, as well as eligibility for preferred work assignments.

It is important to note that some incentives will be more powerful than others. Data analyzed at the Colorado Department of Corrections revealed that inconsistent application of the incentives resulted in a lower rate of treatment participation. Facilities that consistently applied more powerful incentives had the highest rates of treatment compliance. The application of restricted privileges was associated with the highest rate of treatment participation. Offenders who failed to meet treatment participation requirements (i.e., admit committing a sex offense, admit having a problem that they needed to work on, and agree to participate in group treatment) had their privileges

restricted. Those who met these requirements were granted full privileges. The Colorado Department of Corrections' administrative regulation that established restricted privileges is attached in Appendix 3, along with the state statute on restriction of privileges.

As shown in Table 3.2, incentives can play a key role in treatment participation. Comparing the varying incentives used in six prison facilities in Colorado, the differences in program participation were noteworthy. Restricted privileges likely had the greatest impact, even considering other prison differences (not controlled for) such as the institutional culture or having the treatment program in the facility.

In Facility 6 (Table 3.2), prison administrators did not use restricted privileges since the program was not offered in the facility.<sup>31</sup> Restricting privileges was considered a difficult task to manage in a large prison, and not necessary since treatment required moving the offenders to a different facility. This appeared to considerably affect program participation rates: of those recommended for sex offender treatment by the Department, 89 percent either refused treatment or denied committing a sex crime. The table clearly shows the use of privilege/restrictions based on the inmates' choices can considerably affect treatment participation. Therefore, this is an issue that CDCR officials must address when selecting sites for the program since participation in the program is the first step toward reducing recidivism.

Table 3.2. Impact of various incentives on treatment participation at the Colorado Department of Corrections\*

Prison facility	1	2	3	4	5	6
Incentives used	Restricted privileges, loss of earned time & regress to medium security	Restricted privileges & loss of earned time	Loss of earned time, & eligibility for industry jobs (11% of deniers still had industry jobs)	Loss of earned time	Loss of earned time	Loss of earned time inconsistently applied
Percent denying or refusing treatment	1%	22%	46%	50%	77%	89%

**Note:** \*Information is based on the proportion of inmates that were out of compliance with treatment recommendations in 2002.

<sup>30</sup> The Little Hoover Commission. (January 25, 2007). *Solving California's Corrections Crisis: Time is Running Out*. Available at <http://www.lhc.ca.gov/lhcdlr/185/Report185.pdf>.

<sup>31</sup> Inmates could be screened and placed on a waiting list to be moved to a facility that had the program.



Additional studies support the notion that incentives can increase compliance with treatment. Young and Belenko (2002)<sup>32</sup> found drug treatment programs with the highest legal coercion for participation had the highest retention rates. Likewise, Hunter and Figueredo (1999)<sup>33</sup> found that positive treatment outcomes were associated with less denial in juvenile offenders, which was promoted by external contingencies such as legal circumstances or family pressure. Similarly, an outcome study of the Vermont Department of Corrections' sex offender treatment services determined that offenders with longer periods between their minimum and maximum indeterminate sentence were more likely to participate in and complete treatment, conceivably to increase their chances for early parole.<sup>34</sup> Sexual recidivism among those who completed treatment was significantly lower than those who failed to complete treatment and those who had no treatment.

A study recently published by the National Institute of Drug Abuse found that the opportunity to win awards worth as little as \$1 motivated outpatients to stay in behavioral therapy and remain drug-free. At eight community-based addiction treatment programs across the United States, stimulant abusers who could earn a chance to win a prize by providing drug-free urine samples were four times as likely as peers who were not offered this incentive to attain 12 weeks of continuous abstinence. Prizes for the incentive intervention cost the programs about \$200, or \$2.42 a day per participant.<sup>35</sup>

These studies provide compelling reasons to design incentives for treatment compliance. Further, providing incentives to keep offenders engaged in and compliant with treatment once they start the process is another consideration. Both substance abuse and sex offender treatment suffer from high drop out rates, typically over 50 percent. This is understandable: often these are offenders who have failed other (community based) supervision and treatment options prior to coming to prison, and this group

of inmates can be highly impulsive. However, length of time in treatment has been found to be a significant factor in recidivism reduction in both treatment populations. Therefore, providing powerful incentives to stay in treatment can foster increased public safety.

***Providing powerful incentives to stay in treatment can foster increased public safety.***

#### WHEN SHOULD TREATMENT BEGIN? AND HOW LONG SHOULD TREATMENT LAST?

The prison culture does not encourage pro-social lifestyle change. If offenders participate in treatment early in their incarceration term, changes will quickly erode when they become re-immersed in the inmate culture. For that reason, it is preferable to begin treatment near the end of the offender's prison term. However, length of time in treatment is a significant factor in the effectiveness of treatment.<sup>36</sup> Therefore, inmates should begin treatment within a time frame that allows for sufficient treatment duration prior to community transition.

***The prison culture does not encourage pro-social lifestyle change. If offenders participate in treatment early in their incarceration term, changes will quickly erode when they become re-immersed in the inmate culture.***

**Duration of treatment.** Table 3.3 displays the Lowden, et al. (2003) Colorado Department of Corrections outcome findings showing that longer treatment participation was associated with fewer rearrests. Further, using a statistical technique called survival analysis, researchers determined that for each additional month spent in the sex offender program's therapeutic community, participants increased their likelihood of success upon release by one percent per month (12 percent per year) (data not presented). In this

<sup>32</sup> Young, D., and Belenko, S. (2002). Program Retention and Perceived Coercion in Three Models of Mandatory Drug Treatment. *Journal of Drug Issues*, 32(1): 297-328.

<sup>33</sup> Hunter, J.A., Jr., and Figueredo, A. (1999). Factors associated with treatment compliance in a population of juvenile sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, 11(1): 49-67.

<sup>34</sup> McGrath, R. J., Cumming, G., Livingston, J. A., Hoke, S. E. (2003). Outcome of a treatment program for adult sex offenders: From prison to community. *Journal of Interpersonal Violence*, 18, 3-17.

<sup>35</sup> Whitten, L. (2006). Low-Cost Incentives Improve Outcomes in Stimulant Abuse Treatment, *NIDA Notes*, 21(1), at [http://www.drugabuse.gov/NIDA\\_notes/NNvol21N1/Low.html](http://www.drugabuse.gov/NIDA_notes/NNvol21N1/Low.html).

<sup>36</sup> McGrath et al., 2003; Lowden et al., 2003. The findings linking length of time in treatment with positive outcomes are consistent with considerable research about treatment dose and duration in the substance abuse treatment field.

Table 3.3. New arrest is correlated with fewer months in treatment

New felony or serious misdemeanor arrests		Average months in TC* program**
Follow-up period: 12 months	No arrest	27.4
	New arrest	19.3
Follow-up period: 24 months	No arrest	30.1
	New arrest	20.1
Follow-up period: 36 months	No arrest	30.1
	New arrest	17.5

Notes: \*Therapeutic community.

\*\* Time in the therapeutic community (TC) was preceded by, on average, 8-12 months in Phase 1 sex offender treatment and general mental health education programming.

Source: Lowden, K., Hetz, N., Harrison, L., Patrick, D., English, K, and Pasini-Hill, D. (2003). *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders: A Report of Findings*. Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety. Denver, Colorado.

study, the length of time that an offender participated in treatment was significantly related to positive outcomes after release from prison. Given that program participants in Table 3.3 had approximately 8-12 *additional* months in non-TC treatment, we recommend a minimum prison treatment duration of 38-42 months, prior to release on parole with community-based treatment. This recommendation is consistent with testimony from Dr. Thomas Tobin, reported in the HRSO Task Force report, that in-prison treatment “should begin three to five years prior to release into the community.”<sup>37</sup>

***Given that program participants in Table 3.3 had approximately 8-12 additional months in non-TC treatment, we recommend a minimum prison treatment duration of 38-42 months, prior to release on parole with community-based treatment.***

**Additional duration considerations.** Many offenders begin treatment but become frustrated and drop out when they realize how difficult it is to change, only to decide later that they want to try again.<sup>38</sup> Other offenders enter treatment with the idea that they will scam the

***Therapists must have the capability of terminating offenders that are unwilling to complete treatment assignments or are disruptive in group therapy. Offenders can then learn that change requires a significant investment in the process and cannot be undertaken halfheartedly.***

system to obtain participation incentives and have no intention of applying themselves in treatment. Therapists must have the capability of terminating offenders that are unwilling to complete treatment assignments or are disruptive in group therapy. Offenders can then learn that change requires a significant investment in the process and cannot be undertaken halfheartedly. It is important to remember that it is not uncommon for such offenders to come back later, willing to participate on a meaningful level.

Therefore, treatment needs to start near the end of the offender's term but provide enough time for offenders to drop out or be terminated and then recommit to treatment. We recommend that inmates start treatment when they are within four to five years of their parole release date.

***Recognizing that many will start treatment many times, we recommend that inmates start treatment when they are within four to five years of their parole release date.***

<sup>37</sup> California High Risk Sex Offender Task Force. (January 25, 2007). *Report of Recommendations*, page 11.

<sup>38</sup> In Colorado, treatment staff proactively sought out inmates that terminated from or dropped out of treatment to encourage them to re-apply to the program. Approximately 50 percent of inmates who terminated/dropped treatment returned to the program; many returned multiple times.

## TREATMENT PARTICIPATION CRITERIA

If the Atascadero study taught us one thing, it is that sex offenders do not absorb change just by sitting in group therapy and discussing issues. The study appears to confirm the notion that offenders must apply themselves in treatment to reduce their chances of recidivating. Programs generally establish participation criteria to screen out offenders who are unmotivated to work on their problems. The following inmates are typically excluded from treatment participation:

- Offenders who deny ever committing a sex offense
- Offenders who deny having any problems that they need to work on
- Offenders who refuse to participate in treatment
- Offenders who refuse to sign the treatment contract

***The following inmates are typically excluded from treatment participation:***

- ***Offenders who deny ever committing a sex offense***
- ***Offenders who deny having any problems that they need to work on***
- ***Offenders who refuse to participate in treatment***
- ***Offenders who refuse to sign the treatment contract***

These exclusions are based on a general mental health principle that people are able to benefit from therapy only when they acknowledge that they have a problem and have a desire to change. Further, the group environment must be safe for individuals to discuss their crimes; allowing inmates to participate without admitting their guilt will discourage others from discussing their crimes. Offense-specific treatment requires offense-specific discussions.

It has been our experience in the past that individuals who do not meet these fundamental requirements tend to be disruptive during the group process and gain little or nothing from treatment. Since they do not acknowledge problems, they are unable to discuss thoughts and feelings that create the problems. Likewise, they cannot prepare relapse prevention plans. Allowing them to participate

under such conditions tends to reinforce their denial. Thus, their participation in the program is counterproductive and it can undermine the positive efforts of other inmates. Why should those actively participating in the program continue to engage in a difficult change process when those *not* doing so are granted the same program benefits?

***It has been our experience in the past that individuals who do not meet these fundamental requirements tend to be disruptive during the group process and gain little or nothing from treatment.***

Once CDCR identifies the target population and establishes the treatment participation requirements, the criteria should be documented in department policy and consistently followed. This is especially important since the participation criteria are likely to be challenged by offenders.<sup>39</sup> Then, a system needs to be developed to screen offenders on these requirements, as discussed below.

***Once CDCR identifies the target population and establishes the treatment participation requirements, the criteria should be documented in department policy and consistently followed.***

## SCREENING INMATES FOR TREATMENT

The goal of the treatment screening process is twofold: (1) to determine if the inmate meets the participation requirements, and (2) to encourage offenders to qualify for treatment. This latter aspect is a critical part of the screening process since many inmates are initially resistant to treatment. When inmates are resistant, incentives can

<sup>39</sup> CDCR officials can expect inmates to challenge the criteria, the selection process, and decisions made by treatment staff. Some offenders will challenge the rules in an attempt to gain incentives without actually meeting the eligibility criteria and fully participating in treatment.

be discussed. Therefore, it is important to ensure that staff are trained in motivational interviewing techniques.<sup>40</sup>

**Reception.** Incoming offenders can be screened during the CDCR reception process and immediately assigned to a facility that offers sex offender treatment when they meet treatment participation criteria and are within 4-5 years of parole release. Half of the 2,673 sex offenders who were released to parole for the first time in 2005 stayed in CDCR for 25 months or less,<sup>41</sup> indicating that some offenders will need to go directly from reception to a treatment facility.

**Assigned facility.** Those with longer sentences need to be tracked and screened at the appropriate time. Inmates should be screened within 4-5 years of their release date and transferred to a treatment facility when they meet the participation requirements.

**Screening process.** A screening process can be implemented several ways. Some of the options are more cost effective and time efficient than others. The screening process could be undertaken in several ways by:

- Diagnostic staff at the reception facilities,
- Facility mental health staff/case managers in the offender's assigned facility,
- Sex offender treatment staff that screen written questionnaires completed by offenders in their assigned facility and forwarded to the treatment program, or
- Sex offender treatment staff that travel to outlying facilities to screen potential candidates in their assigned facility.

**Training.** Those responsible for screening inmates for treatment participation need training on the following topics:

- Treatment participation criteria,
- Incentives for treatment,
- Techniques to encourage participation, such as motivational interviewing, and
- Procedures to document compliance with the criteria and initiate a facility transfer.

Appendix 3 contains a copy of the Colorado Department of Correction's participation criteria and therapist instructions for screening sex offenders.

**Electronic tracking.** Regardless of the mechanism selected to screen for treatment participation, this task is a major undertaking in a system as large as CDCR. It is vital that the electronic database be implemented to capture treatment status to ensure that the screening information is documented and accessible to program administrators and treatment staff. Otherwise, offenders will be lost in the system and might not get an opportunity to participate in treatment when they become eligible. This is the same system that should flag offenders for screening when they fall within 4-5 years of release, described above in *Tracking Treatment Recommendations, Developing an Electronic Database*.

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<sup>40</sup> According to the Motivational Interviewing web site (<http://motivation-interview.org/clinical/whatismi.html>), motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence. Compared with nondirective counseling, it is more focused and goal-directed. The examination and resolution of ambivalence is its central purpose, and the counselor is intentionally directive in pursuing this goal. See Miller, W.R., and Rollnick, S. (2002). *Motivational interviewing: Preparing people for change, 2nd Edition*. New York: Guilford Press.

<sup>41</sup> According to the CDCR Division of Research's *California Prisoners and Parolees*, Table 47B on page 75, the median length of stay for all sex offenders combined was 25.3 months, although this ranged from a median of 55 months for those convicted of rape to 11 months for those serving time for "other sex crimes." The median is the midpoint of the range of sentences, meaning that half the inmates in that category serve more than that amount, and half serve less. Accessed in April 2007 at <http://www.corr.ca.gov/ReportsResearch/OffenderInfoServices/Annual/CalPris/CALPRISd2005.pdf>.

## Program structure

The program structure that follows applies to both men and women. Facilities operating programs for men and women should be located in proximity to share staff.

### INDIVIDUALIZED ASSESSMENT

Those offenders who meet participation criteria should be transferred to a treatment facility. Prior to starting treatment, the offender should be assessed during a two to four week period. The assessment should entail a combination of offender interviews, psychological testing, actuarial risk assessment instruments,<sup>42</sup> records review and interviews with collateral contacts such as correctional staff and family members. During this time period, the program researcher should also collect demographic and assessment data for program evaluation and research purposes. Offenders should sign an informed consent form that describes that the assessment data will be used for treatment, research and program evaluation purposes. See Appendix 5 for an example of an informed consent form and other relevant sample forms.

**Responsivity factors.** Once they arrive at the treatment facility, offenders should be further assessed to identify specific treatment and responsivity needs. In particular, staff should identify issues that might affect an inmate's ability to learn treatment concepts, i.e., primary language, I.Q., learning disabilities, physical disabilities such as auditory or visual impairments, mental illnesses, and organic brain impairments. Information documented at reception pertaining to medical, mental health, developmental disabilities, and education issues<sup>43</sup> should be available to sex offender therapists.

When possible, treatment groups should be adapted to accommodate the needs of these offenders. For instance, offenders with developmental disabilities should be placed in the same group, and discussions and material should be adapted to their abilities. Similarly, offenders with hearing impairments should be assessed to see if they need the services of a sign language interpreter. Additional considerations, including attention, anxiety, and mood disorders, should also be assessed prior to treatment. These disorders can interfere with an offender's ability to

***Additional considerations, such as problems with attention, anxiety, and mood disorders, should also be assessed prior to treatment. These disorders can interfere with an offender's ability to benefit from treatment, especially if these disorders remain undiagnosed and untreated.***

benefit from treatment, especially if these disorders remain undiagnosed and untreated. The first assessment priority, then, is to identify any conditions that could impair an offender's ability to progress in treatment.

**Criminogenic needs.** Further assessment is necessary to determine criminogenic factors that are associated with the offender's sex offending behavior. A variety of factors could be associated with their behavior, for instance social isolation, criminal thinking, deviant sexual views, deviant peer groups, hypersexuality, substance abuse, etc. These factors are more difficult to identify in an initial evaluation since offenders are seldom forthcoming about this type of information. Therefore, evaluators should obtain information from criminal records, collateral sources and objective tests as well as offender self-report.

As discussed in Section One, one tool that may assist therapists in the assessment of general criminogenic factors is the Level of Service Inventory, available from Multi-Health Systems, Inc.<sup>44</sup> The LSI-R assessment is administered via a structured interview. Supporting documentation should be collected from family members, employers, case files, drug tests, and other relevant sources.<sup>45</sup> The instrument includes 54 items that measure ten components of risk and need. The domains measured are

- Criminal history,
- Education,
- Employment,

<sup>42</sup> As previously discussed, most actuarial scales developed for sex offenders are inadequate to identify low and medium risk offenders.

<sup>43</sup> Petersilia, May 2006, page 12.

<sup>44</sup> In a 1999 study, researchers found that 14 percent of the agencies surveyed in a national study were using the LSI-R with another 6 percent planning on implementing it in the near future. See Jones, D., Johnson, S., Latessa, E., and Travis, L. (1999). *Case classification in community corrections: Preliminary findings from a national survey*. Topics in Community Corrections, National Institute of Corrections. Washington, DC: U.S. Department of Justice.

<sup>45</sup> Andrews, D. and Bonta, J. (1995). *The Level of Supervision Inventory-revised*. Toronto: Multi-Health Systems.



- Financial,
- Family and marital relationships,
- Residential accommodations,
- Leisure and recreation activities,
- Companions,
- Alcohol and drug problems,
- Emotional and personal, and
- Pro-social attitudes and orientations.

Although this instrument has not been normed on sex offender populations, many sex offenders have criminogenic needs that can be identified and weighted by the LSI-R. Further, an analysis of average LSI subscores on a sample of more than 2,000 sex offenders on probation in Colorado found that those who committed a new crime in the three years following placement on probation had significantly higher scores in each need domain, compared to those who did not commit a new crime. Thus, those with higher need scores were more likely to recidivate, and the LSI adequately discriminated different levels of need for this sex offender population.<sup>46</sup>

We understand that CDCR is implementing the COMPAS in some facilities to identify criminogenic needs. We would simply underscore the need to use this type of instrument on the sex offender population. The requirement for criminogenic needs assessments for sex offenders is often overlooked, sometimes because instruments are not “normed” on sex offenders, and sometimes because they are considered a “specialist” criminal group that commits only sex offenses. However, at least half of the group of convicted sex offenders also has records of non-sexual criminal behavior. This group, then, must be screened for criminogenic needs, as is recommended for the general population. This recommendation is consistent with the Expert Panel’s (2007) recommendations for assessment.<sup>47</sup>

**Assessment is ongoing.** Initial criminogenic needs assessments should be revised over time as new information surfaces during the treatment process. Given that this assessment process can be staff-resource intensive, another

option would be to delay this assessment and gather information during the first level of treatment. Treatment becomes more individualized as the offender progresses, thus more comprehensive assessment of the inmate’s criminogenic needs could be completed at the beginning of the second level of treatment. This results in fewer resources being expended on offenders that become non-compliant with treatment, especially since there tends to be a high attrition rate in sex offender treatment. Many offenders agree to participate in treatment but drop out as soon as they realize how difficult it is to acknowledge and work on their problems.

***Treatment becomes more individualized as the offender progresses, thus more comprehensive assessment of the inmate’s criminogenic needs could be completed at the beginning of the second level of treatment. This results in fewer resources being expended on offenders that become non-compliant with treatment, especially since there tends to be a high attrition rate in sex offender treatment.***

Assessment information provides the foundation for the individualized treatment plan. The plan determines how each criminogenic factor will be addressed in treatment. As an example, anger may play a role in some offenders’ sexual offending behavior, and those with anger problems should also participate in anger management treatment. Other offenders may have intrusive sexual thoughts and preoccupation that interferes with treatment such as covert sensitization. These individuals may need medications to reduce these thoughts and help them concentrate on treatment groups and homework. Assessments can help define these issues and advanced phases of treatment can be individualized to address these criminogenic factors.

Another important area to evaluate is the offender’s history of sexually deviant interests and behavior. Before the second level of treatment, offenders should be assessed with objective measures such as plethysmographs and visual reaction time instruments to evaluate deviant sexual arousal and interests.

<sup>46</sup> Harrison, L., and English, K. (2007). *Unpublished data*. Colorado Division of Criminal Justice, Office of Research and Statistics. Available from the authors upon request.

<sup>47</sup> Expert Panel on Adult Offender and Recidivism Reduction Programming. (2007). *Report to the California State Legislature: A Roadmap for Effective Offender Programming in California*. Sacramento, CA: California Department of Corrections and Rehabilitation.

In addition, a sexual history disclosure polygraph process can help determine the level and variety of past sexual offending behaviors. Offenders need to have clear definitions for sexual offending behaviors before an accurate polygraph test can be conducted. Therefore, it is recommended that the polygraph process start in Level Two treatment.

Assessment is labor and cost intensive, but it is a key component of evidence-based programming. The process described here provides essential information for prison treatment planning purposes and, eventually, community supervision strategies.

***It is recommended that the polygraph process start in Level Two treatment.***

#### TREATMENT PROGRAM COMPONENTS

This section describes specific program recommendations for CDCR. It begins by outlining very specific program components that apply to each level of treatment.

**Therapist manuals.** Therapist manuals containing session instructions, handouts, and assignments should be developed for each type of treatment group. The manuals will maintain program integrity by helping therapist conduct groups in a consistent fashion. Quality assurance efforts (discussed in later in this section) should ensure that therapists conduct groups as designed.<sup>48</sup> While following the program manual is important, allowances should be made for therapists to address additional specific issues that arise in group sessions as long as the basic group content is also covered.

The program will change and evolve over time as new information and program strategies become available. Therapist manuals will require revision to incorporate these changes. A record of these changes and dates they were implemented should be maintained for program evaluation purposes.

The Colorado Department of Corrections loans its therapist manuals to agencies that are developing sex offender treatment programs. It is possible that other corrections departments loan out their manuals as well. During the

***It is especially valuable for sex offender treatment programs to have well crafted treatment contracts that outline confidentiality limits, mandatory reporting requirements, program content and offender expectations.***

CDCR program development process, CDCR might want to review other program manuals.

**Treatment contracts and limited confidentiality.** Sex offenders tend to have issues with power and control and many may challenge program rules and restrictions. Consequently, it is especially valuable for sex offender treatment programs to have well crafted treatment contracts that outline confidentiality limits, mandatory reporting requirements, program content and offender expectations. In fact, each treatment component should have a well-defined treatment contract that is reviewed with the offender and signed by both the offender and therapists.<sup>49</sup> Please see Appendix 6 for treatment contract examples.

***We recommend that CDCR use a male and a female co-therapy team to conduct sex offender treatment groups. Many sex offenders have polarized views of men and women. As a result, it is beneficial to have male and female co-therapists conduct groups together.***

**Male and female co-therapy teams.** We recommend that CDCR use a male and a female co-therapy team to conduct sex offender treatment groups. Many sex offenders have polarized views of men and women. As a result, it is beneficial to have male and female co-therapists conduct groups together. Therapists can model equal non-sexual relationships, assertive communication, and the value of multiple perspectives. Based on the offender's pre-existing stereotypes, he/she may tend to discount information from therapists of a specific gender. However, the gender of therapist that the offender is most willing to listen to

<sup>48</sup> Quality assurance and program fidelity are also discussed in Sections One and Two.

<sup>49</sup> A discussion of the limits of confidentiality and Fifth Amendment protections is included in Section Two.

varies from offender to offender. Therefore, therapeutic feedback generally becomes more powerful and less likely to be discounted when both a male and female therapist expresses it. Use of male and female co-therapists also provides a catalyst for a variety of issues to emerge, which can then be addressed in treatment.

There is one disadvantage to using male and female co-therapy teams. If sex offender treatment is the only program that uses co-therapy, the inmate population can easily identify sex offenders by observing inmates that attend groups led by male and female therapists. Nonetheless, even without co-therapy teams, offenders tend to figure out who the sex offender therapists are and can identify sex offenders by noting the inmates that attend the group. To diminish this problem, groups should be provided in a private location, or in a facility where sex offenders are relatively safe.

**Time limited or open ended.** Treatment groups can be structured as open-ended, meaning participants can enter the group at any time, or closed-ended, meaning that participants all start the group together and finish when the goals are achieved. Offenders can be placed in open-ended groups at any time, allowing participants to be substituted when someone drops out or is terminated. However, this method is more effective in process-oriented groups rather than content-oriented groups, especially if the content builds on previously presented material. Therefore, we recommend that the majority of groups, and in particular the first level group, be closed-ended to facilitate group rapport, cohesion and progress.

***We recommend that the majority of groups, and in particular the first level group, be closed-ended to facilitate group rapport, cohesion and progress.***

**Value of homework.** Treatment assignments (homework) extend group and force offenders to think about how the concepts are relevant to them. Assignments also give offenders a chance to practice the techniques that they are learning. Further, assignments give therapists a chance to monitor whether individual group members understand the material. Consequently, most sex offender treatment programs require participants to complete homework assignments that are regularly reviewed by the therapists.

Depending on the location of treatment and associated safety risks, homework tends to identify sex offenders that are housed in general population. It should not be a problem when the offender is housed with other treatment participants. If offenders have difficulty completing homework assignments in the living unit, other arrangements can be made. Time can be arranged before or after group for offenders to complete homework assignments in the treatment area. In addition, group room space can be made available for homework during hours and days of the week when treatment groups are not scheduled. Homework assignments are a vital part of treatment. There should be accommodations to allow the completion of homework assignments in a safe environment.

***Homework assignments are a vital part of treatment. There should be accommodations to allow the completion of homework assignments in a safe environment.***

**Probationary contracts and termination letters.** Sex offender treatment programs should clearly document the offender's status in treatment. This is especially critical when offenders are placed on probation status or terminated from the group. When an offender has marginal group participation, probationary contracts can describe the specific behavior problems and specify steps (in terms of behaviors) that the offender should take to correct the problems. The probationary contract should be reviewed and signed by the offender and therapist. Thus, the contract helps an offenders understand the changes that he/she needs to make, and serves as notice that the offender will be terminated from treatment if the changes are not made. If the offender ends up being terminated, the specific reasons for the termination – referencing the relevant section of the treatment contract – and steps that the offender can take to get back into treatment should be documented in a letter.

These steps will provide clear documentation for staff and inmates for future treatment related decisions. Additionally, when angry, offenders frequently try to create splits, or conflicts, between staff. They may also try to get their family or the court to believe that they were treated unfairly. If the program clearly documents decisions, staff will be able to establish that the offender was treated fairly and given ample of opportunity to comply with treatment requirements.

## Description of treatment stages

We recommend that the CDCR sex offender treatment program include three levels of treatment:

- A. Introduction to group treatment: 1-3 months, 1.5 hr weekly sessions
- B. Level One: 6 months, 4 days/week, 2 hr/day group sessions
- C. Level Two: Average 30 months, 5 days/week, approximately 4 hr/day in various groups and treatment activities in a therapeutic milieu environment.

**Intensity and duration of treatment.** There is a growing body of research literature in criminology that suggests that treatment intensity and duration should be matched to the offender's risk and need level.<sup>50</sup> Further, a frequent finding in the substance abuse treatment literature is that intensity and longer duration in treatment improve outcomes. For example, the National Treatment Improvement Evaluation Study (NTIES) examined patient and treatment characteristics of over four thousand clients in hundreds of treatment programs to identify factors that were associated with treatment outcomes. The findings indicate that *"drug and alcohol use, criminal activity, and employment outcomes were measurably better among individuals who completed their treatment plans, received more intensive treatment and were treated longer."*<sup>51</sup>

In addition, there is evidence in the sex offender treatment literature to suggest that intensity and duration are important factors in reducing recidivism. Lowden, et al. (2003) found the average time in intense treatment for sex offenders that remained arrest free was 33 to 37 months.<sup>52</sup> Similarly, McGrath, et al. (2003) determined that the longer sex offenders were in outpatient treatment and supervision, following prison treatment, the less likely they

were to sexually reoffend. We encourage CDCR to prioritize intensity and duration in the design of its program.

## INTRODUCTORY TREATMENT

Many sex offenders have difficulty admitting to anyone that they committed a sex offense, let alone to a group of inmates. Prison is already an unsafe environment, one in which inmates try to hide from detection as a sex offender. For those who agree to participate, it is beneficial to ease them into the treatment process.

Therefore, the program should be structured so offenders can adjust to a group setting before being expected to discuss sensitive issues. Offenders should attend a limited number of group sessions that focus on general personal change concepts such as cognitive distortions or stress management. Becoming familiar with the group therapy setting, including the rules and expectations, is an important first step in the treatment process. Increasing the inmates' comfort level with the process is very important *prior* to entering a sex offense specific group therapy.

***Becoming familiar with the group therapy setting, including the rules and expectations, is an important first step in the treatment process.***

In this way, inmates can overcome their concerns about group participation prior to overcoming their fear of disclosing their sex offense. This reduces the probability of inmates dropping out of treatment very early in the process. The introductory group can be offered to general population inmates or offered as a group that is specifically designed for sex offenders. Either way, the content of the group should cover issues that are relevant to sex offenders, and cognitive distortions or stress management is relevant to most inmates. Once the offender successfully completes this brief introductory group, the inmate should be ready for the first level of sex offender treatment.

We recommend that this introductory group be scheduled for 1-3 months. The group could be conducted for 1.5 hours per day, one time per week or up to four times per week. Introductory group should follow the 2-4 weeks of assessment discussed above.

<sup>50</sup> The June 2007 report by the Expert Panel made this recommendation, too. See also Lowenkamp, C. T., Latessa, E.J., and Smith, P. (2006). *Does correctional program quality really matter? The impact of adhering to the principles of effective intervention?* University of Cincinnati, Division of Criminal Justice, available at [http://www.uc.edu/criminaljustice/Articles/Correctional\\_Program\\_Quality.pdf](http://www.uc.edu/criminaljustice/Articles/Correctional_Program_Quality.pdf); Andrews, D. A., Bonta, J. and Hoge, R.D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior*, 17, 19-52; and Andrews, D. A., Zinger, I., Hoge, R.D., Bonta, J. Gendreau, P. and Cullen, F.T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, 8, 369-404.

<sup>51</sup> See <http://www.ncjrs.gov/nties97/treat.htm>.

<sup>52</sup> These numbers include average time spent in both Phase 1 and Phase II treatment.

***We recommend that this introductory group be scheduled for 1-3 months. The group could be conducted for 1.5 hours per day, one time per week or up to four times per week.***

#### SEX OFFENSE SPECIFIC TREATMENT GROUPS

**Level One.** The next treatment level group introduces offenders to common contributing factors in sex offending behavior. Content includes methods to change those factors and adopt a more prosocial lifestyle. Although this group is more psychoeducational in nature (meaning that therapists take on a teaching and information-sharing/skill-building role) offenders should still discuss how the material relates to them, individually, during group discussions and homework assignments. By the end of Level One, participants should be able to identify problem areas that contribute to their offending behavior and risk to reoffend. Then, they should continue to address these problems in the next level of treatment.

We recommend that the Level One program implement group sessions that cover the following content:

- Defining sexual offenses – Many offenders rationalize their behaviors and do not define them as sexual offenses
- Identifying and changing cognitive distortions and associated emotions and behavior (e.g., Yochelson and Samenow's criminal thinking errors, Maultsby's Rational Behavior Training, Ellis' Rational Emotive Behavior Therapy)
- Managing sexually deviant urges
- Healthy sexuality
- Interpersonal skills (relationship skills, assertiveness skills, conflict resolution)
- Anger management
- Problem solving
- Education on victim impact
- Defining the behavior chain of events that lead up to offending/offense cycles

These concepts should be introduced in the Level One group and continue to be addressed in Level Two Treatment. Many of these concepts are difficult for offenders to grasp and accept, as the ideas are contrary to

their worldview. Repetition is an important part of treatment: Repeating concepts helps offenders understand and appreciate treatment material over time.

Throughout the course of the group sessions, therapists should consult with other correctional staff to obtain information about the offender's prison behavior. Important contacts include staff from housing, the visiting room, mailroom, dining hall, recreation activities, and work. Behavior outside of group sessions is more indicative of progress, or lack thereof, in treatment. Since inmate self-report in this area is generally unreliable, the therapists should communicate with other facility staff that have opportunities to directly observe the offender's behavior.

***Throughout the course of the group sessions, therapists should consult with other correctional staff to obtain information about the offender's prison behavior. Important contacts include staff from housing, the visiting room, mailroom, dining hall, recreation activities, and work. Behavior outside of group sessions is more indicative of progress, or lack thereof, in treatment.***

Level One should be structured as a closed ended group with a definite start and end date. Offenders that drop out of Level One and later re-enter it should repeat the group, starting at the beginning. This is necessary to form the group relationships and trust that enable offenders to discuss their crimes. Many offenders who drop out were marginally involved in the treatment process and have much to gain by repeating the entire group.

***Level One should be structured as a closed ended group with a definite start and end date. Offenders that drop out of Level One and later re-enter it should repeat the group, starting at the beginning.***

We recommend that Level One group sessions be scheduled for two hours per day, 4 days a week, for



approximately six months, with a male and female co-therapist team. Without sufficient intensity, the prison culture contaminates the treatment effect. This means that therapists should be able to conduct two groups per day since each group will only last two hours. Paperwork, supplemental individual sessions and assessments should be conducted on the fifth day when groups are not scheduled. The six-month time frame will allow the therapists to conduct four closed-ended groups per year.

***We recommend that Level One group sessions be scheduled for two hours per day, 4 days a week, for approximately six months, with a male and female co-therapist team.***

During the course of the six-month program, some offenders are likely to drop out or be terminated from group. Therefore, groups can start off with 12 offenders, a high number for a group even with two therapists, but it will generally become a manageable size over time.<sup>53</sup>

**Completion assessment.** At the end of Level One, therapists should evaluate each offender's group participation to determine if they should advance to the second treatment level or repeat the first group. Offenders may need to repeat the group if they do not understand the concepts or are unwilling to apply them.

***At the end of Level One, therapists should evaluate each offender's group participation to determine if they should advance to the second treatment level or repeat the first group.***

Those that understand and demonstrate evidence of applying the concepts should progress to Level Two treatment. The assessment process should include a review of the offender's:

- Behavior outside of group,
- Quality of participation,
- Knowledge of treatment content, and
- Ability to delineate problems that contribute to their sex offending behavior that they will continue to work on in Level Two treatment.

**Individualized treatment plan.** A comprehensive individualized treatment plan should be completed on all offenders that progress to Level Two treatment. If the assessment is delayed until after Level One, the program staff, as the first step in Level Two, should complete the assessment and treatment plan. Please see Appendix 8-A for an example of an individual treatment plan, and Appendix 8-B for an example of a Personal Change Contract (individualized relapse prevention plan).

***The Level Two treatment should operate as a residential treatment unit or modified therapeutic community that offers a variety of treatment groups and activities tailored to decrease each offender's individual risk factors and build prosocial skills.***

**Level Two.** The Level Two treatment should operate as a residential treatment unit or modified therapeutic community that offers a variety of treatment groups and activities tailored to decrease each offender's individual risk factors and build prosocial skills. To accomplish this, CDCR will need to provide an environment that is conducive to the offenders' change efforts. Ideally, the offenders will be housed together and the unit correctional staff will be trained on and support the treatment concepts. See *Training for Correctional Staff*, later in this section. The milieu should encourage offenders to apply treatment concepts in daily living. Therefore, offenders should be held accountable for their individual change efforts as well as the change efforts of other program participants.

Traditional therapeutic community (TC) methods, such as house meetings and "pulling up" each other's awareness can enhance treatment effectiveness. However, building traditional components such as a hierarchical inmate structure are not recommended since sex offenders thrive in power and control situations. As such, the hierarchical

<sup>53</sup> Wilson (2007) evaluated a program that replicated a successful cognitive behavioral intervention, but the new program changed the service delivery substantially. Rather than reducing recidivism, the new program increased recidivism. The new program increased group size from 10-13 to 26, and compressed the length of the program to 8 weeks from 4-6 months.

If offenders complete all treatment tasks before transitioning to the community, they should continue to participate in maintenance groups while in the institution to help integrate the changes. Returning these offenders to general population following treatment completion is not advised since positive lifestyle changes will likely erode. New, pro-social attitudes and behaviors are not likely to be supported in the prison culture.

CDCR officials should explore whether achieving these changes could be considered a mitigating factor in civil commitment hearings. That would provide a significant and perhaps necessary incentive for offenders to achieve these treatment objectives.

***Returning these offenders to general population following treatment completion is not advised since positive lifestyle changes will likely erode. New, pro-social attitudes and behaviors are not likely to be supported in the prison culture.***

#### **Education and support groups for family members.**

Treatment staff should provide education meetings for appropriate individuals that the offender will rely on for support. This process should begin shortly after the offender enters treatment, and hopefully, before the offender creates conflicts between support members and therapists. CDCR officials should hire a community support program coordinator to organize the education meetings during times that are convenient for employed individuals, such as Saturdays or evenings. The program can be offered in community locations throughout the state or scheduled prior to visiting time at the facility. Either way, the offender should not attend these meetings. Support people need to be able to ask questions and express concerns without the offender present.

The majority of incarcerated sex offenders will complete their prison term and return to the community. After supervision ends, few offenders remain in treatment and their behavior is no longer monitored by a criminal justice agency. Therefore, it is critical for treatment program to build community support for the offender to continue a prosocial lifestyle after supervision ends. Family members or other community support people (e.g., minister, employer, friend, etc.) need to understand the offender's

***Treatment staff should provide education meetings for appropriate individuals that the offender will rely on for support. This process should begin shortly after the offender enters treatment, and hopefully, before the offender creates splits between support members and therapists.***

risk factors and relapse prevention plan. Offenders may have minimized their problems and risk to these individuals in the past. As a result, it may be difficult for them to hear and accept accurate information about the offender's sex offending history and risk factors, especially when they have an investment in thinking the offender is safe.

There is increasing information on the importance of positive support when the offender returns to the community. A Canadian study found that recidivists had more negative social influences than positive, while non-recidivists had the opposite.<sup>54</sup> Similarly, Beech, Fisher, and Thornton, (2003)<sup>55</sup> found that sex offenders whose support consisted of individuals that supported denial, facilitated victim access, and had antisocial attitudes, were at a greater risk for re-offense. A Colorado study found that sex offenders with positive support had significantly fewer probation violations and new crimes than those with negative or no support.<sup>56</sup> For purposes of the study, support was defined as: "having someone significant to the offender and/or a roommate who attends treatment with the offender, has a positive relationship with the probation officer and treatment provider, and is well versed in the offender's probation and treatment requirements."<sup>57</sup> The study also found that family and friends did not necessarily provide positive support and recommended greater efforts to help families become positive support. A study of sex offender

<sup>54</sup> Hanson, R. K. and Harris, A. (1998). *Dynamic predictors of sexual recidivism*. Corrections Research, Department of the Solicitor General, Ontario, Canada.

<sup>55</sup> Beech, A. R., Fisher, D. D., and Thornton, D. (2003). Risk assessment of sex offenders. *Professional Psychology: Research and Practice*, 4, 339-352.

<sup>56</sup> Colorado Division of Criminal Justice (2004). *Report on safety issues raised by living arrangements for and location of sex offenders in the community*. Colorado Division of Criminal Justice, Department of Public Safety. Denver, Colorado.

<sup>57</sup> Ibid, page 31.

structure is a destructive environment for this population. Sex offenders generally have difficulty with peer interactions and, therefore, the environment should create opportunities to improve peer interactions in power equivalent relationships. Thus, peer monitoring required in TCs should be equivalent rather than hierarchical.

**Treatment Focus.** The following are core groups and activities for Level Two programming:

- Sexual history disclosure with polygraph testing
- Journaling daily events to practice cognitive restructuring
- Rational Behavior Training
- Developing a comprehensive relapse prevention plan
- Interpersonal skills, including interpersonal communication and empathy
- Victim empathy and clarification
- Identifying community support systems that will be informed about the relapse prevention plan
- Maintenance and monitoring polygraph testing
- Relapse prevention rehearsal

The following groups or services should be offered as needed based on the individualized assessment and treatment plan:

- Covert sensitization
- Psychotropic medication to address psychiatric issues or intrusive sexual thoughts
- Substance abuse treatment
- Anger management
- Domestic violence
- Trauma treatment, such as EMDR
- Reentry skills

***We recommend that groups and activities at Level Two be structured as half-day treatment and half-day work. Groups can be scheduled four days a week with supplemental individual sessions scheduled on the fifth workday.***

We recommend that groups and activities at Level Two be structured as half-day treatment and half-day work.

Groups can be scheduled four days a week with supplemental individual sessions scheduled on the fifth workday. The treatment can be further enhanced with the addition of a recreational therapist that assists offenders in developing positive leisure time activities and interests. Recreation activities that are led by a skilled therapist can also provide an important venue for offenders to practice and integrate new pro-social interaction skills.

**Polygraph testing.** A key component of Level Two treatment is polygraph testing. Inmates should complete a sexual history polygraph disclosure and receive maintenance/monitoring examinations testing every six months. This testing provides the basis for establishing the offender's risk to the community. Community supervision strategies should be based on the information obtained from the polygraph examinations. Please see procedures described in Section Two, and material in Appendices 18, 19, and 23.

***We strongly recommend implementing the polygraph in the institutional phase of treatment.***

Note that it will be significantly more difficult to obtain complete sexual history disclosure information once the offender returns to the community. Offenders will fear that additional restrictions will be imposed if they reveal previously unknown information. Therefore, we strongly recommend implementing the polygraph in the institutional phase of treatment.

#### LEVEL TWO TREATMENT PROGRESS AND COMMUNITY TRANSITION

Ideally, offenders will complete the following treatment tasks and activities prior to transitioning to community supervision:

- Non-deceptive sexual history as measured by polygraph testing
- Therapist-approved relapse prevention plan
- Educated community support system where each member has a copy of the relapse prevention plan
- Positive institutional behavior as measured by maintenance and monitoring polygraph testing
- Well-rehearsed pro-social coping skills

residency restrictions by the Minnesota Department of Corrections produced similar findings.<sup>58</sup>

Family members and significant people in the offender's life need education about sex offending in general and specific information on the offender's sexual offending patterns and risk factors to become positive support. The earlier the process is started, the greater the chance that the family will accept the information and learn how to become a positive support for the offender. Family education meetings should cover information on sex offending and how to become a positive support for the offender. Positive support should include:<sup>59</sup>

- Accurate knowledge of the offender's instant offense (crime of conviction).
- Accurate knowledge of the offender's methods of deception and manipulation, particularly as they apply to the informed support person.
- Accurate knowledge of rules and expectations (as provided by the offender's supervising probation or parole officer and treatment provider).
- Awareness of the cycle, offense patterns and early abuse signs.
- Familiarity with the offender's schedule and whereabouts.
- Ability to enhance and encourage application of the offender's treatment tools outside of the therapy setting.
- Working relationship with the treatment provider and parole officer.
- Ability to acknowledge the seriousness of the offending behavior.
- Ability, skills and tools to hold the offender accountable early in the onset of risky behaviors.
- Willingness to report non-compliance to the containment team.

Besides family education meetings, the support program coordinator should arrange meetings where the offender can disclose his/her history of sexual offending behavior, risk factors, and relapse prevention plan to the support team prior to community transition. Before the meeting, the coordinator should help prepare the support person(s) for the type of information that he/she might hear. It can be devastating and overwhelming for family members to hear the extent of the offender's problem. To assist the support person, the coordinator should attend the disclosure session and debrief with him/her after the meeting is finished. The disclosure might require more than one meeting.

Although many offenders have family members that are willing to attend education meetings, others have alienated family and friends. These individuals no longer want to be involved in the offender's life. Support models that address this situation include the Safety Net model developed by the Alaska Department of Corrections or the Circles of Support and Accountability model developed in Canada. See Appendix 10 for complete descriptions of this program. The Washington State Institute for Public Policy has identified Circles of Support and Accountability as a promising practice that requires additional research<sup>60</sup> based on a study that found participants, when compared to a matched group of nonparticipants, had a 70 percent reduction in sexual recidivism, 57 percent reduction in all types of violent recidivism and a 35 percent reduction in all types of recidivism over an average follow-up of 4.5 years.<sup>61</sup> Therefore, we recommend that the community support program coordinator also organize efforts to develop similar programs at the CDCR.

<sup>58</sup> Minnesota Department of Corrections. (2003). Level Three Sex Offenders, Residential Placement Issues: 2003 Report to the Legislature. Minneapolis: Author. Available at <http://www.corr.state.mn.us/publications/publications.htm#so>.

<sup>59</sup> Colorado Sex Offender Management Board. (2004). Living Arrangements Guidelines for Sex Offenders in the Community. Colorado Division of Criminal Justice, Department of Public Safety, Denver, CO. Available at [http://dcj.state.co.us/odvsom/sex\\_offender/SO\\_Pdfs/Living%20Arrangements%20Guidelines-SOMB.pdf](http://dcj.state.co.us/odvsom/sex_offender/SO_Pdfs/Living%20Arrangements%20Guidelines-SOMB.pdf).

<sup>60</sup> Aos, S., Miller, M. and Drake, E. (2006). *Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates*. Olympia: Washington State Institute for Public Policy. Exhibit 4, page 9.

<sup>61</sup> Wilson, R., Picheca, J., and Prinzo, M. (2005). Circles of support and accountability: An evaluation of the pilot project in south-central Ontario. Ottawa, Ontario: Correctional Service of Canada.

## Treatment location (facility selection)

### PROGRAM LOCATION

CDCR officials will need to decide if the program should be in multiple facilities or centralized in one prison. We understand that CDRC officials have considered placing the program in multiple facilities. Treatment can be more accessible to offenders if it is located in a variety of facilities. Sex offenders with varied security levels and those that have custody issues with other sex offenders can be separated in different locations and still participate in treatment. These are significant advantages.

However, there are several disadvantages when the treatment program operates in multiple locations. Since the number of offenders participating in treatment at any one location will be smaller, some offenders may be less inclined to participate. A smaller percentage of the population in the facility engaging in treatment makes it more obvious who the sex offenders are. Consequently, many will fear that their safety will be jeopardized. A second issue involves the ability to maintain a consistent team approach across treatment locations. Team meetings and staff training will be more difficult to arrange and will require travel time and resources in addition to the time allocated for the meeting/training. Program consistency will also be more difficult to maintain; different treatment teams are more likely to result in program “drift,” that is, vary in the degree to which they adhere to the program model. Not only can this effect program outcome, but it also complicates program evaluations (and attributing cause and effect) by confounding findings if the program differs across sites.

There are several advantages to locating the program in one prison. Certainly program consistency will be maintained more easily. Another significant advantage is the ability to develop a facility culture that supports treatment since resources are concentrated in one area. Treatment effectiveness is enhanced when the correctional staff understand and support the program. However, it generally takes a few years for this culture to develop. Training programs for correctional staff that cover sex offender risk factors and treatment goals will help facilitate a supportive culture. See *Training for Correctional Staff*, discussed below. Also, with greater numbers of offenders participating in the program, communication between treatment staff and

correctional staff will increase, creating fewer opportunities for offenders to create splits among staff members.<sup>62</sup>

Further, if a significant number of sex offenders are located in one facility, it may create a safer environment. Currently, the stigmatization that results from a sex crime conviction makes them vulnerable to violence from others. It may be easier for CDCR administrators to ensure a safe environment in one location designated for this population.

Certainly, it is easier to create a facility environment that fosters sex offender rehabilitation when the program is located in a single facility. Implementing policies that support treatment such as no pornography and restricted contact with children will be more acceptable if sex offenders constitute a substantial portion of the facility population. If an entire facility is devoted to sex offender treatment, these policies can be issued for the entire population.

There is one potential disadvantage to locating the program in one facility. Participants who transfer out of the treatment site might be identified as sex offenders in the next facility. If the general inmate population has access to information on prior housing placements and is aware of prisons that house sex offenders, participants that are transferred back to general population will be endangered.

***Finally, the primary consideration in program location(s) should be establishing a safe environment. Sex offenders in California prisons are the targets of violence, and parolees informed us that concealing their crime was the only way to prevent this violence.***

Finally, the primary consideration in program location(s) should be establishing a safe environment. Sex offenders in California prisons are the targets of violence, and parolees informed us that concealing their crime was the only way to prevent this violence. Transferring to a different facility or housing assignment, which occurs regularly

<sup>62</sup> Sex offenders encourage conflict among the professionals who work with them. It works to take the attention away from the inmate. It is a common pattern of behavior, and it is often successful. Correctional staff and treatment staff need to be trained in managing these splits and proactively work together to enhance communication to be prepared for these behaviors.



during the course of serving a prison term, results in new attacks if the offender's crimes become known. If program participation "outs" offenders as having committed a sex crime, the program is likely to fail. The CDCR should prioritize the physical safety of these inmates during program assessment, participation and, when necessary, termination/dropout/completion. Not only will this safety provide a powerful incentive for inmates to actively participate in the program but, without it, few inmates will likely pursue treatment.

Given the serious and fundamental safety issues for sex offenders at the CDCR, we recommend that sex offenders be transferred to a designated sex offender treatment facility in the San Diego, Los Angeles, San Luis Obispo, or Sacramento area. The parolees that we interviewed specifically mentioned Mule Creek State Prison, CSP Solano, and the Men's Colony as facilities with environments that could be made safe. Offenders should be

transferred to the prison when they are within 4-5 years of their release date and meet the participation criteria. To maintain safety, the offenders should remain at the prison until they are released to the community. If they drop out or are terminated from treatment, they should lose privileges and be housed in less desirable locations *within the same facility*.

***To maintain safety, the offenders should remain at the prison until they are released to the community. If they drop out or are terminated from treatment, they should lose privileges and be housed in less desirable locations within the same facility.***

Table 3.4. Facility selection considerations

Location of program	Advantages	Disadvantages
<b>Multiple prison sites</b>	Treatment accessible to more inmates	Program "drift" more likely
	Treatment accessible to varying custody/security levels	Team meetings/training requires travel time and funding
		Safety for inmates more difficult to establish
		Offenders may be "outed" if they have program documentation in their cells
		Offenders may be "outed" if they work on homework yet homework is essential to integrate treatment learnings
<b>Single prison with all sex offender population</b>	Program consistency enhanced	Inmates transferring from this prison to another facility are "outed" as sex offenders
	Concentrates resources and expertise	
	Training correctional staff and opportunities for creating culture is enhanced	
	Trained correctional staff will result in fewer conflicts with treatment staff and promote offender change	
	More likely to establish safe environment for sex offenders	
	Easier to implement policies that support treatment	
	Can focus work assignments and accompanying incentives	
	Easier for inmates to keep important program documents in cell	
	Inmates can work on homework assignments	

We understand that most sex offenders are identified to other inmates by their paperwork. As a result of a court decision, inmates have copies of their commitment documents and their prior criminal record. Sex offenders are “outed” when other inmates demand to see this paperwork. Violence against the sex offender may follow. We realize that it may not be possible, but we recommend that CDCR explore alternatives to this current procedure, including removing paperwork from all offenders.

***We realize that it may not be possible, but we recommend that CDCR explore alternatives to this current procedure, including removing paperwork from all offenders.***

#### ADDITIONAL KEY FACILITY CONSIDERATIONS

**Team meetings.** Whether the program is in multiple sites or centralized, all program therapists should be able to meet as a team on a monthly basis to maintain program consistency throughout the system. Consistency is vital to ensuring that the program is implemented properly. Monthly meeting agenda items can include staffing cases, receiving training, and being briefed on program issues and updates. If run properly, this type of meeting helps build a cohesive team. See *Retaining Staff and Preventing Burnout*, discussed below. Therefore, if the program is implemented in multiple facilities, the location(s) should be in proximity to allow therapists to travel to a central meeting place.

***Officials will find that the location of the program is a critical factor in recruiting the proper staff. Each program must be located in an area where qualified therapists can be easily recruited.***

**Recruitment.** Officials will find that the location of the program is a critical factor in recruiting the proper staff. Each program must be located in an area where qualified therapists can be easily recruited. Most therapists are not interested in working with criminal populations, let alone sex offenders. It is imperative that program developers

and senior staff have a reliable pool of qualified applicants from which to select program staff.

***We believe it is important that the program is located near a university that has a social work or psychology program. The CDCR sex offender treatment program can become an internship placement for the school.***

We believe it is important that the program is located near a university that has a social work or psychology program. The CDCR sex offender treatment program can become an internship placement for the school. Not only does this provide a pool from which to recruit staff, but also gives program supervisors a chance to observe interns working with offenders and determine if the interns would make good employees upon graduation. Equally important, it gives the intern a chance to see if they would like to work in the sex offender treatment field.

**Work hours for staff.** The prison schedule needs to be able to accommodate daytime group sessions. As difficult as it is to recruit skilled therapists for this type of work, it will be even more difficult if the majority of treatment is offered outside of the typical work week hours of 8:00AM to 5:00PM. Scheduling the majority of treatment groups during the day will also allow for more efficient use of staff time because staff will be able to conduct morning and afternoon groups. See *Staffing Ratios, Workload Factors*, discussed below.

**Space.** Each of the program facilities will need adequate group rooms and therapist office space. See Appendix 11 for recommendations on program space. If being a known sex offender creates a safety risk, the treatment space should be located in a less visible area of the prison to decrease identification through participation in treatment.

#### FACILITY POLICIES THAT PROMOTE A TREATMENT ENVIRONMENT

**Training for correctional staff.** Correctional staff observe the offender in the living unit, at work, and during visitation. These observations can help the therapist determine whether the offender is applying the concepts he is learning in treatment. If correctional staff are given information on sex offender dynamics and treatment,

they can help reinforce the concepts, which are presented in treatment and provide information on the offender's behavior outside of group. Hence, the treatment program staff should provide regularly scheduled in-service training programs for correctional staff. The training should cover topics such as: sex offenses,<sup>63</sup> sex offender dynamics (including manipulation tactics, staff splitting, etc.), treatment (goals, terminology and techniques) and institutional indications of risk (collecting pictures of children, assaultive behavior, etc.).

**Correctional staff observe the offender in the living unit, at work, and during visitation. These observations can help the therapist determine whether the offender is applying the concepts he is learning in treatment.**

**Restricting pornography.** Although there is not a direct causal relationship between pornography and sex offending, research indicates that exposure to pornography can result in the factors that reinforce the attitudes that sex offense treatment attempts to change: more callous attitudes toward women, increased tolerance of abusive acts, and less negative judgment of sex offenses.<sup>64</sup> These studies also found that men who endorsed rape myths were more affected by exposure to pornography. Following exposure to sexually aggressive media, these individuals had greater acceptance and disinhibition of aggressive behavior with women.<sup>65</sup> One study found teenagers who read or watched pornography were more likely to view sexual assault as an acceptable behavior.<sup>66</sup>

**Following exposure to sexually aggressive media, these individuals had greater acceptance and disinhibition of aggressive behavior with women.**

Besides reinforcing acceptance of sexual aggression, pornography can also condition sexual arousal to abusive situations.<sup>67</sup> Even exposure to nonviolent forms of pornography has been found to increase viewers' interest in and tolerance of less common forms of pornography including violent forms of pornography.<sup>68</sup> Pornography frequently depicts themes of dominance and submission in sexual activity. Women are commonly portrayed as desiring demeaning, abusive or submissive sexual experiences. These portrayals can reinforce inaccurate beliefs about women, children, men, relationships, and sexuality especially in individuals with poor interpersonal relationships. Even viewing nonviolent forms of sexually explicit material has been found to increase sexual objectification of women<sup>69</sup> and trivialization of rape.<sup>70</sup> Dehumanization of victims is a common component of sexually assaultive behavior. Sexually explicit magazines rarely portray relationships where the individuals are interested in each other as human beings beyond fulfilling each other's sexual desires.

Sex offenders generally have poor interpersonal relationships and are particularly vulnerable to these messages. Sexual addicts frequently use pornography as a form of escape and distraction from day-to-day problems as well as a substitute for emotionally intimate relationships.

<sup>63</sup> The Seattle Police Department has a very good, and free, police officer training video titled *Police Rape Training Video*.

<sup>64</sup> Malamuth, N.M. (1985). The effects of aggressive pornography on beliefs in rape myths: Individual differences. *Journal of Research in Personality*, 19, 299-320; Donnerstein, E., Linz, D., and Pentod, S. (1987). *The Question of Pornography: Research Findings and Policy Implications*. New York: Free Press; Zillman, D. and Bryant, J. (1984). Effects of massive exposure to pornography. In N. Malamuth and E. Donnerstein (Eds.), *Pornograph and Sexual Aggression* (pp. 115-138). New York: Academic Press.

<sup>65</sup> Malamuth (1985), and Donnerstein et al, (1987).

<sup>66</sup> Check, J. and Maxwell, K. (1992). *Children's consumption of pornography and their attitudes regarding sexual violence*. Canadian Psychological Association Meeting, Quebec, June 1992, as cited in Rosenberg, 1992.

<sup>67</sup> Malamuth, N. (1981). Rape proclivity among males. *Journal of Social Issues*, 37, 138-157. Malamuth, N. (1985). The effects of aggressive pornography on beliefs in rape myths: Individual differences. *Journal of Research in Personality*, 19, 299-320, as cited in Russell, D. (1998). *Dangerous Relationships: Pornography, Misogyny and Rape*. Newbury Park, CA: Sage Publications, Inc. Donnerstein, E., Linz, D., and Pentod, S. (1987). *The Question of Pornography: Research Findings and Policy Implications*. New York: Free Press.

<sup>68</sup> Zillman, D. and Bryant, J. (1984). Effects of massive exposure to pornography. In N. Malamuth and E. Donnerstein (Eds.), *Pornograph and Sexual Aggression* (pp. 115-138). New York: Academic Press.

<sup>69</sup> McKenzie-Mohr, D. and Zanna, M. (1990). Treating women as sexual objects: Look to the (gender schematic) male who has viewed pornography. *Personality and Social Psychology Bulletin*, 16(2), 296-308. Cited in Russell, D. (1998). *Dangerous Relationships: Pornography, Misogyny and Rape*. Newbury Park, CA: Sage Publications, Inc.

<sup>70</sup> Zillmann and Bryant, 1984.

Check and Guloien (1989)<sup>71</sup> studied the impact of exposure to different types of sexually explicit material on an individual's self reported likelihood of raping. Men who were exposed to sexually violent or nonviolent dehumanizing pornography were twice as likely to report some likelihood of raping than men in the control group who were not exposed to pornography. Ahlmeyer and Simons (2002)<sup>72</sup> analyzed the sexual histories of incarcerated sex offenders. Sex offenders who viewed pornography generally had abused substances and had a greater number of sex offense victims.

***Men who were exposed to sexually violent or nonviolent dehumanizing pornography were twice as likely to report some likelihood of raping than men in the control group who were not exposed to pornography.***

Hanson and Harris (1998)<sup>73</sup> studied sexual offenders who were recidivists and non-recidivists during supervision to identify dynamic risk factors associated with reoffense. The strongest three stable predictor variables associated with reoffense were: sees self as no risk, poor social influences, and sexual entitlement. Recidivists had less remorse for their crimes, believed that sexual crimes could be justified, felt some women deserved to be raped, had attitudes that sexualized children, and felt entitled to express their strong sexual drive. This study highlights the importance of the rehabilitative need to prohibit materials that reinforce sex offenders' sense of sexual entitlement.

In studying the developmental histories of sex offenders, Simons (2004)<sup>74</sup> found that adult offenders who primarily victimized children were more likely to have had early

childhood exposure to pornography that was associated with their own sexual victimization as a child. In the same study, it was found that offenders who primarily victimized adults were more likely to have had exposure to violent media and domestic violence as children. Those offenders who equally victimized children and adults were more likely to have been exposed to pornography prior to age ten.<sup>75</sup> While this retrospective research with adult offenders cannot determine the number of children with similar experiences that did not grow up to commit sex offenses, it does raise concerns about the risks of early exposure to pornography. It also reinforces concerns regarding adult sex offender's ongoing exposure to pornography, as pornography likely played a role in the developmental factors associated with their sex offending.

It is widely accepted in the professional literature that pornography can play a contributing or exacerbating role in the development of sex offending and violence against women. Inmates with histories of sex offending, violence against women, poor interpersonal relationships or attitudes accepting of sex offenses would be at greatest risk to be highly influenced by pornography. Therefore, we recommend that sex offenders be prohibited from possessing pornography or other types of reading material that can be detrimental to their rehabilitative needs. This prohibition can be accomplished with a treatment condition that is specified in the contact or as a facility restriction if an entire facility is devoted to sex offender treatment.

***It is widely accepted in the professional literature that pornography can play a contributing or exacerbating role in the development of sex offending and violence against women. Inmates with histories of sex offending, violence against women, poor interpersonal relationships or attitudes accepting of sex offenses would be at greatest risk to be highly influenced by pornography.***

<sup>71</sup> Check, J. and Guloien, T. (1989). Reported proclivity for coercive sex following repeated exposure to sexually violent pornography, non-violent dehumanizing pornography, and erotica. In D. Zillman and J. Bryant (Eds.), *Pornography: Recent Research, Interpretations, and Policy Considerations* (pp. 159-184). Hillsdale, NJ: Lawrence Erlbaum.

<sup>72</sup> Ahlmeyer, S. and Simons, D. (2002). *Path-analytic models of risk behaviors, age crossover, and sexual victims and offenses*. Poster presentation at the Association for the Treatment of Sexual Abusers 21st Annual Conference, Montreal.

<sup>73</sup> Hanson, R. K. and Harris, A. (1998). *Dynamic predictors of sexual recidivism*. Corrections Research, Department of the Solicitor General, Ontario, Canada.

<sup>74</sup> Simons, D. (2004). *Different pathways to sexual offending*. Poster session presented at the Association for the Treatment of Sexual Abusers, 23rd Annual Research and Treatment Conference. Albuquerque, N.M.

<sup>75</sup> Simons, D., Tyler, C., and Heil, P. (2005, November). *Childhood risk factors associated with crossover offending*. Poster presented at the 24th Annual Association for the Treatment of Sexual Abusers Research and Treatment Conference in Salt Lake City, Utah.

**Child contact.** There is a large body of research, conducted under conditions of guaranteed confidentiality, anonymous survey, or polygraph testing, that indicates that the majority of sex offenders “crossover” in the types of individuals that they victimize. For example some studies have found that approximately half of the offenders convicted of the rape of an adult admitted prior sexual victimization of a child.<sup>76</sup> Since few sexual offenses are reported to law enforcement, criminal justice records rarely contain the full extent of the offender’s sexual offending history. Yet, this information is typically relied on when making decisions regarding sex offender contact with children.

Some prison systems approve sex offender contact with children during visitation since visits are supervised by correctional staff and assumed to be safe. However, we are aware of sex offenders abusing children during prison visits. A further concern is the opportunity that visits create for grooming children to feel comfortable with the offender, thus enabling abuse after the offender

is released from prison. Therefore, we recommend restricting sex offender contact with children unless a comprehensive evaluation of their risk to children is completed. For much more information on this issue, please see Appendices 12 and 1, Colorado Sex Offender Management Board *Standards* regarding sex offender contact with children, and a summary of relevant research studies, respectively.

***Some prison systems approve sex offender contact with children during visitation since visits are supervised by correctional staff and assumed to be safe. However, we are aware of sex offenders abusing children during prison visits.***

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<sup>76</sup> Abel, G. G., Becker, J. V., Cunningham-Rathner, J., Mittelman, M., and Rouleau, J. L. (1988). Multiple paraphilic diagnoses among sex offenders. *Bulletin of the American Academy of Psychiatry and the Law*, 16, 153-168; Heil, P., Ahlmeyer, S., and Simons, D. (2003). Crossover sexual offenses. *Sexual Abuse: A Journal of Research and Treatment*, 15, 221-236; O’Connell, M. A. (1998). Using polygraph testing to assess deviant sexual history of sex offenders. (Doctoral dissertation, University of Washington, 1998). *Dissertation Abstracts International*, 49, MI 48106.



## Community containment

### TREATMENT COMPLETION AND COMMUNITY TRANSITION

Ideally, offenders will complete the following treatment tasks and activities prior to transitioning to community supervision:

- Score non-deceptive on the sexual history polygraph examination
- Complete a therapist-approved relapse prevention plan
- Identify a community support system, and each member has been educated by the community support position, and each has a copy of the relapse prevention plan
- Score non-deceptive on maintenance and monitoring polygraph tests indicating positive institutional behavior
- Demonstrate prosocial coping skills verified by continuous rehearsal

When inmates complete all treatment tasks and are not yet eligible to transition to the community, they should continue to participate in maintenance groups while in the institution to help ingrain the changes. Returning these offenders to general population following treatment completion is not advised since positive lifestyle changes will likely erode. New, prosocial attitudes and behaviors are not likely to be supported in the general prison culture.

***Returning these offenders to general population following treatment completion is not advised since positive lifestyle changes will likely erode. New, prosocial attitudes and behaviors are not likely to be supported in the general prison culture.***

As discussed above, CDCR officials should explore whether achieving these changes could be considered a mitigating factor in civil commitment hearings. That would provide a significant and perhaps necessary incentive for offenders to achieve these treatment objectives.

### IMPORTANCE OF COMMUNITY TREATMENT AND SUPERVISION

The process of transitioning sex offenders to the community should be viewed as part of the treatment program. Many studies underscore the necessity of transitioning inmates into the community with structured, service-oriented programming that is coordinated with programming in the institution. Aos, Miller and Drake (2006)<sup>77</sup> reviewed corrections programs to make recommendations to the state legislature regarding prison recidivism reduction. The authors found that in-prison sex offender treatment programs with aftercare in the community reduced recidivism by 7 percent. California's High Risk Sex Offender Task Force and the Expert Panel both recommended that, to reduce recidivism, CDCR coordinate offender transition services and programming in the community.<sup>78</sup>

***The process of transitioning sex offenders to the community should be viewed as part of the treatment program. Many studies underscore the necessity of transitioning inmates into the community with structured, service-oriented programming that is coordinated with programming in the institution.***

In a study specific to sex offenders, Lowden, et al., (2003)<sup>79</sup> evaluated the outcomes of 3,338 sex offenders one-year following release from the Colorado Department of Corrections. Sex offenders with *both* prison treatment and specialized parole supervision with community

<sup>77</sup> Aos, S., Marna Miller, M., and Drake, E. (2006). *Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates*. Olympia: Washington State Institute for Public Policy.

<sup>78</sup> California High Risk Sex Offender Task Force. August 15, 2006. *Report to the Governor and the Legislature*. Sacramento, CA: Author; Expert Panel on Adult Offender and Recidivism Reduction Programming. (2007). *Report to the California State Legislature: A Roadmap for Effective Offender Programming in California*. Sacramento, CA: California Department of Corrections and Rehabilitation.

<sup>79</sup> Lowden, K., Hetz, N., Patrick, D., Pasini-Hill, D. Harrison, L., English, K. (2003). *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders: A Report of Findings*. Denver: Colorado Department of Public Safety, Division of Criminal Justice, Office of Research and Statistics.

treatment had the best outcomes.<sup>80</sup> Only six percent were arrested for a new crime of any type. Offenders that did not participate in prison treatment and were released without benefit of parole supervision and community treatment had the worst outcomes: Thirty-four percent were arrested for a new crime in the first 12 months following release from prison.

***Sex offenders with both prison treatment and specialized parole supervision with community treatment had the best outcomes.***

Effective community transition requires implementing the containment approach, small parole caseloads, specialized training for officers and others, clear links and protocols that connect community activity with the prison treatment program staff, and the proactive establishment of community support. These topics are addressed below.

#### **The containment approach and parole supervision.**

The containment approach is described in Section Two, and provides the framework for the prison treatment program and the parole transition period. This discussion more specifically targets parole supervision since the containment approach actually centers on the probation and parole officer whose agency has jurisdiction over the offender. Without the involvement of parole, few sex offenders in California would likely volunteer for intense treatment and polygraph testing.

***The containment approach is described in Section Two, and provides the framework for the prison treatment program and the parole transition period.***

As the leader of the community containment team, the officer's role is essential in ensuring the following outcomes of containment implementation:

- Vastly improving communication among the agencies involved;

- Incorporating representatives of sexual assault victims in the decision-making process and so decreasing the likelihood of putting specific victims at risk again;
- Promoting the exchange of expertise and ideas;
- Facilitating the sharing of information about specific cases;
- Increasing team members' understanding of what everyone on the team needs to do his/her job well; and
- Fostering a unified and comprehensive approach to the case, making the day-to-day management and supervision of the offender easier for the officer and more consistent for the offender.<sup>81</sup>

Perhaps most importantly, according to the original containment studies, supervising officers who were engaged in the containment approach reported that they felt they were, in comparison to pre-containment, doing their job well because they had more information about individual offenders and the system was more responsive to concerns voiced by officers.<sup>82</sup>

***Given the apparent effectiveness of the containment approach, we would recommend that the CDCR select parole officers in each region that, first, are willing to work with sex offenders. Next, they must receive special training and be willing to work as a team with polygraph examiners and specially trained therapists.***

**Specially trained parole officers.** Over the past ten years, many jurisdictions across the nation have identified specialized sex offender supervision officers. These officers receive special training and usually manage smaller caseloads. This specialization was found to be a core element of the containment approach.<sup>83</sup>

Given the apparent effectiveness of the containment approach, we would recommend that the CDCR select parole officers in each region that, first, are willing to work

<sup>80</sup> These offenders were released into the containment approach, with specialized supervising officers, sex-offense specific treatment, and polygraph testing.

<sup>81</sup> English, Pullen and Jones (1996).

<sup>82</sup> English (1998).

<sup>83</sup> English, Pullen and Jones (1996).

with sex offenders. Next, they must receive special training and be willing to work as a team with polygraph examiners and specially trained therapists. This is occurring in many jurisdictions in California; several CDCR parole officers (some are now retired) have national reputations. These individuals may be willing to assist in providing training/services required to formally develop containment for all sex offenders leaving the prison treatment program.

***Training therapists and parole officers together will facilitate a collaborative relationship between the two groups.***

The specialized officers should receive training on sex offender dynamics and specialized sex offender supervision using the containment approach. Ideally, this training should be conducted with the training recommended for the prison therapists (see Appendix 13), since many of the training topics will overlap. Further, training therapists and parole officers together will facilitate a collaborative relationship between the two groups.<sup>84</sup> Prison therapists will see the importance of passing on relevant information to the supervising officer once the offender is paroled. Likewise, the supervising officer will know to send information obtained during parole to the prison therapists if the offender returns to prison. Communication is enhanced when professionals know each other, and specialization of job tasks tends to enhance communication across organizations.

***When parole officers notice trends in problem behaviors and parole failures, the information can be shared with the prison treatment providers and the program can be revised to further address those issues and prepare offenders to be successful in the community.***

These groups can also coordinate a consistent continuum of care and jointly collect data to measure outcomes. An open exchange of information can also facilitate revisions to the prison program. When parole officers notice trends in problem behaviors and parole failures, the information can be shared with the prison treatment providers and the program can be revised to further address those issues and prepare offenders to be successful in the community.

**Community treatment.** The containment model requires a team approach that involves sex offense specific treatment in the community. The treatment in the community should be consistent with the treatment approach in the prison – cognitive-behavioral treatment within containment approach that includes a relapse prevention component. The CDCR could develop contracts with private treatment providers that comply with this approach to provide community treatment to parolees. See Appendix 22 for the Colorado Department of Corrections regulation on approved community treatment providers.

***We recommend that community treatment resources be expanded to accommodate the treatment needs of all sex offender parolees. Even offenders that are unable or unwilling to participate in the prison treatment program should be required to participate in treatment in the community.***

Based on our understanding of the California system, CDCR already has contracts with private community providers to pay for the treatment of 300 parolees that are designated as High Risk Sex Offenders (HRSO). These offenders co-pay \$11.50 per month. We recommend that community treatment resources be expanded to accommodate the treatment needs of all sex offender parolees. Even offenders that are unable or unwilling to participate in the prison treatment program should be required to participate in treatment in the community. The treatment requirement could become a standardized parole condition for sex offenders. Failure to comply with the requirement could result in a revocation hearing.

While it may be too expensive for CDCR to pay for the treatment of all sex offender parolees, we recommend the CDCR implement a system that pays for the first month

<sup>84</sup> Note that the original descriptions of the containment approach recommend also including in intensive training the supervisors of specialized officers and administrators who will be key decision makers. This training provides the foundation for understanding the population of offenders and the framework for future program content and resource decisions. It assures that individuals share a common knowledge base and this facilitates working toward common goals (English, Pullen and Jones, 1996; English, 1998, English 2004).

or two of treatment until the offender gets established in housing and a job. Interviews with treatment providers indicated that it is essential that offender is responsible for paying some portion of the treatment expenses.<sup>85</sup> In English et al., (1996), therapists and supervising officers reported that offenders were more invested in the treatment process when they were required to pay for some or all of it. If cost-of-living expenses in California are too high for some offenders to afford treatment, the CDCR could establish a sliding fee scale and subsidize the treatment cost. It is important that treatment providers and polygraph examiners be paid in full when working with this difficult population, and this issue will require monitoring by the parole officer.

***We recommend the CDCR implement a system that pays for the first month or two of treatment until the offender gets established in housing and a job. Interviews with treatment providers indicated that it is essential that offender is responsible for paying some portion of the treatment expenses.***

Note that sex offenders who participate in prison treatment are likely to be significantly easier for parole officers to place into containment in the community. Interviews with parole officers in Colorado indicated that parolees who had engaged in prison treatment expected placement in a treatment program with polygraph testing, and they anticipated the special restrictions placed on them by the parole officer. Overall, the offenders understood the expectations of parole officers.<sup>86</sup> The sex offenders released into containment in California without the benefit of treatment are likely to be more resistant, in general, and parole officers should be prepared for this distinction.

**Polygraph examinations.** Polygraph examiners are important members of the community containment teams. As in prison, sex offenders on parole should be required to com-

plete a non-deceptive sex history polygraph examination (if they have not done so in Level Two treatment), and at least two monitoring examinations each year. Higher risk offenders, and those in need of greater monitoring, may require more frequent examinations.

***We recommend that CDCR identify a pool of polygraph examiners who meet minimum requirements based on qualifications and experience, and direct parole officers to use only this approved pool of providers.***

We recommend that CDCR identify a pool of polygraph examiners who meet minimum requirements based on qualifications and experience, and direct parole officers to use only this approved pool of providers. The list ensures that examiners meet the necessary qualifications for testing this population. Many jurisdictions in California have been using the post-conviction polygraph test with sex offenders for many years, and we recommend building on this pool of experts.

It is important to understand that the use of the polygraph will reveal criminal behavior that would otherwise go undetected, and will require protocols for responding to information disclosed in the process of containment. Using the polygraph in sex offender management substantially increases the workload of the parole officer. It requires frequent communication between the officer and the examiner and treatment provider. Most importantly, the officer must respond to information disclosed in the treatment/polygraph process by imposing restrictions—or initiating revocation procedures—based on specific risk behaviors.

The officer is responsible for ensuring that the offender is participating in regular polygraph examinations. Monitoring the scheduling and taking of exams, and invoking consequences for deceptive exams, is part of the officer's role as leader of the containment team. See Appendix 23 for an example of a polygraph sanctions grid.

**Parole case loads.** In many states, officers that supervise sex offenders have reduced parole caseloads. Reduced caseloads allow the officer to increase collateral contacts with family, employers and others, home visits and searches, collaboration with the team, review of treatment and

<sup>85</sup> English, K., Pullen, S., and Jones, L. (Eds). (1996). *Managing adult sex offenders: A containment approach*. Lexington, KY: American Probation and Parole Association.

<sup>86</sup> Lowden, K., Hetz, N., Patrick, D., Pasini-Hill, D. Harrison, L., English, K. (2003). *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders: A Report of Findings*. Denver: Colorado Department of Public Safety, Division of Criminal Justice, Office of Research and Statistics.



polygraph reports, collaboration with law enforcement and victim services. Obtaining and sharing information about individual offenders takes time, and responding to the additional information is the key to public safety.

***Obtaining and sharing information about individual offenders takes time, and responding to the additional information is the key to public safety.***

Caseload sizes vary nationwide. In some states, a “reduced” caseload size is 60 offenders. In Colorado, probation policy dictates that sex offender supervising officers have caseloads of 25. As one specialized officer reported, “In 17 years, I have had sex offender caseloads of 120, 60 and 25, and I can tell you that 25 is best if you want to know well what your offenders are doing.”<sup>87</sup> Federal probation officers in Southern California with the Ninth Division of the Federal Circuit Court with GPS-monitored sex offenders supervise a maximum of 20 because of the time required to respond to the GPS- and polygraph-generated information. The Minnesota Department of Corrections’ work group on caseload size recently recommended sex offender caseload sizes of 12 for intensive supervision, 30-35 for high-contact offenders, 50-55 for medium-contact offenders, and 90 for low-contact offenders.<sup>88</sup>

Specialized, small caseloads may not be possible in rural areas. However, officers working in these areas nevertheless need training and may need additional resources on occasion to successfully manage this population.

We refer the reader to the discussion of polygraph examinations in Sections Two and Three, along with the associated appendices. Please see Appendix 14 for a variety of contact standards and supervision conditions.

## COMMUNITY SUPPORT

Establishing informed community support is an important treatment consideration for the sex offender population. Many sex offenders are isolated; their secrecy leads to few, if any, meaningful pro-social relationships.

Further, for most offenders, criminal justice supervision is time limited. Once supervision ends, offenders may choose to discontinue treatment, so an informed community support system will assist offenders to maintain lifestyle changes.

To reduce recidivism, then, comprehensive sex offender treatment requires efforts to establish safe environments and positive community support systems. A few examples, below, can provide direction for CDCR administrators to pursue this objective.

**Circles of support and accountability.** As previously discussed, Circles of Support and Accountability, modeled after Canadian natives’ healing circles, have been found effective in the single evaluation to date,<sup>89</sup> and many jurisdictions are attempting to replicate this program. COSAs are composed of five lay volunteers that meet with the offender individually and as a group on a weekly basis as the offender transitions from prison to the community. In a survey, 90 percent of offenders reported that they would have more difficulty adjusting to the community, and 67 percent said they would have been likely to return to criminal behavior, without benefit of the COSA. A 4.5-year follow-up study found that those released with COSA support had reductions in all types of recidivism in comparison to those released without COSA. Specifically, five percent of treated sex offenders with COSA committed a new sex crime versus 16.7 percent of the control group. Likewise, violent recidivism was reduced by 57 percent: 15 percent of the COSA group compared to 35 of the control group. Recidivism for any crime was reduced by 35 percent: 28.3 percent of those with COSA, versus 43.4 percent of the control group. See Appendix 10 for information about implementing this type of program.

**Shared living arrangements.** Twenty years ago, Colorado began using Shared Living Arrangements (SLAs) to house sex offenders in the same treatment program and often with the same supervising officer. This living situation allows the supervising officer to conduct more frequent home visits, and both the officer and the therapist make it clear to SLA residents that there is a blanket expectation that offenders will report other cohabitants’ violations.

<sup>87</sup> Karen Vigil, Colorado probation officer, training event for the Alaska Department of Corrections, May, 2006.

<sup>88</sup> Minnesota Department of Corrections. (Feb. 2007). *Report to the Governor*. Minneapolis, MN: Author.

<sup>89</sup> Wilson, R., Picheca, J., and Prinzo, M. (2005). *Circles of support and accountability: An evaluation of the pilot project in south-central Ontario*. Ottawa, Ontario: Correctional Service of Canada. See also Aos, S., Miller, M. and Drake, E. (2006). *Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates*. Olympia: Washington State Institute for Public Policy. Exhibit 4, page 9.



A Colorado study of SLAs determined the following:

- Those living in SLAs were likely to be high and medium risk offenders, as determined by the Oregon Risk Assessment Scale;
- High risk offenders living in SLAs had fewer technical and criminal violations than offenders living with family, friends or roommates that refused to cooperate with the criminal justice containment team;
- SLA outcomes were equivalent to those participating in the jail work release program;
- SLAs provided an informed positive support system of individuals—mostly other sex offenders—who were aware of the offender’s sex offending history, manipulation tactics, and treatment and supervision requirements;<sup>90</sup> and
- The new sex crime recidivism rate in this study was 12.5 percent: 15 new sex crimes were detected. However, 11 were self-reported during polygraph examinations, 3 were revealed by other therapy members, and one was detected by law enforcement.<sup>91</sup>

All of the new sex crimes were hands-off sex crimes such as voyeurism and exhibitionism, and only one would have been detected without treatment, supervision and polygraph examinations in the community.

**Surveillance officers.** The probation office in Maricopa County, Arizona uses surveillance officers who work with the caseloads of two supervising officers.<sup>92</sup> The job of the surveillance officer is to continuously monitor sex offenders in the community, at home and at work, primarily during

non-work hours. Surveillance officers, then, work mostly at night and on weekends, and focus on monitoring offenders’ leisure time. This arrangement has been replicated in jurisdictions in other states. See Appendix 14 for information about Maricopa County’s supervision program.

**Support groups.** Sex Addicts Anonymous is another community support program that may be beneficial to some sex offenders. However, support programs should only be considered an adjunct and not a substitute for comprehensive offenses specific treatment. Clinicians should be familiar with these types of support groups before determining whether these programs will be beneficial for specific offenders.

Many discussions throughout this report pertain to the necessity of establishing a continuous, seamless transfer of services, support and structure for the offender as he or she leaves the institution and transitions to parole. We echo the recommendations made by the California High Risk Sex Offender Task Force and the Expert Panel, and urge CDCR officials to view containment in the community as an essential component to prison treatment.

***We echo the recommendations made by the California High Risk Sex Offender Task Force and the Expert Panel, and urge CDCR officials to view containment in the community as an essential component to prison treatment.***

<sup>90</sup> Colorado Division of Criminal Justice (2004). *Report on the Safety Issues Raised by Living Arrangements for and Locations of Sex Offenders in the Community*. Denver: Colorado Sex Offender Management Board.

<sup>91</sup> Dethlefsen, A. (2007). Additional analyses on the living arrangements study sample (see Footnote 90). Sex Offender Management Unit, Colorado Division of Criminal Justice, Department of Public Safety. Denver, CO.

<sup>92</sup> See English, Pullen and Jones, 1996.

## Quality control and program evaluation

As previously discussed, program integrity is a critical component of effective programs.<sup>93</sup> Because decreasing recidivism of this population is a major public safety concern, quality assurance should be a key component of the CDCR sex offender program. Frequently program quality assurance is a minor consideration, particularly in large institutions where more immediate safety concerns understandably take priority. However, for more than two decades, corrections research has clarified the importance of proper service delivery. This fact, plus the costs associated with new sex crimes, underscores the necessity of this program component. In addition, program evaluations that report recidivism rates have little meaning if program delivery is not well documented and delivered as planned. The public safety/recidivism-reduction goal of intense programming cannot be achieved if the program—no matter how carefully developed—is not carried out as designed. In the end, recidivism studies will reflect the impact of program implementation versus the program design. And any decision to modify the program design could be based on erroneous conclusions.

***Frequently program quality assurance is a minor consideration, particularly in large institutions where more immediate safety concerns understandably take priority. However, for more than two decades, corrections research has clarified the importance of proper service delivery.***

It is important to track the offenders who have participated in the program. Basic information on each offender should be collected and studied: length of participation, various measures of progress, actual number of hours engaged in treatment, reasons for termination/dropout, reasons for non-participation (such as facility lockdown), work behavior, disciplinary infractions, and status in treatment. CDCR will need this information to monitor the program and to create reports for the legislature.

The person with quality assurance responsibilities (working with the program researcher, discussed below) could be tasked to develop a system to track participation; however, it would be more efficient for the QA person to work with CDCR's MIS (management information system) computer programmers to develop an electronic system in the CDCR information system. Then, each therapist would be responsible for entering the offender's treatment status into the information system. The QA position would be responsible for conducting audits to determine the extent to which therapists were entering information in an accurate and timely manner. See Appendix 15 for an example of a quality assurance document.

## PROGRAM RESEARCH

The program research activities should include assessing the effectiveness of program components to determine whether program enhancements or revisions are needed, sex offender deficits and treatment needs, and overall program outcomes. Finally, the evaluation effort also should include studying the prison and parole treatment outcomes of inmates who do and do not participate in the program.

As discussed in Section One, program integrity is one of nine empirically-based principles of effective correctional programs.<sup>94</sup> Bonta (1997)<sup>95</sup> describes program integrity as: "Conducting the treatment in a structured manner, according to principles outlined, and with enthusiastic and dedicated staff." Landenberger and Lipsey (2005)<sup>96</sup> also list "high quality treatment implementation" as an independent factor that is associated with greater recidivism reductions.

<sup>93</sup> Cullen, G. and Gendreau, P. (2000). Assessing correctional rehabilitation: Policy, practice, and prospects. In *Policies, Processes, and Decisions of the Criminal Justice System – Criminal Justice, 2000*, Volume 3. National Institute of Justice, Washington, D.C.

<sup>94</sup> McGuire, J. (2001). "What works in correctional intervention? Evidence and practical implications," in G. A. Bernfeld, D. A. Farrington, and A. W. Leschied (Eds.). *Offender rehabilitation in practice: Implementing and evaluating effective programs*. New York: John Wiley and Sons, Inc.; Higgins, S. T. and Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers: Research on Contingency Management Interventions*. American Psychological Association; National Institute of Corrections, <http://nicic.org/ThePrinciplesofEffectiveInterventions>; Latessa, E. J. and Lowenkamp, C. (2006). What works in reducing recidivism? *University of St. Thomas Law Journal* 521-535; Andrew, D., Zinger, I., Hoge, R., Bonta, J., Gendreau, P., and Cullen, F. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, 28(3), 369-404; Cullen, G. and Gendreau, P. (2000). *Assessing correctional rehabilitation: Policy, practice, and prospects*. In *Policies, Processes, and Decisions of the Criminal Justice System – Criminal Justice, 2000*, Volume 3. National Institute of Justice, Washington, D.C.

<sup>95</sup> Bonta, J. (1997). *Offender rehabilitation: From research to practice*. Presentation at the Ottawa Conference (2000). Public works and Government Services Canada.

<sup>96</sup> Lipsey, M. W. and Landenberger, N.A. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of 58 experimental and quasi-experimental studies of the effects of cognitive-behavioral therapy (CBT). *Journal of Experimental Criminology*, 1, No. 4, 451-476.

Further, Gendreau and Ross (1987)<sup>97</sup> recommend that program analysis include the following questions:

- To what extent do treatment personnel actually adhere to the principles and employ the techniques of the therapy they purport to provide?
- To what extent are the treatment staff competent?
- How hard do they work?
- How much is treatment diluted in the correctional environment so that it becomes treatment in name only?

These findings, along with the general discussion about evidence-based practices in Section One, support the importance of a quality assurance and program evaluation component in the CDCR sex offender treatment program.

Finally, one treatment program goal might be contributing to the larger field of knowledge regarding sex offending and sex offender treatment. To that end,

CDCR administrators could encourage project staff to undertake treatment efficacy studies and submit the findings for publication in peer-reviewed journals, and present studies at professional conferences. In this way, the program can make a contribution in addition to the treatment gains made by offenders. For example, research undertaken by the sex offender treatment program at the Colorado Department of Corrections is identifying distinct pathways to rape or child molesting based on adverse childhood experiences.<sup>98</sup> Not only will this identify treatment targets, but the information can assist in the development of prevention efforts. In addition, therapists working with this population elsewhere can benefit from lessons learned by those working with inmates. Please see *How Does Treatment Promote Public Safety*, discussed at the beginning of this section.

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<sup>97</sup> Gendreau, P. and Ross, R. (1987). Revivification of rehabilitation: Evidence from the 1980s. *Justice Quarterly*, 4(3), 349-407; Gendreau, P. (1995). The principles of effective intervention with offenders. In A. Harland, *What Works in Community Corrections*. Sage, Newbury Park, NJ.; Gendreau, P. and Ross, R. R. (1979). Effective correctional treatment: Bibliotherapy for cynics. *Crime and Delinquency*, 25, 463-489.

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<sup>98</sup> Many studies at the Colorado Department of Corrections have contributed significantly to the larger body of knowledge regarding sex offender treatment. A current study is examining childhood experiences with abuse, including witnessing domestic violence, and emotional attachment, and has documented distinct pathways to adult attitudes consistent with (1) rapists and (2) child molesters and (3) indiscriminant offenders. These studies include Simons, D., Tyler, C., and Heil, P. (2005, November). *Childhood risk factors associated with crossover offending*. Poster presented at the 24th Annual Association for the Treatment of Sexual Abusers Research and Treatment Conference in Salt Lake City, Utah; Simons, D. (2006). Childhood victimization of sexual abusers: Making sense of the findings. *ATSA Forum*, 18, 1-16; Simons, D., Wurtele, S. K., and Durham, R. L. (in press). Developmental experiences of child sexual abusers and rapists. *Child Abuse and Neglect*.

## Program staffing

### INSTITUTIONAL OR CONTRACT STAFF, OR BOTH?

The CDCR has several options in terms of staffing the program. The first option is to hire full-time CDCR employees to deliver services. The second option involves developing a request for proposals to establish a contracted program. The third option is a combination of CDCR employees and contracted providers. The following considerations for each option are listed below to assist CDCR in selecting an option:

1. **CDCR employees.** If CDCR hires employees, current contractors or staff who have experience conducting sex offender treatment in correctional facilities should play a primary role in the interview and selection process. Jack Wallace, currently a consultant/contractor to CRCD, and Sean Ahlmeyer, CDCR psychologist at the Corcoran Prison, have these qualifications. The CDCR could also invite outside sex offender treatment experts to participate on interview panels. Since psychologist positions are relatively high paid, the CDCR might want to consider staffing the majority of the program with less expensive masters level social work or marriage and family therapist positions. However, psychologists should fill positions that administer psychological testing.

#### *Advantages:*

- Correctional staff may be less likely to view CDCR employees as outsiders and, therefore, view the program more favorably, increasing the odds that the program will become institutionalized.
- It may be easier for CDCR to establish program- and individual-level quality control process with state employees rather than contractors.
- It may be easier for CDCR to maintain responsibility for the successes and challenges related to the program.
- Day-to-day problem solving between treatment and institutional staff may be enhanced with this model.
- It may communicate to all institutional staff that CDCR is committed to integrating programming and rehabilitation into its daily operations and larger mission.

#### *Disadvantages:*

- It requires CDCR to develop and maintain internal expertise in sex offender treatment.
- It requires legislatively allocated and funded positions.
- It adds to the tasks associated with state employees, such as supervision, performance evaluations, etc.
- It requires CDCR to be mindful and supportive of ongoing specialized staff training.

2. **Contract.** If the CDCR chooses to contract with a company to design and implement a sex offender treatment program, the initial selection process must be carefully undertaken using the expertise described below in *Staff Selection*. The contractor will be required to select and train skilled therapists to work in the prison setting.

#### *Advantages:*

- This approach means less up-front work for the CDCR administrators. The contractor will develop program content that must be coordinated with prison operations.
- The contractor may already have expertise and experience in developing and implementing sex offender treatment programs.
- The contractor may have experience recruiting and training staff.

#### *Disadvantages:*

- Prison administrators still need to be closely involved with the contractor as efforts are made to integrate the requirements of the program within the institution.
- A considerable downside can occur if the contract with the company is not renewed in future years. This could result in a significant disruption to the program since new staff will have to be recruited and hired and the program redesigned. To minimize this type of disruption, the contract should require that all program materials, content, and equipment remain the property of CDCR. It is also helpful if the original contractor allows the new contractor to hire the existing staff.

- Contracting for treatment may be viewed as problematic given the recent report by the Office of the Inspector General on the “Special Review Into In-Prison Substance Abuse Programs.”<sup>99</sup>
  - CDCR may lose the opportunity to ensure that research is systematically conducted on the program.
3. **Combination.** A third alternative is to use a combination of CDCR employees and contract staff. The program director, quality assurance positions and program researchers (discussed below) should be CDCR employees. They should maintain responsibility for the program design and materials, staff training, program oversight, research, and program evaluation. The contractor could supply therapists and work with the CDCR staff to design and improve the program over time.

*Advantages:*

- The need for legislatively approved positions is reduced.
- The expertise of the contractor can supplement the CDCR expertise.
- Contract staff can become a recruitment pool for permanent CDCR staff. That is, CDCR officials will have the opportunity to observe the skills of contract employees prior to offering them the protections of a state job.
- Contractors often have greater latitude in recruiting and hiring staff.

*Disadvantages:*

- Two separate entities control program staff, requiring coordination.
- Staff doing the same job may have different salaries and benefits that could create resentment.
- When control of the contract resides outside the sex offender treatment program director, coordination can suffer. This can be easily remedied by ensuring that the program director manages the contract.

## STAFF SELECTION

**General overview.** Based on California’s mental health licensure laws, the following groups of mental health professionals have the appropriate educational background to be considered for treatment provider positions: psychologists, social workers, and marriage and family therapists. However, educational background should not be the sole consideration in hiring decisions. Most graduate programs fail to prepare students to work with offender populations generally, and certainly few include coursework on sex offenders. Yet, treatment with offenders differs from traditional treatment in many important respects. For example, offenders are seldom motivated to seek treatment and are frequently pressured into participation by the criminal justice system. In effect they are coerced clients. Yet most graduate programs teach students only how to work with voluntary clients.

Another critical difference is the risk that the offender population poses relative to “typical” psychotherapy clients. When working with offender populations, and sex offenders in particular, the treatment provider has the additional responsibility to consider the needs of the crime victims and potential victims along with the offender’s needs.

Given that sex offense recidivism is unacceptable and causes significant harm to victims and society, providers must be able to respectfully hold offenders accountable and continually assess their progress in treatment. It is critical that providers have skills and training to work with this difficult population since this group of offenders is characterized by being secretive and manipulative. Further, the wrong type of treatment can actually increase recidivism rates.<sup>100</sup> As a result, when possible, the CDCR should hire staff that are knowledgeable and experienced in treating sex offenders. For staff that do not have extensive experience, CDCR should be prepared to provide the necessary supervision and training. The interview process and reference checks are also important elements in hiring suitable treatment providers; this is discussed below.

**Psychiatric resources.** For certain sex offenders, risk may be reduced by a combination of medication and offense specific treatment, access to psychiatric providers

<sup>99</sup> Office of the Inspector General. (Feb. 2007). *Special Review Into In-Prison Substance Abuse Programs Managed by the California Department of Corrections and Rehabilitation*. State of California. Sacramento, CA.

<sup>100</sup> Washington State Institute for Public Policy. (2000). *Does sex offender treatment work? What are the costs and benefits?* Preliminary results from an economic analysis of sex offender programs. Olympia, WA: Evergreen University.



is also important. Psychiatrists are an important part of sex offender treatment. If CDCR has existing psychiatric resources, the individuals selected to work with program staff should become familiar with the literature on medications that reduce sexual preoccupation, since reduction of sexual drive is an off-label use for many of the medications. Publications by Gene Abel, John Bradford, Don Grubin, Martin Kafka, and Stephen Hucker will provide the psychiatrists an important place to start learning about this specialty.

**Staff characteristics.** When selecting staff to work with sex offenders, the following characteristics are important:

- Comfortable working with sex offenders and their offense behavior
- Able to set limits, and maintain clear and consistent boundaries with clients
- Comfortable confronting clients in a respectful manner and holding them accountable for their behavior while supporting their change efforts
- Comfortable discussing sexual topics
- Comfortable with their own sexuality
- Positive relationships in their lives
- Positive regard for both men and women
- Very strong self-esteem (so that the therapist is not dependent on client feedback to feel okay about the work that they are doing)
- Comfortable challenging distorted beliefs about men and women
- Comfortable not relying on offender self-reported information
- Knowledge of child abuse reporting laws
- Awareness and acknowledgement that they can (and sometimes will) be manipulated by the client
- Ability to remain assertive and respectful while being confronted with the offender's hostility
- Ability to instill hope for change
- Ability to avoid talking about any personal information with offenders
- Comfortable working in a team approach
- Willing to engage in ongoing learning and training to keep skills sharp
- Willing to learn about other professionals' responsibilities

in managing sex offenders (such as polygraph examiners and correctional officers) to maximize team functioning

- Willing to work from a "non-trust" position<sup>101</sup>
- Willing to be in ongoing consultation with supervisors and peers about their effectiveness
- Sensitivity to crime victims' and their families
- Sensitivity to offenders' families

**Interviewing for skills.** We have found that it is helpful to create scenarios and ask job candidates how they would handle the situation as part of the interview process. Examples of these types of interview questions can be found in Appendix 16.

**Checking references.** When checking references, it is helpful to design questions that are neutral and indirectly ask about the qualities that you are looking for, without pointing out the preferred quality. For example, if you want a therapist that can work within a team approach, the question can be worded:

- Does this person prefer to work independently or within a team?
- Does this person prefer to work with clients in individual or group therapy?
- How would this person respond to hostile clients?

The person providing the reference can answer the question without saying something negative about the former employee. Since they do not know what you are looking for, it is more likely that the answer will be accurate.

Another important question to ask pertains to the fact that sex offenders tend to have distorted views of men and women. Therefore, the reference can be asked: How effective would this person be at addressing distortions about men and women?

**Group facilitation.** Besides the qualities listed previously, there are additional considerations when hiring treatment staff. Most of the treatment will be provided in a group setting. The staff must be experts in group therapy.

<sup>101</sup> Mussack and Carich (2001:6) discuss this issue: "Trust is an important issue in all therapeutic settings and is the foundation of facilitating therapeutic change. This creates a dilemma for the sexual abuser treatment professional. A balance of respect and trust with a healthy skepticism and thorough monitoring....Sexual abusers frequently have a view of themselves and the world that is enshrouded in secrecy, distortions, and lies, which is brought into the treatment setting."

**Co-therapy.** Ideally, the CDCR will ensure that two therapists lead every group. Due to the secretive and manipulative nature of sex offenders and the constant exposure to descriptions of their abusive behaviors, it is particularly beneficial to have two therapists co-lead group sessions. That way, they can position themselves across from each other so, together, they can observe all of the group members and monitor the more subtle non-verbal communication that goes on in group as subjects are discussed. A single therapist cannot possibly keep track of all of the dynamics that go on in a group. Also, a therapist working alone is more subject to being manipulated and worn down by group members who gang up on the therapist, trying to get the therapist to relent on holding them accountable.

***A single therapist cannot possibly keep track of all of the dynamics that go on in a group. Also, a therapist working alone is more subject to being manipulated and worn down by group members who gang up on the therapist, trying to get the therapist to relent on holding them accountable.***

Two therapists can support to each other in maintaining offender accountability, debrief with each other regarding the abusive content that they are exposed to, and plan more effective interventions for individual offenders. Another important advantage to having co-therapists is that groups can continue to be held when one therapist is ill or on vacation.

***The recommended staff to inmate ratio for group therapy is 1:6; two therapists allow a group size of 12.***

Additionally, there is a practical reason to schedule two therapists per group: it allows for larger groups. As we discuss below, the recommended staff to inmate ratio for group therapy is 1:6; two therapists allow a group size of 12. Scheduling groups with one therapist, then, will require twice as many group rooms, a resource that is generally scarce in prisons. CDCR will likely find that it is more efficient to have larger groups that are led by two therapists. Please see Appendix 17 for a form that encour-

ages communication between co-therapists and promotes accountability in service delivery.

**Male and female co-therapy teams.** Co-therapy is even more effective when a male and a female therapist facilitate groups. Most sex offenders have difficulty forming genuine relationships with women and men, in part because of their gender role stereotypes. Having a man and a woman co-lead the group helps the therapists identify distortions that specific group members have; they can observe differences in how inmates respond to each therapist. In addition, offenders have a more difficult time discounting the concepts that they learn when both the male and female therapists validate the concept. For example, if a therapist is discussing how pornography can reinforce sex offender's views of women as sexual objects, the offender might have an easier time dismissing the comments if they only come from a female therapist versus a male and a female therapist. Further, co-therapists can model appropriate nonsexual relationships between men and women.

In summary, male and female co-therapists can be more effective in identifying and addressing group members' distortions as well as providing a positive role model for sex offenders.

***Co-therapy is even more effective when a male and a female therapist facilitate groups.***

**Gender and cultural diversity.** The CDCR could designate half of the positions as female therapists and half as male therapists to work as part of a male/female co-therapy team. Since there would be an equal number of male and female positions, the designation should not create a discriminatory practice and should qualify as a Bona Fide Occupational Qualification (BFOQ). However, the CDCR officials should consult with their human resources office on this issue.

An additional hiring consideration is the ability to build a diverse treatment team. Ideally, the therapists' ethnic backgrounds should mirror the diversity of the offender population to eliminate perceived barriers and encourage offender participation. Further, hiring therapists that are bilingual or have skills in working with developmentally disabled, or seriously mentally ill will add to the CDCR's ability to provide treatment formats that are responsive to a variety of offenders' needs.

## STAFFING RATIOS

The number of staff needed for the CDCR sex offender treatment program will depend on the number of sex offenders recommended for and willing to participate in treatment. The length of the treatment program will also influence staffing needs. The following staffing ratios can be used to calculate the number of staff needed after the above factors are determined.

The majority of treatment should be offered in group therapy sessions. A single therapist should have no more than 6 offenders in a group. If the CDRC uses a co-therapist model, groups may contain 12 participants.<sup>102</sup> Therefore, in addition to therapeutic reasons for co-facilitated groups, as discussed above; there are practical reasons as well. Scheduling groups with two therapists will require half the number of group rooms, a resource that is generally scarce in prisons.

***The majority of treatment should be offered in group therapy sessions. A single therapist should have no more than 6 offenders in a group.***

**Workload factors for Level One treatment.** A realistic, although demanding, workload for therapists includes facilitating two groups a day for four days a week. The remaining workweek is reserved for paperwork and report writing, reviewing homework assignments, planning group sessions, scheduling and delivering individual sessions to follow-up with group members, screening new treatment candidates, and communicating with correctional staff to monitor group members' behavior outside of group. Since program intensity is associated with better treatment outcomes,<sup>103</sup> we recommend that the therapists hold groups with the same offenders for two hours a day, four days a week for six months. Structured this way, two therapists will be able to treat two groups of 12 offenders throughout the week, meaning 24 offenders can be in treatment for every 2 therapists.

***Therapist recruitment will generally be easier if groups are scheduled during the hours of 8:00AM to 5:00PM.***

Therapist recruitment will generally be easier if groups are scheduled during the hours of 8:00AM to 5:00PM. Treatment staff should work with the correctional staff to arrange groups during convenient prison movement times to minimize disruption to the facility. If possible, offenders should be assigned to a half-day treatment assignment and a half-day work assignment. One group of offenders should attend group in the morning for two hours and then spend the afternoon at a work assignment. The second group should have the reverse schedule working in the morning and spending the afternoon in treatment. Depending on the daily schedule, if the time periods available in the morning or afternoon extend beyond two hours, the offenders could complete therapy homework to fill the remainder of the half-day treatment assignment.

The program can save money without lowering quality by hiring social workers or marriage and family therapists for the majority of positions since these professionals generally are paid lower salaries than Ph.D. psychologists and are often well trained in group work. However, the program should also have the capability to conduct psychological testing and evaluations, requiring that some positions be designated for psychologists. At a minimum, supervisory positions should be filled by licensed social workers, marriage and family therapists or psychologists.

With these workloads in mind, a formula for Level One staffing can be established:

- For every 24 inmates, 2 therapists (one man and one woman) are needed for six months (two therapists can treat 48 inmates per year).
- For every 10-12 therapists, 1 supervisor is needed.
- For every 200 inmates, 1 community support program therapist is needed.

**Workload factors for Level Two treatment.** This phase of treatment will involve group work and individual sessions within a therapeutic milieu setting. That is, sex offenders should live together in a dedicated housing unit and yard. At this treatment level, there will be significantly more documentation for the therapist to read

<sup>102</sup> Wilson (2007) found a cognitive-behavior program that had previously reduced recidivism in a general population of offenders actually increased recidivism when it was restructured to a class size of 24 inmates from the recommended size of 10 to 13 participants and was condensed to 8 weeks of daily classes from 4 to 6 months of bi-weekly classes.

<sup>103</sup> Lowden et al. (2003).

(sexual history disclosures, polygraph tests, relapse prevention plans, journal entries, homework assignments, etc.) and produce (i.e., individualized treatment plans, progress reports, release plans, letters to families, etc.). Therefore, we recommend that each therapist be assigned a primary caseload of 10 offenders. They will be responsible to review and approve the treatment products of offenders on their primary caseload and conducting group therapy.

***We recommend that each therapist be assigned a primary caseload of 10 offenders.***

Program supervisors, discussed below, primarily supervise and train treatment staff. They do not carry a caseload, although they can be involved in some direct service activities such as substituting for therapists who are ill or on vacation, providing individual contacts/sessions, screening cases for treatment, and occasionally facilitating a therapy group.

**Key partners.** The power of the therapeutic milieu can be significantly enhanced by several adjunct positions. First of all, many sex offenders need to develop constructive leisure time activities as part of their safety management plans. A recreational therapist can ensure that treatment concepts are applied during leisure time activities and teach pro-social recreational behaviors. Work provides another environment where offenders can practice what they are learning in treatment. A work supervisor who is knowledgeable about sex offending patterns of behavior can reinforce the application of treatment concepts at the work site. Likewise, community support positions can work with families and significant others to help them support the offenders' change efforts and safety planning. These key positions will ensure that offenders consistently apply treatment concepts across every aspect of their lifestyle.

**Contract polygraph examiners.** If the program adopts the containment approach (described in Section Two), polygraph examinations will be an important component of the treatment and management process in Level Two as well as community supervision. Polygraph examiners must have several key qualifications to work with this population. They must be a member of the American Polygraph Association or state organizations; they must receive special training (APA requires 40 hours of training specific to this population); they must be willing to work

as a team with program staff, meaning that they would immediately alert program staff to critical information; and they must prepare timely and complete reports with the test questions clearly defined in the report. Examiners should only conduct three full tests in a single day.

It is desirable to develop contracts with several private polygraph examiners that have expertise in Post-Conviction Sex Offender Testing (PCSOT) rather than hiring a full time polygraph examiner. To maintain the credibility of the examination, the polygraph examiner needs to be an objective party. When the examiner is an employee of the institution, the objectivity may be open to criticism.<sup>104</sup> The containment model is based on the use of independent polygraph examiners,<sup>105</sup> although some jurisdictions have trained existing staff to become examiners to ensure that the examiner has the necessary expertise regarding sexual offending and victimization.<sup>106</sup>

***To maintain the credibility of the examination, the polygraph examiner needs to be an objective party. When the examiner is an employee of the institution, the objectivity may be open to criticism.***

Habituation is a concern in repetitive polygraph testing. Offenders may accommodate to the examiner, thereby decreasing the effectiveness of the test. One way to minimize the possibility of habituation is to rotate polygraph examiners. Then, examinees will be tested by

<sup>104</sup> New Jersey recently passed a law requiring polygraph exams for hundreds of sex offenders. To contain costs and maintain control over the process, the New Jersey Department of Corrections recently sent several parole officers to polygraph school. These officers will no longer supervise cases but will instead conduct exams full time.

<sup>105</sup> The recommendation that the polygraph examiner remain independent of the treatment/supervision process was first made in English et al. (1996). It was made again after a second study of "best practices" (English et al., 2000). (English, K., Pullen, S., and Jones, L. (Eds.) (1996). *Managing adult sex offenders: A containment approach*. American Probation and Parole Association, Lexington, KY; English, K., Jones, L., Patrick, D., Pasini-Hill, D., Cooley-Towell, S. (2000). *The Value of Polygraph Testing in Sex Offender Management*. Final research report submitted to the National Institute of Justice. Available at [www.ncjrs.org/pdffiles1/nij/grants/202734.pdf](http://www.ncjrs.org/pdffiles1/nij/grants/202734.pdf).

<sup>106</sup> In one jurisdiction (Framingham, MA) that piloted the containment approach, the parole department established a formal contract relationship with the state police polygraph examiner. The examiner agreed to team with the parole officer and the treatment provider to conduct tests at the parole office on the weekends. Once the program became institutionalized, the DOC paid for a parole officer to become trained as a polygraph examiner.

several examiners rather than becoming overly familiar with the process by having the same examiner for every test. Appendix 18 contains the American Polygraph Association, California Association of Polygraph Examiners and the Colorado Sex Offender Management Board requirements for PCSOT examiners. CDCR can use these documents as models to establish qualification for polygraph examiners.

Also, please see Appendix 19 for a copy of a sex history disclosure form prepared by the polygraph subcommittee of the Colorado Sex Offender Management Board.

With these workload factors in mind, a formula for Level Two staffing can be established:

- For every 10 offenders in treatment, 1 therapist is needed.
- For every 10 to 12 therapists, 1 supervisor and 1 administrative assistant are needed.
- For every 100 inmates, 1 community support program therapist is needed.
- For every 100 inmates, 1 recreational therapist is needed.
- For every 100 inmates a work supervisor is needed.
- For every inmate, a minimum of three examinations per year.<sup>107</sup>

**Workload factors for management and oversight.** In addition to staff skilled in group facilitation, there should be a program director, quality assurance position(s), and a program evaluator/researcher(s).

The **program director** is responsible for developing and documenting the treatment program. This includes the development of clear and consistent goals and measurable objectives.<sup>108</sup> The program director is responsible for developing written procedures, program curricula, and therapist manuals; developing a process for interviewing and hiring staff; developing a process for new and ongoing program staff training; and providing clinical supervision for the program. Additionally, the program director represents the program in internal CDCR meetings and meetings with collaborating agencies. It is vital

that a single individual be granted the responsibility for, and the authority to, manage the program and plan for its future. This level of accountability may have been lacking

***It is vital that a single individual be granted the responsibility for, and the authority to, manage the program and plan for its future. This level of accountability may have been lacking in the in-prison substance abuse programs making program changes more difficult to implement.***

in the CDCR in-prison substance abuse programs making program changes more difficult to implement. The director must have strong support from CDCR officials so that managing the program (rather than defending it) can remain the program director's critical task.

The person placed in the **quality assurance** position should ensure that the program is being conducted as designed by collecting data and providing feedback to managers and treatment staff. The quality assurance provider should review case records to ensure treatment assessments, reports, and plans are complete and individualized. The information obtained from collateral contacts (such as family members) and self-reported during polygraph tests also should be systematically recorded in the treatment file. Further, the quality assurance person should observe service delivery that occurs during therapy groups using structured observation instruments. This person should report to the program director.

The **program evaluator/researcher** should be responsible for evaluating specific components of the program, analyzing offender deficits and treatment needs, studying program revisions and documenting participant outcomes. This person should report to the program director.<sup>109</sup> When studying specific program components (such as implementation of polygraph testing, efforts to enhance treatment motivation, and the impact of additions to the treatment curriculum), the evaluator should establish pre and post measures, and analyze and report

<sup>107</sup> The number of examinations will be driven by the test results. Deceptive tests require repeat testing to clarify the responses.

<sup>108</sup> Listwan, S. J., Cullen, F. T., Latessa, E. J. (2006). How to prevent prisoner re-entry programs from failing: Insights from evidence-based corrections. *Federal Probation*, 70, 3, 19-25.

<sup>109</sup> This position could reside in the research division but needs to directly work with and be accountable to the program director as well as the research director.



the results.<sup>110</sup> Therefore, the evaluator should have sophisticated data base development and analysis skills allowing for complex multivariate analyses. Ideally, they should have experience presenting data to a non-technical audience. Additionally, the position should evaluate outcomes of offenders who participate in the program, including parole violations, parole revocations, successful parole completion, registration compliance and recidivism. To complete this task, information on supervision and treatment during parole would need to be documented and made available for study. Preferably, this information would be entered into the CDCR information system.

With these workloads in mind, a formula for program management and oversight positions can be established:

- For the entire program, 1 Program Director is needed.
- For every 462 offenders in treatment, 1 Quality Assurance Position is needed
- For every 462 offenders in treatment, 1 Research Position is needed

If the program grows in size and treats more than 500 offenders per year, assistant director positions may be needed.

***The program evaluator/researcher should be responsible for evaluating specific components of the program, analyzing offender deficits and treatment needs, studying program revisions and documenting participant outcomes.***

Table 3.5. Staffing requirements for a two-level 462-inmate sex offender treatment program

	Level One	Level Two	Total
Number of offenders treated	312	150 <sup>111</sup>	462
Program director			1.0
Researcher			1.0
Quality assurance			1.0
Supervisors	2.5	1.5	4.0
Administrative assistants	2.5	1.5	4.0
Therapists	14.0	15.0	29.0
Community support coordinators	1.5	1.5	3.0
Recreational therapists	n/a	1.5	1.5
Work supervisors*	n/a	1.5	1.5
Contract polygraph services	n/a	450 exams/year	

**Notes:** The program requires that inmates complete an introductory treatment group prior to participating in Level One. This is a limited number of group sessions that focus on general personal change concepts. When the sessions are offered on a weekly basis, Level One therapists can absorb this task within their defined workload.

\*The work supervisors can be existing employees who are willing to be trained on treatment concepts. These positions must be willing to hold offenders accountable for applying treatment concepts in the work environment. Alternatively, a therapist could be hired and trained on work supervision duties.

<sup>110</sup> As an example, some programs have studied the value of the polygraph in treatment since its use is sometimes controversial. Researchers have documented the amount of information about the offender available to program staff using just the prison file and self-reports during treatment and compared this to information received at the first, second, and third polygraph examination (Ahlmeyer et al, 2000). This information can be compared with data generated from other studies (such as English et al., 2003). Likewise, the researcher can study the extent to which polygraph testing is properly implemented by tracking the rate of non-deceptive polygraph results ("passing the polygraph") and deceptive results ("failing the polygraph") and how this might correlate with other program

components (Heil, P., Simons, D., Ahlmeyer, S. (2003). *Impact of incentives and therapist attitudes on polygraph results*. Presentation at the Association for the Treatment of Sexual Abusers, 22nd Annual Research and Treatment Conference. St. Louis, Missouri.). (See also English, K., Jones, L., Patrick D., and Pasini-Hill, D. (2003). In R. A. Prentky, E. Janus, and M. Seto (Eds.), *Sexually Coercive Behavior: Understanding and Management*. New York: New York Academy of Sciences).

<sup>111</sup> Based on the authors' experience, approximately half of those who participate in Level One are expected to advance to Level Two.

Table 3.5 summarizes the CRCD staffing requirements for a program that treats 462 sex offenders. A total of 46 staff members are needed for the proper implementation of the model described in this report.

Please see Appendix 11 for a list of space and equipment recommendations for these positions.

#### STAFF TRAINING

The CDCR should hire therapists with sex offender treatment experience, as long as that experience is consistent with the type of treatment that will be offered at CDCR (i.e., cognitive/behavioral treatment, group facilitation, tracking behavioral indicators of change, etc.). Nonetheless, it is likely that some of the newly hired staff will not have sex offender treatment experience or training. In both instances, experienced and non-experienced therapists will need training on the actual program that will be offered at CDCR, its goals, objectives, activities, and treatment curricula. Initial training should include information on the therapeutic approach and style, program philosophy, treatment techniques, use of polygraph, sex offender manipulation tactics, maintaining boundaries, and preventing staff burnout. Ongoing training should be scheduled for all staff at regular intervals to manage staff burnout and continually improve skills.

Many agencies prioritize staff training due to the specialized nature of this work.<sup>112</sup> Sometimes this causes conflicts among other agency workers who do not work with sex offenders and have fewer training opportunities, by comparison. However, educating others about the reasons for additional training for sex offender program staff is often helpful. Also, in some agencies, this problem passes in time after the program is institutionalized.

***Staff training is an important quality control mechanism in the management of sex offenders.***

Staff training is an important quality control mechanism in the management of sex offenders.<sup>113</sup> The job specialization required to work with this population requires

significant training because the field continues to evolve. Treatment providers working with this very difficult population are continually exposed to the details of sexual assaults. It is important that staff not become immune to these descriptions of extraordinary harm. Addressing this often violent information in a therapeutic manner requires staff to maintain a balanced perspective and be highly skilled. Receiving and giving training workshops, attending conferences outside the prison, prioritizing in-service training—these must be considered a critical component of the quality control aspect of program operations. It is essential that CDCR administrators prioritize training to ensure that staff maintain a fair, firm and consistent approach to working with this difficult population. For this reason, staff training is a core component of preserving program integrity. Please see Appendix 13 for an example of topics for new staff training.

***It is essential that CDCR administrators prioritize training to ensure that staff maintain a fair, firm and consistent approach to working with this difficult population. For this reason, staff training is a core component of preserving program integrity.***

#### RETAINING STAFF AND PREVENTING BURNOUT

We have interviewed dozens of professionals who work with sex offenders—nearly every one is deeply affected by this work. Sex offender therapists are constantly exposed to graphic descriptions of sex offenses. In addition, they work with a group of offenders that are a highly manipulative and seek power and control over others. These dynamics are played out in interactions with their therapists. Although scrutiny of motives is a valuable skill for sex offender therapists, it becomes problematic when therapists experience burnout and misdirect their scrutiny skills toward their co-workers. This tendency may be more likely when therapists have encountered similarly abusive people in their personal life. Therefore, it is important for programs to implement methods to prevent burnout and promote healthy teams.

A factor that exacerbates the potential for burnout is that few people appreciate the work that prison sex offender

<sup>112</sup> English, Pullen and Jones (1996).

<sup>113</sup> English, K. (2004). The Containment Approach to Managing Sex Offenders. *Seton Hall Law Journal*, 989, 1255-1272.

***Although scrutiny of motives is a valuable skill for sex offender therapists, it becomes problematic when therapists experience burn-out and misdirect their scrutiny skills toward their co-workers.***

therapists are undertaking. There are a variety of typical responses the staff encounter on a routine basis:

- Skepticism that treatment is effective or a good use of the limited corrections budget;
- Frustration that therapists cannot *quickly* “fix” sex offenders or “fix” offenders that are dangerous but unmotivated to change;
- Anger that a reliable inmate worker is being pulled out of a work assignment to attend treatment;
- Anger that a father who is a sex offender is being prohibited from having contact with his child; and
- Anger that therapists recommend consequences when well-liked offenders do not progress in treatment and continue to display high-risk behaviors.

Sex offenders tend to have well-honed manipulation skills and frequently set up splits between staff. This only contributes to the negative feelings being directed at the therapist. Frequently, the one group that understands this dynamic is the other program therapists. Therefore, therapists frequently depend on co-workers for support. Consequently, it is important that the program maintain a healthy team environment to offset these negative influences and prevent staff burnout. Please see Appendix 20 for a complete discussion of the impact of this job on individuals and teams, and methods to prevent problems associated with doing this difficult work.

***It is important that the program maintain a healthy team environment to offset these negative influences and prevent staff burn-out. Please see Appendix 20 for a complete discussion of the impact of this job on individuals and teams, and methods to prevent problems associated with doing this difficult work.***

## Section four: Cost implications

### Introduction

This section is divided into two parts. The first part estimates the annual costs of operating a sex offender program at CDCR for 312 inmates participating in Level One treatment and 150 inmates participating in Level Two. The workload estimates presented in Section 3 provide the basis for the program costs presented below.

The second part of this section provides estimates of the costs averted following program implementation at CDCR. The costs averted are presented for both Level One and Level Two programs since these programs are expected to have different outcomes, based on the evaluation of the Colorado DOC's prison sex offender treatment program.<sup>1</sup> Specifically, compared to sex offenders who do not participate in treatment, those who release from Level One treatment are expected reduce revocations and recidivism rates by 37 and 30 percent, respectively. Those who release from Level Two treatment are expected to reduce revocations and recidivism by 60 and 74 percent, respectively.<sup>2</sup>

The cost estimates are based on explicit assumptions about costs averted. Specifically, the costs averted are based on the expected *lower* rate of revocations (resulting in fewer inmates returned to prison) and fewer new crimes (resulting in reduced victimization and reincarceration costs). Costs are estimated for the first four years of program implementation, and following the release of those who participate in the program in the first four years. Cumulative costs avoided from the first four years of program operation are also presented.

***The two-level CDCR sex offender treatment program is estimated to cost \$3 million annually. This analysis shows that the program is cost beneficial—in terms of savings to taxpayers and victims—by the second year of program operation. The costs averted result from (1) lower revocation and recidivism rates (and the associated prison expenditures) and (2) fewer new sex crime victimizations.***

### Program costs: Level One and Level Two

Table 4.1 describes the number of offenders expected to participate in the program given the recommended staffing levels. From this, we estimate the number estimated to transition to community containment each of the first four years of program operation.

Table 4.1. Program size: Number of inmates

	Level One	Level Two	Total
Number of offenders	312	150	462

Table 4.2 displays the costs of salaries and benefits (at 34 percent of the salary) to staff the CDCR's sex offender treatment program. As described in Section Three, we recommend a program that requires 46 professional staff (the staffing plan is described in detail in Section Three) and is expected to cost approximately \$3,066,468 per year.

This cost includes 29 therapists, 3 of which are expected to be psychologists to ensure that the program has the capacity to conduct psychological testing. This staffing pattern includes one program director, one researcher and one quality assurance professional that will study program fidelity, a necessary program component to ensure that the program operates as planned and reduces recidivism.

<sup>1</sup> Lowden, K., Hetz, N., Patrick, D., Pasini-Hill, D. Harrison, L., English, K. (2003). *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders: A Report of Findings*. Colorado Department of Public Safety, Division of Criminal Justice, Office of Research and Statistics, Denver, CO.

<sup>2</sup> As described in Section Three, Level One is recommended to be six months in duration, 4 days/week, 2 hours/day, and Level Two is a long-term, residential, therapeutic milieu-based program. Compared to Level One, Level Two is considerably more intense and treatment participation ideally will last an average of two to three years. Based on the Colorado study, those who participated in treatment more than 30 months were significantly more likely to remain arrest-free during the first three years following release from prison (see *Treatment Duration* in Section Three). The variation in treatment intensity and duration means that Level Two treatment is expected to reduce revocations and recidivism by more than that reduced by Level One, as it appeared to do in the Colorado study. However, because of the shorter duration, more inmates are expected to participate in Level One programming.

Table 4.2. Staffing costs associated with the CDCR Sex Offender Treatment Program

	Level One	Level Two	Total	Cost per position	Total cost
Program director			1.0	\$72,888 + .34 = 97,670	\$97,670
Researcher			1.0	\$57,372 + .34 = 76,878	\$76,878
Quality assurance			1.0	\$54,648 + .34 = 73,228	\$73,228
Supervisors	2.5	1.5	4.0	\$49,484 + .34 = 66,309	\$265,236
Administrative assistants	2.5	1.5	4.0	\$40,728 + .34 = 54,576	\$218,304
Therapists	14.0	15.0	29.0	\$44,760 + .34 = 59,978 (26) \$67,200 + .34 = 90,048 (3)	\$1,559,428 \$270,144
Community support coordinator	1.5	1.5	3.0	\$44,760 + .34 = 59,978	\$179,934
Recreational therapist		1.5	1.5	\$38,940 + .34 = 52,180	\$78,270
Work supervisor		1.5	1.5	\$55,908 + .34 = 74,917	\$112,376
Polygraphs		3/year	450	\$300/exam	\$135,000
<b>Total</b>	<b>20.5</b>	<b>22.5</b>	<b>46.0</b>		<b>\$3,066,468</b>

## Cost benefit assumptions

### TECHNICAL VIOLATIONS

In 2005, 15 percent of sex offender parolees were revoked.<sup>3</sup> Although there is evidence (Petersilia, 2006) that parole revocations may involve new crimes, this cost analysis assumes that the parole returns are for technical violations and *not* new crimes. This is a conservative assumption, since new crimes prevented would substantially increase the parole crime prevention cost figures.

Using estimates based on the outcome evaluation of the Colorado DOC's sex offender program, for CDCR treatment participants that were released on parole, we make the following assumptions for this analysis:

- Level One will reduce revocations by 37 percent (from 15 percent to 9.45 percent rounded to 9.5 percent)
- Level Two will reduce revocations by 67 percent (from 15 percent to 4.95 percent, rounded to 5 percent)

We assume that more offenders will participate in the programs over time since inmates tend to enter treatment multiple times prior to completion.

We assume that the impact of the program on parole will occur immediately when, in fact, the full impact for Level One offenders may not occur immediately since length of time in treatment improves outcomes, and those participating in the programs early-on may have shorter treatment

durations. The evaluation of the Colorado program found that many offenders who participated in Phase 1 (the equivalent of Level One) averaged between 8 and 12 months in treatment due to entering the program multiple times.

We assume that parolees who return to prison do so for .658 of one year and cost CDCR \$28,483 (\$43,287 per year x .658 of one year).<sup>4</sup>

### RECIDIVISM

According to CDCR, the 2-year recidivism rates of sex offenders in 2005 ranged from 26 percent for those convicted of "lewd act on a child" to 60 percent for those convicted of "other sex offense,"<sup>5</sup> as shown in Table 4.3.

Table 4.3. 2005 return to prison rates for sex offenders

Crime	Recidivism rate	# returned
Rape	35%	86
Lewd act on child	26%	278
Oral copulation	27%	48
Sodomy	30%	18
Penetration w/ object	36%	20
Other sex offense	60%	563

**Source:** CDCR. (ND). *California Prisoners and Parolees*, Table 47B, page 75, available at <http://www.corr.ca.gov/ReportsResearch/OffenderInfoServices/Annual/CalPris/CALPRISd2005>.

<sup>3</sup> CDCR. (ND). *California Prisoners and Parolees*, Table 47B, page 75, available at <http://www.corr.ca.gov/ReportsResearch/OffenderInfoServices/Annual/CalPris/CALPRISd2005>.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.



We assume a 25 percent average recidivism rate across all sex offenders for one year. We conservatively assume that 20 percent of the new offenses would be sex crimes.

Based on the outcome evaluation of the sex offender treatment program in Colorado, we assume the following new crime recidivism rates at one year:

- 30 percent reduction in Level One (17.5 percent rather than 25 percent)
- 74 percent reduction in Level Two (6.5 percent rather than 25 percent)

We assume that more offenders will complete the programs over time since inmates tend to enter treatment multiple times prior to completion.

We assume that the impact of the program on recidivism will occur immediately when, in fact, the full impact for Level Two offenders may not occur immediately since length of time in treatment improves outcomes, and those participating in the programs early-on may have shorter treatment durations.

We assume that recidivists returning to prison on a new crime cost CDCR \$43,287 per year. We calculate the averted cost of *only the first year* of the new sentence when, in fact, half of those returning on new sex crimes will stay for at least two years, and the other half will “stack up” in prison for more than two years,<sup>6</sup> adding considerable costs to CDCR that are not include in this estimate. Hence, our estimates are conservative.

Table 4.4. Costs averted by Level One and Level Two programs

	Year 1	Year 2	Year 3	Year 4	Cumulative after 4 years
<b>Level One</b>					
Number that completed program	150	200	250	250	
PAROLE REVOCATION NO TREATMENT: Expected failure 15%	22.5 inmates	30 inmates	37.5 inmates	37.5 inmates	
PAROLE REVOCATION TREATMENT: New fail rate 9.5% expected failures	14.25 inmates	19 inmates	23.75 inmates	23.75 inmates	
Revos averted: Level One	8.25	11.0	13.75	13.75	<b>46.75 revos averted</b>
Return costs averted: \$28,485 per return	\$235,001	\$313,335	\$391,669	\$391,669	<b>\$1,331,674 revo costs averted</b>
RECIDIVISM, NO TREATMENT (25%)	37.5	50	62.5	62.5	<b>212.5</b>
20% new sex crimes	7.5	10	12.5	12.5	
Victim costs \$132,014 per victimization averted with treatment	\$990,105	\$1,320,140	\$1,650,175	\$1,650,175	<b>\$5,610,595 victim costs averted</b>
RECIDIVISM, TREATMENT (17.5%)	26.25 instead of 37.5	35 instead of 50	43.75 instead of 62.5	43.75 instead of 62.5	<b>149 new crimes instead of 212.5</b>
Prison costs averted (\$43,287)	11.25 beds saved x \$43,287 = \$486,979	15 beds saved \$649,305	18.75 beds saved \$811,631	18.75 beds saved \$811,631	<b>63.75 beds saved \$2,759,546</b>
Assume 20% of prevented crimes were sex crimes	2.25 x \$132,014 = \$297,032	3 fewer victims \$396,042	3.75 fewer victims \$495,053	3.75 fewer victims \$495,053	<b>13-14 fewer sex crime victims</b>
<b>Total Level One costs averted</b>	<b>\$2,000,917</b>	<b>\$2,678,822</b>	<b>\$2,678,822</b>	<b>\$3,348,528</b>	<b>\$11,384,995</b>

Table 4.4 continued next page.

<sup>6</sup> Ibid.

Table 4.4. Costs averted by Level One and Level Two programs (Continued from previous page.)

	Year 1	Year 2	Year 3	Year 4	Cumulative after 4 years
<b>Level Two</b>					
Number remaining treatment compliant at release	20	50	100	100	
Parole REVOCATIONS no treatment (15%)	3	7.5	15	15	
Parole REVOCATIONS treatment (5%)	1	2.5	5	5	<b>13.5 revos averted</b>
Return costs averted: Level Two	2 x \$28,485 = \$ 56,970	(5) \$142,425	(10) \$284,850	(10) \$284,850	<b>\$769,095 revo costs averted</b>
RECIDIVISM, NO TREATMENT (25%)	5	12.5	25	25	<b>67.5</b>
RECIDIVISM, TREATMENT (6.5%)	1.3 instead of 5	3.25 instead of 12.5	6.5 instead of 25	6.5 instead of 25	<b>17.6 new crimes instead of 67.5</b>
Prison costs averted (\$43,287)	3.7 beds saved x \$43,287 = \$160,162	9.25 beds saved \$400,405	18.5 beds saved \$800,810	18.5 beds saved \$800,810	<b>\$2,162,187 prison costs averted</b>
Victimization costs averted at \$132,014	3.7 x .2 = .74 .74 x \$132,014 = \$97,690	9.25 x .2 \$244,226	18.5 x .2 \$488,452	18.5 x .2 \$488,452	<b>\$1,253,163 prison costs averted</b>
<b>Total Level Two costs averted</b>	<b>\$314,822</b>	<b>\$787,056</b>	<b>\$1,574,112</b>	<b>\$1,574,112</b>	<b>\$4,250,102</b>
<b>Total estimated savings, Level One and Level Two</b>	<b>\$2,315,739</b>	<b>\$3,465,878</b>	<b>\$4,922,640</b>	<b>\$4,922,640</b>	<b>\$15,626,897</b>
<b>Total program costs</b>	<b>\$3,066,468</b>	<b>\$3,066,468</b>	<b>\$3,066,468</b>	<b>\$3,066,468</b>	<b>\$12,265,872</b>
<b>Estimated cost benefit</b>					<b>\$3,361,025</b>

***The described prison treatment program has the estimated potential to save \$3,361,025 by the fourth year of operations, after program costs are subtracted from victim and criminal justice cost savings.***

The results of this preliminary cost analysis indicate that the described prison treatment program has the potential to save an estimated \$3,361,025 by the fourth year of operations, after program costs are subtracted from victim and criminal justice cost savings.

The analysis presented here is extremely conservative, meaning that the actual cost savings to CDCR, taxpayers and victims is likely to be greater. For example, we excluded 80 percent of the victim costs since we calculated only the costs of sex crimes victimizations, which we assumed would account for 20 percent of the recidivism crimes.

Further, this analysis does not include any assumptions about CDCR treatment participation diverting individuals from civil commitment. The cost of civil commitment in California is more than three times the cost of prison, and the average length of stay appears to be a minimum of five years.

In sum, the program, if implemented as described, has the potential to produce a cost benefit to taxpayers and potential victims. However, even if the program were not cost effective, the savings in reduced victimization and human suffering alone would provide ample justification to offer the program to California inmates.

***Even if the program were not cost effective, the savings in reduced victimization and human suffering alone would provide ample justification to offer the program to California inmates.***

## Section five: At a glance – next steps for CDCR officials

1. Decide on staffing method: in-house or contracted treatment staff.
2. Select a program director or someone who will begin the development of the program.
3. Identify the pool of eligible inmates.
4. Develop a computer tracking system for identification of eligible inmates and program evaluation variables.
5. Identify program size.
6. Identify a committee to gather program material and develop treatment manuals. The committee needs to include correctional staff. Committee tasks:
  - a. Design and implement research and quality control capabilities.
  - b. Develop policies and procedures for the program.
  - c. Identify incentives.
  - d. Developing informed consent forms, treatment contracts, etc.
  - e. Develop link between the program and the community.
7. Select a location.
8. Hire staff.
9. Train treatment staff.
10. Train correctional officers. Train parole officers.
  - a. Prepare facility policies and staff.
  - b. Identify facility-specific committee of correctional and treatment staff who develop correctional staff training and institutional policies regarding access to pornography and contact with children.
11. Identify a committee of treatment staff, parole officers and community therapists to develop continuity of treatment into the containment model in the community.
12. Admit inmates into program.
13. Facility program committee continues meeting at least quarterly to identify and resolve problems.
14. After one year of programming, convene facility program committee to review QA material, research in progress, and identify system and programmatic issues and solutions; modify policies and practices as needed.



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## **Appendix 1**

### **Research studies that call into to question the safety of sex offender contact with children**

**Published in the Colorado Sex Offender Management Board  
Standards and Guidelines**

Information compiled by Peggy Heil, 2000

# RESEARCH REGARDING SEX OFFENDER CONTACT WITH CHILDREN

## Likelihood of Children to Disclose Sexual Victimization:

1. The National Women's Study surveyed a representative sample of 4009 adult women in the United States in 1990. They re-interviewed the women in 1991 and in 1992. During the survey 341 women identified that they had been the victim of a childhood rape prior to the age of 18. Rape was defined as any nonconsensual sexual penetration of the victim's vagina, anus, or mouth by a perpetrator's penis, finger, tongue, or an object, that involved the use of force, the threat of force, or coercion. Only 44 (13%) of the women ever reported a childhood rape to authorities. Two hundred ninety seven (87%) of the women did not report any of their childhood rapes to authorities. In looking at the victims who did report the rape, a higher percent involved physical injury or life threat. In addition, reported cases were twice as likely to involve an offender who was a stranger to the victim. Unreported cases were more likely to involve an offender who was a relative or an acquaintance of the victim. This is similar to previous research that found victims are less likely to report abuse when the offender is a relative or acquaintance. (Arata, 1998; Ruback, 1993; Williams, 1984; Wyatt & Newcomb, 1990). Whether or not the rape was reported, one third of the victims of childhood rape met the criteria for PTSD-lifetime and one half met the criteria for Major Depression-lifetime. (Factors Related to the Reporting of Childhood Rape by Rochelle F. Hanson, Heidi S. Resnick, Benjamin E. Saunders, Dean G. Kilpatrick, and Connie Best, *Child Abuse & Neglect*, Vol. 23, No. 6, pp. 559-569, 1999)
2. Russell, 1984, conducted in-person interviews with 930 randomly selected adult female residents of San Francisco. The survey compared the reporting rates for different types of sexual assaults. Eight percent of rapes of adult women were reported to law enforcement. The reporting rate for extra familial child sexual abuse was even lower. Six percent of extra familial abuse was reported to law enforcement. The lowest rate of reporting was incestuous abuse. Only 2% of incestuous abuse was reported to law enforcement. None of the sexual abuse that was committed by female perpetrators was reported to law enforcement.
3. Sorenson and Snow, 1991, studied 116 child sexual abuse cases where the children disclosed the abuse. They looked at common patterns of disclosure. When initially questioned, many of the child victims denied being abused. When they did disclose, their first report was tentative and unconvincing followed by phase where they provided a detailed account of the abuse. Frequently after disclosure the children recanted the report but eventually acknowledged the detailed account was accurate. (Sorenson, T., and Snow, B., 1991, as cited in *False Negatives in Sexual Abuse Disclosure Interviews* by Louanne Lawson and Mark Chaffin, *Journal of Interpersonal Violence*, Vol. 7, No. 4, December 1992, pp. 532-542)

4. Lawson and Chaffin, 1992, studied 28 cases where a child was diagnosed with a sexually transmitted disease. They selected cases where there was a high probability of child sexual abuse. The children were older than three but premenarcheal. Prior to the diagnosis of the sexually transmitted disease, the children had not been suspected of being sexually abused. After being diagnosed, the children were interviewed by a trained sexual abuse investigator. Only 12 (43%) of the children disclosed abuse in the initial interview. One of the most important factors in whether or not the children disclosed was the attitude of the caretaker. Sixty three percent of the children with a supportive caretaker disclosed the abuse. When the caretaker was unsupportive and did not believe the child could have been sexually abused only 17% of the children reported. Lawson and Chaffin state that children explain delayed disclosure by saying they fear being disbelieved, punished, or unprotected. (False Negatives in Sexual Abuse Disclosure Interviews by Louanne Lawson and Mark Chaffin, *Journal of Interpersonal Violence*, Vol. 7 No. 4, December 1992, pp. 532-542)
5. “Victims of nonstranger sexual assault may be more likely to keep their experience secret because of guilt and shame, more likely to be blamed by themselves and others, and less likely to see themselves as deserving of sympathy and professional help.” (Ending Violence Against Women Project’s Non-Stranger Sexual Assault Training Manual)
6. Lamb and Edgar-Smith, 1994, studied the disclosure experiences of 60 incest victims. One third of the sample had been sexually abused for more than five years. Half of the group had been assaulted on a weekly basis. The mean age for first victimization was age eight and mean age for disclosure was age eighteen. Only 36% of the victims disclosed before age 14. Those who disclosed the abuse in childhood had a more negative experience than those who first disclosed the abuse as an adolescent or adult. Children were more likely to disclose to a parent (34.5%) followed by friends (25.5%). These disclosures were intended to directly stop the abuse (47.4%) or to get support (21.1%). Unfortunately these disclosures did not always stop the abuse and in general childhood disclosures were less positively received and perceived as less helpful. Adults were more likely to disclose abuse as the result of an evocative experience (45.7%) or to get support (31.4%). (Aspects of Disclosure by Sharon Lamb and Susan Edgar-Smith, *Journal of Interpersonal Violence*, Vol. 9 No. 3, September 1994, pp. 307-326)
7. Roesler and Wind, 1994, studied 228 female incest victims who responded to a questionnaire after watching Marilyn Van Derbur Atler’s televised disclosure of her incestuous victimization. On average, the first abuse started at age six and lasted until 13.8 years old. The average length of abuse was 7.8 years. Victims did not disclose the abuse until the average age of 25.9, indicating an average length of 20 years from time of first abuse to disclosure. Approximately one third (36.1%) of the sample disclosed prior to age 18. These disclosures were made at the average age of 14.6 and were most commonly made to a parent. Victims who disclosed as adults were more likely to tell friends or intimate partners at the average age of 25.9 followed by therapists at the

average age of 37.6. In general, victims perceived parents as responding less favorably to disclosure. In 51.9% of the childhood disclosures, the abuse continued for at least another year. The abuse had stopped more than a year prior to childhood disclosure in 25.3% of the cases and the abuse stopped the year of disclosure in 22.8% of the cases. When asked the reasons for not disclosing the abuse, 33.3% listed fear for their safety, 32.9% listed shame/guilt, 28.5% listed repression of memories, 18.9% said it would not help to tell, 14% listed fear for the impact on the family or protection of a family member, 9.6% feared blame or punishment from people other than the perpetrator, 3.5% listed loyalty to the perpetrator. They speculate that childhood disclosures have less positive results due to the fact that they are generally made to adult members of the family who probably have the most reason to fear change as a result of the disclosure. (Telling the Secret: Adult Women Describe Their Disclosures of Incest by Thomas A. Resler and Tiffany Weissmann Wind, *Journal of Interpersonal Violence*, Vol.9 No. 3, September 1994, pp. 327-338)

8. Two other studies (Finkelhor, 1979; Sauzier, 1989) have reported that of the child sexual abuse victims who disclose their abuse, the majority disclose their abuse as adults. (Aspects of Disclosure by Sharon Lamb and Susan Edgar-Smith, *Journal of Interpersonal Violence*, Vol. 9 No. 3, September 1994, pp. 307-326)

### **Likelihood of Children to Re-report Sexual Victimization:**

9. William Marshall has reported findings from an unpublished project conducted within child protective agencies in Ontario in the mid-1970s. The project was unsystematic in the sense that some, but not all victims of incest over approximately a three-year period were contacted. A child protective services caseworker located a number of children who had reported molestation by a relative. She found that many cases were recanted when the family did not believe the victim, or when the victim was believed but was poorly treated by family members. Once the children had been located, the caseworker asked the children if they would report the incident if they were molested again. Almost 100% answered “no”. The reasons they gave included the following: Practically no one believed them when they told or, if they did believe, they became hostile to the victim for getting the perpetrator in trouble and removing him from where he was needed; the child held him/herself responsible for the father’s absence from the family; or the outcome almost always ended up being more devastating to the child than to the perpetrator. (Information presented at the Association for the Treatment of Sexual Abusers Annual Research and Treatment Conference; personal communication with William Marshall 11/6/98).

### **Evidence of High Frequency and Crossover in Sex Offending Behavior:**

Analogy: With substance abusers, no one would recommend that the abuser only is at risk for abusing the substance he or she was known to abuse. For example, an alcoholic who drank beer would not be told he would only need to avoid beer and could drink whiskey or wine. It is a commonly accepted view that a substance abuser will switch to other substances depending on availability.



10. Gene Abel et al. conducted a breakthrough study in 1983 that gave us information on the frequency and variety of sexual offending behaviors sex offenders have committed. He received a federal certificate of confidentiality to study sex offenders. Individuals in this study could admit to current offending behaviors without fear that the information would be reported to law enforcement. He studied 411 sex offenders and found that on average over a twelve year period each offender had attempted 581 crimes, completed 533 crimes, had 336 victims, and committed an average of 44 crimes a year. These crimes included hands off sex offenses such as exposing, peeping and obscene phone calls. Additionally, he found that 50.6% of the rapists involved in the study had also molested children. (Retraining Adult Sex Offenders: Methods and Models, Safer Society Press, by Fay Honey Knopp)
11. In 1983, Abel et al. studied incest offenders who had involved themselves sexually with female children. He found that 44% of these offenders had offended against unrelated female children, 11% had offended against unrelated male children, 18% had committed rapes, 18% had committed exhibitionism, 9% had engaged in voyeurism, 5% had engaged in frottage, 4% had engaged in sadism, and 21% had other paraphilias. In this study it was determined that 59% of the child molesters developed deviant sexual interest during adolescence. (Information reported in the article, "Incest" by Judith Becker and Emily Coleman, in the Handbook of Family Violence, Van Hasselt et al, 1987.)
12. In 1985, Rob Freeman-Longo reported on a group of 23 rapists and 30 child molesters involved in an institutional forensic mental health sex offender program. Arrest records indicated rapists had an average of 1.9 offenses each for a group total of 43 arrests for sex offenses. The 23 rapists as a group admitted committing a total of 5090 various incidents of sex offending behaviors that included 319 child molestations and 178 rapes. Arrest records indicated child molesters had an average of 1.5 arrests each. While in treatment, the 30 child molesters as a group admitted 20,667 offenses which included 5891 sexual assaults on children and 213 rapes on adult women. (Sexual Abuse in America: Epidemic of the 21<sup>st</sup> Century, by Freeman-Longo and Blanchard, 1998, Safer Society Press, Brandon, VT)
13. In 1988, Abel et al. conducted an eight-year longitudinal study of 561 male sexual assaulters who sought voluntary assessment and/or treatment at the University of Tennessee Center for the Health Sciences in Memphis and at the New York State Psychiatric Institute in New York City. The study collected information on the offenders self reported patterns of deviant sexual behavior under a guarantee of confidentiality that was obtained under Federal Regulation 4110-88-M. After an extensive interview they diagnosed each offender and looked at the percentage of paraphiliacs (individuals with a deviant sexual interest) who had multiple paraphilias (more than one type of deviant interest).

Diagnosis	Number of subjects	Number of paraphilias				
		1	2	3	4	5+
Pedophilia (nonincest) female	224	15.2%	23.7%	19.2%	14.7%	27.2%
Pedophilia (nonincest) male	153	19.0%	26.8%	19.6%	12.4%	22.2%
Pedophilia (incest) female	159	28.3%	25.8%	17.0%	5.7%	23.3%
Pedophilia (incest) male	44	4.5%	15.9%	20.5%	18.2%	40.9%
Rape	126	27.0%	17.5%	19.0%	12.7%	23.8%
Exhibitionism	142	7.0%	20.4%	22.5%	15.5%	34.4%
Voyeurism	62	1.6%	9.7%	27.4%	14.5%	46.8%
Obscene phone calling	19	5.3%	5.3%	21.1%	21.1%	47.5%
Public masturbation	17	5.9%	17.6%	0.0%	17.6%	58.8%

(The Nature and Extent of Sexual Assault, Handbook of Sexual Assault: Issues, Theories, and Treatment of the Offender, edited by W.L. Marshall, D.R. Laws, and H. E. Barbaree, 1990)

14. Colorado Department of Corrections Sex Offender Treatment Program has found similar patterns to those reported by Gene Abel with the sex offenders participating in treatment and polygraph assessment. The program collected data in 1998 on the number of known victims of the first 36 sex offenders to participate in two polygraph evaluations. On average, for each offender there were 2 known victims documented in official records. After the first polygraph exam inmates disclosed on average 165 victims per offender. By the second polygraph exam the same inmates, on average, disclosed 184 victims per offender. These crimes included hands-on sex offenses such as rape and pedophilia as well as hands-off sex offenses such as exhibitionism, voyeurism and obscene phone calls. Approximately 80% of these offenders were still deceptive on their polygraph examinations, suggesting that even more offenses were committed. (Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000). The Impact of Polygraphy on Admissions of Victims and Offenses of Adult Sex Offenders, *Sexual Abuse: A Journal of Research and Treatment*, Vol. 12, No. 2)
15. O'Connell, 1998, found a significant increase in crossover behaviors from clinical interview to polygraph examination in non-incarcerated adult sexual offenders across three sources. After polygraph testing, 30% of sexual offenders reported engaging in nine or more deviant behaviors. Sixty-four percent of rapists admitted to molesting a female child and 21% of opposite-sex child molesters raped a female adult. (O'Connell, M.A. (1998). Using polygraph testing to assess deviant sexual history of sex offenders. Doctoral dissertation, University of Washington, 1998. Dissertation Abstracts International, 49, MI 48106.)
16. In 1999, Ahlmeyer et al. analyzed a larger sample of 143 inmates who participated in polygraph evaluations at the Colorado Department of Corrections. In this sample, 89 % of the inmates self reported that they had crossed over in the type of the offenses they committed by either: committing offenses with either victims of different ages (adults and children) and/or victims of different sexes (males and females) and/or victims from different types of relationships.

Information compiled by Peggy Heil, 2000

It was determined that 71% of the total sample acknowledged crossing over in the age of the victims they assaulted.

- Of the 82 offenders who were only known to have child victims in official records, 82% (67) later admitted to also having adult victims.
- Of the 52 offenders who were only known in official records to have adult victims, 50% (26) later admitted to having child victims during the process of polygraph examination. An additional 15.5% (8) scored deceptive to questions regarding sexual contact with children, 9.5% (5) scored non-deceptive to questions regarding sexual contact with children, 19% (10) could not be determined since an unrelated question on their exam was scored deceptive, and 6% (3) were never asked a sexual contact with children question on a polygraph exam.

It was determined that 36% of the sample acknowledged crossing over in the sex of the victims they assaulted.

- Of the 19 offenders who were only known to have male victims in official records, 63% (12) later admitted to having female victims.
- Of the 113 offenders who were only known to have female victims, 25% (28) later admitted to having male victims.

It was determined that 86% of the sample acknowledged having victims in two or more of the following categories: relative, stranger, acquaintance, or position of trust.

- Of those offenders who were only known to have offended against non-relative victims, 62% admitted to also having victims who were relatives.

Again the majority of the individuals in this sample (82%) were still scoring deceptive on some areas of their polygraph evaluations, indicating that the percent of cross over may be higher than the numbers self reported by these offenders. (Poster Presentation at the Association for the Treatment of Sexual Abusers 18<sup>th</sup> Annual Research and Treatment Conference, Lake Buena Vista, Florida 1999)

17. Ahlmeyer et al., 2001, studied the disclosures of hands on sex offenses in a sample of 223 incarcerated sex offenders. All of the subjects were participating in an intensive treatment program and polygraphed on their deviant sexual history disclosures. When reviewing the official record information, 81 inmates were identified as only having adult victims. In the process of treatment and polygraph testing 42 (51.9%) of the inmates admitted to also having child victims. For the total sample, 70% admitted having adult and child victims, 17.5% admitted only having adult victims, and 12.6% admitted only having child victims. Even with these admissions, approximately 70% of the sample had deceptive polygraph tests.
18. The Colorado Division of Criminal Justice (2000), under a National Institute of Justice research grant, analyzed data from 180 sex offender case files in three states that had implemented the post-conviction polygraph to varying degrees (Texas, Oregon, and Wisconsin). The sample included both probation and parole cases. Their research found that polygraph combined with treatment significantly increases the known rate of offending and crossover in sex offenders. After treatment and polygraph, nearly 9 out of 10 sex offenders who were identified as having sex offenses against adults also admitted committing sex offenses against children. Based on a file review, 35 offenders were

initially identified as having victims over the age of 18. Prior to treatment and polygraph only 18 (48.6%) of these offenders were identified as having victims under the age of 18. After treatment and polygraph 80 offenders admitted to victims over the age of 18. Seventy of these 80 offenders (87.5%) also admitted to committing a sex offense against someone under the age of 18. Sixty one (76.3%) of the 80 offenders admitted to having victims age thirteen and under. (Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety, March 2000)

### **Risks of Supervised Sex Offender Contact With Children:**

19. In a 1996 study by Gary Davis, Laura Williams and James Yokley, 142 child molesters were polygraphed to determine if they were having deviant fantasies and masturbating while thinking about a known minor. Only 3% of offenders who were not permitted contact with children were having deviant fantasies and masturbating while thinking about a known minor. Of the child sex offenders who were permitted supervised contact with children, 59.5% were having deviant fantasies and masturbating while thinking about a known minor. (An Evaluation of Court-Ordered contact Between Child Molesters and Children: Polygraph Examination as a Child Protective Service by Gary Davis, Laura Williams, and James Yokley. Paper presented at 15<sup>th</sup> Annual ATSA Conference, November 1996.)
20. In 1999, the Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections compiled polygraph test responses to questions regarding contact with children in the prison visiting room. The study involved a sample of 36 offenders who were polygraphed while participating in the second phase of the Sex Offender Treatment and Monitoring Program. The sex offenders were asked whether they had ever masturbated to thoughts of a known child they had seen in the prison visiting room. Eight offenders (22%) denied masturbating to thoughts of a known child and were nondeceptive on the polygraph exam. Sixteen offenders (44%) admitted to or were deceptive to questions on the polygraph exam that would indicate the offender had masturbated to thoughts of a known child they had seen in the visiting room. Twelve offenders (33%) were deceptive to other questions on the polygraph test and as a result it could not be determined whether they had masturbated to thoughts of a child seen in the visiting room.
21. In 1999, Underwood, Patch, Cappelletty, and Wolfe reported on a sample of 113 child molesters. On average, each offender committed 88.6 offenses. Many of the offenders in the sample acknowledged molesting a child while a non-collaborating person was present. The following percentage of the sample engaged in the listed behaviors:
  - Molested one child when another child was present - 54%;
  - Another adult was present - 23.9%; a child & adult were present - 14.2%
  - Molested a child when they knew the other person was awake - 44.3%
  - Molested a child when another child was in the same bed - 25.7%; when another adult was in the same bed - 12.4%; when another adult and child were in the same bed - 3.5%.

Information compiled by Peggy Heil, 2000

The child molesters listed the following reasons for molesting a child while a non-collaborating person is present: increased excitement - 77%; sense of mastery - 77%; compulsive sexual behavior - 75.2%; and stupidity -38.9%.

(Do Sexual Offenders Molest When Other Persons Are Present? A Preliminary Investigation by Rocky Underwood, Peter Patch, Gordon Cappelletty, and Roger Wolfe, published in the July 1999 issue of Sexual Abuse: A Journal of Research and Treatment)

## **Impact of Abuse:**

22. Rape in America: a Report to the Nation, in 1992 reports finding of a phone survey 4009 women across the United States. Based on the results of this survey, 1 out of 8 women are estimated to have been the victim of forcible rape sometime in their lifetime. It was determined that in 78% of the rapes, the victim knew the offender. Only 30% of the rapes resulted in the victim being physically injured. But, when compared to women who were never sexually assaulted, female sexual assault victims were 3.4 times more likely to have used marijuana; 5.3 times more likely to have used prescription drugs non-medically; 6.4 times more likely to have used hard drugs; 3 times more likely to have had a major episode of depression; 6.2 times more likely to have developed PTSD; 5.5 times more likely to have current PTSD; 4.1 times more likely to have contemplated suicide; and 13 times more likely to have attempted suicide. The majority of these women had not abused alcohol or drugs prior to being sexually assaulted. (Rape in America: A Report to the Nation by the National Victim Center and the Dept. of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, Charleston, SC, April 1992)
23. “Sexual assault committed by someone known to the victim is as traumatic, and often more traumatic, than stranger sexual assault because self-blame is increased and the ability to trust others is destroyed.” (Koss, Kinero, Seibel, and Cox, 1988 as cited in the Ending Violence Against Women Project’s Non-Stranger Sexual Assault Training Manual)
24. “Beitchman et al., (1992), in their recent review, conclude that there is almost a consensus that abuse by a father or stepfather is associated with worse outcome and that duration and frequency of abuse may be a negative predictor of adult outcome, even when controlling for abuse involving violence or force (which is usually of shorter duration but is related to worse outcome). Duration and frequency within that duration are also correlated with abuse by a father or stepfather (Finkelhor, 1979; Russell, 1983) and so in this way may be associated with worse outcome.” (Aspects of Disclosure by Sharon Lamb and Susan Edgar-Smith, Journal of Interpersonal Violence, Vol. 9 No. 3, September 1994, pp. 307-326)
25. Hunter (2000) conducted research to determine differences between victims of sexual abuse who became offenders, victims of sexual abuse who did not become offenders, and offenders who were never victims. He evaluated 235 juvenile males between the ages of 13 and 17: 55 adolescent child molesters with a history of sexual victimization; 72 adolescent child molesters with no history of sexual victimization; 28 adolescents with a



history of sexual victimization, but no history of sexual perpetration; 40 adolescents with a history of emotional or behavioral problems, but no history of sexual victimization or perpetration; and 40 adolescents with no emotional or behavioral problems and no history of sexual perpetration. The greater the number of molestations perpetrated against the child, the younger the age of the child and the greater the delay in reporting the molestations increased the likelihood that a victim would perpetrate against others. However, if the victim perceived their family as being supportive of him/her after the abuse was disclosed, they were less likely to sexually perpetrate against younger children. He came to the following conclusions: "The greater the family support experienced by an individual upon reporting the said molestations, the less likely the individual was to himself perpetrate a sexual molestation." His findings are consistent with Goodman, Taub, Jones, England, Port, Rudy, and Prado (1994) and Waterman (1994). These researchers also documented that child sexual abuse victims were more likely to sexually perpetrate against younger children when they perceived their families as unsupportive of them when their abuse was revealed. (The Influence of Personality and History of sexual Victimization in the Prediction of Juvenile Perpetrated Child Molestation by John A. Hunter, Behavior Modification, February 2000) It is important to note that the majority of sexual abuse victims do not become sexual abusers. These findings, though, point out the importance of validating the trauma the child has experienced, and supporting and protecting the child in his/her recovery.

26. "Support from one's family also has been found to be associated with child (Conte & Schuerman, 1987) and adult outcome in general (Peters, 1988), but not all studies have found a relationship between specific family factors and adult outcome." (Aspects of Disclosure by Sharon Lamb and Susan Edgar-Smith, Journal of Interpersonal Violence, Vol. 9 No. 3, September 1994, pp. 307-326)
27. In her book, Just Before Dawn (1989), Jan Hindman cites research she conducted over 15 years involving 543 victims of child sexual abuse. She found that even in the most severe cases of sexual abuse, child victims frequently are asymptomatic. It may be years before symptoms are triggered in future developmental stages. Hindman's findings also indicate that ongoing demands for a relationship with the offender or his support system, without the benefit of significant intervention, contribute to severe and ongoing traumatic impact as the victim matures. "Sex offenders typically want to create certain elements in the sexually abusive scenario that will reduce their guilt and responsibility. Effort may be exerted to have the victim feel as though he/she has caused the offender to act inappropriately. While this attitude may help the offender rationalize the deed, it has a profound effect on the trauma bonding (continued demands for a relationship with the perpetrator or those significant to the perpetrator, interfering with the victim's capacity to resolve the abuse and feelings about the perpetrator) felt by the victim." "Even if the perpetrator was incapacitated, incarcerated or absent, the victim remained connected and in a trauma bond."

### **Risks of Reunification:**

28. In 1995, Marshall reported that family reunification provides the following risks: Victims may not want the family to reunify, but may feel pressured into it; even after treatment, 80% of families separate within 5 years; there is an increased chance the victim will not report if victimized again; or the victim may get the impression that the family is important and that he/she is not. (Wisconsin Sex Offender Treatment Network, Inc. training tapes; personal communication with William Marshall 11/6/98)
29. In 1998, Jim Tanner conducted a research study on the polygraph results of 128 sex offenders who were under supervision and participating in offense specific treatment in the community. The sample consisted of 99 offenders with a current charge for a crime against a child and 29 offenders with a current charge for a crime against an adult. Each of the offenders had participated in one baseline and at least one maintenance polygraph examination. The study looked at the offender's behavior between the time period of the sexual history polygraph and maintenance polygraph. Based on the polygraph examination results, 31% of the offenders had sexual contact with a minor during the maintenance polygraph time period. Thirty five percent of sex offenders with a current charge for a crime against a child admitted to or were deceptive to sexual contact with a child. The percent of sex offenders with a current charge for a crime against an adult who admitted to or were deceptive to sexual contact with a child was 17%. Since the majority of the offenders with crimes against adults were not polygraphed on whether they had sexual contact with a child, the percent that had sexual contact with a child may be under represented.

In addition, 25% of the offenders in this study had unauthorized contact with a minor. Twelve percent of the offenders had forced someone to have sex since the baseline examination. Forty one percent were engaging in new sex offense behaviors. Overall, 86% of this sample was engaging in new high-risk behaviors and/or new crimes at least 18 months into treatment. On average, each offender was engaging in 2.5 different high-risk behaviors. (Incidence of Sex Offender Risk Behavior During Treatment, Research Project Final Report, by Jim Tanner, for Teaching Humane Existence, Inc. 2/4/99)
30. In 1997, Karl Hanson and Andrew Harris conducted research on dynamic predictors of sexual reoffense. The following factors were significantly associated with reoffense: General excuses/justifications/low victim empathy, sexual entitlement, attitudes tolerant of rape, attitudes tolerant of child molesting, sees self as no risk, sexual risk factors (pornography, excessive masturbation, deviant sexual fantasies, preoccupation with sex), access to victims, and negative social influences. (Dynamic Predictors of Sexual Reoffense Project 1997 presented at The Association for the Treatment of Sexual Abusers 16<sup>th</sup> Annual Conference, October 16, 1997, Arlington, Virginia)

**Contraindications to Family Reunification:**

- Sexual perpetration against a child
- Sexual interest in children
- Domestic violence/history of assaultive behavior
- Bestiality
- High rate of crossover and no prior access to children
- No history of stable relationships

**Revised August 29, 2001**

## Appendix 2

### Officially Recorded Sex Crimes Significantly Under-represent Actual Deviant Behavior

#### Research Summary Tables

1. Studies of sex offender self-report
2. Continuation: Studies of sex offender self-report
3. Studies of victims of sex crimes

<b>OFFENDER STUDIES:</b> <i>guaranteed confidentiality, polygraph or anonymous survey</i>	<b>Emerick &amp; Dutton (1993)</b>	<b>Elliot (1994)</b>	<b>Lisak (1999)</b>	<b>Gene Abel et al. (1983 through 2000)</b>
<b>Description of sample group</b>	76 "high risk" adolescent child molesters who were referred to a hospital treatment facility	1723 juveniles studied from age 11 to age 34. 423 of the juveniles were violent. 80 of the violent juveniles committed sex offenses	Distributed questionnaires to 1,881 men 122 (6.5%) men reported rape behaviors	Community sample of 561 paraphiliacs living in New York City and Memphis
<b>Data collection techniques utilized</b>	Polygraphed self report	Self report under federal certificate of confidentiality	Questionnaire with voluntary paid follow up interview	Self report under federal certificate of confidentiality
<b>Number of self reported sex offenses reflected in official records</b>	35% of the self reported hands on sexual assaults were identified in official records	1.1 % of self reported rapes resulted in arrest	0% in official records – The group of 122 rapists admitted: 386 rapes, 20 sexual assaults, 365 child molestations, 91 physical child abuses, 264 physical partner abuses	1.7% of admitted offenses resulted in arrest (1983) 3% of admitted rapes and child molestations (1987) .7% of admitted hands off offenses (1987)
<b>Age of onset of deviant sexual behavior</b>	Median age for onset of hands-on offenses was 13	Sexual assault (rape) initiated between the ages of 14 and 20 with the peak age being 16		Average age of onset of deviant sexual behavior in population of juvenile sex offenders is age 11
<b>Time period from the initiation of sex offense behavior to detection</b>	3.5 years		Undetected rapists	
<b>Crossover</b>	42.6% assaulted male and female children 41.7 abused victims from multiple social relationships	92% of rapists had aggravated assaults prior to initiating rape. Non-contact sex offenses appear to be a step to violent sexual assault	44% multiple rapists, 13.9% other forms of peer sex assault, 18% child sexual abuse, 10.7% physical child abuse, 38.5% physical adult intimate partner abuse, and 58% other forms of interpersonal violence	Significant rates of crossover with every category of sex offender (non-contact and contact sex offenses included) The majority had 3 to 5 paraphilias

<b>OFFENDER STUDIES:</b> <i>guaranteed confidentiality, polygraph or anonymous survey</i>	<b>English et al. (2000)</b>	<b>Freeman-Longo (1985)</b>	<b>Weinrott &amp; Saylor (1991)</b>	<b>Ahlmeier et al. (1999 &amp; 2000)</b>
<b>Description of sample group</b>	180 sex offenders on probation or parole in three states (WI, OR, TX)	23 rapists 30 child molesters participating in an institutional forensic mental health sex offender program	99 incarcerated sex offenders 37 rapists 67 child molesters	143 sex offenders participating in the CO Dept. of Corrections' Sex Offender Treatment and Monitoring Program
<b>Data collection techniques utilized</b>	Polygraphed self report	Anonymous self report survey	Confidential self report survey	Polygraphed self report
<b>Number of self reported sex offenses reflected in official records</b>	3 to 5 times the number of victims were disclosed during the treatment/polygraph process	.8% of rapists' self reported sex offenses resulted in arrest .2% of child molesters' self reported sex offenses resulted in arrest	Child molesters had 1 victim (median) in official records, but admitted 6 victims (median) Rapists had 1.8 victims (mean) in records but admitted 7 (median)	1% of the group's self reported victims and offenses were identified in official records
<b>Age of onset of deviant sexual behavior</b>	Average age for Incest hands-off 11, hands-on 11.5; Non-incest hands-off 11.3, hands-on 13.7	Rapists age 18 Child molesters age 15		Average age of first sex offense (including non-contact sex offenses) was 12
<b>Time period from the initiation of sex offense behavior to detection</b>		Rapists average 6 years Child molesters average 13 years		Average of 16 years
<b>Crossover</b>	29% reported both male and female victims 33% admitted both adult and child victims 82% admitted committing more than one type of hands-on offense	23 rapists reported 5090 sex offenses including 319 child molestations and 178 rapes 30 child molesters reported 20,667 offenses including 5891 child sex assaults and 213 rapes on adult women	12% of child molesters admitted attempted or completed rapes 32% of rapists admitted child molestation 34% of extra familial offenders has also admitted incest 50% of incest offenders admitted extra familial child sex abuse	36% report both male and female victims 71% report both child and adult victims 86% report victims from two or more types of relationships




<b>SEXUAL ASSAULT VICTIM REPORTING RATES</b>	<b>Russell (1984)</b>	<b>Rape in America (1990-1992) Factors Related to the Reporting of Childhood Rape Hanson et al. (1999)</b>	<b>Rape in America (1990-1992) Are Sex Offenders People Too? Social Considerations in Treatment, Saunders</b>	<b>Sexual Assault in Colorado (1998) CO Dept. Of Public Health &amp; Center for Disease Control and Prevention</b>	<b>Extent, Nature, and Consequences of Intimate Partner Violence &amp; Rape Victimization Tjaden &amp; Thoennes (2000 &amp; 2006)</b>
<b>Description of sample group</b>	930 randomly selected adult female residents in San Francisco	Nationally representative sample of 4009 women in the United States	Nationally representative sample of 4009 women in the United States	Survey of 948 women and 784 men living in Colorado	Nationally representative sample of 8000 women and 8000 men
<b>Data collection techniques utilized</b>	In-person interviews	Telephone survey	Telephone survey	Telephone survey	Confidential telephone survey
<b>Percentage of sex offenses reflected in official records</b>	8% of completed or attempted rapes were reported to law enforcement; 3% resulted in the arrest of the offender 6% of extra-familial child abuse is reported; 1.3% resulted in convictions 2% of incest abuse is reported; .5% resulted in convictions	13% of rapes of female children are reported to law enforcement	16% of rapes of adult women are reported to law enforcement  .8% of rapes resulted in the imprisonment of an offender for 1 or more years	Less than 16% of rapes of adults are reported to law enforcement	19% of rapes of adult women are reported to law enforcement 7% resulted in a prosecution 17% of rapes of adult women <i>by intimate partners</i> are reported to law enforcement 3% resulted in a conviction 2% resulted in a jail or prison sentence 13% of rapes of adult men

Information Compiled by Peggy Heil      Revised 3/16/07

## Appendix 3-A

### Administrative Regulation for Restricting Privileges Colorado Department of Corrections



<u>ADMINISTRATIVE REGULATION</u>    COLORADO DEPARTMENT OF CORRECTIONS		REGULATION NUMBER  600-05	PAGE NUMBER  1 OF 6
		CHAPTER: Offender Classification	
		SUBJECT: Restriction of Offenders' Privileges in Correctional Facilities	
RELATED STANDARDS: ACA Standards 4-4449		EFFECTIVE DATE: October 1, 2006	
		SUPERSESSION: 10/01/05	
		Joe Ortiz Executive Director	
OPR: LCF	REVIEW MONTH: July		

#### I. POLICY

It is the policy of the Department of Corrections (DOC) to restrict the privileges of offenders confined in state correctional facilities who refuse to perform required labor, participate in available educational/vocational education, work programs, or undergo assigned counseling.

#### II. PURPOSE

The purpose of this administrative regulation is to ***establish procedures for withholding privileges, such as those defined in CRS 17-20-114.5, from offenders who refuse to participate in required labor, educational, or work programs, or who refuse to undergo available counseling or combination of the foregoing, [4-4449]*** and to allow for the documentation and review of such offenders for return of privileges upon their participation in such programs or counseling.

#### III. DEFINITIONS

- A. Contract Worker: Any person employed under contractual arrangement to provide services to the DOC: any person employed by private or public sector agencies who is serving under DOC special assignment to provide services or support to DOC programs. The employee/employer relationship lies with the contractor. All Department agreements are for a specified period, renewable, and not paid by a state warrant.
- B. DOC Employee: Someone who occupies a classified, full or part-time, position in the State Personnel System in which the Department has affect over pay, tenure, and status.
- C. Participate: An offender who is active in a labor, educational, treatment, or work program resulting in satisfactory or above progress review (2.0 or above).
- D. Privileges: Include, but are not limited to, single cell occupancy, television, radio, tokens, snacks,

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hobby work/tools, typewriters, and appliances such as hot pots, fans, and coffee pots.

- E. Refusal: Any condition caused by the offender's actions/conduct which precludes their participation in work assignments or recommended programs, specified in their individual diagnostic summary, or a program recommended by their case manager or a Mental Health DOC employee/contract worker.
- F. Required Programs: Programs that are required by state statute, law, or recommended by diagnostic assessment, mental health evaluation, or case management.
- G. Restricted Privileges (RP) Status: A condition created by an offender who refuses to participate in assigned programs or is terminated for cause.
- H. Volunteer: A person who has been approved by Faith and Citizen Programs and the respective facility Administrative head/designee to provide services without compensation for DOC correctional Programs, and has successfully completed approved DOC volunteer training and/or volunteer aftercare training, and facility specific orientation.

#### IV. PROCEDURES

##### A. Restricted Privileges Status Review

A restricted privileges status review shall be initiated for any DOC offender who refuses to participate in, or is terminated from, a DOC sanctioned work or treatment program, to which the offender is assigned, or who is a new arrival to the facility and is already on restricted privileges status.

- 1. DOC employees, contract workers, or volunteers supervising a work, educational, and/or treatment program shall immediately complete an incident report and will notify appropriate case manager(s) and unit supervisor(s) when an offender refuses to participate in, or is terminated from, an assignment.
- 2. Case management shall determine if the offender meets the criteria for placement on restricted privileges status.
  - a. If the offender is subject to restricted privileges status, the case manager shall complete DC Form 600-05A, obtain the offender's signature, and forward it to the case manager III for a facility classification review.
  - b. In the event an offender is placed on restricted privileges status, the offender's case manager shall notify the offender of the decision and furnish the offender with a completed copy of DC Form 600-05A. This formally notifies the offender of this status and the condition created that resulted in the offender being placed on restricted privileges status.
  - c. An offender who is incapable of participating in a work or program assignment due to a documented medical condition shall not have privileges restricted.
- B. When an offender is placed on restricted privileges status by the facility classification committee, the offender has 15 working days to appeal the decision to the administrative head of the facility.

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1. To appeal the decision, the offender should complete AR Form 600-05B in the space provided and forward it to the administrative head, or designee, who shall render a decision within ten working days of receipt of the appeal.
  2. Failure to appeal within 15 working days shall constitute a forfeiture of the appeal right.
  3. Restricted privileges status will be implemented, regardless of status of appeal, until a decision is made.
- C. Restricted privileges status shall be effective the date of the classification approval and will be for a minimum period of 90 days.
- D. To be removed from restricted privileges status an offender must be unassigned for 60 days, and participate in an assigned program equivalent to the program causing placement on RP status, at a satisfactory level, for a period of 30 days and continue satisfactory participation.
1. The offender may complete AR Form 600-05C and forward the form to the case manager to initiate a review. An offender may request a review by the classification committee to be removed from restricted privileges status no more than once every 60 days. The case manager may request a review.
  2. In the event the classification review removes the offender from restricted privileges status, all property will be returned to the offender and all other privileges shall be restored, as soon as practical, within facility operating guidelines.
- E. During restricted privileges status the following will occur:
1. No television in the cell.
  2. No radio in the cell.
  3. No canteen (with the following exceptions):
    - a. Offenders who have a medical condition, verified in writing by Clinical Services, that require they have access to specific food items not supplied by the facility.
    - b. Offenders who require specific items, not supplied by the facility, for religious practices, as verified by the Correctional Programs manager.
    - c. Medications and hygiene items.
    - d. Tennis shoes.
    - e. Thermal underwear.
  4. Offenders must turn in all the privilege items.
    - a. DOC employees will inventory and secure the items.
    - b. Perishable items will be inventoried and destroyed.



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- c. All "grandfathered" property items will be permanently removed and the offender will be brought into strict compliance with administrative regulation 850-06, *Offender Property*.
5. Offenders on restricted privileges status will only be allowed the standard initial state issued clothing, with the following exception: the green trousers will be replaced with three orange colored pants. (Refer to administrative regulation 850-05, *Offender Bedding and Clothing Issue and Dress Code*.)
6. Offenders on restricted privileges status will not be allowed to recreate with general population offenders and will be on an alternate recreation schedule, if the facility schedule allows.
7. Health care appliances, assistive devices, or medical support equipment as defined in administrative regulation 850-06, *Offender Property*, shall not be removed unless with the permission and under the supervision of Clinical Services.
- F. Any new arrival offender, or offender released from segregation, shall have ten working days to become assigned to a program/job or placed on a waiting list for program/job participation.
  1. Should the offender refuse any assigned work/program, the offender shall be reviewed for restricted privileges status.
  2. Offenders on restricted privileges status, arriving at a facility shall have their file reviewed by the case manager to determine if any condition that initiated restricted privileges status still exists. The result of that file review will be forwarded to the facility classification committee for determination of continued restricted privileges status.
- G. Restricted Privileges Housing: An offender placed on restricted privileges status will remain within their assigned unit and will be double bunked with another restricted privilege status offender, so as to preclude shared use of privileged items (where applicable), or be moved to another designated living unit. Restricted privileges cells may be designated by the living unit supervisor.
- H. Violation of Restricted Privileges Status: Offenders found in violation of their restricted privileges status are subject to the charge of "Disobeying a Lawful Order," Class II-25, under the Code of Penal Discipline.
- I. When multiple programs are recommended, the offender's case manager shall determine the order in which the programs will be assigned if scheduling conflicts occur.

## V. RESPONSIBILITY

- A. Administrative heads shall:
  1. Assure that documentation exists identifying offenders on restricted privileges status and the duration of time each offender is on this status.

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2. Establish procedures to review and approve or deny placing offenders on restricted privileges status.
  3. Establish offender appeal procedures for an offender assigned to restricted privileges status.
- B. Case managers shall be responsible for the appropriate documentation and initiation of restricted privileges status reviews through the classification committee.

#### VI. AUTHORITY

- A. CRS 17-1-104.3. Correctional facilities - locations - security level.
- B. CRS 17-20-114.5. Restriction of privileges in correctional facilities - restriction of privileges because of lawsuit filed without justification.
- C. CRS 17-22.5-405. Earned time.
- D. CRS Title 17, Article 32 - Correctional Education Program.
- E. CRS 18-1.3-211. Sentencing of felons - parole of felons - treatment and testing based upon assessment required.
- F. Montez Remedial Plan (Chapter XVI), August 27, 2003

#### VII. HISTORY

September 15, 2005  
September 15, 2004  
October 1, 2003  
October 1, 2002  
November 1, 2001  
November 1, 2000  
November 1, 1999

- ATTACHMENTS:
- A. DC Form 600-05A, Restricted Privileges Form
  - B. AR Form 600-05B, Restricted Privileges Status Appeal Form
  - C. AR Form 600-05C, Review of Restricted Privileges Status
  - D. AR Form 100-01A, Administrative Regulation Implementation/Adjustments

**RESTRICTED PRIVILEGES**

OFFENDER NAME:	DOC #:	DATE:
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Reason for request for Restricted Privileges:

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Case Manager Signature
**CLASSIFICATION DECISION**☐ Approved☐ DeniedComments: 

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Classification Chairperson Signature

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Date
**RESTRICTED PRIVILEGES:**

Privileges that may be restricted shall include, but not be limited to single cell occupancy, television, radio, tokens (where available), snacks, and other privileges as the DOC may specify, as per CRS 17-20-114.5. Offenders found violating their restricted privileges status (either in possession of restricted items or the offender is found within a restricted area, e.g., gymnasium, hobby shop, etc.) will be charged with a Class II-25 offense, "Disobeying a Lawful Order," as outlined in the *Code of Penal Discipline*.

I UNDERSTAND THE ABOVE RESTRICTIONS OF PRIVILEGES.

---

Offender Signature

---

Date

Distribution:    Department File (white)  
                      Working File (canary)  
                      Living Unit  
                      Offender (pink)

Attachment "A"  
 Page 1 of 1

**RESTRICTED PRIVILEGES STATUS APPEAL FORM**

Offender Name: _____	DOC No: _____
Living Unit: _____	Case Manager: _____
Effective Date of Restricted Status: _____	
Basis for Appeal: _____	
_____	
_____	
_____	
_____	
_____	
_____	
Offender Signature/DOC# _____	Date _____

<b>APPEAL DECISION</b>	
Restricted Status is: <input type="checkbox"/> Upheld	<input type="checkbox"/> Reversed
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	
Administrative Head _____	Date _____

**REVIEW OF RESTRICTED PRIVILEGES STATUS**

OFFENDER NAME:	DOC #:	DATE:
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Reason for request for Restricted Privileges review: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Offender Signature

**CASE MANAGER RECOMMENDATION**

☐ Remove from Restricted Privilege Status

☐ Remain on Restricted Privilege Status

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Case Manager Signature

\_\_\_\_\_  
Date

**CLASSIFICATION DECISION**

☐ Remove from Restricted Privilege Status ☐ Remain on Restricted Privilege Status

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Chairperson Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date

xc:    Working File  
      Offender  
      Housing Manager  
      Living Unit Supervisor

Attachment "C"  
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**ADMINISTRATIVE REGULATION  
IMPLEMENTATION/ADJUSTMENTS**

AR Form 100-01A (11/15/05)

CHAPTER	SUBJECT	AR #	EFFECTIVE
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(FACILITY/WORK UNIT NAME) \_\_\_\_\_  
WILL ACCEPT AND IMPLEMENT THE PROVISIONS OF THE ABOVE ADMINISTRATIVE REGULATION:

☐ AS WRITTEN    ☐ NOT APPLICABLE    ☐ WITH THE FOLLOWING ADJUSTMENTS TO MEET  
LOCALIZED OPERATIONS/CONDITIONS

(SIGNED) \_\_\_\_\_ (DATE) \_\_\_\_\_  
Administrative Head

Attachment "D"  
Page 1 of 1





## Appendix 3-B

### Colorado Restricted Privileges Statute

Colorado Statutes/TITLE 17 CORRECTIONS/CORRECTIONAL FACILITIES AND PROGRAMS/Facilities/ARTICLE 20 CORRECTIONAL FACILITIES/17-20-114.5. Restriction of privileges in correctional facilities - restriction of privileges because of lawsuit filed without justification.

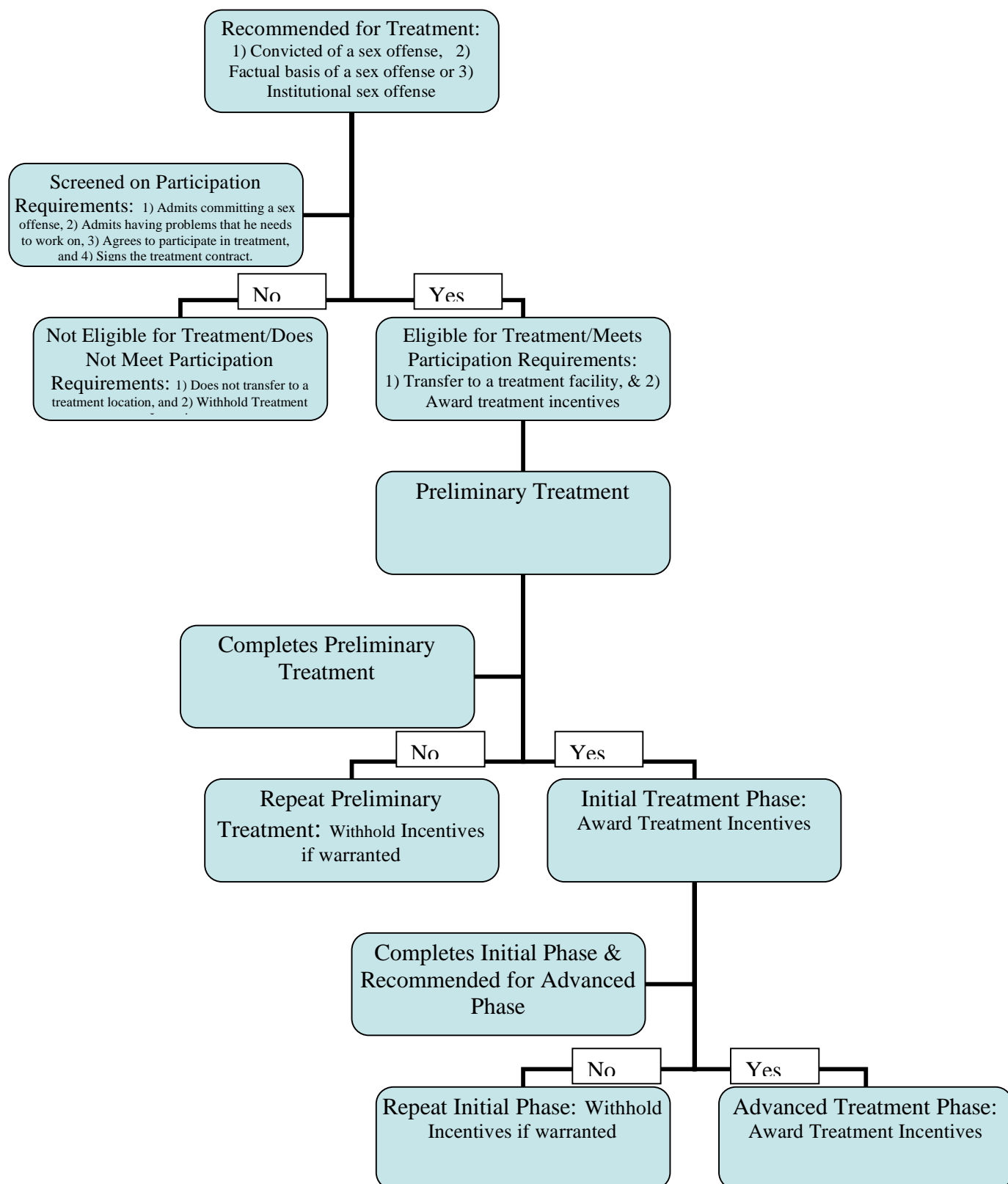
**17-20-114.5. Restriction of privileges in correctional facilities - restriction of privileges because of lawsuit filed without justification.**

(1) Any person convicted of a crime and confined in any state correctional facility listed in section [17-1-104.3](#) is not entitled to any privileges that may be made available by the department. If any such person is required by the department to perform any available labor, participate in any available educational program or work program, undergo any available counseling, or any one or a combination of the foregoing and such person does not perform the labor, participate in the program, undergo the counseling, or do any one or a combination of the foregoing as required by the department, the department shall deny specified privileges to such person. The privileges that the department shall deny to such person include, but are not limited to, television, radios, entertainment systems, and access to snacks. If the department denies television privileges, it may allow a person to watch television for educational purposes, including public television broadcasts transmitted to or available to the facility. A person who is physically unable to perform labor, participate in an educational program or work program, or undergo counseling may be allowed the privileges specified in this subsection (1). Nothing in this subsection (1) shall be construed to grant as a right any such labor, program, or counseling or any privileges listed in this subsection (1).

(2) (a) If any person is convicted of a crime and confined in any state correctional facility listed in section [17-1-104.3](#) or in any facility that houses adult offenders and such person files a lawsuit against the state of Colorado or against any state government official, officer, employee, or agent, the department or its agent having custody of the person shall deny specified privileges to such person if, upon the motion of any party or the court itself, a state or federal court finds that the action, or any part thereof, lacked substantial justification, was baseless, or was malicious or that the action, or any part thereof, was interposed for harassment. As used in this subsection (2), "lacked substantial justification" has the same meaning as that provided for such term in section [13-17-102](#) (4), C.R.S.

(b) The privileges denied to a person pursuant to the provisions of this subsection (2) include, but are not limited to, the privileges described in subsection (1) of this section. The department or its agent having custody of the person shall deny the privileges to the person for a period not to exceed one hundred twenty days for any such lawsuit.

# Appendix 4-A Flow Chart for Treatment Recommendations





(c) The department or its agent having custody of the person may not deny privileges to a person pursuant to the provisions of this subsection (2) if the court determines the lawsuit was asserted by the person in a good faith attempt to establish a new theory of law in Colorado.

(d) The department or its agent having custody of the person may determine not to deny privileges to a person pursuant to the provisions of this subsection (2) if, after filing the lawsuit, a voluntary dismissal of the action is filed within a reasonable time after the person filing the dismissal knew, or reasonably should have known, that he or she would not prevail in the action.

**Source: L. 94:** Entire section added, p. 1407, § 1, effective July 1. **L. 95:** Entire section amended, p. 300, § 1, effective July 1. **L. 2000:** (1) amended, p. 844, § 37, effective May 24.

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## Appendix 4-B

### Screening Inmates for Treatment: Instructions for Therapists





COLORADO DEPARTMENT OF CORRECTIONS  
SCREENING SEX OFFENDERS

The screening interview is the offender's first introduction to the Sex Offender Treatment Program. The tone of this interview is important in establishing the sex offender's receptiveness to the treatment program. Inmates have a difficult time admitting to committing sex offenses and having a problem. This is the first hurdle they must get over in order to engage in treatment.

We want to use the screening interview to make it easier for an inmate to admit to having a problem. Therefore, it is important that he does not experience the therapist as intimidating, demeaning, or adversarial. Opening up about his problems becomes more difficult when his shame and embarrassment is reinforced. The therapist's attitude should be empathetic, encouraging, and direct. Try to keep the interview congenial. Make it clear that it is the inmate's choice whether he wants to participate in therapy or whether he meets the participation requirements. We do not want to make it more difficult for him to come back later and admit that he has a problem.

One way to start screening interviews on a positive note is to tell the offender that he needs to be evaluated for the Sex Offender Treatment Program. Ask if he is interested in participating. Explore whether he has previously participated in treatment and what his experience was. Be sure to positively reinforce any interest in treatment and any admissions he may make.

Many offenders who were not initially amenable to treatment are able to meet the criterion over time through additional interviews. Therefore, it is important to "keep the door open" for those who fail to meet the screening criterion. Comment on the progress made on each screening form and at each interview. Even if the offender made no progress, reinforce the fact that he continued to try.

\*Although we refer to the inmate as a male throughout this document, the information contained herein applies equally to male and female offenders.

In order to qualify for Phase I, the inmate must meet the following participation requirements:

- 1) He must have 8 years or less to Parole Eligibility Date and 18 months or more to Discharge Date.
- 2) He must have successfully completed at least one of the required prerequisite groups. These groups are Basic Mental Health, Life Skills, and Drug and Alcohol Education.
- 3) He must admit to sexually abusive behavior and be willing to discuss it.
- 4) He must acknowledge that he has a current problem in the area of sexual abuse.
- 5) He must be motivated to work on his problems. This is demonstrated by: 1) a willingness to acknowledge and discuss problems, 2) a willingness to participate in group, 3) a willingness to address problematic patterns and behavior, and 4) a willingness to acknowledge the risk of reoffense.
- 6) He must comply with conditions of the group contract which include compliance with blood testing and law enforcement registration.

#### SCREENING SCENARIOS

Inmates may present several issues during screening. The following is a list of common scenarios and recommended responses:

**1) The inmate may admit to past crimes but not admit to the current sex offense.**

**RESPONSE:** As long as the inmate is admitting to one sex offense and feels that he has a current problem in the area, he qualifies for participation in group. Explain to the inmate that he initially qualifies for group but that as he progresses in group, we will expect him to take increased responsibility for his sex offending behavior.

**2) The inmate may deny committing a sex offense.**

**RESPONSE:** Avoid getting into a power struggle with the inmate and stating that you know he did it. This will make it more difficult for him to come back later and admit that he has a problem. Acknowledge that you were not there when the offense was committed and as a result, must depend on the written documentation in the file. Explain that it has been your experience that many offenders are embarrassed about their offenses and have a hard time talking

about them. You may want to point out that you are a sex offender therapist and that there is probably nothing they can say that you have not heard before.

State that based on his file, we are recommending sex offender treatment. Explain that it is important for people who have problems to understand and develop alternative skills to prevent repeating the behavior. State that you understand how difficult it can be to admit to committing a sex offense, but that you hope in the future, if he feels he has a problem in this area, he will recontact Mental Health. We will be happy to rescreen him.

**3) The inmate states that he committed a sex offense but he does not have an ongoing problem in that area.**

**RESPONSE:** Explain that he does not currently qualify for participation in sex offender treatment since he does not feel he has a problem he needs to work on. Make it clear that sex offender treatment will continue to be recommended since we still feel he presents a high risk to reoffend. Explain that sex offense behavior is learned and that he will always be able to repeat the behavior. He will be particularly high risk to reoffend when he is experiencing stress. One of the ways for him to prevent reoffending is to recognize that he is still at risk and to monitor for signs that he is slipping back into problem behavior. If he is convinced that he will not reoffend, he will ignore warning signs and it will be more difficult to prevent reoffense.

Explain that it would be unfair to place him in a group if he does not feel he has a problem. The groups are designed for people who want to work on their problems. If he does not have any problems, he will be unable to participate in the process. The group participation requirements are based on a general mental health principle that people are only able to benefit from psychotherapy if they acknowledge they have a problem and have a desire to change. It would also be unfair to people who feel they have a problem and want to talk about it in group to have individuals in group who are saying they don't have a problem.

State that we will continue to recommend treatment and that in the future, if he feels he has a problem in this area, he can recontact Mental Health and we would be happy to rescreen him.

**4) The inmate admits to committing a sex offense and having a problem, but wants individual therapy.**

**RESPONSE:** Tell the inmate that you can appreciate how difficult it may seem to discuss behavior and problems they have kept secret for years with a group of people. Explain that his inability to trust people probably contributed to his choice to commit a sex offense. He will be placed in a group of people who have similar problems to his. Explain that it is important for him to find out he is not

the only person who has this problem. Explain that it is also important for his recovery to develop positive peer relationships which he can learn in group. In group, he can find out how it feels to be accepted even though people know all about his problem behaviors. All the reasons he does not want to be in group are all the reasons why he should be in group therapy. State that group therapy is the preferred therapy for sex offenders and it is the only type of sex offender therapy offered at DOC.

5) The inmate states that he never committed a sex offense but is willing to participate in the group because he might learn something.

**RESPONSE:** Explain that the group is only for sex offenders. It takes significant courage to admit committing a sex offense. As a therapist you respect that courage and you will protect their right to openly discuss their offenses with other sex offenders. Placing non-sex offenders in group would disrupt this process and would be unfair to those individuals who had the courage to risk being open.

Make it clear that you will be recommending sex offender treatment based on his record. Explain that it is important for people who have the problem to understand it and develop alternate skills to prevent repeating the behavior. State that you know how difficult it can be to admit to committing a sex offense, but that you hope in the future, if he feels he has a problem in this area, he will recontact Mental Health. We will then be happy to rescreen him.

6) He states that he has already participated in sex offender treatment.

**RESPONSE:** Compliment him for his efforts to change. Ask him where he received treatment, what was covered in treatment, and if we can send for his treatment records. State that if he has been in treatment, he knows that recovery is a lifelong process and that he needs to continue to work on his issues. If it appears that his treatment was similar to Phase I, tell him we can send for his treatment records and evaluate which phase of treatment he should be in. Ask him to write out what he learned about his relapse cycle. Inform him that Phase II builds on material presented in Phase I and that his treatment would have to cover the same material in order to recommend Phase II.

We have waived the requirement for Phase I for some individuals, however, most of these individuals were not successful in Phase II. If you feel the inmate may be a candidate for Phase II after your screening and information from the treatment provider, call the TC coordinator to have the inmate screened by TC staff prior to recommending Phase II.

7) The inmate states that he cannot discuss his charges because his case is under appeal.

**RESPONSE:** State that many inmates have participated in group while they are appealing their case. Explain that CRS 12-43-214 (IV) states that "information provided by the client during therapy sessions is legally confidential in the case of licensed marriage and family therapists, clinical social workers, professional counselors and psychologists, and certified school psychologists, . . .", therefore, they can admit their offense to the therapist without jeopardizing their appeal. In addition, CRS 12-43-218 (1) states: " A licensee (L.C.S.W., L.P.C., Ph.D.) or certified school psychologist shall not disclose, without the consent of his client, any confidential communications made by the client to him, or his advice given thereon, in the course of professional employment; nor shall a licensee's or certified school psychologist's employee or associate, whether clerical or professional, disclose any knowledge of said communications acquired in such capacity; nor shall any person who has participated in any therapy conducted under the supervision of a licensee or certified school psychologist, including, but not limited to, group therapy sessions, disclose any knowledge gained during the course of such therapy without the consent of the person to whom the knowledge relates."

Inform him that he will document his cycle of abuse in therapy which will be sent to his parole officer or community corrections agent if he progresses to the community. This document will not include an admission of the specific criminal offenses he has been charged with, however, it will describe types of sex offense behaviors he engages in. Explain to the offender that it is his choice whether he wants to participate in treatment or if he meets the participation requirements. You can also tell him to talk to his lawyer if he is unsure. Explain that we believe he has a problem in this area and that we will continue to recommend treatment. If in the future he feels he has a problem in this area and wants to participate in treatment, he can recontact Mental Health and we would be happy to rescreen him.

**8) The inmate states that his offense was over 10 years ago and he has not committed any similar offense since that time.**

**RESPONSE:** If you are unsure whether the offender's situation meets the guidelines for recommending treatment, fill out a Sex Offender Treatment Team Staffing Form and present the case at the next Sex Offender Treatment Team meeting.

**9) The inmate has been terminated from treatment before.**

**RESPONSE:** Screen the inmate to determine if he meets the participation requirements and to check on why he was terminated from the program. Explain that he will be a low priority for treatment if he has had two or more opportunities to participate in Phase I. Therefore, it will be important for him to successfully complete Phase I this time. He needs to think about the reasons why he was terminated from Phase I and should have a good idea of

what he plans to do differently to prevent this from happening again.

Have him fill out Screening Form Questionnaire #2. Ensure that he has defined and taken responsibility for the reason he was terminated. Also check to make sure that he has a reasonable idea of what he can do to prevent the same problems from happening again. If he is not able to develop a realistic plan, give him some suggestions and ask him to fill out this section of the questionnaire again.

**10) The inmate is wavering on whether he committed a sex offense and/or whether he has a problem.**

**RESPONSE:** Explain the need to talk about his sex offense behavior and problems in order to benefit from treatment. Point out that at times he seems to want to admit and talk about his problems, but that at other times it seems difficult for him to do so. State that you know this is difficult to admit but important in order for him to change. Explain that he currently does not meet the participation requirements, but that you would like him to think about the things you have talked about and fill out a screening questionnaire. Ask him to take a screening questionnaire, fill it out, and return it to you. Be encouraging and compliment him if he has made any progress from prior screening interviews.

**11) The inmate states that he committed a sex offense but that his real problem is alcohol or drug addiction.**

**RESPONSE:** Reinforce the fact that he recognizes he has problems with drugs and alcohol. Help the inmate see in a non-threatening way that alcohol and drug addiction is a parallel problem to sex offending behavior, not the cause of it. Explain that drugs and alcohol loosen inhibitions, but that they do not cause people to commit sex offenses. Point out that many people have alcohol and drug addictions, however, most of these people do not commit sex offenses. You may also want to ask him if he committed a sex offense every time he got drunk or high in order to point out that there is no direct causal relationship between using drugs and committing sex offenses. Explain that there are other reasons why he committed a sex offense which he needs to understand in order to ensure that he does not reoffend.

If he continues to insist that he only has a drug or alcohol problem, explain that he does not meet the participation requirements and it would be unfair to place him in a group if he does not feel he has a problem. The groups are designed for people who want to work on their problems. The group participation requirements are based on a general mental health principle that people are only able to benefit from psychotherapy if they acknowledge that they have a problem and have a desire to change. It would also be unfair to people who feel they have a problem and



want to talk about it in group to have individuals in group who are saying they don't have a problem. Encourage his participation in drug and alcohol treatment and explain that we will continue to recommend sex offender treatment. If in the future he feels he has a problem in this area, he should recontact Mental Health.

12) The inmate claims he does not know if he committed the sex offense because he was in an alcoholic blackout during the time of the offense.

**RESPONSE:** Explain that he does not currently meet the participation requirements for the SOTP since he does not know if he has a problem in this area. Explain that people do not engage in behaviors that are uncharacteristic for the person during alcoholic blackouts. They would not engage in behavior that they had not previously thought about doing or had done in the past. Ask him to think about whether he had engaged in the behavior before and/or had fantasies about committing sex offenses. Ask him to give it some thought and recontact you if he determines that he has a problem with sex offender behavior.

Explain that he does not meet the participation requirements and it would be unfair to place him in a group if he does not feel he has a problem. The groups are designed for sex offenders who want to work on their problems. The group participation requirements are based on a general mental health principle that people are only able to benefit from psychotherapy if they acknowledge that they have a problem and have a desire to change. It would also be unfair to people who feel they have a problem and want to talk about it in group to have individuals in group who are saying they don't have a problem. Encourage his participation in drug and alcohol treatment and explain that we will continue to recommend sex offender treatment. If in the future he feels he has a problem in this area, he should recontact Mental Health and we will be happy to rescreen him.

13) The inmate states that he committed a sex offense but that he has found God and no longer has a problem.

**RESPONSE:** Compliment him on making a positive change in his life. Explain that religion can be a very important part of a healthy lifestyle and that sex offender treatment and religion are complementary, not conflictual. State that treatment provides another opportunity for him to work on his problems. You might also explain that there are many similarities in what we teach in group and Christian principles.

If you feel it would be helpful, remind him that the Lord helps those who help themselves. State that even though someone has God in their life, they continue to work in order to earn money. They do not depend on God to provide them with money without working. Explain that this is similar to working on their problems. They

cannot expect God to take away their problems without also working on those problems themselves.

If he continues to deny having a problem, explain that he does not meet the participation requirements and it would be unfair to place him in a group if he does not feel he has a problem. The groups are designed for people who want to work on their problems. The group participation requirements are based on a general mental health principle that people are only able to benefit from psychotherapy if they acknowledge that they have a problem and desire to change. Encourage his continued participation in religion and encourage him to talk to his minister about treatment. State that we will continue to recommend sex offender treatment. If in the future he feels he has a problem in this area, he should recontact Mental Health.

## **Appendix 4-C**

### **Sample Participation Criteria (See Screening Instructions in Appendix 3)**

#### **REQUIREMENTS FOR PARTICIPATION IN SOTP:**

In order to participate in the Sex Offender Treatment Program you must first meet the following requirements:

- 1) You must have 8 years or less to Parole Eligibility Date;
- 2) You must have successfully completed the Core Curriculum Group;
- 3) You must admit to sexually abusive behavior and be willing to discuss it;
- 4) You must acknowledge that you have a current problem in the area of sexual abuse;
- 5) You must be motivated to work on your problems as demonstrated by:
  - a. a willingness to acknowledge and discuss problems,
  - b. a willingness to participate in group,
  - c. a willingness to address problematic patterns and behavior, and
  - d. a willingness to acknowledge the risk of reoffense; and
- 6) You must comply with the conditions of the group contract.



## **Appendix 5**

### **Multiple Examples of Informed Consent Forms, Limited Immunity Agreements, Waivers of Confidentiality**

#### **Sample Informed Consent for Assessment Obtained from the Colorado Department of Corrections**

STATE OF COLORADO  
DEPARTMENT OF CORRECTIONS  
SEX OFFENDER TREATMENT & MONITORING PROGRAM  
**INFORMED CONSENT**

I understand that I am being asked to complete the Sex Offender Treatment and Monitoring Program (SOTMP) psychological testing component of the program. These tests will be used for assessment, treatment planning, program evaluation, and research. My involvement in this testing has been solicited by the SOTMP as a participant in sex offender treatment. Participation will require me to complete a battery of self-report questionnaires and other types of tests and assessments disclosed during the testing period.

I understand that all information collected will be strictly confidential. I understand the SOTMP collaborates with other Department approved research entities on program evaluation and research studies, which may require my results to be pooled with data from other sources. The findings generated from these projects will not identify me personally in any way, nor will the publication of any data resulting from these tests identify me personally in any way.

I hereby acknowledge and certify that I have read the above and have been given a satisfactory statement of the nature, purpose, and duration of the tests, and means by which the results from these tests will be obtained. I have had my questions answered to my satisfaction, and so willingly consent to participate in this component of the program. A copy of this informed consent will be placed in my mental health file and a copy will be archived in a locked storage unit with my testing.

Date: \_\_\_\_\_

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

DOC Number: \_\_\_\_\_

**THE CROSSROAD TO FREEDOM HOUSE**  
**Therapeutic Community at Arrowhead Correctional Center**  
**P O. Box 300**  
**Canon City, Colorado 81215-0300.**

Acknowledgement of Non-Confidentiality & Waiver

I \_\_\_\_\_, DOC # \_\_\_\_\_, have been informed and acknowledge that I have no rights of confidentiality regarding my treatment at The CrossRoad to Freedom House Therapeutic Community. I have been informed that whatever I tell the Treatment Team (the Treatment Team includes relevant work supervisors, instructors, and correctional staff is not privileged or private within the Therapeutic Community. This includes all information about me and my past behavior as evidenced by my institutional file. All resident information is Therapeutic Community information.

Staff agrees to keep confidentiality within the following guidelines: Information will be given to the correctional system. This includes case managers, parole officers, the Parole Board, and community correction centers. The information given will include level of participation, motivation, deviant sexual history, relapse prevention information, polygraph results, problem areas and/or general progress as well as any information regarding situations that could result in injury to myself or others. If I am a sex offender, information regarding patterns of criminal behavior and acting out will be shared with law enforcement and information on my treatment will be released to my victim upon request.

In making this decision, I understand that if any such right of confidentiality or privilege of privacy exist or, subsequent to execution of this waiver, are held to exist by statute or rule of law, I hereby waive any and all such rights as they apply to my treatment within The CrossRoad to Freedom House Therapeutic Community. I am making this decision of my own volition without coercion or threat of punishment.

\_\_\_\_\_ Inmate Signature and DOC# \_\_\_\_\_ Date

\_\_\_\_\_ DOC witness \_\_\_\_\_ Date

## **Sample immunity agreement**

**Obtained from James M. Peters  
Assistant U.S. Attorney  
Boise, ID**

The parties jointly make the following recommendations:

- a) Psycho-Sexual Assessment -- The defendant will submit to a sex offender evaluation pursuant to Title 18, United States Code, Section 3552(b) prior to sentencing in this case. A qualified mental health professional experienced in treating and managing sexual offenders, such as a member of the Association for the Treatment of Sexual Abusers (ATSA), will conduct the evaluation. The defendant agrees to submit to all evaluation procedures at the direction of the treatment provider, including phallometry and polygraph testing if the treatment provider deems them necessary.
- b) Waiver of Confidentiality -- The defendant agrees to waive any right to confidentiality and allow the provider conducting the psycho-sexual evaluation (and any subsequent treatment) to supply a written report(s) to the United States Probation Department.
- c) Contact with Minors -- The Defendant may not have direct or indirect contact with children under the age of eighteen, unless approved in advance, in writing, by his probation officer.
- d) Access to Minors -- The Defendant will not reside or loiter within 100 feet of schoolyards, playgrounds, arcades or other places, establishments and areas primarily frequented by children under the age of eighteen.
- e) Occupational Restriction - The defendant may not engage in any paid occupation or volunteer service which exposes him either directly or indirectly to minors, unless approved in advance, in writing, by his probation officer.
- f) Restriction on Computer/Internet Use -- The Defendant may not possess or use a computer or other electronic device connected to the Internet without the prior permission, in writing, from his probation officer.
- g) Possession of Sexually Explicit Matter Involving Minors -- The Defendant will not possess any child pornography, or



sexually explicit visual or text (written) material involving minors.

- h) Polygraph Testing -- The Defendant agrees to participate in polygraph testing to monitor his compliance with supervised release and treatment conditions, at the direction of his probation officer and/or treatment staff.
- i) Post-Incarceration Treatment - At the direction of his probation officer, the Defendant will successfully complete any course of treatment related to his offense, as directed by his probation officer, including but not limited to cognitive/behavioral treatment for sexual deviancy by a qualified mental health professional who is experienced in treating and managing sexual offenders, such as a member of the Association for the Treatment of Sexual Abusers (ATSA). The defendant will follow the rules of the treatment program as if they are the orders of the Court.
- j) Search Provision - The Defendant will be subject to a search of his person, home or vehicle, and any objects or materials (including computers and other types of electronic storage media) found therein, at the discretion of his probation officer.
- k) Sex Offender Registration/Megan's Law/Adam Walsh Act Provision - The defendant has been advised, understands and agrees that under the Sex Offender Registration and Notification Act, a federal law, the defendant must register and keep the registration current in each of the following jurisdictions: the location of the defendant's residence, the location of the defendant's employment; and, if the defendant is a student, the location of the defendant's school. Registration will require that the defendant provide information that includes name, residence address, and the names and addresses of any places at which the defendant is or will be an employee or a student. The defendant understands that federal law requires that he must update his registrations not later than three business days after any change of name, residence, employment, or student status. See 42 U.S.C. § 16913(c).

The defendant has also been advised and understands that Idaho law requires that such registration be updated with the sheriff of the county within two working days of coming into any county to establish permanent or temporary residence, commencement of employment or enrollment as a student in an educational institution, and provides that nonresidents employed in counseling, coaching, teaching,

supervising or working with minors in any way, regardless of the period of employment, must register prior to the commencement of such employment with the sheriff of the county. See I.C. 18-8307 (4)(a)(b).

The defendant understands that failure to comply with these obligations subjects the defendant to prosecution for failure to register under federal law, 18 U.S.C. § 2250, which is punishable by a fine or imprisonment, or both, and may also subject the defendant to prosecution under state failure to register laws.

1) Conditional Use/Derivative Use Immunity - As a condition of court-mandated evaluation and treatment, the defendant will be required truthfully to reveal his entire sexual history, including the possibility of other sexual crimes. In recognition of the fact that full disclosure of that history is a necessary component of effective treatment, the government agrees that the defendant's admissions during psycho-sexual evaluation and sex offender treatment, to sexual crimes (*excluding homicide*) previously undisclosed to any law enforcement entity, will not be used against the defendant in a new criminal prosecution. See *United States v. Antelope*, 395 F.3d 1128 (9th Cir. 2005), and *Kastigar v. United States*, 406 U.S. 441 (1972). However, the parties agree that this use immunity and derivative use immunity, is expressly conditioned, upon: 1) the defendant successfully completing sexual deviancy treatment, and 2) the defendant not materially violating the rules of supervised release, and/or committing a sexual crime or a crime involving the sexual exploitation of children after the date of this agreement. If the defendant fails to complete all aspects of treatment, or fails to comply with all material supervised release requirements, or reoffends as described above, then this immunity agreement is rescinded and the government may use defendant's statements against him.

**PROBATION DEPARTMENT**

**STATE OF COLORADO**

**SEX OFFENDER RELEASE OF INFORMATION**

I authorize the exchange of and disclosure of information pertaining to me, between the department of probation, \_\_\_\_\_ Judicial District, State of Colorado, and members of the Interagency Community Supervision Team. This includes the therapist for the victim in my offense. This is in compliance with the Additional Conditions of Supervision for Sex Offenders and the Standards and Guidelines of the Colorado Sex Offender Management Board.

This information may be communicated either orally or in writing and will be used for supervision and/or investigation purposes, and may be reported to the District Court of the \_\_\_\_\_ Judicial District, Combined Courts, State of Colorado.

- ☒ Sex offender treatment provider/program approved by the Colorado Sex Offender Management Board.
- ☒ Polygraph examiner approved by the Colorado Sex Offender Management Board.
- ☒ Abel Screen/plethysmograph examiner.
- ☒ Victim(s) therapist and other involved professionals.
- ☒ Physician as indicated by the Interagency Community Supervision Team (monitored medication, Antabuse, etc.)
- ☒ Employer(s).
- ☒ Federal, state, county, or city law enforcement agencies.
- ☒ \_\_\_\_\_ County Department of Social Services.
- ☒ -Other \_\_\_\_\_.

**Information will include the following:**

Referral Information

Diagnostic Information

Data

Attendance Information

Progress Information

Termination Information

Monthly Progress Reports

Other \_\_\_\_\_

Name and Identification Information

Medical History and Examination

Treatment History

Criminal History Information

Criminal Status Information

Substance/Medication Monitoring

This release of information remains in effect until formal termination of probation supervision by the court.

Name of Defendant: \_\_\_\_\_  
(Print)

Signature

/Date

Witness

/Date

Appendix 6  
Two Examples of Treatment Contracts

**Sample Treatment Contract for a Therapeutic Milieu or Advanced Phase of  
Treatment  
Obtained from the Colorado Department of Corrections**

THE CROSSROAD TO FREEDOM HOUSE  
Therapeutic Community at Arrowhead Correctional Center  
P.O. Box 300  
Canon City, Colorado 81215-0300

TC CONTRACT

Having been granted the privilege of this treatment opportunity by my acceptance into The CrossRoad To Freedom House Therapeutic Community Program, I the undersigned client agree to the following terms and conditions:

1. That I will abide by all rules and regulations established by the DOC (COPD) and TC, including the following Cardinal and Basic Rules:
  - A) No use of drugs or alcohol.
  - B) No violence or threats of violence.
  - C) No stealing.
  - D) No sexual acting out.
  - E) No violating confidentiality.
  - F) No gambling.
  - G) Acceptance of authority.
  - H) Appearance.
  - I) Punctuality.
  - J) No impulsive behavior.
  - K) Manners.
  - L) No horseplaying.
2. I understand the TC program to be highly structured and confrontive. I also understand that the therapeutic techniques of intense group therapy will be employed as an approach to solving my behavior problems. I understand that the following are aspects of the program:
  - A) That most individuals who enter The CrossRoad To Freedom House have low frustration tolerance and poor impulse control related to their problematic behavior and/or chemical usage. Consequently, the structure of the environment in the TC is somewhat frustrating and often uncomfortable for the typical resident. This structure is designed to help you with these problems.

- B) Since my family or support system will be important in my recovery process, I will be expected to inform them of my past offenses and problems and include them in my relapse prevention planning. My primary therapist will be involved with this process. I will be expected to share my relapse cycle with my parole officer, family (support system), and/or community corrections center.
  - C) I will be required to take Psychological or other tests, which may include drug and/or alcohol screening and/or plethysmography and/or polygraph.
  - D) All reading materials and pictures must be approved by staff. Certain reading materials with pornographic or violent content, or any material related to my deviant behavior; will not be allowed in the TC.
  - E) Because acknowledging and ridding myself of the secret lifestyle I have led is important to my recovery, my incoming/outgoing mail (with the exception of legal mail) will be opened and may be read.
  - F) I will not be allowed to choose my roommate. Any roommate assignment can be changed by staff at any time.
  - G) Areas that will be discussed in group include: my behavior (in group, the community, at work, etc.) information on my behavior from correctional records (PSIR, disciplinary reports, chronological notes, performance plans etc.) and homework and reading assignments (including daily thoughts/interactions journal).
  - H) That I will be held responsible for informing my primary therapist of all visits/visitors I receive and any significant life changes/events that may occur while I am a resident of The CrossRoad To Freedom House.
  - I) That the TC treatment team includes relevant work supervisors, instructors, and correctional staff.
2. I understand that I will be expected to contribute significant effort to the TC and that I will display a willingness to work towards assertive, not aggressive, communication with other residents and staff I will talk about my own thoughts, feelings and experiences and will be willing to be questioned about them. I will respect other residents' rights to talk about their thoughts, feelings and experiences. I will not threaten or ridicule others, nor will I use sexual or racial slurs. I also understand that I will be expected to:
- A) Perform all work and treatment assignments given to me by the treatment program staff.

- B) Attend all groups, sessions, lectures/seminars and program activities as prescribed by treatment program staff.
  - C) My conduct is to be appropriate and positive, both within the treatment program complex and the institution at large (visiting room, hallways, yard, etc.).
  - D) Assist the treatment program staff in developing my individualized treatment plan, and follow that plan.
  - E) I will be expected to make my treatment in the TC a priority in my life. The treatment schedule is intensive. Other education and treatment programs may need to be postponed during the orientation and community phase of treatment.
  - F) That I will be required to work in TC assigned work areas and/or attend vocational classes as part of treatment.
  - G) That I will be asked to speak for myself. It is important to talk about your own thoughts, feelings and experiences appropriately and respect other group members rights to talk about theirs. This includes not ridiculing, humiliating, or making light of any group members sexually deviant behaviors. It also means not making any sexual or racial slurs.
4. I understand that I will not receive any preferential treatment or extraordinary privileges for any reason.
5. I understand that throughout the time that I reside in The CrossRoad To Freedom House my behavior, attitude, and clinical treatment needs are subject, to continual and periodic assessment. Consequently, staff may determine at any time that my assignment to the treatment program is not appropriate. I agree to abide by the recommendations made by the program staff.
- A) I understand that this Therapeutic Community treatment program is a recommended treatment program for me and will remain a recommended treatment program throughout my incarceration.
  - B) I understand that I can be suspended or terminated from the Treatment Community based upon the consensus of treatment staff that I have failed to make sufficient progress towards my treatment goals, over time.

- C) I understand that my failure to attend all assigned program groups, sessions, and activities (other than absences excused in advance by treatment staff) may result in my termination from the TC program.
  - D) I understand that I may be terminated from the program for violation of major TC rules such as acting out violently or threatening to do so, engaging in dishonest or illegal behavior, using chemicals, sexually acting out, breaking confidentiality, or failing to make suitable progress in the program.
  - E) I understand that if I am convicted of a Class I COPD violation, I will be terminated immediately. Class II or III COPD violations may result in termination at the discretion of staff.
  - F) I understand that if I am suspended from any component of the TC Program, I will be placed on Suspension Status. At the earliest possible convenience, a team meeting will be scheduled to make a final decision regarding my program status.
  - G) I realize that if I am terminated or withdraw from this program, it will be documented in the working and departmental files and the information will be available to the parole board. I also realize that I may be subject to reclassification as a result of my termination/withdrawal, as well as possibly lose other privileges as deemed necessary.
6. If I wish to withdraw from the TC, I will be expected to inform "the staff in writing and discuss my decision with staff and residents as directed by my primary therapist.
  7. The CrossRoad To Freedom House program has been thoroughly and completely explained to me and any and all questions pertaining to the program have been answered to my complete satisfaction.

**IN ADDITION, SEX OFFENDERS WHO PARTICIPATE IN THE TC PROGRAM WILL BE EXPECTED TO COMPLY WITH THE FOLLOWING CONDITIONS:**

1. You will have no contact with any victims of your sexually aggressive behavior unless approved in advance and in writing by the Sex Offender Treatment and Monitoring Program (SOTMP) Team. Contact includes physical, visual, written, and telephone contact. You also will not directly or indirectly encourage anyone else to have contact with any of your victims. If you wish to be considered for an exception, you must submit a written request to your primary therapist explaining the reasons you are requesting contact with your victim. Your primary therapist will staff your request with the SOTP Team.



2. You will never use the last names of your victims or anyone related to your victims during any group discussions (victims are entitled to confidentiality).
3. You shall cooperate with any requests from your victims to obtain your status regarding any sexually transmitted diseases including HIV.
4. If you have a history of molesting children, you shall have no contact with children, including your own children, unless approved in advance and in writing by the SOTP Team. The SOTP team will only make exceptions for therapeutic reasons. If you wish to be considered for an exception, you must submit a written request to your primary therapist explaining the reasons you are requesting contact with children. Your primary therapist will staff your request with the SOTP Team.
5. If you have a history of molesting children, you shall not date or befriend anyone who has children under the age of 18 unless approved in advance and in writing by the SOTP Team. If you wish to be considered for an exception, you must submit a written request to your primary therapist and explain the reason for your request along with a safety plan. Your primary therapist will staff your request with the SOTMP Team.
6. If you have a history of molesting children, you shall not access or loiter near children in the visiting room or participate in any volunteer activity that involves contact with children except under circumstances approved in advance and in writing by the SOTP Team. If you wish to be considered for an exception, you must submit a written request to your primary therapist and explain the reason for your request. Your primary therapist will staff your request with the SOTP Team.
7. You shall not have any material related to your sexual abuse cycle, or any pornography/sexually explicit materials in your possession, nor will you look at any pornographic/sexually explicit materials at any time. You will not watch sexually provocative television shows nor listen to music or watch other television shows that support your sexual abuse cycle. This includes visual, auditory, telephonic, or electronic media, and computer programs or services that support your sexual abuse cycle. You shall not patronize any place where such material or entertainment is available. You shall not utilize "900" or adult telephone numbers or any other sex-related telephone numbers.
8. Other special conditions related to your sexual abuse cycle may be imposed by the SOTMP Team. This may include restricting you from high-risk situations and limiting your access to potential victims .
9. You will comply with any DOC or State requirements for blood testing, registration and sexually transmitted diseases.

10. You will not be abusive or excessively controlling in any way towards members of your family, group members, or others. You will also make every effort not to manipulate people as a way to avoid dealing with your problems or to avoid taking responsibility for your actions.
11. If you are involved in, or in the past have been involved in, any type of mental health treatment by someone outside the Department of Corrections, you will need to sign a Release of Information Form so that we can communicate with that therapist about your treatment in this program as well as to find out what you have been working on.
12. You will inform your therapist of any significant events in your life such as deaths, parole plans, changes in relationships, marital status, DOC infractions, court actions, dependency and neglect petitions, compliance with medical treatment, etc.
13. You shall comply with recommended medications when it has been determined, after evaluation from a DOC psychiatrist or physician, that a specific medication may enhance your ability to benefit from treatment and/or reduce your risk of reoffense.
14. You shall identify individuals who can be part of your community support system when you are released. You shall provide these individual's addresses to your primary therapist. If you do not have a support person in the community, you shall work with your primary therapist to identify, at a minimum, one individual who can provide support to implement your relapse prevention plan when you are released.
15. You shall develop a relapse prevention plan (Personal Change Contract) which will be shared with your parole officer, approved treatment provider, family (support system), and/or community corrections center.
16. In the development of your relapse prevention plan, sex offenders who have perpetrated against children shall not date or befriend anyone who has children under the age of 18, unless approved in advance and in writing by your primary therapist.
17. If you are a candidate for parole, you shall submit your parole plans to your primary therapist for review and approval 60 days prior to your parole hearing.
18. If you have discretionary parole which can result in a discharge of your sentence while incarcerated, you shall actively seek and accept parole.
19. The SOTMP believes that sex offenders can be more safely returned to the community if they transition back into the community with supervision, treatment, and support. We believe community corrections placements and parole

can provide these transition components. In order to receive a positive recommendation for community corrections placements and parole, you must meet the following:

- a. You must be actively participating in phase II and applying what you are learning.
  - b. You must have completed a non-deceptive polygraph assessment on your deviant sexual history. If you have taken a recent monitoring polygraphs exam, it must also be non-deceptive.
  - c. You must have completed a comprehensive Personal Change Contract which is approved by the SOTMP Team.
  - d. You must have, at a minimum, one identified support person who has attended family/support education and has reviewed and received a copy of your Personal Change Contract.
  - e. You must be practicing relapse prevention with no institutional acting out behaviors within the last year.
  - f. You must be able to be supervised in the community without presenting an undue risk to public safety.
  - g. You must be compliant with any DOC psychiatric recommendations for medication which may enhance your ability to benefit from treatment and/or reduce your risk of reoffense.
20. If you will be discharging your sentence, you shall submit a discharge plan to your primary therapist 6 months prior to your discharge date.
21. Information will be given to the correctional system. This includes case managers, parole officers, the Parole Board, community correction centers, and any other professionals involved in assessing, treating, and behaviorally monitoring your risk for sex offending behavior. The information given will include your attendance, level of participation, motivation, deviant sexual history, relapse prevention information, polygraph results, problem areas, and/or general progress. Even after you complete or are terminated from this program, information on your past participation and your current treatment status will be released to the system.
22. The goal of this program is "No more victims". In an effort to prevent further victimization, information regarding your criminal patterns of behavior will be released to law enforcement. If you are suspected of committing a crime, treatment information may be shared with law enforcement officials for the purpose of providing public safety.

23. Videotapes are confidential and will not be released or shown to anyone who is not on the Sex Offender Treatment Team, without your written consent.

### RESPONSIBILITIES OF THE THERAPIST

As a resident of the TC, I understand that my input is important and valued; however, in all matters the final responsibility for and authority over the Therapeutic Community belongs to the staff.

The treatment team will be responsible for:

1. Keeping confidentiality within the following guidelines:
  - A) Information will be given to the correctional system; this includes case managers, parole officers, the Parole Board, and community correction centers. The information given will include my attendance, level of participation, motivation, deviant sexual history, relapse prevention information, polygraph results, problem areas, and/or general progress. If you are a sex offender patterns of criminal behavior and acting out will be shared with law enforcement. Even after you complete or are terminated from this program, information on your past participation and your current treatment status will be released to the system.
  - B) Information regarding your status in sex offender treatment and the quality of your participation will be released to your victim if your victim specifically requests the information.
  - C) Treatment staff may make more specific notes on my progress in the TC files. The TC files are only seen by the treatment team or my current group therapist.
  - D) Group therapists who are not on the TC staff will have access to my TC file only while they are the therapist of my group.
  - E) Any information regarding situations that could result in injury to myself or others (including security issues, escapes, etc.) cannot be kept confidential.
  - F) Therapists are legally required to report any child abuse. Any specific information indicating prior or current child sexual abuse will be reported to the Department of Social Services.
  - G) Treatment staff will never give information to inmates outside the TC program or to the general public without my written consent.

- H) Videotapes are confidential and will not be released or shown to anyone who is not on the treatment team without my written consent.
  - I) Issues regarding group that are discussed outside of group (whether between group members or between a group member and the therapists) shall be brought up in the next group session.
2. Treatment staff are responsible for monitoring TC residents to make sure they are following the treatment contract and terminating those residents who fail to progress in treatment. Treatment staff has final responsibility for making any and all decisions regarding the Community. I understand that staff will discuss and verify my behavior with correctional staff. The staff will write a final evaluation of my participation in the Community that will include their treatment recommendations.

I have been recommended for participation in The CrossRoad to Freedom House Therapeutic Community Treatment Program. Although there are certain privileges associated with participation in recommended programs, I understand that participation is voluntary and that I have the right to refuse treatment. I understand that the privileges associated with participation in recommended programs can include progressive moves, awarding of earned time, and additional privileges such as canteen, use of appliances, participation in recreational programs.

I have read, understand, and agree to all of the above. I am aware that information about my treatment and my relapse cycle will be released to case managers, parole officers, the Parole Board, and community corrections centers and boards

Signed: \_\_\_\_\_ DOC # \_\_\_\_\_ Date:

Witness: \_\_\_\_\_ Date:

Rev. 10/31/97

## **THE HINDMAN FOUNDATION**

### **ADULT SEX OFFENDER TREATMENT CONTRACT**

This treatment contract especially prepared for

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#### ***PROGRAM PHILOSOPHY***

The treatment philosophy of THE HINDMAN FOUNDATION is one of accountability and restitution to victims of sexual abuse. Within this philosophy is an understanding that there are four levels of victims and offenders in the program will demonstrate respect for these levels of victims.

- ❖ First, there is a child or adult that was robbed of sexual safety by the actions of the offender. This is the primary victim and this victim(s) will be the focus of restitution by each offender preparing a clarification scrapbook. The clarification "Restitution" scrapbook will be prepared regardless of the relationship between the offender and the victim and regardless of whether the victim may be available to receive the scrapbook.
- ❖ The second level of victim is the family of the direct victim. Mothers, fathers, husbands, wives, grandparents, or partners are all traumatized by the actions of the offender. These indirect victims will always be considered to be a focus of restitution requirements of the offender in the THE HINDMAN FOUNDATION offender program.
- ❖ The third level of victim is the community in which the crime has taken place. Because of the actions of sex offenders, everyone in the community has been harmed. Community restitution will be required of each offender in the form of restrictions to contact with children or other vulnerable people, and in the form of guaranteeing community safety by passing polygraph examinations and other treatment compliance requirements of all treatment rules and contract restrictions. The consistent theme for the program in that sex offender treatment is not an automatic right and therefore it is considered to be a privilege to reside in the "community" of Shasta County.
- ❖ The forth level of victim is the society. It is commonly known that victims of sexual abuse can be scarred for life and because of that damage; they

often need lifetime services from society to manage their trauma. Each offender will be required to prepare a clarification scrapbook for each primary victim with the hope that through this process, the damage from sexual abuse will be repaired and the burden of society to heal the victim will be lessened. Each offender in the program will comply with strict rules that require restitution to society in efforts designed to heal the victim.

## ***PHILOSOPHY OF ACCOUNTABILITY***

This unique program philosophy implements an intrusive, long-term therapeutic approach designed to accomplish treatment goals through ***Offender Accountability***. This approach holds offenders accountable for their actions in the treatment program, in the community and within all aspects of their lives. Accountability is demonstrated in such ways as requiring offenders to involve pertinent support system family members or partners in therapy in order to enhance family and community surveillance. Offenders are held accountable for treatment rules and supervision compliance through monitoring polygraph examination that are the financial responsibility of the offender.

Offender accountability is also manifested by the requirement for offenders to establish an honest and open relationship within the treatment program by admitting to all past sexual crimes, which a Full Disclosure Polygraph Examination will verify. Offenders will be held accountable for providing any emotional or psychological damage repair (in the form of clarification) for any primary victim as directed by clinical staff. When offenders move into the "Graduate Group" they will be held accountable to a monthly community project for the duration of their period of supervision, requiring them to move toward accountable citizenship. Being financially responsible for treatment is also an important significant measure of accountability in the THE HINDMAN FOUNDATION program. But most important, the philosophy of offender accountability requires that throughout the duration of treatment, all sex offenders, at all times, recognize that the needs of ***victims*** always take precedent of any need of the offender.

## ***PROFESSIONAL ACCOUNTABILITY***

In addition to offender accountability, there is professional accountability from all staff members, clinical and administrative, to provide offenders with the most respectful, ethical and honest treatment available. Sex Offenders are assured that their dignity will always be maintained within the confines of the treatment contract agreement and that both rewards for success and consequences for violations will occur in a fair and supportive manner. It is the commitment of



THE HINDMAN FOUNDATION that a “victim-centered” sex offender program is not only respectful to those who suffer but this approach is also the most helpful contribution that can be made in helping sex offenders readjust their lives and move into recovery.

### ***PROGRAM GOALS***

The first goal of the THE HINDMAN FOUNDATION sex offender program is to repair the damage to victims—at all four levels. The offender’s need will always be secondary to the needs of the victim.

The second goal of the THE HINDMAN FOUNDATION sex offender program is to compensate the community and society by requiring the offender to establish and open and honest relationship with the program and identify previously undisclosed victims so the healing process for those victims, other than the “crime of conviction” victim can begin the healing process.

The third goal of the THE HINDMAN FOUNDATION sex offender program is to reduce recidivism and re-offense by teaching and giving offenders responsibility and tools to manage their own behavior. This goal is a contribution to the sex offender’s hopeful recovery toward a crime-free future.

### ***PRE-ADMISSION INFORMATION***

#### **PROGRAM QUALIFICATIONS**

In order for the Pre-Admission Process and the Initial Program Screening to be implemented, there is several basic qualification criteria that must exist or must be absent before steps to the pre-admission process can begin.

- ❖ Prospective participants must have plead guilty in a court of law and they must not have put their victim through a trial unless they are entering treatment on parole, after a period of incarceration.
- ❖ Prospective participants must have admitted to their crime because of “true guilt” for the crime of conviction, not because of some other reason and they must continue to discuss their guilt when they enter treatment without any attempt to justify their guilty plea.

- ❖ Prospective participants must have a pending legal sentence and must be “court-ordered” into *this specific treatment program* with legal consequences the result of program failure.
- ❖ Prospective participants must have completed the process of sentencing before admission to treatment commences.

## INITIAL PROGRAM SCREENING

Each offender who is considered for the THE HINDMAN FOUNDATION sex offender program will be offered an **Initial Program Screening** by staff only after two separate screening processes have occurred by members of the multidisciplinary team. This first screening involves a joint decision by the District Attorney and the Corrections Staff to have found that the potential program participant qualified and should be at least considered for felony probation. Secondly, a “288.1 court-appointed psychological evaluation has shown that the offender is not at risk to abscond or leave jurisdiction, is non-violent, non-psychotic and has an adequate Intelligence Quotient (I.Q.) to successfully comprehend and completed all assignments and requirements. If for some reason the “288.1 court appointed evaluation does not occur, the offender can be referred for **Initial Program Screening** if it is clear that those aforementioned criteria do not exist for the offender.

A court order indicates when members of the THE HINDMAN FOUNDATION team may conduct the **Initial Program Screening**. These interviews will be held at the treatment center or where the offender is incarcerated. The purpose of the **Initial Program Screening** is to further evaluate the offender’s attitude and amenability to the program. A brief overview of program requirements will be the focus of discussion. This process will usually occur over a 2 to 3 hour period and the results of the interview will be submitted in written form to the Presentence Investigator for attachment to final sentencing documents. **Initial Program Screening** fee is \$90.00 and must be paid at the time of the interview. At the time of screening the offender will be provided information on important issues relating to confidentiality and other patient rights.

## **PATIENT BILL OF RIGHTS**

It is important that every offender entering into the treatment program understand certain rights, obligations, and limits of obligations by professionals. The following are considered important issues and the offender’s signature at the

end of this contracts guarantees that these rights, limits and obligations are understood.

- ❖ I understand that my evaluation and treatment is confidential, except in some designated situations. I understand that California law protects my confidentiality, but I also understand that in some situations the Court may intervene regarding my records. I understand that should THE HINDMAN FOUNDATION receive a subpoena for my records, I recognize that I will be provided an opportunity to be informed of this subpoena, (whenever possible) and that all respect and dignity will be provided to me within the restriction of the subpoena.
- ❖ I understand that case consultation may occur with THE HINDMAN FOUNDATION staff in order to enhance my evaluation and or treatment. I understand that I am protected with privacy and dignity and that case consultation will only occur within this clinic or with others in the designated circumstances. I also recognize that I have a right to inquire about any case consultation that occurs with other staff.
- ❖ I understand that if a medical emergency should exist, whereby information that is pertinent to my medical condition is requested, professionals at THE HINDMAN FOUNDATION will need to provide that specific information in order to assist in my emergency medical situation.
- ❖ I understand that professionals at THE HINDMAN FOUNDATION are required by state law to report information obtained by the evaluation process or through the treatment process that indicates a clear and immediate danger to another person or clear and present danger to myself.
- ❖ I understand that confidentiality of my involvement in the program may be at risk if I am not financially responsible and THE HINDMAN FOUNDATION must seek legal assistance to collect fees.
- ❖ I also understand by law, staff at THE HINDMAN FOUNDATION is required to report abuse of the children, the elderly or the disabled, regardless of the offender's rights to confidentiality. I understand that a special consideration in this contract provides for reports of child abuse I make through describing my past sexual history that allows special protections of "no prosecutions". (See Section District Attorney's Agreement Not to Prosecute.)

## **TREATMENT COMPONENTS**

### CONTINUUM OF CARE

THE HINDMAN FOUNDATION' offender program operates on a **Continuum Of Care**, approach which means that as offenders make progress they will move on a continuum from intense restrictions and few privileges to more freedom and less financial burden. If however, privileges are awarded to the offender because of progress but thereafter, compliance begins to weaken or irresponsibility becomes evident, offenders will move back on the continuum to not only fewer privileges and more treatment obligations, but also toward the possibility of program expulsion and incarceration.

### GROUP TREATMENT

The main process of sex offender treatment is through group therapy. There are three levels of group treatment at THE HINDMAN FOUNDATION and these group levels contribute to the **Continuum of Care** philosophy. These three groups include:

THE ORIENTATION GROUP

THE HONOR GROUP

THE COMMUNITY SERVICE GRADUATE GROUP

Specific components, requirements and criteria for each group will be explained in detail and in writing through other documents made available at THE HINDMAN FOUNDATION. For the purpose of this contract the following is a brief but pertinent description.

### ORIENTATION GROUP

Offenders will begin treatment in the Orientation group and remain in this group until the New Member Packet is completed which contains a variety of assignments and learning activities. Included in the required tasks is not only preparation of sexual history, and presentation of sexual history in the "HONOR" group, but the offender must pass a Full Disclosure Polygraph Examination verifying that an open and honest relationship has been established with the clinical team. While in the Orientation Group, offenders will have few privileges and significant financial burdens as attendance in the Honor Group, generally as a "silent observer" will also be required. Once the offender has passed the Full Disclosure Polygraph Examination, attendance will only be required in the Honor Group and it is possible that some privileges may be earned.

### HONOR GROUP

The Honor Group is the main focus of treatment for offenders and its' main focus in to honor victims. Offenders in the honor group should have learned

information from the Orientation Group that would allow them to manage their lives in the community and demonstrate empathy and respect toward other group members, especially those visiting from the Orientation Group who will be presenting their sexual histories in preparation for their Full Disclosure Polygraph Examinations. In the Honor Group, offenders will not only be monitored for their work on their own victims but their empathic and helpful behavior to other sex offenders, and treatment staff will be evaluated.

The “product” of the Honor Group is that each sex offender will prepare a “Clarification and a Clarification Scrapbook” for their primary victim(s). This Clarification will be prepared by all offenders regardless of whether the victim is willing or available to receive the Clarification and the Clarification scrapbook. Part of the philosophy of the Honor Group is to always hope that at sometime in the future, some contribution of recovery could be made to the offender’s victim and for this reason, all offenders will be required to prepare exactly what the victim needed for emotional and psychological restitution from the offender.

#### COMMUNITY RESTITUTION GRADUATE GROUP

After the offender has completed all requirements of the Orientation Group and the Honor Group, AND has at least one full year of successful Maintenance Polygraph Examinations, AND is current with all financial obligations, transfer to the Community Restitution Graduate Group is possible. Members of this group will have earned many new privileges, and may be involved with family therapy where reunification or contact with children may be considered. Even though Maintenance Polygraph examinations will continue, members of this group will have only one group therapy requirement per month and they will be required to complete a pre-approved community project each month as a for of “Community Restitution”. Members of this group will be considered reliable leaders of the offender program and may assist and counsel other offenders or contribute to victim needs in the SHASTA TREATMENT ASSOCIATIES PROGRAM.

#### INDIVIDUAL THERAPY

The main focus of treatment for offenders is group therapy. Individual therapy will be available only for offenders who have needs beyond the group process. THE HINDMAN FOUNDATION believe that secrecy or privacy between a therapist and an offender, about those core program goals would not be helpful to the sex offender and may be disrespectful to other offenders who are attempt to establish and open and honest relationship with group members. If the offender has serious or special needs, independent of group goals, individual therapy will be available at the offender’s expense.

#### FAMILY INVOLVEMENT & FAMILY THERAPY

The family of the offender will be an important component in accomplishing a pathway to recovery. Ideally, family members will be involved in some type of

endeavor such as the Mother's Group, Couples Group, or victim therapy. Even though the offender will be prohibited from contact with victims, it is the philosophy of THE HINDMAN FOUNDATION that if the victim and other family members are also involved in the program, receiving individual treatment in the program and in anticipating the offender's completion of the Clarification and the Clarification scrapbook, the offender tends to be much more motivated to rapidly make changes and the victim and the family has an opportunity to feel comfort in not only the same type of treatment but in monitoring the offender's progress.

In situations where the offender completes and presents the Clarification and the Clarification scrapbook, traditional family therapy may occur with the first purpose to resolve any abuse issues with other family members, but to secondly consider the possibility of contact or reunification. Obviously family involvement and family therapy will not be pertinent with all offenders, but it is the philosophy of THE HINDMAN FOUNDATION that most children are abused by someone in the family and often by someone for whom they care. Resolving these family issues toward either reunification or ending the relationship are better to be completed under therapeutic conditions and while the offender continues to be monitored through Maintenance Polygraph Examinations.

#### PARTNERS GROUP

Although sex offenders are always responsible for their own actions, partners of the offender can be helpful in contributing to the offender's success. The Partners Group is available for wives, husbands, fiancés, roommates, girlfriends, boyfriends, a parent or any other person who may be directly involved with the offender's lifestyle. Offenders will not be allowed to continue a "partner" relationship with anyone who is not willing to be involved in the Partner Group process.

This group will focus on understanding re-offense issues, criminal thinking, sexual deviancy, and victim trauma. This group will assist partners in learning strategies for helping the offender maintain compliance but most importantly, they will gain skills in assisting the victim and making contributions to the victim's Clarification scrapbook.

#### COUPLES GROUP

All offenders in a "living-together" relationship with another person will be required to attend the Couples Group on a monthly basis ***with their partner.*** This group is free of charge but if attendance does not occur, a make-up individual session will need to occur for the usual therapy fee. It is the philosophy of THE HINDMAN FOUNDATION that offenders always has a better chance of maintaining success if their partners are involved in therapy and the Couples Group is an opportunity for both the offender and the partner to interact with others couples to enhance education, support and encouragement.

## CLARIFICATION

The "Clarification" is a complicated process that requires the offender to prepare various written components that have been known to heal victims and reduce trauma. The "Clarification" process is also the best contribution to teaching the offender "victim empathy" which is known to be a significant deficit in sex offender thinking. Each offender, regardless of access to the victim will be required to prepare the clarification, present the clarification to the offender group for critique and approval and then complete a Clarification Scrapbook for the victim. Each offender recognizes that by signing this contract the prepared Clarification Scrapbook (that contains sensitive material about the crime of conviction) may be placed in the permanent custody of the victim or the victim's guardian at some time in the future.

## **TREATMENT TOOLS**

### **MULTIDISCIPLINARY INTERAGENCY TEAM**

Sex offenders involved in THE HINDMAN FOUNDATION must recognize that this program is a member of the Shasta County Multidisciplinary Team of professionals who respond to child abuse. This "team" consists of representatives from the District Attorney's Office, Probation & Parole Department, Victim-Witness Program, Child Protection Services, as well as other therapists for both victims and offenders. These professionals meet on a regular basis to discuss cases, coordinate prosecution, conduct screening of offenders, make appropriate referrals and most importantly, monitor compliance of offenders in the sex offender treatment programs.

## TREATMENT ADDENDUM

Each sexual offender involved in the program will have a specialized Treatment Addendum to this contract. The Treatment Addendum will outline exactly what treatment obligations are expected, the frequency of therapeutic sessions as well as treatment fees. As the offender's status changes through the ***Continuum of Care***, a new Treatment Addendum will be prepared.

## CONFIDENTIALITY

There are various aspects to confidentiality for offenders while involved in the program and many of those issues are already explained in the previous section of ***Patient Bill of Rights***. Beyond those issues pertaining to California State law, several other matters pertaining to confidentiality also exist as part of treatment protocol.



Since therapists at THE HINDMAN FOUNDATION attend and participate in the Multidisciplinary Interagency Team for the purpose of monitoring community safety, each sex offender, by signing this contract, agrees that information pertaining to the following three issues is not protected by confidentiality for those professional involved in the Multidisciplinary Team.

*Attendance*  
*Level of Progress*  
*Cooperation*

All other therapeutic issues related to the offender's treatment remain under the guidelines of confidentiality but in order to guarantee community safety, THE HINDMAN FOUNDATION must have the ability to discuss, with members of the interagency team, matters relating to the offender's attendance, level of progress and cooperation.

Sex offenders in the program also have obligations concerning confidentiality. Each offender should expect dignity and respect concerning privacy of sexual and treatment matters from therapists, but from other sex offenders, as well. By signing this contract, each sex offender pledges to respect confidentiality of other group members. Although general treatment topics or program information is not expected to be confidential, issues relating to personal information about other offenders, discussions that occur in the treatment process, or even the identification of co-group members are strictly prohibited. Violations of the confidentiality rules, by any offender, are subject to program dismissal.

#### POLYGRAPH

An important contribution to treatment success and to community safety is the polygraph examination. Two types of polygraph examinations will be used, The Full Disclosure Polygraph Examination and the Maintenance Polygraph examination. Sex offenders in the program are financially responsible for these examinations and they are responsible for providing constant information to the group and to therapists concerning progress in securing funds for polygraphs.

The Full Disclosure Polygraph Examination will be completed once sex offenders have prepared, in written form (according to program instructions), an entire sexual history involving many categories. Written preparation of the sexual history will occur outside the Honor Group, but each offender will be required to verbally present the sexual history, prior to polygraph examination, in the Honor Group for support, critique and approval. Once the offender has received approval from the treatment team and the Honor Group the Full Disclosure Polygraph Examination will be scheduled.

Maintenance Polygraph Examinations will be required of all offenders in order to assure that all probation/parole and treatment obligations are being followed. These examinations will occur at various frequencies according to the offender's compliance or noncompliance.

#### POLYGRAPH ADDENDUM

A special Polygraph Addendum will be attached to this contract for each sex offender in the program. The addendum will describe timelines for polygraph completion, frequency of Maintenance Polygraphs as well as fees.

#### DISTRICT ATTORNEY'S AGREEMENT NOT TO PROSECUTE

This agreement not to prosecute is entered into by the District Attorney of the county of Malheur, State of Oregon, and the undersigned sex offender of this treatment contract.

The District Attorney of Malheur County, desires to encourage an open and honest relationship between therapist and offender, and to facilitate the identification of sexual abuse victims in order to make appropriate treatment referrals, clarification and restitution for those victims. In order to accomplish these objectives, the District Attorney agrees that information relating to past acts of non-violent child sexual abuse or annoyance, indecent exposure, and sexually obscene/annoying phone calls in which the offender was a participant or may otherwise have criminal liability, which are disclosed by the offender to the program therapist after execution of this agreement, will not be used in any criminal prosecution initiated in the County of Shasta, under the following circumstances.

1. The offender has entered a plea of guilty.
2. The offender has enrolled in and been ordered by the court as a term and condition of probation to participate in treatment with THE HINDMAN FOUNDATION, or other programs specifically approved by the District Attorney and the Court, as set forth in the pleas agreement or sentencing documents.
3. The District Attorney has not set forth, in writing, another understanding regarding treatment disclosures or uncharged crimes.
4. This agreement applies only to crimes, which may have been committed within the jurisdictional limits of Malheur County.
5. This agreement applies only to the specific types of crimes indicated above which occurred prior to and were not disclosed or known to the

prosecution prior to the entry of a guilty pleas in this case. Those matters are controlled by the specific terms of the plea agreement.

Nothing in this agreement should be construed to abrogate the obligations of any person to report suspected child abuse under California law, or any other obligation under law or professional ethical codes or guidelines to report ongoing or threatened criminal activity or harm to another.

Upon the completion of formal sentencing in this case, this agreement shall become part of this Sex Offender Treatment Contract.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Offender

\_\_\_\_\_  
Date

\_\_\_\_\_  
Deputy District Attorney

#### CONTACT RESTRICTIONS & ADDENDUM

By virtue of committing a sexual crime, sexual offenders have taken advantage of vulnerability. Therefore, the right to move about the community and have contact with vulnerable individuals has been lost and can only be regained through program compliance. Each sex offender involved in the program will have a specialized Contact Addendum attached to this contract outlining exact restrictions regarding contact with vulnerable individuals. If contact restrictions change, a new Contact Addendum will be prepared.

#### **SEXUAL ISSUES**

##### SEXUAL DISCUSSIONS

Offenders involved in the sex offender program will be required to discuss and complete assignments regarding sexual matters. As part of the overall purpose of becoming honest and being realistic about recovery, past and current sexual behavior will be the subject of topic. Offenders must understand that to be open and honest about sexual matters will be considered an indication of success.

Additionally, sex offenders will have an obligation to be considerate of others in the program regarding their sexual discussions and histories. Each offender must demonstrate respect and support to others when personal sexual issues are part of the discussion.

Beyond sharing and supporting other offenders, each participant will be required to share pertinent sexual information to those who need this information to assist in the offender's ongoing surveillance and recovery.

Requirements regarding whom the offender will share this information with will be made by the offender's therapeutic team at THE HINDMAN FOUNDATION.

#### SEXUAL MATERIAL

Sex offenders in the program have been involved in deviant sexual activities and therefore, while involved in treatment there are strict prohibitions on exposure to or possession of any material that would prevent the offender from developing healthy sexual thoughts and desires. The following material will be prohibited by all offenders throughout their involvement in the treatment program.

1. Visual depictions of children engaged in sexual activity, including photographs, drawings, artworks or computer-generated images.
2. Erotic writings featuring or involving children.
3. Any other visual, aural, oral, computerized or written materials intended for the purpose of causing sexual arousal featuring or describing children in a sexual or erotic manner.
4. Any material not specially intended as erotic, but used for arousal or other sexual purpose featuring children. These items could include such items as children's clothing, photographs of children, photographs of victims, or any particular objects such as toys or baby paraphernalia.
5. Visual, aural, oral, computerized or written depictions of "snuff" pornography, i.e. sexual or violent acts resulting in death of one or more of the participants, either actual or simulated.
6. Visual, aural, oral, computerized or written depictions of illegal acts, such as kidnapping, rapes, violent assaults, and other violent sexual acts.
7. Items used for inappropriate arousal including but not limited to fetish items such as inappropriate underwear or other clothing items, True Detective type of magazines, sadomasochistic materials if the items are linked to inappropriate or criminal arousal patterns.
8. Material showing male or female genitalia, lewd exhibition of the anus, women's nipples, or overt sexual activity involving adults, or animals.
9. Visual, aural, oral, computerized or written material provided, sold, or otherwise produced by organizations specifically advocating sexual

relations between children and adults and/or sexual deviant or violent activities, such as the North American Man/Boy Love Associations, including newsletters and membership cards.

10. Materials pertaining to the offender's victim, which might be used to annoy or harass the victim directly or indirectly.
11. Any use of the Internet or other computer access relating to sexual or criminal conduct or items previously indicated in this section relating to sexual material.
12. Any unique or specific items identified by THE HINDMAN FOUNDATION deemed to be inappropriate and interfering with the sex offender's ability to make progress and complete treatment.

### SEXUAL ACTIVITIES

Sex offenders involved in the program are forbidden to engage in any sexual activities/behaviors that suggest abusive or controlling behavior, with any person, even an adult partner. Arousal to, or efforts at masturbation to sexually deviant fantasies will not be permitted. Sex offenders are also forbidden from sexual contact with any other offender in the program because of the nature of vulnerability in these situations.

### SEXUALLY TRANSMITTED DISEASES

Because THE HINDMAN FOUNDATION concentrates on the needs of victims and restitution to the community, sex offenders must implement a **STD-HIV** screening test for these health issues and offenders must be financially responsible for this testing process. This testing requirement can provide relief to victims and their families and it also allows the offender to take on the responsible of a community health issue, which may affect many people's lives.

Offenders must seek permission from a therapists to proceed with the testing, providing SHASTA TREATMENT STAFF with pertinent information as to where the offender intends upon taking these tests. The sex offender must always make arrangements to have the test results sent to his/her private therapist. The results of these tests will be discussed privately with the therapist and the offender not in the group process. By signing this contract sex offenders agree to not only the aforementioned testing, but also agree to secure treatment that is medically recommended.

### TREATMENT RULES

As a commitment to sex offenders, and their need to change, THE HINDMAN FOUNDATION sex offender program will have a document explaining all Treatment Rules. This extensive set of rules is designed to bring respect and

dignity to offenders, to the program and to the way offenders treat other offenders. Although these rules are strict and may seem cumbersome, they are designed to assist offenders in “practicing” a change in behavior from selfishness (which encouraged their past crimes) while in treatment, with the hope that this positive mirrored or practiced behavior will assist offenders in not only changing their entire life-time response to others, but these strict rules are also designed to assist offenders in recognizing that sex offender treatment is a privilege, not an automatic right, and this understanding may greatly enhance the offender’s possibility to make changes and be successful in recovery.

#### FAILURE TO PROGRESS

Sex offenders in the THE HINDMAN FOUNDATION program are required to make continual and meaningful progress in the treatment program. They will be expected to take an active part in treatment, taking initiative for their own completion of goals but they are also expected to take an active part in encouraging and assisting in the successful of other offenders in the program.

Outside of the treatment program, sex offenders will have other obligations especially to the probation and parole department and to the community. Treatment failure therefore could involve non-compliance inside the treatment rules and contract or treatment failure could also include violations outside the treatment program pertaining to requirements demanded by various members of the Multidisciplinary Interagency Team.

If an offender should fail to make progress the following steps will be taken;

- ❖ The therapist will provide a verbal reprimand to the offender either individually or in the group process. In this verbal reprimand, it will be made perfectly clear to the offender what changes need to be made to attain compliance.
- ❖ Should failure to progress continue, a formal written reprimand will be submitted to the offender, with a copy of the reprimand provided to the probation/parole officer. This written reprimand will contain a timeline within which the offender must correct the problem.
- ❖ If failure continues, a formal termination from the treatment program will be submitted to the probation/parole officer summarizing the course of the offender’s failure and reasons for program dismissal.
- ❖ In some situations, reapplication to the program may occur but only with a joint recommendations from the Multidisciplinary Interagency team, and only if the offender has a clear and precise proposal for how the inappropriate behavior can be changed and if the offender can justify why

the Multidisciplinary Interagency team should at least consider readmission.

#### FINANCIAL RESPONSIBILITIES

The sex offender program at THE HINDMAN FOUNDATION is founded on the concept of "restitution" and in addition to emotional and psychological restitution being required from all offenders, to their victims, there is a financial responsibility as well. Through the Treatment Addendum, as part of this contract, therapeutic schedules AND FEES for treatment will be explained. It will be expected that all offenders will be financially responsible for their treatment, at all times, since this is another way to evaluate the offender's effort to pay restitution.

Those offenders who recognize treatment fees as part of the privilege of living in the community and avoiding incarceration will make every effort possible to budget money so that payments are weekly current. Those offenders who recognize that the fees for services at THE HINDMAN FOUNDATION offender program are drastically lower than other mental health treatment will view fee payment with a grateful attitude. And, those offenders who recognize that beginning the program has an obligation of extensive fees but that through compliance, the program becomes less expensive will always have an enhanced opportunity to move forward on the ***Continuum of Care*** approach.

#### ***STATEMENT OF UNDERSTANDING***

Signatures at the closure of this contract indicate the sex offender understands and has agreed to abide by the terms stated herein. Offenders who have signed this contract are agreeing that the terms of this contract have been explained. Offenders signing this contract also admit that they had opportunities to inquire about items in the contract, to ask questions, and to seek legal advice from their attorney before signing the contract.

This sex offender Treatment Contract was signed on \_\_\_\_\_ and in doing so the offender indicates a readiness to comply with all aspects of the contract.

The sex offender's signature on this document indicates not only compliance to the contract items on this contract but adherence to the following Addendums

ADDENDUM I.      No Contact Order \_\_\_\_\_  
ADDENDUM II.     Polygraph Requirements \_\_\_\_\_  
ADDENDUM III.    Treatment Requirements \_\_\_\_\_

\_\_\_\_\_  
Offender's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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05/05/02



## Appendix 7

### Treatment Termination Documentation

# STATE OF COLORADO

## DEPARTMENT OF CORRECTIONS

Fremont Mental Health  
P. O. Box 999  
Canon City, Colorado 81215--00999  
Phone (719) 269-5024  
FAX (719) 269-5040

Ortiz  
Executive Director



William Owens  
Governor

Joe

## MEMORANDUM

**DATE:**

**TO:**

**FROM:**

**RE: SOTMP Treatment Termination**

After team Staffing, effective this date, you have been terminated from the Sex Offender Treatment and Monitoring Program Phase I. The reason for termination is:

- A. \_\_\_\_ Unsuccessful period of probation for:
- \_\_\_\_ Persistent minimization of the sex offense
  - \_\_\_\_ Denial or severe minimization of problem areas and/or patterns of behavior
  - \_\_\_\_ Denial of risk of re-offense
  - \_\_\_\_ Persistent resistance to material presented in group
  - \_\_\_\_ Non-participation in group discussions
  - \_\_\_\_ Failure to comply with any of the conditions of the contract
  - \_\_\_\_ Tardiness
  - \_\_\_\_ Failure to complete homework assignments
  - \_\_\_\_ Other:
- B. \_\_\_\_ Inmate was terminated without a period of probation for the following reason:
- \_\_\_\_ Unexcused absence
  - \_\_\_\_ Dangerous/disruptive behavior (threats, verified breaches of confidentiality, etc.)
  - \_\_\_\_ COPD conviction for sexual misconduct or sexual abuse
  - \_\_\_\_ Refusal to participate
  - \_\_\_\_ Denial of being a sex offender
  - \_\_\_\_ Other
- C. \_\_\_\_ You were terminated due to your behavior. When you earn your way back to SOTMP wait list status, you will not receive a Mental Health recommendation for earned time for program participation until you are participating in group at the level you

were at prior to termination. Termination from SOTMP means that there are issues related to your offending pattern that you appear to be unwilling to address and change at this time. You may have made some progress in treatment, however you do not appear willing to address these important areas that are critical to your change efforts. Termination is a time out to help you understand the importance of addressing these issues and to develop a plan for change. Being terminated does not mean the end of treatment unless you choose to make it so.

D. \_\_\_\_ You may re-apply to be considered for wait list status within 30 days from the date of termination. You will need to complete the following assignments and address the following issues which led to your termination.

E. \_\_\_\_ Administrative termination (no loss of earned time recommended)

A. \_\_\_\_ Inmate continues to be recommended for SOTMP.

B. \_\_\_\_ The above does not contain Confidential information and will be shared with your case Manager.

C. Comments/description of behavior if not described in probation contact:

### **Assignments:**

### **Termination Issues:**

---

**Date**

**Therapist Signature**

**Therapist Signature**

cc: Mental Health File  
File: TerminationContract

revised 2-7-03



## **Appendix 8**

### **Sample Treatment Plan**

Inmate:

Date:

Primary Therapist:

Identified Strengths:

1. Sexual (Sexual offenses, crossover behaviors, arousal patterns, sexual dysfunction, sexual preference, appropriate arousal, use of sexually explicit material, fantasies, masturbation)

Identified Problems:

Plan:

Progress:

2. Denial (level of denial, level of deception)

Identified Problems:

Plan:

Progress:

3. Evaluation of Self (Self Esteem, Life Goals, Motivation to Change, Belief in Ability to Change)

Identified Problems:

Plan:

Progress:

4. Mental Health (O.B.S., Mental Illness, Character Traits, Psychiatric Diagnosis)

Identified Problems:

Plan:

Progress:

5.Developmental (I.Q., Learning Disabilities, Injuries to brain, school adjustment and progress, Trauma)

Identified Problems:

Plan:

Progress:

6.Medical: (medical conditions/medications impacting offending behavior or response to evaluation and treatment, medication use or abuse, pharmacological needs)

Identified Problems:

Plan:

Progress:

7.Drug/Alcohol Use (Pattern of use, relapses)

Identified Problems:

Plan:

Progress:

8.Violence and Coercion (level of violence assaultiveness, escalation of violence, sadism)

Identified Problems:

Plan:

Progress:

9.Stability and Quality of Relationships (Family of Origin, Romantic Relationships, Children)

Identified Problems:

Plan:

Progress:

## 10. Communication Style (Peers, Authority Figures, Males vs. Females, Participation in Group)

Identified Problems:

Living Unit Goals:

Case Manager Goals:

Plan:

Progress:

## 11. Work Skills

Identified Problems:

Work Supervisor Goals:

Plan:

Progress

## 12. Living Skills (Budgeting, Cooking, Cleaning, Peer Relationships, Responsibility for Community)

Identified Problems:

Living Unit Goals:

Plan:

Progress:

## 13. Recreation and leisure time

Identified Problems:

Recreation Therapist Goals:

Plan:

Progress:

14.Parole Plan/Community Corrections Plan (Location, Support System, Treatment, Support Groups, Minimizing High Risk Factors)

Identified Problems:

Case Manager Goals:  
Plan:

Progress:

---

Inmate Signature and DOC Number

---

Date

---

Primary Therapist

---

Date

**Update at the End of each Block Schedule**



### Individual Treatment Plan Quarterly Tracking

Inmate Name and DOC Number: \_\_\_\_\_

Primary Therapist: \_\_\_\_\_

Date: \_\_\_\_\_

Current TC Level: \_\_\_\_\_

Date Level Achieved: \_\_\_\_\_

Did the offender advance to a new level during the block schedule? Y N

If yes, did the offender complete the test battery: Y N

Was the test battery checked for completeness: Y N

Was the test battery forwarded to research: Y N

Did the offender take a polygraph exam during the block schedule? Y N

If yes, was the data form updated? Y N N/A

Was the sanctions grid completed? Y N N/A

Was a copy of the sexual history, data form, and/or sanctions grid sent to research?  
Y N

Sample Good Lives Model Individualized Treatment Plan  
Obtained from the Colorado Department of Corrections

Treatment Plan

Inmate: John Doe #12345679

Date: May 1, 2005

Primary Therapist: Jane Smith

I. Needs: Self

**1. Autonomy (Self-esteem and Personal Power)**

**Client Difficulties:**

**Mean:** Client indicates that he has met his needs for self-esteem through sexually assaulting young females under the age of 13, sexual contact with non-consenting adults, sex with strangers, including affairs during marriage. Client has stated that he has used sex as the ultimate form of acceptance. He sought sexual interactions with children to meet his need for power. He meets his self-esteem needs by presenting himself in a pretentious manner.

**Scope:** His self-esteem/power needs were met over his needs of work, relatedness with his family, and needs for intimacy with his wife. Client has sacrificed relationships with others (family, friends, therapist) to pursue his need for self-esteem and power.

**Conflict:** His methods for accomplishing these needs conflicted with needs for intimacy with his wife, his needs for relatedness with others, and his needs of appropriate recreation.

**Capacity:** He lacks a sense of self (a clear sense of identity), being authentic with others, and self-acceptance.

**Identified Strengths:** The client's intellect indicates that he has the capacity for problem solving. He is willing to ask others for help, which addresses his issue of perfectionism. This issue is also related to his offending. Client exhibits some insight into his power and self-esteem issue, as he openly admits to struggling with wanting to portray himself as "the good person" and protect himself by not disclosing the extent of his sexual offending.

**Identified Treatment Issues:** Client has an extensive history of perceiving himself as inadequate due to his belief that he could not live up to his parents high expectations. He has created personas to be seen as important and reports that he has exploited others to receive attention from peers. He seeks attention by not taking turns during conversations and treatment groups. He has verbalized the fear of not being able to change beliefs that have been ingrained for so long. Client struggles with perfectionism.

**Competencies Needed:** Client needs to have meaningful accomplishments. He needs to establish genuine relationships with others and develop empathy. Client needs to examine interests and values to determine a sense of self.

**Resources Needed:** Rational Behavior Training, group therapy, peer support, opportunities to set and achieve goals, opportunities to assist others in their treatment, and leadership experiences in TC.

**Treatment Goals:**

1. Work on increasing self-esteem based on healthy meaningful accomplishments
2. Work on acceptance of self by acknowledging and embracing vulnerability.
3. Develop sense of self by identifying interests, values, and plans for future.
4. Develop genuine relationships with others.
5. Open up to peers and staff about issues that may be uncomfortable for him.
6. Obtain personal power by expressing desires and future plans to family and friends.
7. Obtain personal power through helping others without exploitation.
8. Take responsibility for self-injuring and sexual offending behaviors without self-deprecation. Separate behaviors from sense of self.
9. Distinguish old me behaviors from new me behaviors.
10. Establish a leadership role at TC by leading groups, mentoring new members and serving as support for others.

**Objectives: (To be accomplished by the end of block)**

1. Client will document three positive attributes and strengths weekly and report to therapist.
2. Client will document behaviors that assisted others and describe how it benefited the person.

**Progress:**

Completed BOT, RBT and IPCS. He uses switch cards in group and makes a concerted effort to take turns speaking in group and conversations. Client has identified some plans for future.

**2. Spirituality.** Client expresses a desire to remain active in the Catholic Faith and in his relationship with God.

**Identified Strengths:** Client has remained active in his church and expresses a desire to fulfill spiritual needs.

**Identified Treatment Issues:** Has not identified specific parishes or developed a relationship with a priest.

**Competencies Needed:** To be an active member of the congregation, client needs to have the skills to establish healthy relationships with others and develop an honest and genuine relationship with self.

**Resources Needed:** Spiritual Counseling, Rational Behavior Training, Group therapy, Peer Support, and Leadership experiences in TC.

**Treatment Goals:**

1. Identify Catholic churches in the area where he plans to be released.
2. Identify support person willing to attend services with him.

**Objective: (To be Accomplished by the end of block)**

Identify potential parishes to attend services and names of priests to contact.

**Progress:** Client reports that he currently attends church services on Sundays. He spends time in prayer every night.

### **3. Creativity**

**Identified Strengths:** He finds enjoyment in making crochet blankets, cross stitch items and other arts and craft projects. He has an interest in learning new patterns and new projects. He is willing to invest the time needed to complete projects.

**Identified Treatment Issues:** He has had difficulty sharing arts and crafts projects with peers in the community. Client has identified only a few ways to express his creativity.

**Competencies Needed:** Client needs to explore additional ways to satisfy his creativity need that he will continue to engage in after release from prison.

**Resources Needed:** opportunities to explore creativity interests, support from peers, advisement from therapist and recreational staff.

**Treatment Goals:**

1. Develop healthy ways to express creativity
2. Experience a sense of accomplishment by expressing creativity in positive manner
3. Use/Share creativity knowledge/experience to help others.

**Objectives: (To be Accomplished by the end of block:**

1. Client needs to research and document three possibilities of expressing creativity that will be satisfying outside of prison.

**Progress:**

### **4. Happiness/Inner Peace**

**Client Difficulties:**

**Mean:** Client indicates that he has met his needs of inner peace (alleviation of emotional pain) through having affairs and sexually assaulting his nieces. He stated that he used sexual gratification as a means to alleviate pain and to satisfy physical gratification.

**Scope:** His need of happiness was met over his needs for intimacy with his wife. Through the perceived rejection by his wife and the subsequent emotional pain

caused by the strained relationship, the client has sacrificed his relationships through sexual affairs and sexual offending behaviors.

**Conflict:** His methods for accomplishing these needs conflicted with needs for intimacy with his wife and his needs for relatedness with others.

**Capacity:** Client stated that lacks the ability to express his feelings, express sexual wants with wife, and lacks appropriate coping skills to deal with emotional pain. These issues have affected his happiness.

**Identified Strengths:** Client stated that he is open to receiving assistance from others and demonstrated a willingness to support others during times of difficulty. He has demonstrated some insight into his need for effective self-regulation strategies.

**Identified Treatment Issues:** Client states that he needs to learn better coping skills other than masturbation and fantasies about children. He can improve his self-esteem by learning methods for conflict resolution, problem-solving, and coping skills.

**Competencies Needed:** coping skills, empathy, help with emotional regulation, and healthy adult attachment (social connectiveness to others).

**Resources Needed:** Rational Behavior Training, Group therapy, Peer Support, Conflict Management techniques, Covert Sensitization, and Relaxation Techniques.

### **Treatment Goals:**

1. Learn coping skills to assist during times of stress. Client will not use masturbation to children, force, or victims.
2. Learn to regulate emotion
3. Identify sexual assault cycle including identifying triggers and coming up with interventions.
4. Develop a GLM that will help him live a life that meets all of his needs in a socially acceptable manner.
5. Work on developing healthy boundaries and empathy for others by recognizing how his behaviors affect others, attending to others verbal and nonverbal cues, and adjust his interaction accordingly.

### **Objectives: (To be accomplished by the end of block)**

1. Client will identify new and healthy beliefs by:
  - a. documenting fears (2 or 3) and
  - b. the sources from which those fears originated (1-3).
  - c. he will then ask peers for feedback and
  - d. document the beliefs, fears, sources, and peer feedback (provide to the therapist).

## **II. Needs: Social and Biological**

### **1. Sexual and Relatedness**

**Client Difficulties:**

**Mean:** Client indicates that he has met his sexual and relatedness need through sexually assaulting young females under the age of 13, sexual contact with non-consenting adults, and nine affairs during marriage. Client has stated that he has difficulty managing sexual impulses as he has used sex as a method of coping during times of stress.

**Scope:** His sexual needs were met over his needs of work, relatedness with his family, and needs for intimacy with his wife.

**Conflict:** His methods for accomplishing these needs conflicted with needs for intimacy with his wife. His need for sexual contact with children conflicted with needs for relatedness with family.

**Capacity:** He lacks the capacity for developing intimate relationships with others.

**Identified Strengths:**

Client has insight into sexual behavior and provides insightful feedback to peers. Client is intelligent and has sufficient social skills. Client has a strong support system and a desire to establish healthy relationships with others. Client demonstrates a normal sexual interest in adolescent and adult females according to a sexual interest assessment. He reports that he currently does not struggle with masturbating to fantasies of minors, force, or victims. This has been a problem for him in the past. Client states that he is willing to use relaxation techniques, talking to peers, seeking support from family, and therapist during times of stress. He does not demonstrate attitudes supportive of sexual assault with children or women.

**Identified Treatment Issues:**

Client appears to struggle with insecure attachment as a result of moving frequently, sister's illness, and caregiver inconsistency during early development. Client was sexually abused by an older, admired male acquaintance when he was 12 years old. Client needs treatment for possible trauma. Client needs to develop skills that will help him establish intimate, genuine relationships with others. He needs to develop a sense of identity and self-acceptance in order to relate to others on a more intimate level. In the past, he has used sex (i.e., pornography, masturbation, affairs, and sexual interactions with children) as a coping mechanism. He reported that in the fifth grade he was in a school that was predominantly black and he was beat up frequently by a group of peers for being a minority in the school. He was previously terminated from Phase II treatment for making racially offensive remarks. He needs to establish appreciation for other cultures.

**Child Victims:** His victims consist of the following: Inmate's record indicates he sexually assaulted his three nieces ages 13, 12 and 10. He also has disclosed at his age 23 looking at the vagina of a nine year old daughter of a co-worker. At his age 12, he looked at the vagina of a 6 year old neighbor. At age 15, he touched the bare vagina of a 9 year old female while he was babysitting. At age 16, he also touched the bare vagina of a 10 year old female he was babysitting. At age 17, he forced his hand down the pants of his sister's 17 year old friend who was developmentally disabled and touched her breasts, buttocks and vagina on

one occasion. At age 17, he sexually assaulted a 17 year old female while she was passed out. He sexually assaulted his developmentally disabled sister, Dana, age 10, at his age 12 consisting of rubbing his penis against her nude buttocks and fondling her vagina with his hands.

**Adult Victims:** He also took nude pictures of his sister at age 27, at his age 29. In one document he reported the incident happening at his age 35, her age 33. He also attempted to fondle the breasts of his two sisters-in-law while rubbing their backs.

**Additional Victims:** He disclosed having sexual contact with a dog at age 17 consisting of inserting his finger into the dog's vagina.

**Additional Sexual Issues:** He admits to taking nude pictures of his sister and numerous other females (all but his sister he reported were consensual). He had sexual contact with a prostitute at age 21 in Okinawa while in the military. He has been to adult bookstores and to topless bars. He masturbated on two occasions in a video booth at the bookstores. He used the internet to view pornography up to 3-4 times a day. He admitted to voyeurism on two occasions and exposing himself at parties on two occasions.

**Relatedness Treatment Issues:** Client demonstrates insecure attachment; he avoids intimacy and fears vulnerability. He reports that he has tried to control his sister physically and his wife verbally. His relationship with his parents has been strained, as he perceives that he was unable to live up to their expectations. He was adopted at age 2 years old. His parents adopted his sister shortly thereafter. At that time he regressed in toilet training. He was urinating behind his door. He was placed on medication and received therapy. According to client, therapist stated that this behavior occurred due to anger at his parents. His treatment was effective, with the exception of one incident that occurred during the fourth grade. The client had an encopretic episode in school, which resulted in the teacher telling the class. Client stated that he felt shameful about this incident.

**Competencies Needed:** coping skills, empathy, trauma treatment, help regulating emotions, healthy adult attachment (social connectiveness to others), cultural appreciation, identification of verbal and nonverbal cues in others.

**Resources Needed:** Trauma treatment, Rational Behavior Training, Cultural Diversity Training, Group therapy, Peer Support, Leadership in TC, Relaxation Techniques.

### **Treatment Goals:**

1. Learn coping skills to assist during times of stress. Client will not use masturbation to children, force, or victims.
2. Learn to regulate emotion
3. Identify and address attachment issues
4. Receive treatment for his sexual abuse
5. Identify sexual assault cycle including identifying triggers and coming up with interventions.
6. Updating Personal Change Contract to include new interventions and insights into his relapse prevention plan.

7. Client will not view material related to his sexual assault cycle including pictures of children in his victim pool ages 6-17 and adult women in provocative dress and/or situations (i.e., underwear, nude, sexual scenes).
8. Work on developing healthy boundaries and relationships by recognizing how his behaviors affect others, attending to others verbal and nonverbal cues, and adjust his interaction accordingly.
9. He will display vulnerability with peers by disclosing and expressing his emotions appropriately as he experiences them
10. Client will focus attention on others' feelings and needs to increase empathy.
11. Client will continue to participate on cultural diversity committee.
12. Developing a healthy relationship to parents with self-acceptance.
13. Work on methods of meeting the needs of his children in appropriate manner.

**Objectives (To be accomplished by end of block):**

1. To increase empathy and develop intimate relationships with others, client will document interactions with family and peers, identifying feelings and perceptions of others and self during these interactions.
2. Encourage support to contact therapist to be active in his treatment progress (call support education coordinator and primary therapist).

**Progress:**

Client completed Phase I. He is non deceptive on both first and second baseline polygraphs. He struggled in December 2003/early 2004 being deceptive on two maintenance polygraphs in regards to viewing x-rated materials. He also participated in a specific issue polygraph in reference to the sexual assault he committed against his sister. He was non-deceptive. He has completed the following groups: BOT, Cycle, Journaling I and II, RBT, and IPCS. He is participating in PCC and Concept. He will continue to work on his PCC independently with feedback from staff and peers. He is working on identifying personal goals.

He keeps therapist informed on any incidental contact with inappropriate material in the form of addendum.

**2. Excellence in Work, Education, and Financial**

Client expresses an interest in maintaining a career as a truck driver, diesel mechanic, or a meteorologist. He graduated from high school and joined the Marines, serving 9 years. He received a court marshal in the Marines for sexual assault. He was acquitted of these charges and later was honorably discharged. His parents wanted him to pursue college; however, he enjoyed working as a truck driver. This remains a subject of discord between he and his parents.

**Identified Strengths:** Client has a high school diploma. Client has experience with truck driving. Client values hard work, has maintained a stable employment history. Client demonstrates a strong work ethic.



**Identified Treatment Issues:** Client needs a plan with alternatives to meet his career goals prior to leaving prison. Client needs to research requirements to establishing a career within these fields. Client needs to pursue career that satisfies his interests and skills.

**Competencies Needed:** education for meteorologist, technical training for mechanic.

**Resources Needed:** information from library regarding career options, financial aid, and budget counseling.

**Treatment Goals:**

1. Identify career options taking into consideration interest, values, education, and skills.
2. Identify requirements to obtain employment within the careers of interest.
3. Devise a plan to obtain employment within his field of interest prior to release.

**Client Objectives (To be accomplished by end of block)**

1. Research and document requirements for obtaining employment within his employment of interest.

**Progress:** Client has worked in the greenhouse since being at \_\_\_\_\_. He maintains positive evaluations from employment supervisors.

### **3. Recreation and Leisure Time**

**Client Difficulties:**

**Mean:** Client indicates that he has met his recreational needs through associating with individuals who engaged in heavy drinking and sex with strangers. He reported engaging in 75 to 100 sexual partners, many of which consisted of one-night stands.

**Scope:** His recreational needs were met over his needs of relatedness with his family and needs for intimacy with his wife.

**Conflict:** His methods for accomplishing these needs conflicted with needs for intimacy with his wife.

**Capacity:** He lacks the capacity for engaging in healthy recreation.

**Identified Strengths:** Client has good social skills and enjoys the company of others. Client participates in sports and card games at the TC.

**Identified Treatment Issues:** Client needs a plan to develop healthy relationships with others and to identify activities that he enjoys.

**Competencies Needed:** coping skills, empathy, healthy adult attachment (social connectiveness to others), cultural appreciation, identification of verbal and nonverbal cues in others.

**Resources Needed:** Organized activities

**Treatment Goals:**

1. Identify individuals that will provide support and engage in recreational activities with the client.
2. Identify activities that he will engage in on a weekly basis during incarceration and when he is released into the community

**Client Objectives (To be accomplished by the end of block)**

1. Client will explore and document realistic activities that he will participate in on a daily/weekly basis after he is released from prison.

**Progress:** Client has been documenting activities on his activity calendar.

**4. Health and Nutrition**

Client reports that he has chronic hip pain and shoulder pain.

Client is not taking any medication. Client is coded a P2, which indicates that he has mild mental health needs. He was previously on medication for depressive symptoms. He had suicidal ideations after the discovery of the index offense. With respect to drug/alcohol use (Pattern of use, relapses), client is coded a 1 for substance abuse issues, reflecting no apparent need for substance abuse treatment. He has admitted to experimenting with illegal drugs in the past.

**Competencies Needed:** exercise program and knowledge of nutrition.

**Resources Needed:** books on exercise and nutrition, check-up from physician and psychiatrist.

**Treatment Goals:**

1. Establish and maintain an exercise program and healthy nutrition.
2. Continue abstinence from illegal drug use and excessive alcohol usage.
3. Maintain mental health stability
4. He will notify mental health if he is experiencing depressive symptoms.

**Client Objectives (To be accomplished by the end of block)**

1. Daily exercise routine and document in daily calendar.

**Progress:** Client continues to exercise and has been researching healthy nutrition. Client remains abstinent from illegal substances.

**5. Intellectual stimulation (thinking, reading ) or Education**

**Identified Strengths:** Client has an interest in learning to speak a foreign language, such as German or Russian. He has an ability to learn things quickly. He has confidence that he can learn new things.

**Identified Treatment Issues:** Due to low self-esteem, he is hesitant to seek peers that may be knowledgeable of foreign languages.

**Competencies Needed:** Willingness to approach peers

**Resources Needed:** Foreign language books, peer that is knowledgeable of foreign languages.

**Treatment Goals:**

1. To have the ability to speak another foreign language at a conversational level.
2. Identify other methods of meeting this need.

**Objectives: (To be accomplished by the end of block)**

1. Obtain books or learning material to study a foreign language
2. Identify at least one peer that has knowledge of a foreign language

**Progress:**

Identified at least one peer that has knowledge of foreign language, which was documented in progress form.

III. Parole Plan/Community Corrections Plan (Location, Support System, Treatment, Support Groups, Minimizing High Risk Factors)

Treatment Goals:

Needs parole plan to an environment that does not have children or potential victims.  
Needs to educate with the help of staff, support people in the environment he will parole to that are willing to hold him accountable for his behaviors.

**Case Manager Goals:**

Treatment Goals

Develop parole plan  
Obtain registration information  
Obtain information regarding treatment and parole  
Obtain information regarding ID and medical care.  
Identify potential residence and employment that will maximize success.  
Client will continue to educate with the help of staff, support in the community (new and his wife).  
He will continue to sign releases of information to insure staff can communicate with his support.  
He will need to have new support contact primary therapist and support education coordinator.

**Resources Needed:** Resource guide that contains all contact information to help when he is released.

**Client Objectives (To be accomplished by the end of block)**

1. Expand support network beyond his wife by identifying (and documenting) at least one additional candidate.

Progress:

He has participated in a therapeutic disclosure with his parents and his ex-wife.

---

Client Signature and DOC Number

---

Date

---

Primary Therapist

---

Date

Update at the End of the Block Schedule

## Appendix 8-B

### Colorado Department of Corrections Sex Offender Treatment and Monitoring Program *Personal Change Contract*

Name: \_\_\_\_\_ DOC#: \_\_\_\_\_

Date: \_\_\_\_\_

A Personal Change Contract is a plan to address a wide variety of areas and issues for you in your recovery; it is like a road map for your life. A Contract should be flexible enough to be changed, updated and added to as you learn more about yourself and how you relate to the world around you. You will want your contract to reflect your new understanding as it grows. The Contract should include your plans to change in prison and the community. This Contract should serve as your guide for implementing and maintaining positive changes in your life. This is a document that you should use for the rest of your life whether you are under supervision or have discharged your sentence. The Contract should also help your support system understand and assist you in your change efforts.

Preparing this document will take time, thought and effort. It will be important to review this document with others, including your support system, as you write it so they may help you with its development.

#### I. Describe Your Values As Part of Your Relapse Prevention

After identifying your personal and cultural values, write-out specific ways you will demonstrate implementing these values in your life.

##### A. Personal values I will use to make my life meaningful:

Describe the values you will use to make your life meaningful and support your change efforts. Your values will be able to be a guide to your thoughts and behavior whether you are living in prison or in the community. The value should help you contribute to society instead of being self-serving. An example of a self-serving value would be: My goal is to make as much money as possible, get married and have children. An example of a meaningful value would be: My life will have value by caring about other people. My life will have value by contributing to the prevention of sexual abuse. This value is not dependent on achievement and can be carried out whether you are in prison or the community. Write out specific ways you plan on carrying out these values. For example: When I notice a TC member is distressed or is isolating, I will ask him how I can help.

**B. Cultural values that support my change efforts:**

Describe cultural values (religion, family, heritage, political, etc.) that support your change efforts. Some examples of cultural values would be: Treat others as you would like others to treat you. Human life is sacred. Respect and care for your family. Write out specific ways you plan on carrying out these values. For example: I will support my child's caregiver financially without having contact with my child so he/she will be safe; I will support the caregiver's parenting decisions without interfering or becoming intrusive.

**II. Describe Your Sexual Offenses**

In this section, describe the details of all the different sexual crimes you have committed, including the following areas:

- A. Sex and age range of your victims. For example: boys ages 6 through 9 and females ages 17 through 37.
- B. Specific sexual acts, including exactly what you did to your victims. For example: fondle, perform oral sex, masturbate, anal intercourse, forced intercourse, etc.
- C. Assault process, including how you planned and set up your offense, the methods you used to groom people, exactly how you committed your sexual offenses, your thoughts, feelings, and actions. Brief examples: I became friends with the victim's parents and started helping them with projects; I followed a woman I saw on the street and after several nights of observing her patterns, I would break into her home and rape her at knifepoint; I would trick or bribe children by . . . , and then I would tell the kids to cooperate or they will get hurt, etc.

**III. Describe Your Deviant Cycle**

Detail the phases of your deviant cycle by describing the thoughts, feeling and behaviors (camera checkable) of each phase. Be sure to include changes in social life, work, school, home, sleep patterns, appetite, appearance, finances, alcohol and drug use, driving, and cultural and spiritual values.

**A. Core Beliefs:**

List your distorted core beliefs about self, women, men, sex, children, family, and the world

**B. Pretend-Normal Phase:**

For example:

Thoughts – "I need to look good for my boss, wife, etc.". "I need to look good for my work supervisor and case manager". "If I look responsible they will never believe it about me." "I go will go to a place of worship every week."

Feelings – fear, confident, self-pity, in control

Behaviors – I buy flowers for my wife. I work overtime doing extra projects for my boss. I have a nicely manicured lawn. I don't drink. I only put RFG's in on

myself. I don't violate any COPD rules. I compliment the unit officer. I agree with anything the therapist says.

### C. Build-up Phase:

For example:

Thoughts – "I think everyone is mistreating me." "Women don't like me." "My case manager is lazy and won't help me." "Inmates talk about me behind my back."

Feeling – depressed, lonely, angry

Behaviors – I turn down social invitations. I start looking at pornography. I get quiet, scowl at people, drive around looking at young women, and start drinking. I spend all my free time in my cell. I get in arguments with my roommate. I don't shave. I eat more food.

### D. Acting Out Phase

For example:

Thoughts – "I want someone else to feel the pain I feel." "I care about this child and he cares about me." "He disrespected me and deserves to be hurt."

Feelings – powerful, excited, aroused, angry

Behavior – I rape my wife. I sexually abuse my 13 year-old neighbor. I rape my roommate.

### E. Justification Phase

For example:

Thoughts – "I didn't really hurt anyone." "I was just teaching him about sex." "I will never do this again."

Feelings – shame, fear, regret

Behaviors – I isolate from others. I avoid eye contact with people I care about. I call in sick at work. I change my appearance. I only sleep four hours a night.

## IV. Describe Tactics/Manipulations/Abuse of Your Support System

Describe the various ways you have abused or manipulated your family, members of your support system and other relationships in your life. For example: I make my mother feel guilty when she questions my behavior. I hit my wife when she questions my actions. I get my family to think other people are picking on me and then they get angry with the other people instead of me. I convince my family the victim lied and I am not really a sex offender. Include any risk factors you have identified in your Support System Risk Factors Assignment.

## V. Safety Plan

### A. External Interventions

#### 1. Environmental Restrictions

As a sex offender who will continue to struggle with urges, you will need to set up a containment system to successfully manage your risk to reoffend so you will have NO MORE VICTIMS. Your parole officer, therapist, polygraph examiner, and support system will be part of your

containment system. You need to think of restrictions your support system can help you implement to decrease your risk. These restrictions will apply to work, social situations, recreation, and housing. For example: If you should not be around children, your contract should state: I will arrange a specific time to call my wife so my children will not answer the phone; I will sit in the visiting room with my back to the pop machine. I will not go to parties where children will be present. If you are an alcoholic, your contract should state: I will take antabuse; I will not use alcohol and I will not go to bars.

## 2. Notifications

You will need to inform significant individuals (i.e., boss, minister, potential partners or others you may have a relationship with) in your life that you are a sex offender and will always struggle with urges. With the help of your support system you will work on managing your risk. In order to allow these individuals to help you, you will need to talk to these people and request their support in your treatment. Identify those individuals you will need to inform and describe when and what you will tell them about yourself, sex offending history and cycle. Describe how you will give them permission to confront you and report you when they think you are engaging in high-risk behaviors or close to acting out. For example, if I am going to do something social with someone I met at work, I will tell them I am a sex offender and I cannot be around children. I will answer any questions they may have. I will ask whether they are still comfortable going to the activity with me. I will ask whether they have children and plan how I will avoid contact with their children and other children during the activity. I will also inform my therapist and support system so I can talk about the disclosure and how it went.

## B. Internal Interventions

Internal interventions should include cognitive, emotional, and behavioral interventions. Examples include: When I recognize I am using victim stance, I will complete an RSA and call a person in my support system to ask for help with victim stance; When I have a deviant urge, I will use covert sensitization and call my support system to ask for help that evening; I will keep a daily journal and review the journal frequently to look for criminal thinking errors and have my therapist review the journal regularly; When I notice I am withdrawing and depressed, I will call my therapist and support system or submit an RFG; If I reoffend, I will call the police and report my crime.

## 1. Personal Strengths

What have you learned about yourself that will help you live a healthy life. For example: I have developed honest friendships at the TC and I will be able to establish similar relationships when I am in the community; I have participated in the TC and I have a commitment to change; Although treatment has been challenging, I have continued to persevere; I enjoy



playing the guitar and I can spend time relaxing while playing music; I enjoy baseball and can play on a recreational team to socialize with peers; I have completed a horticulture vocational training program and can work in a greenhouse.

**2. Positive Self-Enhancing Activities (Balanced Lifestyle)**

Describe how you will spend your time including: social, family, spiritual, treatment, support groups, recreation, education, work, and community service. Describe a typical week, and then add those events you will participate in on a monthly basis and on a yearly basis. Describe your balanced lifestyle now and how you want it to look when you are released. Describe how will you monitor your compliance with this plan.

**VI. Circle of Support and Accountability**

**A. Professional**

The professionals listed below make-up the containment model. Describe how each of these professionals may facilitate accountability and what their role is in your support system.

1. Parole officer
2. Therapist
3. Polygraph examiner

**B. Personal**

1. List your identified support system
2. For each person identify when you have completed the following:
  - a. Filled out an Identified Support System assignment
  - b. Invited the individual to a Support Education Meeting
  - c. Confirm this individual attended a meeting
  - d. Completed the "Support Assessment Assignment" (If yes, attach it to the Contract),
  - e. Attended a disclosure meeting with the individual.
3. A therapist has reviewed this information.

**C. Work**

1. List individuals from your current places of employment who you have included in your support system.
2. Describe what you have done to inform your current work supervisor that you are a sex offender and about your issues.
3. List those individuals who will be in your support system at your job in the community. If you don't know where you will be working, describe a plan to inform your employer about your issues and to develop a support system at work.

**D. Living Arrangement**

1. Describe where you will be living. If you don't know where you will be living, describe the type of place that will be a safe living arrangement.
2. Describe how will you prevent high-risk situations in your living arrangement (e.g., contact with children).
3. If the people you are living with in the community are not attending the Support Education Meeting, explain why?

**Signatures**

Inmate name and DOC#	Date

Primary therapist	Date

PCC Group therapist	Date

PCC Group therapist	Date

TC Program Coordinator	Date

This material was adapted by Colorado Department of Corrections Sex Offender Treatment and Monitoring Program from Safer Society Series by Bays, Freeman-Longo, and Hildebran

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## Appendix 9

### Support System Advisement

#### DISCLOSURE/ADVISEMENT

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#### NOTICE TO THE SUPPORT SYSTEM OF OFFENDERS SUBJECT TO SEX OFFENDER SPECIFIC SUPERVISION AND TREATMENT

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The offender has either been convicted of a sexual assault offense or has indicated his/her willingness to plead guilty. You need to be aware that any community-based sentence will require the offender's participation in sex offender treatment. Sex offender treatment methods are often misunderstood, even by highly qualified attorneys and non-specialized therapists. Attorneys often are alarmed by what they hear about this treatment. Psychotherapists, not familiar with the literature, typically feel that such methodology is contrary to basic therapeutic techniques. Some ministers fear the therapy doesn't allow for the offender's spirituality. Sex offender treatment challenges offender's perception and way of thinking. They often complain about the personal discomfort they experience, exacerbating the concern of their support system. Research has shown treatment can be effective in reducing the risk to public safety, while at the same time increasing the number of defendants receiving community-based sentences for sex offenses. It is important for all persons to know from the beginning that the offender will undergo treatment different from traditional psychotherapy.

#### DIFFERENCES IN THE TREATMENT:

**The criminal justice system chooses the treatment provider, NOT the offender.** Offenders often feel they should have the right to choose the therapist that makes them most comfortable. Since sex offender treatment is not yet taught in most graduate schools, and because the criminal justice system has the responsibility to protect the public, the criminal justice system has to make certain the therapy used will actually enhance community safety. Thus, all persons convicted of sexually related offenses will be required to attend treatment with a therapist approved by the Sex Offender Management Board (SOMB) and the probation department or community corrections program. The offender will be responsible for payment of all treatment-related bills.

**Mandated treatment** has a poor reputation in mental health circles. Research has shown that a) this process takes years, not weeks or months, b) offenders often feel uncomfortable during this process, c) offenders will believe they are "cured" long before they are ready to be released from treatment. As a result, offenders drop out before they have realized the benefits of this treatment unless they are required to attend by the Court.

**Lack of confidentiality.** Confidentiality is a cornerstone of traditional therapy. However, secrecy allows sex offenses to flourish. Sex offender treatment involves the probation officer/community corrections agent, the victim's therapist, the social services worker, and others. No one will be revealing the personal business of the offender to persons with no need to know, but each offender in sex offender treatment is required to waive his/her right to confidentiality. The exact nature of that waiver varies slightly among treatment agencies.

**Goals.** Setting treatment goals has traditionally been done by the therapy offender. In sex offender treatment, history has proven that the offender is incapable of setting treatment goals that are in his/her, or the community's, best interest. Thus, the community supervision team sets those goals. The team establishes the value that sexual abuse is harmful and the offender must change attitudes and behaviors that may lead to a re-offense.

**Trusting** the offender has always been the basis of psychotherapy. The offender has been regarded as the best source of information even when there has been suspicion that the offender's perception might not be reliable. Sex offenders' invalid perceptions are often a precursor to offending behavior, and to realign the offender's perspective closer to reality is one of the treatment goals. To do so requires that the therapist rely on other sources of information, and by implication to withhold trust from the offender. Experienced sex offender therapists can do this while continuing to treat the offender with respect.

**Rescuing.** Experienced sex offender therapists will not rescue the offender from legal consequences of his/her behavior. They will report probation and program violations to the criminal justice system.

**Confrontation.** Sex offender treatment involves the challenging of the offender's perceptions and beliefs. This confrontation is uncomfortable for the offender but has proven to be necessary for the offender to truly gain insight into his/her behavior.

**Group therapy.** Effective sex offender treatment must be done in group therapy. In individual therapy it is too easy for an offender to manipulate even an experienced, competent therapist. Group members have "been there" themselves and can effectively confront and support the new group member.

**Admission.** The offender must admit he or she engaged in INAPPROPRIATE SEXUAL BEHAVIOR TO WHICH HE OR SHE PLED GUILTY or OF WHICH HE OR SHE WAS CONVICTED. It is impossible to teach a person to control a behavior he/she says has never been practiced.

**Physiological monitoring.** The offender will be required to undergo polygraph, plethysmograph, visual reaction time measures or other instruments

recognized to measure sexual interest as directed by the probation officer and/or therapist.

**Additionally**, special conditions of probation will be imposed which will result in limitations and changes in the offender's current lifestyle. Additional conditions of probation will include but are not limited to: no contact with children, no consumption of alcohol or of any illegal substance for personal use or for the purpose of grooming a victim, residence approval by the supervising probation officer, registration as a sex offender and genetic marker (DNA) testing.

- ◆ Per statute, offenders will be required to comply with an offense specific evaluation prior to sentencing. This must be done by a provider who is approved by the Sex Offender Management Board. In addition, the offender may be required to be evaluated to determine if he or she is a sexually violent predator. Offenders living out of state may, therefore, be required to remain in or return to Colorado for said evaluation.
- ◆ Discovery Material. Once a conviction has been entered, it is inappropriate for an offender to possess discovery materials used in the case as they may be sexually stimulating for some offenders and could constitute a violation of probation.

I have read and understand the above provisions.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Signature of Offender



Appendix 10-A  
Safety Net Offender Manual

A Training Manual for  
COMMUNITY PREVENTION TEAMS FOR  
PREVENTION OF SEXUAL OFFENSES:

a Relapse Prevention Approach  
for \_\_\_\_\_  
(Offender's Name)

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DEPARTMENT OF CORRECTIONS  
COMMUNITY BASED SAFETY NET FOR SEXUAL OFFENDERS  
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## INTRODUCTION

Preventing a relapse into crime by sexual offenders is difficult. The purpose of this training is to decrease the chance of relapse into crime. This manual shows how community leaders, family members, individuals from social services, and probation work with the offender after their release from jail. These people work on teams that will help the offenders refrain from improper sexual behavior. This manual is designed to be a resource for people wishing to help prevent sexual abuse in the community. It explains what sexual offending is, how the sexual offender is treated, and how to prevent relapse. The manual has been written to help the members of the team understand how they can help to decrease the chance that the offender will return to a life of crime.

# **OVERVIEW**

## Chapter 1

## **OVERVIEW**

### Guided Questions and Answers:

**1. What are four purposes of the Community Based Safety Net Program?**

- 1) To reduce the chance that an offender will commit another crime and go to jail.**
- 2) To increase safety and improve the chance that the offender can safely remain in the community.**
- 3) To train safety net members to see dangerous behaviors and help the offender stop.**
- 4) To help the therapist, Probation Officer, and others step in so that the chance of relapse is lowered.**

**2. How will the Community Based Safety Net Program make your community a safer place to live?**

**The Community Based Safety Net Program will make your community a safer place to live because community members will know about sexual offenders. They will be able to help probation officers and therapists watch sexual offender's behavior. They will be able to help sexual offenders keep from committing another crime and going to prison.**

Important Vocabulary:

**Community Safety Net team** - Any number of people that agree to work together to help a sexual offender keep from committing another sexual abuse crime. Examples: Probation officer, approved therapist, village elder, priest, school teacher, or any concerned community member.

**Inappropriate sexual behavior** - Any sexual action that involves unwilling partners or that presents a danger to the individual or others.

**Offender** - Lawbreaker. A person who has committed a crime.

**Relapse prevention plan** - A program to keep an offender from slipping back into criminal behaviors.

## **COMMUNITY BASED SAFETY NET PROGRAM**

### Overview

The Alaska Department of Corrections (DOC) has developed a program to improve community help for sex offenders who have been convicted of sex offenses and are living in the community on probation or parole. In order to reduce the chance that an offender will commit another crime and go to jail, it is necessary to have strong support. The members of the safety net team will be trained to recognize dangerous signs and alert the offender, the therapist, and probation officer.

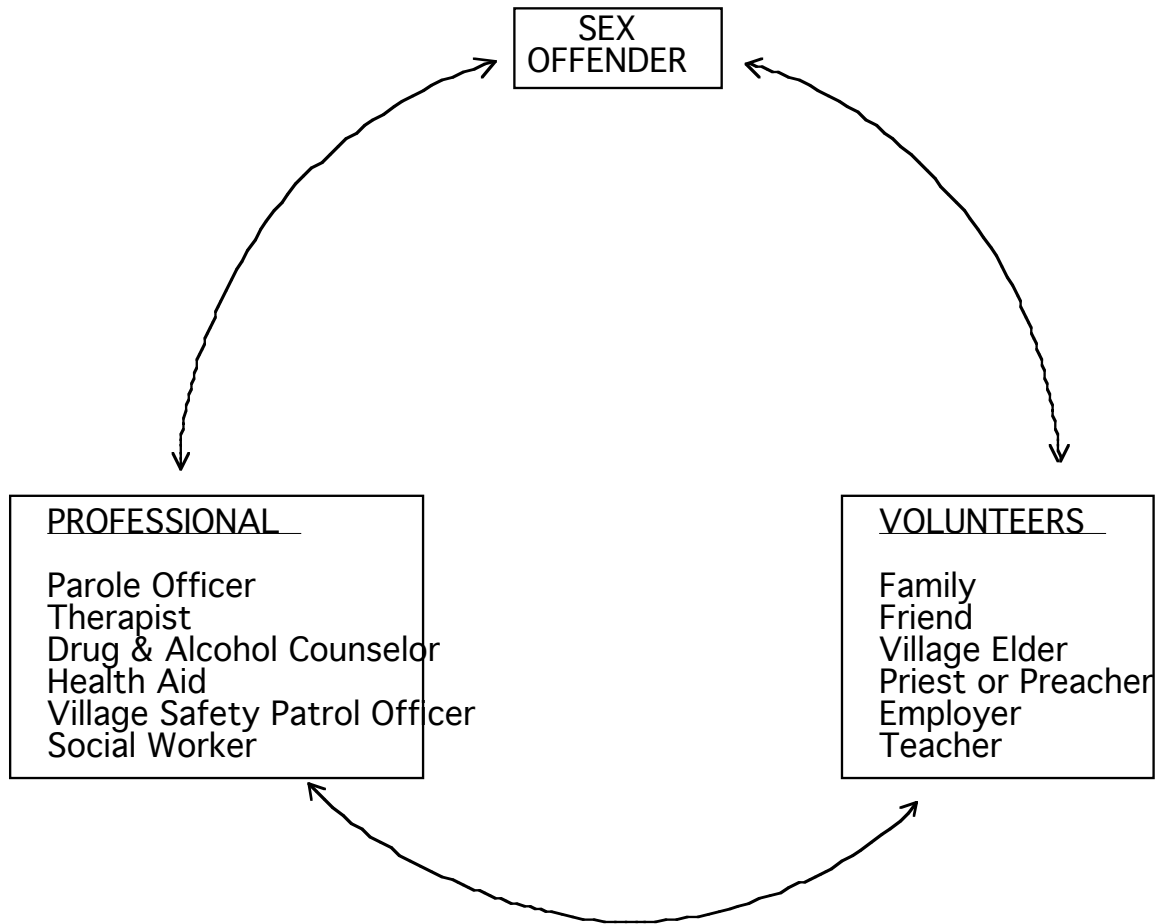
Sexual offenders are people who have been convicted of having sex with a person against their will. This is inappropriate sexual behavior. Inappropriate sexual behavior is forcing someone to have sex, or having sex with children, or anyone under 16 years of age, or any adult that cannot make a responsible decision for themselves (drunk or mentally retarded).

The Alaska Department of Corrections uses something called Relapse Prevention for the treatment of sex offenders. Relapse prevention is based on the idea that sex offenders can control their behavior, but they need your help. The main purpose of treatment is to teach offenders like \_\_\_\_\_ (offender's name) to manage and control their behavior. The community support program is to train people who already know \_\_\_\_\_ (offender's name) well to see problem behaviors and help him stop. The safety net helps \_\_\_\_\_ (offender's name) maintain a relapse prevention plan. The team members are trained to see problem behaviors in order to help the therapist, Probation Officer, and others to help the offender stop these problem behaviors.

The safety net will include people such as probation officers, mental health counselors, substance abuse counselors, vocational counselors, and

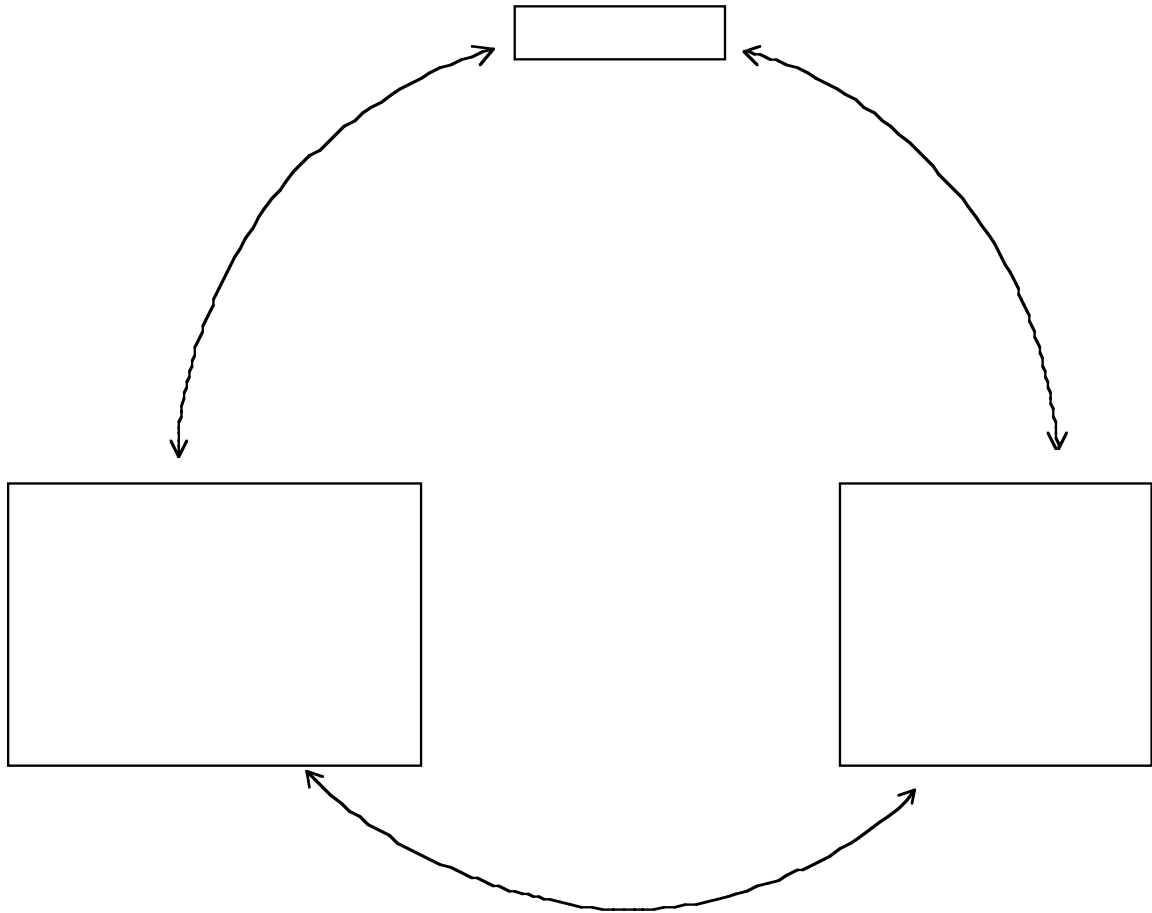
village health aides. In addition, other support persons may include family members, village elders, religious leaders, employers, co-workers, friends, or anyone else who spends a lot of time with \_\_\_\_\_(offender's name). Many of these people see \_\_\_\_\_ (offender's name) everyday and may notice behaviors and problems which if ignored could lead to another crime. This will increase safety in the community and improve the chance that \_\_\_\_\_(offender's name) can safely remain in the community. If trained to see danger signs and share that information with the probation officers, the volunteers can help the probation officers to better manage \_\_\_\_\_(offender's name) (Trainer's note: Video testimony "If only they had shared").

## COMMUNITY SUPPORT TEAM





# COMMUNITY SUPPORT TEAM



# **RELAPSE PREVENTION**

## Chapter 2

## RELAPSE PREVENTION

### Guided Questions and Answers:

1. Q. What does it mean for a person to “relapse”?  
A. To a sex offender this means to commit another sexual offense.
2. Q. What is relapse prevention?  
A. This is a program that an offender can use so that he can change the way he acts.
3. Q. Do alcohol and/or drugs cause a person to commit a criminal offense?  
A. No. But alcohol and drugs can make the offender more dangerous because he will be less afraid of being caught or see less reasons for stopping his behavior.
4. Q. How does the safety net team help the offender get back on track?  
A. By listening to the offender; asking what is going on; encouraging the offender to continue to work on his relapse plan.

### Important Vocabulary:

**Relapse:** To slip back to old ways that are not healthy. To a sex offender this means to commit a sexual offense. To an alcoholic this means to have a drink.

**Relapse prevention:** A program that the offender can use so that he can change the way he acts.

## RELAPSE PREVENTION

Relapse Prevention is a program that \_\_\_\_\_ (Offender's name) can use so that he can change the way that he acts. Some words can mean different things to different people. In this book the word relapse means to slip back or fall back into old ways that are not healthy. Relapse prevention is trying to make sure that a person does not slip back or fall back into the old ways which allowed him to sexually offend, hurt others, hurt himself, and go to jail.

Some people think that a sexual offense just happens and that there is no reason for it. Some people think that because the offender was drunk or using drugs he did nothing wrong. Some people believe that it was the alcohol or drugs that **caused** the crime. **THIS IS NOT TRUE.** Some people also believe that being a victim of sexual abuse is the cause of an offender's abusive behavior now. **THIS IS NOT TRUE.** Many victims never become offenders. If you look very close at sexual crimes you will usually find that several events or things happened before the crime. This is also true in \_\_\_\_\_(offender's name) case. These events lead up to the crime and are some of the reasons why the sexual offense happened.

Treatment helps the offender learn about parts of themselves that need to be improved. Most sex offenders don't control their thoughts and behaviors very well. When \_\_\_\_\_ (offender's name) does not control his thoughts and behaviors well he is in danger of committing another crime. To help \_\_\_\_\_ (offender's name) avoid a relapse, he has a plan. The safety net team is a part of \_\_\_\_\_ (offender's name) plan. He may share more details of his relapse plan later. You do not need to know all of the plan, but to be a support and to help to \_\_\_\_\_ (offender's name) it is important to know that he moves from one step to the next step as he gets closer to sexually offending.

As \_\_\_\_\_ (offender's name) goes through his day he may experience feelings of sexual excitement. Some of these feelings will be normal, and others will not. It is possible for \_\_\_\_\_ (offender's name) to control his sexual excitement, by controlling the thoughts, feelings, and behaviors that go along with the sexual excitement. Some of the time \_\_\_\_\_ (offender's name) will think that these feelings are exciting and feel good and will choose not to control them. But it is very important for him to control his sexual excitement because this will lead to a reoffense.

The way for \_\_\_\_\_ (offender's name) to control his inappropriate sexual excitement is to use a correcting choice. He has the ability to make this choice. If he does not make the choice to control his sexual excitement, he needs your help. If \_\_\_\_\_ (offender's name) does not use a corrective choice he will move towards a dangerous situation. When he is in a dangerous situation he thinks of ways he can reoffend and not get caught. You may see some problems with the way \_\_\_\_\_ (offender's name) thinks. These are examples of what \_\_\_\_\_ (offender's name) is thinking when he is in a dangerous situation (if possible, offender assists trainer in filling in list).

\_\_\_\_\_ ( offender's name) **Thinking When He Is In A Dangerous Situation**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

When \_\_\_\_\_ (offender's name) makes a correct choice he will move back toward safety. This is why it is important for him to talk about what is going on for him. As he talks, you will hear him talk about decisions that do not sound real good. When you ask \_\_\_\_\_ (offender's name) why he is thinking dangerous thoughts, he should be able to correct his thinking.

If no correction is made \_\_\_\_\_ (offender's name) moves toward a dangerous situation and could commit another crime. Sometimes he will choose to correct all by himself. Sometimes it will take somebody saying something to help him. If \_\_\_\_\_ (offender's name) still does not correct, it may take somebody doing something to help him get back to his plan. This is where the safety net can help \_\_\_\_\_ (offender's name) get back on track and not commit more crimes.

After \_\_\_\_\_ (offender's name) moves back toward safe thinking he will feel bad about the poor choice he just made. He may feel like he failed and will always be a bad person. The safety net team can help \_\_\_\_\_ (offender's name) by encouraging him to continue to work on himself. **DON'T TREAT \_\_\_\_\_ LIKE A FAILURE !** If he continues to work hard on his relapse plan, he will begin to feel better about himself. When \_\_\_\_\_ (offender's name) is **NOT** working on his relapse plan he will try to feel better about himself by thinking about only the positive and enjoyable things before, during, and after his offense. This is similar to an alcoholic thinking about having one drink and choosing not to think about what it feels like to be sick the next day. (video: High Risk Situations)

Remember, \_\_\_\_\_ (offender's name) may share with you that he is doing okay. He may even look like he is doing okay. But if he is not really following his own plan, he may start to put himself in a dangerous situation that may lead to a reoffense. These are the things you should look for. These are the things \_\_\_\_\_ (offender's name) **SHOULD** be doing to correct his behavior. If he does not the next chapter will help you know what to do.

1. 

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2. 

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3. 

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4. 

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5. 

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# **ROLE OF VOLUNTEER MEMBERS OF THE SAFETY-NET TEAM**

## **Chapter 3**

## **ROLE OF VOLUNTEER MEMBERS OF THE SAFETY-NET TEAM**

### Guided Questions and Answers:

1.   **Q.**   What are four ways the Safety Net Team help in the community?  
      **A.**   1) To reduce the chance that an offender will commit another violent crime and return to jail.  
            2) To create a support system in the community to help with supervision and treatment needs of the offender.  
            3) To train community members to recognize dangerous behaviors.  
            4) To make the community a safer place to live.
2.   **Q.**   What is the job of the Safety Net Team?  
      **A.**   To **LOOK, LISTEN, ASK, and ACT!**

### Important Vocabulary:

**Probation Officer** - A court officer who investigates, reports, and supervises convicted offenders on probation.

**Relapse** - The offender slips back into behaviors that lead to a crime.

**Risky Thinking** - Thinking that is not good. Errors in a person's thinking.

**Therapist** - A person who has received the necessary training and experience to provide treatment for a sexual offender.

**Volunteer** - A person who gives help or does a service.

## ROLE OF VOLUNTEER MEMBERS OF THE SAFETY-NET TEAM

This training is to help you understand your job on the safety net team. It is important during this training to ask questions about your role. Anytime you have questions, you should ask.

It is very hard to get out of jail and come back to your home town. Your job is to keep working with \_\_\_\_\_ (offender's name). To work with him means to **look** at his behaviors and **listen** to him when he talks. It is also hard to find people to talk to who will encourage the offender to have respect for society. You should **listen** to \_\_\_\_\_ (offender's name) and talk with him. **Listening** is very important because it lets \_\_\_\_\_ (offender's name) talk out problems and decide for himself what is the best thing to do.

Sex offenders do not use good thinking. There may be errors in the way they think. Sometimes this can be called risky thinking. When you **Listen** to \_\_\_\_\_ (offender's name) and hear him talk about thinking that does not sound good, you should **ask**, "What is going on?" **Look** at \_\_\_\_\_ (offender's name) behaviors. It is your job to **ask** about the way \_\_\_\_\_ (offender's name) is thinking. It is your job to **ask** others about how he is doing. It is up to \_\_\_\_\_ (offender's name) to make the decision to change. It is not your responsibility to change \_\_\_\_\_ (offender's name).

An example of risky thinking could be an offender deciding to live with his sister who has several small children. Another example would be an offender deciding it is not important to go to work. (Trainer gives examples of \_\_\_\_\_ (offender's name) risky thinking and asks volunteers

what they would do). (Trainer's note: use handout **LOOK, LISTEN, ASK, ACT.**)

Sometimes you might see the offender doing things that do not seem right. An example could be choosing to be with old friends who do not work and use drugs. Another example is choosing to get drunk. Again, you **look** at \_\_\_\_\_ (offender's name). behavior. You **listen** to him talk. You **ask** him what is going on.

### HOW TEAM MEMBERS ASK ABOUT DANGEROUS BEHAVIORS:

It is helpful to tell \_\_\_\_\_ (offender's name) when you see (**look**) his danger signs. This should not be done in a mean way or an angry way. If the talk becomes angry it can actually push a person towards more problem behaviors. It is helpful to tell \_\_\_\_\_ (offender's name) what danger signs you are seeing (**look**). **Ask** \_\_\_\_\_ (offender's name) about his dangerous behavior. When you **ask** him about his dangerous behaviors, it is good to say exactly what you see (**look**). It is good to **ask** what is going on. It is good to tell him why you think it is dangerous. You might say, "I see this. What is going on?" When \_\_\_\_\_ (offender's name) is asked about his dangerous behavior he may have mixed up feelings. If \_\_\_\_\_ (offender's name) gets angry when you **ask** him what is going on, you may choose to share (**ACT**) his dangerous behaviors with your contact person and **ask** what they think.

Joseph had been living back in his community for six months and looked like he was doing well. He had been seen walking through the high school football field several times in the past few weeks, but no

one in the community said anything to him. However, one of the students told her mother that she was uncomfortable seeing him doing this. The mother called a member of the safety net team.

The safety net member called Joseph and talked with him about what was seen. She shared with him that these were dangerous behaviors. She reminded him that he could take the road on the other side of the lake and that was safer. In this way Joseph was given enough information to make the changes. He also knew the community was watching out for itself. Joseph did not say much on the phone but was not seen walking through the high school football field again.

If the safety net member had not talked with Joseph over the phone, Joseph may have continued with his dangerous behavior until he convinced himself to go where the girls swim team meets at night for training. If Joseph was seen walking through the football field again, what should the safety net member do next?

### IMPORTANT THINGS TO REMEMBER:

1. It is not important that the offender "like" you; it is important that you respect each other.
2. Do not try to control or manipulate the person. Be yourself. Speak with respect. Do not cuss.
3. Try not to talk about your own problems or sexual experiences.
4. Be ready to stop your meetings when you find that either of you are getting angry or frustrated. This is important when you feel uncomfortable with the offender. It is okay to ask the offender to leave and go home.
5. When you disagree with the offender be direct and firm without forcing him into a corner where he can only attack. Do not verbally attack the offender.

WHAT DOES THE SAFETY NET MEMBER DO IF THEY THINK THE OFFENDER IS GOING TO RE-OFFEND OR YOU FIND OUT HE HAS RE-OFFENDED?

In some cases the offender might choose not to change his behaviors. If this happens he will move closer and closer to relapse and back to criminal behaviors. It is important to share what you know with the other safety net members so the safety net team can decide what to do next to help the offender get back to safety and keep the community safe. It is important to share what you know with the therapist or probation officer. (Trainer's note: return to **LOOK, LISTEN, ASK, ACT** handout). If you choose to do nothing there is a greater chance that sooner or later he will sexually re-offend and go back to jail. When you share with the therapist or probation officer, they will take steps to stop the relapse before the offender commits another sexual offense. You will also be protecting any victims that he might offend. The therapist and the probation officer are able to do many things to help the offender keep from re-offending and going back to jail.

The members of the safety net team need to know that is important for them to share any information about dangerous and criminal behaviors that involves the offender. This is necessary for the safety of the entire community. It is especially important for those people who could be hurt by his dangerous behavior.

### RULE 1

You know that the offender is getting ready to re-offend and won't stop acting in a dangerous way, then the therapist or probation officer must be contacted. **ACT!**

### RULE 2

If you are not sure if the offender is getting ready to re-offend or not, contact the therapist or probation officer. **ACT!**



**LOOK**

**LISTEN**

**ASK**

**ACT**

# **REASONS TO SHARE**

## Chapter 4

## **REASONS TO SHARE**

### Guided Questions and Answers:

1.   **Q.   When should members of the Safety Net Team share information about an offender?**  
**A.   They should use the decision tree to decide, but if they do not know whether or not they should share, then they should share. It is better to be safe than sorry.**
2.   **Q.   Why should the Safety Net Team share information about an offender?**  
**A.   To keep a potential victim safe. To keep the community safe. To help the offender keep from going to jail.**
3.   **Q.   Who does the Safety Net Team contact to share information?**  
**A.   The Safety Net Team shares information with the therapist or probation officer.**

## **REASONS TO SHARE**

It is easier for \_\_\_\_\_ (offender's name) to stop his dangerous behavior and make a corrective choice when he knows other people have seen his bad choices. Sometimes this will be enough to help him make a corrective choice. When all the people on the safety net team know about his bad choices they can talk about how to best help \_\_\_\_\_ (offender's name) get back on track. (role play)

Listed below are some examples of dangerous behaviors and bad choices:

(NOTE: the offender should put a check mark by any that apply)

selling drugs or bootleg alcohol  
using alcohol or drugs  
getting in fights  
not accepting being told "no"  
having a lot of anger  
driving around just to "look"  
giving a ride to a hitch-hiker  
hanging out with friends that use drugs or alcohol  
going to topless bars or "strip" joints  
going to drinking or drug parties  
staying off by himself a lot  
baby-sitting for someone  
giving gifts to children or a potential victim  
keeping secrets  
feeling inferior to a sexual partner  
inappropriate employment  
following a potential victim  
trying to pick up a woman who is drinking alcohol  
masturbating a lot  
watching dirty movies or reading sexy books  
showing private body parts in public  
sexually rubbing against a victim  
peeping in windows

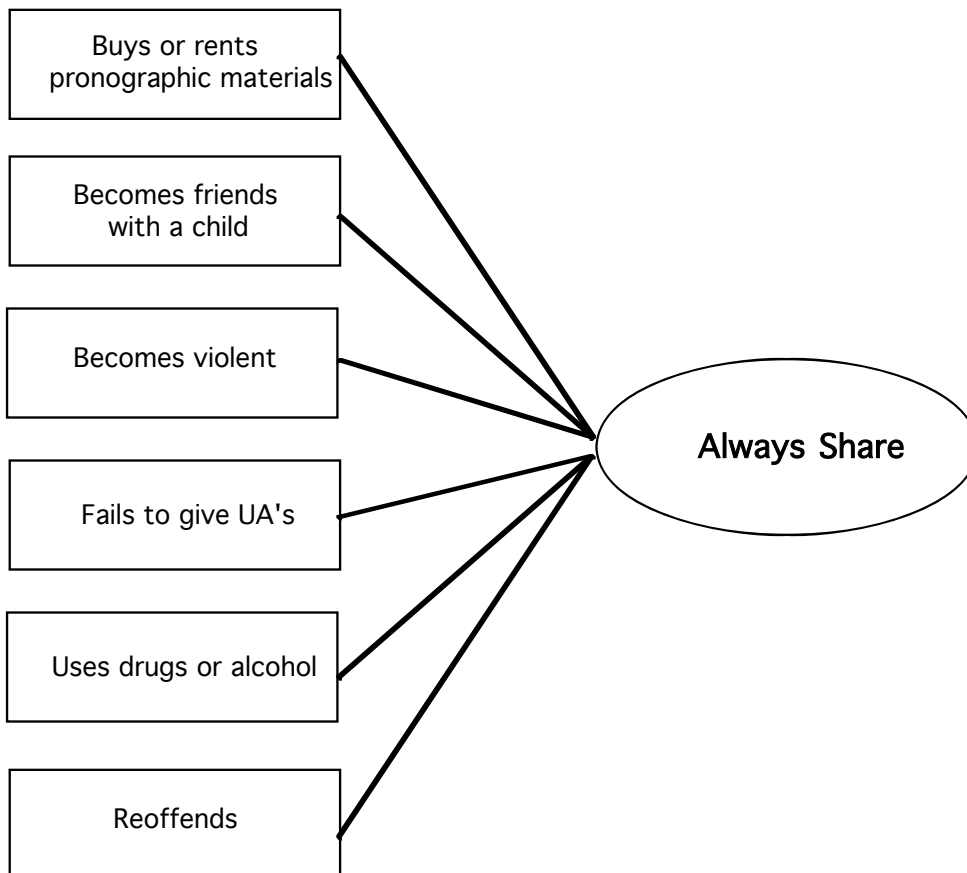
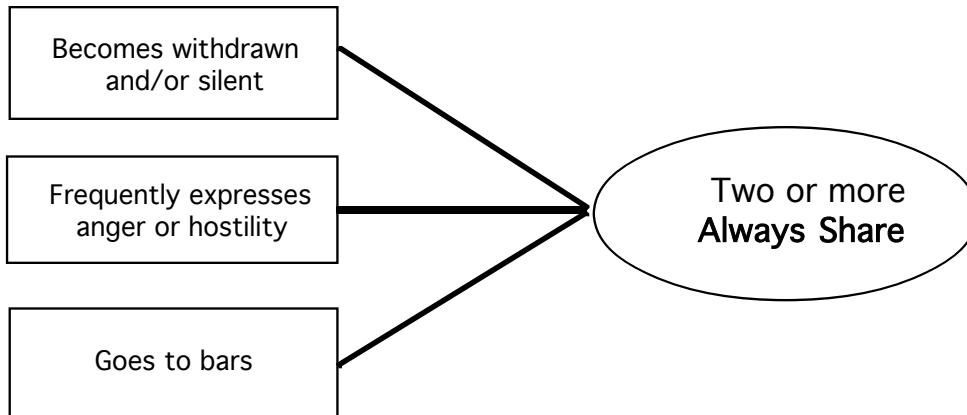
In addition to the things listed above the members of the Safety Net Team may see other things that indicate that the offender is beginning to have difficulty. Physical signs could include when the offender does not shave or wash, not sleeping, or being sick. The offender may begin to be late or not show up at all for things like A. A. meetings, counseling sessions, or taking a Urinary Analysis (UA). Social signs could be things like having a very bad attitude, being angry with feelings of hate or revenge, feeling depressed, thoughts of killing or hurting oneself or someone else.( refer to dangerous thinking list from chapter 2)

It is very important that \_\_\_\_\_ (offender's name) be able to talk about how dangerous his behaviors are. Some people have found the best thing to ask is "On a scale of 1 to 10, how close are you to committing a crime?" The following page has what is called a **DECISION TREE**. This can help the Safety Net Members decide when to share information about \_\_\_\_\_ (offender's name) dangerous behaviors.

## SAMPLE DECISION TREE

Red Flags Leading to Relapse

Decision to Share

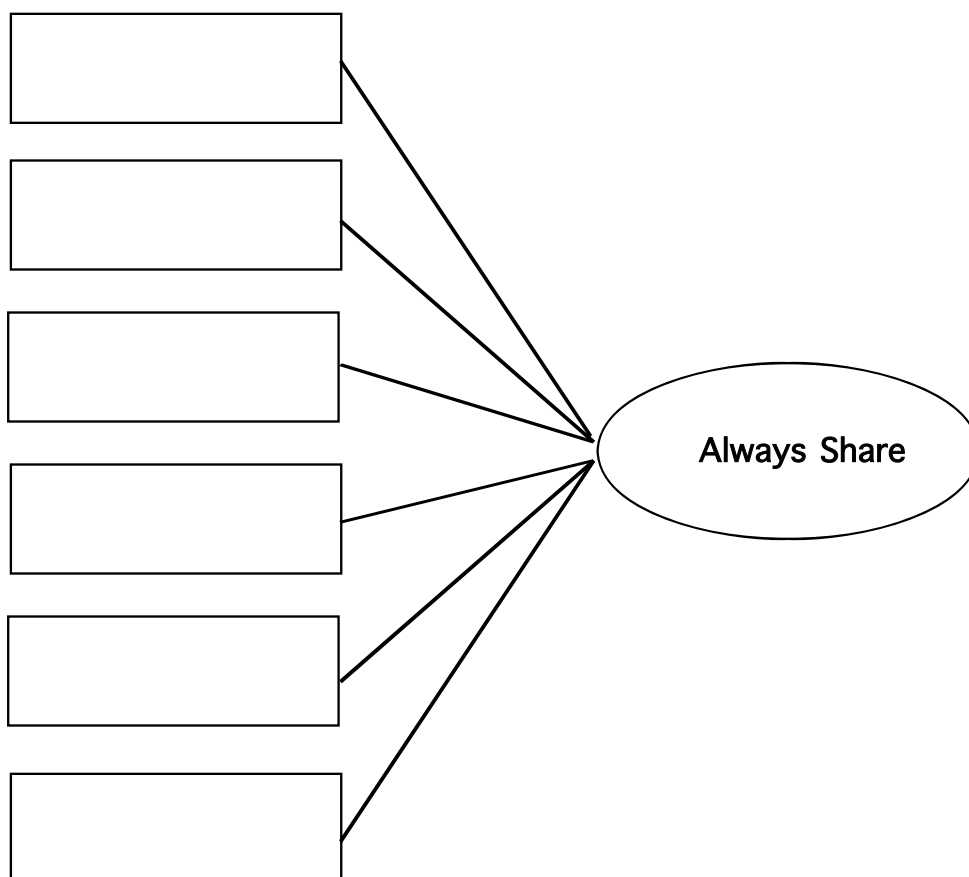
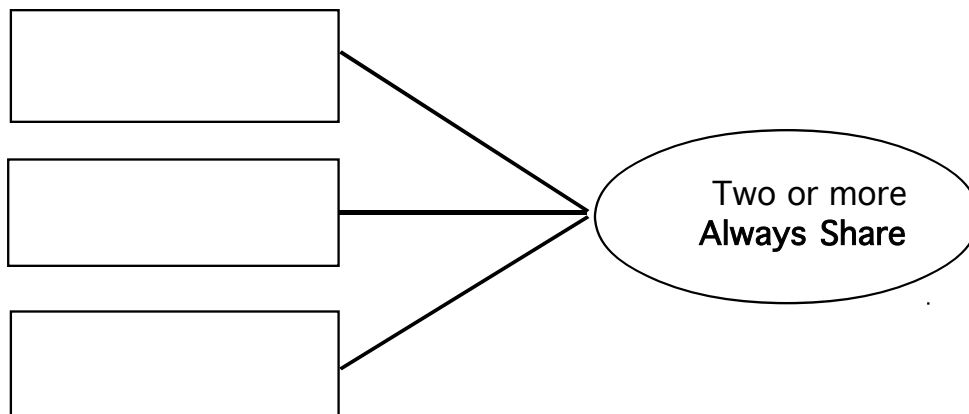


## DECISION TREE

\_\_\_\_\_ (Offender's Name)

Red Flags Leading to Relapse

Decision to Share





## SAFETY NET CONTRACT

This contract is between \_\_\_\_\_ (offender's name) and the members of the Safety Net Team. By signing this contract \_\_\_\_\_ (offender's name) gives his permission for the team members to share information they think is important with the therapist or probation officer.

I \_\_\_\_\_ (offender's name) give permission and encourage everyone on the Safety Net Team to share information in order to help me with my relapse prevention plan. I realize that if I am making bad choices and I am getting close to a new offense, I might try to talk you out of sharing. But it is important for you to share anyway to help me get back to healthy and safe choices. Listen to me now, not when I am using dangerous thinking. As soon as you think I might be in trouble, **share** - do not wait.

Signed,

\_\_\_\_\_  
(offender's signature)

### Safety Net Team Members:

- |          |          |
|----------|----------|
| 1) _____ | 2) _____ |
| 3) _____ | 4) _____ |
| 5) _____ | 6) _____ |

# **CASE STUDIES**

## Chapter 5

## **CASE STUDIES**

This chapter will provide you with an opportunity to apply what you have just learned about relapse prevention. You will be told about two offenders' cases and be asked to act as if the offender is the person you are trying to help. The offenders and their stories are made up but the stories are very much like the stories of real offender. You will learn how to see relapse behaviors in these offenders and you will be given the chance to come up with a plan to help each one. The idea in this chapter is to help you use what you have learned to help a "real" person. You will go through all of the steps that you will need to know in order to be helpful to a real offender in your community. It is possible that the offender you will be working with will not be like the ones that are made up. It is also possible that the offender you help may be like both of these offenders. It is important to talk to the Probation Officer if you have any questions.

## **CASE STUDY A: HARRY**

At the end of this section we will ask you to answer these questions. We are giving them here so you know what to look for.

### Guided Questions:

- 1. List the types of behaviors that Harry is likely to show which would lead him to commit another crime.**
- 2. What would you do if you thought Harry was doing any one or several of the things you listed above?**
- 3. Why is it important to know about these behaviors?**
- 4. When would you be able to do something that would help keep Harry from reoffending?**
- 5. What types of help would you give to Harry in the situations you gave above?**
- 6. What would you do if your help did not stop Harry? How else would you help Harry to stop?**

## **CASE STUDY A:**

Harry is 32 years old. He has been in jail for 14 months. He was put in jail for the sexual abuse of a child. He had gotten to know this child for two years before committing the actual sexual offense that landed him in jail. In planning his crime, Harry first hung out at the elementary school near his house. He watched for children that interested him. He became interested in a ten year old girl and watched her very closely. He also began following the child home, and would spend lots of time watching her play. After a few months of watching the child, Harry began letting her see him. He would often look at her and smile. This type of behavior continued for a few weeks until he had a chance to talk with the child in private. Harry found that chance one day while she was chasing a ball into an alley. Harry followed her and helped her get the ball. Harry asked the child what her name was. He talked with her about her friends and what she liked to do at school.

After a while, Harry would wait for the child after school, and would talk with her quite a bit. He would follow her on to the playground, and watch her play with the other children. There was even a time when Harry got mad at some of the other children who were teasing the child. For the next several months, Harry would spend as much time watching and talking with the child as he could. When he wasn't with the child, he would go home and think about her while touching his private parts.

Harry did not have any close friends his own age and had not had a job in 10 years. He had been living at home with his mother, where he spent most of his time drinking and lying around. His mother gave him money for doing chores around the house such as taking out the garbage and making his bed. However, Harry stole money from his mother's purse when he needed more.

Harry's mother did not tell him to look for a job, because he got easily angered. Harry's mother was afraid of his anger, and therefore tried not to bother him. When Harry got angry, he punched walls, threw furniture, and broke things that were easily within his reach. He hit his mother once during an argument over finding a job. The only way Harry felt better after getting angry was to touch his private parts and think about the little girl.

Sometimes Harry would get angry and storm out of the house. Usually, he had been drinking before he got mad. He would end up at the playground where he knew he could find the child. He would then ask to see her private parts, and would sometimes touch her while he touched himself. This would help with his anger, and he would feel better afterwards. This continued for several weeks before Harry was caught. He was sentenced to 14 months in jail, plus three years probation.

Harry has served his jail sentence and has been released. He is on probation which includes seeing a therapist once a week and taking part in the community safety net program. Harry has already met with the members of the community support team. With the help of his therapist, Harry has told about his behaviors that took place before his offense. These included the following:

- Harry usually drinks quite a bit throughout the day.
- Harry is more easily angered when drinking, and flies into a rage over little things.
- Harry looks for ways to deal with his anger. He feels that the best way to deal with this anger is to touch his privates and think about children.
- Sometimes the only way Harry can get excited is to either think about or be with a child.

The reasons why some people have inappropriate sexual feelings are different from person to person. Early life happenings, learned behaviors, family, and having been sexually abused oneself have effects on a person's sexual feelings. However, not all sex offenders have similar histories. Many people who become sex offenders have histories similar to those people who never sexually offend. It is true, for example, that many sexual offenders were sexually abused as children. However, most people who were sexually abused as children do not become sexual offenders. It is difficult to predict what causes people to become sexual offenders.

It is not necessary to find out why the offender acts and thinks as he does in order to be able to help him change. In fact, stressing the reasons behind his behavior can provide him with an excuse or someone to place the blame on. In order for an offender to learn how to change his behavior, he must be willing and able to take responsibility for his own actions. By allowing him to blame his parents, or childhood, etc., he is taking much of the blame off himself. Then he will not learn to stop his actions. Without taking responsibility for his own behavior, the sexual offender is giving himself permission to continue engaging in improper sexual behavior. It is not until the offender realizes that he is in control of his own behavior, and he takes responsibility for his actions, that he can begin to learn proper behaviors.

There are, however, good reasons to look at an offender's past behavior. Although the past life of a sexual offender does not mean he will become an offender, it is important to know about the offender's past life. This will help you to know how he learned to think about things, how he learned to solve his problems and what needs to be corrected. In the case of Harry, it would be helpful to understand a little about how he was brought up and how some of his thinking styles developed.

Harry grew up in a home where his parents fought often. His father would often get drunk. Then there would be a fight either between his father and mother or between his father and himself. When Harry's father was drunk, he would hit Harry and his mother and would yell at them. He would say hurtful things such as telling Harry how stupid he was and how he would never amount to anything. He would also tell Harry that he regretted ever being his father. Once when Harry was eleven years old, his father became very angry and held a knife to his throat. He was yelling at Harry's mother, threatening to kill Harry if she did not stop bothering him about his drinking. Harry grew up hating his father, and resenting his mother for not being strong enough to stand up to her husband.

Once when Harry was thirteen years old, his father wanted to teach him how to fight "like a man." He began jabbing at Harry, until he knocked him out. Harry felt ashamed that he was not strong enough or to fight his father. He hated feeling weak. Soon Harry began fighting a lot at school. At first he would beat up children much younger and smaller than himself. Eventually he started to take on children his own age and size. Harry was known as a bully. He was suspended from school many times. Harry's father left the home when Harry was fourteen. Harry has not had contact with his father since then.

When Harry entered high school, he was a bit older than the other kids in his class because he had been held back in school. He acted tough most of the time and would hang out with the crowd of school bullies. Harry and all of his friends would drink alcohol on a regular basis. They would also use marijuana when they could get it. Harry was suspended from school often, for getting caught with alcohol and/or marijuana. Each time he would get suspended or experience other penalties for his behavior, he would blame the



school or the person giving him the penalty. Harry was not able to see what was wrong about his behavior. He would become angry when he would get in trouble for the things he had done. When he would get angry he would fight with others and punish others for his unhappiness.

Harry never graduated from high school. He was kicked out during his senior year for repeated alcohol and marijuana abuse. Although some of his friends stayed with him for a while, it wasn't long before Harry was spending most of his time alone. He had tried to get odd jobs but would end up getting in fights with his bosses, causing him to be fired often. He always blamed his boss when he lost a job. After being fired, he would find reasons why his boss "didn't know anything", and did not realize what a good employee Harry really was. Harry would never see what was wrong with his behavior that caused him to lose his job. He would become very angry at anyone who tried to suggest that he had something to do with being fired.

Harry's actions are almost always the same. He is easily angered, particularly when he is punished for wrongdoing. He does not understand that many of the penalties he experiences are a result of his behavior. He does not see his own bad behaviors. When Harry is angered he becomes violent and can not control it. He yells and throws things and frequently ends up in a fist fight with the person he is angry at. Sometimes when he is angry he gets drunk before fighting. Often, he uses alcohol to calm himself down. When Harry is drunk he makes poor decisions. He seems to act without thinking and usually somebody gets hurt.

Harry believes that the only ways to calm himself down are to drink until he passes out, masturbate, or find a sexual partner. Since Harry does not know how to behave around people, it is difficult for him to make friends with people his own age, particularly women. Therefore, it is difficult for him to

find a girlfriend his own age that he can feel comfortable around. This is one of the reasons why Harry tries to have sex with children. It is easier for Harry to be friends with and control people who are much younger than himself. He knows how to get children to trust him. Once he has built the trust of a child, he abuses the child sexually.

1. In the space provided below, list the types of behaviors that Harry is likely to show which would lead him to commit another crime.

2. What would you do if you thought Harry was doing any one or several of the things you listed above?

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4. When would you be able to do something that would help keep Harry from reoffending?

5. What types of help would you give to Harry in the situations you gave above?

6. What would you do if your help did not stop Harry? How else would you help Harry to stop?

### Answers to case study A questions

1. The types of behaviors you might see Harry doing which would lead to a new crime are: drinking alcohol; not controlling his temper; hanging around places where children play.
2. You could talk to Harry to ask him if he thought his behavior might be leading to a new crime. If you do not agree with Harry's answer, you could suggest he stop whatever it might be, such as drinking, hanging around playgrounds, etc. If this still does not help Harry stop, you could call Harry's therapist, or Probation Officer, or whatever professional you are able to contact (**ACT**).
3. The importance of knowing about Harry's behavior is to know what to look for that could lead to a new offense.
4. You would be able to help when Harry first begins to drink alcohol, when his anger begins to get out of control, or when Harry begins going to the playground. Certainly you would **ACT** if these behaviors slipped by you and you suddenly realized Harry had found a new victim. The help would then be to **NOTIFY** an authority immediately! (**ACT**)
5. You would give any help gently, but firmly, and as quickly as possible.
6. If Harry wouldn't stop, then you would call his therapist or probation officer immediately. (**ACT**).

## **CASE STUDY B: MARVIN**

At the end of this section we will ask you to answer these questions. We are giving them here so you know what to look for.

### Guided Questions:

- 1. List the types of behaviors that Marvin is likely do which would lead him to commit another crime.**
- 2. What would you do if you thought that Marvin was doing any one or several of the things you listed above?**
- 3. Why is it important to know about these behaviors?**
- 4. When would you be able to do something that would help keep Marvin from re-offending?**
- 5. What types of help would you give in the various situations you gave above?**
- 6. What would you do if your help did not stop Marvin? How else could you help Marvin to stop?**

## **CASE STUDY B:**

Marvin is a 49 year old male who will be released from jail in two weeks. He has been in jail for 4 years and will be returning to his home where he will live with his wife. Marvin was charged with the sexual assault of a 25 year old woman. Before the assault, Marvin spent several months following this woman, and thinking about what it would be like to have sex with her. Marvin would spend his time hanging around the local pool hall. He had a job as a seasonal fisherman, and would spend most of the year in his home town with nothing to do.

When Marvin was not working, he would try not to be at home. Marvin had many things at home which he was to do but would not do them. This would make his wife upset. She would become angry at him for not helping at home. When Marvin returned home he knew he would “be in trouble.” He did not like being at home. He would find other places to go to. Marvin’s favorite hangout was at the pool hall. He could play a game of pool or sit quietly and watch others. Marvin did not have many friends and liked to be left alone, to sit and think and watch other people.

While sitting in the pool hall Marvin saw his future victim. She came in with friends and played some pool. Marvin did not feel good about talking to her so he sat and watched while she was there. Over the next few weeks he watched the woman while she was at the pool hall but did not speak with her. During this time, Marvin kept thinking about having a relationship with her.

One day, Marvin asked her if she wanted to play a game of pool. She said yes. They did not talk much during the game but Marvin had fun. After the game, Marvin sat in the corner and watched the woman with her friends. Marvin began to think that the woman wanted to have a relationship with him

too. Marvin was shy and he did not want to talk to her again. He continued to watch her while she was in the pool hall. As time went on, Marvin decided to follow the woman home “just to see where she lived.” He made sure she did not see him.

Soon Marvin began to follow the woman home every night and started to hide outside of her house while she was home. He began to have thoughts about having sex with the woman and started touching his privates when he thought of her.

As Marvin spent more and more time following his victim, he spent less time at home. This made Marvin have more problems at home with his wife. She would get angry when he would not listen to her and he stayed away from home even more than he had in the past. His home life was getting worse. Marvin had more fights with his wife. Marvin felt unhappy at home and spent more time away from there. He would go to the pool hall or watch his victim.

After a few months of following this woman and thinking about her, Marvin had told himself that they were going to have a relationship together. He thought that she would be better than his wife. After a very angry fight with his wife, Marvin thought that he would feel better if he went to the victim’s house. He wanted to look in the window at her and masturbate again. This had let him feel better when he did this in the past.

Marvin went to the house but no one was there. Marvin waited for the woman and began to think about looking at and touching her clothes and bed. He broke into her house. After looking at her things he waited for her. He was still angry from the argument with his wife. He sat and thought about how angry he was and how good he would feel when he saw the woman and touched himself. When the woman got home, he grabbed her. He thought to



himself that she wanted to have sex with him also. When the woman said no, he got angry with her. Marvin began to hit the woman and felt excited. Marvin then raped her. After the rape, Marvin ran from the house. The woman called the police. The next day Marvin was arrested for sexual assault.

Marvin will be paroled at the end of the month. He will see a therapist once each week. The meeting with Marvin and his safety net team has already happened. With the help of his therapist, Marvin has found that certain behaviors happened just before his offense. These behaviors are signs that he may reoffend if he does not do something different.

These behaviors include:

- Marvin has few friends.
- Marvin and his wife fight at home.
- Marvin stays away from home more often after a fight.
- Marvin thinks about other women and has sexual thoughts about them when he has troubles with his wife.
- Marvin imagines that his desire for a relationship with someone is shared by the other person even when they have had little or no contact.

Marvin's Behavior  
may look like this:



Marvin has few good friends.



He hangs out at the pool hall.



Marvin sees his victim.



He has sexual thoughts  
about her.



He follows her home.



Marvin watches her and  
masturbates.



He has a fight with  
his wife.



Marvin breaks into the  
woman's home.



**SEXUAL OFFENSE**

If Marvin was the offender you were asked to help, you would need to know what his behavior looks like, and what behaviors lead to another crime. Even though Marvin may want to change his behavior, changing will probably be hard for him. As a member of his safety net team, you would be asked to help him to see the behaviors that are likely to lead to another crime.

1. In the spaces provided below, list the types of behaviors that Marvin is likely to do which would lead him to commit another crime.

2. What would you do if you thought that Marvin was doing any one or several of the behaviors that you listed above?

3. Why is it important to know about Marvin's problem behaviors?

4. When would you be able to do something that would help keep Marvin from reoffending?

5. What types of help would you give in the various situations you gave above?

6. What would you do if your help did not stop Marvin? How else could you help Marvin to stop?

### **Answers to Case Study B questions**

1. The types of behaviors you might see Marvin doing which would lead to a new crime are: hanging out at the pool hall, fighting with his wife; staying alone without his friends.
2. You could talk to Marvin and ask him if he thought his behavior might be leading to a new crime. If you do not agree with Marvin's answer, you could suggest he stop doing whatever behavior he was doing, such as stop hanging around the pool hall, etc. If this still does not help Marvin stop, you could call his therapist or his Probation Officer, or what ever professional you are able to contact (**ACT**).
3. It is important to know about Marvin's behavior so you can know what to **LOOK** for that could lead to a new crime.
4. You would be able to help when Marvin first starts to hang around the pool hall, when he starts fighting with his wife, or when Marvin starts to stay alone all the time. Certainly you would **ACT** if these behavior slipped by you and you suddenly realized Marvin had found a new victim. The help would then be to **NOTIFY** an authority immediately! (**ACT**)
5. You would give any help gently, but firmly, and as quickly as possible.
6. If Marvin wouldn't stop, then you would call his therapist or probation officer immediately. (**ACT**)

# **CASE STUDIES**

## Chapter 5

## **CASE STUDIES**

This chapter will provide you with an opportunity to apply what you have just learned about relapse prevention. You will be told about two offenders' cases and be asked to act as if the offender is the person you are trying to help. The offenders and their stories are made up but the stories are very much like the stories of real offender. You will learn how to see relapse behaviors in these offenders and you will be given the chance to come up with a plan to help each one. The idea in this chapter is to help you use what you have learned to help a "real" person. You will go through all of the steps that you will need to know in order to be helpful to a real offender in your community. It is possible that the offender you will be working with will not be like the ones that are made up. It is also possible that the offender you help may be like both of these offenders. It is important to talk to the Probation Officer if you have any questions.

## **CASE STUDY A: HARRY**

At the end of this section we will ask you to answer these questions. We are giving them here so you know what to look for.

### Guided Questions:

- 1. List the types of behaviors that Harry is likely to show which would lead him to commit another crime.**
- 2. What would you do if you thought Harry was doing any one or several of the things you listed above?**
- 3. Why is it important to know about these behaviors?**
- 4. When would you be able to do something that would help keep Harry from reoffending?**
- 5. What types of help would you give to Harry in the situations you gave above?**
- 6. What would you do if your help did not stop Harry? How else would you help Harry to stop?**



## **CASE STUDY A:**

Harry is 32 years old. He has been in jail for 14 months. He was put in jail for the sexual abuse of a child. He had gotten to know this child for two years before committing the actual sexual offense that landed him in jail. In planning his crime, Harry first hung out at the elementary school near his house. He watched for children that interested him. He became interested in a ten year old girl and watched her very closely. He also began following the child home, and would spend lots of time watching her play. After a few months of watching the child, Harry began letting her see him. He would often look at her and smile. This type of behavior continued for a few weeks until he had a chance to talk with the child in private. Harry found that chance one day while she was chasing a ball into an alley. Harry followed her and helped her get the ball. Harry asked the child what her name was. He talked with her about her friends and what she liked to do at school.

After a while, Harry would wait for the child after school, and would talk with her quite a bit. He would follow her on to the playground, and watch her play with the other children. There was even a time when Harry got mad at some of the other children who were teasing the child. For the next several months, Harry would spend as much time watching and talking with the child as he could. When he wasn't with the child, he would go home and think about her while touching his private parts.

Harry did not have any close friends his own age and had not had a job in 10 years. He had been living at home with his mother, where he spent most of his time drinking and lying around. His mother gave him money for doing chores around the house such as taking out the garbage and making his bed. However, Harry stole money from his mother's purse when he needed more.

Harry's mother did not tell him to look for a job, because he got easily angered. Harry's mother was afraid of his anger, and therefore tried not to bother him. When Harry got angry, he punched walls, threw furniture, and broke things that were easily within his reach. He hit his mother once during an argument over finding a job. The only way Harry felt better after getting angry was to touch his private parts and think about the little girl.

Sometimes Harry would get angry and storm out of the house. Usually, he had been drinking before he got mad. He would end up at the playground where he knew he could find the child. He would then ask to see her private parts, and would sometimes touch her while he touched himself. This would help with his anger, and he would feel better afterwards. This continued for several weeks before Harry was caught. He was sentenced to 14 months in jail, plus three years probation.

Harry has served his jail sentence and has been released. He is on probation which includes seeing a therapist once a week and taking part in the community safety net program. Harry has already met with the members of the community support team. With the help of his therapist, Harry has told about his behaviors that took place before his offense. These included the following:

- Harry usually drinks quite a bit throughout the day.
- Harry is more easily angered when drinking, and flies into a rage over little things.
- Harry looks for ways to deal with his anger. He feels that the best way to deal with this anger is to touch his privates and think about children.
- Sometimes the only way Harry can get excited is to either think about or be with a child.

Harry's Behavior  
may look like this:



Harry drinks alcohol.



Harry thinks others are "bugging him"  
and argues or avoids people.



He gets angry at others and can  
not control his anger.



He goes to the playground.



Harry finds the child.



**SEXUAL OFFENSE**

Harry's Behavior  
may look like this:



Harry drinks alcohol.



Harry thinks others are "bugging him"  
and argues or avoids people.



He gets angry at others and can  
not control his anger.



He goes to the playground.



Harry finds the child.



**SEXUAL OFFENSE**

The reasons why some people have inappropriate sexual feelings are different from person to person. Early life happenings, learned behaviors, family, and having been sexually abused oneself have effects on a person's sexual feelings. However, not all sex offenders have similar histories. Many people who become sex offenders have histories similar to those people who never sexually offend. It is true, for example, that many sexual offenders were sexually abused as children. However, most people who were sexually abused as children do not become sexual offenders. It is difficult to predict what causes people to become sexual offenders.

It is not necessary to find out why the offender acts and thinks as he does in order to be able to help him change. In fact, stressing the reasons behind his behavior can provide him with an excuse or someone to place the blame on. In order for an offender to learn how to change his behavior, he must be willing and able to take responsibility for his own actions. By allowing him to blame his parents, or childhood, etc., he is taking much of the blame off himself. Then he will not learn to stop his actions. Without taking responsibility for his own behavior, the sexual offender is giving himself permission to continue engaging in improper sexual behavior. It is not until the offender realizes that he is in control of his own behavior, and he takes responsibility for his actions, that he can begin to learn proper behaviors.

There are, however, good reasons to look at an offender's past behavior. Although the past life of a sexual offender does not mean he will become an offender, it is important to know about the offender's past life. This will help you to know how he learned to think about things, how he learned to solve his problems and what needs to be corrected. In the case of Harry, it would be helpful to understand a little about how he was brought up and how some of his thinking styles developed.

Harry grew up in a home where his parents fought often. His father would often get drunk. Then there would be a fight either between his father and mother or between his father and himself. When Harry's father was drunk, he would hit Harry and his mother and would yell at them. He would say hurtful things such as telling Harry how stupid he was and how he would never amount to anything. He would also tell Harry that he regretted ever being his father. Once when Harry was eleven years old, his father became very angry and held a knife to his throat. He was yelling at Harry's mother, threatening to kill Harry if she did not stop bothering him about his drinking. Harry grew up hating his father, and resenting his mother for not being strong enough to stand up to her husband.

Once when Harry was thirteen years old, his father wanted to teach him how to fight "like a man." He began jabbing at Harry, until he knocked him out. Harry felt ashamed that he was not strong enough or to fight his father. He hated feeling weak. Soon Harry began fighting a lot at school. At first he would beat up children much younger and smaller than himself. Eventually he started to take on children his own age and size. Harry was known as a bully. He was suspended from school many times. Harry's father left the home when Harry was fourteen. Harry has not had contact with his father since then.

When Harry entered high school, he was a bit older than the other kids in his class because he had been held back in school. He acted tough most of the time and would hang out with the crowd of school bullies. Harry and all of his friends would drink alcohol on a regular basis. They would also use marijuana when they could get it. Harry was suspended from school often, for getting caught with alcohol and/or marijuana. Each time he would get suspended or experience other penalties for his behavior, he would blame the school or the person giving him the penalty. Harry was not able to see what

was wrong about his behavior. He would become angry when he would get in trouble for the things he had done. When he would get angry he would fight with others and punish others for his unhappiness.

Harry never graduated from high school. He was kicked out during his senior year for repeated alcohol and marijuana abuse. Although some of his friends stayed with him for a while, it wasn't long before Harry was spending most of his time alone. He had tried to get odd jobs but would end up getting in fights with his bosses, causing him to be fired often. He always blamed his boss when he lost a job. After being fired, he would find reasons why his boss "didn't know anything", and did not realize what a good employee Harry really was. Harry would never see what was wrong with his behavior that caused him to lose his job. He would become very angry at anyone who tried to suggest that he had something to do with being fired.

Harry's actions are almost always the same. He is easily angered, particularly when he is punished for wrongdoing. He does not understand that many of the penalties he experiences are a result of his behavior. He does not see his own bad behaviors. When Harry is angered he becomes violent and can not control it. He yells and throws things and frequently ends up in a fist fight with the person he is angry at. Sometimes when he is angry he gets drunk before fighting. Often, he uses alcohol to calm himself down. When Harry is drunk he makes poor decisions. He seems to act without thinking and usually somebody gets hurt.

Harry believes that the only ways to calm himself down are to drink until he passes out, masturbate, or find a sexual partner. Since Harry does not know how to behave around people, it is difficult for him to make friends with people his own age, particularly women. Therefore, it is difficult for him to find a girlfriend his own age that he can feel comfortable around. This is one

of the reasons why Harry tries to have sex with children. It is easier for Harry to be friends with and control people who are much younger than himself. He knows how to get children to trust him. Once he has built the trust of a child, he abuses the child sexually.



If Harry was the offender you were asked to help, you would need to know what his behavior looked like. You would have to **see** what behaviors led to a new crime. Even though Harry may have good intentions to change his behavior, he will most likely have difficulty doing so. As a member of his safety net team, you would be asked to help him to see the behaviors that will lead to a new crime and going back to jail.

1. In the space provided below, list the types of behaviors that Harry is likely to show which would lead him to commit another crime.
2. What would you do if you thought Harry was doing any one or several of the things you listed above?
3. Why is it important to know about these behaviors?

4. When would you be able to do something that would help keep Harry from reoffending?

5. What types of help would you give to Harry in the situations you gave above?

6. What would you do if your help did not stop Harry? How else would you help Harry to stop?

### Answers to case study A questions

1. The types of behaviors you might see Harry doing which would lead to a new crime are: drinking alcohol; not controlling his temper; hanging around places where children play.
2. You could talk to Harry to ask him if he thought his behavior might be leading to a new crime. If you do not agree with Harry's answer, you could suggest he stop whatever it might be, such as drinking, hanging around playgrounds, etc. If this still does not help Harry stop, you could call Harry's therapist, or Probation Officer, or whatever professional you are able to contact (**ACT**).
3. The importance of knowing about Harry's behavior is to know what to look for that could lead to a new offense.
4. You would be able to help when Harry first begins to drink alcohol, when his anger begins to get out of control, or when Harry begins going to the playground. Certainly you would **ACT** if these behaviors slipped by you and you suddenly realized Harry had found a new victim. The help would then be to **NOTIFY** an authority immediately! (**ACT**)
5. You would give any help gently, but firmly, and as quickly as possible.
6. If Harry wouldn't stop, then you would call his therapist or probation officer immediately. (**ACT**).

## **CASE STUDY B: MARVIN**

At the end of this section we will ask you to answer these questions. We are giving them here so you know what to look for.

### Guided Questions:

- 1. List the types of behaviors that Marvin is likely do which would lead him to commit another crime.**
- 2. What would you do if you thought that Marvin was doing any one or several of the things you listed above?**
- 3. Why is it important to know about these behaviors?**
- 4. When would you be able to do something that would help keep Marvin from re-offending?**
- 5. What types of help would you give in the various situations you gave above?**
- 6. What would you do if your help did not stop Marvin? How else could you help Marvin to stop?**

## **CASE STUDY B:**

Marvin is a 49 year old male who will be released from jail in two weeks. He has been in jail for 4 years and will be returning to his home where he will live with his wife. Marvin was charged with the sexual assault of a 25 year old woman. Before the assault, Marvin spent several months following this woman, and thinking about what it would be like to have sex with her. Marvin would spend his time hanging around the local pool hall. He had a job as a seasonal fisherman, and would spend most of the year in his home town with nothing to do.

When Marvin was not working, he would try not to be at home. Marvin had many things at home which he was to do but would not do them. This would make his wife upset. She would become angry at him for not helping at home. When Marvin returned home he knew he would “be in trouble.” He did not like being at home. He would find other places to go to. Marvin’s favorite hangout was at the pool hall. He could play a game of pool or sit quietly and watch others. Marvin did not have many friends and liked to be left alone, to sit and think and watch other people.

While sitting in the pool hall Marvin saw his future victim. She came in with friends and played some pool. Marvin did not feel good about talking to her so he sat and watched while she was there. Over the next few weeks he watched the woman while she was at the pool hall but did not speak with her. During this time, Marvin kept thinking about having a relationship with her.

One day, Marvin asked her if she wanted to play a game of pool. She said yes. They did not talk much during the game but Marvin had fun. After the game, Marvin sat in the corner and watched the woman with her friends. Marvin began to think that the woman wanted to have a relationship with him

too. Marvin was shy and he did not want to talk to her again. He continued to watch her while she was in the pool hall. As time went on, Marvin decided to follow the woman home “just to see where she lived.” He made sure she did not see him.

Soon Marvin began to follow the woman home every night and started to hide outside of her house while she was home. He began to have thoughts about having sex with the woman and started touching his privates when he thought of her.

As Marvin spent more and more time following his victim, he spent less time at home. This made Marvin have more problems at home with his wife. She would get angry when he would not listen to her and he stayed away from home even more than he had in the past. His home life was getting worse. Marvin had more fights with his wife. Marvin felt unhappy at home and spent more time away from there. He would go to the pool hall or watch his victim.

After a few months of following this woman and thinking about her, Marvin had told himself that they were going to have a relationship together. He thought that she would be better than his wife. After a very angry fight with his wife, Marvin thought that he would feel better if he went to the victim’s house. He wanted to look in the window at her and masturbate again. This had let him feel better when he did this in the past.

Marvin went to the house but no one was there. Marvin waited for the woman and began to think about looking at and touching her clothes and bed. He broke into her house. After looking at her things he waited for her. He was still angry from the argument with his wife. He sat and thought about how angry he was and how good he would feel when he saw the woman and touched himself. When the woman got home, he grabbed her. He thought to himself that she wanted to have sex with him also. When the woman said no,

he got angry with her. Marvin began to hit the woman and felt excited. Marvin then raped her. After the rape, Marvin ran from the house. The woman called the police. The next day Marvin was arrested for sexual assault.

Marvin will be paroled at the end of the month. He will see a therapist once each week. The meeting with Marvin and his safety net team has already happened. With the help of his therapist, Marvin has found that certain behaviors happened just before his offense. These behaviors are signs that he may reoffend if he does not do something different.

These behaviors include:

- Marvin has few friends.
- Marvin and his wife fight at home.
- Marvin stays away from home more often after a fight.
- Marvin thinks about other women and has sexual thoughts about them when he has troubles with his wife.
- Marvin imagines that his desire for a relationship with someone is shared by the other person even when they have had little or no contact.

Marvin's Behavior  
may look like this:



Marvin has few good friends.



He hangs out at the pool hall.



Marvin sees his victim.



He has sexual thoughts  
about her.



He follows her home.



Marvin watches her and  
masturbates.



He has a fight with  
his wife.



Marvin breaks into the  
woman's home.



**SEXUAL OFFENSE**



If Marvin was the offender you were asked to help, you would need to know what his behavior looks like, and what behaviors lead to another crime. Even though Marvin may want to change his behavior, changing will probably be hard for him. As a member of his safety net team, you would be asked to help him to see the behaviors that are likely to lead to another crime.

1. In the spaces provided below, list the types of behaviors that Marvin is likely to do which would lead him to commit another crime.

2. What would you do if you thought that Marvin was doing any one or several of the behaviors that you listed above?

3. Why is it important to know about Marvin's problem behaviors?

4. When would you be able to do something that would help keep Marvin from reoffending?

5. What types of help would you give in the various situations you gave above?

6. What would you do if your help did not stop Marvin? How else could you help Marvin to stop?

### Answers to Case Study B questions

1. The types of behaviors you might see Marvin doing which would lead to a new crime are: hanging out at the pool hall, fighting with his wife; staying alone without his friends.
2. You could talk to Marvin and ask him if he thought his behavior might be leading to a new crime. If you do not agree with Marvin's answer, you could suggest he stop doing whatever behavior he was doing, such as stop hanging around the pool hall, etc. If this still does not help Marvin stop, you could call his therapist or his Probation Officer, or what ever professional you are able to contact (**ACT**).
3. It is important to know about Marvin's behavior so you can know what to **LOOK** for that could lead to a new crime.
4. You would be able to help when Marvin first starts to hang around the pool hall, when he starts fighting with his wife, or when Marvin starts to stay alone all the time. Certainly you would **ACT** if these behavior slipped by you and you suddenly realized Marvin had found a new victim. The help would then be to **NOTIFY** an authority immediately! (**ACT**)
5. You would give any help gently, but firmly, and as quickly as possible.
6. If Marvin wouldn't stop, then you would call his therapist or probation officer immediately. (**ACT**)



## **Appendix 10-B**

### **Safety Net Manual for Therapists and Supervising Officers**

# **COMMUNITY BASED SUPPORT NETWORK FOR SEX OFFENDERS: A TRAINING MANUAL FOR NON-PROFESSIONALS**

## **Resource Guide for Therapists and Probation Officers**

This resource guide is provided to accompany the training manual for community prevention teams and includes information which will help the probation officer and therapist incorporate the Safety Net concept into working with sex offenders in the community.

### **Introduction**

During fiscal year 1993, the Alaska Department of Corrections was awarded federal assistance by the National Institute of Corrections to develop a training manual for non-professionals who would be members of a community based support network for sex offenders. The manual was to be designed to assist in the training of non-professionals and probation officers in working with and supervising sex offenders in community placement. There is a critical need, especially in more rural communities, to strengthen and supplement the community care component by creating a natural support system to enhance the supervision and treatment needs of the offender.

The "natural supports" model, also referred to as the "safety net" model, is one which is used in the field of developmental disabilities. The concept is to train non-professionals and professionals who are part of the individual's daily support network to become "experts" on that particular individual in order to be able to help monitor the person's care and treatment. The concept has also been used in work with suicidal people in Bush areas in Alaska.

The Alaska DOC endorses the Relapse Prevention model of treatment for sex offenders. This model is based on the philosophy that although there is no cure for sexual deviancy, all offenders are capable of change. Sexually aberrant behavior can be controlled when offenders acquire certain skills which aid them in recognizing the antecedents of sexually deviant behavior and learn alternatives to sexual abusiveness. The focus is on teaching sex offenders to manage and control their behavior. A natural supports program supports and enhances the application of the relapse prevention model in the community by educating significant persons in the offender's community about details of the offender's relapse cycle. External collateral contacts help to provide natural support to the relapse prevention model. Since offenders are not consistently reliable informants in regard to their own relapse processes, having the external supporters to recognize and deal with high-risk behavior should enhance probation and parole supervision and decrease the probability of relapse.

The community network of natural helpers includes professionals such as probation officers, mental health counselors, substance abuse counselors, vocational counselors, educators, village health aides, clergy, etc. In addition non-professional support persons might include family members, village elders, employers, co-workers, friends, etc. Many of these individuals have daily contact with the offenders and are in a position to observe behaviors and attitudes which may signal oncoming relapse. If trained to recognize high risk signs, natural support helpers can assist probation officers and other professionals in the supervision and management of the offender. This would enhance safety in the community and improve the probability of successful community placement.

Completion of the Training Manual for Safety Net Members was a collaborative effort between DOC and the Center for Human Development of the University of Alaska-Anchorage. After the manual was developed, a pilot project was conducted to test its use. Efforts are currently

underway to further develop the use of the safety net concept, as well as the manual, in areas throughout the state. Among other future plans, we intend to establish a pool of Master Trainers who can travel to outlying areas to provide training in the use of the safety net concept with sex offenders in the community.

## **Safety-Net Standards**

The following information is taken from the Standards of Care established for the Sex Offender Treatment Programs operated by the DOC in Alaska:

Sex offenders are typically secretive about the behaviors and thought processes which lead to relapse. Any successful approach to treatment 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 that offenders high risk signs and relapse process. This "safety-net" of "natural-helpers" 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 defined as 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 or "natural-helpers" are trained to recognize pre-relapse signs and to report such signs to various members of the treatment team including therapists and probation officers. Natural helpers 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 P.O. to take corrective measures when an offender slips into a pre-relapse cycle.

The following standards must be followed in creating a safety-net:

1. All sex offenders in Community SOTP's should have a safety-net.
2. The minimum size for a safety-net is three persons. There is no maximum size but a typical safety-net would 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 treatment team can also be members of the safety-net but the safety-net can not be entirely made up of treatment 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 must 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 including but not limited to training which employs the DOC safety-net training manual.
9. Objectivity and a willingness to report pre-relapse signs is 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 Officer must give approval for all safety-net members.
11. The removal of a safety-net member may be recommended by the treatment team or the Field Probation Officer, but the final decision to remove a member is made by the Probation Officer. All removals are subject to review by the Criminal Justice Planner for the Division of Institutions.

### **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 later in this document. 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 reincarceration. A number of therapeutic interventions lie in between these extremes.

The supervision of the sex offender is an essential part of the treatment protocol. All contractors and other approved providers must report technical violations to the Field Probation Officer as soon as possible after becoming aware of such violations.

### **Some Practical Considerations**

In working on this project, particularly when we were in the process of operationalizing the manual and the concepts behind it, several practical problems arose that needed to be addressed in order for the process to continue. In an effort to help those who decide to try the concept, we will share some of these:

Planning Time: It may take a month lead time for the preparatory work necessary to successfully train the safety net team members. You will have to juggle schedules, often with several people who have varying work schedules. It seems best to have several time options available. In some cases, you may need to have more than one training session in order to train all of the members. Additionally, there may be cases where you will want to meet with a given team member individually.

Training Time: It will take one or two meetings of the team to fully train the members, dependent upon the degree to which the members become comfortable with the material. Each session should run for two hours and can be held on separate days/weeks.



Team Member Selection: It is important to select team members who are in a position to have frequent contact with the offender.

There may be times when someone in the offender's life could benefit from the information provided in the manual, although they do not plan to be an active member of the Safety Net Team. For example, when the perpetrator is a child molester, it might be good for the parents of his victim to have the training, although you should probably not include these people in the safety net team.

Relapse Prevention Plan: Therapists may wish to include a copy of the offender's R.P.P. for the safety net members in the training manual.

# GLOSSARY

## A

**Abstinence** - Abstinence means to abstain or say “No” to something. for sex offender’s abstinence means to say “no” to and stay away from deviant sexual fantasies, thoughts about abusing someone, materials, like pornography that will lead the offender to commit a sexual offense.

**Aftercare Plan** - A program for dealing with problem areas the offender may have when released from prison.

**Approved Provider** - A therapist who has received the necessary training and experience to provide intervention for sexual offenders. The Department of Corrections must okay the Approved Provider

**Arousal Control** - Arousal is an urge or feeling about something or someone. It is possible for a person to control arousal by controlling the thoughts, feelings, and behaviors associated with the arousal. Some of the ways of teaching control of sexual arousal are covert sensitization, masturbatory satiation, masturbatory reconditioning, and penile plethysmography. Only the Approved Provider should use these techniques with the offender.

**Assault Cycle** - A chain of events that lead to a reoffense. A cycle is like a rotating circle and occurs when the person behaves in the same pattern again and again. The circle is linked together like the links of a chain. Each link is a type of thought, feeling, or behavior that the person experiences. The assault cycle is the list of behaviors or links that lead the offender toward an assault. Sometimes the assault may be a physical assault, a verbal assault, or a sexual assault.

**Assessment** - An evaluation or judgment made by a person or persons.

## B

**Blockage** - When the offender has normal sexual urges but something stands in the way of being able to express them normally. Example: being brought up to believe masturbation is immoral or wrong, and the only way to meet sexual needs is with a partner.

## C

**Case Study** - An example.

**Condition Violations** - Breaking any parole or probation conditions.

**Coping Response** - A coping response is a thought, a feeling, or a behavior that helps the offender to move away from a place of risk and towards abstinence. A coping response can also be called a corrective response. Examples of coping responses are: the offender said no to using alcohol; the offender said no to drinking alcohol with his father or mother. Many offenders use coping responses that do not work. For example, saying no to alcohol, but saying yes to marijuana. A true coping response would be to say no to both alcohol and marijuana.

**Community Based Treatment** - Therapy available in the community for released sexual offenders.

**Community Safety Net Team** - Any number of people that agree to work together to help a sexual offender keep from committing another sexual abuse crime. Can be either professional or

non-professional. Examples: Probation Officer, therapist, village elder, priest, school teacher, or any concerned community member.

**Community Treatment** - Therapy available in the community for released sexual offenders.

**Confront** - To come face to face with (with all the evidence).

**Coping Response** - Actions, or steps, a sex offender can take to help him deal with relapse behavior.

**Corrective Coping Response** - Any intervention that helps the offender restore his sense of self-control over his thinking and behavior and return to a place of safety. Examples: saying no to drugs and alcohol; positive self-talk; refusing to baby-sit.

**Curfew** - An order or regulation that requires the offender to leave the streets at a certain hour.

## **D**

**Dangerous Situations** - A dangerous situation is a kind of thinking, or a kind of feeling, or a place or event that lowers the control of the offender has over himself and increases the risk or chance of a lapse.

**Defense Mechanism** - A defense mechanism is a way the offender tries to avoid dealing with truth or reality.

**Deviant Behavior** - Behavior not normally accepted in a community. Example: having sex with children is deviant behavior because it is not acceptable in the community and it is against the law.

## **E**

**Emotional Needs** - A psychological feeling that needs to be relieved; usually a feeling of arousal or agitation.

**Empathy** - Empathy is being aware of and concerned about the feelings and events that are happening for another person. To have empathy, a person should be able to see the victim as a whole human being who can feel pain, hurt, happiness, joy, confusion, fulfillment and shame. Sexual offenders do not show empathy because they think more about themselves than they do about the victim.

**Enabler** - An example of an enabler is someone who gives a person alcohol when they know that the person is more likely to reoffend when they drink. An example of someone who "enables" a sexual offender would be someone who failed to report the offender's lapse or relapse behavior. This would enable the person to continue the behavior.

**Exhibitionist** - A person who has a tendency to publicly expose their sex organs; indecent exposure of the genitals for sexual arousal.

## **F**

**Felony** - A crime more serious than a misdemeanor.

**Field Probation Officer** - A professional person that supervises the offender in the community, balancing the needs of the community, the offender, and the requirements of the court.

## **G**

**Gender** - Either of the male or female sex.

**Grooming Behavior** - To get into readiness for sexual abuse; to preparing a future victim so they will allow sexual contact to occur. Grooming is like playing with someone to get them to like you and gain their trust, except that the person intends to use the victim for sex. Trust is important to the offender so that the victim will not tell anyone what is going on. Examples of grooming: Giving alcohol to an underage person so they will allow sex to occur; giving toys or privileges to children for the same reasons.

## **H**

**High Risk Behaviors** - Circumstances that threaten the offender's sense of self-control. Examples: substance abuse; hanging around a potential victim; and social isolation.

## **I**

**Inappropriate Sexual Behavior** - Any sexual action that involves unwilling partners or that presents a danger to the individual or others.

**Incarceration** - To be in prison; subject to being confined.

**Incest** - Sexual intercourse between persons so closely related that they are forbidden by law to marry; the crime of participating in such a relationship.

**Intervene** - To come between or stop some action for protection of others.

**Intervention** - to interfere in another person's behavior to prevent an action or to maintain a condition; to come between.

Example: to stop high risk behavior and possible sexual abuse.

**Institutional Probation Officer** - The person who supervises the offender while the offender is in prison.

**Institutional Program of Treatment** - Training and therapy that an offender attends while in prison.

## **L**

**Lapse** - To sink or slip gradually; an emotion, fantasy, thought, or behavior that is part of an offender's relapse pattern. Lapses are not sex offenses, but are high risk behaviors that can lead to a sexual offense.

**Lapse Contract** - This is a signed paper between the offender and the Approved Provider that says how much the offender is allowed to lapse or slip. The agreement is so that the offender can learn how to manage himself appropriately. The contract talks about waiting before starting to lapse, that the offender must report the lapse to the Approved Provider and the Probation Officer immediately, and the consequences for slipping.

## **M**

**Manipulate** - To manage or control another person or a situation for your own benefit or personal gain.

**Masturbation** - Stimulating of the sex organs for pleasure. Playing with yourself.

**Milieu** - Surroundings; environment. Also known as program or treatment milieu. Milieu is an approach to treatment which is highly structured and offers the program participants a variety of

treatment activities. Offenders are housed together in a treatment setting and each hour of the day is accounted for in the program structure and the program participant's personal schedule.

**Minimize** - To represent as having the least degree of importance of value.

**Misdemeanor** - A crime less serious than a felony.

**N**

**Notify** - To inform or make something known.

**O**

**Observable Cycle** - Behavior that can be seen by others that is part of a pattern of behaviors; Examples: going to strip joints, dancing with intoxicated women, hanging around children's play areas.

**Observable Signs of Relapse** - Behaviors that can be seen as warning signs and signal the need for a behavior change. Example: hanging out in video arcades where young children also hang out; walking through school yards; buying pornography.

**Offender** - Lawbreaker. A person who has committed a crime.

**P**

**Parole** - Early conditional release where the offender has to follow conditions set by the parole board.

**Pedophile** - A sexual deviant who prefers children as their sexual object.

**Pornography** - Stories, pictures, and movies that are intended to arouse sexual excitement.

**Probation** - A period of supervision that is imposed by the court at the time of sentencing. Probation may occur instead of jail time, or in addition to jail.

**Profanity** - Swearing or cursing.

**Professional** - A person employed and specially trained to work with offenders.

**R**

**Rape** - Sexual intercourse with a person without their consent.

**Recidivism** - A tendency to go back to a previous condition or behavior; relapse into criminal behavior.

**Rehabilitation** - To restore a person to a healthy mental and moral state through treatment and training.

**Reinforcer** - Any event that increases the strength of the behavior it follows. Can be a reward, or the removal of a discomfort (like prison).

**Reinforcement** - The procedure of increasing the strength of a behavior by following it with a reward (reinforcing event.)

**Relapse** - The offender slips back into behaviors that lead to crime.

**Relapse Behavior** - Conduct that shows the offender is slipping back into offensive behavior. To a sex offender this means to commit a sexual offense. To an alcoholic this means to have a break.

**Relapse Pattern** - Certain risky behaviors repeated by the offender before committing a crime.

**Relapse Prevention Plan** - A program to keep an offender from slipping back into criminal behaviors.

**Restitution** - Making good of something, or giving something equal for some injury.

## **S**

**Self-esteem** - Satisfaction with oneself.

**Sexual Arousal** - An urge or feeling about something or someone that is sexual. Most of the time a person will think that these feelings are exciting and feel good. Some people will find these feelings when they look at or touch someone in a sexual way, such as in masturbation.

**Sexual Assault** - To violently or forcefully have, or involve sex, by forcing, or manipulating another person.

**Sentencing** - Punishment determined or declared by the court.

**Stressors** - Any event or situation that causes stress.

**Stress Reactions** - Physical or emotional difficulty that can result from an uncommon experience.

## **T**

**Thinking Error** - A distorted way of thinking that allows a criminal lifestyle to continue. When a person thinks about an experience that has happened to them, or thinks about something they have seen or felt, the person makes a decision on what the experience means. A thinking error occurs when the person makes decisions about the meaning that are not correct. Most sex offenders have distorted errors in their thinking.

**Treatment Intervention** - Therapy a sexual offender receives from an Approved Provider.

**Treatment Model** - A description of the kinds of things that you want to see the person do in the future.

## **V**

**Victim** - A person that is tricked, injured, destroyed, subject to hardship, or mistreatment.

**Victim's Resistance** - A victim will resist or fight against being manipulated or used by an offender. Some offenders become very excited and aroused when the victim resists or fights against them. Other offenders do not want the victim to fight or resist.

## **W**

**Warning Sign** - A behavior that gives notice beforehand that a relapse is about to occur; a behavior that calls attention to potential sexual abuse.

## **SEXUAL OFFENSES STATUTES**

The following section contains descriptions of the various laws which define the crime of sexual assault. This material is from Chapter 11, Article 4 of the Alaska Statutes.

### Section:

- 410. Sexual assault in the first degree
- 420. Sexual assault in the second degree
- 425. Sexual assault in the third degree
- 432. Defenses
- 434. Sexual abuse of a minor in the first degree
- 436. Sexual abuse of a minor in the second degree
- 438. Sexual abuse of a minor in the third degree
- 440. Sexual abuse of a minor in the fourth degree
- 445. General provisions
- 450. Incest
- 455. Unlawful exploitation of a minor
- 460. Indecent exposure
- 470. Definitions

## **Detailed Description**

### **Section 11.41.410 Sexual assault in the first degree.**

- (a) A person commits the crime of sexual assault in the first degree if,
  - (1) being any age, the defendant engages in sexual penetration with another person without consent of that person;
  - (2) being any age, the defendant attempts to engage in sexual penetration with another person without consent of that person and causes serious physical injury to that person;
  - (3) being over the age of 18, the defendant engages in sexual penetration with another person
    - (A) who the defendant knows is mentally incapable and
    - (B) who is entrusted to the defendant's care
      - (i) by authority of law; or
      - (ii) in a facility or program that is required by law to be licensed by the Department of Health and Social Services.
- (b) Sexual assault in the first degree is an unclassified felony and is punishable as provided in Alaska Law.

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\*\*\*This law protects against unconsented penetration or attempted penetration for any age.

\*\*\*This law protects against a person over 18 having sex with someone who is in a foster care situation or is in a state facility

\*\*\*This law also protects the persons who are mentally incapable

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### **Section 11.41.420. Sexual assault in the second degree.**

- (a) an offender commits the crime of sexual assault in the second degree if
  - (1) the offender engages in sexual contact with another person without consent of that person;
  - (2) being over the age of 18, the offender engages in sexual contact with a person
    - (A) who the offender knows is mentally incapable; and
    - (B) who is entrusted to the offender's care
      - (i) by authority of law, or
      - (ii) in a facility or program that is required by law to be licensed by the Department of Health and Social Services; or
  - (3) being over the age of 18, the offender engages in sexual penetration with a person who the offender knows is
    - (A) mentally incapable; or
    - (B) incapacitated.
- (b) sexual assault in the second degree is a class B felony.

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### **Section 11.41.425. Sexual assault in the third degree.**

- (a) an offender commits the crime of sexual assault in the third degree if being over the age of 18, the offender engages in sexual contact with a person who the offender knows is
  - (1) mentally incapable; or
  - (2) temporarily incapable of appraising the nature of the person's conduct and is physically unable to express unwillingness to act.
- (b) Sexual assault in the third degree is a class C felony.

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### **Section 11.41.432. Defenses.**

- (a) It is a defense to a crime charged under AS 11.41.410. a) (3), 11.41.420 (La) (2), 11.41.420. (a) (3), or 11.41.425. that the offender is
  - (1) mentally incapable; or



(2) married to the person and neither party has filed with the court for a separation, divorce or dissolution of the marriage.

(b) except as provided in (a) of this section, in a prosecution under AS 11.41.410, or 11.41.420, it is not a defense that the victim was, at the time of the alleged offense, the legal spouse of the defendant. (§ 4 ch 96 SLA 1988; am § 27 ch 50 SLA 1989).

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\*\*\*This law protects spouses from unconsented sexual attempts at penetration.

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**Section 11.41.434. Sexual abuse of a minor in the first degree.**

(a) An offender commits the crime of sexual abuse of a minor in the first degree if

(1) being 16 years or older, the offender engages in sexual penetration with a person who is under 13 years of age or aids, induces, causes, or encourages a person who is under 13 years of age to engage in sexual penetration with another person;

(2) being 18 years of age or older, the offender engages in sexual penetration with a person who is under 18 years of age and who

(A) is entrusted to the offender's care by authority of law; or

(B) is the offender's son or daughter, including an illegitimate or adopted child, or stepchild;

or

(3) being 18 years of age or older, the offender engages in sexual penetration with a person who is under 16 years of age, and the victim at the time of the offense is

(A) residing as a member of the social unit in the same household as the offender and the offender is in a position of authority over the victim;

or

(B) temporarily entrusted to the offender's care.

Sexual abuse of a minor in the first degree is an unclassified felony and is punishable as provided in AS 12.55.

(b) Sexual abuse of a minor in the first degree is an unclassified felony and is punishable as provided in Alaska Law.

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**Section 11.41.436. Sexual abuse of a minor in the second degree.**

(a) An offender commits the crime of sexual abuse of a minor in the second degree if

(1) being 16 years of age or older, the offender engages in sexual penetration with a person who is 13, 14, or 15 years of age and at least three years younger than the offender, or aids, induces, causes, or encourages a person who is 13, 14, or 15 years of age and at least three years younger than the offender to engage in sexual penetration with another person;

(2) being 16 years of age or older, the offender engages in sexual contact with a person who is under 13 years of age or aids, induces, causes, or encourages a person under 13 years of age to engage in sexual contact with another person;

(3) being 18 years of age or older, the offender engages in sexual contact with a person who is under 18 years of age and who

(A) is entrusted to the offender's care by authority of law; or

(B) is the offender's son or daughter, including an illegitimate or adopted child, or a stepchild;

(4) being 16 years of age or older, the offender aids, induces, causes or encourages a person who is under 16 years of age to engage in conduct described in AS 11.41.455(a)(2) - (6); or

(5) being 18 years of age or older, the offender engages in sexual contact with a person who is under 16 years of age, and the victim at the time of the offense is

(A) residing as a member of the social unit in the same household as the offender and the offender is in a position of authority over the victim; or

(B) temporarily entrusted to the offender's care.

(b) Sexual abuse of a minor in the second degree is a class B felony.

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**Section 11.41.438. Sexual abuse of a minor in the third degree.**

(a) an offender commits the crime of sexual abuse of a minor in the third degree if, being 16 years of age or older, the offender engages in sexual contact with a person who is 13, 14, or 15 years of age and at least three years younger than the offender.

(b) Sexual abuse of a minor in the third degree is a class C felony.

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**Section 11.41.440. Sexual abuse of a minor in the fourth degree.**

(a) An offender commits the crime of sexual abuse of a minor in the fourth degree if, being under 16 years of age, the offender engages in sexual penetration or sexual contact with a person who is under 13 years of age and at least three years younger than the offender.

(b) Sexual abuse of a minor in the fourth degree is a class A misdemeanor.

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**Section 11.41.445. General Provisions**

(a) In a prosecution it is an affirmative defense that, at the time of the alleged offense, the victim was the legal spouse of the defendant unless the offense was committed without the consent of the victim.

(b) In a prosecution, whenever a provision of law defining an offense depends upon a victim's being under a certain age, it is an affirmative defense that, at the time of the alleged offense, the defendant reasonably believed the victim to be that age or older, unless the victim was under 13 years of age at the time of the alleged offense.

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**Section 11.41.450. Incest.**

(a) a person commits the crime of incest if, being 18 years of age or older, that person engages in sexual penetration with another who is related, either legitimately or illegitimately, as

- (1) an ancestor or descendant of the whole or half blood;
- (2) a brother or sister of the whole or half blood; or
- (3) an uncle, aunt, nephew, or niece by blood.

(b) Incest is a class C felony.

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**Section 11.41.455. Unlawful exploitation of a minor.**

(a) a person commits the crime of unlawful exploitation of a minor if, in the state and with the intent of producing a live performance, film, photograph, negative, slide, book, newspaper, magazine, or other printed material that visually depicts the conduct listed in (1) - (6) of this subsection, the person knowingly induces or employs a child under 18 years of age to engage in, or photographs, films, or televises a child under 18 years of age engaged in, the following actual or simulated conduct:

- (1) sexual penetration
- (2) the lewd touching of another person's genitals, anus, or breast;
- (3) the lewd touching by another person of the child's genitals, anus, or breast;
- (4) masturbation;
- (5) bestiality; or
- (6) the lewd exhibition of the child's genitals.

(b) A parent, legal guardian, or person having custody or control of a child under 18 years of age commits the crime of unlawful exploitation of a minor if, in the state, the person permits the child to engage in conduct described in (a) of the section knowing that the conduct is intended to be used in producing a live performance, film, photograph, negative, slide, book, newspaper, magazine, or other printed material that visually depicts the conduct.

(c) Unlawful exploitation of a minor is a class B felony.

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**Section 11.41.460. Indecent Exposure.**

(a) An offender commits the crime of indecent exposure if the offender intentionally exposes the offender's genitals to another person with reckless disregard for the offensive, insulting, or frightening effect the act may have on that person.

(b) Indecent exposure before a person under 16 years of age is a class A misdemeanor. Indecent exposure before a person 16 years of age or older is a class B misdemeanor.

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**Section 11.41.470. Definitions.**

(1) Incapacitated. Temporarily incapable of appraising the nature of one's own conduct and physically unable to express unwillingness to act;

(2) Mentally incapable. Suffering from a mental disease or defect that renders the person incapable of understanding the nature or consequences of the person's conduct, including the potential for harm to that person;

(3) Victim. The person alleged to have been subjected to sexual assault in any degree or sexual abuse of a minor in any degree;

(4) Without consent. A person that

(A) with or without resisting, is coerced by the use of force against a person or property, or by the express or implied threat of death, imminent physical injury, or kidnapping to be inflicted on anyone; or

(B) is incapacitated as a result of an act of the defendant.

## **CHILD PROTECTION STATUTES**

The following section contains descriptions of the child protection laws, taken from Chapter 17 of the Alaska Statutes. The purpose of these statutes are to protect children from harm through abuse or neglect. The statutes detail who is required to report and particular situations when professionals are required to make reports. These statutes also include information on termination of parental rights and the immunity from prosecution of those who make reports.

### Section:

- 10. Purpose
- 20. Persons required to report
- 22. Training
- 23. Reporting regarding child pornography
- 25. Duties of public authorities
- 27. Duties of school officials
- 30. Action on reports; termination of parental rights
- 40. Central registry; confidentiality
- 50. Immunity
- 60. Evidence not privileged
- 64. Photographs and x-rays
- 68. Penalty for failure to report
- 69. Protective injunctions
- 290. Definitions

## **Detailed Description**

### **Section 47.17.010. Purpose.**

In order to protect children whose health and well-being may be adversely affected through the infliction, by other than accidental means, of harm through physical injury or neglect, mental injury, sexual abuse, sexual exploitation, or maltreatment, the legislature requires the reporting of these cases by practitioners of the healing arts and others to the department. It is not the intent of the legislature that persons required to report suspected child abuse or neglect before they make the required report to the department. Reports must be made when there is a reasonable cause to suspect child abuse or neglect in order to make state investigative and social services available in a wider range of cases at an earlier point in time, to make sure that investigations regarding child abuse and neglect are conducted by trained investigators, and to avoid subjecting a child to multiple interviews about the abuse or neglect. It is the intent of the legislature that, as a result of these reports, protective services will be made available in an effort to

- (1) prevent further harm to the child;
- (2) safeguard and enhance the general well-being of children in this state; and
- (3) preserve family life unless that effort is likely to result in physical or emotional damage to the child.

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### **Section 47.17.020. Persons required to report.**

(a) The following persons who, in the performance of their occupational duties, have reasonable cause to suspect that a child has suffered harm as a result of child abuse or neglect shall immediately report the harm to the nearest office of the department:

- (1) practitioners of the healing arts;
- (2) school teachers and school administrative staff members of public and private schools;
- (3) social workers;
- (4) peace officers, and officers of the Department of Corrections;
- (5) administrative officers of institutions;
- (6) child care providers;
- (7) paid employees of domestic violence and sexual assault programs, and crisis intervention and prevention programs as defined in AS 18.66.900;
- (8) paid employees of an organization that provides counseling or treatment to individuals seeking to control their use of drugs or alcohol.

(b) This section does not prohibit the named persons from reporting cases that have come to their attention in their nonoccupational capacities, nor does it prohibit any other person from reporting a child's harm that the person has reasonable cause to suspect is a result of child abuse or neglect. These reports shall be made to the nearest office of the department.

(c) If the person making a report of harm under this section cannot reasonable contact the nearest office of the department and immediate action is necessary for the well-being of the child, the person shall make the report to a peace officer. The peace officer shall immediately take action to protect the child and shall, at the earliest opportunity, notify the nearest office of the department.

(d) This section does not require a religious healing practitioner to report as neglect of a child the failure to provide medical attention to the child if the child is provided treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner of the church of denomination.

(e) The department shall immediately notify the nearest law enforcement agency if the department

- (1) concludes that the harm was caused by a person who is not responsible for the child's welfare;
- (2) is unable to determine
- (A) who caused the harm to the child; or

- (B) whether the person who is believed to have caused the harm has responsibility for the child's welfare; or
- (3) concludes that the report involves
  - (A) possible criminal conduct under AS 11.41.410 - 11.41.455; or
  - (B) abuse or neglect that results in the need for medical treatment of the child
- (f) If a law enforcement agency determines that a child has been abused or neglected and that (1) the harm was caused by a teacher or other person employed by the school or school district in which the child is enrolled as a student, (2) the harm occurred during an activity sponsored by the school or school district in which the child is enrolled as a student, or (3) the harm occurred on the premises of the school in which the child is enrolled as a student or on the premises of a school within the district in which the child is enrolled as a student, the law enforcement agency shall notify the chief administrative officer of the school or district in which the child is enrolled immediately after the agency determines that a child has been abused or neglected under the circumstances set out in this section, except that if the person about whom the report has been made is the chief administrative officer or a member of the chief administrative officer's immediate family, the law enforcement agency shall notify the commissioner of education that the child has been abused or neglected under the circumstances set out in this section. The notification must set out the factual basis for the law enforcement agency's determination. If the notification involves a person in the teaching profession, as defined in AS 14.20.370, the law enforcement agency shall send a copy of the notification to the Professional Teaching Practices Commission.
- (g) A person required to report child abuse or neglect under (a) of this section who makes the report to the person's job supervisor or to another individual working for the entity that employs the person is not relieved of the obligation to make the report to the department as required under (a) of this section.

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#### **Section 47.17.022. Training.**

- (a) A person employed by the state or by a school district who is required under this chapter to report abuse or neglect of children shall receive training on the recognition and reporting of abuse and neglect.
- (b) Each department of the state and school district that employs persons required to report abuse or neglect of children shall provide
  - (1) initial training required by this section to each new employee during the employee's first six months of employment, and to any existing employee who has not received equivalent training; and
  - (2) at least once every five years, appropriate in-service training required by this section as determined by the department or school district.
- (c) Each department and school district that must comply with (b) of this section shall develop a training curriculum that acquaints its employees with
  - (1) laws relating to child abuse and neglect;
  - (2) techniques for recognition and detection of child abuse and neglect;
  - (3) agencies and organizations within the state that offer aid or shelter to victims and the families of victims of child abuse or neglect;
  - (4) procedures for required notification of suspected abuse or neglect;
  - (5) the role of a person required to report child abuse or neglect and the employing agency after the report has been made;
  - (6) a brief description of the manner in which cases of child abuse or neglect are investigated by the department and law enforcement agencies after a report of suspected abuse or neglect.
- (d) Each department and school district that must comply with (b) of this section shall file a current copy of its training curriculum and materials with the Council on Domestic Violence and Sexual Assault. A department or school district may seek the technical assistance of the council or the Department of Health and Social Services in the development of its training program.

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**Section 47.17.023. Reports regarding child pornography.**

A person who, in the course of processing or producing visual or printed matter, either privately or commercially, has reasonable cause to suspect that the matter visually depicts a child engaged in conduct described in AS 11.41.455(a) shall immediately report this to the nearest law enforcement agency, and provide the law enforcement agency with all information known about the nature and origin of the matter.

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**Section 47.17.025. Duties of public authorities.**

(a) A law enforcement agency shall immediately notify the department of the receipt of a report of harm to a child from abuse. Upon receipt from any source of a report of harm to a child from abuse, the department shall notify the Department of Law and investigate the report and, within 72 hours of the receipt of the report, shall provide a written report of its investigation of the harm to a child from abuse to the Department of Law for review.

(b) The report of harm to a child from abuse required from the department by this section must include:

- (1) the names and addresses of the child and the child's parent or other persons responsible for the child's care, if known;
- (2) the age and sex of the child;
- (3) the nature and extent of the harm to the child from abuse;
- (4) the name and age and address of the person known or believed to be responsible for the harm to the child from abuse, if known;
- (5) information that the department believes may be helpful in establishing the identity of the person believed to have caused the harm to the child from abuse.

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**Section 47.17.027. Duties of school officials.**

(a) If the department or a law enforcement agency provides written certification to the child's school officials that

- (1) there is reasonable cause to suspect that the child has been abused or neglected by a person responsible for the child's welfare or as a result of conditions created by a person responsible for the child's welfare;
- (2) an interview at school is a necessary part of an investigation to determine whether the child has been abused or neglected; and
- (3) the interview at school is in the best interests of the child, school officials shall permit the child to be interviewed at school by the department or a law enforcement agency before notification of, or receiving permission from, the child's parent, guardian, or custodian. A school official shall be present during an interview at the school unless the child objects or the department or law enforcement agency determines that the presence of the school official will interfere with the investigation. Immediately after conducting an interview authorized under this section, and after informing the child of the intention to notify the child's parent, guardian, or custodian, the department or agency shall make every reasonable effort to notify the child's parent, guardian, or custodian that the interview occurred unless it appears that the department or agency that notifying the child's parent, guardian, or custodian would endanger the child.

(b) A school official who, with criminal negligence, discloses information learned during an interview conducted under (a) of this section is guilty of a class B misdemeanor.

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**Section 47.17.030. Action on reports; termination of parental rights.**

(a) If a child, concerning whom a report of harm is made, is believed to reside within the boundaries of a local government exercising health functions for the area in which the child is believed to reside, the department may, upon receipt of the report, refer the matter to the appropriate health or social services agency of that local government, the department shall, for each report received, investigate and take action, in accordance with law, that may be necessary to prevent further harm to the child or to ensure the proper care and protection of the child.

(b) A local government health or social services agency receiving a report of harm shall, for each report received, investigate and take action, in accordance with law, that may be necessary to prevent further harm to the child or to ensure the proper care and protection of the child. In addition, the agency receiving a report of harm shall forward a copy of its report of the investigation, including information the department required by regulation, to the department.

(c) Action shall be taken regardless of whether the identity for the person making the report of harm is known.

(d) Before the department or a local government health or social services agency may seek the termination of parental rights under AS 47.10.080(c)(3), it shall offer protective social services and pursue all other reasonable means of protecting the child.

(e) In all actions taken by the department or a health and social services agency of a local government under this chapter that result in a judicial proceeding, the child shall be represented by a guardian ad litem in that proceeding, the child shall be represented by a guardian ad litem in that proceeding. Appointment of a guardian ad litem shall be made in accordance with AS 25.24.310.

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**Section 47.17.040. Central registry; confidentiality.**

(a) The department shall maintain a central registry of all investigation reports but not of the reports of harm.

(b) Investigation reports and reports of harm filed under this chapter are considered confidential and are not subject to public inspection and copying under AS 09.25.110 and 09.25.120. However, in accordance with department regulations, investigation reports may be used by appropriate governmental agencies with child-protection functions, inside and outside the state, in connection with investigations or judicial proceedings involving child abuse, neglect, or custody. A person, not acting in accordance with department regulations, who with criminal negligence makes public information contained in confidential reports is guilty of a class B misdemeanor.

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**Section 47.17.050. Immunity.**

(a) Except as provided in (b) of this section, a person who, in good faith, makes a report under this chapter, permits an interview under AS 47.17.027, or participates in judicial proceedings related to the submission of reports under this chapter, is immune from civil or criminal liability that might otherwise be incurred or imposed for making the report of permitting the interview, except that person who knowingly makes an untimely report is not immune from civil or criminal liability based on the delay in making the report.

(b) Notwithstanding (a) of this section, a person accused of committing the child abuse or neglect is not immune from civil or criminal liability for the child abuse or neglect as a result of reporting the child abuse or neglect.

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**Section 47.17.060. Evidence not privileged.**

Neither the physician-patient nor the husband-wife privilege is a ground for excluding evidence regarding a child's harm, or its cause, in a judicial proceeding related to a report made under this chapter.

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**Section 47.17.064. Photographs and x-rays.**

(a) The department or a practitioner of the healing arts may, without the permission of the parents, guardian, or custodian, take the following actions with regard to a child who the department or practitioner has reasonable cause to suspect has suffered physical harm as a result of child abuse or neglect:

- (1) take or have taken photographs of the areas of trauma visible on the child; and
- (2) if medically indicated, have a medical or radiological examination of the child performed by a person who is licensed to administer the examination.



(b) The department of a practitioner of the healing arts shall notify the parents, guardian, or custodian of a child as soon as possible after taking action under (a) of this section with regard to the child.

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**Section 47.17.068. Penalty for failure to report.**

A person who fails to comply with the provisions of AS 47.17.020 or 47.17.023 and who knew or should have known that the circumstances gave rise to the need for a report, is guilty of a class B misdemeanor.

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**Section 47.17.069. Protection injunctions.**

(a) A court may enjoin or limit a person from contact with a child if the attorney general establishes by a preponderance of the evidence that the person

- (1) has sexually abused a child;
- (2) has physically abused a child; or
- (3) has engaged in conduct that constitutes a clear and present danger to the mental, emotional, or physical welfare of a child.

(b) This section does not limit the authority of the attorney general of the court to act to protect a child.

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**Section 47.17.290. Definitions.**

- (1) “child” means a person under 18 years of age;
- (2) “child abuse or neglect” means the physical injury or neglect, mental injury, sexual abuse, sexual exploitation, or maltreatment of a child under the age of 18 by a person under circumstances that indicate that the child’s health or welfare is harmed or threatened thereby; in this paragraph, “mental injury” means an injury to the emotional well-being, or intellectual or psychological capacity of a child, as evidenced by an observable and substantial impairment in the child’s ability to function;
- (3) “child care provider” means an adult individual, including a foster parent or an employee of an organization, who provides care and supervision to a child for compensation or reimbursement;
- (4) “criminal negligence” has the meaning given in AS 11.81.900;
- (5) “department” means the Department of Health and Social Services;
- (6) “immediately” means as soon as is reasonable possible, and no later than 24 hours;
- (7) “institution” means a private or public hospital or other facility providing medical diagnosis, treatment, or care;
- (8) “maltreatment” means an act or omission that results in circumstances in which there is reasonable cause to suspect that a child may be a child in need of aid, as described in AS 47.10.010(a)(2), except that, for purposes of this chapter, the act or omission need not have been committed by the child’s parent, custodian, or guardian;
- (9) “mental injury” means an injury to the emotional well-being, or intellectual or psychological capacity of a child, as evidenced by an observable and substantial impairment in the child’s ability to function in a developmentally appropriate manner;
- (10) “neglect” means the failure by a person responsible for the child’s welfare to provide necessary food, care, clothing, shelter, or medical attention for a child;
- (11) “organization” means a group of entity that provides care and supervision for compensation to a child not related to the caregiver, and includes a child care facility, pre-elementary school, head start center, child foster home, residential child care facility, recreation program, children’s camp, and children’s club;
- (12) “person responsible for the child’s welfare” means the child’s parent, guardian, foster parent, a person responsible for the child’s care at the time of the alleged child abuse or neglect, or a person responsible for the child’s welfare in a public or private residential agency or institution;
- (13) “practitioner of the healing arts” includes chiropractors, mental health counselors, dental hygienists, dentists, health aides, nurses, nurse practitioners, occupational therapists,

occupational therapy assistants, optometrists, osteopaths, naturopaths, physical therapists, physical therapy assistants, physicians, physician's assistants, psychiatrists, psychologists, psychological associates, audiologists licensed under AS 08.11, hearing aid dealer licensed under AS 08.55, religious healing practitioners, acupuncturists, and surgeons;

(14) "reasonable cause to suspect" means cause, based on all the facts and circumstances known to the person, that would lead a reasonable person to believe that something might be the case;

(15) "school district" means a city or borough school district or regional educational attendance area.

(16) "sexual exploitation" includes

(A) allowing, permitting, or encouraging a child to engage in prostitution prohibited by AS 11.66.100 - 11.66.150, by a person responsible for the child's welfare;

(B) allowing, permitting, encouraging, or engaging in activity prohibited by AS 11.41.455(a), by a person responsible for the child's welfare.

**THINKING ERRORS COMMON TO THE CRIMINAL  
AND CORRECTIVES\***

\*Taken from The Criminal Personality, Yochelson and Samenow

This section lists and describes the thinking errors that criminals often show. These errors are often the way that they are able to justify their crime or delay their treatment. Thinking errors are frequently ingrained in the thoughts of the sexual offender and will be very difficult to change. Corrective strategies for each of the thinking errors are also offered.

1) **ENERGY:** The criminal is full of energy: wants action, wants to move when bored, is mentally active with many ideas about what would make life more exciting. He doesn't know how to cope with boredom.

**CORRECTIVE:** Re-focus energy. Fulfill all duties or obligations first. Apply effort to overcome boredom (anger + self-pity = fatigue). Develop self-caused enthusiasm.

2) **FEAR:** The offender has many fears. These fears last or are persistent. They are intense, especially fear of being caught for something, fear of injury or death, and fear of being put down.

**CORRECTIVE:** Learn to make fear useful as a guide for responsible living. Fear can come before action that results in injury and is a motive for self-improvement.

3) **ZERO STATE:** The offender feels he is an absolute nothing, a zero; feeling absolutely worthless, and hopeless. His greatest fear is that he is a nothing. He makes up for this by trying to prove he is everything.

**CORRECTIVE:** Learn to see self as others do. Lower high expectations that are not realistic. Make wise decisions. Recognize Murphy's Law ("If anything can go wrong, it will!"). Learn to have faith that feelings of worthlessness are temporary.

4) **ANGER:** Working with him is like a war against anger. He responds with anger to anything or anyone he sees as opposing what he wants for himself. Anger is a major way of controlling people and conditions.

**CORRECTIVE:** Get rid of anger. Do not just control it. Remember that anger is never needed to solve a problem. Find errors of thinking that led to anger. Recognize costs of anger. Apply level headed thinking and reasoning. Learn to accept that frustration is common to everyone. Not getting what you want does not have to automatically lead to anger.

5) **PRIDE:** Criminal Pride is a false high evaluation of oneself. He thinks he is better than anyone else, even when this is clearly not the case. Criminal Pride preserves his rigid self image as a powerful totally self-determined person. "If I bend, I break," sums up the thinking of risking everything for a trivial matter. Threats of punishment or consequences may mean nothing to him when he sees himself having to choose between backing down or maintaining his Criminal Pride.

**CORRECTIVE:** Revise definitions of manhood. See others' points of view. Correct self image based on realistic accomplishments. Develop trust and respect for mutual rights. Consider effects of injuries on others.

6) **POWER THRUSTING:** The criminal needs power and control over others, especially to bring himself out of a "zero state." He spends his life seeking power over others instead of improving himself. His greatest power excitement is doing the forbidden and getting away with it. He seeks power and control in all areas of his life.

**CORRECTIVE:** Learn to put self in the other's place. Be aware of the purpose and effects of his actions. Apply control to self instead of others. Apply effort to rightfully acquire power to benefit others. Learn to accept feeling bad at times. Work out of it by setting realistic goals. Allow a practical time frame for accomplishing those goals.

7) **SENTIMENTALITY:** He may express a lot of tenderness or sentimentality about mothers, old people, invalids, babies, animals etc. These sentiments are not backed up by

responsible, caring behavior. The people he “loves” are often those he hurts the most, and are often the people who are easiest for him to control and dominate.

**CORRECTIVE:** Learn to bring sentiments together instead of isolating (fragmenting) them. Practice lasting care for others, serving others. Learn true concern, not just wishes.

8) **RELIGION:** He may be very active in religion, but it is isolated. He doesn’t practice its principles in his daily behavior. Like sentimentality, his religious beliefs do not stop him from criminal thinking or criminal actions. Instead they support his self-image as a “good and decent” person.

**CORRECTIVE:** Practice following rules and standards in daily behaviors. Do a daily moral inventory. Use religious or spiritual beliefs to truthfully judge oneself instead of others. Recognize that church attendance and words do not make a person good; good actions are necessary.

9) **CONCRETE THINKING:** The offender focuses on particular objects and events. He doesn’t see larger patterns, or general concepts. He misses the point. He may misuse words, not understanding their concepts, such as “love,” “friendship,” “truth,” etc. Pays attention to the surface, shallow meanings without looking for deeper meanings. His understandings are literal and handy.

**CORRECTIVE:** Learn to think conceptually. Develop concepts of family life, money, morality, etc. Learn to see the “big picture” instead of isolating events. Look for the overall meaning or message in situations instead of just the details alone. Apply inner principles to thoughts and actions.

10) **FRAGMENTATION:** Extreme changes in the criminal’s mental state occur within short periods of time. There is a pattern of starting something, then changing his mind. He goes with whatever he’s thinking about at the moment, “forgetting” anything that might oppose his current plan. Fragmentation is used to dismiss sentimentality and religion when they don’t fit with current desires or plans.

**CORRECTIVE:** Develop an outlook to give consistency to life. Stop and check out present plans against guiding principles before acting. Integrate thoughts, words, and actions. Learn to think about conflicts and study the facts.

11) **UNIQUENESS:** He considers himself special, one-of-a-kind, and totally different from others, especially other criminals. Although in reality he may be very predictable and very much like other criminals he wants to be “above” the rest and accents his “unique” set of conditions.

**CORRECTIVE:** In group, find how he is like the others. When pointing out others’ problems or errors, follow up by examining how this relates to oneself also. Observe ordinary people solving life problems and apply to oneself. Search for ways he is like the others instead of how he is different.

12) **PERFECTIONISM:** He has extreme standards for perfection but does not apply them consistently. He may apply his high standards to others, then criticize them when they fall short in any way he deems important. His perfectionism depends on what he values. This is usually something he wants to do at the moment. He uses perfectionism to avoid a difficult task because he might not succeed “perfectly.”

**CORRECTIVE:** Learn what is worth the effort for self-improvement, not to prove oneself to be better than everyone else. Learn proper balance and proportion. Check out standards to see if they are realistic. Learn to accept others.

13) **SUGGESTIBILITY:** He is easily swayed toward any behavior he likes, especially when he’s bored and looking for action and excitement. He may take huge risks with behavior that leads to something he wants. He does not accept responsible suggestions about thinking and behavior. He does not use responsible people for role models. He does not want to be like them.

**CORRECTIVE:** Direct his focus away from crime and toward responsible conversation, reading materials, TV, and associates.

**14) LONERISM:** The criminal leads a secretive life, “One against the world.” He feels he is apart from others even if he is socially active. Although he voices feelings of care, he is never so tight with anyone that he can’t get up and go if something more exciting comes along. He is willing to risk relationships by committing crimes, going to prison, etc.

**CORRECTIVE:** Learn to become an active, involved part of social groups, family, etc. Learn the meaning of interdependence, making and keeping commitment opening oneself up and allowing oneself to be vulnerable. Learn the meaning of intimacy and apply effort to overcome fears.

**15) SEXUALITY:** His fantasies run towards rape-like behaviors involving abuse, domination, power, and control. His sexuality is motivated by bending someone to his will through violence, force, threats, intimidation or manipulations of all kinds. Conquest is needed and the “partner” is a owned.

**CORRECTIVE:** Remove power, control, conquest, and bold unfair acts. Replace them with mutual, worthy, valued, loyal interpersonal relationships. Get rid of stereotypes and learn to view others as whole human beings instead of objects. Consider feelings and rights of others in all interactions. Develop sensitivity to needs of others. Look for mutual fulfillment instead of using people unfairly and short-term excitement.

**16) LYING:** Lying is a way of life for the criminal—it’s another way to gain power and to save him from consequences. More common than pre-planned lying is automatic, habitual lying. He lies by leaving out important facts or twisting them. Lying explains what is real to him. It helps him maintain control by withholding information from others.

**CORRECTIVE:** Stick to the facts. Imagine that a situation was videotaped and compare his version to the one which the viewer would see if he had access to the whole picture. Learn to accept consequences as part of life. Practice accurately reporting facts even when they make the offender look bad or lead to negative consequences. Set honesty as a consistent value, not something to be discarded when handy.

**17) CLOSED CHANNEL:** Secrecy = power. He does not give out information about himself. He has a closed mind and does not take in messages that go against his way of thinking. He will not listen to people that challenge his viewpoint and doesn’t hear what he doesn’t want to hear.

**CORRECTIVE:** Develop a wide open channel of two-way communication. Request self-criticism. Look for help to correct errors. Provide information about inner thoughts and actions and ask for feedback responses — then listen to them with an open mind. Do away with secrecy as a way of life.

**18) “I CAN’T”:** He uses “I can’t” when he means “I won’t,” when he isn’t willing to do something. He uses this to escape responsibility, but at the same time believes there is nothing he can’t do if he wants to.

**CORRECTIVE:** Recognize that this is really a statement of refusal rather than inability. Remind him of his willingness to go out of the way to get things he wants. Apply this willingness to required tasks. Bring about free choice, “I can” and “I do.”

**19) THE VICTIM STANCE:** When he is held accountable for his actions, he blames others and portrays himself as a victim. Having no regard for the rights of others, he expects total respect for his rights and desires from everyone. If he doesn’t get what he wants or feels that he’s entitled to, he sees himself as poorly treated and thus a victim. He sees how he has always been a victim but not how he has victimized others. (Note: A criminal who refuses to give up the

victim stance will not change. According to Samenow and Yochelson, this particular error is the single best predictor regarding the change process.)

**CORRECTIVE:** Learn the difference between being held accountable for one's own actions (receiving consequences) and being a victim (harmed or having rights violated with no control or choice in the matter). Take responsibility for decisions and actions.

**20) LACK OF TIME PERSPECTIVE:** He demands success and possession of what he wants right away. He doesn't use the past to learn from experience, nor does he learn to make realistic plans for his future. He wants everything now.

**CORRECTIVE:** Get a realistic outlook of time. Develop patience. Delay satisfaction. Take past patterns into account to evaluate current situations. Plan realistic future goals and practice working slowly and steadily towards them.

**21) FAILURE TO PUT YOURSELF IN ANOTHER'S POSITION:** While he demands every break and consideration for himself, he doesn't stop to think about what other people think, feel, or expect. He may not only disregard another's position, he may act as they don't exist when planning to get his way. He does not recognize how many people are affected by his actions, nor the effect on individuals.

**CORRECTIVE:** Stop and list all people possibly affected by an action before acting. Imagine being in another's place, then review the situation from their outlook. Recognize that other's rights and feelings are as important as own. Develop empathy — the ability to actually feel what another is feeling by putting himself in their shoes. Practice being considerate and helpful.

**22) FAILURE TO CONSIDER INJURY TO OTHERS:** His life has caused lots of injury to those around him, but he doesn't view himself as hurting others. When held accountable he sees himself as the injured party. He can witness tears, physical and verbal resistance, and even physical symptoms of injury and still deny that he has hurt someone.

**CORRECTIVE:** Develop care and consideration to the feelings of others. Consider the impact on all people. Inventory costs to the victims. Develop and experience self-disgust for injuring others.

**23) FAILURE TO ASSUME OBLIGATION:** He has no sense of real obligation or duty. He uses any excuse for failure in these areas. Obligations interfere with what he wants to do. Obligation is seen as a position of weakness that leaves him vulnerable to others' control. Obligations are irritating to him. If pushed, he will respond with resentment and anger.

**CORRECTIVE:** Make a pledge to fulfill obligations — to do work, pay bills, obey laws, develop moral sense inside self. Recognize that everyone has obligations. Carry out obligations to others as you would want others' obligations to you to be honored.

**24) FAILURE TO ASSUME RESPONSIBLE INITIATIVES:** He doesn't want to assume responsible initiatives (planning and starting projects) because: a) they don't provide excitement and power thrust of forbidden activities, b) they do not guarantee success or triumph, and c) he is often afraid that taking on responsible tasks will expose his lack of knowledge. He is a "get-by artist," expecting others to figure out everything that needs to be done, tell him how, and make it easy for him to accomplish.

**CORRECTIVE:** Learn to make plans and tasks to help oneself improve or help others. Motivation develops only after an initiative is taken. Learn by doing. Actively look for ways to improve self and situations, then act on responsible plan.

**25) OWNERSHIP:** He doesn't really recognize that there is such a thing as "theft" — if he's looking at it, wants it, it's his (including human beings). He doesn't recognize that other people own things. He considers himself a decent person with a right to have everything that suits him — he "deserves" to have it. He sees people as pawns or checkers waiting to be dealt

with as he wishes. He justifies to himself taking something from someone else by saying they don't need it as much as he does, they don't deserve it, they don't care if he has it, etc.

**CORRECTIVE:** Develop legitimate ownership of possessions—earn them. Learn to accept that he cannot have everything he wants. Respect the boundaries of others. Refuse to excuse stealing or taking things by analyzing how or why someone else got them.

**26) FEAR OF FEAR:** The criminal is afraid that fear will keep him from doing things. Fear is his enemy and he is angry about it. Sometimes he uses drugs or alcohol to get rid of fear. When he sees fear in others he points it out, scorns it, and is ready to pounce. When he experiences fear (including doubt, concern, apprehension, anxiety) he denies it or considers it a put-down.

**CORRECTIVE:** Make fear a useful tool. Recognize its value as a guide to reconsider plans. Check out fears with others. Examine if a fear needs to be faced and overcome or if it is rational and needs to be heeded. Abstain from drugs or alcohol. Recognize that fear of failure keeps one on one's toes to make a good effort. Develop empathy for fear in others. Recognize doubts, concern, fear, worry, and anxiety as helpful and normal.

**27) LACK OF TRUST:** Trusting someone shows weakness, to the criminal. Although he refuses to trust others, he demands that they trust him, even though his behavior clearly shows he is not trustworthy. Trust, to him, means someone will back him up in a crime. "Trusting God" means that if he prays at the right time, God will get him out of a spot. The criminal relies on control, not trust. His favorite victims are those who are most trusting. He can con them into believing he has their best interests at heart while he makes selfish use of their trust.

**CORRECTIVE:** Choose whom to trust with what—do fact finding. Earn trust by reliable behaviors over time. Recognize that trusting requires strength and ability to take risks, not weakness.

**28) REFUSAL TO BE DEPENDENT:** Like anyone else, the criminal is dependent upon others for some things in life. But he doesn't see himself this way. To him, dependence = weakness and makes him vulnerable. He does not understand the concept of interdependence or people depending on each other. He likes others to depend on him even though he is not dependable.

**CORRECTIVE:** To build relationships, learn to experience interdependence, give and take of caring and nurturing. Learn to share. Make allowance for others' faults. Accept that everyone is vulnerable or unprotected in some ways at different times.

**29) LACK OF INTEREST IN RESPONSIBLE PERFORMANCE:** He does not have the feeling of content that comes from doing a task well or putting out long-term effort. Responsible performance looks dull and boring because it does not promise instant excitement. When he does become interested in a responsible project, his interest is short-lived unless he feels the excitement of being noticed a lot.

**CORRECTIVE:** Act responsibly to develop interest from the experience. Stress doing rather than feeling. Learn to give self-approval where it is due instead of demanding approval from others.

**30) PRETENTIOUSNESS:** This means he has greatly over-rated ideas about himself. He likes to be showy. He thinks he is the best, will be the best, but not that he will do his best. He may like to flash money, drive a big car, or appear superior to others, feeling he doesn't need to put forth the same effort as others to be a success or get what he wants. His goals are unreal because he isn't willing to follow through with the real work it takes to finish an honest task.

**CORRECTIVE:** Replace pretensions with sensible expectations or goals. Responsibly earn what you get. Learn patience and tolerance for tedious work. Accept lower-voltage excitement. Base self-worth on inner qualities and good deeds instead of superficial standards.



**31) FAILURE TO ENDURE ADVERSITY:** It takes “effort” to do what a person doesn’t want to do. The criminal puts out little effort but he may put out a lot of energy doing things he does want to do. Instead of putting up with the adversity or hardships of life, he escapes into criminal thought and actions. Adversity is anything that isn’t going his way. He refuses to accept anything he can’t control.

**CORRECTIVE:** Accept that there must be consequences for failure. Put forth effort to avoid failure. Remind yourself of the energy that is there when you want to do something. Direct the energy towards responsible efforts instead. Remember that everyone experiences hardships or adversity. Work to find solutions instead of giving up efforts.

**32) POOR DECISION-MAKING FOR RESPONSIBLE LIVING:** He doesn’t use sound reasoning, fact-finding. He doesn’t think about costs, risks, or other choices. He is unwilling to ask questions and learn the facts before making decisions. If he what wants is not supported by the facts, he will not want to hear them.

**CORRECTIVE:** Be cautious and careful in considering consequences. Replace shrewdness with concern. Become honest, willing to change, flexible, open-minded, fact-finding, and manage time. Ask questions, get feedback from reliable people. Think carefully about risks. Consider impact of all options on others.

**33) CORROSION AND CUT-OFF:** A criminal may stop himself from a criminal activity because of his feelings for right and wrong. He may have a sincere wish to change, sentimental or religious thinking, or fear of getting caught. He stops these thoughts that stop crime by corrosion or cutting-off those thoughts. Corrosion is a mental process in which he slowly drowns out the “conscience” by repeating more thoughts of the crime, until his desire to commit the crime is greater than the other thoughts that might have stopped him. Cut-off is a mental process that gets rid of the “conscience” thoughts quickly and completely. He blocks out the thoughts that stop the crime and shifts his entire focus onto the crime. He blocks out the memory of how bad he’ll feel later.

**CORRECTIVE:** Experience self-disgust and use it as a tool to remind self of consequences of crime. Use guilt and fear as useful tools to guide daily behavior. List and analyze long and short term results of past crimes. Do not allow self to dwell on (fantasize) excitement of criminal acts.

**34) BUILDING UP THE OPINION OF ONESELF AS A GOOD PERSON:** The criminal convinces himself that he really is a good and decent person and rejects the idea that he is a criminal even though he has clearly committed criminal acts that are not “good and decent.” The false image of himself as a good guy permits him to continue crime. He makes the harm he has caused seem small and may refer to a planned serious crime as “a mistake.” His crimes may lead to lifetimes of horrible pain or even death for victims, but he will view the fact that he has done some good deeds as “canceling out” the harm he’s done.

**CORRECTIVE:** Recognize how the harm done in a criminal lifestyle is greater than the good one has done. Do a balance sheet of good deeds and evil acts. Make a daily inventory of conscience. Check out how sincere a good deed is with another reliable person.

**35) DEFERMENT:** He is going to stop his crimes or assault cycle and he’s going to do his hardest work — tomorrow. But, today he can’t. He thinks that one day it will be easier to change but that day never comes.

**CORRECTIVE:** Learn to see things in stages. Learn from the past. Recognize that there are three choices: continue as one is with all the consequences (prison, etc.), commit suicide, or CHANGE. Set responsible, realistic goals daily and carry out work required. Do it now. Eliminate excuses and “I can’t” attitude.

**36) SUPEROPTIMISM:** If he decides he wants to do something, he considers it as good as done. As he approaches a criminal act, he reaches a state of absolute certainty that he won’t get

caught, regardless of how unrealistic his plan is. He doesn't examine reasonable doubts about anything if he wants it done. If someone says "maybe," he thinks they mean "yes." If he decides to become a reliable person, he is sure of his success and considers the change to have already happened just because he wants it that way. He uses super optimism to convince himself that he doesn't really have to do any work to make things turn out all right—this applies to release, future job, future friends, and lovers, etc.

**CORRECTIVE:** Get rid of super optimism by fact-finding, weighing choices, asking for input, and feedback from responsible people.

**NINETEEN TACTICS USED BY THE  
CRIMINAL TO AVOID CHANGE\***

\*Taken from The Criminal Personality, Samenow and Yochelson

The following are behaviors the offender may display when he is trying to avoid change.

**1) Building himself up by putting others down:** Sexual offenders often try to take charge by attempting to put others down. They tend to defend themselves by attacking others. This attack can be verbal or physical. Usually the offender will use verbal attacks first. This should be thought of as a sign that the offender is trying to build himself up. He may finally rely on physical attack (sexual assault) to feel superior to others. Sexual offenders tend to use wise cracks to make others look dumb. They accuse others of having the same or worse faults as they have. Sexual offenders get a sense of winning or superiority by embarrassing others. Remember that behavior that intends to put others down is a signal that the offender is feeling inferior. He may end up engaging in lapse or relapse behavior as a result of those feelings.

**2) Feeding others what he thinks they want to hear:** Sexual offenders keep trying to size up others. This is especially true when offenders have to deal with people in authority. Sexual offenders attempt to tell people in authority what they think they want to hear. By using these different, sneaky ways, they try to manipulate people in authority. This is a game of power and control in an attempt to gain a personal advantage. Sexual offenders try to convince others that they are honestly trying to change their behaviors, and tend to appear open and agreeable. Sexual offenders appear to understand and think about their relapse behavior plan. They do this to make others think they are having some impact on the offender. It is likely that when dealing with people in authority, the offender is trying to figure out the answer they think those in charge want to hear. Most sexual offenders put up an act of doing what they are supposed to and wanting to change even if they are, at the same time secretly breaking the rules. This is why it is important for the safety net team to be aware when dealing with sexual offenders. They will attempt to portray themselves as doing well in the eyes of people in authority, which includes all members of the safety net team. The team must work together to determine the extent to which the offender is actually trying to prevent relapse and the extent to which he is trying to fool you.

**3) Feeding others what he thinks they ought to know:** Sexual offenders decide when they want to give up information. When a sexual offender is asked what he has been up to lately, he will most often give a vague response. It is unlikely that the offender will admit to engaging in behaviors that can be considered lapse or relapse. Most offenders are less interested in changing their behaviors and more interested in learning how to do what they want (re-offend) without getting caught. They will be likely to tell you things that make them look important and unlikely to tell you things that make them look bad.

**4) Lying:** Sexual offenders do not trust most situations in which they are held responsible. Sexual offenders try to get away from punishment and do what they can to get a privilege or get a release from their responsibilities or duties. Offenders realize that the truth will usually hurt them. They make up lies to keep from getting hurt. Offenders tend to use denial ("I do not remember" or "That never happened."), offer excuses, or blame others to try to avoid responsibility. "Lies of omission" are the most common. These types of lies are ones where the offender does not tell the whole story, leaving out the parts that make them look bad. Offenders know that telling a part of the truth may be the best way to con others. They may tell the person in authority how tired they are when they return from work. They do not add that they are tired because they have been engaging in a daily habit of drinking and looking for victims. When found out, the offender may insist that he has been truthful in stating how tired he was and will expect credit for making this statement. When offenders are caught lying, they tend to power thrust and divert attention by asking questions such as "Wouldn't you lie in this situation?" They may insist that anyone who says he would not is lying. Sometimes offenders open up and reveal something and then later deny it, saying it was just a con. Offenders tend to prefer this to facing the consequences of whatever came out in the open. By saying they were "conning," they convey the idea that they are now telling the truth, which of course they are

not. “Distortion” is a form of lying in which the offender twists the facts to his advantage. He distorts his report of what occurred by shifting the emphasis, bragging and leaving out part of what happened.

**5) Vagueness:** Offenders tend to use phrases such as “In a way,” “I guess,” “To a degree” as a way to side-step issues. They use these phrases to hide a wrong-doing. Offenders are typically very good at avoiding giving a direct answer. They may talk around issues by saying a lot of words that do not mean anything. They will talk about how everyone in the world should be a certain way and give examples that are just not possible in real life.

**6) Attempting to confuse:** Offenders often try to confuse people, believing this gives them the upper hand. Offenders often change their stories. When confronted or challenged, they try to shift the blame to the other person. The offender accuses them of being confused. They are not likely to admit purposefully trying to confuse another person. Offenders often try to confuse by talking too fast or too slowly and always getting off track. They try to draw attention to someone else. Offenders often try to confuse people by beginning to tell something and stopping in the middle. They admit they were lying and are now going to tell the truth. Offenders believe that by admitting to lying, others will give them credit for honesty, believing everything they say later.

**7) Minimization:** When offenders are confronted for wrong-doings, they tend to defend themselves by playing down or minimizing their actions. Offenders see the offense as less serious than others do. They try to minimize their actions to save their own skins. Offenders would refer to the most serious crimes as a “mistake.” Instead of admitting to sexual offense, the offender may say he was alone “talking” with the victim or that he had no control over the circumstances that “placed” him and the victim alone together. Sexual offenders tend to see themselves as the victim when confronted about their behavior. They do not take responsibility for their actions but instead try to blame others or circumstances for events that took place. An offender will often attempt to get authority figures to feel sorry for them as a means of avoiding paying the consequences for their actions.

**8) Diversion:** Offenders attempt to keep people busy by focusing their attention in any other direction so that they can take the attention off themselves and their behavior. The types of diversions used by sexual offenders include dwelling on one point when asked to discuss behaviors instead of telling the whole story. Offenders also have a tendency to label something as a “problem” so that they can discuss it at length, thus distracting others from more important matters. Another form of diversion is where the offender recounts his qualities and good ideas. By doing this, the criminal continues to build up the opinion of himself, which gives him further license to continue with his old ways. Bringing up racism is another way of diverting. The criminal may take the offensive with charges of racism when he has failed to divert people in authority through other means. When confronting offenders, it is important to remember that they will try to divert your attention away from topic being discussed. It is necessary to keep yourself focused, and avoid being led down the wrong path by the offender.

**9) Assent; To Agree To Something:** Offenders often say yes when they don’t really mean it. The offender may use agreement to cut short an argument or discussion and gain points. By agreeing, the offender can make others believe progress has been made. He may agree to rules but not apply or practice them in his daily living. Agreeing to a rule and being guided by it in daily living are two different issues. An offender may be very agreeable to various rules, but not willing or able to actually abide by them in real life. Time will tell if the offender is being true to his word. Over time you will discover if the offender is agreeing to something as a way of controlling you or agreeing to something because he has plans to follow do it.

**10) Silence:** Offenders have a way of keeping secrets from others by using silence. They may try to control a meeting or group by saying nothing. Offenders do not want others to know what is going on in their minds. They tend to view those people who try to “figure them out” as nosy. However, when others try to control by saying nothing, offenders get very angry because they want to know what is in the minds of others. Besides using silence, offenders may also use short sentences such as: “I do not know,” “I do not care,” “No comment,” “I forgot,” or “Nothing happened.” In other words, offenders want to know everything there is to know about others but do not want others to know about them.

**11) Selective Attention and Perception:** Offenders only pay attention to what they want. They tend to ignore everything that is not related to what they want. Offenders have closed minds and hear only what agrees with their way of thinking. Most criminals think that others think as they do. When others try to express opinions that are different from the offender’s, he will tend to belittle that opinion, or make the other person seem less knowledgeable than the offender. It is difficult for people in authority to get the offender to realize something he does not want to. Offenders tend to have their minds made up about certain issues. It is not easy to change their minds.

**12) Total Inattention (not paying attention):** When offenders are not interested in what is being said (which usually happens when they are being told something they do not want to hear), they just make a few nods of the head to make it look as they are listening. Really, they are not listening at all. In the meantime, they turn their attention to more exciting things (usually criminal things). If they get caught off guard by a question about what is being said, they tend to blame the person who is talking for not making their question clear enough.

**13) Tardiness and Missing Groups/Appointments (No Show):** When offenders first begin a rehabilitation program, they often go through a honeymoon period. During this period, they usually make a strong effort to work on their treatment program. After a while, they realize that in order to change, they need to make a long term commitment and effort. Once many offenders realize the amount of work necessary to change, they start giving up on their program. Some signs of giving up are late arrival to treatment meetings, leaving early or not showing up at all. Offenders usually offer phony excuses for their lack of motivation. This suggests that the offender would rather continue being a criminal than working to become a better person. It is necessary to confront the offender about his behavior if he begins to show signs of giving up on his treatment program. The offender should be reminded that in order to comply with parole obligations, he must maintain an active role in his treatment.

**14) Confession:** The purpose of confession is to be responsible for your actions, however that is not often the case with offenders. Offenders often assume that confessing a violation gives them the right to some kind of break from punishment. Offenders typically think that their honesty and confession should result in forgiveness of their crime. Often, a confession does not include the entire truth but rather little bits of truth with the rest of the story left out. Offenders typically confess small infractions to help conceal the major infractions. Offenders believe that by telling you some of their crimes (usually the less major ones) you will forgive them and not require them to deal with their major issues. It is necessary to keep in mind that confessions are often made as ways to manipulate you into believing. The more you know about the behavior patterns of the offender, the better able you will be to help avoid lapse or relapse.

**15) Misunderstanding:** The criminal often uses a perceived or made up confusion, or lack of understanding, as a way of lessening what he will be expected to do. When a criminal says, “He understands me,” he means, “He agrees with me.” When confronted by his failure to perform responsibly, he often claims that there was a “misunderstanding” between him and the confronted. Even when two parties clearly set a time, date, and place for a meeting, if the

criminal doesn't show up, he may claim there was a misunderstanding. In this way a criminal feels that he can excuse his behavior.

**16) Generalizing a Point to Absurdity:** When he hears that he will be required to do something he doesn't like, the criminal takes what is said and distorts it so it is impossible to achieve. He uses this as an excuse not to conform. Someone may point out that because the criminal lacks an education and job skills, he may have to take a job at which he starts at the bottom. The criminal then accuses the person of "asking him to be a flunky the rest of his life." The criminal responds to the strict requirements for becoming responsible by calling a non criminal a "puritan," "robot," etc. This does reflect the criminal's view of what responsibility entails, but is a calculated tactic to make the program's philosophy seem absurd. Discrediting the program offers an excuse to avoid change.

**17) Deliberate Postponement:** There are times when the criminal does not intend to do what is required. He plans to put off duties or tasks indefinitely. This is an unvoiced refusal. This is not postponement for legitimate reasons. It is a chronic delay in doing assignments or meeting requirements in order to avoid the required work. Statements like: "I am not ready yet," "I can't do it overnight," "I have to do things one at a time," etc., are used to "buy time" when he is actually refusing. He then blames the other party for expecting too much instead of confronting his own lack of effort. In this way he shifts the responsibility for his lack of work. Behind this is the criminal's doubt that he truly wants a different kind of life.

**18) Claiming that He Has Changed Enough to Leave Program:** When the criminal is bored, restless, and seeking excitement, he says he's ready to leave and stand on his own feet. Wanting to be a success without effort, he will claim he has "changed" because he has corrected a behavior one time, in one situation, after a lifetime of repeatedly violating. He will claim that this is proof that he has "reformed" and is capable of leading a life free of relapse. The chances for this single change to be carried over to other situations and over time in all area of his life after a minimal attempt at treatment is slim at best.

**19) Putting Others on the Defensive — The Tactics of Attack:** The criminal may become combative and attacks in a many ways. He may be very critical, sarcastic, abusive, etc. Anger is the habitual way in which the criminal tries to achieve control. Nothing will be gained from a discussion with an angry, abusive criminal so he uses this as a way to avoid contact. In programs in which criminals are encouraged to 'vent' and 'open up with their feelings,' a criminal will use this as an opportunity to attack others and verbally assault, claiming that this is a form of "dealing with his anger problem." In fact, it is simply increasing his anger problem by allowing him to disregard the rights of others, as well as attempting to gain control.

## ASSAULT CYCLE

The Assault Cycle is like a spinning circle that occurs when the person behaves in the same way again and again. The circle is linked together like a chain. Each link is a thought, feeling, or behavior. The assault cycle is the list of behaviors or links that lead the offender towards an assault. The assault may be physical, verbal, or sexual. A person can start at any point in the circle. Without intervention from the offender or the safety net these stages eventually lead to relapse.

In this example, five of the stages are followed in order. A description of the thoughts or behaviors of a imaginary sexual offender comes after the name of the stage.

### Stress

James is unable to cope with his job. He feels that his boss is too hard on him. He loses his job after a fight with his boss. This makes him more upset.

### Withdrawal

James feels sorry for himself. He feels that the world is out to get him so he stays away from other people as much as possible.

### Pre-occupation

James has deviant sexual thoughts.

### Plan

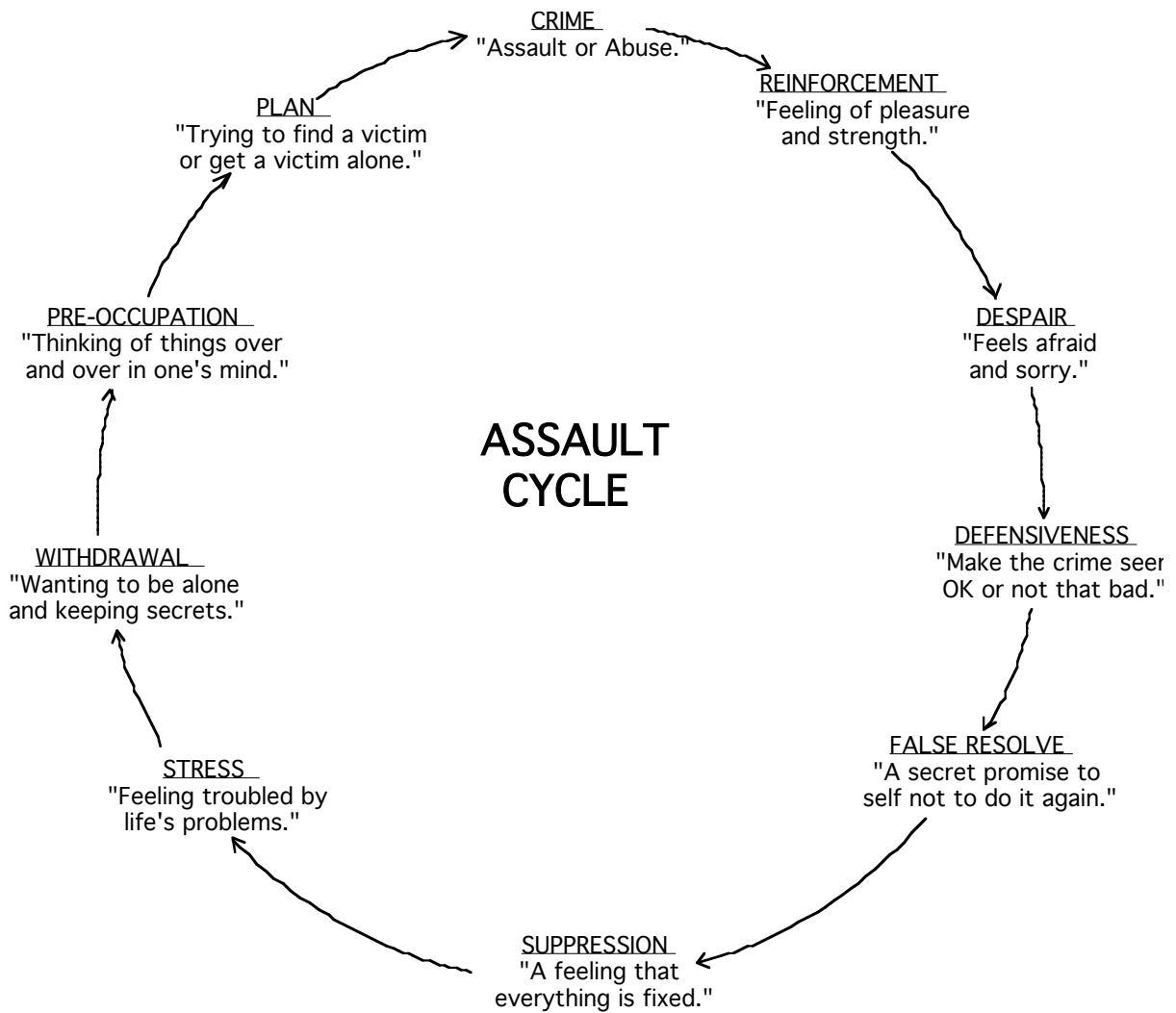
The deviant thoughts continue and James plans how he would do those things he is thinking about.

### Offense

James commits a rape

The offender will continue around the cycle until something interrupts it. That is often the function of the safety net.





## ASSAULT CYCLE STAGES

### REINFORCEMENT:

#### Reward:

Getting something desired that feels good.

(Example: Raping or molesting someone and not getting caught. Getting what is desired and not getting caught helps a person to decide to do it again.)

#### Release:

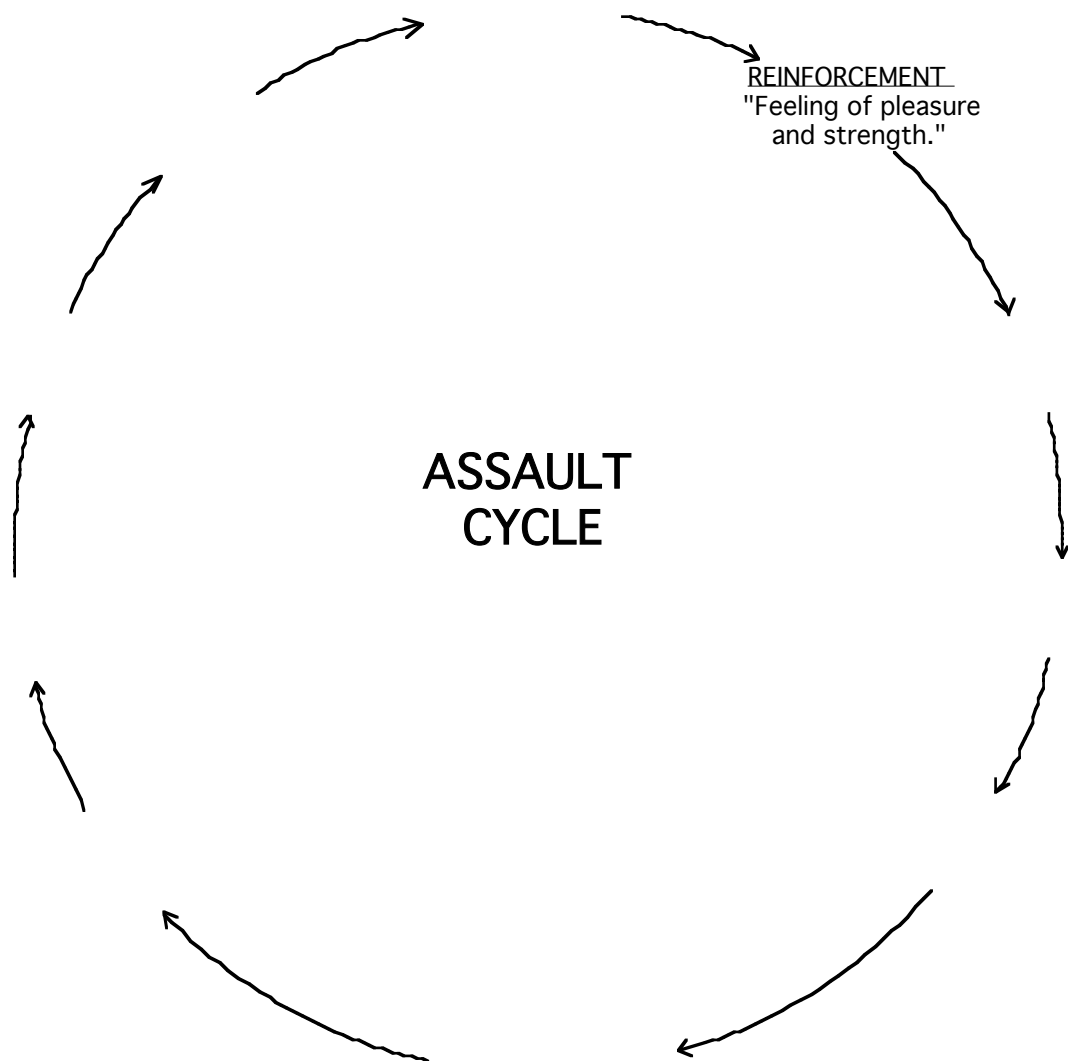
Getting turned on and having the opportunity to reach orgasm. To feel good and temporarily take away tensions or anxiety.

#### Sexual gratification:

Feeling good and “finished” physically after having a form of sex.

#### Emotional/Psychological gratification:

Feeling good about having power and control over the sexual victim. Convincing a person to have sex provides a sense of control of the situation and provides a sense of power.



**DESPAIR:**

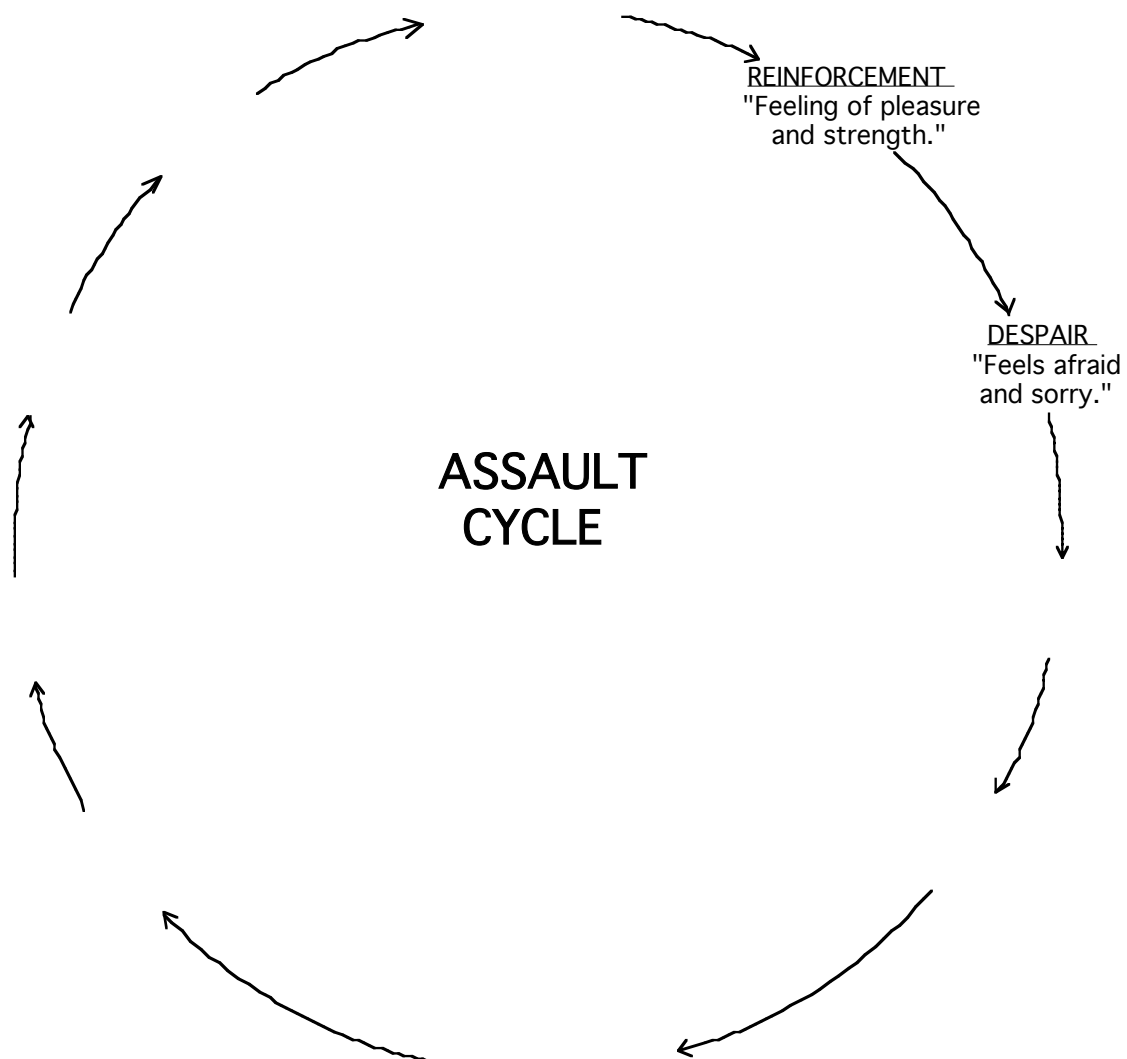
The offender experiences a number of feelings that lead to despair. There may be a passing feeling of guilt or shame related to the crime that was committed. If the person has some degree of conscience, they may feel self-disgust or in extreme cases, self-hatred. Knowing that they have committed a sexual crime and feeling unable to resist their desires, they may feel powerless to stop their inappropriate behavior. They may also experience a loss of self-importance as a result of their guilt feelings.

**Zero State:**

This is an experience of feeling that he is an absolute nothing, a zero; feeling absolutely worthlessness, hopelessness, and futility. His greatest fear is that he is a nothing.

**Fear:**

His fears are widespread, persistent, and intense, especially fear of being caught for something, fear of injury or death, and fear of being put down. These fears can be debilitating to the point of causing despair for the offender.



## **DEFENSIVENESS:**

### Denial:

Not assuming responsibility for your actions. Saying to yourself, “I did not do anything wrong” or saying, “I do not remember,” when you do but do not wish to talk about it, or admit it to yourself or others.

### Lying to self and others:

Telling yourself and others, “I am innocent of whatever charges. I do not know why the state put me in jail. Maybe the state troopers do not like me.” Or lying to self by saying, “I should never have pleaded ‘no contest.’ I would not be in jail if.....” Again, not assuming responsibility for your actions causes lying to yourself or to others.

### Minimizing:

Making the whole story of your crime “short and sweet.” Saying things like: “It was really nothing. I just touched the child for a few minutes. I didn’t hurt her or him. She had been molested before and asked for it. People do that sort of thing all the time. It was no big deal.”

### Justifying:

This ties in closely with minimizing. You minimize to justify your actions. “I was drunk when I committed my crime. My victim wanted me to do it. I just did it to please him or her.”

### Other examples of justification statements are:

I did it with my victim because I was having problems with....

I had been smoking grass and felt high.

I did it to show my love and how much I care.

People had sex with me many times when I didn’t want it, so I can do it to others.

I was molested as a child so that is why I did it.

### Sometimes justification is in the form of feeling rage at being charged for a crime:

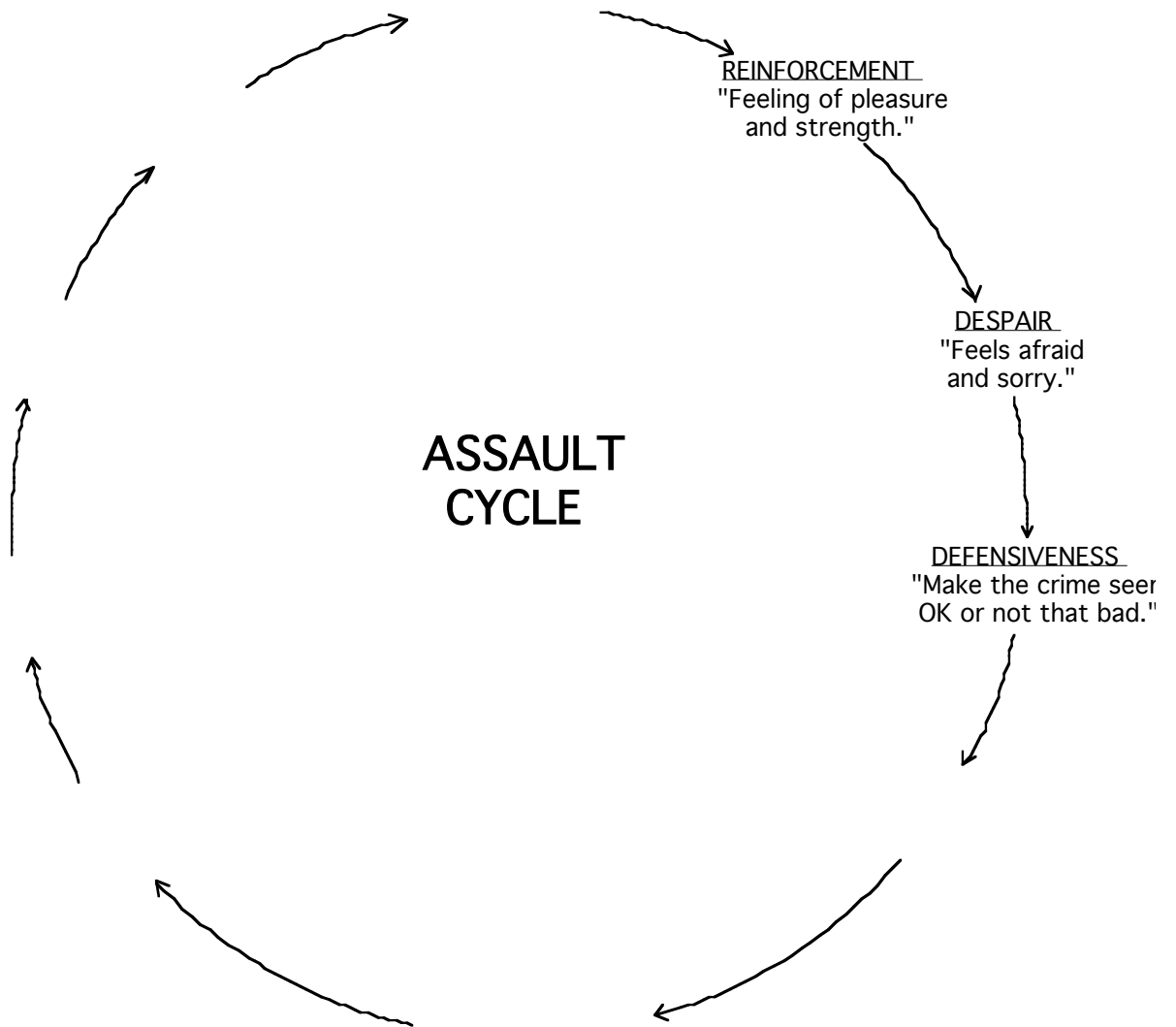
I have not done all the things they accused me of doing.

I would like to bust the head of the DA for accusing me of such things—I could not have done such an awful thing.

### Playing the victim is another way of justifying:

I feel I am the victim here since I am being charged like this.

I am the one in jail. I have been humiliated, lost my job, wife, etc. No one understands. (Poor Me).



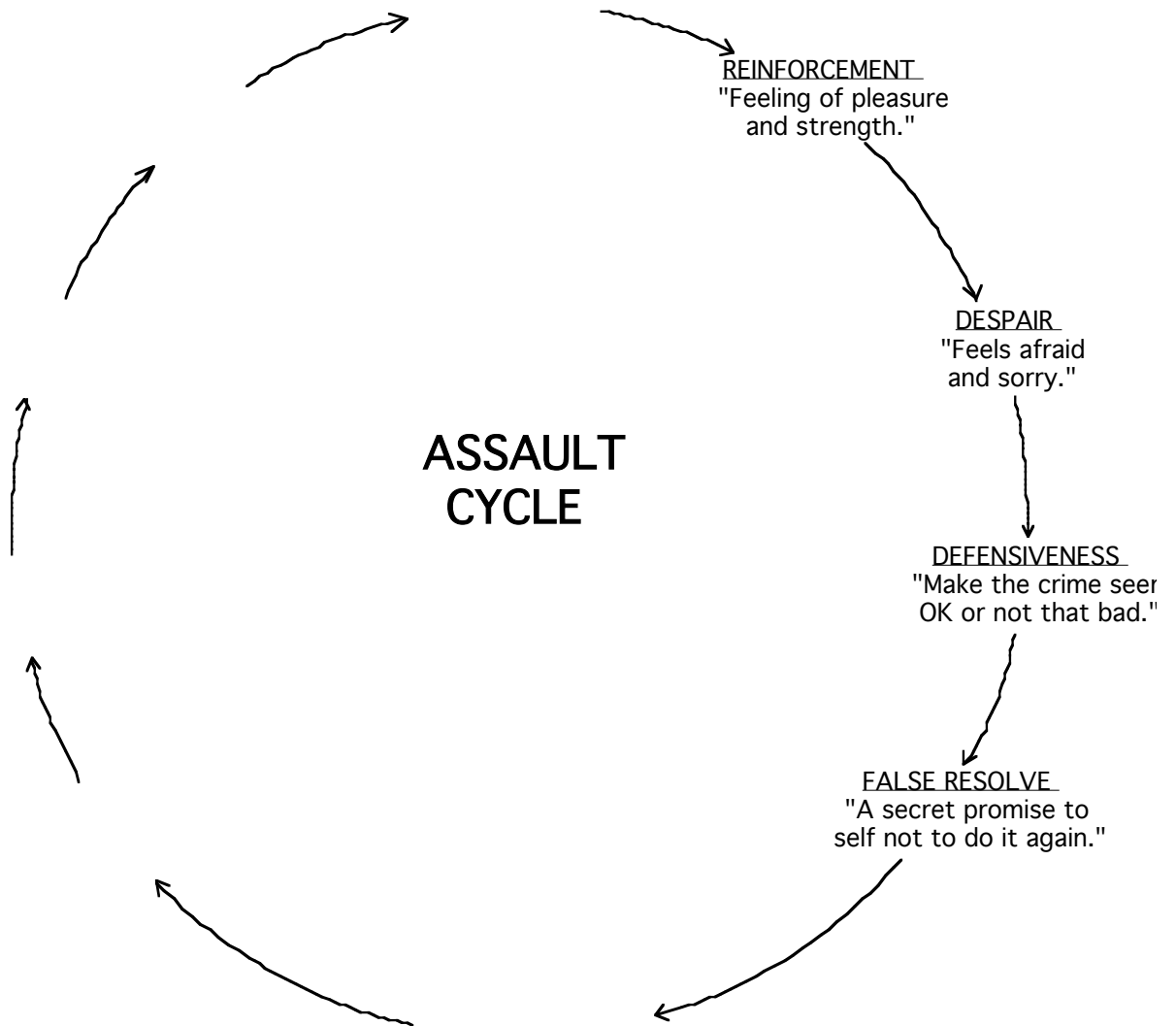
**FALSE RESOLVE:**

Here the offender says: "It will never happen again, I have learned my lesson, all I have to do is think about being in jail." Some offenders say they have a "religious conversion," state they have "found God," or "gotten saved." Actions speak louder than words. Secret actions continue and the offender tries to get away with things. They may fail to follow the rules of prison.

**Superoptimism:**

Everything is going to turn out well. I will never do anything wrong again.





## **SUPPRESSION:**

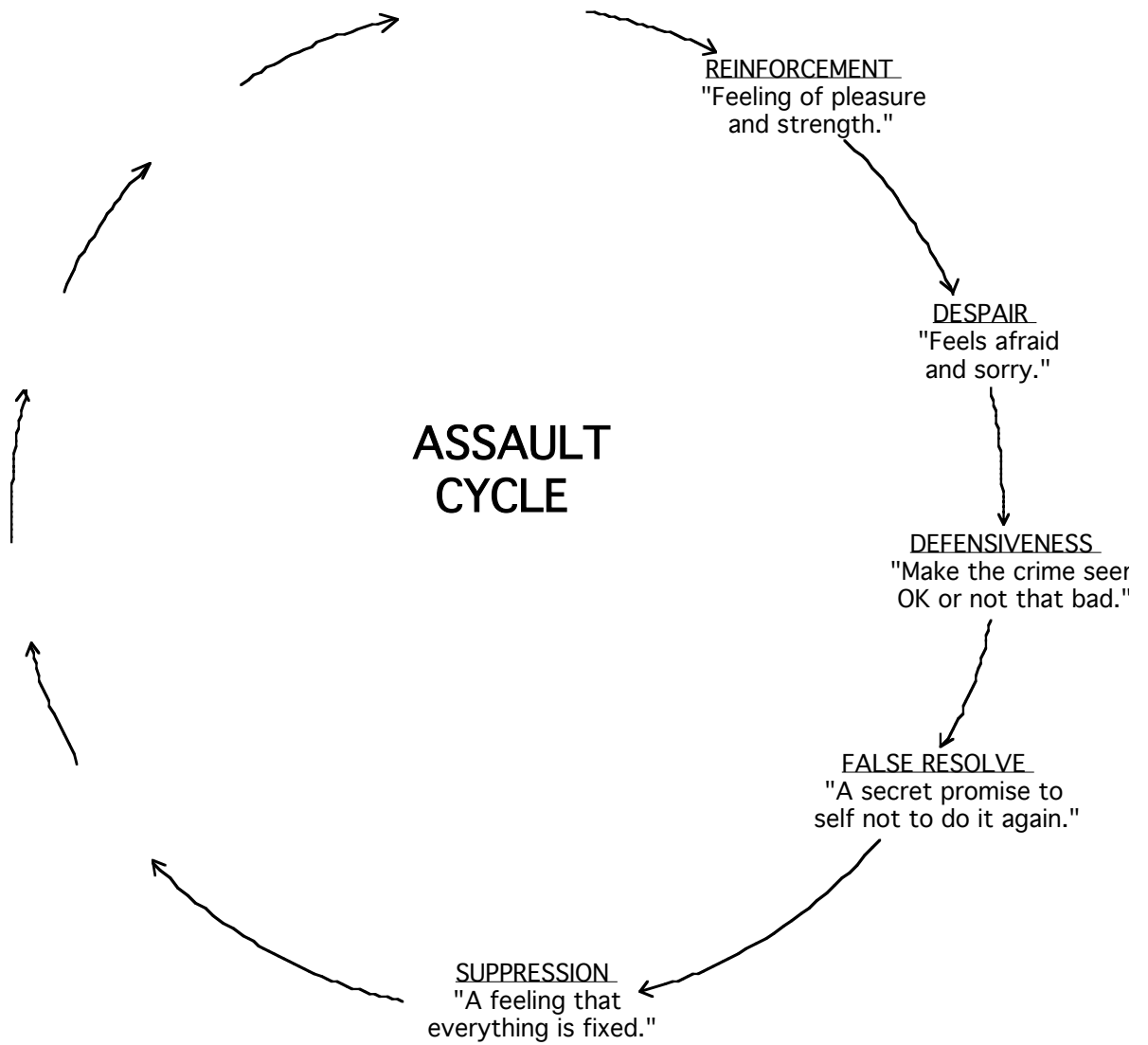
“Everything is OK. I am a decent person.” The offender tries to forget about the crime and pretends it never happened. He does not think of the victim or of the crime.

### Forgetting:

The offender will try to forget his crime. Often, this will involve the use of drugs and alcohol to help him forget. By being drunk or high the offender keeps himself from thinking of the crime and lessens its impact on him.

### “No one will know.”:

The offender believes that his crime is hidden and that no one will find out what happened. He believes that his crime was so well planned and completed that no one could possibly know.



## **STRESS:**

### Failure to cope with common situations:

Examples of common situations include the loss of a temporary job, paying all bills timely, making decisions about things that happen to most people and doing everything that is expected that is not out of the ordinary.

### Failure to cope with uncommon situations:

The person is unable to handle unexpected bad things in life like the death of a loved one (wife, child, parent). Another example is losing a job you have had for a long time and thought you would have for the rest of your life. Another example is losing a home or other property unexpectedly by fire. The person is not able to ask for help when help is needed or not willing to receive and accept help when it is offered.

### Struggle to live a double life:

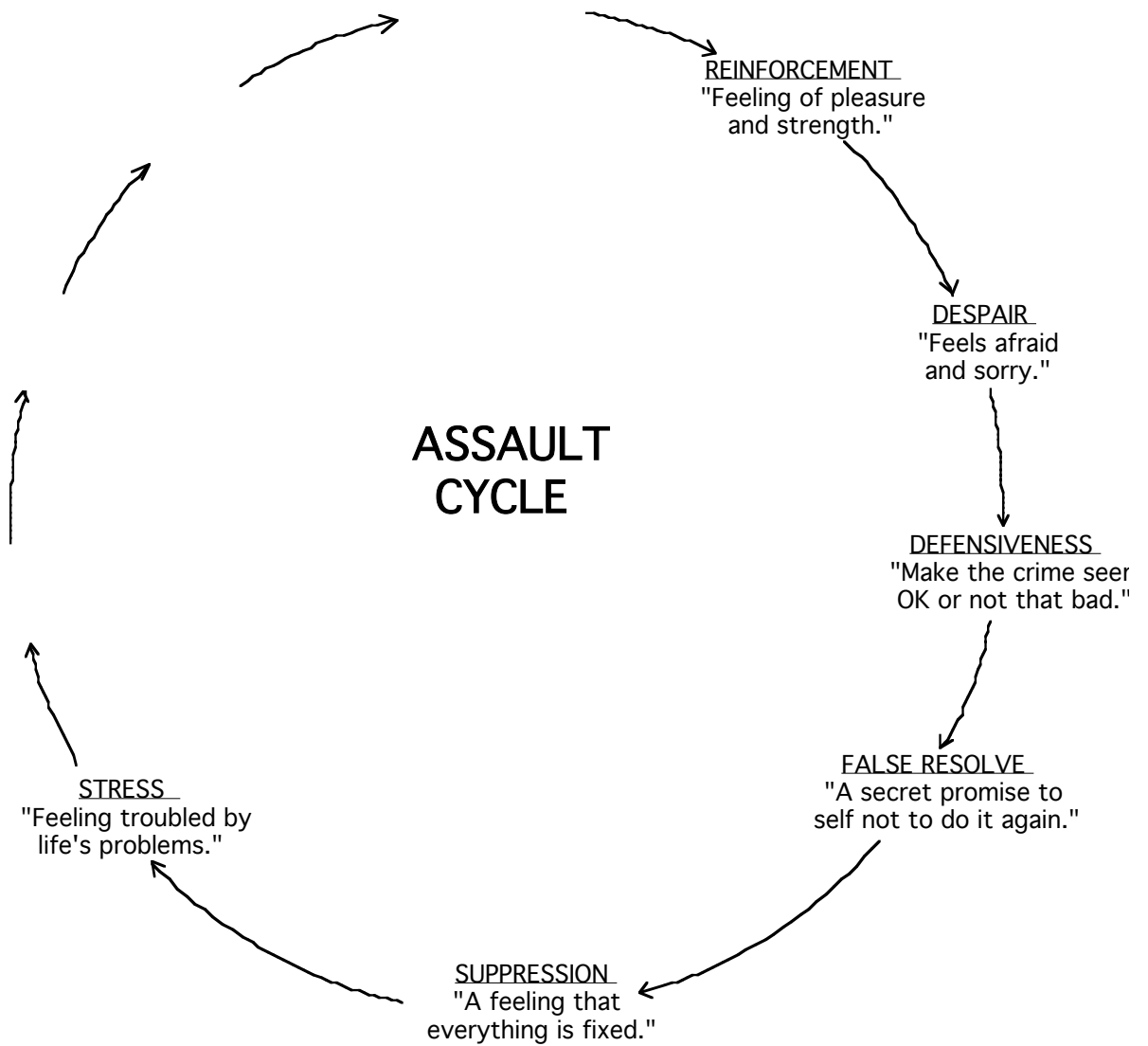
The person pretends that they are like any other person while at the same time knowing that you are not. Doing secret things they know they should not be doing (like committing crimes) while in front of family and friends and others showing your self as a “nice” person.

### Uncontrolled emotions:

Anger is especially vulnerable. Not being able to control yourself or your behaviors causes impulsive behavior. The more angry a person gets, the less control they have over themselves.

### Letting problems build up:

When problems are kept inside and a person thinks about them often, they blow them out of proportion in their mind. Not talking and getting problems out causes more and more stress.



## **WITHDRAWAL:**

### Secrecy:

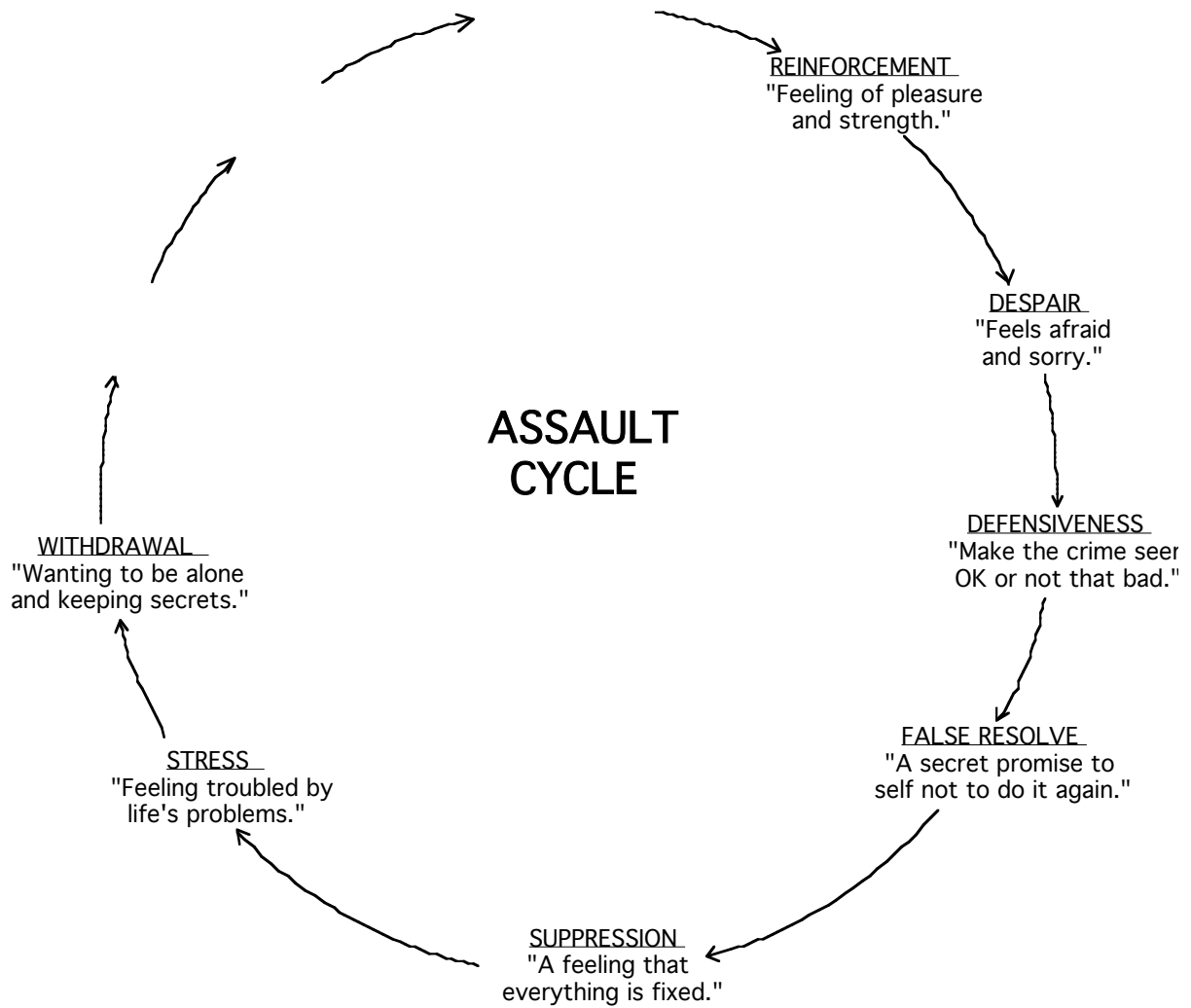
Secrecy = power. He does not give out information about himself. He is not receptive to challenges to his perspective. He does not hear what he does not want to hear.

### Lonerism:

The offender leads a secretive life, "One against the world." He feels he is apart from others even if he is socially active. Although he voices sentimentality, he is never too close to anyone that he can't get up and go at a moment's notice if something more exciting comes along. He is willing to risk relationships by committing crimes, going to prison, etc.

### Self-Pity:

The offender will use self-pity - "poor me" - as an excuse to avoid contact with people. He will use his feelings as a way to remove himself from social interaction to sulk.



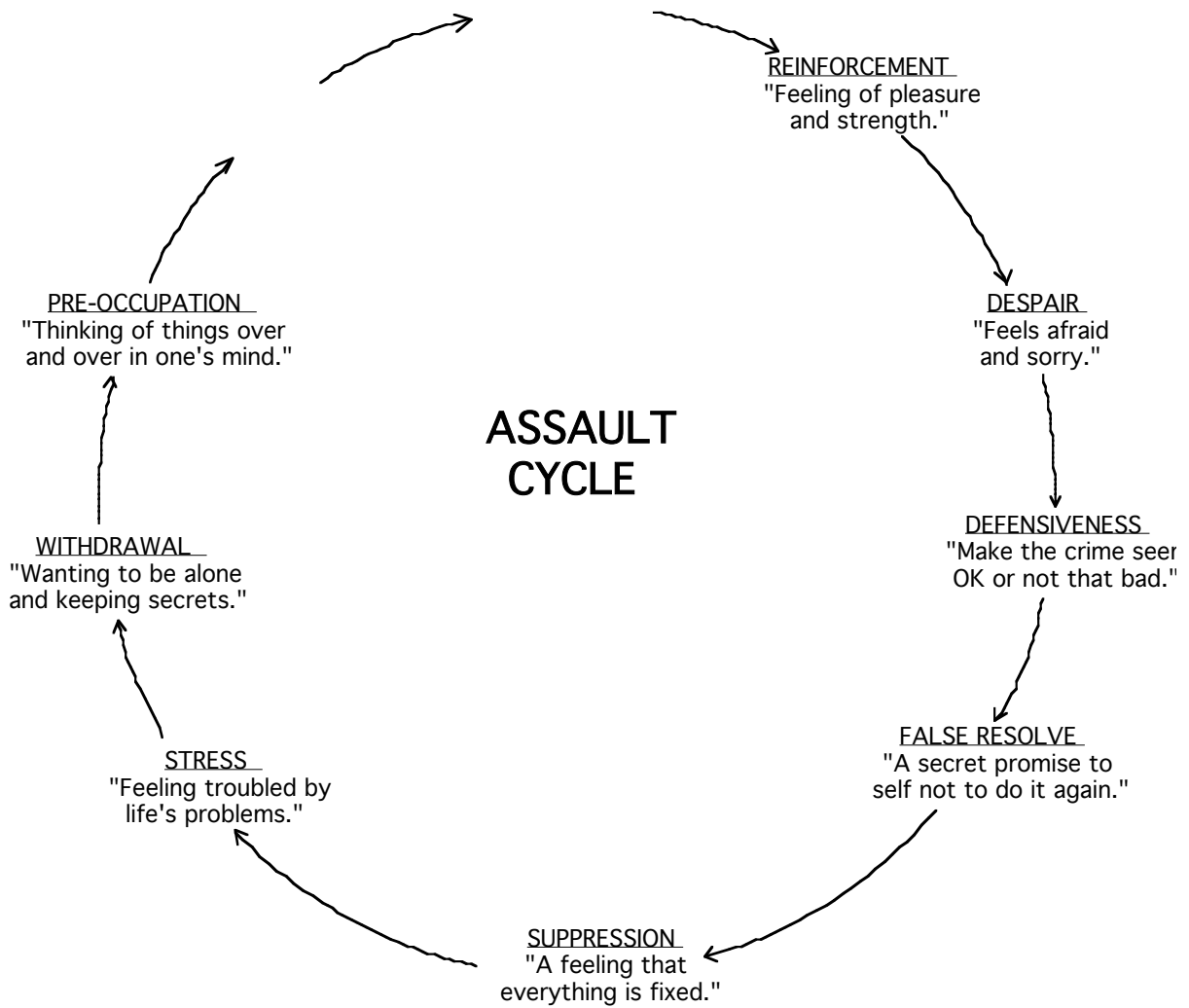
**PREOCCUPATION:**

The offender demonstrates a number of errors in thinking about sexual situations. These include: seeing people as objects, fantasies of revenge, involvement with deviant masturbation, pornography, strip shows, prostitution, nudism, “swinging,” promiscuity, affairs, cruising, etc...

**Deviant Sexual Fantasies:**

All encounters, people and situations may be thought of sexually. His fantasies include rape-like behaviors involving abuse, power, and control. His sexuality is motivated by forcing his will on someone through violence, force, intimidation, or manipulations of all kinds. “Victory” is essential and the “partner” is a possession. The offender exhibits an obsessive search for sexual stimuli.





## **PLAN:**

### Selecting:

Picking or choosing your victim.

### Grooming:

To get the victim ready for the assault. There are many ways to do this such as: buying them something, treating them nice, giving them compliments. It is anything used to get them to like you and trust you so you can do what you want to them.

### Ritualization:

Following the same steps over and over again. You use the same method each time you commit an offense. You fantasize about committing a sex crime like you had done before. Because you got by with it in the past you repeat yourself exactly. You pick someone up, buy them a drink, take them for dinner, and then have sex, either willingly or by raping. It is the same pattern over and over.

### Stalking victim:

Searching for the right victim at the right time. Following your victim, watching every move he/she makes just so you can take them when you want them.

### Setting up self:

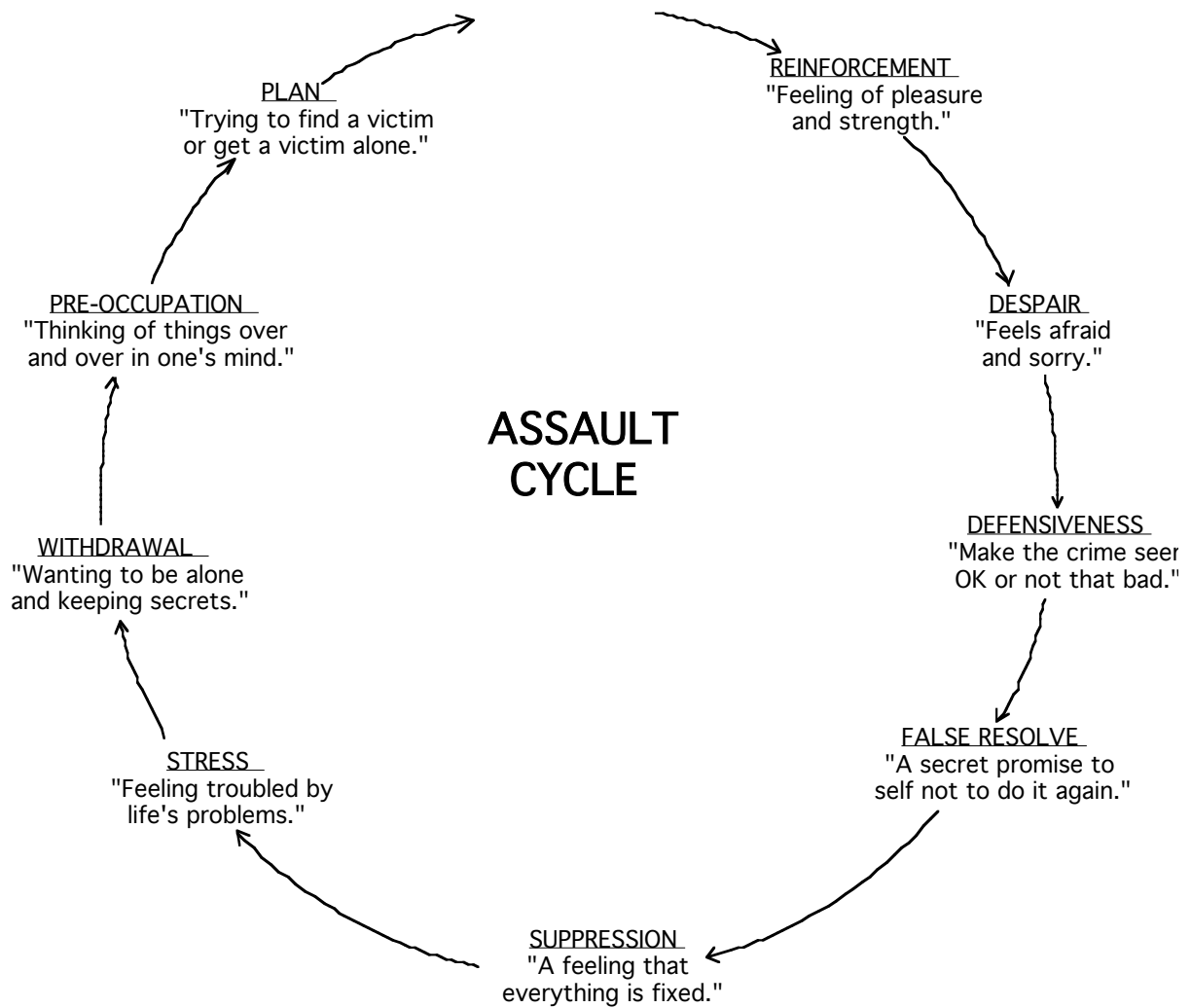
Putting yourself in a situation where you will have the opportunity and courage to act out on your inappropriate sexual fantasies. Going to bars and having too much to drink and taking drugs are examples.

### Looking for the opportunity, time, and place to commit the offense:

Trying to figure out the best time and place to commit your offense so that no one will see you.

### Rehearsal:

Thinking about how you are going to commit your crime and picturing in your mind how it is going to go. Practicing it step by step so that your plan will work and you will be able to get by with it.



## **CRIME:**

### Exhibitionism:

Showing your privates; flashing and getting a kick out of it. (Flasher).

### Voyeurism:

Getting turned on by watching other people undress, touch each other, have any kind of sexual contact, or looking at someone else's private parts. (Peeping Tom).

### Obscene Phone Calls:

Getting turned on by "Phone Sex."

### Harassment:

Making verbal or suggestive advances to another person who does not want to be bothered. Trying to "hit on" someone over and over again, when he or she has already told you to stop.

### Frottage:

Bumping or rubbing another person and getting excited by this behavior.

### Molestation:

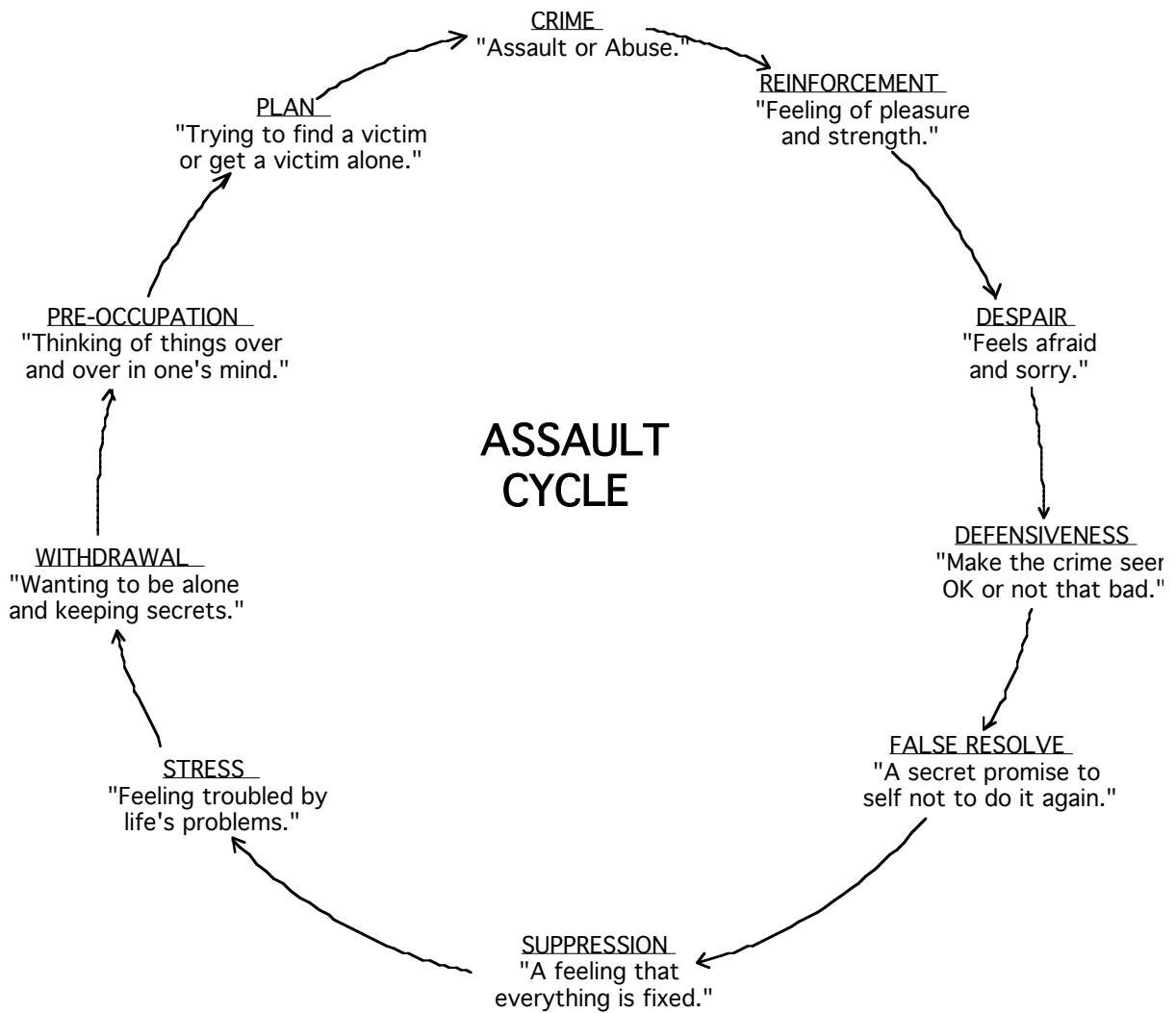
Touching another person to get turned on. Touching the private parts of a minor child.

### Rape:

Have sex with another person who does not want it. Rape is any form of penetration (including vagina, mouth, anus insertion) with a person who is not consenting.

### Violation of the Rights of Others:

Doing anything to another person who is a minor, even if they consent, or to any person when they do not want you to do it. (In the eyes of the law, minors are not old enough to give their consent.)



## RISKY THINKING, NOT DISEASE

A sexual offense is the result of errors in a person's thinking. Sexual abuse is not a disease and therefore cannot be considered treatable or curable. It is necessary to think of sexual offense as a series of errors in thinking that lead the offender to make a series of decisions which lead to lapse or relapse. These decisions can be considered thinking errors. Thinking errors lead to feelings, then feelings lead to dangerous behaviors. Thinking errors must occur before the actual offense takes place. By realizing that the sexual offense is the result of engaging in a series of behaviors, the idea of intervention (stepping in to stop the behaviors) can more easily be understood.

Sexual offense does not "just happen". The offender must break through or get over some barrier that under normal circumstances prevents people from committing sexual offenses. For many reasons, these barriers are not strong enough to keep the offender from engaging in relapse behavior. It is therefore necessary to strengthen these barriers through intervention. In order for the Safety Net Team to be helpful in assisting with intervention, it will be important to understand the steps that lead people to break through their barriers and ultimately commit sexual offenses.

The preconditions that must be present for a sexual offense to occur can be divided into four categories: 1) **Motivation**, 2) **Internal Barriers**, 3) **External Barriers**, 4) **Victim's Resistance**.

**1) Motivation** is the first precondition and is defined as a desire on the part of the offender to molest a child or rape another person. It is something within the offender that makes him want to commit a sexual offense. For most sexual offenders, the motivation is their sexual urges, fantasy, or thought. Not every urge, fantasy, or thought, however, is a motivation that leads to a sexual offense. It is possible that an offender can have urges, fantasies, and thoughts that lead to intervention and not offense. The offender must overcome other barriers that also stand in the way of offending. There can be many reasons the offender develops the motivation to break through the barriers that lead to offending. The motivation may have developed because of emotional needs, experiences of sexual arousal, or by the blockage of normal sexual expression.

**Emotional Needs** can increase the motivation to offend, and lead to a breakdown of the barriers. Many offenders have a need for power and control. Some offenders relate better socially with children. It is also possible that the offender feels emotionally young or lonely and does not feel comfortable with people his own age. Additionally, the offender may feel insecure about himself and be afraid of rejection. He may feel angry and take the anger out on others. Any or all of these factors can contribute to the motivation that breaks through the barriers that lead to sexual offense. It is possible to introduce intervention at this stage, thus strengthening the barriers and stopping an offense.

**Sexual Arousal** can also lead to breaking down the barriers. The offender may be motivated to offend because he has sexual urges toward children. This may have happened as a result of the offender being molested as a child, having told no one, and the person who molested him was never caught. An experience such as this might have taught the offender that sex with children is safe because you do not get caught. It is also possible that the offender who was molested as a child, tried to stop feeling powerless and helpless about being molested by putting himself in the role of the abuser. It is also possible that the offender had early sexual experiences that were arousing and exciting. In an effort to recreate that satisfaction and reward, he continues to have sexual contact with children. In some cases, sexual interest is formed as a result of exposure to pornography.

**Blockage** happens when the offender had normal sexual urges but something stood in the way of being able to express them normally. For instance, the offender may have been brought up to believe that masturbating is immoral or wrong, and the only way to meet sexual needs is with a partner. The offender may be too shy or insecure to risk getting involved with another person, and may feel safer having a relationship with a child or a total stranger. It is also possible that the offender does not have good social skills (interactions with people) thus feeling awkward in relationships with other people. This awkwardness may have played a part in blocking the offender from expressing his sexual feelings normally.

**2) Internal Barriers** are the things we tell ourselves that keep us from hurting others. Once an offender has the motivation to commit a sexual offense, he has to convince himself that he should commit the offense. To convince himself of this, he has to get past his fear of getting caught. He has to decide that the victim's feelings do not matter, and ignore the fact that he knows it is wrong. The offender's desire to commit an offense has to be stronger than his conscience which tells him that he should not do it. These internal barriers are strong in most people, however, in sexual offenders they are usually very weak.

All people talk to themselves inside their own minds. We make silent comments and observations about the world around us, how we feel and what we think. Certain kinds of mistaken self-talk breaks down internal barriers against offending. The offender may have told himself that he was so smooth, cool, and smart, that he would never get caught. He may have told himself that he is so angry that he had a right to take out his anger on anybody who was available by forcing them to have sex. If the offender is under stress (where everything seems to go wrong), or depressed, he might have told himself that it did not matter what he did, or he did not care what happened. It is possible that the offender understood how harmful sexual abuse was to those who were victimized. This can happen when the offender has also been a victim, such as having grown up in a family with other sexual offenders and victims. It is likely that such an offender did not learn what normal sexual boundaries are, thus leading to a break down in his own normal internal boundaries against offending.

**3) External Barriers** need to be overcome by the offender once he has decided he wants to offend and that he will offend. To overcome this barrier, which leads the offender closer to relapse, he has to find a way to do it. In order to engage in a sexual offense, the offender has to get a victim alone and make sure no one is watching for a long enough time to commit the crime. External barriers are very important because the offender can have the urge and make the decision to offend, but cannot do so without access to the victim. Building up external barriers is a big part of intervention. This is also where the treatment team and individual offender can have a lot of control over.

In order to gain access to a victim, the offender must first make several choices. For instance, the offender may volunteer or be asked and agree to baby-sit, he may go to the playground where little children play, he may go to a park and watch for potential victims, or a number of other things which put him in contact with potential victims. By avoiding such contact the offender is making a conscious choice to walk away from temptation. Sometimes the offender is unable to make such a choice, and the treatment team can make the choice for him, thus introducing intervention and assisting to avoid relapse.

For sexual offenders, it is a lot harder to offend when they stay away from potential victims. Although this is one of the simplest steps in relapse prevention, it is often the step most difficult for the offender to take. It is almost as if the offender wants to prove that he is cured by subjecting himself to the temptation to reoffend. Remember that sexual offense is not a disease and therefore cannot be cured. That is why it is important for the offender to avoid situations that put them at risk for offending. The sexual offender will never be cured, he may however, be able to manage his thinking errors to avoid relapse.

Managing thinking errors is a lot like kicking an addiction. People who are trying to quit smoking, for example, will have a more difficult time if they hang around cigarette machines. In fact, they would most likely start smoking again. However, by avoiding exposure to cigarettes, thus avoiding temptation, the person who is trying to quit will be much more successful. This is also true of sexual offenders. By avoiding tempting situations, the sexual offender will be less likely to break through the barriers that can keep him from reoffending. The building up of barriers takes planning and thinking ahead. It is necessary for the offender to make life changes so that he will have fewer opportunities to reoffend. The treatment team can assist him in making these changes, thus lessening the chance that the offender will engage in behaviors that lead to lapse or relapse.

**4) Victim's Resistance** is another barrier that the offender must break through before committing an offense. This is accomplished by giving the victim candy, threatening the victim, making the victim feel sorry for the offender, or forcing the victim to do what the offender wants. Offenders become very skilled at picking victims whose resistance they can overcome. For example, some offenders pick victims such as very young children, who will be easy to offend against and who will not be able to tell anyone about the offense. Offenders tend to find victims who they can overpower, thus breaking through the barrier of resistance, leading to sexual offense.

The four preconditions can be considered a blueprint for how offenders commit their sexual offenses. It can also be viewed as a blueprint for providing intervention by assisting the offender to recognize which of their barriers are weak, and helping them to build them up. By assisting the offender to build up all of the barriers, it is hoped that at least one of them will become strong enough to prevent the offender from committing a reoffense. It is also important to remember that intervention can take place at any point before relapse. Therefore, many of the behaviors that the offender must engage in before actually offending can be redirected.

Assisting the offender to change his way of thinking and thus building up the barriers that keep him from reoffending is not an easy thing to do. Most offenders try to avoid change and therefore resist attempts by others to help change their behavior. The resistance is often manifested as thinking errors. Thinking errors are one of the main differences between those who commit sexual offenses and those who do not. The offender will most likely engage in specific tactics to avoid taking responsibility for his own actions and thus creating change in his behavior.



**INSTRUCTORS SYLLABUS  
INTRODUCTION TO RELAPSE PLANNING  
SEX OFFENDER TREATMENT PROGRAM  
HILAND MOUNTAIN CORRECTIONAL CENTER  
(Background information for instructors)**

CLARIFICATION NOTE: The following material is used at the Hiland Mountain Correctional Center as the Instructors syllabus in teaching Relapse Prevention to Sex Offenders. Approved Treatment Providers within the State of Alaska are encouraged to research the literature and individualize this topic as is appropriate for the local area and offenders. The extent of knowledge on Relapse Prevention with respect to sex offenders is rapidly expanding and should be continually reviewed.

**INTRODUCTION**

Relapse Prevention is a self control intervention program that an individual can use to anticipate and intervene in order that a problem behavior is not repeated. Relapse is defined as reverting or sliding back to old behaviors that are not healthy for the individual. It was originally developed for individuals with a substance abuse problem and has been successful in helping individuals who struggle with addictive behaviors such as gambling, weight loss, and sexual deviance. Relapse occurs when the attempts made by the individual to change or modify a target behavior breaks down. Relapse Prevention has two main purposes: 1) identifying the events that lead up to the deviant behavior and 2) determining the processes that are operating which cause the individual to move toward relapse. (Gordon & Marlatt, 1989). The prevention of relapse is a program that combines behavioral arrangement skills with cognitive processes to “intervene” and thereby modify the specific behavior that has been targeted.

Sexually deviant behavior is defined as any inappropriate sexual behavior that involves non-consenting partners (this includes partners under the age of 18 years old or individuals judged by the Alaska Court System as being adult but unable to be responsible for personal decisions), or behaviors that present a danger to the individual or others, and as defined by Alaska Statute. Sexual deviancy can be thought of as an addictive behavior that can be treated with techniques similar to those of other addictive disorders. In such disorders the focus is not to “cure” or remove all temptation, but to develop ways to manage and cope with the ongoing sexual desires, to teach the individual to be responsible to internal and external stressors (Salter, 1988).

The Sex Offender Treatment Program used by D.O.C. suggests that two conditions are present for an individual to commit a sexual offense. These include the individual developing a deviant sexual attraction or desire and a process of thinking that allows for him to act on a desire that he knows to be unacceptable and criminal. The Sex Offender Treatment Manual also suggests that a sex offense is not an isolated event, rather the result of a long term style of thinking and acting in ways that are distorted and in error.

The Treatment Manual also states “...over-emphasis on the “why” question can detract the offender from the work involved in changing by providing an opportunity to “excuse” his behavior by blaming parents, early life situations, cultural or family background, etc.” The desires within an individual for sexually deviant behavior and distorted thinking should not be viewed as a “disease” that can be “cured”. The only prescribed medicine for deviant desires and distorted thinking is for the individual to engage in a new system of thinking wherein the offender chooses to manage inappropriate sexual desires by eliminating the deviancy and to correct the series of distorted thinking errors. It is difficult to learn and apply these new skills. It is also difficult for the offender to begin to assume responsibility for his behaviors. This is

especially true when the offender has spent such a large portion of his life thinking in concrete terms that are self-serving, through obtaining control over others. The primary point in the change process is that the offender must want to change and desire to abandon the deviant desire and distorted thinking.

Throughout the United States a variety of treatment approaches have been used to offer intervention and treatment for sexual offense. Approved Treatment Providers are encouraged to maintain a review of the literature which will allow for the development of an aftercare program that is applicable for the community and individual offender. The Sex Offender Treatment Program at Hiland Mountain Correctional Center employs a treatment model that accounts for the etiology or stages of development and causation for the inappropriate sexual behavior.

The program for working with sexual offenders in Alaska is organized around a particular clinical model. This model suggests that the sex offender thinks in a very “concrete” manner. This means that the way in which the offender thinks interferes with the way in which information is processed in the higher cortical functions of the brain. This style of thinking leads to a series of cognitive distortions or errors in thinking. The series of thinking errors or distorted thinking adds together to alter the way in which the offender views the world around him and his relationship with others in society.

The process of faulty or distorted thinking is what interferes with the contextual formation and organization of attributes which require social judgment such as: Character (the moral structure of an individual); Identity (who and what we think of ourselves); Psycho-sexual development (the thoughts and feelings an individual has about their own sexuality); Self-regulation (the ability of an individual to control their thoughts, feelings, and behaviors); Insight (the ability of an individual to understand and learn from what is actually happening within their thoughts, feelings, and behaviors); Empathy (the ability for an individual to understand and feel for the thoughts of grief and feelings sorrow of another individual).

The Sex Offender Treatment Program at Hiland Mountain views offenders as displaying a one sided mind set. A onesided mind set is defined as a style of thinking in which an individual thinks and processes information with the view that one’s self is the center and object of all experience, followed by behavior that is in accordance with the perception that the individual’s thought process is valid and at the exclusion of all others. This style of thinking leads to an increase in desire to look primarily for self satisfaction and results in attributes of jealousy and selfishness. As a result of not viewing “both sides” of a problem, the individual obtains a distorted picture of the conditions of reality and what behaviors society expects from all members. The one-sided mind set can be viewed as a variable that is demonstrated early on in the individuals life experiences and would have import in the formation of the personality.

In using a one sided mind set, the offender makes choices that state “I want what I want, when I want it, and how I want it”. The offender may use this approach to life for many years without being required to consider the thoughts, feelings, or rights of others. The one sided lifestyle breaks down when the individual encounters groups within society such as the public school system, the police, or the court system that will not allow the one sided approach to life to continue. The individual is expected to accept reality: The world is two sided and the rights of the group are generally more important than those of the individual.

Sexual Offense occurs when two conditions are present. The individual approaches life with the one sided mindset that the wants and desires of the offender are more important than the victim and the offender experiences a deviant sexual attraction for the victim.

## THE MODEL

The Alaska Department of Corrections endorses a Relapse prevention model for the treatment of sex offenders. Treatment Providers are encouraged to develop and implement a Relapse Prevention Model as future studies and literature expand. The model endorsed by D.O.C. uses the material of Freeman-Longo, Gordon and Marlatt, Marquis, Pithers, and Atrops.

The model is based on the philosophy that although there is no cure for sexual deviancy, all offenders are capable of change and that sexually deviant behavior can be controlled. Control is obtained when offenders acquire certain skills which aid them in recognizing the distorted thinking errors, that lead the individual to the implementation of a series of tactics which have been used to avoid change, through an assault cycle, and through various high risk situations and lapses (short term departures or breaks) to a relapse or return to a criminal sexual offense. As the offender learns the steps within his own individual relapse plan, true correctives can be employed that will result in alternatives to sexual abusiveness. The focus of treatment is to offer a larger number of appropriate coping responses that the offender can use to manage and control inappropriate thoughts, feelings and behaviors.

## THE RELAPSE SEQUENCE

The completed Relapse Sequence is a chronological listing of approximately 8 to 12 primary events that are described in detail on the Relapse Prevention Plan. These events are situations that cause the offender to perceive a loss of personal control or a lack of balance in his lifestyle. The sequencing of the events is crucial in that when the offender experiences the event, distorted thinking is applied to interpret the situation, and “false” or inappropriate correctives are applied. When the false corrective, which is based on distorted thinking, does not work the offender moves towards the next major event. The events progress and include the areas of Negative Affective State, Personal Immediate Gratification, and Abstinence Violation Effect, and result in the relapse to sexual offending.

These events that cause an imbalance in lifestyle can be thought of as major high risk situations and are the major topic headings in the Relapse Plan. The Relapse Sequence is developed in order that the Offender can have an abbreviated version of the Relapse Plan of only a few steps.

## THE RELAPSE PLAN

A Relapse Prevention Plan is built upon a foundation of personal history and developed in several distinct stages. The personal history includes information concerning the demographics, constitutional factors, developmental history, and history of offense(s). Treatment involves looking at the characterological structure used by the offender. The model focuses on the core of the personality.

The first stage is to be accomplished while the individual is in the Beginning Stage of treatment. The plan focuses on the chronological sequence of major events that created a life style imbalance for the individual and led to the instant offense. The details and sequencing of these events is critical in that the best predictor of future behavior is to examine the causes for the behavior in the past. History repeats itself. These events are to be identified and then arranged in a sequence that leads towards the offense. Each high risk event has specific cognitive distortions associated with it that should be identified. Alternative approaches are to be developed that focus on correct thinking and true correctives. Offering a larger number of appropriate coping strategies that the individual can employ to decrease the level of deviancy provides the offender with choices other than re-offending. The offender is encouraged to develop cue cards that can be used to practice the correctives to a specific target behavior. Practicing, reviewing, and updating the coping strategies will help the offender to be able to

perform the intervention through routine practice rather than using complex operational thought. This is particularly important when the individual is experiencing anxiety or panic.

The second stage in the development of a Relapse Prevention Plan is accomplished in the Intermediate Stage of treatment. The offender identifies problem areas that occurred earlier in his life that contributed towards the general sense of life style imbalance. These problem areas are the events occurring in the family of origin, the offender's immediate family and relationships, school, work, finances, and time management. Again the distorted thinking errors, tactics used to avoid change, and the assault cycle are to be identified and interwoven with the Beginning Stage Plan.

While in the Advanced Stage of treatment the offender further develops the coping strategies and strengthens his correctives through identification of coping behaviors, proactive behaviors that can be implemented, and management conditions that support group members can use. In speaking of coping behaviors and correctives it is common for offenders to speak in terms of saying "No" to situations without finding events to which the offender can say "yes". Proactive behaviors offer the opportunity to exercise choices that address the issue of immediate gratification. This is accomplished through use of the plan on a daily basis and working with role plays and guided fantasies to implement the corrective techniques and look for areas that are weak and in need of improvement.

Many offenders have difficulty recognizing the difference between stress and negative consequences. Stress can be thought of as an external factor that an individual has little, if any control over (such as the stress of traveling a long distance when the weather is very inclement). A negative consequence can be thought of as something that occurs internally, that the individual could have chosen to control and control responsibly, and the individual must now face the negative consequence (such as choosing to drink alcohol, then choosing to drive a vehicle, receiving a citation from a police officer, and the individual must now "pay" a negative consequence) for the choice. This concept is fundamental in that there are more things occurring before, during, and after the offense than "just the sexual event" or "just the alcohol". Major life stressors such as thinking only about self, viewing the world in a very one sided way, an absence of social skills, under-developed and unapplied coping responses, undisciplined abuse of mood and mind altering substances, prior criminal activity, chronic under employment, financial dilemmas, marital discord, inability to resolve conflicts, or prior victimization are examples of "stressors" that an individual can control. Each of these events are critical in the life of any individual.

The philosophy of program asserts that in addition to stressors such as those listed, the individual offender (with rare exception) has experienced life in such a way that many of the characteristics of a personality disorder are displayed. Unless the personality disorder can be clinically ruled out, the relapse plan should be developed upon the tenets of how this individual personality manifests itself in the terms of the major life stressors.

It should be noted that while in the Beginning Stage the offender was required to obtain and maintain control of deviant arousal as measured by a plethysmograph device. The plethysmograph can be used to help the offender to recognize the level or percentage of arousal that he perceives he is experiencing and then comparing this perception with what the device actually measures. One component of the relapse plan should include recognition of the affective, cognitive, and behavioral cues and correctives that the offender learned to use to maintain control of the deviant arousal. The offender can use the knowledge of what the manageable level of arousal "feels" like in order to self-monitor when control is being lost and a different coping strategy of the relapse plan must be employed.

Sex offenders appear to have difficulty managing the internal representation of context or information that can be used to manage an appropriate behavioral response.lacks development of the character traits such as the trait of empathy or the trait of sorrow.

Assessment interviews indicate that many offenders demonstrate a one sided mind set and in most cases associate with friends who also have a one sided mind set. Together they develop a distorted view or picture of the world that allows the individual to behave as he perceives to be appropriate. In many cases the individual is living in a home with individuals who are either also somewhat one sided or the rules of order in the home allow the individual to behave as he perceives is appropriate. In the course of normal development a child is taught to appreciate and respect the opinions and rights of other children while in the stage of solitary play. As the child grows and moves toward the stage of group play the child develops a concept of identity and acceptance of self by others based on how the child honors the rights and opinions of other group members. Individuals who think in a one sided manner miss parts of this developmental stage.

This style of faulty and distorted thinking contributes toward the offender displaying a type of personality disorder.

## SAMPLE RELAPSE PLAN

### RELAPSE PREVENTION PLAN:

### ONE-SIDED MINDSET

RISK FACTORS which contribute towards past offense(s)	SAME/SIMILAR RISK FACTORS History may repeat in present/future; Past pattern may alter and/or assume new forms
<p><u>Past Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Don't tell me "no".</li> <li>2 I am right, and better than you.</li> <li>3 What I say goes.</li> <li>4 Lack of trust of others - I was sexually abused.</li> <li>5 Stereotypical view of men and women.</li> </ol> <p>Note: The past behavior is similar to the tactics used as a child:</p> <ol style="list-style-type: none"> <li>a. Say what I want.</li> <li>b. Have a tantrum if told no.</li> <li>c. Act out - fight or silent pout.</li> </ol> <p><u>One-sided Thinking</u></p> <ol style="list-style-type: none"> <li>1 I want what I want. I am entitled.</li> <li>2 Thinking of myself and not caring what happens to others.</li> <li>3 I am the oldest, biggest, and have the most money.</li> <li>4 Others are selfish people who will hurt you.</li> <li>5. Women should stay home, cook, and clean because they are weaker than men.</li> </ol>	<p><u>Present Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Not asking others for help. I do things my way.</li> <li>2 I'm not that bad a person. I just made a mistake.</li> <li>3 Don't argue with me or tell me what to do.</li> <li>4 Don't trust anyone.</li> <li>5 Look at the surface of a woman - sexualize her.</li> </ol> <p><u>Possible Future Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 I want what I want. I am entitled.</li> <li>2 Thinking of myself and not caring what happens to others.</li> <li>3 I am the oldest, biggest, and have the most money.</li> <li>4 Others are selfish people who will hurt you.</li> <li>5 Women should stay home, cook, and clean because they are weaker than men.</li> </ol>
SELF-MANAGEMENT	MANAGEMENT BY OTHERS
<p><u>Two-sided Thinking</u></p> <ol style="list-style-type: none"> <li>1 I need help from others to get things done. Two heads are better than one.</li> <li>2 Others have feelings also.</li> <li>3 Listen to what others say and try to understand.</li> <li>4 I'm just as human as they are. Look at their point of view.</li> <li>5 Men and women are the same. Women can think and have emotions.</li> </ol> <p><u>Coping Behavior</u></p> <ol style="list-style-type: none"> <li>1 I will not think I am the best because others are as good as me.</li> <li>2 Accept "no" for an answer.</li> <li>3 Stop and listen to others.</li> <li>4 Stop being fearful and thinking like a criminal.</li> <li>5 Stop putting women down.</li> </ol> <p><u>Proactive Behavior</u></p> <ol style="list-style-type: none"> <li>1 I will do my best.</li> <li>2 Look and ask for support, go to an AA meeting, visit with my support group.</li> <li>3 Ask the people who will be affected by my behavior what they think.</li> <li>4 I can trust myself if I act responsibly.</li> <li>5 Respect women for who they are (whole person).</li> </ol>	<p><u>Clinically Oriented Conditions</u></p> <ol style="list-style-type: none"> <li>1 Discuss my wants and what I perceive I need.</li> <li>2 Look for correctives for my tactics when I correct my way.</li> <li>3 Maintain journal of anger lapses, and sexual thoughts.</li> <li>4 Sex Offender counseling Aftercare.</li> <li>5 Describe/log the 5 Thinking Errors and Tactics I use most often each day with my correctives to them.</li> </ol> <p><u>Parole Conditions</u></p> <p><u>Probation Conditions</u></p>

## SAMPLE RELAPSE PLAN

RELAPSE PREVENTION PLAN:	ONE-SIDED DEVIENT LIFESTYLE
<p style="text-align: center;"><b>RISK FACTORS</b> which contribute towards past offense(s)</p>	<p style="text-align: center;"><b>SAME/SIMILAR RISK FACTORS</b> History may repeat in present/future; Past pattern may alter and/or assume new forms</p>
<p><u>Past Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Juvenile delinquency encouraged by parents and family members.               <ol style="list-style-type: none"> <li>a. School behavior</li> <li>b. Runaway</li> <li>c. Fire-setting</li> <li>d. Stealing and destruction of property</li> <li>e. Sexualization</li> </ol> </li> <li>2 Hung out with criminals.</li> <li>3 My life style causes others to withdraw from me.</li> </ol> <p><u>One-sided Thinking</u></p> <ol style="list-style-type: none"> <li>1 I can do things by myself.</li> <li>2 I don't need anyone.</li> <li>3 I can do as I want.</li> <li>4 I have the money so I own them.</li> <li>5. Women like men to take advantage of them</li> </ol>	<p><u>Present Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 I don't take care of my family.</li> <li>2 Stop being responsible.</li> <li>3 Don't listen to others for feedback.</li> <li>4 Blaming others.</li> <li>5 Making sarcastic remarkd to put someone c in a crowd.</li> </ol> <p><u>Possible Future Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Not be responsible - housing, job, alcohol, family, etc.</li> <li>2 Withdrawing from others and not showing thoughts and feelings.</li> <li>3 Using money or drugs to manipulate others get what I want.</li> </ol>
<p style="text-align: center;"><b>SELF-MANAGEMENT</b></p>	<p style="text-align: center;"><b>MANAGEMENT BY OTHERS</b></p>
<p><u>Two-sided Thinking</u></p> <ol style="list-style-type: none"> <li>1 I can ask for help and suggestions.</li> <li>2 Think of other's feelings. I am not alone in this world.</li> <li>3 What I want is not always what I need.</li> <li>4 Money does not buy long term happiness.</li> <li>5 View women as wquals with thoughts and feelings.</li> </ol> <p><u>Coping Behavior</u></p> <ol style="list-style-type: none"> <li>1 I will not withdraw from others.</li> <li>2 Don't fight - talk about problems.</li> <li>3 Stay away from criminal thinkers and drug users.</li> <li>4 Stop sexualizing/manipulating others.</li> </ol> <p><u>Proactive Behavior</u></p> <ol style="list-style-type: none"> <li>1 I will share my thoughts and feelings honestly.</li> <li>2 Continue to work with AA and support group.</li> <li>3 Stay open to feedback from support group.</li> <li>4 Look for new friends who are appropriate choices.</li> </ol>	<p><u>Clinically Oriented Conditions</u></p> <ol style="list-style-type: none"> <li>1 Responsible commitment to program:               <ul style="list-style-type: none"> <li>- AA/NA</li> <li>- Sex Offender Group</li> <li>- Work</li> <li>- Financial.</li> </ul> </li> <li>2 Look at past behavior - find new corrective</li> <li>3 Descrive how I use fear and anger.</li> <li>4 How do I do well in one area of my life and be responsible in another.</li> <li>5 Who am I controlling and how?</li> </ol> <p><u>Parole Conditions</u></p> <p><u>Probation Conditions</u></p>

## SAMPLE RELAPSE PLAN

### RELAPSE PREVENTION PLAN:

### RELATIONSHIPS

RISK FACTORS which contribute towards past offense(s)	SAME/SIMILAR RISK FACTORS History may repeat in present/future; Past pattern may alter and/or assume new forms
<p><u>Past Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Lack of intimacy -               <ol style="list-style-type: none"> <li>a. Not sharing feelings</li> <li>b. Fear of getting close</li> <li>c. Fear of being hurt.</li> </ol> </li> <li>2 Angry at wife because she -               <ol style="list-style-type: none"> <li>a. Fear of confronting</li> <li>b. Fear of being rejected</li> <li>c. Fear of failing.</li> </ol> </li> <li>3 Put work over relationship -               <ol style="list-style-type: none"> <li>a. Place to be alone even when people are around</li> <li>b. I don't have to be responsible, just do what I'm told</li> <li>c. Live a double life</li> <li>d. Use money to get control of others.</li> </ol> </li> <li>4 It is easier to perform for a child.</li> </ol> <p><u>One-sided Thinking</u></p> <ol style="list-style-type: none"> <li>1 I like this relationship because of sex.</li> <li>2 Why can't she keep the house clean?</li> <li>3 She should want what I want.</li> <li>4 Men don't cry or have feelings.</li> <li>5 If I'm drinking, I won't hurt her feelings.</li> <li>6 Let her do things her way. I'm going to work.</li> <li>7 People at work appreciate me more than her.</li> <li>8 I'm not hurting the child. Besides, she likes it.</li> </ol>	<p><u>Present Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 I fear I will lose my family if I open up and talk</li> <li>2 I feel like a victim when I talk with her.</li> <li>3 I don't want to talk or I may be hurt</li> <li>4 Run from problems and use tactics to get my way.</li> </ol> <p><u>Possible Future Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Married life is a dead end.</li> <li>2 If I tell her about my deviancies, she will leave me.</li> <li>3 Avoid relationships because I fear the conflict</li> <li>4 Being rigid or judging others.</li> <li>5 If I can't have my way I will be abusive.</li> </ol>
SELF-MANAGEMENT	MANAGEMENT BY OTHERS
<p><u>Two-sided Thinking</u></p> <ol style="list-style-type: none"> <li>1 Our relationship is more than sex.</li> <li>2 I have unrealistic expectations.</li> <li>3 Other people's wants are as important as mine.</li> <li>4 Everyone has feelings. Talk to express my needs.</li> <li>5 When I drink, I don't think. I hurt people.</li> <li>6 What is fair for her and fair for me.</li> <li>7 People like the work I do. This is different than the type of person I am at home.</li> <li>8 Stop running away from my wife - this hurts the child.</li> </ol> <p><u>Coping Behavior</u></p> <ol style="list-style-type: none"> <li>1 Say "no" to thoughts of weakness.</li> <li>2 Say "no" to my one-sided selfishness.</li> <li>3 Do not run from problems.</li> <li>4 Do not overwork, set boundaries.</li> <li>5 Stop - Do not fantasize about children.</li> </ol> <p><u>Proactive Behavior</u></p> <ol style="list-style-type: none"> <li>1 Talk about feelings.</li> <li>2 Offer help, do house jobs/get wood, clean up after myself.</li> <li>3 Talk and deal with my problems openly.</li> <li>4 Go home after work and talk. Do not hide at work, the bar or at a friend's house.</li> <li>5 It is harder to be responsible with my wife, but it is also more fulfilling.</li> </ol>	<p><u>Clinically Oriented Conditions</u></p> <ol style="list-style-type: none"> <li>1 Attend marital counseling.</li> <li>2 Attend engagement encounter prior to forming a live-in relationship.</li> <li>3 Avoid partners who will be dependent on me to enable me.</li> <li>4 Practice conflict resolution in a counseling setting.</li> <li>5 Journal how I value work over my relationship</li> <li>6 Describe how I use dominance to control and what are my correctives.</li> </ol> <p><u>Parole Conditions</u></p> <p><u>Probation Conditions</u></p>



## SAMPLE RELAPSE PLAN

### RELAPSE PREVENTION PLAN:

### SETTING UP THE SEXUAL ASSAULT

RISK FACTORS which contribute towards past offense(s)	SAME/SIMILAR RISK FACTORS History may repeat in present/future; Past pat may alter and/or assume new forms
<p><u>Past Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Victim               <ol style="list-style-type: none"> <li>a. Look for girls who look innocent, just out of puberty (12), smaller than me, and are shy.</li> <li>b. Girls who come from broken homes and would be curious about drugs or alcohol.</li> <li>c. Girls who are runaways</li> </ol> </li> <li>2 Groom               <ol style="list-style-type: none"> <li>a. Let parents think I can help be a good father or baby-sitter.</li> <li>b. Give gifts or money. Buy drugs, pop, candy. Let her do things the parents say "no" to.</li> <li>c. Use lies and threats to keep victims quiet. Present self as a really "good guy".</li> </ol> </li> </ol> <p><u>One-sided Thinking</u></p> <ol style="list-style-type: none"> <li>1 I know she likes me and wants sex.</li> <li>2 She will enjoy it if I touch her.</li> <li>3 It's okay if I'm around younger people.</li> <li>4 She is having problems that I can help her with.</li> <li>5 I wonder what she looks like without clothes.</li> </ol>	<p><u>Present Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Try to be dominant with:               <ul style="list-style-type: none"> <li>- angry tantrum assaults.</li> <li>- passive/aggressive actions.</li> <li>- be submissive to play the role of a victim in order to maintain control (Masochistic to Sadistic)</li> </ul> </li> <li>2 Try to rescue and enable others:               <ul style="list-style-type: none"> <li>- Grooming the victim and the support group to get the victim alone.</li> </ul> </li> </ol> <p><u>Possible Future Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 I'm an adult and can choose who I will be around.</li> <li>2 Accepting a job where I can have access to victims.</li> <li>3 Very nice to children.</li> <li>4 Stalking and isolating a victim.</li> </ol>
SELF-MANAGEMENT	MANAGEMENT BY OTHERS
<p><u>Two-sided Thinking</u></p> <ol style="list-style-type: none"> <li>1 Children are not sexually attracted to adults and neither are women unless they say yes when sober.</li> <li>2 It is wrong to fondle the victim.</li> <li>3 I should be with people my own age.</li> <li>4 Take care of my own problems.</li> <li>5 Think of an appropriate age consenting adult.</li> </ol> <p><u>Coping Behavior</u></p> <ol style="list-style-type: none"> <li>1 I will not be with people who are like my victim.</li> <li>2 Say "no" to grooming.</li> <li>3 Stop sexualizing - Leave the area.</li> <li>4 Never be alone with a potential victim.</li> <li>5 Remember the experience of court and going to jail.</li> </ol> <p><u>Proactive Behavior</u></p> <ol style="list-style-type: none"> <li>1 Make friends with people my own age with good boundaries.</li> <li>2 Respect other people's boundaries.</li> <li>3 Remember how to manage arousal as in masturbation and pornography.</li> <li>4 Talk about my lapses with P.O., therapist, and support group</li> <li>5</li> </ol>	<p><u>Clinically Oriented Conditions</u></p> <ol style="list-style-type: none"> <li>1 Set boundaries.</li> <li>2 Self disclose thoughts/fantasies.</li> <li>3 Maintain journal.</li> <li>4 Using pronography to initiate a relationship</li> </ol> <p><u>Parole Conditions</u></p> <p><u>Probation Conditions</u></p>

## SAMPLE RELAPSE PLAN

### RELAPSE PREVENTION PLAN:

### SEXUAL OFFENSE

RISK FACTORS which contribute towards past offense(s)	SAME/SIMILAR RISK FACTORS History may repeat in present/future; Past pattern may alter and/or assume new forms
<p><u>Past Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Get drunk, show up late for work.</li> <li>2 Make a mistake at work.</li> <li>3 Boss told me to be responsible or get fired.</li> <li>4 I hold my anger in, be silent, withdraw.</li> <li>5 All the way home I get more and more angry.</li> <li>6 At home I start a fight with family to feel justified.</li> <li>7 I act out sexually against my child.</li> </ol> <p><u>One-sided Thinking</u></p> <ol style="list-style-type: none"> <li>1 I only think and care about myself.</li> <li>2 I didn't do anything wrong and everyone picks on me.</li> <li>3 My family and boss deserve my anger.</li> <li>4 I don't care about my victims.</li> <li>5 No one knows and it won't hurt this child.</li> <li>6 It is better if I "teach" the child about sex.</li> </ol>	<p><u>Present Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Acting out against other people or property (fighting, stealing).</li> <li>2 Blaming others for what I do wrong.</li> <li>3 Stay by myself to feel sorry for myself and out sexually (masturbate to deviant fantasies).</li> </ol> <p><u>Possible Future Pattern or Event</u></p> <ol style="list-style-type: none"> <li>1 Drinking and drug use so I can feel better.</li> <li>2 Blaming.</li> <li>3 Looking for someone to feel sorry for me.</li> <li>4 Not showing up at work, meeting, etc.</li> <li>5 Looking for people that I can molest or rape.</li> </ol>
SELF-MANAGEMENT	MANAGEMENT BY OTHERS
<p><u>Two-sided Thinking</u></p> <ol style="list-style-type: none"> <li>1 Be honest with myself - This will hurt me if I go back to jail.</li> <li>2 It is wrong to hurt someone else.</li> <li>3 I cause my own problems. Be responsible.</li> <li>4 I deserve my own anger, not my family or my boss. I will talk with them when I cool down.</li> <li>5 She is a person, do not hurt her.</li> <li>6 Remember the 3 stages of Zero stage - everyone will know.</li> <li>7 She doesn't need to be taught about sex, and I am not the teacher.</li> </ol> <p><u>Coping Behavior</u></p> <ol style="list-style-type: none"> <li>1 Stop. Leave the area. Call for help.</li> <li>2 Do not be alone.</li> <li>3 Do not use alcohol or drugs.</li> <li>4 Stop deviant thoughts.</li> <li>5 Eliminate expectations of others.</li> </ol> <p><u>Proactive Behavior</u></p> <ol style="list-style-type: none"> <li>1 Call P.O., Police, support group for help.</li> <li>2 Do mediation, positive self-talk.</li> <li>3 Get someone to help me quick.</li> <li>4 Call AA sponsor - work with higher power.</li> <li>5 Talk with spouse, loved one.</li> <li>6 Do a behavior check.</li> <li>7 Explain my Assault Cycle to someone.</li> <li>8 Use correctives from High Risk cards.</li> </ol>	<p><u>Clinically Oriented Conditions</u></p> <ol style="list-style-type: none"> <li>1 Share openly about: <ul style="list-style-type: none"> <li>- masturbation.</li> <li>- assault cycle.</li> </ul> </li> <li>2 Review my journal - Look for how I use correctives.</li> <li>3 Supervised relationship.</li> <li>4 AA meeting/sponsor.</li> </ol> <p><u>Parole Conditions</u></p> <p><u>Probation Conditions</u></p>

# **GUIDELINES FOR HANDLING VIOLATIONS OF CONDITIONS OF PAROLE AND PROBATION (TECHNICAL VIOLATIONS)**

## **Introduction**

During fiscal year 1993, the Alaska Department of Corrections was awarded federal assistance by the National Institute of Corrections to develop a sex offender support network training manual for non-professionals. The manual is designed to assist in the training of non-professionals and probation officers in working with and supervising sex offenders in community placement.

The project is a collaborative effort between DOC and the University of Alaska-Anchorage, the staff of whom developed a manual for training “safety-net members” in the community to recognize and report pre-relapse signs. The idea is to train people close to offenders to recognize and report early warning signs of relapse and to, therefore, enhance the probability of successful community placement of probationers and parolees through early intervention strategies. After the manual was developed, a pilot project was conducted to test its use. Efforts are currently underway to further develop the use of the safety net concept, as well as the manual, in areas throughout the state.

## **Purpose of Guidelines**

If the program functions as envisioned a number of technical violations will be identified for some offenders. These guidelines are intended to assist probation officers in handling these situations consistently and appropriately. While the hope is that most offenders can be maintained successfully in the community, the primary concern of DOC is community safety. It is believed, however, that if precursors to offense are identified early in the relapse chain, successful interventions can often be made which will allow for the offender to safely continue community placement.

## **Responsibility for Enforcing Sanctions**

The field probation officer is ultimately responsible for imposing and enforcing sanctions which are determined to be appropriate. The P.O., however, should rely upon input from all members of the treatment team whenever possible before making a final decision. Although the final decision normally rests with the P.O. the following should be considered:

- 1) If the severity of the technical violation and the risk to the community is considered low and the P.O. recommends revocation/reincarceration, he/she must provide justification for the recommendation.
- 2) Conversely, if the severity of the technical violation and the risk to the community is high and the P.O. does not recommend revocation/reincarceration justification for this recommendation must be provided.

## **LINES OF ORGANIZATION AND SUPERVISION**

The following defines the organization of the entire safety net of natural supporters.

<u>Personnel</u>	<u>Responsibility</u>
DOC Central Office	This is the upper management team in charge of developing and managing the supervision system of care.
Field Supervisor(s)	There may be one or more field managers who supervise on-line staff (probation officers).
Field Probation Officers	On-line workers, probation officers, who directly supervise offenders and make decisions and judgements that effect management and care of offenders.
Health Care Providers	Professional and para-professional treatment specialists who deliver direct services to offenders and input to the P.O.
Natural Helpers	Interested persons who have agreed to observe the offender's behavior and report potential pre-relapse signs including condition violations and high risk signs.

### **Guidelines for Handling Technical Violations**

Any member of the safety net team may contact the probation officer to report a technical violation. This may include health care providers such as substance abuse counselors, mental health counselors, sex offender therapists etc. as well as non-health care safety net members, such as family , employers, village elders, clergy etc.

When a violation is reported the P.O. has several options depending upon the seriousness of the violation, the probability of risk to the community, the availability of alternative methods of treatment intervention etc. It is the purpose of these guidelines to offer guidelines to field probation officers to assist them in making decisions regarding the action on a technical violation. The guidelines will also assist the Department in developing a consistent approach to handling technical violations which is in accord with overall departmental policy and philosophy.

The following factors should be considered by the P.O. before making a decision regarding a technical violation:

1) The Number of High Risk Factors Present.

The greater the number of high risk factors present the closer an offender generally is to a relapse. For example, a rapist who is using alcohol or drugs as well as pornography is likely to be closer to a reoffense than if only one factor is present. Although any factor alone can signal a reoffense, generally the greater the number of factors converging the higher the probability of an offense.

2) The Offender's Supervision History.

The P.O. should consider prior history of technical violations. Consider the seriousness of the violations as well as the offender's attempts to self correct or respond to interventions by the P.O. Also consider the offender's attitude towards past and present violations. Does he

recognize the seriousness and importance of the violation? Also what is his attitude towards the system? Is he angry, rebellious, blaming, superficially compliant or does he appear to have a true sense of his own risk to the community and a genuine interest in “getting back on track.” How willing is he to accept increased supervision and further therapeutic intervention.

3) The Relative Seriousness of the Infraction(s).

The probation officer should rate the violation(s) along a continuum of low to high seriousness. The seriousness should not only be rated according to legal standards but also for the proximity in the offense chain to the actual relapse behavior. For example, consider the following pattern: A child molester’s assault cycle consists of a) going to a playground, b) flying a kite to attract children, c) talking to the child, d) inviting the child for ice cream, e) driving to a secluded spot, and f) fondling the child’s genitals. Information that the offender has just purchased a kite may be less serious than if he had been seen having ice cream with a child.

4) The Offender’s History of Dangerousness and Violence.

The P.O. should consider who the offender has been violent towards as well as the frequency and the form the violence has taken. Things to consider here include history of fighting\brawling, domestic violence towards women, children or both, use of weapons, etc.

5) Prior History of Victimizing.

The P.O. should consider the frequency of sexual assaults in the offender’s past as well as the number of total victims. Look for a history of repetitive and/or compulsive assaults. Do not rely upon offender accounts alone. Use as much collateral information as is available.

6) The Offender’s “Risk Score” on the Probation\Parole Score Sheet.

This should be examined in addition to any other specific estimates of dangerousness\risk as it is a broader estimate of risk than other more specific measures.

7) The Likely Form of Sexual Behavior Upon Reoffense.

When the probability of an offense is judged to be low, the probable harm caused by the offense should be considered and the risk considered higher under conditions of greater harm. For example, if an offender’s risk of reoffense is considered low but his offense pattern includes penetration, the risk should be rated higher than if his offense pattern was to expose himself without direct contact with the victim.

8) The Victims at Risk.

The P.O. should consider the range of potential victims including their ages and gender(s), as well as their vulnerability. The greater the number of victims, the greater the risk as it is more difficult to isolate the offender from those he harms. Those offender’s who abuse highly vulnerable victims such as mentally or physically handicapped, very young victims, elderly victims etc. pose a greater risk. The availability of victims should also be of prime concern.

9) The Appropriateness of the Support Network.

It is important to consider the objectivity and safety- mindedness of natural helpers on the safety net team as well as other support persons close to the offender. Are there signs of enabling behaviors, minimizing, denial, etc. on the part of support persons. Dangerousness increases to the extent that such tendencies exist. Also consider how likely it is that the support members will report pre-relapse signs. Finally, consider the number of support persons available, their frequency of contact with the offender, and their ability to directly observe behavior accurately.

10) The Mental State of the Offender.

It is important to consider the mental status of the offender in terms of contact with reality, emotional stability, behavioral impulsivity, cognitive ability, and substance abuse. It is most important to determine the degree to which such factors will effect the offender’s ability to

follow therapeutic and management sanctions aimed at reducing the probability of a reoffense. Mental health treatment providers, DOC approved sex offender therapists, substance abuse counselors and other therapeutic personnel can offer assistance in evaluating the offender's ability to comply with intervention strategies.

11) The Offender's Amenability to Treatment.

Generally Level I and Level II offenders are more amenable than Level III offenders. Input from the sex offender therapist (DOC Approved Provider) and other members of the treatment team is critical.

12) The Availability and Suitability of Alternatives.

The P.O. should consider the availability and suitability of alternatives to incarceration and the probability that these alternatives will be successful in stabilizing the offender and breaking the reoffense chain. For example, an offender who abuses under the influence of alcohol has recently broken his sobriety. Can he be placed in an alcohol treatment center? What is the likely effectiveness of this approach? Has the approach succeeded or failed in the past?

### **RED FLAGS FOR REVOCATION**

The purpose of the natural support training manual is to prevent relapse and improve offender survivability in the community. Community safety remains the primary objective and should never be compromised. In certain situations revocation proceedings are unavoidable and necessary. These situations include the following:

- 1) A reoffense
- 2) An offender is in violation of a condition of probation/parole and has not responded to intervention for correction and remains in the relapse cycle.
- 3) An offender is in violation of a condition of probation/parole and the P.O., in consultation with the treatment team, has determined that necessary interventions are unavailable and that relapse is imminent.
- 4) An offender is in violation of a condition of probation/parole and the offender is unable to comply with the intervention strategies due to his mental state and mental health options (e.g., hospitalization) are unacceptable or less appropriate i.e., the offender requires residential sex offender treatment.
- 5) An offender is in violation of a condition of probation/parole and, in the judgment of the treatment team, the danger to the community is so high that the benefits of attempting to maintain the offender in the community are outweighed by the potential for harm.

### **PROCEDURES**

- 1) When the Probation Officer receives a report of a technical violation s/he shall investigate the report by interviewing all relevant parties/witnesses as soon as is feasible.
- 2) Witnesses and other relevant parties should be interviewed before the interview of the offender is conducted unless, in the Probation Officer's judgement, postponing the interview of the offender would jeopardize community safety.

- 3) After determining all relevant facts and obtaining input from all relevant parties the Probation Officer shall determine what action to take and complete the Technical Violations Rating Form.
- 4) Once a decision has been made regarding appropriate sanctions and/or revocation, this information shall be conveyed to the offender's treatment team members and when appropriate to other safety-net members including natural helpers.
- 5) If applicable the Probation Officer shall file for revocation.
- 6) A copy of the Technical Violations Rating Form shall be sent to the Criminal Justice Planner in the Division of Institutions for purposes of data collection.

## **HIERARCHY OF SANCTIONS**

Field probation officers have a range of options and sanctions they can apply to fit the needs of a variety of situations. These options are as follows:

- 1) Verbal Warning.

In some cases all that is necessary is to remind the offender of his probation\parole conditions or clarify the meaning or extent to which those conditions apply.

- 2) Written Warning.

It is frequently important to clarify conditions in writing and give written notice of warning as well as noting potential consequences for noncompliance.

- 3) Change of Conditions of Probation\Parole.

The field P.O. typically has the ability to apply special sanctions and conditions to improve management of the case when special conditions and needs apply. Thus when the P.O. becomes aware of factors which effect community safety that were not evident at the time conditions were set special instructions can be given to the offender. These should be in writing and sent to the offender as well as all members of the treatment team.

- 4) Outpatient Therapeutic Sanctions.

The P.O. in consultation with the treatment team may determine that additional outpatient therapeutic measures such as increased frequency of therapy sessions, AA meetings, or other treatments can reduce the risk of reoffense to safe levels.

- 5) Alternative Therapeutic Placements.

There are situations in which a P.O. in consultation with the treatment team may determine that a residential therapeutic setting, such as a substance abuse detox and/or treatment facility, psychiatric hospital or other therapeutic setting may be most appropriate in reducing risk to the community and stabilizing the offender. Placement in a residential facility can only occur through court or parole board order unless the offender is willing to enter the facility on a voluntary basis.

- 6) Alternative Correctional Placement.

Placement in a CRC or other closely monitored supervision may at times be deemed a safe and appropriate alternative to reincarceration in prison. Placement at a CRC can only occur when an appropriate order exists. Under certain conditions and if the sentencing order allows the P.O. may place the offender under House Arrest employing electronic monitoring to manage the offender's movements in the community.

7) Reincarceration.

If other measures are thought to be inadequate to protect the community and stabilize the offender the P.O. should file a petition to revoke probation\parole and seek reincarceration.



# TECHNICAL VIOLATIONS RATING FORM

## Field Probation Officers Rating Sheet

Describe the condition violation in detail:

Rate the following 12 factors using a scale of 1 to 5 as shown below:

1 	2 	3 	4 	5 
low		moderate		high
severity		severity		severity

- \_\_\_\_\_ Number of high risk factors present.
- \_\_\_\_\_ Offender's supervision history.
- \_\_\_\_\_ Relative seriousness of infraction(s).
- \_\_\_\_\_ Offenders history of dangerousness and violence.
- \_\_\_\_\_ Prior history of victimizing.
- \_\_\_\_\_ Offenders "Risk Score" on probation/parole score sheet.
- \_\_\_\_\_ Likely form of sexual behavior upon reoffence.
- \_\_\_\_\_ Victims at risk.
- \_\_\_\_\_ Appropriateness of support network.
- \_\_\_\_\_ Mental state of the offender.
- \_\_\_\_\_ Offender's amenability to treatment.
- \_\_\_\_\_ Availability and suitability of alternatives.

Comments:

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Average "severity" score. \_\_\_\_\_

Number of factors with five rating. \_\_\_\_\_

Number of factors with four or five rating. \_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If revocation is being pursued check below all sanctions attempted prior to the recommendation for revocation.

\_\_\_ Verbal warning(s)

\_\_\_ Written warning(s)

\_\_\_ Change of conditions of probation/parole

\_\_\_ Outpatient therapeutics sanctions(s)

\_\_\_ Alternative therapeutics placements(s)

\_\_\_ Alternative correctional placements(s)

\_\_\_ Prior revocation hearing(s)

\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_

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## Appendix 11

### **Staff Space and Equipment Recommendations**

For every therapist (social worker, psychologist or marriage and family therapist), supervisor, researcher, or quality assurance position:

- 120 square foot office
- Desk and chair
- 2 guest chairs
- Bookcase
- File cabinet
- Computer, monitor and printer (or networked to a printer)
- Phone
- Wastepaper basket, tape dispenser, stapler
- Operating funds for supplies and copying offender reading and homework assignments
- Training funds

One 300 square foot group room for every two therapists (or every four therapist if there is time in the prison schedule to hold two consecutive group sessions in the same room during the morning and afternoon):

- 5' x 7' black or white board
- VCR, Monitor and Chart
- 2 folding tables
- 14 chairs

One centralized 240 to 300 square foot work area where the administrative assistant can be stationed:

- Computer, monitor and printer (or networked printer)
- Computer table and chair
- Phone
- 4 drawer file cabinet for every 400 inmates served
- Copier
- Fax machine
- Camcorder with tripod for recording role plays
- Space to store supplies
- Wastepaper basket, tape dispenser, and stapler

One room where polygraph tests can be conducted:

- The room must be free from distractions (visual or auditory) that would prevent an examinee from focusing on the exam



## **APPENDIX 12**

### **COLORADO SEX OFFENDER MANAGEMENT BOARD**

#### ***STANDARDS REGARDING***

#### **CONTACT WITH CHILDREN**

**(SEE ALSO APPENDIX 1)**

# **COLORADO SEX OFFENDER MANAGEMENT BOARD**

## **STANDARDS AND GUIDELINES FOR THE ASSESSMENT, EVALUATION, TREATMENT AND BEHAVIORAL MONITORING OF ADULT SEX OFFENDERS**



Colorado Department of Public Safety

Division of Criminal Justice  
Office of Domestic Violence &  
Sex Offender Management

700 Kipling Street, Suite 3000  
Denver, CO 80215  
(303) 239-4442 or (800) 201-1325 (in Colorado)  
website: <http://dcj.state.co.us/odvsom/>  
email: [somb@cdps.state.co.us](mailto:somb@cdps.state.co.us)

*Revised June 2004*

### **5.700 ♦ Sex Offenders' Contact with Victims and Potential Victims**

**5.710 Sex offenders shall have no contact with any child under the age of 18 or adult/ child victims of the offender's sex offenses until the Community Supervision Team unanimously agrees that the offender has met the corresponding criteria listed in Standard 5.741 through 5.742, Section A, B, or C as applicable. Additionally, offenders shall not meet any of the Exclusionary Criteria listed in Standard 5.720.**



Contact is intended to refer to any form of interaction including:

- Physical contact, face to face, or any verbal contact;
- Being in a residence with a child or victim;
- Being in a vehicle with a child or victim;
- Visitation of any kind;
- Correspondence (both written and electronic), telephone contact (including messages left on a voice mail or answering machines), gifts, or communication through third parties;
- Entering the premises, traveling past or loitering near the child or victim's residence, school, day care, or place of employment;
- 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.

The rationale for contact restrictions involves both known and unknown factors regarding the offender's risk for sexual recidivism. The accuracy of risk prediction is limited to available information even when a sex offense specific evaluation has been completed. The offense for which a person is convicted is not necessarily a reliable indicator of the offender's risk to children or victims<sup>1</sup>. As an offender participates in treatment and supervision, a more accurate assessment can be made to determine his/her specific risks to children and victims with whom he/she may request contact. An important aspect of ongoing risk assessment is measuring an offender's ability to comply with the requirements of treatment and supervision<sup>2</sup>.

A growing body of research indicates most sex offenders supervised by the criminal justice system have more extensive sex offending histories, including multiple victim and offense types, than is generally identified in their criminal justice records<sup>3</sup>. Some of this research has been conducted with convicted sex offenders in Colorado. Research also indicates that children and victims are particularly vulnerable and are unlikely to report or re-report abuse<sup>4</sup>.

The SOMB recognizes the significance of the relationship between a parent and his/her child and also recognizes the risk that a sex offender can pose to his/her own children. There are multiple factors that must be considered in making a determination of an offender's risk to his/her own children. When contact between a sex offender and a child under the age of eighteen (18) who meets the definition of "own child" in this document is being considered, the offender shall complete the Parental Risk Assessment (PRA) as described in this document in order to assess whether child contact is appropriate. This assessment will result in a determination of risk level and make recommendations in an individualized plan for level and type of contact, if any, with the offender's own children. No sex offender will have any contact with his/her own children until he/she has undergone a Parental Risk Assessment and has been determined to be an acceptably low risk. Please see Section A for further information.

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<sup>1</sup> Knopp, F.H. (1984); Freeman-Longo, R., Blanchard, G. (1998); Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000); English, K. (1998); Heil, P., Ahlmeyer, S., Simons, D. (2003); Ahlmeyer, S. (1999); Becker, J., and Coleman, E. (1987); Abel, G., Rouleau, J. (1990); Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety (2000); Tanner, J. (1999); Hanson, R., Harris, A. (1998); Hindman, J. (1989).

<sup>2</sup> Hanson, R.K., Harris, A. (1998).

<sup>3</sup> Knopp, F.H. (1984); Freeman-Longo, R., Blanchard, G. (1998); Ahlmeyer, S., Heil, P., McKee, B., and English, K. (2000); English, K. (1998); Heil, P., Ahlmeyer, S., Simons, D. (2003); Ahlmeyer, S. (1999); Becker, J., and Coleman, E. (1987); Abel, G., Rouleau, J. (1990); Office of Research and Statistics, Division of Criminal Justice, Colorado Department of Public Safety (2000); Weinrott, M. & Saylor, M. (1991).

<sup>4</sup> Marshall, W. (1998); Hanson, R.F., et al. (1999); (1992). *Rape in America: A Report to the Nation*; Underwood, R., Patch, P., Cappelletty, G., Wolfe, R. (1999); Hindman, J. (1989); Colorado Coalition Against Sexual Assault (1998); Cardarelli, A. (1998).

*Discussion Point: For offenders who have already been sentenced and have non-victim children under the age of 18 with whom they desire contact, it is important for the offender to participate in the Parental Risk Assessment in order to determine appropriateness and level of contact.*

Community Supervision 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 treatment 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 Community Supervision Team based on current risk.

It is the responsibility of treatment providers, evaluators and other community supervision team members to follow these Standards and Guidelines. Treatment providers, particularly after a Parental Risk Assessment has been completed, have the most expertise and are in the best position to accurately assess an offender's risk to his own children and are ethically obligated to ensure child safety remains the highest priority. This may result in decisions that are difficult for both the offender and the criminal justice system. While the Court has authority and discretion in sentencing matters, the treatment provider is an independent entity who is responsible to maintain best clinical practices. In rare instances, the referring agency may request services that are in conflict with the Standards due to a court order. It is important to recognize that treatment under unsafe conditions is not beneficial to the offender or others in the treatment program and undermines treatment program integrity<sup>5</sup>.

In order to maintain program integrity, treatment providers and evaluators who receive referrals for offenders in circumstances which conflict with these Standards should refuse to accept or continue to treat offenders who do not agree to comply with the requirements in the Standards and Guidelines 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.

*Discussion Point: During any time that an offender is not in treatment, 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.*

Sections 5.741 through 5.742 A, B, and C of this Standard state the requirements for contact with children. This contact shall be supervised unless the offender has met the criteria in Standard 5.750 for unsupervised contact. See Standards 5.760-5.763 for Approved Supervisor requirements.

### **5.720 Exclusionary Criteria**

Due to extreme risk, when any of the following are present, the community supervision 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:

- Pedophilia (Exclusive Type, per DSM IV-TR, 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**
- A Colorado court or parole board has ruled the offender is a Sexually Violent Predator.

### **5.730 Parental Risk Assessment (PRA)**

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<sup>5</sup> Quinsey, V.L., Harris, G.T., Rice, M.E., Cormier, C.A. (1998).

When a sex offender has any children under the age of eighteen (18) who meet the definition of “own child” in this document, the offender wants to have contact with his/her children, none of them are his victims, it does not appear that he or she has more than one item on Tier I on the PRA Flowchart, and it does not appear that the offender will be sentenced to the Department of Corrections, a Parental Risk Assessment as described in this document shall be initiated in order to assess the appropriateness of child contact. This assessment shall be initiated at the time of the offense specific evaluation. The assessment will result in a determination of risk level and a recommendation for an individualized plan regarding level and type of contact, if any, with the offender’s own children. It is important to acknowledge that risk levels can change and that the plan must be continually assessed and revised as necessary throughout the period of criminal justice supervision. For offenders in the Department of Corrections, when a PRA has not been completed, the Department of Corrections treatment team should conduct a PRA.

The Parental Risk Assessment should occur after a plea has been entered, after conviction or upon acceptance of an Interstate Compact case and shall be completed by a listed Sex Offender Management Board Evaluator/Treatment Provider. Contact with an offender’s children shall be prohibited prior to, and during, the offense specific evaluation. A recommendation regarding an offender having contact with his/her own children cannot be made until a Parental Risk Assessment has been completed as part of the offense specific evaluation. If the Parental Risk Assessment does not occur during the offense specific evaluation, it may be completed at a later time; however, the offender should not have contact with his/her own children until the Parental Risk Assessment has been completed.

*Discussion Point: The SOMB recognizes that in cases involving DHS, where a criminal case has not been filed, it may be useful to conduct an evaluation similar to a PRA in order to make informed decisions regarding child contact. This standard is not intended to preclude that from occurring.*

*Discussion Point: Ideally, the sex offender should not have contact with his/her own children until a PRA is completed and finds contact is appropriate. However, if a court has allowed contact absent the completion of a PRA, it should not preclude a PRA from being completed.*

*Discussion Point: If all components of the Parental Risk Assessment have not been completed within a six month period of time, portions of the testing may need to be re-administered. Additionally, if an offender yields deceptive or inconclusive results on the polygraph exam, he/she may retest in a timely manner and have those results incorporated into the Parental Risk Assessment*

If the Parental Risk Assessment, which includes a polygraph, indicates **high risk** with regard to his/her own children, the offender shall meet the criteria in Standards 5.741 through 5.742 (A) before contact can be initiated.

If the Parental Risk Assessment, which includes a polygraph, indicates **low risk** with regard to his/her own children and the offender has no known history of sexual behavior with his/her own children, criteria listed in Standards 5.741 through 5.742 (A) shall be waived with regard to his/her own children.

If the Parental Risk Assessment, which includes a polygraph, indicates **moderate risk** with regard to his/her own children and the offender has no known history of sexual behavior with his/her own children, teams may use their discretion in allowing written or telephone contact or therapy sessions with the offender’s own children prior to the offender meeting all the criteria listed in Standards 5.741 through 5.742 (A). If the offender’s risk is assessed as moderate based on dynamic factors, (e.g. employment, support systems, etc.) the team may revisit the PRA conclusions if those factors change.

*In the Parental Risk Assessment, using the PRA Decision Flow Chart in Appendix F, the provider shall render an opinion of high, moderate, or low risk and the results shall be provided and explained to referral sources. If the evaluator believes that aggravating or mitigating factors exist that impact the outcome indicated by the Decision Flow Chart, such factors should be documented in the PRA report to support a differential opinion regarding risk level. The offender’s risk shall be acceptably low or the criteria listed in Standards 5.741 through 5.742 (A) shall be met prior to allowing contact with children.*

## PARENTAL RISK ASSESSMENT

The Parental Risk Assessment is a series of clinical interviews and standardized tests that will provide information regarding a variety of factors associated with risk. The assessment addresses risk level specifically with regard to the offender's own children. Evaluators should be aware of mandatory child abuse reporting laws, and report accordingly. The information listed in the chart below states the minimum requirements needed to complete the Parental Risk Assessment.

### PARENTAL RISK ASSESSMENT

Evaluation Areas – Required	Evaluation Procedures
<b>EVALUATE PARENTAL RISK</b>	
<b>KEY:</b> <ul style="list-style-type: none"> <li>• Required</li> <li>○ Options within a specific category</li> </ul>	
<i>Offender's Attachment Style</i>	<ul style="list-style-type: none"> <li>• History of Relationship Attachment</li> <li>○ Clinical Interviews</li> <li>○ Collateral sources</li> <li>• Standardized Tests (Must complete a minimum of one of the following):               <ul style="list-style-type: none"> <li>○ The Attachment Style Questionnaire (ASQ: Feeney, Nollar &amp; Hanrahan, 1994)</li> <li>○ Bartholomew Attachment Inventory</li> <li>○ Adult Attachment Interview (George, C., Kaplan, N., &amp; Main)</li> <li>○ The Adult Attachment Projective (AAP: George)</li> <li>○ Hazan &amp; Shaver Adult Attachment Scale</li> </ul> </li> </ul>
<i>Offender's Empathy</i>	<ul style="list-style-type: none"> <li>• History of empathy with Children</li> <li>○ Clinical Interviews</li> <li>○ Collateral sources</li> <li>▪ Standardized Tests:               <ul style="list-style-type: none"> <li>○ Hanson's Empathy for Children Test</li> </ul> </li> </ul>
<i>Offenders Ability for Family Stability</i>	<ul style="list-style-type: none"> <li>• History of stability of relationships and prior absences from the home</li> <li>○ Clinical interviews</li> <li>○ Collateral sources</li> <li>• History of domestic violence               <ul style="list-style-type: none"> <li>• Restraining orders</li> <li>• Arrests</li> </ul> </li> <li>• Documentation of conviction of a crime of domestic violence, or if none then perform a Standardized Test:               <ul style="list-style-type: none"> <li>○ SORAG</li> <li>○ Hanson's Empathy for Women Test</li> </ul> </li> <li>○ Collateral information</li> </ul>

<i>Offender's Parenting Skills</i>	<ul style="list-style-type: none"> <li>• History of payment or non-payment of child support, and reasons for non-payment</li> <li>• Prior access to children in a home environment <ul style="list-style-type: none"> <li>○ Clinical interview</li> <li>○ Collateral information</li> </ul> </li> <li>• Parenting Ability <ul style="list-style-type: none"> <li>○ Knowledge of child's life</li> <li>○ Knowledge of parenting skills</li> <li>○ Knowledge of child's developmental stages &amp; needs</li> <li>○ Parental boundaries</li> <li>○ Empathy</li> <li>○ Standardized test</li> <li>○ Parenting Perception Scale</li> </ul> </li> <li>• Risk of Physical Abuse <ul style="list-style-type: none"> <li>○ History of abuse or maltreatment of children</li> <li>○ Social Services records</li> <li>○ Collateral Sources</li> <li>○ Standardized Test <ul style="list-style-type: none"> <li>○ Child Abuse Potential Inventory (Milner, 1986)</li> </ul> </li> </ul> </li> </ul>
<i>Offender's stability</i>	<ul style="list-style-type: none"> <li>• Clinical interview &amp; Collateral Information (all of the following are required): <ul style="list-style-type: none"> <li>○ History of compliance with supervision and treatment requirements</li> <li>○ History of stable employment</li> <li>○ History of frequent moves</li> <li>○ Interview regarding family of origin (parental models, family environment and stability, abuse)</li> <li>○ Financial</li> <li>○ Drug &amp; alcohol history</li> </ul> </li> </ul>
<i>Offender's Arousal to/Sexual Interest in Children</i>	<ul style="list-style-type: none"> <li>• Standardized Tests (Minimum of one of the following): <ul style="list-style-type: none"> <li>○ Abel Assessment of Sexual Interest</li> <li>○ Plethysmograph</li> </ul> </li> </ul>
<i>Offender's Historical Sex Offending Behaviors as verified through official record, polygraph, or any other credible source such as social services records</i>	<ul style="list-style-type: none"> <li>• Any history of sexually abusing anyone under the age of 18 <ul style="list-style-type: none"> <li>○ Official records</li> <li>○ Collateral information</li> <li>○ Self report</li> </ul> </li> <li>• Polygraph <ul style="list-style-type: none"> <li>• Any history of sexual conduct with relatives who were under the age of 18</li> <li>• Any history of sexual contact with other minors</li> </ul> </li> <li>• Any history of sexual contact with animals <ul style="list-style-type: none"> <li>○ Official records</li> <li>○ Collateral information</li> <li>○ Self report</li> </ul> </li> <li>• Assess level of prior access to children</li> </ul>
<i>Offender's Criminal Risk - Risk for future criminal/sexual behavior</i>	<ul style="list-style-type: none"> <li>• Elements of current or previous offenses through interviews and collateral sources <ul style="list-style-type: none"> <li>○ Past behaviors from criminal justice and social service records</li> <li>○ Validated risk assessment instrument</li> </ul> </li> </ul>

<i>Offender's Cognitive Distortions</i>	<ul style="list-style-type: none"> <li>• Interview or Standardized Tests (Use any test listed below or equivalent test) <ul style="list-style-type: none"> <li>○ Multiphasic Sexual Inventory</li> <li>○ Abel Assessment Cognitive Distortion Scale</li> <li>○ Bumby Cognitive Distortion</li> <li>○ Clinical interview</li> <li>○ Collateral Information</li> </ul> </li> </ul>
<i>Offender's Psychological Functioning</i>	<ul style="list-style-type: none"> <li>• Clinical interview/Collateral Information/ Standardized Tests</li> <li>• Sadistic Behavior Elements of previous offenses/collateral sources</li> <li>• Psychopathy level or Mental Abnormality must do a minimum one of the following tests: <ul style="list-style-type: none"> <li>○ Psychopathy Checklist Revised (PCLR)</li> <li>○ Psychopathy Checklist Screening Version</li> <li>○ MCMI III (Narcissistic + Antisocial + Paranoid)</li> </ul> </li> <li>• Personality disorder (minimum of one below): <ul style="list-style-type: none"> <li>○ MMPI 2</li> <li>○ MCMI III</li> <li>○ PAI</li> <li>○ DSM diagnosis from clinical interview</li> </ul> </li> <li>• Other Mental Health Concerns</li> </ul>
<i>Offender's Responsibility and Level of Denial</i>	<ul style="list-style-type: none"> <li>○ Clinical interview</li> <li>○ Shannon/Brake Levels &amp; Types of Denial</li> <li>○ Collateral Data</li> </ul>

<p><i>Offender's Support System and Home Environment</i></p>	<ul style="list-style-type: none"> <li>• Clinical interview/Collateral Information regarding the following areas when relevant to the offender's risk of contact with children               <ol style="list-style-type: none"> <li>1. When the non-offending parent/child are willing to be part of the evaluation process, resulting information will be incorporated into the PRA</li> <li>2. Does the offender's partner or support system believe the offender has committed a sex offense and support compliance with treatment and supervision?</li> <li>3. Do they acknowledge any possibility of risk to the children?</li> <li>4. Are they dependent on the offender for financial or emotional support?</li> <li>5. Are there issues of unequal power and control in the partner/support system relationship?</li> <li>6. Does partner/support system have any difficulties in confronting the offender?</li> <li>7. Do any dynamics involving fear and/or power imbalance exist in the partner/support system relationship?</li> <li>8. Other than the offender, what other support systems does the partner depend on?</li> <li>9. Assess partner/support system's parenting skills, including strengths and limitations.</li> <li>10. Assess partner/support system's level and type of attachment to the children.</li> <li>11. Assess partner/support system's current level of functioning.</li> <li>12. Assess partner/support system's current problems as a result of the offender's arrest.</li> <li>13. Assess partner/support system's current ability to recognize and respond to the needs of the children</li> <li>14. Assess what the partner/support system has told the children about the offender.</li> <li>15. Assess what the partner/support system feels are the children's most immediate needs.</li> <li>16. Are they willing and able to be involved in significant other's treatment/education and to have the children participate in treatment/education?</li> <li>17. Are they willing and able to stop contact if the children are at risk?</li> <li>18. Review collateral information from other providers involved with the family.</li> <li>19. Describe any Social Services involvement with the family. Does the partner have a record of Social Services involvement.</li> <li>20. Known risks presented in neighborhood.</li> </ol> </li> </ul>
<p style="text-align: center;"><b>SEE INTRODUCTION TO PRA FLOWCHART AND PRA DECISION FLOWCHART IN APPENDIX F IN ORDER TO MAKE FINDINGS.</b></p>	

*Discussion Point: Individual plans regarding child contact should address whether the offender needs parenting classes.*

## 5.740 Criteria for Contact with Children

### Section A - Sex Offenders' Contact with Their Own Children

The following criteria shall apply to a sex offender's supervised contact with his/her own children \* when the children are not the victims of the offender and when the Parental Risk Assessment has indicated the offender is moderate or high risk with regard to his/her own children.

\* This includes children with whom the offender has a parental role, including but not limited to: biological, adoptive, and stepchildren.

If any of the offender's children are victims of his/her offenses, Section C shall dictate the offender's contact with all of his/her children. Please refer to Section C for criteria regarding contact issues under those circumstances.

**5.741 (A)** The treatment provider, in conjunction with the community supervision team, shall:

1. Support the child's wishes when the child does not wish to have contact with the offender;
2. Arrange contact in a manner that places the child's safety first. When assessing safety, both psychological and physical well-being shall be considered;
3. Ensure consultation with, and the support of, the custodial parent or guardians of the child prior to authorizing contact. When the child has a therapist, they shall also be involved in the approval process;
4. Ensure that contact does not conflict with any existing court or parole board directives;
5. Ensure the offender has an approved supervisor present within visual and hearing range during all contacts.

**5.742 (A)** Treatment providers, in conjunction with the community supervision team, shall ensure the offender achieves the following criteria before contact can be initiated. For those offenders assessed through the Parental Risk Assessment as moderate risk to their own children, teams may use discretion in allowing written, telephone or therapeutic contact prior to the completion of these criteria.

1. The offender accepts responsibility for offense related behavior and any significant differences (i.e. regarding the sexual behavior in which the offender has engaged, use of force, and threats) between the offender's statements, the victim's statements and corroborating information about the abuse have been resolved;
2. The offender has yielded non-deceptive results in all the required areas of the sexual history disclosure polygraph process and has yielded non-deceptive results on the most recent maintenance polygraph. The content of the maintenance polygraph shall have addressed behavior that puts victims/children at risk. Furthermore, there shall not be concerns regarding significant risk related behavior.



Some offenders have a history of persistent arousal to minors. Although they may be able to meet 5.742 criteria, because of the likelihood that proximity to children will trigger or increase this arousal, the team shall frequently reassess the offender's ability to maintain a reduced level of arousal<sup>6</sup>. The team shall terminate an offender's approval for contact with minors if there is behavior or other evidence to indicate arousal to minors cannot be managed.

3. Plethysmograph or Abel Assessment for Sexual Interest results indicate a reduction in, or absence of, any sexually deviant arousal/interests and the offender consistently demonstrates the use of cognitive and behavioral interventions to interrupt deviant fantasies and behaviors;
4. The offender has disclosed information related to risk and other relevant factors as prescribed by the team. The team will make a determination of who should receive this information;
5. The offender consistently demonstrates an understanding of and has written his/her deviant cycle and accepts the possibility of re-offense. The offender has developed a written relapse prevention plan for intervention to the satisfaction of the community supervision team;
6. The offender consistently demonstrates an understanding of the impact of the abuse on the victim(s) and their family, as evidenced by behavioral accountability and self-regulation;
7. The offender consistently demonstrates an understanding of the impact of his/her behavior on his/her own family, as evidenced by behavioral accountability and self-regulation;
8. The offender consistently demonstrates an understanding of and is willing to respect the child's verbal and non-verbal boundaries and need for privacy;
9. The offender consistently demonstrates an understanding of how to safely participate in having contact with child(ren);
10. The offender is willing to accept limits or prohibitions on contact as established by the community supervision team with input from the child, child's other parent or guardian, or child's therapist and will put the child's needs first;
11. The offender is willing to plan for contact, to develop and utilize an approved safety plan for all contact, to accept supervision during contacts, and to terminate contact when requested by the community supervision team, the approved Supervisor, or the child. The safety plan shall be approved in advance and in writing by the team and signed by the offender;
12. The offender consistently demonstrates compliance with supervision conditions;
13. The offender consistently demonstrates satisfactory progress in treatment, including consistent compliance with treatment conditions.

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<sup>6</sup> Davis, G., Williams, L., Yokley, J. (1996); (1999) Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections.

## **Section B - Sex Offenders' Contact with Persons Under the Age of 18**

The following criteria applies specifically to supervised contact with persons under the age of 18 who are not the offender's own children or the victims of the offender. This section shall apply to relatives in a non-parental role. Please refer to sections A and/or C for criteria regarding contact issues under those circumstances.

- 5.741 (B)** The treatment provider, in conjunction with the community supervision team, shall:
1. Support the child's wishes when the child does not wish to have contact with the offender;
  2. Arrange contact in a manner that places the child's safety first. When assessing safety, both psychological and physical well-being shall be considered;
  3. Ensure consultation with, and the support of, the custodial parents or guardians of the child prior to authorizing contact. When the child has a therapist, they shall also be involved in the approval process;
  4. Ensure that contact does not conflict with any existing court or parole board directives;
  5. Ensure the offender has an approved supervisor present within visual and hearing range during all contacts.

- 5.742 (B)** Treatment providers, in conjunction with the community supervision team, shall ensure the offender achieves the following criteria before contact can be initiated:

1. The offender accepts responsibility for offense related behavior and any significant differences (i.e. regarding the sexual behavior in which the offender has engaged, use of force, and threats) between the offender's statements, the victim's statements and corroborating information about the abuse have been resolved;
2. The offender has yielded non-deceptive results in all the required areas of the sexual history disclosure polygraph process and has yielded non-deceptive results on the most recent maintenance polygraph. The content of the maintenance polygraph must have addressed behavior that puts victims/children at risk. Furthermore, there must not be concerns regarding significant risk related behavior.

Some offenders have a history of persistent arousal to minors. Although they may be able to meet 5.742 criteria, because of the likelihood that proximity to children will trigger or increase this arousal, the team shall frequently reassess the offender's ability to maintain a reduced level of arousal<sup>7</sup>. The team shall terminate an offender's approval for contact with minors if there is behavior or other evidence to indicate arousal to minors cannot be managed.

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<sup>7</sup> Davis, G., Williams, L., Yokley, J. (1996); (1999) Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections.

3. Plethysmograph or Abel Assessment for Sexual Interest results indicate a reduction in, or absence of, any sexually deviant arousal/interests and the offender consistently demonstrates the use of cognitive and behavioral interventions to interrupt deviant fantasies and behaviors;
4. The offender has disclosed information related to risk and other relevant factors as prescribed by the team. The team will make a determination of who should receive this information;
5. The offender consistently demonstrates an understanding of and has written his/her deviant cycle and accepts the possibility of re-offense. The offender has developed a written relapse prevention plan for intervention to the satisfaction of the community supervision team;
6. The offender consistently demonstrates an understanding of the impact of the abuse on the victim(s) and their family, as evidenced by behavioral accountability and self-regulation;
7. The offender consistently demonstrates an understanding of the impact of his/her behavior on his/her own family, as evidenced by behavioral accountability and self-regulation;
8. The offender consistently demonstrates an understanding of and is willing to respect the child's verbal and non-verbal boundaries and need for privacy;
9. The offender consistently demonstrates an understanding of how to safely participate in having contact with child(ren);
10. The offender is willing to accept limits or prohibitions on contact as established by the community supervision team with input from the child, child's other parent or guardian, or child's therapist and will put the child's needs first;
11. The offender is willing to plan for contact, to develop and utilize an approved safety plan for all contact, to accept supervision during contacts, and to terminate contact when directed by the community supervision team, the approved Supervisor, or the child. The safety plan shall be approved in advance and in writing by the team and signed by the offender;
12. The offender consistently demonstrates compliance with supervision conditions;
13. The offender consistently demonstrates satisfactory progress in treatment, including consistent compliance with treatment conditions.

<b>Section C - Sex Offender Contact with Adult and Child Victims as well as Siblings of Victims</b>
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**5.741 (C)** The following criteria applies to any contact with adult or child victims and their non-victim siblings.

Treatment providers, in conjunction with the community supervision team, shall:

1. Support the victim or non-victim siblings' wishes when either does not wish to have contact with the offender;
2. Collaborate, whenever possible, with a victim's therapist or advocate, or guardian, custodial parent, foster parent, and/or guardian ad litem when the victim is under eighteen years of age, in making decisions regarding communication, visits, and reunification;
3. Arrange contact in a manner that places victim safety first. When assessing safety, both psychological and physical well-being shall be considered. When the child has a therapist, they shall also be involved in the approval process;
4. Ensure that contact is not in conflict with any existing court or parole board directives;
5. Before recommending contact with a victim or any non-victim siblings, assess the offender's readiness and ability to refrain from re-victimizing, i.e. to avoid coercive and grooming statements and behaviors, to respect the victim's personal space, and to recognize and respect the victim's indication of comfort or discomfort;
6. Ensure the offender has an approved supervisor present within visual and hearing range during all contacts with child victims and non-victim siblings.

**5.742 (C)** Treatment providers, in conjunction with the community supervision team, shall ensure the offender achieves the following criteria before contact can be initiated:

1. The offender accepts responsibility for offense related behavior and any significant differences (i.e. regarding the sexual behavior in which the offender has engaged, use of force, and threats) between the offender's statements, the victim's statements and corroborating information about the abuse have been resolved;
2. The offender has yielded non-deceptive results in all the required areas of the sexual history disclosure polygraph process and has yielded non-deceptive results on the most recent maintenance polygraph. The content of the maintenance polygraph must have addressed behavior that puts victims/children at risk. Furthermore, there must not be concerns regarding significant risk related behavior.

Some offenders have a history of persistent arousal to minors. Although they may be able to meet 5.742 criteria, because of the likelihood that proximity to children will trigger or increase this arousal, the team shall frequently reassess the offender's

ability to maintain a reduced level of arousal<sup>8</sup>. The team shall terminate an offender's approval for contact with minors if there is behavior or other evidence to indicate arousal to minors cannot be managed.

3. Plethysmograph or Abel assessment for sexual interest results indicate a reduction in, or absence of, any sexually deviant arousal/interests and the offender consistently demonstrates the use of cognitive and behavioral interventions to interrupt deviant fantasies and behaviors;
4. The offender has disclosed information related to risk and other relevant factors as prescribed by the Team. The Team will make a determination as to who will receive this information;
5. The offender consistently demonstrates an understanding of and has written his/her deviant cycle and accepts the possibility of re-offense. The offender has developed a written relapse prevention plan for intervention to the satisfaction of the community supervision team;
6. The offender consistently demonstrates an understanding of the impact of the abuse on the victim(s) and their family, as evidenced by behavioral accountability and self-regulation;
7. The offender consistently demonstrates an understanding of the impact of his/her behavior on his/her own family, as evidenced by behavioral accountability and self-regulation;
8. The offender consistently demonstrates an understanding of and is willing to respect the victim's and non-victim siblings verbal and non-verbal boundaries and need for privacy;
9. The offender consistently demonstrates an understanding of how to safely participate in having contact with the victim and his/her non-victim siblings;
10. The offender is willing to accept limits or prohibitions on contact set by parents or legal guardians, or victim/non-victim sibling's therapist during the time the victim/non-victim siblings is under the age of eighteen and puts the victim's/non-victim siblings needs first. The offender accepts that others will decide about visitation, including the victim/non-victim siblings and the community supervision team;
11. The clarification process has commenced and sufficiently progressed. The primary purpose of the clarification process is to recognize and address past and potential victim harm embedded in the relationship between the offender and the victim. It is not designed to be used primarily for furthering or preventing future contact.
12. The offender is willing to plan for contact, to develop and utilize an approved safety plan for all contact, to accept supervision during contacts, and to terminate contact

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<sup>8</sup> Davis, G., Williams, L., Yokley, J. (1996); (1999) Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections.

when requested by the community supervision team, the approved supervisor, or the child. The safety plan shall be approved in advance and in writing by the team and signed by the offender.

13. The offender consistently demonstrates compliance with supervision conditions;

14. The offender consistently demonstrates satisfactory progress in treatment, including consistent compliance with treatment conditions.

#### **5.750 Unsupervised Contact with the Offender's Children (under age 18) \***

The criteria listed below are to be used by the community supervision team when considering granting an offender unsupervised contact with his/her own children. Offenders shall not be allowed to have unsupervised contact with children who are not his/her own.

\* For those offenders for whom the 5.742 criteria are waived pursuant to the results of the Parental Risk Assessment which includes the polygraph exams, this criteria does not apply, unless new information of concern has arisen.

- Unsupervised contact shall never be allowed for a sex offender diagnosed with any type of pedophilia (per DSM IV-TR).
- In any case where unsupervised contact is being requested, the community supervision team shall consider the child's needs; specifically, the protection and emotional needs of the child.
- Support the child's wishes when he/she does not want to have unsupervised contact with the offender.
- When there is a therapist working with the child the therapist shall be involved in the decision to grant unsupervised visitation. When the child is not currently seeing a therapist, the community supervision team may want to consult with a third party therapist or advocate who has expertise in child sexual abuse to discuss general issues surrounding unsupervised contact.
- The community supervision team shall unanimously agree that unsupervised contact will not place the child in danger and shall not consider unsupervised contact if there are any known or expressed concerns by the child involved. The offender shall develop a safety plan regarding the child involved, which shall be approved in advance and in writing by the Community Supervision Team.

Offenders being considered for unsupervised contact with their children shall:

- a) Not have committed any offenses against any of the children in question;
- b) Not meet any of the Exclusionary Criteria (as referenced earlier in Standard 5.720);
- c) Have met and demonstrated compliance with all criteria in Standard 5.742 (A) for a minimum of six months without evidence of increased arousal or sexual acting out, as verified by ongoing polygraph testing (minimum of the two most recent maintenance polygraph exams being non-deceptive). Not show any deviant arousal to, or interest in, children as confirmed through current clinical and physiological measures;
- d) Have demonstrated consistent compliance with supervision conditions;

- e) Have demonstrated satisfactory progress in treatment, including consistent compliance with treatment conditions.

Community supervision teams shall thoroughly document reasons for all decisions made regarding an offender's unsupervised contact with his/her children.

The privilege of unsupervised contact shall be immediately revoked upon identification of any risk to the children involved or non-compliance with any of the criteria listed here or in Standard 5.740 through 5.742.

**5.760 Contact with children shall be in the presence of a trained and approved supervisor with the exception of those offenders who have met the criteria for unsupervised contact with their own children (see Standard 5.750).**

*Discussion Point: Team members should never abdicate any part of their authority or responsibility regarding an offender to an Approved Supervisor. Teams should continually evaluate and assess the performance of the Approved Supervisor and revoke Approved Supervisor status if necessary.*

**5.761 Qualifications of an Approved Supervisor - Prior to allowing a person to be an Approved Supervisor, the team shall ensure that he or she has the following qualifications:**

- 1) Is not currently under the jurisdiction of any court or criminal justice agency for a matter that the team determines could impact his/her capacity to safely serve as an Approved Supervisor;
- 2) Has no prior convictions, as defined by SOMB Statute, for unlawful sexual behavior or child abuse or neglect. If ever accused of unlawful sexual behavior or child abuse, presents information requested by the team so that the team may assess current impact on his/her capacity to serve as Approved Supervisor. \*  
Must agree to undergo and pay for a complete criminal history background check;
- 3) Has no significant cognitive or intellectual impairment;
- 4) Has no significant mental health or substance abuse problems;
- 5) Has no significant health limitation that interferes with the performance of his/her duty;
- 6) Has adequately resolved any issues regarding personal history of victimization;
- 7) The offender has no history of perpetrating domestic violence or any other form of victimization against the supervisor
- 8) Is not hostile toward systems designed to intervene;
- 9) Is willing to maintain open communication with the team and report offender behavior;
- 10) Is willing to maintain protection of children as the highest priority and believes this outweighs any offender or family interests;
- 11) Acceptance by the children and children's custodial parents/guardians;
- 12) Demonstrates empathy for offender's victims.

\* In very rare circumstances, the Community Supervision Team may choose to make an exception to the prohibition about a misdemeanor child abuse conviction. The reasons for this exception should be made by the unanimous agreement of the Community Supervision Team and documented in writing.

**5.762 The Community Supervision Team shall ensure that the Approved Supervisor knows the following information:**

- 1) The underlying factual basis of the present offense(s) omitting information pertaining to a victim's identity;
- 2) The offender's statement of responsibility;
- 3) The offender's complete and verifiable sexual history disclosure (omitting any victim identity) and does not deny or minimize the offender's responsibility or the seriousness of sexual offending;
- 4) What constitutes sexual offending and other abusive behavior and the ongoing risk the offender presents to children;
- 5) The offender's risk factors, deviant sexual arousal patterns, offense cycle, and grooming behaviors;
- 6) That treatment progress and offender risk is variable over time;
- 7) The offender's mental health issues without making excuses for his/her behavior;
- 8) The offender's community supervision conditions, including Standard 5.710, treatment contract expectations, and rules regarding the approved contact;
- 9) The offender's requirement to provide the team with a written safety plan regarding supervised contact;
- 10) That the offender may have the ability to manipulate the approved supervisor;

**5.763 The treatment provider shall develop a written contract that is signed by the team members and the approved supervisor. The contract shall state the responsibilities and duties of the approved supervisor. The contract shall require the following from the approved supervisor:**

**Duties and Responsibilities**

- 1) Maintain qualifications and stay current on the knowledge and responsibilities as referenced in Standards 5.761 through 5.762;
- 2) No consumption of alcohol or mind-altering substances while acting as an approved supervisor;
- 3) Maintain confidentiality regarding victim information;
- 4) Ensure compliance with all rules as specified by the team;
- 5) Only allow contact with children approved by the team;
- 6) Never leave the offender alone with a child or victim and always be within sight and sound of the offender and the child/victim during contact;
- 7) Intervene when high risk situations or behaviors occur (i.e. terminate contact, report concerns to the community supervision team);
- 8) Assess the child's emotional and physical safety on a continuing basis and terminate contact immediately if any aspect of safety is jeopardized.
- 9) Maintain open and honest communication with the team, reporting all of offender's cycle-related behaviors and attitudes, responding to inquiries by the team, and when requested, meet with the team;
- 10) Provide documentation of contacts to the team as required;
- 11) Express any concerns to the team regarding the offender's behaviors, including but not limited to, non-compliance with the contract or treatment conditions, cycle behavior, etc.);



**The following shall be specified in the written contract:**

- Names of children with whom the approved supervisor is allowed to oversee any type of contact
- Type of contact allowed (face to face, physical, video, written, phone),
- Locations of contact
- Time/day of contacts
- Activity/events in which the offender may participate
- Other adults who may be present
- If the approved supervisor is not in compliance with all of the requirements, the community supervision team may discontinue or modify any contact privileges or the approval status of the supervisor.
- An explanation of a supervisor's potential civil liability for negligence in enforcing stated rules and limitations.

**5.770 When the offender communicates with any child, the community supervision team shall always screen the offender's communication and ensure that it is appropriate. This Standard can be waived for an offender's own non-victim children once the offender has met the criteria in 5.750.**

**5.780 Family Reunification** – Prior to considering family reunification the offender shall have met the criteria listed in 5.750 and the community supervision team shall unanimously agree that family reunification is appropriate.

\* For those offenders for whom the 5.742 (A). criteria are waived pursuant to the results of the Parental Risk Assessment which includes the polygraph exams, this criteria does not apply unless new information of concern has arisen.

Family Reunification is defined as the offender living in the same residence with his/her children.

Due to ongoing risk of re-offense, family reunification in cases of sexual assault or sexual abuse is rarely indicated.

When a child protective agency is involved in a case in which the offender is on probation or parole, any efforts toward family reunification should be carefully coordinated with the community supervision team as described in these Standards.

Family reunification shall never take precedence over the safety of any former victim or the offender's own children. If reunification is indicated, after careful consideration of the potential risks over an extended period of time, supervising officers and treatment providers shall carefully monitor the process.

Family reunification shall never be considered when the spouse/partner or caretaker is not actively involved in the offender treatment process and the child(ren)'s treatment process as applicable as recommended by the team. He/she should be willing and able to fully support all conditions imposed by the community supervision team.

**5.790 Circumstances Under Which Criteria May Be Waived**

Allowing contact prior to fulfillment of the criteria outlined in Section 5.742 of these Standards and Guidelines should occur only in **rare** circumstances. In addition, the entire team shall have

worked with the offender and agree that there is minimal risk of any crossover or additional crimes of opportunity. While it is not appropriate for the criteria to be waived in its entirety for ongoing contact, there may be parts of the criteria that may be waived or postponed.

Occasionally, the team may approve a broader waiver of 5.742 criteria for a one-time contact only, such as for a child's contact with the offender in a therapy session to assist non-victim children in adjusting to the offender's removal from the home. Any approval for this kind of closure/explanation session shall be in writing and the community supervision team shall determine all the particulars of that session. If the child(ren) has a therapist or an advocate, that person should also be present. The community supervision team shall take every precaution to ensure that the children with whom a sexual offender is doing this kind of closure or explanation session are not his/her primary victims.

Additionally, when victim clarification work is being conducted in a therapist's office between a victim and offender, contact may occur.

In cases where the team determines that it would not be safe to have the offender in a session with his/her child(ren), a video taped or audio taped presentation by the offender might be a suitable alternative. In cases where a face-to-face meeting or a tape is not appropriate, another option for contact with his/her children would be a letter from the offender. The letter shall be approved by the team and if possible by a victim advocate or therapist prior to its presentation to the child(ren). Whenever possible, an advocate or therapist for the child or children should be present when the letter is presented to the child or children.

There may be instances when an adult victim desires contact with an offender prior to 5.742 C. criteria having been achieved. Teams should staff these situations and determine if contact should be allowed and under what circumstances (e.g. with a therapist present, telephone contact, etc.) Victim safety and offender rehabilitation shall remain the priorities.

**When making a decision to waive any part of the criteria, there shall be full consensus of the team. An explanation of the specific circumstances and reasons shall be documented, including the potential risk to the community, victim(s), and potential victims involved.**

#### **5.711 Potential Adult Victims**

The Board recognizes that it is not possible to limit a sex offender's contact with all adults in the community. However, care should be taken to limit the offender's access to places and groups where he or she has a history of accessing victims (e.g.: bars, clubs, singles groups, senior centers, medical care facilities, campuses, etc.) or where he or she may present a current risk.

It is also imperative that consideration be given to protecting at-risk adults. Treatment providers and other members of community supervision teams shall not allow sex offenders to have unsupervised contact with adults who are at particular risk for victimization due to mental status, disability, or incapacity. Decisions to allow any contact with at-risk adults should be made using the same criteria as for child contact. [See Standard 5.742 (B)].

## **EXPLANATION OF “NO CONTACT/RESTRICTED CONTACT WITH CHILDREN”**

**A sex offender must make every attempt to avoid being in contact with children.**

A child (or minor) is defined as anyone under the age of eighteen (18) years old.

“Contact” means any of the following:

1. Actual physical touching.
2. Any communication, direct or indirect, including personal visits, talking on the telephone, letters or written notes, non-verbal communication such as body language (waving, gesturing) and facial expressions (winking, smiling, email and any other form of electronic communication, photographs or cards.
3. Engaging in a relationship, or taking any action which furthers a relationship with a child, such as giving gifts or sending messages through other people.
4. Inquiring about the health, welfare or well-being of any minor. If information is provided by third parties, unsolicited information shall be reported to your treatment team immediately. Solicited information is prohibited without prior permission from the Community Supervision Team (CST).

Sex offenders are prohibited from going to places which cater to children and should avoid going to other locations at times when children are likely to be present. For example, an offender should not shop at times when it is likely that children will be in the store. Any offender should not go to places primarily used by children, such as schools, video arcades, public parks or playgrounds, public pools, amusement parks, recreation centers, or attend public events where families or children are likely to be present, such as carnivals or sporting events designed for those under the age of 18. It is an offender’s responsibility to carefully evaluate all areas where children may be present and plan accordingly. An offender will not be permitted to attend family functions on holidays or special occasions when children are present, until and unless he has received written permission from his CST and has an approved supervisor whom the CST has approved. Even in these cases, the parents or legal guardian of the children involved must be informed regarding the offender’s status as a sex offender, his probationary sentence and conditions and consent to the contact.

If an offender encounters a child who is a stranger, the offender must not pay attention to the child, look at the child, or talk to the child. If a child persists in trying to communicate, the offender must leave immediately.

If an offender is in a public place and encounters a child whom the offender knows, the offender must avoid the child, and immediately leave the public place.

If children are present in the waiting area of the probation office or any other office, the offender must check in for his/her appointment, then wait in a designated area until he/she is called.

If an offender must remove himself from the area in order to prevent any type of contact it must be done in a manner that does not draw attention to himself/herself.

If an offender is approved to go to a place where children are present, it is the offender’s responsibility to make special arrangements so that no contact with children will be

made. The offender must also get prior written permission from the CST and may be required to write a safety plan.

If an offender is in a private area such as his/her residence or a friend's residence, and a child enters, the offender must leave immediately. If a child comes into an offender's yard to play or ask questions, the offender must go inside the residence immediately. If a child comes to an offender's door for any reason, the offender must not answer the door. It is the offender's responsibility to disclose his/her offense to others when necessary to gain support in avoiding contact with children.

It is possible for a sex offender to have supervised visitation with specific children once the offender has progressed sufficiently in treatment and obtained an "approved supervisor" and has received written permission from the CST. The probation officer will explain the procedure of obtaining an approved supervisor. It is a privilege to have supervised contact with children. Any violation of the visitation contract may result in termination of visitation.

An offender shall maintain a "contact log" listing incidental/accidental contact with children. Unauthorized contact with children is monitored through community surveillance and polygraph testing. Therefore it is important for the offender to report all contacts with children to the CST. The CST will provide specific instructions regarding maintaining a contact log.

**Contact with any victim(s) outside of the therapeutic setting is absolutely prohibited. If an offender encounters a victim, the offender must leave the place immediately.**

It is the offender's responsibility to ask questions and understand the concepts in the advisement.

I have received an identical copy of the "Explanation of 'No Contact/Restricted Contact with Children'" and I have read it carefully with full understanding. I understand that any violation of this requirement will be reported to the court for action, which may include revocation of probation and imposition of sentence.

Defendant	Date
Probation Officer/Witness	Date

Explanation of "No Contact with Children" Form, REVISED July 2007  
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## Appendix 13

### **Sample Training Program for Newly Hired Staff Obtained from the Colorado Department of Corrections**

#### **STAFF TRAINING WORKING WITH SEX OFFENDERS**

- Monday -
- Introductions
  - Victim Sensitivity Video
  - Rape: A New Perspective Video
  - What General Population Studies of Victimization Can Tell Us about Sex Offending
  - Victim Issues – Victim Treatment Provider
  - What Offender Studies Using Confidentiality or Polygraph Can Tell Us about Sex Offending
  - Sex Offender Typologies
  - Model for Understanding Sex Offenders
  - Special Populations:
    - Sadists
    - Psychopaths
    - DD
    - OSMI
    - Females
    - Juveniles
- Tuesday -
- Sex Offender Management Board Standards
  - Containment Model
  - Research on the Effectiveness of Treatment
  - DOC RAM Team Continuum
  - DOC Identification of Sex Offenders
    - Administrative Reviews
  - DOC's Sex Offender Treatment and Monitoring Program
    - Core Curriculum
    - Phase I
    - Phase II
    - Lifetime Formats & Criteria for Parole
    - Joint Community Transition Planning
    - Parole Board Summaries
    - Family Support/Education Program
    - Circles of Support
  - RAM supervision
    - RAM Supervision Video
    - Supervision of Minimum to Life Sex Offenders
    - Approved Treatment Providers
    - Law Enforcement Network
    - RAM Directives
  - Law Enforcement Notification/Registration/DNA Testing/SVP
  - ViCAP

Wednesday - Effective Supervisory/Therapeutic Approach with Sex Offenders  
Value of Accountability  
Value of Collateral Information  
Working Effectively on a Team  
Sex Offender Manipulation Tactics  
    Videotaped Interviews with DOC Sex Offenders  
Screening Sex Offenders  
Sex Offender Evaluations and Treatment Plans  
    Abel Assessments & Plethysmograph  
Documenting Probation and Termination Conditions  
Responding to Lawsuits and Grievances  
Staying Sane While Working with Sex Offenders - Job Impact and How to Manage It

Thursday - Special Conditions of Treatment and Supervision  
    Contact with Children:  
        • Review of Research  
        • Texas Justice Video  
        • Marilyn Van Derbur Video  
        • Truth, Lies and Sex Offenders Video  
        • Sex Offenders Family Relationships Video  
    Family Responsibility vs. Reunification  
    Pornography  
    Internet Use  
    Pharmacotherapy with Sex Offenders

Friday - DOC Polygraph Procedures  
    Small Group Exercise  
    Treatment/Supervision Planning Based on Official Record and Polygraph Information  
    Coding Polygraph Information Exercise  
    Coding Sanctions Grid Exercise  
    Treatment Scenarios  
    Parole Supervision Scenarios

Handouts:


- PowerPoint Copies
- Sex Offender Management Board Standards and Guidelines
- Sex Offenders: Myths, Facts & Treatment
- Research Supporting Restricted Contact With Children & Family Handout
- Personal Change Contract Handout
- SOTMP Treatment Contracts
- Screening Sex Offenders Handout
- Transition to Parole Guidelines
- RAM Directive/Parole agreements

## Appendix 14

Supervision: Surveillance, caseload size, and contact standards





<u>ADMINISTRATIVE REGULATION</u>    COLORADO DEPARTMENT OF CORRECTIONS		REGULATION NUMBER	PAGE NUMBER
		250-49	1 OF 5
		CHAPTER: Adult Parole, Community Corrections, and Youthful Offender System	
		SUBJECT: Contact Standards	
RELATED STANDARDS: ACA Standards NONE		EFFECTIVE DATE: February 1, 2007	
		SUPERSESSION: 02/01/06	
OPR: PCY	REVIEW MONTH: November	Aristedes W. Zavaras Executive Director	

I. POLICY

It is the policy of the Department of Corrections (DOC), Adult Parole, Community Corrections, and Youthful Offender System to maintain contact standards for every offender under the supervision of Adult Parole or Community Corrections. An offender shall be monitored by the CPO at a level which supports public safety and is determined by the Level of Service Inventory (LSI).

II. PURPOSE

The purpose of this administrative regulation is to establish guidelines, standards, and responsibilities for Adult Parole and Community Corrections associated with contact standards for offenders. Minimum contact standards shall be established and standardized according to the classification level determined by the LSI.

III. DEFINITIONS

- A. Level of Service Inventory (LSI): Risk/needs assessment instrument which measures the needs of an offender and assesses the level of supervision of the offender.
- B. Residence of Record: The place (house, apartment, room, or specific location) where an offender does, in fact, reside and which has been approved by a community parole officer.

IV. PROCEDURES

- A. An offender shall be contacted in one or more of the following locations: in the community, place of employment, residence of record, Parole/Community office, Community Corrections centers, Approved Treatment Provider offices, and any other location where contact is made with the offender or with individuals who have specific knowledge about the offender.
- B. Upon release from a DOC facility or Community Corrections facility to regular parole supervision, the offender will be classified "NEW." The CPO shall supervise this offender under "Maximum" contact

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standards until the LSI can be completed (within 30 days of release) and the level of supervision is determined.

C. Following are the minimum contact standards for **ISP - Community** and **ISP - Parole**:

1. Weekly personal face-to-face contact with the CPO or program contract workers (for the purpose of this administrative regulation, program contract workers may include an approved treatment provider, TASC contract workers day reporting, division approved providers, designated law enforcement representatives, etc.) at any location. A face-to-face contact does not include submission of a UA/BA without a documented case management meeting. At least 50 percent of these contacts shall be between the CPO and the offender.
2. A personal face-to-face home visit within the first 30 calendar days from release and each time there is a change of residence. One personal face-to-face home visit every two months. Home visits should be conducted when the offender is most likely to be home, which is during the offender's assigned curfew.
3. Employment visitation and monitoring at least twice each month.
4. Monthly contact (face-to-face collateral, telephonic, electronic, or documentary) with program contract workers at any location to verify treatment participation and progress.
5. Daily telephone contact between the offender and C-Wise.

D. Following are the minimum contact standards for parolees classified at the **MAXIMUM** level of supervision:

1. Two times a month personal face-to-face contact with CPO or program contract workers (for the purpose of this administrative regulation, program contract workers may include an approved treatment provider, TASC contract workers day reporting, division approved providers, designated law enforcement representatives, etc.) at any location. A face-to-face contact does not include submission of a UA/BA without a documented case management meeting. At least one of these contacts shall be between the CPO and the parolee.
2. A personal face-to-face home visit:
  - a. Within the first 30 calendar days.
  - b. Within 30days of a change of address.
  - c. Annually thereafter.
3. Monthly employment visits or verifications.
4. Monthly contact (face-to-face collateral, telephonic, electronic, or documentary) with program contract workers at any location to verify treatment participation and progress.
5. Bi-monthly telephone contact between the offender and C-Wise.

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E. Following are the minimum contact standards for parolees classified at the **MEDIUM** level of supervision:

1. One time a month personal face-to-face contact with CPO or program contract workers (for the purpose of this administrative regulation, program contract workers may include an approved treatment provider, TASC contract workers day reporting, division approved providers, designated law enforcement representatives, etc.) at any location. A face-to-face contact does not include submission of a UA/BA without a documented case management meeting. At least one of these contacts every other month shall be between the CPO and the parolee.
2. A personal face-to-face home visit:
  - a. Within the first 30 calendar days.
  - b. Within 30days of a change of address.
  - c. Annually thereafter.
3. Monthly employment visit or verification.
4. Monthly contact (face-to-face collateral, telephonic, electronic, or documentary) with program contract workers at any location to verify treatment participation and progress.
5. Bi-monthly telephone contact between the offender and C-Wise.

F. Following are the minimum contact standards for parolees classified at the **MINIMUM** level of supervision:

1. Quarterly face-to-face contact between the CPO and the parolee at any location with monthly reports mailed in all other months.
2. A personal face-to-face home visit:
  - a. Within the first 30 calendar days.
  - b. Within 30days of a change of address.
  - c. Annually thereafter.
3. Quarterly employment visit or verification.
4. Monthly contact (face-to-face collateral, telephonic, electronic, or documentary) with program contract workers at any location to verify treatment participation and progress (if the parolee is in a treatment program).
5. Bi-monthly telephone contact between the offender and C-Wise.

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G. The YOS contact standard will be as follows:

1. Level One: Shall constitute the highest level of supervision of the youth and should be provided during the initial 60 days of placement into the community aftercare or the initial 30 days after return from remediation. Supervision standards for level one shall consist of the following:
  - a. The CPO shall have personal contact with the youth at least twice per week. One contact may be by community aftercare DOC employee or program contract workers.
  - b. The CPO shall conduct at least two home visits per month.
2. Level Two: Level two shall constitute the intermediate level of community supervision and may be employed after the youth satisfactorily completes the initial 60 days of supervision in level one. The youth will be placed in level two for approximately 90 days. Supervision standards for level two shall consist of the following:
  - a. The CPO shall have personal contact with the youth at least once per week. One contact may be by community aftercare DOC employee or program contract workers.
  - b. The CPO shall conduct at least one home visits per month.
3. Level Three: Level three shall constitute the lowest level of community supervision. Level three follows only after the youth has been supervised in level two for a minimum of 90 days. Supervision standards for level three shall require the following:
  - a. The CPO shall have personal contact with the youth at least once per month.
  - b. The CPO shall conduct at least one home visit every six weeks plus a minimum of one field visit exclusive of home visits.

H. CPOs may conduct field contacts/home visits during non-business hours (evening hours, early morning hours, or weekends, with supervisory approval and in compliance with AR 1450-14, *Overtime and Compensatory Time for DOC Employees*).

#### V. RESPONSIBILITY

- A. It is the responsibility of the director of Adult Parole, Community Corrections, and Youthful Offender System to ensure overall compliance with this administrative regulation.
- B. It is the responsibility of the associate directors, managers, and supervisors to ensure regional compliance with this administrative regulation.
- C. It is the responsibility of CPOs to comply with the provisions of this administrative regulation.

#### VI. AUTHORITY

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17-27.5-102. Minimum standards and criteria for the operation of intensive supervision programs.

VII. HISTORY

June 15, 2005  
June 15, 2004  
December 15, 2003

- ATTACHMENTS:
- A. AR Form 250-49A, Contact Standards Grid
  - B. AR Form 100-01A, Administrative Regulation Implementation/Adjustments

## CONTACT STANDARDS GRID

	<i>Face to Face</i>	<i>Home Visits</i>	<i>Employment Visits/ Verification</i>	<i>Treatment Verification</i>	<i>Telephone Contact</i>
<b>ISP Parole</b>	One per week (a)	One w/in the first month then every other month thereafter (b)	Twice a month	One per month	Daily
<b>ISP Inmate</b>	One per week (a)	One w/in the first month then every other month thereafter (b)	Twice a month	One per month	Daily
<b>MAXIMUM</b>	Twice per month (a)	One w/in the first Month (b)	One employment verification per month	One per month	Bi-Monthly
<b>MEDIUM</b>	One per month (a)	One w/in the first month (b)	One employment verification per month	One per month	Bi-Monthly
<b>MINIMUM</b>	One w/in the first month	One w/in the first month (b)	N/A	One per month	Bi-Monthly
<b>YOS Level 1</b>	2 per week (a)	2 per month	N/A	N/A	None
<b>YOS Level 2</b>	1 per week (a)	1 per month	N/A	N/A	None
<b>YOS Level 3</b>	1 per month	1 every 6 weeks	N/A	N/A	None

Program contract workers: TASC contract workers, approved treatment providers, community corrections and designated law enforcement representatives.

- (a) Every other face to face contact can be from program contract workers.
- (b) One personal face to face home visit within 30 days of release and each time there is a change of residence, and annually thereafter.

**ADMINISTRATIVE REGULATION  
IMPLEMENTATION/ADJUSTMENTS**

AR FORM 100-01A (11/15/05)

CHAPTER	SUBJECT	AR #	EFFECTIVE
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(FACILITY/WORK UNIT NAME) \_\_\_\_\_  
WILL ACCEPT AND IMPLEMENT THE PROVISIONS OF THE ABOVE ADMINISTRATIVE REGULATION:


☐ AS WRITTEN    ☐ NOT APPLICABLE    ☐ WITH THE FOLLOWING ADJUSTMENTS TO MEET  
LOCALIZED OPERATIONS/CONDITIONS

(SIGNED) \_\_\_\_\_ (DATE) \_\_\_\_\_  
Administrative Head

Attachment "B"  
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<p align="center"><u>ADMINISTRATIVE REGULATION</u></p>  <p align="center">COLORADO DEPARTMENT OF CORRECTIONS</p>		REGULATION NUMBER	PAGE NUMBER
		250-48	1 OF 16
		CHAPTER: Adult Parole, Community Corrections, and Youthful Offender System	
		SUBJECT: Intensive Supervision of Sex Offenders and the Community Parole Sex Offender Program	
RELATED STANDARDS: ACA Standards None		EFFECTIVE DATE: February 15, 2007	
		SUPERSESSION: 03/01/06	
OPR: PCY	REVIEW MONTH: November	Aristedes W. Zavaras Executive Director	

### I. POLICY

It shall be the policy of the Department of Corrections (DOC), Adult Parole, Community Corrections, and Youthful Offender System to operate an Intensive Supervision Program for offenders convicted or adjudicated of sex offenses in the state of Colorado or any other state to include offenders who are identified by the Parole Board as needing a sex offense specific evaluation and/or treatment, offenders who have a history of deviant sexual behavior, and offenders sentenced under the Colorado Sex Offender Lifetime Supervision Act of 1998 that are eligible to be supervised in the community. It shall include those offenders who have been determined by the Parole Board or a judge to be a Sexual Violent Predator (SVP). As a public safety measure offender management shall be through active community based planning for assessment, treatment, behavioral monitoring, supervision and coordination with law enforcement, and with involvement in other treatment modalities.

### II. PURPOSE

The purpose of this administrative regulation is to establish guidelines that will promote a smooth transition into structured community based supervision programs for sex offenders sentenced to, or released from the DOC. It is to establish uniform supervision standards consistent with current statute and with the Sex Offender Management Board (SOMB) guidelines. It shall provide guidelines for consistent statewide supervision of sex offenders and establish a method to collect data and determine suitable outcome measures.

### III. DEFINITIONS

- A. Abel Assessment for Sexual Interest (Abel Screen): An assessment instrument that gives an objective measurement of deviant sexual interests.
- B. Approved Treatment Provider (ATP): An individual, group, or agency who, after applying to the review board, is determined qualified to provide mental health or substance abuse treatment, or assessment, to DOC offenders.
- C. Clinical Polygraph (Polygraph): An instrument used for the purpose of detecting deception or

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verifying truth of statements of a person under criminal justice supervision and/or treatment for the commission of sex offenses.

- D. Community Corrections Board: The governing body of any unit of local government, or a corrections' board which may be appointed by the governing body of a unit of local government, or any unit of local government, pursuant to Colorado State Revised Statute 17-27-102(2).
- E. Community Corrections Center: Any private or public facility under contract to the Department of Public Safety or the Department of Corrections to provide residential treatment and transitional services for DOC offenders.
- F. Community Supervision Team: A community based supervision and monitoring team that shall, at a minimum, include the supervising community parole officer, therapist, and polygrapher. To ensure the best approach to managing the offender, other individual(s) or agencies that have an interest in the offender may be included as members of this team. The supervising community parole officer shall coordinate this team and shall have final authority regarding supervision team differences.
- G. Continuity of Care: Efforts to facilitate effective mental health treatment by making appropriate referrals and providing relevant information regarding mental health needs and treatment history to recipient of the referrals.
- H. DCIS: Department of Corrections Information System (computer system). DOC's main computer system used for offender management, business operations, and communications.
- I. Electronic Surveillance: Utilization of electronic systems to closely observe and monitor an offender including, but not limited to the following:
  - 1. Electronic monitoring.
  - 2. Electronic paging.
  - 3. Global positioning system.
  - 4. Other approved technology as required.
- J. Offender: Any individual under the supervision of the criminal justice system to include community correction clients, parolees, correctional clients, probationers, or youthful offender system residents.
- K. Plethysmograph: A device that measures erectile responses in males to both appropriate and inappropriate stimulus material.
- L. Sex Offender Lifetime Supervision: Applies to those offenders sentenced to lifetime supervision under the provision of the Colorado Sex Offender Lifetime Supervision Act of 1998 that have been granted parole by the Colorado Board of Parole.
- M. Sex Offender Management Board (SOMB): In 1992, the Colorado General Assembly passed legislation which created a Sex Offender Management Board to develop standards and guidelines for the assessment, evaluation, treatment, and behavioral monitoring of sex offenders.

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- N. Sex Offender Task Force: A group of community parole officers, team leaders and supervisors from all regions of Colorado that currently, or have in the past, supervised sex offenders. The Sex Offender Task Force will make policy recommendations to Community/Parole management, create and standardize procedures pertaining to the supervision of sex offenders, and provide training to CPOs who will supervise sex offenders.

#### IV. PROCEDURES

##### A. Case Assignments, Training, and Unit Staff Meetings

1. Within the Denver metro area all offenders classified as S4, S5, or those that are required to register shall be assigned to the Community/Parole Sex Offender Program (CPSOP) for supervision. The community parole officers (CPOs) assigned to this special unit shall be committed for a minimum of two years by their associate director. Team leaders and supervisors shall be committed to the assignment for a period of two years. These time frames may be changed due to promotional opportunities or other circumstances as determined by the associate director.

Outside the Denver metro area sex offender cases shall be assigned in accordance with regional standards of practice by the associate director.

2. Training and scheduled unit meetings are mandatory for CPOs supervising sex offenders.
  - a. It is recommended that all officers supervising sex offender cases complete the following:
    - 1) “Basic Training for the Supervision of Sex Offenders” provided by the Sex Offender Task Force (SOTF).
    - 2) For CPOs assigned to the Denver metro area CPSOP program, a minimum of 20 hours with the unit’s team leader functioning as a mentor with the team leader advising the supervisor of progress or of additional training needs.
    - 3) Participate in a minimum of 20 hours of training annually, specifically related to sex offender community supervision and management which is fiscally responsible by using local resources whenever possible. This training may include theory, academic study, in-service training with DOC clinicians (facility program experts working with offenders who have demonstrated sexual deviancy), therapeutic intervention techniques, research analysis of sex offender dynamics, assessment technology, or law enforcement techniques.
  - b. CPSOP unit meetings shall be scheduled monthly. Officers in rural areas shall attend one CPSOP unit meeting or SOTF each quarter unless attendance is waived by their supervisor. SOTF meetings shall be scheduled quarterly.

- B. Review process when an offender is a S-2 or S-3 and a history of sex offending behavior is

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discovered:

1. All CPOs shall review the files of offenders rated S-3 for sex offender issues and obtain additional information from CCIC/NCIC, police agencies, prior treatment providers, probation or court records, Sex Offender Treatment and Monitoring Program (SOTMP) and other DOC employees who supervise sex offenders as needed to determine if prior assessment/evaluation have been completed and/or to substantiate the need for sex offender treatment to be ordered by the Parole Board. The CPO may also staff the information with a member of the Sex Offender Task Force.
2. All S-2 offenders shall be staffed with a member of the Sex Offender Task Force regarding the appropriateness of a sex offender evaluation. Prior to authorizing a sex offender evaluation, the CPO shall complete the search for additional information as listed above and check the file for an evaluation and, if none, shall contact the Sex Offender Treatment and Monitoring Program to determine whether an evaluation was completed in a facility.
3. If an evaluation is determined to be needed, a request for one will be made to the SOTMP prior to the offender's release. If the evaluation cannot be done prior to release, a modification of the parole order shall be submitted by the CPO to the Parole Board, in accordance with administrative regulation 250-37, *Modification of Parole Conditions*.
4. The CPO shall complete the "Community/Parole Sex Offender Program, Screening Form" (Attachment "A").
5. When an evaluation is warranted, the offender shall be referred to an ATP provider and the information shall be shared with the therapist and/or polygrapher. The offender shall sign a release of information form allowing for the sharing of information.
6. If the offender is not recommended for a sex offender evaluation or treatment the CPO and the supervisor shall make note of that on Attachment "A" and forward the attachment to the working file or to the CPO who will be assigned the case for placement in the working file.

C. Pre-Parole or Community ISP Investigations for Sex Offenders

1. All investigations shall be thoroughly investigated in a timely manner to determine the validity of the plan and to assess the need for community based services. The results of the investigation shall be documented on the CPSOP community placement/pre-parole investigation form (Attachment "B").
2. The investigation shall determine, but is not limited to:
  - a. Appropriateness of residence for parole/community ISP purposes (in view of victim pool or victim assessability).
  - b. Cooperation of sponsor(s) with community/parole authorities.
  - c. Officer safety.
  - d. Proximity of residence to schools, parks, day care centers or other facilities where children may gather.

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- e. Criminal history of all occupants of the residence.
- f. Recommendation of appropriate community based treatment program(s).
- g. Recommendation for some form of electronic monitoring.
- h. Consideration of needs for community based resources for parolees in conjunction with re-entry DOC employees, contract workers, and volunteers.
- i. Victim notification requirements.

D. Supervision

1. Officers assigned to the Community/Parole Sex Offender Program (CPSOP) shall maintain a case load of not more than 26 offenders.
2. If a CPO who is not assigned to the CPSOP unit discovers that an assigned offender may be a sex offender, the CPO shall staff the case with a CPSOP supervisor or SOTF member who will staff the case to determine whether the offender needs to be reassigned to a different CPO.
3. At the initial office visit, the offender shall sign the "Parole IOV Directive" (see AR 250-51 *Initial/Reoccurring Office Visits*, Attachment "G"), "Firearms Advisement" (see AR 250-51 *Initial/Reoccurring Office Visits*, Attachment "C"), the "Sex Offender Supervision Directive/Lawful Order" (see AR 250-51 *Initial/Reoccurring Office Visits*, Attachment "I"), "Notice to Register as a Sex Offender" (see AR 550-06, *Sex Offender Registration*, Attachment "A") (if applicable), C-Wise Directive and Lawful Order, and the "Restitution/Lawful Order Directive" (see AR 250-18, *Restitution*, Attachment "A") (if applicable). The offender shall sign all appropriate releases of information. The offender shall be given copies of all documents.
4. The CPO shall check DCIS/ QTBLOOD within seven days of the initial office visit to verify that the offender's blood has been drawn to provide DNA to the Colorado Bureau of Investigation. The CPO shall comply with the provisions of AR 300-24, *Offender DNA Testing*, within 30 days.
5. The CPO shall refer the offender to the local law enforcement jurisdiction for Sex Offender Registration per Colorado Revised Statutes. Registration is required within five working days of release or within five working days of establishing residency within the jurisdiction. Verification shall be made by the CPO that the offender completed his/her registration as required. The offender shall be notified of their duty to register upon every subsequent change of address and annually as required by law.
6. The offender shall be monitored by the CPO at a level which supports public safety. Caseload contact standards outside the Denver metro area shall meet statutory requirements

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with the associate director determining the regional standards of practice by incorporating the following guidelines where feasible. The offender shall have six face to face contacts per month with the CPO or program contract workers (for the purpose of this administrative regulation, program contract workers may include an approved treatment provider, TASC contract workers, re-entry specialist, designated law enforcement representative, etc.). At a minimum, three of these face to face contacts shall be between the CPO and the offender. The Denver metro area (CPSOP Unit) caseload contacts shall consist of a combination of:

- a. Daily telephone contact.
- b. One mandatory PHV per month.
- c. Employment visitation two times per month which may be a personal visitation, verification by pay stub or telephonic verification.
- d. Treatment visitation once per month to verify participation and progress.
- e. Treatment staffing as needed to be scheduled by the CPO, at least quarterly.
- f. Collateral contacts as needed.
- g. Surveillance activities, as needed, to be staffed with the team leader and approved by the supervisor.
- h. POVs as needed.

E. Supervision of Lifetime Sex Offenders

1. Selection Process

Offenders sentenced under the provisions of the Colorado Sex Offender Lifetime Supervision Act of 1998, and having been granted parole, or released to Community Corrections shall be assigned to the Community Parole Sex Offenders Program (CPSOP). To minimize the risk to the public, to the greatest extent possible, the lifetime component of this program is designed to have a caseload ratio of ten parolees to one CPO to maintain compliance with supervision criteria mandated in CRS 18-1.3-1005.

2. Levels of Supervision

- a. Offenders sentenced under the provisions of the Colorado Sex Offender Lifetime Supervision Act of 1998 shall be supervised according to the following time frames:
  - 1) Class 2 or 3 felony conviction - 20 years.
  - 2) Class 4 felony conviction - 10 years.
- b. **Level of supervision shall be measured by behavior that indicates lessened risk, not by the passage of time.**

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- c. Participation in the lifetime program shall continue until the sex offender can demonstrate that he/she has successfully progressed in treatment and would not pose an undue threat to the community if placed on a lower level of supervision. For non-compliance at any level the CPO shall have the option to arrest or move the offender to a more restrictive supervision level after notifying the Parole Board and petitioning the Parole Board for a review hearing.
- d. Offenders under lifetime supervision shall be supervised on a five tier system of supervision as outlined below:
  - 1) Level 5 - The offender shall have eight face to face contacts with the CPO or program contract workers (for the purpose of this administrative regulation program contract workers may include an approved treatment provider, TASC contract worker, re-entry specialist, designated law enforcement representative, etc.) At a minimum four of these face to face contacts shall be between the CPO and the offender. In the Denver metro area the CPSOP unit caseload contacts shall consist of a combination of:
    - a) Daily telephone contact.
    - b) Two mandatory PHVs per month.
    - c) Employment visitation two times per month which may be a personal visitation, verification by pay stub or telephonic verification.
    - d) Treatment visitation once per month to verify participation and progress.
    - e) Treatment staffing as needed to be scheduled by the CPO, at least quarterly.
    - f) Collateral contacts as needed.
    - g) Surveillance activities, as needed, to be staffed with the team leader and approved by the supervisor.
    - h) POVs as needed.
    - i) Curfew.
    - j) No out of state travel permit.
  - 2) Level 4 - The offender shall have seven face to face contacts with the CPO or program contract workers (for the purpose of this administrative regulation program contract worker may include an approved treatment provider, TASC contract worker, re-entry specialist, designated law

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enforcement representative, etc.) At a minimum four of these face to face contacts shall be between the CPO and the offender. In the Denver metro area the CPSOP unit caseload contacts shall consist of a combination of:

- a) Daily telephone contact.
- b) Two mandatory PHVs per month.
- c) Employment visitation two times per month which may be a personal visitation, verification by pay stub or telephonic verification.
- d) Treatment visitation once per month to verify participation and progress.
- e) Treatment staffing as needed to be scheduled by the CPO, at least quarterly.
- f) Collateral contacts as needed.
- g) Surveillance activities, as needed, to be staffed with the team leader and approved by the supervisor.
- h) POVs as needed.
- i) Curfew.
- j) No out of state travel permit.

- 3) Level 3 - The offender shall have six face to face contacts with the CPO or program contract worker (for the purpose of this administrative regulation program contract worker may include an approved treatment provider, TASC contract worker, re-entry specialist, designated law enforcement representative, etc.) At a minimum, three of these face to face contacts shall be between the CPO and the offender. In the Denver metro area the CPSOP unit caseload contacts shall consist of a combination of:

- a) Daily telephone contact.
- b) Two mandatory PHVs per month.
- c) Employment visitation two times per month which may be a personal visitation, verification by pay stub or telephonic verification.



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- d) Treatment visitation once per month to verify participation and progress.
  - e) Treatment staffing as needed to be scheduled by the CPO, at least quarterly.
  - f) Collateral contacts as needed.
  - g) Surveillance activities, as needed, to be staffed with the team leader and approved by the supervisor.
  - h) POVs as needed.
  - i) Curfew.
  - j) No out of state travel permit.
- 4) Level 2 - The offender shall have four face to face contacts with the CPO or program contract worker (for the purpose of this administrative regulation program contract worker may include an approved treatment provider, TASC contract worker, re-entry specialist, designated law enforcement representative, etc.) At a minimum, two of these face to face contacts shall be between the CPO and the offender. In the Denver metro area the CPSOP unit caseload contacts shall consist of a combination of:
- a) Daily telephone contact.
  - b) One mandatory PHV per month.
  - c) Employment visitation two times per month which may be a personal visitation, verification by pay stub or telephonic verification.
  - d) Treatment visitation once per month to verify participation and progress.
  - e) Treatment staffing as needed to be scheduled by the CPO, at least quarterly.
  - f) Collateral contacts as needed.
  - g) Surveillance activities, as needed, to be staffed with the team leader and approved by the supervisor.
  - h) POVs as needed.

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- i) Curfew optional.
- 5) Level 1 - The offender shall have two face to face contacts with the CPO or program contract worker (for the purpose of this administrative regulation program contract worker may include an approved treatment provider, TASC contract worker, re-entry specialist, designated law enforcement representative, etc.) At a minimum, one of these face to face contacts shall be between the CPO and the offender. In the Denver metro area the CPSOP unit caseload contacts shall consist of a combination of:
  - a) Daily telephone contact.
  - b) One mandatory PHV per month.
  - c) Employment visitation two times per month which may be a personal visitation, verification by pay stub or telephonic verification.
  - d) Treatment visitation once per month to verify participation and progress.
  - e) Treatment staffing as needed to be scheduled by the CPO, at least quarterly.
  - f) Collateral contacts as needed.
  - g) Surveillance activities, as needed, to be staffed with the team leader and approved by the supervisor.
  - h) POVs as needed.
  - i) Curfew optional.
- e. The level of supervision shall be measured by behavior that indicates lessened risk, not by the passage of time. For movement to a lower level of supervision, at a minimum the following must occur:
  - 1) Community supervision team staff and concurrence.
  - 2) Compliance with all conditions of supervision.
  - 3) Parole Board notification and concurrence.
  - 4) Two consecutive non-deceptive monitoring polygraphs.
- f. Upon completion of 20 years of parole for any sex offender convicted of a Class II or Class III felony or completion of ten years of parole for any sex offender convicted of a Class IV felony, the Parole Board shall schedule a hearing to

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determine whether the sex offender may be discharged from parole. The CPO and the treatment provider shall make recommendations to the Parole Board whether the sex offender has met criteria for discharge from parole.

g. Transfers

- 1) Cases transferred from region to region shall comply with current regional practices that may include but are not limited to:
  - a) Transfer residence is approved by receiving region.
  - b) Assignment is made to CPO.
  - c) Confirmation of change of residence with local law enforcement by sending regions.
  - d) Confirmation of registration with local law enforcement in new region within five working days of arrival.
- 2) The interstate transfer of lifetime offenders should not routinely take place; however, those offenders that apply for interstate compact services must meet the mandatory acceptance criteria. All requests for interstate transfer shall be processed in accordance with administrative regulation 1300-01, *Interstate Transfer of Parole Supervision to Compact States*.

F. Supervision of Sexually Violent Predators (SVP)

1. If not on lifetime SXO supervision, standards should be consistent with IV.D.6.
2. The investigating CPO shall also determine if the court or the Parole Board has determined if the sexually violent predator is subject to community notification. If community notification is required, the investigating CPO shall, prior to completion of the pre-parole investigation, notify the local law enforcement agency for the jurisdiction in which the sexually violent predator resides or plans to reside upon release from incarceration. As part of the community notification process the CPSOP, division representative, supervisor, or designee shall make every effort to become part of the local community notification team.
3. The supervising CPO shall advise the offender if he/she has been identified as a sexually violent predator and if he/she is subject to community notification. The supervising CPO shall also issue a directive advising the offender that he/she SHALL NOT attend the community notification meeting. The CPSOP, division representative, supervisor, or designee shall attend the community notification meeting.
4. SVP offenders will not be allowed to parole to a homeless shelter.

G. Law Enforcement Interaction

The CPO shall develop a working relationship with local law enforcement by:

1. Sharing Intel information that consists of but is not limited to: the presentation of

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information such as the release, residence, and modus operandi of the sex offender to the local Sex Crimes Unit within 30 days of release.

2. Encouraging law enforcement officers to accompany the CPO when conducting home visits.
3. Attending intelligence meetings sponsored by law enforcement agencies and when possible periodically host the information sharing meeting.
4. When necessary, request law enforcement to assist in conducting surveillance activities.
5. When necessary, request law enforcement to assist in arresting an offender for a suspected violation.
6. Assisting local law enforcement in providing community notification when an offender is identified as a sexually violent predator (SVP).
7. Verifying the registration of the offender who is required to register as a sex offender within 14 days of release.

#### H. Treatment

The CPO shall refer the offender to an approved treatment provider for sex offender therapy-no later than two weeks after release onto parole, placed into a Community Return to Custody Facility, or onto community ISP placement. CPO's outside the Denver metro area shall follow the regional standards of practice if therapeutic resources are limited.

1. The CPO outside the Denver metro area shall attempt to develop resources for treatment in those areas of no or limited resources or develop a plan to have the offender live within another city/town within the region that offers treatment.
2. Treatment should be provided in a group setting and not on a one to one basis.
3. When multiple treatment modalities are ordered as a condition of placement on parole, placement into a Community Return to Custody Facility, or onto the community ISP program, sex offender treatment shall be considered the primary referral.

#### I. Polygraph Protocol

1. Within ten days of parole or community ISP placement, the CPO shall determine the type of polygraph last administered, the date it was administered, and the test results. The CPO will staff with a community based ATP therapist and/or the CPSOP unit to determine the appropriate nature of the next polygraph to be administered.

Unless a sexual history disclosure polygraph was previously found non-deceptive during the previous 12 months, the CPO shall direct the offender to complete this polygraph within 30 days of entering community based treatment.

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2. Under Sex Offender Management Board (SOMB) guideline 3.740, the CPO shall establish a polygraph schedule based upon the offender's performance in therapy, suspicion of inappropriate sexual behavior, or alleged parole/community violations.
  - a. Maintenance polygraphs shall be conducted at no more than six month intervals.
  - b. Specific incident polygraphs may be conducted at any time with the frequency and purpose staffed with the team leader or supervisor.
3. The CPO shall set a schedule for future polygraphs or determine the need to arrest the offender in the following circumstances:
  - a. When a polygraph is found deceptive, inconclusive or tampered with the CPO shall ensure that a specific issue polygraph is conducted within 30 days of the results being known.
    - 1) If the offender is deceptive or is inconclusive on the subsequent polygraph exam an immediate staffing with the team leader and/or supervisor shall take place to determine appropriate action.
    - 2) In the event the deception indicates the potential of a new victim the CPO shall immediately staff the case with the team leader and/or supervisor to determine possible action/sanctions.
  - b. There are COPD/parole violations.
  - c. The therapist reports the offender is not making any progress.
  - d. Offenders refusing to take a polygraph and/or plethysmograph/Abel assessment for sexual interest (Abel screen) shall be arrested (when local jails agree to hold technical violators) and a parole complaint filed or notice of charge served.
  - e. If the offender attempts to defeat or circumvent the polygraph (e.g., putting something in his/her ears, holding breath, etc.), the offender shall pay for a second test which will be conducted within 30 days and may be subject to sanctions. Attempt to defeat or circumvent the second polygraph shall result in arrest and a complaint filed or notice of charge served.
  - f. Any admissions or statements regarding a violation of community supervision or criminal offense may result in arrest, investigation, complaint filed, or Notice of Charges served.

J. Supervision Level

1. Any non-lifetime offender must be supervised at maximum level until he/she has a non-deceptive sexual history disclosure polygraph and a non-deceptive maintenance polygraph.
2. The offender must have completed at least one year under community supervision, before the CPO may consider the parolee for medium supervision.

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K. Plethysmograph/Abel Screen Testing

1. Within six months of release to community supervision, the offender shall be tested for sexual arousal/interest by administering a plethysmograph or Abel screen (when neither test has been previously administered during a mental health sex offense specific evaluation or treatment program).
2. If the offender attempts to defeat or circumvent the plethysmograph/Abel screen (e.g., putting something in his/her ears, holding breath, etc.), the offender shall pay for a second test that shall be re-scheduled immediately and may result in arrest and/or the filing of a parole complaint or the service of a Notice of Charges. Attempt to defeat or circumvent the second test shall result in arrest (when local jails agree to hold technical violators) and a complaint filed or Notice of Charges served.

L. CPO and Therapist Interaction

1. The Community Supervision Team (comprised of the CPO, therapist, and polygrapher, when necessary) shall regularly conduct staffings to determine ongoing needs of the offender, share information, compliance issues, and other relevant matters.
2. The CPO shall advise the therapist/polygrapher of any significant changes in status (residence, employment, arrest, absconds, escapes etc.) within one working day.
3. No offender shall be placed on financial suspension from therapy sessions without a Community Supervision Team staffing. Any sex offender placed on financial suspension shall be subject to sanctions including but not limited to, a parole complaint or summons/notice of charge served. Financial suspension shall not exceed 45 days. The CPO shall direct the offender to resolve the financial suspension as quickly as possible.
4. Unsuccessful discharge from therapy shall result in arrest and a complaint filed or Notice of Charges served.

M. Classification

Non-lifetime sex offenders shall be supervised at a maximum level. Consideration for supervision at a lower level shall occur when:

1. The offender has provided a non-deceptive sexual history polygraph.
2. The offender has provided two non-deceptive maintenance polygraphs.
3. The offender has demonstrated full compliance with conditions of supervision.
4. The offender has demonstrated full compliance with treatment expectations.
5. The offender has been under community supervision for at least one year of parole.
6. The treatment team recommends a medium supervision level.

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N. Early Discharge

Any offender who is ordered to participate in sex offender offense specific treatment as part of community based supervision shall not be considered for early discharge.

O. Notification at Time of Discharge

The CPO shall notify CBI and local law enforcement when sex offenders, who are required to register, discharge from parole.

V. RESPONSIBILITY

- A. It is the responsibility of the director of Adult Parole, Community Corrections, and Youthful Offender System to ensure the overall implementation of this administrative regulation.
- B. It is the responsibility of the associate directors, managers, and supervisors to ensure regional compliance with this administrative regulation.
- C. It is the responsibility of the CPOs to adhere to the procedures set forth in this administrative regulation.

VI. AUTHORITY

- A. 16-3-101. Arrest - when and how made.
- B. 16-3-102. Arrest by peace officer.
- C. 16-11.7-101 through 16-11.7-107. STANDARDIZED TREATMENT PROGRAM FOR SEX OFFENDERS.
- D. 18-3-412.5. Failure to register as a sex offender.
- E. 18-1.3 1001-18-1.3 1010. LIFETIME SUPERVISION OF SEX OFFENDERS.
- F. Sex Offender Management Board Guidelines.

VII. HISTORY

March 1, 2006 (superseded AR 250-39)  
July 1, 2005  
July 1, 2004  
November 15, 2003

- ATTACHMENTS:
- A. AR Form 250-48A, Community/Parole Sex Offender Program, Screening Form
  - B. AR Form 250-48B, Community/Parole Sex Offender Program, Community

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Placement/Pre-Parole Investigation form

C. AR Form 100-01A, Administrative Regulation Implementation/Adjustments



## COMMUNITY/ PAROLE SEX OFFENDER PROGRAM Screening Form

Date: \_\_\_\_\_

DOC # \_\_\_\_\_ Offender Name: \_\_\_\_\_ Completed by CPO: \_\_\_\_\_

1. Current S Code \_\_\_\_\_ Current P Code \_\_\_\_\_

2. Required to Register?   Y   N      Board ordered: _____   Quarterly: _____   Annually _____
--

3. Previous history of convictions?   Y   N      Misdemeanor \_\_\_\_\_   Felony \_\_\_\_\_

4. Number of convictions for sex offenses:   Juvenile \_\_\_\_\_   Misdemeanor \_\_\_\_\_   Felony \_\_\_\_\_

5. Number of arrests for sex offenses with NO conviction? \_\_\_\_\_

6. History of COPD violations for sex offender issues?   Y   N

If YES then:      Number of violations? \_\_\_\_\_

Type of violations? \_\_\_\_\_

Where violations occurred? \_\_\_\_\_

7. Age at first sex offense conviction? \_\_\_\_\_ Self-reported \_\_\_\_\_ or Documented \_\_\_\_\_

8. History of:   Arson \_\_\_\_\_   Bedwetting \_\_\_\_\_   Fire Setting \_\_\_\_\_   Cruelty to Animals \_\_\_\_\_

9. Previous sex offender treatment provider? \_\_\_\_\_

10. Was a S4 hearing required?   Y   N      Date hearing completed? \_\_\_\_\_

Final Rating \_\_\_\_\_ Documentation in Working File?   Y   N

11. Parole Board ordered evaluation/assessment/ treatment?   Y   N

12. History of Domestic Violence?   Y   N      Misdemeanor \_\_\_\_\_   Felony \_\_\_\_\_

13. Proposed S Code for Community Supervision? \_\_\_\_\_

14. Will the Community/Parole Sex Offender Program (CPSOP) supervise this offender?   Y   N
---

15. Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Attachment "A"

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# COMMUNITY /PAROLE SEX OFFENDER PROGRAM

## Community Placement/Pre-Parole Investigation

Name: \_\_\_\_\_ DOC # \_\_\_\_\_

Program: Com Residential \_\_\_\_ ISP Inmate \_\_\_\_ Pre-Parole \_\_\_\_ Interstate Transfer \_\_\_\_

Community Corrections Board Approval: Yes \_\_\_\_ No \_\_\_\_ County \_\_\_\_\_

Secondary referral: County \_\_\_\_\_ Approved or Denied Date: \_\_\_\_\_

Residence Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Apartment \_\_\_\_ Duplex \_\_\_\_ Mobile Home \_\_\_\_ Single Family Home \_\_\_\_ Motel \_\_\_\_ Homeless Shelter \_\_\_\_

OTHER: \_\_\_\_\_

Sponsor Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_

Sponsor SSN: \_\_\_\_\_ DL/ID# \_\_\_\_\_ Arrests: Y N

Occupants in Residence: # of Adults \_\_\_\_ # of Juveniles \_\_\_\_ Whereabouts of Victim known: Y N

Occupants Data (please print) (list all children – use back of sheet if needed)

Name:	DOB:	Relationship:	DL/ID #	Arrests: Felony or Misd	Probation/Parole

NCIC/CCIC check of sponsor and occupants completed on \_\_\_\_\_.

**If the offender is required to register the following MUST be completed:** CRS 16-22-107 Colorado Sex Offender Registration Act.

Occupant/owner aware of offender history of unlawful sexual behavior? Yes No

Address under investigation is in fact a residence? Yes No

Occupant/ owner will allow person to reside at residence? Yes No

If released to parole, address complies with conditions imposed by the parole board? Yes No

Victim Notification: Yes \_\_\_\_ Date verified \_\_\_\_\_ N/A \_\_\_\_

Weapons in residence: Yes \_\_\_\_ No \_\_\_\_ Verified weapons removed on \_\_\_\_\_.

**Community Placement/Pre-Parole Investigation Page 2**

## Vehicle Data:

Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ Plate \_\_\_\_\_

Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ Plate \_\_\_\_\_

Make \_\_\_\_\_ Model \_\_\_\_\_ Year \_\_\_\_\_ Plate \_\_\_\_\_

CPO RECOMMENDATIONS: Favorable \_\_\_\_ Unfavorable \_\_\_\_ Submit New Plan \_\_\_\_  
Accept \_\_\_\_ Reject \_\_\_\_ Close \_\_\_\_ Hold \_\_\_\_ (Pending more information, etc.)

Participate in CPSOP \_\_\_\_ Mental Health (type) \_\_\_\_\_ Drug/Alcohol \_\_\_\_

Sex Offender Registration \_\_\_\_\_ ISP(# of days \_\_\_\_\_) No Driving \_\_\_\_ No Bars \_\_\_\_

TASC \_\_\_\_ No Gang Contact \_\_\_\_ No financial transaction devices \_\_\_\_ No Pets \_\_\_\_

Other: \_\_\_\_\_

No contact with: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CPO Signature: \_\_\_\_\_ Agent # \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Agent # \_\_\_\_\_ Date: \_\_\_\_\_

**ADMINISTRATIVE REGULATION  
IMPLEMENTATION/ADJUSTMENTS**

AR FORM 100-01A (11/15/05)

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(FACILITY/WORK UNIT NAME) \_\_\_\_\_  
WILL ACCEPT AND IMPLEMENT THE PROVISIONS OF THE ABOVE ADMINISTRATIVE REGULATION:

☐ AS WRITTEN    ☐ NOT APPLICABLE    ☐ WITH THE FOLLOWING ADJUSTMENTS TO MEET  
LOCALIZED OPERATIONS/CONDITIONS

SIGNED) \_\_\_\_\_ (DATE) \_\_\_\_\_  
Administrative Head

Attachment "C"  
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## **Appendix 14**

### **Regarding Supervision / Contact Standards**

#### **Alaska Department of Corrections High Risk Signs for Sex Offenders**

##### **Child Abusers:**

##### **Disinhibitors:**

##### **Alcohol \_\_**

Check in fridge, freezer, cabinets, back of the toilet, closets and garage. Check liquids in non-alcoholic containers. Check trash for cans and bottles, look in vehicles, smell of alcohol on offender's breath, and perform random UA's. Report if offender is seen in establishments that serve alcohol, or if he has been visiting drinking friends or relatives.

##### **Drugs \_\_**

Check cupboards, medicine cabinets, dressers, containers, notice smell of pot in residence, look for drug paraphernalia, prescription drugs, and prescription drugs prescribed for others, perform random UA's. Report suspicion that offender having contact with drug users/dealers or that he is dealing himself.

##### **Child Pornography \_\_**

X-rated material, photographs of children, children's clothing catalogues, home videos of children, Look through albums, check magazines, check computer files,

Emotional factors:

##### **Depression \_\_**

Look for isolation, irregular or erratic sleep patterns, disheveled appearance, calling in sick or not showing for work or meetings, loss of energy and lack of interest in normal pleasurable activities, obvious sadness and crying spells, suicidal gestures or talk.

A recent emotional loss such as separation, divorce, death, rejection, loss of job or demotion, loss of a friendship or support group. Check with partners, friends of offender, family, employers, treatment staff, safety-net members and others who have contact with the offender.

##### **Anger/ irritability \_\_**

Look for problems in interpersonal relationships, blaming of others, overly defensive, threats, and increases in aggressive language, violent acts, argumentativeness, defiant and oppositional patterns. Check with partners, friends of offender, family, employers, treatment staff, safety-net members and others who have contact with the offender.

#### Mental Illness \_\_\_\_

In mentally ill offenders look for a deterioration in functioning including poor self-grooming, hallucinations, delusional thinking, paranoia, etc. Check with partners, friends of offender, family, employers, treatment staff, safety-net members and others who have contact with the offender.

#### Grooming of Victims:

##### Presence of child enticers \_\_\_\_

He's a "child magnet." Look for toys, stuffed animals or articles of interest to victims in the age group he offends against. For example, look for teen music or a walkman for offense against teens. Remote control cars or video games are enticements for middle childhood victims. Look for Gameboy and other video game players along with video games. Notice if he has a flashy bike or car that would attract kids. Determine if he has hobbies that attract kids. Pets may be enticers for several age groups.

##### Presence of equipment used in offense \_\_\_\_

Look for photo equipment for those who used this in offense (still and video cameras). Owning a computer and having access to the internet may be a factor for some.

##### Victim contact/attempts at contact \_\_\_\_

Determine if offender is spending time in areas where children congregate (playground, parks, athletic fields, school, swimming pool, malls, and video parlors). Report suspicions that the offender may be observing victims from his car or apartment. What can he see from his windows, what is his route to and from work? Report any unauthorized contact with the victim or potential victims. Report suspicions that the offender may be following potential victims. Investigate the offender's neighborhood for proximity to schools and the presence of children. Also look for contact with children at the workplace. Check odometer for unexplained driving around. Report any evidence that offender is picking up underage hitchhikers.

##### Presence of active grooming behaviors \_\_\_\_

Try to determine if the offender is giving gifts to children or organizations frequented by children. Report any physical contact with children (hugging, placing them on his lap, kissing, holding hands rubbing himself against a child, horseplay, tickling a child, and/or showing a lot of attention to children. He may also be hanging out with friends who have children or dating someone with children. Other grooming behaviors include babysitting, Volunteer work in children's organizations and corresponding with children (check computer for correspondence, and chat room visits)

##### Resistance to treatment/supervision \_\_\_\_

Determine if the offender is missing or late for therapy meetings, probation meetings, or adjunct treatment meetings (AA,NA, Anger management, mental health appointments). Determine if he tries to reschedule meetings frequently and complains about how inconvenient they are. Resistance is also indicated by non-amenability to treatment or poor progress in any treatment program. He may also manipulate the PO, therapist, and others. He fails to mention problems, presenting everything as "fine or great" even though you suspect or know he's having problems. You feel he's being secretive or phony. He tries to play the system and plays one member of the treatment/supervision team against the other. He tries to take control of the interview or visit. He tries to be buddy-buddy with you, giving you complements and telling you that you are the best of all the people he works with. He tries to focus on irrelevant issues. He

tries to impress you with his strengths or accomplishments and distracts the conversation away from his weaknesses and problems.

Presence of Pre-relapse attitudes \_\_\_\_

In conversation with the offender he conveys any of the following attitudes and beliefs:

Denies offense (I only pled guilty because my attorney told me to).

Believes he won't re-offend

Won't take no for an answer

Holds attitudes tolerant of sexual abuse (it's ok in certain circumstances)

Blames the victim

Has low empathy for victims (Doesn't see how his offense hurt the victim)

Justifies or minimizes his offense

Doesn't see how his offense hurt others in addition to the victim

He will not make personal sacrifices to avoid high risk situations (tests the conditions of probation/parole prohibiting avoidance of these situations)

He just wants to put the offense behind him and gets angry when it's brought up.

### **Rapists:**

### **Disinhibitors:**

Alcohol \_\_\_\_

Check in fridge, freezer, cabinets, back of the toilet, closets and garage. Check liquids in non-alcoholic containers. Check trash for cans and bottles, look in vehicles, smell of alcohol on offender's breath, and perform random UA's. Report if offender is seen in establishments that serve alcohol, or if he has been visiting drinking friends or relatives.

Drugs \_\_\_\_

Check cupboards, medicine cabinets, dressers, containers, notice smell of pot in residence, look for drug paraphernalia, prescription drugs, and prescription drugs prescribed for others, perform random UA's. Report suspicion that offender having contact with drug users/dealers or that he is dealing himself.

Pornography\_\_\_\_

Check for x rated material and "soft" pornographic material. Also look for materials that may depict violence towards women such as some R-rated films and certain magazines. Also report knowledge or suspicions that offender frequents massage parlors, adult book stores, or strip clubs. Check computer files for pornography.

Anger/ irritability \_\_\_\_

Look for problems in interpersonal relationships, blaming of others, overly defensive, threats, and increases in aggressive language, violent acts, argumentativeness, defiant and oppositional patterns. Check with partners, friends of offender, family, employers, treatment staff, safety-net members and others who have contact with the offender.

Overly self-confident \_\_\_\_

Note if offender presents unrealistic self-confidence. The offender is self-centered and has an inflated sense of self worth. He puts others down, acts like a know-it-all, is easily offended and defensive when challenged, feels he's better than everyone else, and is intolerant and insensitive to others. He is strongly effected by rejection from women, has a high need to impress others especially women.

#### Mental Illness\_\_

In mentally ill offenders look for a deterioration in functioning including poor self-grooming, hallucinations, delusional thinking, paranoia, etc. Check with partners, friends of offender, family, employers, treatment staff, safety-net members and others who have contact with the offender.

#### Grooming of Victims

##### Victim contact \_\_

Report unauthorized contact or attempts to contact the victim (direct or indirect). Contact includes phone contact, third-party contact, mail or e-mail.

##### Predatory behavior \_\_

Report if you suspect that the offender is cruising for victims (check odometer; have him keep a driving log). Spending time in areas where women would be available and isolated (parking lots late at night, isolated streets, peeping in windows, exposing self). Observing potential victims from car or apartment. What can he see from his windows, what is his route to and from work? Following potential victims (stalking) and picking up hitchhikers should be reported. Assess contact with women on the job (repairman, door to door sales).

##### Grooming potential victims \_\_

Note if offender is living with female roommate(s), dating someone who doesn't know he's a rapist, corresponding with women (letters, phone contact, answering personal ads, Chat room visits). Evaluate neighborhood of offender's residence (apartment building with a lot of single women).

##### Presence of equipment used in offense \_\_

This includes photo equipment for those who used this in offense (still and video cameras). It would also include "rape kit" materials if this was part of offense. This would include rope, handcuffs, weapons, sexual clothing, sexual aids, and other materials, clothing, or equipment used in the commission of the sexual assault.

##### Resistance to Treatment/Supervision \_\_

Determine if the offender is missing or late for therapy meetings, probation meetings, or adjunct treatment meetings (AA, NA, Anger management, mental health appointments).

Determine if he tries to reschedule meetings frequently and complains about how inconvenient they are. Resistance is also indicated by non-amenability to treatment or poor progress in any treatment program. He may also manipulate the PO, therapist, and others. He fails to mention problems, presenting everything as "fine or great" even though you suspect or know he's having problems. You feel he's being secretive or phony. He tries to play the system and plays one member of the treatment/supervision team against the other. He tries to take control of the interview or visit. He tries to be buddy-buddy with you, giving you complements and telling you that you are the best of all the people he works with. He tries to focus on irrelevant issues. He tries to impress you with his strengths or accomplishments and distracts the conversation away from his weaknesses and problems.



Presence of Pre-relapse attitudes \_\_\_\_

In conversation with the offender he conveys any of the following attitudes and beliefs:

Denies offense (I only pled guilty because my attorney told me to).

Believes he won't re-offend

Won't take no for an answer

Holds attitudes tolerant of sexual abuse (it's ok in certain circumstances)

Blames the victim

Has low empathy for victims (Doesn't see how his offense hurt the victim)

Justifies or minimizes his offense

Doesn't see how his offense hurt others in addition to the victim

He will not make personal sacrifices to avoid high risk situations (tests the conditions of probation/parole prohibiting avoidance of these situations)

He just wants to put the offense behind him and gets angry when it's brought up.

Developed by Rose Munafo & Anthony Mander  
Alaska Department of Corrections

## Field Surveillance Checklist for Sex Offender High Risk Signs

Name of Offender: \_\_\_\_\_

OBSCIS Number: \_\_\_\_\_

Date of Surveillance: \_\_\_\_\_

Surveillance Site(s): \_\_\_\_\_

Persons Contacted: \_\_\_\_\_

.....

### Potential Victim Profile:

Gender: \_\_\_\_\_

Age Range: \_\_\_\_\_

Relationship to Victims: \_\_\_\_\_

Vulnerabilities of Victims\*: \_\_\_\_\_

### Offender's Typical Grooming Pattern\*\*:

### Usual/Typical Disinhibitors\*\*\*:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Observations from surveillance conducted on \_\_\_\_\_:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Note if physically/mentally impaired, pre-verbal, intoxicated, etc.

\*\* Grooming Pattern: child enticers like toys, teenage magazines, flashy bikes or cars, etc.; equipment used to offend, like cameras; spending time where victims are present, cruising looking for victims, etc.; giving gifts to kids or organizations involved with kids; physically contacting children, on-line chat rooms, etc.; pre-relapse attitudes such as denial, refusal to take no for an answer, minimizing, testing conditions of probation

\*\*\* Disinhibitors: alcohol/drugs, pornography, materials that can be used as child pornography such as clothing catalogues, home videos, etc., changes in emotional state such as depression, anger, irritability, in mentally ill offenders look for deterioration in functioning such as hallucinations, paranoia, poor self-grooming

Form developed by Rose Munafo & Anthony Mander  
Alaska Department of Corrections

## ADDITIONAL CONDITIONS OF PROBATION FOR ADULT SEX OFFENDERS

<div style="border-bottom: 1px solid black; margin-bottom: 5px;"> <span style="float: right;">County, Colorado</span> </div> <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> County Court             <input type="checkbox"/> District Court         </div> <p>Court address:</p> <p>Phone Number :</p> <hr style="border: 0.5px solid black;"/> <p><b>PEOPLE OF THE STATE OF COLORADO vs.</b></p> <p><b>Defendant:</b></p>	<div style="display: flex; justify-content: space-around; align-items: center; height: 150px;"> <div style="text-align: center;">▲</div> <div style="text-align: center;">▲</div> </div> <p style="font-weight: bold; font-size: 1.2em;">COURT USE ONLY</p>
<p>Attorney or Party Without Attorney (Name and Address):</p>  <div style="display: flex; justify-content: space-between;"> <p>Phone Number:</p> <p>E-mail:</p> </div> <div style="display: flex; justify-content: space-between;"> <p>FAX Number:</p> <p>Atty. Reg.#:</p> </div>	<p>Case Number:</p> <p>ML Number:</p> <p>SID Number:</p> <div style="display: flex; justify-content: space-between;"> <p>Division</p> <p>Courtroom</p> </div>
<p><b>ADDITIONAL CONDITIONS OF PROBATION FOR ADULT SEX OFFENDERS</b></p> <div style="display: flex; justify-content: space-around; align-items: center;"> <input type="checkbox"/> <b>SOISP</b> <input type="checkbox"/> <b>NON-SOISP</b> </div>	

The defendant will be supervised by the probation officer and will comply with the following Additional Conditions of probation until further order of the court:

1. **Sex Offender Intensive Supervision Probation:** You will be supervised on Sex Offender Intensive Supervision Probation (SOISP), pursuant to Section 18-1.3-1007, C.R.S. until further order of the court.
  
2. **Registration:** Pursuant to Section 16-22-106(1)(a) and 16-22-108, C.R.S., you must register as a sex offender with the local law enforcement agency within 5 business days after being given notice to register. If you move, you must re-register within 5 business days following your move. You must also fill out an address change form with the law enforcement office you last registered with. Regardless of whether or not you move, you must register annually on your birth date.
  
3. **Genetic Marker Testing:** You shall submit to a blood test to determine genetic markers (DNA) in accordance with Section 16-11-204.3, C.R.S. and shall pay a fee of \$128 to the Sex Offender Identification Fund for said testing.

4. You shall have no contact with any child under the age of eighteen (18), including your own children, nor attempt contact except under circumstances ordered by the court and approved in advance and in writing by the probation officer in consultation with the community supervision team. Contact includes correspondence, written or verbal, telephone contact, or any communication through a third party.
5. If you have incidental contact with children, you will be civil and courteous to the child and immediately remove yourself from the situation. You will discuss the contact at your next treatment session and probation appointment.
6. You shall not reside or be in a residence with any child under the age of eighteen (18), including your own children, unless ordered by the court .
7. You shall have no contact with any victim (the victim of the current offense or a victim from any other offense) including correspondence, telephone contact, or communication through a third party except under circumstances approved in advance and in writing by the probation officer in consultation with the treatment provider. You shall not enter onto the premises, travel past or loiter near where any victim resides.
8. You shall not go to or loiter near schoolyards, parks, playgrounds, swimming pools, arcades or other places primarily used by children under the age of eighteen (18).
9. You must inform your probation officer of all your significant relationships and may be required by the probation officer to inform certain people of your present offense and restrictions. You shall not date or marry anyone who has children under the age of eighteen (18), unless approved in advance and in writing by the probation officer in consultation with the treatment provider.
10. You shall not be employed or participate in any volunteer activity where you have contact with children under the age of eighteen (18) except under circumstances approved in advance and in writing by the probation officer in consultation with the treatment provider.
11. You shall not possess, utilize or subscribe to any sexually oriented or sexually stimulating material to include, but not limited to, mail, computer, television or telephone, nor patronize any place where such material or entertainment is available.
12. Any change of residence must receive prior approval by the probation officer and those with whom you reside must know that you are a sex offender.
13. You shall abide by any curfew imposed by the probation officer.
14. You shall not hitchhike or pick up hitchhikers.
15. You shall attend and actively participate in a sex offender evaluation and treatment program approved by the probation officer. You will abide by the rules of the treatment program, and the treatment contract and will successfully

complete the program to the satisfaction of the probation officer and the treatment provider.

16. You will be financially responsible for all evaluations and treatment unless other arrangements have been made through your probation officer or treatment provider.
17. You shall not change treatment programs without prior approval of the probation officer.
18. You shall submit, at your own expense, to any program of psychological or physiological assessment and monitoring at the direction of the probation officer or treatment provider. This includes the polygraph, plethysmograph and/or the "Abel Assessment for Sexual Interest" to assist in treatment, planning and case monitoring.
19. You shall sign Releases of Information to allow the probation officer to communicate with other professionals involved in your treatment program and to allow all professionals involved to communicate with each other. This will include a release of information to the therapist of the victim of your offense.
20. You shall not purchase, possess or consume alcoholic beverages.
21. You shall not purchase, possess or utilize any mind altering or consciousness altering substance without a written lawful prescription.
22. You shall not be allowed to subscribe to any internet service provider, by modem, LAN, DSL or any other avenue and shall not be allowed to use another person's internet or use the internet through any commercial venue until and unless approved by the supervision team. When access have been approved, you agree to sign, and comply with, the conditions of the "Computer Use Agreement. Additionally, you will allow your probation officer, or other person trained to conduct computer searches, including a non-judicial employee and the offender may be required to pay for such a search.
23. You will not be allowed to possess or view any discovery materials, to include photos or videos, or souvenirs of your victim(s).

24. \_\_\_\_\_  
\_\_\_\_\_
25. \_\_\_\_\_  
\_\_\_\_\_

**BY THE COURT:**

\_\_\_\_\_

JUDGE

DATE

I have received an identical copy of the Additional Conditions of Probation and I have read them carefully with full understanding. I understand that any violation of the

Additional Conditions of Probation will be reported to the court for action, which may include revocation of probation and imposition of sentence.

_____		_____	
Defendant	<b>(printed)</b>	Date	Witness <b>(printed)</b>
Date			
_____		_____	
Defendant Signature		Witness Signature	

**JDF446P R01/03,    ADDITIONAL CONDITIONS OF PROBATION FOR ADULT SEX OFFENDERS**

# CASE STUDIES ON THE CENTER FOR SEX OFFENDER MANAGEMENT'S NATIONAL RESOURCE SITES

2<sup>nd</sup> Edition

Revised

April 2001

Prepared by  
Center for Sex Offender Management  
Pages 24-29

## Maricopa County, Arizona

### INTRODUCTION

Maricopa County is a mostly urban jurisdiction, with over 4 million people living in a metropolitan area that includes the cities of Phoenix, Scottsdale, Tempe, and Sun City. Approximately two-thirds of the state's population resides within the county. The county also includes significant rural areas.

### LOCAL AND STATE BACKGROUND

In 1985, the Arizona State Legislature passed a statute that permitted lifetime probation for some sex offenders. This statute was the impetus for the creation of Maricopa County's specialized sex offender supervision program, which began in 1987 and became formal in 1993, under the authority of the county Adult Probation Office. The office had experienced a dramatic increase in its sex offender caseload over the previous ten years. Subsequent state legislation has also affected the sex offender population. This legislation has caused a growth in the number of juvenile sex offenders, as young as 14 years of age, sentenced to adult probation. Also, more than 50 sex offenders are currently at the state hospital awaiting hearings for involuntary commitment under Arizona's sexual predator law. The constitutionality of the involuntary commitment sexual predator law has been upheld and the numbers at the state hospital continue to increase.

A statewide protocol for community supervision of sex offenders is currently under

development by probation officers from the specialized unit, treatment providers, and other criminal justice officials.

## THE MARICOPA COUNTY APPROACH

### The Population

Maricopa County's Adult Probation Office had about 1,400 sex offenders under supervision by June 2000. Nearly 1,200 offenders, mostly high risk, were being supervised by three specialized units. Over 850 of those offenders in the specialized units were serving lifetime probation sentences. Nearly all had been convicted of felonies.

### Maricopa County Team Membership

*Probation.* The supervision units consist of 23 specialized probation officers and 19 surveillance officers. **The average caseload size for probation officers is 52 offenders. Surveillance officers work with two probation officers, averaging about 63 offenders each.** Probation officers supervise progress in dealing with behavioral and life issues and compliance with program conditions. Surveillance officers make random field visits, particularly in the evening and on weekends, and work closely with the other officers.

*Intensive Supervision.* The department also has "intensive probation supervision." About 200 sex offenders are on intensive supervision at any given time. **According to state statute, each intensive probation officer has a maximum caseload of 25 and is supported by a surveillance officer.**

*Maintenance Caseloads.* Beginning in 1997, three of the specialized probation officers were assigned larger "maintenance" caseloads. These caseloads consist of sex offenders who have been on probation for several years and are considered to pose a low risk to the community. These offenders receive periodic field visits, and maintenance polygraphs are administered about once per year.

*Treatment Providers and Polygraph Examiners.* Probation officers work closely with private treatment providers. All offenders supervised by the unit are required to participate in treatment. In locating providers, the department issues requests for proposals (RFPs) and outlines specifically the way in which they expect treatment to be carried out. As a result of these RFPs, a group of treatment providers has been selected by the department. Polygraph examiners are also selected through an RFP process.

*Prosecutors, Judges, Law Enforcement, and Victim Advocates.* Probation staff informally collaborate with prosecutors and law enforcement officers in the Sex Crimes Units of the County Attorney's Office and individual police agencies. Cross-training is conducted as often as possible for probation officers, prosecutors, law enforcement officers, and victim advocates. Prosecutors and law enforcement officers are likely to support probation



sentences because they are confident that offenders will receive treatment and will be held strictly accountable for their actions. In turn, probation officers are confident that violators returned to court will receive appropriate responses from prosecutors. The county's judicial liaison has also been supportive of the specialized unit. He sets policy for over 23 criminal judges and six commissioners in the county, and understands the importance of ordering specialized terms and conditions for this population. In addition, the department works on community notification and joint training with the Sheriff's Office and the 26 police departments in the county. Probation staff have formed an alliance with the state's largest victim advocacy group, the Arizona Sexual Assault Network (AZSAN), and the Center Against Sexual Abuse (CASA) for cross-training, joint efforts on legislative issues and collaborative responses to public concerns about community notification. Community meetings are convened collaboratively when issues arise that warrant a meeting forum for community notification.

## The Supervision and Collaboration Process

*Assessment.* As part of the pre-sentence process, assessments are performed (when attorneys allow them) to help determine the sentence recommendation, and if appropriate, conditions of probation. Since 1991, 16 specialized conditions for sex offenders (including no contact with children, testing, treatment, computer related terms, and limited confidentiality) are usually added to probation at sentencing. Individuals commonly receive up to one year in jail as part of their probation sentence. Young offenders frequently begin their probation sentence on intensive supervision due to other criminal behavior and risk. Officers find that many of these youth have not finished high school, have no job experience, and need the extra structure for stability. However, most offenders begin supervision as part of a larger specialized caseload. Once an offender is sentenced, polygraphs and the Abel Screen II are administered as part of the initial assessment process; the Minnesota Multiphasic Personality Inventory (MMPI) and other tests (plethysmograph, Multiphasic Sex Inventory II (MSI-II), Adult Interest Card Sort, Interview, the Sexual Violence Risk Appraisal Guide (SO-RAG), and the Rapid Risk Assessment for Sex Offender Recidivism (RRASOR)) may also be administered. Offenders may be ordered to pay for the assessment process as part of their sentence. A small appropriation is available to supplement offender payments for those with verified need. The evaluation process includes required attendance at a 35-hour class on sexuality and sexual deviancy. These classes are designed to help sex offenders learn correct sexual information, explore new concepts and begin to examine stereotypes, victimization, and their own behavior. Offenders are also introduced to the expectations of cognitive behavioral therapy, testing requirements (including regular polygraphs), and reunification procedures, if appropriate. Their spouses or partners are encouraged to attend these groups.

*Treatment and Monitoring.* When the initial class is completed, offenders attend treatment groups once per week. Depending on the individual situation, polygraphs are planned every six months in the beginning of the supervision period. Probation officers and treatment staff have found that it is most effective to have polygraphs scheduled regularly. The probation and surveillance officers provide the polygraph examiner with areas of concern. New disclosures of previous offenses generally become treatment issues, depending on the number and age of victims. New sex offenses revealed through polygraph are pursued as violations and commonly prosecuted. Probation team members attend treatment groups on a random but regular basis. They maintain open

communication with therapists. Regular staffings are held between probation officers and treatment providers. Regular attendance at treatment groups continues until treatment goals are realized and behavior is stabilized. Although treatment generally lasts for 18 to 24 months, offenders remain in maintenance treatment at varying levels, depending on risk and other individual factors.

*Probation Collaboration.* Probation staff communicate frequently with the courts when problems arise or when specific information is requested. The unit supervisor speaks regularly to presiding judges about issues of legal interpretations, policy and protocol, and occasionally about specific cases. All key collaborators participate in monthly meetings of the Interagency Council on Child Abuse. Finally, probation staff report quarterly to the Community Punishment Advisory Committee—a group that includes judges, prosecutors, defense attorneys, and concerned private citizens.

*Violations.* Sex offenders in the unit are monitored closely. Surveillance officers must make regular unannounced visits and check with employers and families about the offenders' behavior. When violations are detected, responses are agreed upon through case staffings. Generally, depending on the type of violation, probation staff respond with increased supervision and surveillance. For example, an individual may be given a curfew or moved to intensive probation supervision. If one treatment provider dismisses an offender from treatment, the offender is often referred to another agency for treatment. This decision is made by the probation officer, not the probationer

An analysis of the 2,344 offenders supervised by the unit(s) from May 1993 through August 2000 provides probation violation information. The study found that 926 (39.5 percent) had been taken back to court for a violation at least one time. Significant violations included: 295 (31.9 percent) that did not comply with treatment; 274 (29.6 percent) used/abused alcohol or drugs; and 249 (26.9 percent) had contact with children. (Some offenders may have had multiple violations.) Approximately 344 offenders (14.7 percent of those supervised) were revoked to prison, including four who went to prison from probation on two separate occasions. Offenders reinstated to intensive probation supervision numbered 331 (14 percent of those supervised), including 14 on two occasions and one on three occasions. Approximately 160 offenders (6.8 percent of those supervised) committed a new criminal offense—including 42 new sex offenses (17 indecent exposures, three viewing/using child pornography, and 22 various contact offenses), 24 failure to register offenses, and 94 various other offenses. Further analysis of the new sex offenses revealed that the crimes generally occurred after family or friends allowed access to children, even when they were aware of the offender's history.

*Restitution and Supporting Victim Recovery.* One central goal of sex offender management in Maricopa County is to support victim recovery. Treatment providers and probation staff reach out to identified victims of offenders on probation, listen to each victim's needs, and utilize that input in the management and treatment of that specific offender. Whenever possible and appropriate, communication between the offender's therapist and the specific victim's therapist is encouraged, and funding to support specialized victim therapy is offered. In intrafamilial offense cases, management and treatment strategies focus upon supporting the development of a healthy, self-sufficient family unit that is independent of the offender and aligned with victim recovery goals. These issues are addressed before any possibility of visitation and reunification are addressed.

*Reunification.* Probation staff describe family reunification as a difficult process. All of the treatment providers in Maricopa County facilitate partners' groups. They have found that offenders' partners are often angry and confused, and do not want to acknowledge the sex offender's behavior or become involved in treatment. However, partner involvement in groups is encouraged as a necessary part of the reunification process, an additional safeguard against reoffending, and a chance for partners to gain support and a greater understanding of their own issues. Reunification is gradual and well-supervised. It generally does not begin until the offender has nearly completed treatment and has a detailed plan in place for relapse prevention.

## Special Service Components

Maricopa County has developed programs for specialized populations, including Spanish speaking offenders, those with mental disorders, the developmentally disabled, and substance abusers. Evening groups have also been created for offenders serving short jail terms who are released on work furloughs.

## Sex Offender Notification Enforcement and Tracking Team

The Mesa Police Department, in cooperation with the Maricopa County Adult Probation Department and the Center Against Sexual Abuse, has pioneered new and ongoing approaches to community notification and management of offenders. All three entities of the team are housed together in an off-site location. Information pertaining to each offender that falls under community notification guidelines is shared during formal and informal staffings. Decisions about the scope and method of community notification and other pertinent issues are discussed openly during staffings. The team uses a community policing philosophy of engaging the assistance of law enforcement officers, volunteers, probation officers, counselors, and block watch captains. All team members are present for door-to-door notifications and community meetings. Thus far, the team has had success in educating communities where offenders were living about the offender's supervision requirements and counseling services available for current and former victims of similar offenses. Team members also get a sense of the level of community acceptance of the offender and of potential problems.

## Data Collection and Evaluation

The Maricopa County program was favorably reviewed in a 1994 report by Dr. Judith Becker of the University of Arizona. Monthly statistical reports are provided by probation officers. These reports form the basis for analysis of violations; further analyses are in process with the support of a grant from the U.S. Department of Justice.



# Appendix 15

## Colorado TC QA Review Checklist

Inmate Name \_\_\_\_\_ DOC # \_\_\_\_\_  
Staff \_\_\_\_\_

Review Date \_\_\_\_\_ Primary  
Therapist \_\_\_\_\_

ITEM	NA	YES	NO
Copy of Treatment Contract in mental health file			
Completed Clients Rights in mental health file			
Completed Informed Consent (SOTMP TESTING) in mental health file			
Earned Time Award matches treatment status			
Computer matches Block Schedule for all groups being attended			
Treatment Plan: Current, signed and appropriate to inmate's issues			
Treatment Plan Updates completed at end of Block Schedule			
Probation/Notice status copied to case manager			
Completed Polygraph Decisions Grid			
File and Tx Plan documents completion of groups			
Homework folder contains polygraph, assessment, sex hx			
Homework folder contains Inmate Monthly Report for each month			
Parole Board Summary contains standard SOTMP language			
Individual Contacts documented in DCIS and Mental Health File			
Psychiatric Consultation Current			
Sex Hx Data Summary Sheet completed and updated for addendums			
Satisfactory progress in TC treatment levels and group completion			
Comments			

--	--	--	--

Place form in section three of mental health file and TC homework folder.

## **Appendix 16**

### **Sample Interview Questions for a**

### **Therapist and for a Treatment Supervisor**

### **Obtained from the Colorado Department of Corrections, Sex Offender Treatment and Monitoring Program**

#### **Therapist**

1. Briefly review your education and past work experience relevant to this position.
2. Why are you interested in working in the corrections setting?
3. Are you willing to work a flexible schedule?
4. Do you prefer to work independently or as a member of a team?
5. What type of co-workers do you enjoy working with and what type of co-worker do you have difficulty working with?
6. What are your clinical strengths? Weaknesses?
7. What theories do you have about why people commit sex offenses?
8. What therapeutic approach do you feel would be most effective with sex offenders and what experience do you have using this approach?

Follow up: Which do you think is most beneficial with sex offenders:

Individual, Group, or Family?

9. Do you feel therapy in prison should be coerced or voluntary? For instance, an inmate cannot move to a minimum restrictive facility or get earned time unless he is doing recommended programs.
10. We use the polygraph to verify treatment compliance and sexual history. Are you familiar with the polygraph and what is your opinion of its use as a treatment tool?
11. We use male and female co-therapists, why would you think this would be important?

#### **We are going to ask several situational questions**

12. Situational: You and your co-therapist disagree on whether a sex offender would be terminated from group. How would you resolve it?
13. Situational: A sex offender asks you if you have ever been a victim. How would you respond?
14. Situational: You are running a sex offender group with your co-therapist, an inmate in the groups gets along well with you and all the officers in his unit, but he seems to be

having difficulty getting along with your co-therapist. What would you look for and how would you handle the problem?

15. Situational: A sex offender in your group falls in love with you (or your co-therapist) and tells you this privately. He asks you not to tell anyone. What would you do and what would you tell him, if anything?

16. Situational: The program has a contract that states that an inmate will be terminated from group if he has an unexcused absence. An inmate in your group who seems very motivated and has been doing well in treatment misses a group session because he overslept. How would you handle this situation?

17. Situational: An inmate admits to committing a sex offense but does not feel he has an ongoing problem in that area. For example: It only happened once and that was a long time ago; or, he was drinking then and he's been sober for three years; or, he has become a Christian and Christians don't do that kind of thing. How would you handle this?

18. Situational: An inmate has been doing well in group but you found out he lied to you about keeping Penthouse and Playboy magazines in his room. How would you handle this situation?

19. Situational: You have a report from a female officer that a member of your group was nude when she went by his cell during count. When you ask the inmate about this lie tells you that he just happened to be changing clothes when the officer walked by. This inmate is a good group member. How would you handle this situation?

20. It has been said that many people go into the mental health profession to heal their own issues. Please comment on this.

21. What are the reasons you have left jobs previously and why are you leaving your current position?

22. What will supervisors/references/co-workers say about your attendance and performance during the last year?

23. The Department of Corrections conducts a thorough background check and integrity interview. Is there anything that may come up in your background check that you would like to explain to us ahead of time?

24. Discuss the DOC Training Academy and on-call requirement.

25. Are you eligible for licensure in Colorado?

26. If you were offered the job, when would you be able to start?

27. Are you willing to spend one day observing the SOTMP?

28. Do you have any questions for us?



**Sample Interview Questions for a Supervisor**  
**Adapted from a Colorado Department of Corrections Supervisor Interview**

1. Please outline your qualifications and/or previous work experience that would qualify you to supervise a sex offender treatment program.
2. What are important elements of a treatment program for sex offenders?
3. Are you certified with the Sex Offender Management Board at the full operating level? (Is there an equivalent in California?)
4. Explain how you would ensure that staff working under your supervision would motivate clients to progress through the program in a timely fashion.
5. What theories do you have about why people commit sex offenses?
6. Describe your management style.
7. How do you keep a team invested in the team concept?
8. Explain how you would deal with conflicts between staff members that you supervise.
9. How do you recognize when an employee is being impacted negatively by his/her job?
10. How do you maintain morale in the people that you would supervise? How would you improve morale?
11. Consistency in treatment is an important element of helping offenders change. How would you ensure that staff follow program philosophy, policies, and procedures.
12. How tolerant are you in dealing with a work environment's shortcomings and inconsistencies?
13. In what ways are correctional staff important to sex offender treatment programs?
14. How would you effectively work with correctional staff to create a positive working relationship while meeting the needs of the treatment program?
15. What do you like about providing sex offender treatment? What is your least favorite part of providing sex offender treatment?
16. The polygraph is not traditionally used in treatment. In what ways do you think it is therapeutic and in what ways is it non-therapeutic?
17. What do you believe are your outstanding qualities for this job?
18. What would you struggle most with in this job?
19. What skills would you need to develop for this job?
20. Explain why you would want this position?
21. Do you have any questions for us?



# Appendix 17

## **Sample Group Processing Form and Instructions Obtained by the Colorado Department of Corrections**

### Memorandum

TO: SOTMP Therapists

FROM: Peggy Heil, SOTMP Program Director

DATE: March 3, 2003

SUBJECT: Co-therapist Group Processing Form

The attached form was developed as a tool to focus therapists' group processing discussions. It is our hope that this tool will be helpful in assessing and continually enhancing your group therapy skills specific to sex offender treatment. Time should be allotted after each group session to verbally process with your co-therapist. Each day add notes to the attached Group Processing Form. Jointly, at the end of the week, finalize one form for each sex offender group you conduct. Copy the form for each therapist and turn in the weekly forms with your time sheet.

Group therapy continually presents new situations and dynamics that are challenging to deal with. As therapists, there are always additional skills and knowledge that we can learn to make our therapy more effective. Taking time to assess our strengths and areas for improvement is an important step in increasing our skills and maintaining a more uniform therapeutic approach. This form is intended to facilitate that process. The section on "Clinical staffings/Training needs" provides a place where you can identify topics for team staffings and training needs. This will give all of us the opportunity to brainstorm responses to challenging clinical issues and expand our skills.

The form is intended to generate valuable group processing discussion. It is our expectation that the discussion will be in-depth, however, you only need to document concise answers on the form. It is our hope that you will feel safe in honestly assessing your therapy skills and will not fear disclosing areas for improvement. As supervisors and therapists we recognize that we continually need to upgrade our skills and that it is a clinical strength to be able to accurately assess our skills. This information will be used to provide more relevant supervision and training for our team.

# Co-therapist Group Processing Form

Week of Group Session: \_\_\_\_\_ Number of Group Sessions  
for Week: \_\_\_\_\_

Reasons for any cancellations:

Did therapists provide a positive role model?

Started group on time

Kept preliminary group activities to a maximum of 10 minutes (i.e. announcements, RFG's, check-ins, etc.)

Was alert and focused during the entire group session

Displayed balance, shared decision making, and support of each other

Covered all material/issues assigned for group session(s)

Did therapists hold the group members accountable during group?

Required group members to follow the group rules and contract

***Required homework to be completed and turned in***

**Provided feedback on homework**

Helped offenders to consider how the concepts applied to them

Respectfully confronted distortions, denial, minimizations and rationalizations

(Phase I) Spent 2 hours per week checking up on offenders' behavior outside of group

(TC) Followed up on pertinent group issues during the week with primary therapist, housing staff, worksite staff, and case management.

Displayed knowledge of offenders' issues in feedback to group members (i.e. sex offense, criminal hx, polygraph, homework, cell house/visiting room/work site behavior)

Communicated assertively with Group Members?

Allowed offenders to discuss their true thoughts and asked offenders questions that helped them think things through themselves

Confronted offenders in a respectful manner

Avoided shaming the offenders

Encouraged feedback from other group members instead of a dialogue between one offender and a therapist

Avoided lecturing (except when teaching a skill)

Acknowledged progress of group members (i.e. "You were able to listen to the group feedback today without getting defensive.")

Apologized for errors and cleaned up your messes (i.e. "I'm sorry, I allowed the group to get off track last session. I want to get everyone focused on RSA's.")

Gave offenders time to collect themselves when they were overwhelmed or shut down (i.e. "You don't seem to be able to hear any of this feedback right now. What is going on for you right now? Do you need some time to think about this?")

Provided hope for change

Issues to follow up on next session:

Clinical Staffings/Training Needs:

Group: \_\_\_\_\_

Facility: \_\_\_\_\_

Co-therapists: \_\_\_\_\_

Co-therapist: \_\_\_\_\_  
Phase I Manual. New Co-therapist Group Processing

## Appendix 18

### **Polygraph Qualification Requirements from Multiple Organizations**

#### **American Polygraph Association Standards for Post-Conviction Sex Offender Testing**

##### **3.11 Standards for Post-Conviction Sex Offender Testing (PCSOT)**

3.11.1. PCSOT examiners are required to satisfy the provisions set forth in the Standards of Practice for investigative examinations as well as the following mandatory standards:

3.11.2 Minimum Training: A minimum of 40 hours of specialized instruction through PCSOT certification training approved by the APA, beyond the basic polygraph training course requirements, is required for those who practice sexual offender testing.

3.11.3 Written Examination: Passing a final written examination, approved by the APA or its designated representative is required prior to receiving a diploma for the training. The written examinations are required to be properly controlled and protected to prevent exposure of the test questions or answers to any unauthorized persons.

3.11.5 Maintaining of Written Examinations: The instructors of the approved course are required to maintain a copy of the final written examination. Upon completion of the 40-hour PCSOT course instructors are required to administer the examination to those students who qualify for the final examination. Upon completion of the examination the instructor are required to submit the tests to the APA National Office for scoring verifications.

3.11.6 Recording Requirements: All PCSOT polygraph examinations submitted for quality control are required to be audio/visually recorded in their entirety. When required for quality control purposes these recordings will be made available. All recorded physiological data is required to be retained as part of the examination file as long as required by regulation or law, but for a minimum of one year.

3.11.7 Conflict of Interest: PCSOT examiners who are therapists/treatment providers shall not conduct polygraph examinations on an individual that they directly or indirectly treat or supervise.

3.11.8 PCSOT examiners who are probation or parole officers shall not conduct a polygraph examination on any individual that they directly or indirectly supervise.

**California Association of Polygraph Examiners**  
**Information obtained from the website:**

Several examiners in California are Certified by C.A.P.E. to conduct sex offender polygraph examinations and have completed a 40 hour C.A.P.E sponsored training program presented by Behavioral Measures (Eric Holden, Ph.D.). Those examiners have taken and successfully passed a written examination following the completion of the course. A Certificate of certification in Sex Offender Polygraph Examinations has been awarded to those members and each has agreed to follow the Guidelines for Clinical Polygraph Examination of Sex Offenders adopted by C.A.P.E. in 1997.

Persons trying to locate examiners for Sex Offender Testing and guidelines adopted are urged to contact a member of the Board of Directors of C.A.P.E. for more information or to verify Certification. You may utilize the following E-Mail address for this purpose:  
[secretary@californiapolygraph.com](mailto:secretary@californiapolygraph.com)



## Colorado Sex Offender Management Board Qualifications

**4.500 POLYGRAPH EXAMINER - Full Operating Level:** Polygraph examiners who test adult sex offenders must meet the minimum standards as indicated by the American Polygraph Association, the American Society for Testing and Measures, and the Association for the Treatment of Sexual Abusers, as well as the requirements throughout these Standards.

Polygraph examiners who conduct examinations on adult sex offenders shall adhere to best practices as recommended within the polygraph profession.

To qualify at the Full Operating Level to perform examinations of adult sex offenders, an applicant must meet all the following criteria:

- A. The individual shall have graduated from an accredited American Polygraph Association (APA) school and shall have a baccalaureate degree from a four year college or university;
- B. The individual shall have conducted at least two hundred (200) criminal specific-issue examinations broken down into the following categories:
  - 1. Of these 200 examinations, a minimum of half or one hundred (100) must be post-conviction sexual offender (adult or juvenile) polygraph examinations;
  - 2. Of these 100 examinations, a minimum of half or fifty (50) must be post-conviction adult sexual offenders;
  - 3. Of these 50 examinations, twenty (20) must be sexual history (see Note); twenty (20) must be maintenance/monitoring; and the remaining ten (10) may be from any or a combination of the three categories (specific issue, sexual history, maintenance/monitoring).

Note: A sexual history examination is identified by question areas that verify a subject's entire sexual history and may include documentation provided by the subject prior to the examination.

- C. The individual shall have completed 64 hours of specialized clinical sex offender polygraph examiner training;

Following completion of the curriculum (APA school) cited in Section 4.500 (A) of these Standards, the applicant shall have completed an APA approved forty hour training specific to post-conviction sexual offending which focuses on the

areas of evaluation, assessment, treatment and behavioral monitoring and includes, but is not limited to the following:

- Pre-test interview procedures and formats
- Valid and reliable examination formats
- Post-test interview procedures and formats
- Reporting format (i.e., to whom, disclosure content, forms)
- Recognized and standardized polygraph procedures
- Administration of examinations in a manner consistent with these Standards
- Participation in sex offender community supervision teams
- Use of polygraph results in the treatment and supervision process
- Professional standards and conduct
- Expert witness qualifications and courtroom testimony
- Interrogation techniques
- Maintenance/monitoring examinations
- Periodic/compliance examinations

The applicant must **also** complete twenty-four (24) hours of specialized training in any of the following areas:

- Behavior and motivation of sex offenders
- Trauma factors associated with victims/survivors of sexual assault
- Overview of assessment and treatment modalities for sex offenders
- Sex offender denial

The aggregate of the required APA approved forty hour training specific to post-conviction sexual offending and the twenty-four (24) hours of specialized training make up the 64 hours of training post-graduation from an APA accredited polygraph school.

If an applicant wishes to substitute any training not listed here, it is incumbent on the applicant to write a justification demonstrating the relevance of the training to this standard.

- D. In concert with the generally accepted standards of practice of the polygraph profession, the individual shall adhere to the Professional Code of Ethics (2001) published by the Association for the Treatment of Sexual Abusers (ATSA). The individual shall demonstrate competency according to the individual's respective professional standards and conduct all examinations in a manner that is consistent with the reasonably accepted standard of practice in the clinical polygraph examiner community;
- E. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the Standards. These references shall include, but not be limited to, other members of the community supervision team;
- F. 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;

- G. Submit to a current background check and be fingerprinted (Section 16-11.7-106 (2) C.R.S.).

**4.510 Continued Placement on the Provider List:** 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 board. Requirements are as follows:

- A. The polygraph examiner must demonstrate continued compliance with these Standards;
- B. 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 (See Standard 4.500 C);
- C. Shall conduct a minimum of 100 post-conviction sex offense polygraph examinations in the 3-year listing period;
- D. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board 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;
- E. 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;
- F. 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;
- G. Submit to a current background check and be fingerprinted (Section 16-11.7-106 (2) C.R.S.);
- H. Report any practice that is in significant conflict with the Standards;

- I. Comply with all other requirements outlined in the Sex Offender Management Board Administrative Policies.

**4.600 POLYGRAPH EXAMINER - Associate Level:** A clinical polygraph examiner at the Associate Level is an individual who otherwise meets the Standards for Full Operating Level but who does **not** have:

- A. A baccalaureate degree from a four year college or university and/or,
- B. Who has not yet completed two hundred (200) post-conviction polygraph examinations broken out into the following categories:
  - 1. Of these 200 examinations, a minimum of half or one hundred (100) must be post-conviction sexual offender (adult or juvenile) polygraph examinations;
  - 2. Of these 100 examinations, a minimum of half or fifty (50) must be post-conviction adult sexual offenders;
  - 3. Of these 50 examinations, twenty (20) must be sexual history (see Note); twenty (20) must be maintenance/monitoring; and the remaining ten (10) may be from any or a combination of the three categories (specific issue, sexual history, maintenance/ monitoring).
- C. The examiner shall obtain supervision from a clinical polygraph examiner at the Full Operating Level under these Standards for each remaining polygraph examination up to the completion of 200 polygraph exams as specified in standard 4.500 (B). The supervision agreement must be in writing.

All applicants must have an application on file with the SOMB that includes the supervision agreement. Supervision must continue for the entire time an examiner remains at the Associate Level.

The supervisor of a clinical polygraph examiner shall review samples of the videotapes of clinical polygraphs and/or otherwise observe the examiner; and provide supervision and consultation on question formulation for clinical polygraph exams, report writing, and other issues related to the provision of polygraph testing of adult sexual offenders. Supervisors must review and sign off on each polygraph examination report completed by an Associate Level polygraph examiner under their supervision.

If the Associate Level polygraph examiner has met all the requirements for Full Operating Level status except for obtaining a bachelor's degree, the supervision requirement that supervisors sign off on each exam may be waived by the SOMB Application Review Committee if the following conditions are met:

The Associate Level polygraph examiner submits:

- Documentation that all other criteria for Full Operating Level status have been met
- Evidence of continuing work toward obtaining a B.A. degree with a proposed completion date.

- Evidence that the examiner is continuing to conduct clinical polygraph exams
- A letter from the examiner's supervisor indicating their proficiency and their willingness to lower the intensity of supervision to one hour per month.

D. The applicant shall have completed all training as outlined in Standard 4.500 (C) of these Standards;

If an applicant wishes to substitute any training not listed here, it is incumbent on the applicant to write a justification demonstrating the relevance of the training to this standard;

- E. In concert with the generally accepted standards of practice of the polygraph profession, the individual shall adhere to the Professional Code of Ethics (2001) published by the Association for the Treatment of Sexual Abusers (ATSA). The individual shall demonstrate competency according to the individual's respective professional standards and conduct all examinations in a manner that is consistent with the reasonably accepted standard of practice in the clinical polygraph examiner community;
- F. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the Standards. These references shall include, but not be limited to other members of the community supervision team;
- G. Submit documentation that the examiner has engaged in periodic peer review by other clinical polygraph examiners listed at the Full Operating Level operating separately from the examiner's agency. Peer review must be conducted bi-annually at a minimum;
- H. 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;
- I. Submit to a current background check and be fingerprinted (Section 16-11.7-106 (2) C.R.S.).

**4.610 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

**Continued Placement on the Provider List:** 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:

- A. The polygraph examiner must demonstrate continued compliance with these Standards;
- B. The applicant shall have completed all training as outlined in Standard 4.500 (C) of these Standards;
- C. Conduct a minimum of 75 clinical polygraph examinations in the 3 year listing period;
- D. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board 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;
- E. 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;
- F. 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;
- G. Submit to a current background check and be fingerprinted (Section 16-11.7-106 (2) C.R.S.);
- H. Report any practice that is in significant conflict with the Standards;
- I. Comply with all other requirements outlined in the Sex Offender Management Board Administrative Policies.

**4.620 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, as indicated in Standard 4.500 (B);

- 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;

**4.630 Period of Compliance:** Individuals who have been listed on the Provider List as clinical polygraph examiners and who do not meet one or more of the revised standards for qualifications for clinical polygraph examiner may request a period of compliance not to exceed one year from the effective date of these Standards.

Any new applicants must be in compliance with the standards of practice when they apply.





# Position Paper for Clinical Polygraph Examinations in Sex Offender Treatment

Revised January 23, 2004.

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## **Clinical Polygraph Examinations in Sex Offender Treatment**

The polygraph instrument precisely records physiological measurements that are interpreted in accordance with specific protocols by professional polygraphists with specialized training. These interpretations are used to form professional opinions about whether an examinee was attempting deception while answering specific “relevant” questions during the examination.

The California Coalition on Sexual Offending (CCOSO) supports post-conviction (clinical) polygraph testing of sex offenders. The CCOSO believes that post conviction sexual offender polygraph testing (PCSOT) motivates clients to be truthful about their past sexual behaviors, possible recent relapses, and high-risk conduct.

### **Benefits**

PCSOT is an effective and important management and treatment tool that can help lower sexual and general criminal recidivism during supervision and treatment [1]. Further, PCSOT dramatically increases disclosure of relevant historical information, allowing for more precise targeting of treatment interventions [2-4]. PCSOT also increases clients’ propensity to engage in honest relationships outside the treatment setting, thereby improving quality of life for examinees and those around them. Demonstrable benefits during supervision and treatment suggest that offenders whose treatment includes PCSOT may be less likely to reoffend after treatment and supervision ends. Therefore, available evidence suggests that PCSOT improves community safety.

### **Test Accuracy and Treatment Provider Responsibilities**

A properly administered single issue polygraph examination can be an effective method for helping knowledgeable professionals distinguish truthfulness from attempted deception during the sex offender management and treatment process [5-10]. The CCOSO also recognizes legitimate concerns over polygraph’s limitations due to issues of standardization, reliability, and validity. However, adhering to standardized examiner training and offender-testing practices [11-13] is believed to reduce error rates. To date, there is no evidence that gender effects test accuracy or utility. Altogether, research and collective experience suggest that PCSOT can meaningfully inform sex offender treatment and that this is particularly true when it is one of a comprehensive battery of management and treatment tools applied in the context of an effectively implemented containment program [14, 15].

Test validity and reliability have not been empirically studied specifically in the PCSOT setting. The CCOSO recognizes that polygraph is a complex procedure, the outcomes of which can be synergistically affected by [16]:

- Examiner experience, characteristics, and practices
- Examinee experiences, characteristics, culture and behavior
- Program culture within which it is integrated
- Idiosyncratic situational factors
- Instrumentation and interpretation procedures
- Base rates of attempted deception in the population being tested
- Pre-examination data collection procedures

Although existing accuracy studies do not include individuals under the age of eighteen or persons with intellectual disabilities, more than a decade of collective experience suggests that it is reasonable to use polygraph as a clinical tool with youth thirteen to eighteen years old and with developmentally disabled individuals. Confidence in charts from such individuals should decline with declining age beginning at eighteen and/or level of intellectual functioning. Determining the appropriateness of polygraph testing with minors and intellectually impaired individuals or using polygraph results to assist with decision making in their cases requires consideration of these limitations.

As with any test, professionals who utilize examination results for making case management and treatment decisions should understand and account for all relevant factors and place test results in their proper perspective in each case. Both under-valuing of and over-relying on PCSOT can be detrimental to assessment and treatment; contributes to inappropriate decisions, and places the community at increased risk.

## **Examination and Examiner Guidelines**

The California Association of Polygraph Examiners ([CAPE](#)), the [American Polygraph Association](#) (APA) and other professional polygraph organizations have developed guidelines defining examiner competence and ethical examiner practices. The CCOSO collaborates with the CAPE and other professional polygraph organizations to maximize ethical PCSOT best-practices and encourages further study to improve PCSOT utility and accuracy, and to establish differential standards for use with various populations.

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## **Confidentiality – Violations During Treatment**

Sex offender management and treatment necessitates limiting traditional patient-psychotherapist privilege and confidentiality. Clients should be encouraged to self-report misbehavior. This is best accomplished by informing them that “Deception Indicated” polygraph chart interpretations can lead to increased surveillance, restrictions and thorough investigations, making discovery of illicit behavior more likely. However, consequences for illicit behavior may be mitigated if clients self-disclose violations rather than waiting to be discovered.

## **Confidentiality – Deviant History**

PCSOT's usefulness as a clinical tool derives from its ability to elicit historical information, allowing psychosexual behavioral patterns to be more fully revealed, better understood, and more effectively managed and changed. However, client disclosures of potentially incriminating information to mandated reporters could lead to further prosecution. This may end the very treatment the information was intended to enhance.

Excepting the obligation to protect potential victims at current risk, using a clinical polygraph examination to extract incriminating historical information is only ethical when clients are protected from the legal consequences of their honest self-report about pre-treatment behaviors. Some jurisdictions encourage PCSOT use and avoid constitutional challenges by providing limited legal immunity to examinees. Such immunity may enhance test utility in that it calls for nothing to be withheld. Proponents of this method also point out that its use allows authorities to locate previously unreported victims and contact them for purposes of offering counseling and supportive services.

Another method of safeguarding clients from potential consequences of honest historical self-report is to collect only information that does not identify particular victims (e.g. victim #1, #2, etc.). Some programs prefer this method even when immunity is available, since some clients may not completely trust immunity grants and might be more likely to attempt concealing potentially incriminating information, even when they are promised limited immunity. Some advocates for the victim anonymity method also assert that immunity that generates victim outreach re-victimizes some former victims by unwanted invasion of their privacy. Finally, advocates of the victim anonymity method point out that immunity grants combined with victim outreach are unfair to former victims who would have initiated prosecutable reports at a later time.

**The CCOSO recommends the following to enhance test accuracy, balance client confidentiality with community safety, and protect program integrity [17].**

1. Treatment providers and polygraph organizations should
  - Establish standardized methods for collecting pre-test information and preparing sex offender examinees for polygraph examinations.
  - Conduct robust studies across age, gender and I.Q. ranges to establish test validity and reliability so that the polygraph can be generalizable across populations when interpreting test findings.
2. Examiners should always mention and briefly explain the limitations of polygraph findings as they apply to specific cases in their reports.

3. PCSOT should be used in a [containment model](#) context.
4. Examiners working on Containment Teams should adhere to [guidelines](#) promulgated by the [CAPE](#) and other [professional polygraph organizations](#).
5. All crimes and rule violations committed during treatment should be promptly reported to appropriate officials. Clients should be informed in writing before beginning treatment, that such reports will be made.
6. Clients should not be prosecuted for crimes committed before beginning treatment when such prosecution would rely on disclosures made in the treatment setting. Written limited immunity agreements with prosecutors and/or refraining from collection of victim identities are acceptable methods of protecting clients from such prosecution.
7. Treatment providers and supervision officers should be knowledgeable about the ways in which various factors can affect test results and utility before employing PCSOT in their practices. These factors include but are not necessarily limited to:
  - Examiner experience, characteristics, and practices
  - Examinee experiences, characteristics, culture and behavior
  - Program culture within which it is integrated
  - Idiosyncratic situational factors
  - Instrumentation and interpretation procedures
  - Base rates of attempted deception in the population being tested
  - Pre-examination data collection procedures
8. Polygraphy should not be the only form of monitoring used by a containment team. Other methods such as electronic surveillance, collateral contacts, face-to-face meetings with the individual, chemical testing and unannounced field visits should be regularly employed.
9. Polygraph charts should never be the sole basis for making significant case decisions.
10. Particular caution is warranted with clients who:
  - a. Are between the age of thirteen and eighteen
  - b. Manifest impaired reality testing
  - c. Take medications or have health conditions known to effect the physiological responses on which polygraphy relies
  - d. Appear unable to produce “Deception Not Indicated” charts even when independent information makes it highly unlikely they are being deceptive

- e. Have cognitive/intellectual functioning deficits.
11. Polygraph, correctional, and psychotherapy professionals should actively cooperate and encourage joint research and other ventures to enhance PCSOT standardization, validity and reliability. This would in turn, enhance accuracy, utility and ethical practice.
  12. CCOSO members using any testing procedures, including polygraph examinations should avoid under-reliance or over-reliance on test results by noting appropriate strengths and limitations of those tests when reporting outcomes or in court testimony.

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9. Saxe, L., D. Dougherty, and T. Cross, *Scientific Validity of Polygraph Testing: A Research Review and Evaluation—A Technical Memorandum*. 1983, U.S. Congress Office of Technology Assessment: Washington, D.C. p. 127.
10. Raskin, D., G.H. Barland, and J.A. Podlesny, *Validity and Reliability of Detection of Deception: Final Report*. 1976, National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U.S. Department of Justice: Salt Lake City, Utah.
11. Holden, E.J., *Pre- and Post-Conviction Polygraph: Building Blocks for the Future - Procedures, Principles and Practices*. Polygraph, 2000. **29**(1): p. 69-98.
12. CAPE, *CAPE Guidelines for Clinical Polygraph Examination of Sex Offenders - Post Conviction*. 2001, California Association of Polygraph Examiners.
13. APA, *Standards for Post Conviction Sex Offender Testing*. 1995, American Polygraph Association.
14. English, K., et al., *The value of polygraph testing in sex offender management*. 2000, Colorado Department of Public Safety, Division of Criminal Justice, Office of Research and Statistics: Denver.
15. English, K., S. Pullen, and L. Jones, *The containment approach: An aggressive strategy for community management of adult sex offenders*. Psychology, Public Policy, and Law, 1998. **4**(1 / 2).
16. Kokish, R., *The current role of Post Conviction Sex Offender Polygraph Testing in Sex Offender Treatment (in publication)*. Journal of Child Sexual Abuse, 2004.

17. Blasingame, G., *Suggested clinical uses of polygraphy in community-based sexual offender treatment programs*. Sexual Abuse: A Journal of Research and Treatment, 1998. **10**(1): p. 37-45.

### **World Wide Web Links**

California Association of Polygraph Examiners (CAPE)  
[www.californiapolygraph.com](http://www.californiapolygraph.com)

CAPE Sex Offender Polygraph Testing Guidelines  
<http://www.ccoso.org/internal/SexTestingGuidelines.doc>

CCOSO Position Paper on Sex Offender Containment  
[www.ccoso.org/papers/containment.html](http://www.ccoso.org/papers/containment.html)

Polygraph Examiner Associations  
[www.polygraphplace.com/docs/state.htm](http://www.polygraphplace.com/docs/state.htm)



## APPENDIX 19

### COLORADO SEX OFFENDER MANAGEMENT BOARD

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## SEXUAL HISTORY DISCLOSURE

### TO ASSIST COMMUNITY SUPERVISION TEAMS IN THE IMPLEMENTATION OF THE SEXUAL HISTORY POLYGRAPH DISCLOSURE PROCESS



**Colorado Department of Public Safety  
Division of Criminal Justice  
SEX OFFENDER MANAGEMENT BOARD**

Polygraph Committee

February 2002  
*Revised December 2005*

## Sexual History Disclosure - Instructions

1. Complete pages 4 through 24 first. (Complete the table of contents / summary, page 3, after completing pages 4 through 24.
  - Write your name and date of birth at the top of every page.
  - Sign and date all pages when they are completed.
  - Do not leave any pages blank.
  - For any behaviors that do not apply, you must clearly indicate that in writing, on the page.
2. Complete **one** Sexual Contact Form (Attachment) for each identified person in pages 4 through 24.
  - Make additional copies of individual pages or the Sexual Contact Form (Attachment) as necessary.
  - Do not leave any item blank. Answer YES or NO to every item.
3. Complete the Table of Contents / Summary Page (page 3) after you have completed pages 4 through 24.
  - Provide all of the summary information requested for each item (A through U) on page 3
  - Do not leave any item blank. (including attached sexual contact forms), all sexual contacts/behaviors should be totaled at the bottom of the Table of Contents / Summary page (page 3).
4. Complete page 25 (other behaviors).
  - Attach a written summary description of your involvement in any of the behaviors listed on page 24 (other behaviors)
  - Additional pages should be hand-numbered with small letters next to the existing page numbers. For Example, page 25-1, would pertain to item 1 on page 25 (deviant fantasies), while page 25-22 would pertain to item 22 on page 25 (sexual infidelity).
5. You may list approximate ages if exact ages are not known (do not leave ages blank).
6. List all sexual contacts/behaviors up to and including the date you are completing the form.
7. Attempt to list sexual contacts/behaviors in chronological order.
8. If you need further assistance or have questions, contact your therapist or supervising officer.
9. Review your written disclosure with your treatment group and supervision and treatment team members prior to your polygraph examination date.
10. Provide your treatment provider and supervising officer with copies of your completed sexual history disclosure.
11. Keep a copy of your disclosure for your own records.
12. Take a copy of your disclosure to your polygraph examination - your examiner may not need to read it, but you may want to refer to it. (It is better to have it and not need it, than to need it and not have it.)
13. Direct all questions about the polygraph test to the polygraph examiner. Soliciting information about the polygraph, from friends, books or other media, is unlikely to improve your test results, and tends to be correlated with cynicism, resistance, un-resolved test results, and failure to progress in treatment.
14. Any attempt to falsify or alter your polygraph examination results, or produce inauthentic polygraph examination data, may be regarded as a non-compliant and deliberate attempt to interfere with a process intended to assure and promote safety in the community and your progress in treatment, and may become the basis for sanctions in treatment and supervision.

## Sexual History Disclosure - Table of Contents and Summary

• <b>Instructions</b> .....	page 2
• <b>Contents / Summary</b> .....	page 3

	YES	NO	# persons	# times	last time	Page
A. After age 18, sexual contact with anyone under age 15	YES	NO	_____	_____	_____	4
B. Sexual contact with relatives or family members	YES	NO	_____	_____	_____	5
C. Forced or violent sexual contact (prevent escape or resistance)	YES	NO	_____	_____	_____	6
D. Opportunistic sexual contact with helpless or incapacitated persons	YES	NO	_____	_____	_____	7
E. Prior to age 18, sexual contact with anyone 4 or more years younger	YES	NO	_____	_____	_____	8
F. After age 25, sexual contact with anyone age 15 or 16	YES	NO	_____	_____	_____	9
G. Sexual contact with anyone under age 18 while in a position of trust	YES	NO	_____	_____	_____	10
H. Coercive (non-violent) sexual contact	YES	NO	_____	_____	_____	11
I. Frottage (sexual rubbing against unsuspecting persons )	YES	NO	_____	_____	_____	12
J. History of computer solicitation (solicitation via any electronic devices)	YES	NO	_____	_____	_____	13
K. Voyeurism (peeping)	YES	NO	_____	_____	_____	14
L. Exhibitionism (public nudity)	YES	NO	_____	_____	_____	15
M. Prostitution (soliciting or pandering)	YES	NO	_____	_____	_____	16
N. Public masturbation (masturbation in public places)	YES	NO	_____	_____	_____	17
O. Theft/use of others' undergarments/clothing/property for sexual behavior	YES	NO	_____	_____	_____	18
P. History of stalking (for sexual or aggressive reasons)	YES	NO	_____	_____	_____	19
Q. Child Pornography (use / production / distribution)	YES	NO	_____	_____	_____	20
R. Sexual contact with animals (including reptiles or insects)	YES	NO	_____	_____	_____	21
S. Institutional sexual contact (out of home placement)	YES	NO	_____	_____	_____	22
T. Obscene Phone Calls	YES	NO	_____	_____	_____	23
U. Arson and sexually motivated fire-setting behaviors	YES	NO	_____	_____	_____	24

• <b>Other Behaviors Checklist</b> .....	page25
• <b>Sexual Contact Form (make additional copies as needed)</b> .....	Attachment - page 26

<b>Summary</b>	
Number of adult victims as adult:	male _____ + female _____ = total _____
Number of underage victims as an adult:	male _____ + female _____ = total _____
Number of victims as a juvenile:	male _____ + female _____ = total _____
Total:	male _____ female _____
Total number of identified offenses ( = sexual contact forms) _____ Age at first identified offense _____	

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

A.

**Sexual contact with anyone under age 15, after you turned age 18**

Include all persons with whom you engaged in any form of rubbing or touching of a person's sexual organs (i.e., breasts/chest area, buttocks, vaginal area, penis), either over or under clothing, if for the purpose of sexual arousal, sexual gratification or stimulation, or sexual curiosity, along with all persons whom you caused or allowed to rub or touch your private parts, either over or under clothing, for the purpose of sexual arousal, sexual gratification or stimulation or sexual curiosity. Also include persons with whom you engaged in any sexual petting (i.e. sexual hugging and kissing) behaviors.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Sexual Contacts	First Sexual Contact (Month/Yr)	Last Sexual Contact (Month/Yr)	Type of Sexual Contact

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

B.

Sexual Contact with Relatives of Family Members

Include sexual contact with all person related by blood, marriage (excluding spouse or someone in a spousal role) or adoption (e.g., mother, father, sister, brother, aunt, uncle, grandparents, grandchildren, cousins, nieces, nephews, step-children, in-laws). Include all relatives with whom you engaged in any sex play games (e.g., mommy-daddy, house, doctor, show-me, spin-the-bottle, truth-or-dare, etc.) or sexuality education lessons.

Complete a separate Sexual Contact Form (Attachment) for each listed contact.

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Sexual Contacts	First Sexual Contact (Month/Yr)	Last Sexual Contact (Month/Yr)	Type of Sexual Contact

Signature/Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

C.

Forced (Violent) Sexual Contacts

Sexual contact with any person (including spouses or partners) whom you physically hit or struck, physically restrained using your body strength or any object, or threatened to harm through the use of weapons, including implied or improvised weapons, threatening gestures, or verbal threats of harm, including threats of harm towards the person's relatives or family members (including pets), in order to prevent the person from resisting or escaping.

Complete a separate Sexual Contact Form (Attachment) for each listed contact.

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Forced Sexual Contacts	First Forced Sexual Contact (Month/Yr)	Last Forced Sexual Contact (Month/Yr)	Type of Force (Violence)

Signature/Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

D.

Opportunistic Sexual Contact with Sleeping, Incapacitated, or Helpless Persons

Include all sexual contacts involving persons when they were (or appeared) asleep, severely intoxicated, drugged/sedated, unconscious, mentally or physically incapacitated. Also include sexual peeping or voyeurism against persons who were (or appeared to be) asleep or incapacitated.

Complete a separate Sexual Contact Form (Attachment) for each listed contact.

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Opportunistic Sexual Contacts	First Opportunistic Sexual Contact (Month/Yr)	Last Opportunistic Sexual Contact (Month/Yr)	Describe method of Access

SIGNATURE/DATE: \_\_\_\_\_

E.

**Sexual contact with anyone 4 or more years younger than you, while you were under age 18**

Include all persons with whom you engaged in any form of rubbing or touching of a person's sexual organs (i.e., breasts/chest area, buttocks, vaginal area, penis), either over or under clothing, if for the purpose of sexual arousal, sexual gratification or stimulation, or sexual curiosity, along with all persons whom you caused or allowed to rub or touch your private parts, either over or under clothing, for the purpose of sexual arousal, sexual gratification or stimulation or sexual curiosity. Also include persons with whom you engaged in any sexual petting (i.e. sexual hugging and kissing) behaviors. Include all younger children with whom you engaged in any sex play games (e.g., mommy-daddy, house, doctor, show-me, spin-the-bottle, truth-or-dare, etc.) or sexuality education lessons.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Sexual Contacts	First Sexual Contact (Month/Yr)	Last Sexual Contact (Month/Yr)	Type of Sexual Contact

**SIGNATURE/DATE:** \_\_\_\_\_



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

F.

Sexual contact with anyone age 15 or 16, after you turned age 25

Include all persons with whom you engaged in any form of rubbing or touching of a person's sexual organs (i.e., breasts/chest area, buttocks, vaginal area, penis), either over or under clothing, if for the purpose of sexual arousal, sexual gratification or stimulation, or sexual curiosity, along with all persons whom you caused or allowed to rub or touch your private parts, either over or under clothing, for the purpose of sexual arousal, sexual gratification or stimulation or sexual curiosity. Also include persons with whom you engaged in any sexual petting (i.e. sexual hugging and kissing) behaviors.

Complete a separate Sexual Contact Form (Attachment) for each listed contact.

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Sexual Contacts	First Sexual Contact (Month/Yr)	Last Sexual Contact (Month/Yr)	Type of Sexual Contact

SIGNATURE/DATE: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

G.

**Sexual contact with anyone under age 18, with whom you had any type of position of trust (i.e. babysitter, teacher, coach, relative to minor, foster parent, etc.)**

Include all persons with whom you engaged in any form of rubbing or touching of a person's sexual organs (i.e., breasts/chest area, buttocks, vaginal area, penis), either over or under clothing, if for the purpose of sexual arousal, sexual gratification or stimulation, or sexual curiosity, along with all persons whom you caused or allowed to rub or touch your private parts, either over or under clothing, for the purpose of sexual arousal, sexual gratification or stimulation or sexual curiosity. Also include persons with whom you engaged in any sexual petting (i.e. sexual hugging and kissing) behaviors.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Sexual Contacts	First Sexual Contact (Month/Yr)	Last Sexual Contact (Month/Yr)	Type of Sexual Contact

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

H.

Coerced (non-violent) Sexual Contacts

Sexual contact with any person (including spouses or partners) whose compliance you obtained through any non-violent form of coercion (i.e, bribery, manipulation, money, drugs, friendship), despite the person's expressed or implied reluctance.

Complete a separate Sexual Contact Form (Attachment) for each listed contact.

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Coerced Sexual Contacts	First Coerced Sexual Contact (Month/Yr)	Last Coerced Sexual Contact (Month/Yr)	Type of Coercion (non-violence)

Signature/Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I.

**Frottage or Opportunistic Sexual Rubbing, Bumping or Touching Against Strangers or Unsuspecting (non-incapacitated) Persons**

Include sexual touching of others' private parts during any play, horseplay, wrestling or athletic activities, or unsuspecting persons in public places (e.g., persons at school, work, stores, gym, crowds, etc.)

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Opportunistic Sexual Contacts	First Opportunistic Sexual Contact (Month/Yr)	Last Opportunistic Sexual Contact (Month/Yr)	Describe method of Access

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**J.**

**Solicitation via Computer or Electronic Devices**

Include all sexual contacts/interactions and attempted sexual contacts/interactions via computer or electronic devices, including e-mails, chat rooms, cyber-sex, live web-cams, electronic bulletin board systems, Internet Relay Chat, DCC chat channels, private bulletin boards, other user groups. List ages or approximate ages at time of contact(s). Include law enforcement agents who posed as person willing to engage in any of the above sexual contacts, even though the actual contact may have been prevented.

**I. Describe how you attempted to seek sexual contacts/interactions on the computer or electronic devices (including frequency & time frames):**

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**II. List persons with whom you had in-person or face-to-face contact as a result of meeting through a computer or electronic device.**

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person's Name or Identifier	Gender (F/M)	Age(s) at Time	Your Age(s) at Time	Where did you meet or attempt to meet	Number of Face to Face Contacts	Number of Sexual Contacts	Type of Sexual Contact

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**K.**

**Voyeurism or Sexual Peeping**

Include all sexual behaviors involving peeping or voyeurism, including all attempts to look into someone's home, bedroom, bathroom, or bedroom, without Person knowledge or permission, in attempt to view someone naked, undressing/dressing, or engaging in sexual acts. Include all voyeurism attempts involving using or creating a hole opening to view others for sexual arousal, including all attempts to use any optical devices (i.e., mirror, binoculars, or telescope) to view others for sexual purposes.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person Name or Identifier	Relationship To You	Person SEX (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Incidents	First Incident (Month/Yr)	Last Incident (Month/Yr)	Brief Description (Where, method, devices used, etc.)

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**L.**

**Exhibitionism or Indecent Exposure**

Include all incidents in which you accidentally or intentionally exposed your bare private parts to unsuspecting persons in public places. Include incidents when you wore loose or baggy clothing that allowed your sexual organs to become exposed to others. Also include mooning, streaking, shining, or flashing behavior, and public urination while in view of others.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Incidents	First Incident (Month/Yr)	Last Incident (Month/Yr)	Brief Description (Where, how, etc)

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**M.**

**Prostitution**

Include all sexual contacts in which you paid for sex, or performed sexual acts for money, property, or favors.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person Name or Identifier	Location	Person SEX (F/M)	Person Age(s) at Time	Your Age(s) at Time	Max # Sexual Contacts	First Sexual Contact (Month/Yr)	Last Sexual Contact (Month/Yr)	Brief Description (Form of Payment, Your Role in Transaction, etc)

**Signature/Date:** \_\_\_\_\_



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

N.

### Public Masturbation

List all incidents of masturbation in public places (i.e., outside your residence, bedroom, or bathroom) in which you could view others or could possibly be observed by others while masturbating, including public restrooms, workplace/school, vehicles, and others' homes.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Location of Property (City/State)	Owner of Property	Relationship To You	Date/s of Incident (Month/Yr)	Your Age(s) at Time	Number of Masturbation Incidents at Location	Brief Description (Method, objects/property used, length of time remained at scene. Leaving semen or ejaculate for others to contact, etc.)

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**O.**

**Use or Theft of Underwear, Undergarments, or Personal Property for Masturbation or Sexual Arousal**

Include taking or keeping undergarments (including other trophies or personal property) from sexual partners, relatives, friends, or strangers for masturbation or sexual arousal. Include all incident in which you tried on or wore another person's underwear or undergarments without their knowledge or permission. Also include all incidents in which you returned someone's underwear or undergarments after using them for masturbation or sexual arousal.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Name or Identifier of Property Owner	Relationship To You	Person's Age(s) & SEX	Description of Property	Your Age(s) at Time	Max # Incidents	First Incident (Month/Yr)	Last Incident (Month/Yr)	Brief Description (How & where property obtained, How property used, Frequency of use, Current location of property)

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**P.**

**Stalking Behaviors**

Include all behaviors involving following someone without their awareness or permission, for either sexual or aggressive purposes. Include all incidents of following someone to their home, workplace or vehicle, or following others around a store, aisle, parking lot, campus, or community. Include all other efforts to monitor or observe another person's behavior without their knowledge.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person's Name or Identifier	Relationship To You	Person's SEX (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Incidents	First Incident (Month/Yr)	Last Incident (Month/Yr)	Brief Description (Where, method, devices used, type of contact made, etc.)

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Q.**

### Child Pornography

Include all activities related to viewing, possessing, using, producing, or distributing of nude or sexualized images of minors (persons under age 18).

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	My Age(s) at Time	Max # Incidents	First Incident (Month/Yr)	Last Incident (Month/Yr)	Description of Material (Where, What, How, Your Participation, Type, etc.) and How Were Materials Used? (For Masturbation, Traded/Exchanged, Sold, Shown to Others, Transferred via Computer or Electronic Device, etc.)

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**R.**

**Sexual Contact with Animals**

Include all sexual behaviors involving domesticated, farm/ranch, or wild animals, whether living or deceased, and whether whole or dismembered. Include all sexual contact with pets, whether your own or others.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Type of Animal	Owner of Animal	Your Age(s) at Time	Max # Contact s	First Sexual Contact (Month/Yr)	Last Sexual Contact (Month/Yr)	Brief Description (Type of sexual act, where, method, devices used, etc.)

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**S.**

### Institutional Sexual Contact

Include all sexual contact with persons in institutions including jail, prison, detention facilities, group or foster homes, treatment centers, medical or psychiatric hospitals, nursing homes, or any out of home placement.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person's Name or Identifier	Relationship To You	Person's Gender (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Sexual Contacts	First Sexual Contact (Month/Yr)	Last Sexual Contact (Month/Yr)	Type of Sexual Contact

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**T.**

### History of Obscene Phone Calls

Include your age, or approximate age, and a description of your behaviors at the time.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Person's Name or Identifier	Relationship To You	Person 's SEX (F/M)	Person's Age(s) at Time	Your Age(s) at Time	Max # Obscene Phone Calls	First Obscene Phone Call (Month/Yr)	Last Obscene Phone Call (Month/Yr)	Description (Words used, Threats made, Masturbation, etc.)

**Signature/Date:** \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

U.

**Arson or Fire-setting Behaviors**

Include all behaviors involving fire-setting for destructive or sexual purposes.

**Complete a separate Sexual Contact Form (Attachment) for each listed contact.**

Description of Property Burned (Occupied or Unoccupied?)	Owner of Property	Relationship To You	Location of Property (City/State)	My Age(s) at Time	Date of Fire-setting Incident (Month/Yr)	Brief Description (Method, Devices Used, Length of time remained at scene, Sexual Arousal &/or Masturbation, etc.)

**Signature/Date:** \_\_\_\_\_



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### Other Behaviors

**Attach separate page(s) to describe all 'YES' responses.**

			Frequency	Last Time
1. Experienced deviant fantasies	YES	NO	_____	_____
2. Masturbated to deviant fantasies	YES	NO	_____	_____
3. Cruising behaviors	YES	NO	_____	_____
4. Made photos/videos of self or others for sexual purposes	YES	NO	_____	_____
5. Abused animals	YES	NO	_____	_____
6. Arousal to offending memories	YES	NO	_____	_____
7. Abuse or assault of a spouse or partner	YES	NO	_____	_____
8. Participation in cults or hate groups	YES	NO	_____	_____
9. Alcohol usage	YES	NO	_____	_____
10. Illegal drug usage	YES	NO	_____	_____
11. Provided alcohol/drugs to minors	YES	NO	_____	_____
12. Contact with victim/s after restriction	YES	NO	_____	_____
13. Violated treatment/supervision rules	YES	NO	_____	_____
14. Necrophilia (sex contact with dead animals or people)	YES	NO	_____	_____
15. Self-mutilation	YES	NO	_____	_____
16. Use of feces for sexual purposes	YES	NO	_____	_____
17. Use of urine for sexual purposes	YES	NO	_____	_____
18. Use of inanimate objects for sexual arousal or masturbation	YES	NO	_____	_____
19. Nudity in public places	YES	NO	_____	_____
20. Sexual contact in public places	YES	NO	_____	_____
21. Consensual sexual contacts (non-abusive and not unlawful)	YES	NO	_____	_____
22. Sexual infidelity	YES	NO	_____	_____
23. Casual sexual contacts (persons known less than 24 hours)	YES	NO	_____	_____
24. Sexual contact with same sex partners (as a juvenile and adult)	YES	NO	_____	_____
25. Group sex activities	YES	NO	_____	_____
26. Consensual bondage activities	YES	NO	_____	_____
27. Sexual sadism (arousal to another's pain or humiliation)	YES	NO	_____	_____
28. Sexual masochism (arousal to your own pain or humiliation)	YES	NO	_____	_____
29. Anal sex activities	YES	NO	_____	_____
30. Sexual victimization	YES	NO	_____	_____
31. Pornography Use	YES	NO	_____	_____
32. Violent pornography	YES	NO	_____	_____
33. Pornography production / distribution (made nude image/s of self or other)	YES	NO	_____	_____
34. Masturbating to non-pornographic sexually stimulating images	YES	NO	_____	_____
35. Computer sex behaviors (cyber sex / sex-chat via computer or electronic device)	YES	NO	_____	_____
36. Use of non-human objects for sexual behavior	YES	NO	_____	_____
37. Telephone sex behaviors (phone sex lines, obscene phone calls)	YES	NO	_____	_____
38. Used a personal or dating service (telephone, computer or electronic device)	YES	NO	_____	_____
39. Visited or frequented topless bars / strip clubs	YES	NO	_____	_____
40. Visited or frequented adult bookstores or novelty shops	YES	NO	_____	_____
41. Visited or frequented erotic massage parlors (used erotic massage services)	YES	NO	_____	_____
42. Transsexualism (wanting to be a member of the opposite sex)	YES	NO	_____	_____
43. Transvestitism (dressing as a member of the opposite sex )	YES	NO	_____	_____

Signature/Date: \_\_\_\_\_

Your Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## SEXUAL CONTACT FORM

Person's Name/Identifier: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Gender: Female / Male Person's Age(s) at Time of Contact: \_\_\_\_\_ Your Age(s) at Time of Contact: \_\_\_\_\_

TYPE OF CONTACT / BEHAVIOR: (Circle words that apply)	CIRCLE	MOST POSSIBLE TIMES
1. Rubbed / touched person's breasts/chest area over clothing	YES NO	
2. Rubbed / touched person's bare breasts/chest area	YES NO	
3. Rubbed / touched person's vagina / penis area over clothing	YES NO	
4. Rubbed / touched person's bare vagina / penis	YES NO	
5. Rubbed penis / vagina against person's clothed vagina / penis / breasts / buttocks	YES NO	
6. Rubbed penis / vagina against person's bare vagina / penis / breasts / buttocks	YES NO	
7. Put tongue in person's mouth (i.e., French Kissing)	YES NO	
8. Placed mouth / tongue on person's clothed vagina / penis	YES NO	
9. Placed mouth / tongue on person's bare vagina / penis area	YES NO	
10. Put mouth / tongue on person's anus, even slightly	YES NO	
11. Put finger inside person's vagina, even slightly	YES NO	
12. Put finger in person's anus, even slightly	YES NO	
13. Put penis inside person's vagina, even slightly	YES NO	
14. Put penis against / in person's anus, even slightly	YES NO	
15. Put object in person's vagina / anus (ointment, vibrator, stick, other)	YES NO	
16. Masturbated in presence of person	YES NO	
17. Ejaculated in presence of person	YES NO	
18. Masturbated using person's clothing / photos / property	YES NO	
19. Ejaculated in or on person's anus / vagina / body / mouth	YES NO	
20. Made / possessed nude or partially nude photos / videos of person	YES NO	
21. Provided drugs / alcohol to person	YES NO	
22. Person rubbed my penis / vagina over clothing	YES NO	
23. Person touched / rubbed my bare penis / vagina	YES NO	
24. Person placed mouth / tongue on my bare penis / vagina	YES NO	
25. Person placed penis against / in my anus / vagina	YES NO	
26. Person put finger in my anus / vagina, even slightly	YES NO	

List other sexual behavior(s) with this person (not included above): \_\_\_\_\_

First contact? \_\_\_\_\_ Last contact? \_\_\_\_\_ Total sexual contacts? \_\_\_\_\_ Frequency? \_\_\_\_\_

Where did these contacts occur? \_\_\_\_\_

How did you gain this person's compliance? \_\_\_\_\_

Describe any use of physical force (restraint, strike) against person. \_\_\_\_\_

Describe any threats to harm this person, or family (weapons, gestures, statements). \_\_\_\_\_

Describe any type of physical pain you caused this person. \_\_\_\_\_

Did you cause this person to be sexual with others? If so, whom? \_\_\_\_\_

Who else was present at the time of these contacts? \_\_\_\_\_

Do you consider this person a victim? YES NO

Coding (circle which disclosure pages apply): A B C D E F G H I J K L M N O P Q R S T U

Signature/Date: \_\_\_\_\_

## Appendix 20-A

### **DRAFT NOT FOR CITATION WITHOUT PERMISSION FROM AUTHORS**

#### **Chapter xxx: The Personal Impact of the Job on Professionals**

By Peggy Heil<sup>1</sup> and Kim English

*At times, it feels as though I have become somewhat numb to some of the horrific information we are exposed to. Yet I maintain through these periods, particularly with the help of my coworkers. I realize that my senses can only handle so much, and that is when I look for a better perspective from someone else who is involved in this kind of work.*

— Colorado Department of Corrections  
SOTMP Sex Offender Treatment Provider

Many administrators have worked diligently to develop a quality treatment/supervision program for sex offenders. In the process they can easily overlook the negative impact that working with sex offenders can have on employees and the resulting impact on the program. This "job impact," if not successfully addressed, can quickly move from individual employees to affect the larger agency program, including all members of containment teams: the treatment provider, polygraph examiner, and supervising officer who work together to manage sex offenders in the community. This chapter addresses job impact on individual professionals; the following chapter describes the potential impact on collaborating teams.

Many types of jobs affect employees negatively—this much is not news. However, sex offender management exposes professionals to the extraordinary violence and deception practiced by these offenders. Among the effects of this exposure are threats to their personal safety, increased awareness of personal risk, exposure to traumatic material, and hostility from clients and clients' families. They can also suffer from the hostile responses of other professionals who do not agree with the program's approach to holding sex offenders accountable (or, conversely, those who believe the program is not holding them accountable enough).

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<sup>1</sup>Peggy Heil was founder and director of the Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections between 1985 and 2004. The program began with one full-time therapist and several general mental health therapists who were willing to conduct sex offender treatment groups. The program now has 30 full time therapists and one full-time researcher. Over the years, as the program expanded and changed (the polygraph was introduced into the program in 1995), members of the therapist team have struggled with and overcome many challenges, some of which relate to the complexities of working with sex offenders.

Our profession's leaders--including every agency administrator--must expect that several core aspects of this work will affect all of us. Administrators must implement appropriate responses to help some specialists cope with this aspect of the job. Not doing so is likely to harm the day-to-day performance of program staff and containment teams and, as a result, to compromise public safety.

Supervisors cannot prevent job impact, but they can prepare staff for the potential stressors and symptoms they may experience and help them develop coping methods. Supervisors can also monitor the team environment and morale, intervening at the first signs of job impact. This chapter reviews the research related to this type of job impact, describes common symptoms in individuals, and makes recommendations for preventing job impact from affecting the quality of sex offender management services.

## **Background**

In our 1996 publication (English, Pullen and Jones, 1996), Pullen and Pullen (xxx) described how secondary trauma harms individual professionals responsible for sex offender management: the sex offender turns his or her anger and manipulation (backed by years of practice) on the supervising officer, works to undermine all efforts at being held accountable, and, through this lack of cooperation, presents an ongoing danger by not complying with treatment and supervision conditions. Moreover, the practitioner's graphic knowledge of the violence perpetrated by the many sex offenders on his or her caseload along with a heightened awareness of the victims' pain introduce traumatic material into the lives of professionals who manage and treat sex offenders.

We now think of secondary trauma as one of several possible repercussions to making a career commitment to this work. Our current field research has found that the introduction of the polygraph into treatment/supervision programs exacerbates the job impact on those involved in sex offender management. Our research on the polygraph (English, 1998; Ahlmeyer et al., 1999; Ahlmeyer, Heil, McKee and English, 2000; and Patrick, Pasini-Hill and English, this volume) indicates that sex offender risk cannot be assessed without incorporating the polygraph into treatment, but the additional information comes at a great cost to staff.

## **What the Literature Suggests**

*The ordinary response to atrocities is to banish them from consciousness....Folk wisdom is filled with ghosts who refuse to rest in their graves until their stories are told....But far too often secrecy prevails, and the story of the traumatic event surfaces not as a verbal narrative but as a symptom (Herman, 1992:1).*

For sex offenders, revealing the secrets of the atrocities they have inflicted on others is at the core of the treatment process. Secrets are these offenders' means to an atrocious end; therefore, taking responsibility for all the harm they have done means identifying every assault

and every victim, along with acknowledging the preparation and planning necessary to carry out the crimes.

Do we need to know every victim? Every crime? Yes, for accepting anything less than complete disclosure means that the offender—rather than the professional—is in control of the information about his or her past crimes. In addition, without complete disclosure, the therapist and supervising officer will almost undoubtedly miss an age group or gender that the offender assaulted, and treatment/supervision plans may then be dangerously incomplete.

For professionals, knowing the details of the crimes is necessary but painful. They become vicarious witnesses to each assault. As Herman notes,

*Those who bear witness are caught in the conflict between victim and perpetrator. It is morally impossible to remain neutral in this conflict. The bystander is forced to take sides (Herman, 1992:7).*

Herman goes on to explain that the perpetrator asks the bystander to do nothing, and the victim asks the bystander to share the burden of the pain.<sup>2</sup> Further, the perpetrator “does everything in his power to promote forgetting” and his arguments to forget or rationalize “prove irresistible when the bystander faces [the arguments] in isolation” (p.8). Dealing with the information necessary to manage sex offenders, then, must be done in collaboration with others who are also specially trained to do this work. Stamm (1995:xii) summarizes the need for collaboration: “I believe this is a task too difficult to be done entirely alone; that it can only be done, not by the community, but in the context of community.”

Dr. Charles Figley coined the phrase “compassion fatigue” to describe the stress that directly accompanies exposure to others’ traumatic material. Specifically, research has found that this type of stress affects public safety officers<sup>3</sup> (Figley, 1995) and even those who teach or train on the topic of trauma (McCammon, 1995). What distinguishes temporary professional stress from intrusive and disruptive job impacts is that professionals begin to organize their lives around the traumatic material (VanderKolk, McFarlane, and Weisaeth, 1996).

Rosenbloom, Pratt, and Pearlman (1995:68) identify the common features of compassion fatigue, or vicarious trauma, as they call it. First, the effects of repeated exposure to traumatic material are *cumulative*, gradually changing beliefs about the world (“Are people basically good?” “Am I abusive?”). Next, the effects are *permanent*, that is, resulting in lasting changes about how we view the world and ourselves. Third, the effects are *emotionally intrusive* and

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<sup>2</sup>Dr. Judith L. Herman’s book *Trauma and Recovery* is an important resource for professionals working with sex offenders. We recommend it to both administrators and line staff, and hope that our references to it in this chapter will encourage others to read it.

<sup>3</sup>Police, fire fighters, EMTs and other emergency workers report that they are most vulnerable to compassion fatigue with dealing with the pain of children (see Beaton and Murphy, 1995).

painful, for certain images and feelings may remain with the professional long after contact with a particular client has ended.

Rosenbloom et al. (1995) describe the very personal impact as disruptions in a person's basic needs for safety, trust, esteem, intimacy and control.

- Safety relates to increased fears for children, spouses, pets, and ourselves. Exposure to the details of sexual offending, for example, challenges the strategies we use to make our environments safe.
- Disruptions in trust occur with repeated exposure to betrayal, such as incest, or as errors in judgment lead us to distrust others and question our trust in ourselves. "Is this person trustworthy? Can I trust my own appraisal of his character?" The impact from a disruption in trust may lead to isolation behavior—just when it is most important to connect with colleagues.
- Feeling overwhelmed by interactions with manipulative sex offenders may interfere with one's sense of self-esteem. Concerns about one's competence may arise ("Can I do this job?"), along with what Rosenbloom et al. (1995) refer to as other-esteem. Individuals who value seeing the good in others may be profoundly affected by consistent exposure to callous and brutal behavior by sex offenders. Professionals reacting in this fashion may become cynical, pessimistic, or arrogant rather than excited and enthusiastic about new ideas or about the future.
- Troubles with intimacy may lead either to distancing from others or to avoiding being alone. It may mean that, by the end of the day, we can't hear about one more negative event or that we can't talk about anything BUT work. Our relationships with others become less connected as we struggle to distance ourselves from the pain associated with the information we need to do our job.
- A disruption of control or power can occur with exposure to horrific events that are outside the control of the victim. When this is the case, one response is fear and hopelessness. Often, ambiguity becomes difficult to tolerate. Another response is to become more and more controlling in work and personal life to capture the perceived loss of personal power resulting from exposure to the details of sexual assault. This is the manifestation of parallel process. See chapter xx for a further discussion of parallel process. However, according to Rosenbloom et al. (1995), the effects of compassion fatigue or vicarious trauma can be lessened, particularly when organizations institutionalize responses through supervision, adequate time off, flexible work hours, and strong training program components. Early intervention is an important part of moderating the effects of working with populations that deliver traumatic material.

## **Long-Term Risk Management and Job Impact**

Sex offender treatment and management are long-term efforts. Offenders often have contact with the same containment team members for years. Over time, unfortunately, the offender and the professional sometimes learn to accommodate each other in ways that

undermine public safety. The following is a description of how this process works, first in terms of the offender and then in terms of the supervising officer or treatment provider.

**Accommodation by the Offender.** When a sex offender has worked with a containment team member over time, he or she may begin to feel comfortable. The offender will look for ways to divert attention away from treatment or supervision and toward other issues: other group members, inequities of various sorts, family members, or other members of the containment team. Through this process of manipulation and deflection—for which the offender has had decades of practice—he or she learns to predict more accurately what the therapist or supervising officer will say and do. Over time, the offender adjusts his or her statements and behavior to meet the expectations of the treatment provider or supervising officer. The offender may display fewer defensive reactions and fewer obvious problem behaviors. Because the professional sees fewer problem behaviors, it is easy to believe that the offender is making necessary changes and progressing well in treatment and under supervision.

**Accommodation by the Professional.** Many sex offenders resent the intervention of the criminal justice system and feel hostile toward members of the containment team. In the face of frequent hostility, it is common for a professional to react by subtly adjusting his or her behavior to avoid triggering the offender's hostility or other unpleasant emotion. Professionals may be unaware of the changes they have made to prevent triggering these responses. As a result of no longer experiencing the offender's hostility (combined with the offender's accommodation, discussed above), it is easy to conclude that the offender is progressing in treatment. The therapist or the supervising officer may feel satisfaction that treatment is effective with the offender. Quite naturally, then, the therapist and officer turn their attention to a different offender, one that is currently exhibiting overt symptoms. In the process of these occurrences, the professional becomes pleased with the offender's progress and, correspondingly, his or her own ability to facilitate healthy change through treatment. Over time, the therapist or the officer may feel that obtaining collateral information about the offender's behavior outside of the group setting is unnecessary. Obtaining information and feedback from other members of the containment team seems unnecessary, too. Polygraphs may go unscheduled, and supervising officers may decide that they have a lower risk case and so reduce intense surveillance.

Meanwhile, the offender can continue destructive patterns of behavior outside of treatment and supervision, which, most likely, will not be detected because of the professional's lack of suspicion. The professional may not follow through with monitoring to determine the offender's actual behavior. At this point, containment and treatment are in jeopardy.

This common scenario is the result of a specific impact of the job: the difficulty of dealing with master manipulators and the human tendency to avoid conflict and hostility. Sex offenders do not want anyone to control their deviant lifestyles, and over time they work to gain a sense of predictability and control over those who try to interfere with their lives. Therapists and supervising officers, unless carefully selected and trained for their jobs, may forget that they are involved with such manipulators (getting the professional to forget this is one of the offender's objectives for the duration of supervision). For this reason, it is *only* through

evaluating collateral information about the offender that a pattern of behavior (good or bad) can be determined. Gathering collateral information on *every* sex offender consistently and continually throughout the supervision and treatment period is the only way to assess whether the offender is on track.

## **Consider the Accommodation Scenario, But...**

**Enter: the polygraph.** Since sex offenders are so effective in their manipulations and their ability to hide what they are doing, therapists can be shocked when polygraph results indicate that the offender has not changed.<sup>4</sup> This shock can result in several reactions. A common response is to reject the polygraph information. Another possible response when the professional believes the polygraph data is to lose confidence in his or her ability as a therapist or supervising officer. Alternatively, he or she may become pessimistic about the ability of sex offender treatment and supervision to effect change. Given what we know about sex offenders (Abel et al., 1988; 1990; Ahlmeyer et al., 2000; Chapter xxx, this volume), the productive response is to feel relief that there is an additional, more objective, outside source of information--one that is significantly more reliable than the offender's self-report or behavior in group.

The path of least resistance, however, is to ignore the polygraph-generated information or to ignore or delay scheduling a polygraph examination and to avoid seeking collateral information about the case. Unfortunately, these avoidant responses are very common, according to polygraph examiners and other professionals interviewed during our field research. We believe this coping response to the offender's perpetually manipulative tendencies is not only common but is a very serious reaction, as it undermines implementation of the containment approach.

Supervisors and team members need provide assistance to professionals who struggle with polygraph information. Supervisors must train and orient staff to understand that responding to information generated by the treatment/polygraph process will define large portions of their job. Responding to polygraph data means seeking additional information and confronting the offender. This is hard work. Usually, responding to the polygraph information appropriately means again dealing with the offender's hostility. One way for supervisors to support staff is to attend group and confront the offender along with the regular therapist. This accomplishes two things: it honors how difficult it sometimes is to address offenders, and it models the necessary method for managing hostile and manipulative sex offenders in terms of polygraph examination results.

## **The Polygraph Breaks Denial--The Offender's and Ours**

Polygraph feedback increases every professional's exposure to the frequency of sexual

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<sup>4</sup>While this shock is most common for therapists, who become very invested in believing their clients change over time, it can also happen with supervising officers, who may also expect progress and may feel pressure to identify low risk sex offenders.



assaults committed by the offenders with whom they are working. It is common for offenders to commit hundreds of sex crimes against many types of victims. In fact, among the significant number of polygraph examinations we have reviewed, we would be hard-pressed to identify a single offender who self-reported only a few crimes and whose polygraph exam then found “No Deception Indicated.”

The Sex Offender Treatment and Monitoring Program (SOTMP) at the Colorado Department of Corrections requires sex offenders participating in Phase II of the program to complete a sex history assignment that details their lifetime sexual assault activity.<sup>5</sup> Program participants know that they will receive polygraph examinations on the completeness of the sex history document in a few months. Most sex history documents are dozens of pages long. These histories reflect a significant amount of detailed information about the offender’s deviant sexual behaviors and patterns, including specific information about each assault and each victim. This assignment allows the offender to disclose a lifetime of secrets, which is the first step in breaking his/her destructive behavior.<sup>6</sup>

The treatment/polygraph process requires the containment team to review the information from the sex history and use it as the basis for the treatment and supervision plan. (See Chapter xxx, Collaboration is Key). However, this increased awareness of the offender’s secret life, the extent of the larger problem, combined with graphic visual images of specific assaults that are detailed in the documented sex history can be overwhelming to the professionals involved in the case. Professionals were exposed to significantly more assault and victim information at the SOTMP after the polygraph was introduced into the program in 1995. To prevent this information from becoming overwhelming, program administrators recommended that staff limit their reading of sex histories to one day per week.

Besides exposure to past offenses, monitoring polygraph tests often indicate that the offender is continuing to engage in high-risk behaviors. Maintenance polygraph examinations are also likely to reveal information that is disappointing to staff, particularly when they believed that the sex offender was in compliance with treatment and supervision. Unfortunately, maintenance exams often reveal significant activity that might be unexpected, reinforcing (and breaking *our* denial) that the offender is indeed dangerous and continually at risk to reoffend.<sup>7</sup>

It is natural for people to become overwhelmed when they are unable to integrate difficult

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<sup>5</sup>Phase I of the SOTMP is a six-month psycho-educational program serving approximately 360 offenders per year. Phase II requires the completion of Phase I and is a 96-bed therapeutic community offering intense group treatment and lifestyle intervention.

<sup>6</sup>The SOTMP uses the Sex History Questionnaire developed by RSA in Lakewood. With permission from RSA, a copy of this questionnaire is reprinted in appendix

<sup>7</sup>As presented in Chapter xxx, we found 25% of maintenance examinations revealed new crimes or high risk behavior. This is likely an underestimate of actual behavior since nearly one-third of the offenders were scored deceptive on their exams and only three to four questions were asked on each the exam.

and traumatic information. Dr. Judith Herman (1992) describes this, in part, as the result of repeated exposure to extraordinary harm—which can occur from reading multiple sex history journals. This lack of integration can occur because professionals feel the need to rush on to other job tasks, resulting in a lack of time to talk about the disturbing nature of the material. It can occur when they are surprised or unprepared for the extent of the horror or when they experience a lack of professional support to talk about how the material has affected them.

When professionals become overwhelmed, they are at higher risk to use unproductive coping skills to manage day-to-day emotions and activities. Among those who work with sex offenders, unproductive coping mechanisms that are frequently seen include avoidance, anger, over-control, or all three. These maladaptive coping skills may include the following behaviors:

1. Not noticing the sex offender's problem behaviors;
2. Failing to hold the offender accountable;
3. Overcompensating for the horror over what the offender has done by becoming nurturing and, consequently, not confronting the offender when appropriate;
4. Working harder than the offender to try to help him change;
5. Thinking that no one understands (see Pullen and Pullen, 1996);
  - I'm the only one who understands this offender
  - I'm the only one who can get through to this offender
  - I'm the only one who knows how treatment should be done
  - I'm the only one who knows the truth;
6. Taking out frustrations or becoming abusive and demeaning to coworkers, offenders, or both;
7. Unleashing bad feelings on coworkers because it feels safer to be inappropriate with coworkers than with clients.

The first four on this list are individual reactions that compromise the treatment and supervision of the offender. The other examples reflect how these coping mechanisms spill over to colleagues with whom the professional needs to collaborate and communicate to ensure that the offender's risk is being identified, managed, and contained. Offenders are adept at identifying and fueling conflict between staff members. This conflict eventually results in compromised treatment, as it opens up an opportunity for the offender to manipulate and divert attention away from himself.

## **Job Impact Survey of Therapists Who Work With Sex Offenders**

The SOTMP at the Colorado Department of Corrections conducted an anonymous<sup>8</sup> job

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<sup>8</sup>A previous survey attempt did not assure confidentiality, and only three staff out of 20 returned the questionnaire. Lorri White, Ph.D., helped us obtain assistance from the Center for Creative Leadership in Colorado Springs for the second survey. Susan Hyne at the Center for Creative Leadership, helped the SOTMP conduct an anonymous job impact survey by preparing individual computer disks with the questionnaire for each employee. Therapists were asked to complete the survey within one week (during work time) and then drop the disk into a

impact survey with 23 therapists working in the Sex Offender Treatment and Monitoring Program (SOTMP). Eleven of the therapists were women and 12 were men. At the time of the survey, most of the women were between the ages of 30 and 49, and most of the men were between 40 and 49. Eight of the women and seven of the men had worked for the prior to the introduction of polygraph testing into the treatment program.

The self-administered survey questionnaire asked respondents to identify with whom they discussed the impact of their job. Respondents could provide multiple responses. Three out of four of the men (75 percent) talked to coworkers; half of them talked to family, and two men (17%) said they talked about the impact of their job to friends. One-fourth of the men (25 percent) discussed the impact of their job with no one. Compared to the men, the women therapists were equally likely to report talking to coworkers (73 percent) and family (55 percent), but the women were more than three times more likely to talk to friends (64 percent). Again, two of the 11 women reported that they talked to no one. For both groups, coworkers represented an important outlet for discussions about job impact. When job impact is not addressed it is likely to be acted out against coworkers. This results in negative team relationships and fewer resources to cope with job impact. Staff may lose an important coping mechanism: each other.

The questionnaire asked respondents, “Prior to starting the job, what type of training would have been helpful?” Most of the men reported that they felt unprepared to treat this population and ended up learning on the job. One man said he would have liked training specifically on the SOTMP curriculum “because I am learning the information almost at the same time the inmates in group are.” One-third of the men<sup>9</sup> directly expressed that training on job impact prior to starting their work with sex offenders would have been helpful. Following are some comments of these men:

- “Training regarding the impact on you as a therapist, preparation, and review of how to deal with the impact.”
- “Training in the area of sex offender treatment that would provide appropriate, yet pragmatic, ways of dealing with not only the inmates’ issues but therapists’ issues as well. In other words, having the person be involved in a survey such as this one.”
- “Training on what this type of work will do to your belief system about your gender and your views about sex.”

Overall, the women’s responses indicated a need to know more about sex offenders prior to beginning the work. Three women reported a need for research-based information and easy

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sealed box. Disks were returned to the Center for Creative Leadership for analysis. The Center performed this work as a community service activity, and we are grateful for its assistance, and, in particular, Susan Hyne’s help and support.

<sup>9</sup>Nine of the 12 men responded to this question.

access to books and journals. Following are some training needs expressed by the women:<sup>10</sup>

- “Determining if an inmate is doing a good job or subtly trying to manipulate staff. It gets confusing sometimes.”
- “I would have liked to have known the impact of working with sex offenders before doing so.... I have heard ‘leave work at work’ but sometimes that’s not possible. Part of the clinical supervision needs to include understanding how SO treatment affects the therapist.... We need to develop a plan for this.”
- “Additional clinical supervision for a longer period of time would also have been helpful, particularly if more allowance had been given for a learning curve. My initial feeling was that there was no room for mistakes, when I first entered the field.”

It is important to consider these comments. Many therapists enter this field without specific training that addresses treating and managing sex offenders. Some of the respondents initially did not feel confident in their ability to provide treatment to sex offenders but; as the last comment illustrates, some may feel significant pressure to do the work correctly. They may feel pressed to appear capable when, in fact, they feel unprepared. In their attempts to appear skillful, they may find it difficult to ask for help and feedback. It is this dynamic that makes it crucial for program administrators to provide initial and ongoing training and clinical supervision. Failure to do so may leave staff feeling unsupported and unprepared.

The survey instrument presented a list of possible personal impacts respondents might have experienced as a result of working with sex offenders. Staff were asked to mark those that applied to them, and to list additional impacts that did not appear on the questionnaire. At least five of the 12 men noted that the following job impacts applied to them:

1. Fear for your children’s personal safety due to the knowledge of sex offenses obtained from work.<sup>11</sup>
2. Fear for your spouse’s personal safety due to knowledge of sex offenders obtained from work.
3. Annoyance with the system.
4. Decreased belief that people you meet in your social life are trustworthy.
5. Finding yourself suspecting many people of being sex offenders.
6. Fear for your spouse’s personal safety from released sex offender clients.
7. Feeling betrayed by clients—I believed that the client was trying to change and he was just conning me.
8. More conservative in sexual activity.
9. Fear for your children’s personal safety from released sex offender clients.
10. Decreased sex drive/interest.
11. Feeling you are doing more work than the client.

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<sup>10</sup>Seven of the eleven women answered this question.

<sup>11</sup>Based on age groupings, it is possible that a larger proportion of the men than the women were married with children. However, the data was collected in a

12. Feeling confused about what constitutes normal sex--finding yourself getting more conservative in your sexual beliefs.

Half of the men wrote a narrative response, which suggests that the menu of preselected responses did not tap the men's experiences as well as the women's. We identified several themes in the men's' comments. Confusion or change in their personal views about sexual behavior or behavior with children appeared to be repeated themes in their self-reported narrative comments. The men also reported being suspicious or cynical about the motives of others, especially regarding issues of power and control. Sadness or anger was expressed by the men as a result of the material they had been exposed to. The men's' comments also reflect a sense of hyper-vigilance about their own behavior, along with questioning motives behind the behavior of others. The men also reported a sense of isolation.

The written narratives from the men were extremely personal. Their comments reflected the deep pain this work can cause. Although we decided not to present these comments out of respect for their openness and willingness to share their personal experiences, we regret not being able to share their thoughts. Their words--and not ours--are the most compelling and powerful arguments for the need for administrations to address the issue of job impact.

A common stereotype is that working with sex offenders will affect women more negatively than men, perhaps because it seems likely that they will be more empathetic towards victims and thus more disturbed by the crimes committed by these offenders. This stereotype needs to be avoided, however, because men are equally empathetic and are often extremely distressed by the experiences of victims. The difference may be that men have fewer outlets for expressing their feelings, so it is vital that administrators provide outreach and support activities to both men and women who work with sex offenders.

The women therapists responded somewhat differently from the men on the question related to job impact. The following items received at least five responses from women therapists at the SOMTP:

1. Fear for your own personal safety at home from released sex offender clients.
2. Annoyance with the system.
3. Finding yourself desensitized to graphic discussions or depictions of sex and sex offenses.
4. Decreased belief that people you meet in your social life are trustworthy.
5. Finding yourself suspecting many people of being sex offenders.
6. Being over-protective of children.
7. Feeling you can never learn enough to be effective at this work.
8. Feeling victimized by the clients' hostility.
9. Annoyance with coworkers.
10. Feeling confused about what constitutes normal sex--finding yourself getting more conservative in your sexual beliefs.
11. Feeling that your own power and control issues have been triggered and feeling a need to control.
12. Feeling that life is unfair and that systems don't work well.

13. Feeling like you are a radical on a crusade and other people think you are weird.
14. Fear for your children's personal safety from released sex offender clients.

The responses from the women reflected themes of control and safety. Frustration—with coworkers and the system—was also expressed. The questionnaire items apparently better reflected the women's experience, as only four of the women wrote additional narrative comments. Two of these comments were as follows:

- In response to increased pressure at work, I feel overemotional about many issues, large and small, in my private life....
- Experiencing unwanted visual images that reoccur unexpectedly. There is one that took several years to shake, and I still haven't done it completely. This is probably the main one that has affected my dreams.

The survey also revealed some positive aspects of the job, which keep therapists invested in the work. The majority of men and women endorsed the following items as the rewards or gratifications they get from working with sex offenders:

- Being part of a team;
- Being challenged by the work;
- Feeling like you are addressing an important problem;
- Feeling the work is interesting; and
- Enjoying working with people who are committed to addressing a serious problem.

One of the most frequent responses of the men, was that they enjoyed co-therapy.

As this survey reflects, professionals may experience a variety of potential impacts as a result of working with sex offenders. Some of these impacts are unavoidable, such as an increased knowledge of sex offenders. Many impacts can be lessened or moderated by providing adequate training and supervision. It is also important to maintain a supportive team environment which allows professionals to debrief with other coworkers.

## **The Stages of Professional Development in Working with Sex Offenders**

**Professional Development: The Early Years.** Few professional schools educate students to work with offender populations, let alone provide education on working with sex offenders or other involuntary clients. Most people working in this field, then, develop their expertise on the job and by attending workshops on topics that relate to sex offenders. Some programs provide up-front training to new staff, but even this training is no replacement for knowledge and experience gained from actually dealing with hostile, manipulative, and secretive offenders with violent and long-standing offending patterns.

Many staff may feel uncertain of their abilities when they first begin this work. They encounter many situations for which their education and training did not prepare them. They

may be uncertain of the best way to respond to the challenges and distractions sex offenders use to test staff. In their desire to look competent, they may not inform supervisors of their struggles to respond effectively to sex offenders, they may not express how lost they feel. This problem can be alleviated when administrators provide up-front training that covers common manipulation and distraction tactics used by sex offenders and helpful ways to respond to these tactics. This training should also introduce the concept of job impact and the importance of debriefing with supervisors and coworkers.

During the initial work period (the actual time period varies considerably among professionals), supervisors should schedule regular and frequent supervisory meetings with the employee. These meetings, which should continue at a minimum for one year, can help the new professional become more skilled with sex offenders and more comfortable with the job. If the supervisor does not provide this assistance, other coworkers often will. Occasionally, the coworker who starts to mentor the new professional will be an individual who is in an overconfident phase (Phase Two) of their professional development. He or she may be recruiting team members to support his or her point of view in disagreements with other team members. The overconfident professional will provide clear direction and support to the new staff member. In return, he or she may expect the new staff member to support his or her point of view as the only correct answer. Although the new staff member thus receives support, this pattern jeopardizes the cohesiveness of the team.

**Phase Two: Confidence Grows.** After a few years on the job,<sup>12</sup> professionals tend to feel more confident in their ability to clinically evaluate sex offenders' risk and progress in treatment. They may experience a sense of relief that they can handle many situations they struggled with before. They may become more confident of their ability to judge and respond to these situations and may even become overconfident of their ability to evaluate sex offenders. At this point, if the polygraph is introduced into the program, these professionals are likely to be significantly impacted by the information that surfaces in the treatment/polygraph process. The use of the polygraph at this stage of a professional's development of expertise may shake his/her confidence and might even negatively impact feelings about the job in the following ways:

1. If the polygraph information conflicts with their opinion of risk or treatment progress, they may reject the information.
2. If they believe the polygraph results, they may feel extremely discouraged about their own abilities, just as they were beginning to feel more confident in their ability to "read" sex offenders.
2. They may get discouraged at the conflict between their assessment of treatment progress and the risk information obtained during the polygraph, and they may conclude that treatment does not work.

At this stage, therapists may tend to disagree with other co-workers and have a difficult time maintaining supportive relationships with co-workers who disagree with their opinions. There may be disagreements about assessments of risk or progress of specific clients, about whether the polygraph data is valid, or even whether treatment is worthwhile. These basic

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<sup>12</sup>For a few professionals, Phase Two begins within months of beginning the job.

disagreements can cause serious disruption to the team when individuals feel their opinions are not valued or validated by other team members.

Because all of these individuals care deeply about trying to prevent sexual assaults, they may feel it is crucial for others to hear their viewpoint and agree with it. The disagreements can easily become personalized if they believe that others don't respect their professional expertise, or that others don't care about this problem as much as they do. Professionals may seek out coworkers who will validate their opinions restricting the expression of other viewpoints. We discuss these issues in greater detail in the following chapter, "The Impact of the Job on Collaborative Teams."

**Phase Three: A Balanced Approach.** As professionals successfully move past the middle stage of professional development (unfortunately, some do not), their confidence in their abilities becomes balanced by a new found comfort with what they do not know. These professionals realize they do not have all the answers; they know they can be manipulated; and they recognize how difficult it is for offenders to make and sustain changes. Experienced professionals working with the Colorado Sex Offender Management Board incorporated the following statement into the standards for lifetime supervision of sex offenders:

"Progress in treatment is not linear, incremental, static, nor reliable and must be consistently re-assessed. Progress is multi-dimensional; high risk can exist despite progress on many dimensions. Risk in any single dimension must be taken seriously. Concerns expressed by any individual member of the community supervision team must be taken seriously. Progress indicated by repetitive testing over extended periods of time may be invalid due to deception, habituation, and socially desirable responsiveness. Consequently, results of such tests should not stand alone and multiple measures should always be used to indicate risk."(Colorado Sex Offender Management Board, *Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders, Lifetime Supervision Criteria*, 1999:1<sup>13</sup>).

This statement acknowledges the difficulty in evaluating and facilitating change in sex offenders. Professionals at this level welcome additional techniques and tools to become more effective with sex offenders. They see the necessity of outside sources of information and objective measures of change.

Many professionals at this level will welcome the polygraph as an additional tool to assess change and monitor sex offenders. Although professionals at this level may still be disappointed

<p>"The more you know about sex offenders, the more you know you don't know." --Van Whisman, Supervisor, Community Corrections, Colorado [retired]</p>
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<sup>13</sup>We would like to thank therapists and longtime Colorado SOMB members Greig Veeder and Steven Brake for this helpful contribution to the Lifetime Supervision Criteria.



by the information that is revealed during the polygraph process, they value having the information. These professionals recognize that sex offender containment is an evolving field ; and they seek consultation and perspective from other professionals.

We spend considerable time in the following chapter discussing a number of ways the impact of working with sex offenders can move from individual feelings to reverberations for the larger team. Understanding these group dynamics is pivotal to successfully implementing a comprehensive containment approach because containment is about collaboration and communication. Both collaboration and communication will quickly break down when negative job impacts reveal the sensitivity of professionals who are in conflict about how to “[hold] sex offenders accountable every step of the way” (English, Pullen and Jones, 1997).

For this reason, the issue of job impact must be a priority with administrators who believe in the containment approach. It is an essential aspect of quality control for proper program implementation. Ensuring that staff are emotionally healthy and functioning at peak performance is the only way to guarantee that humane, consistent and effective services are delivered to sex offenders.



## Appendix 20-B

### DRAFT

### NOT FOR CITATION WITHOUT PERMISSION FROM AUTHORS

## Chapter xx: The Impact of the Job on Collaborative Teams

By Peggy Heil, Becky Romano<sup>1</sup> and Kim English

*Sharing the traumatic experience with others is a precondition for the restitution of a sense of a meaningful world.*  
--Judith Herman, 1992:70

### Introduction

Professionals who work with sex offenders need to be comfortable working in a team environment, since it takes more than one person to manage sex offenders effectively. The team is also important because coworkers may be the primary support system for professionals who are dealing with the impact of the job.

Teams that manage sex offenders take a variety of forms. Although we talk primarily about the containment team, which consists of the treatment provider, the supervising officer, and the polygraph examiner, other teams are equally important. Agency and interagency teams of specialized professionals dealing with the day-to-day management of sex offenders rely on each other for consistency of practice, important case and policy information, and mutual solutions to problems. Policy teams represent another type of collaborative entity important in the containment approach.

According to English, Pullen, Jones and Krauth (1996), this collaboration is not only essential in the development of a jurisdiction's containment approach, but it also serves as a protection against the negative impact that dealing with sex offenders can have on professionals. Professionals who collaborate productively reported the following advantages to working together (English, Pullen, Jones and Krauth, 1996):

- Teamwork led to greater accountability of sex offenders.
- Professionals better understood the responsibilities of their colleagues.
- Fewer conflicts occurred among each other.
- Teamwork was more likely to influence broad correctional policy debates.
- Burnout was easier to manage.

In this chapter, we discuss the powerful negative influence that individuals who are struggling with job impact<sup>2</sup> can have on the larger team. This discussion focuses on agency

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<sup>1</sup> Becky Romano is Coordinator of the Developmentally Disabled Sex Offender Treatment for the Sex Offender Treatment and Monitoring Program, Colorado Department of Corrections.

<sup>2</sup>Please see Chapter xxx for a discussion of the impact of working with sex offenders on professionals.

teams, but the group dynamics are very much the same for containment teams, interagency teams, policy teams, and other collaborators working in the field of sex offender management. The solutions presented here may require modification to make them applicable to specific types of teams. However, one thing is clear: the agency supervisor or treatment program director plays a large part in developing solutions to team problems. Administrators in agencies managing and treating sex offenders must provide the resources and time required to implement and institutionalize ways to mitigate the negative impact of the job on their staff. Those at the top of the chain of command need to realize how difficult this work is for those working face-to-face with sex offenders.

## Exposure to Abusive Acts Increases With Polygraph Information

As the previous chapter makes clear, when the polygraph is incorporated into the treatment process, it gives containment professionals important information about the offender's history of abusive acts. As the chapter also points out, the additional information increases the professional's exposure to violent, manipulative, and deceitful material. This information provides fodder for the mind's eye and places each professional not only at the scene of the crime but at each salient moment that preceded the crime.

*Witnesses...are subject to the dialectic of trauma. It is difficult for an observer to remain clearheaded and calm, to see more than a few fragments of the picture at one time, to retain all the pieces, and to fit them together. It is even more difficult to find a language that conveys fully and persuasively what one has seen. Those who attempt to describe the atrocities that they have witnessed also risk their own credibility. To speak publicly about one's knowledge of atrocities is to invite the stigma that attaches to victims.*

—Judith Herman (1992:2)

We must give a voice to this important aspect of working with sex offenders. Recognizing the potential impact of the job on one's personal and professional life becomes more important as use of the polygraph increases.

The impact of the job affects professionals first as individuals and then as team members. Because the essence of sex offender containment is collaboration, an individual's experience of negative job impact, if not successfully addressed, will adversely affect the containment team--the three-member polygraph examiner/treatment provider/supervising officer team. It will also impact program teams, including groups of treatment providers and specialized officers. Any breakdown of these teams distracts the members' focus from working effectively with sex offenders.

## How Individuals Can Affect Teams

The cohesiveness of a containment team can influence the degree to which individual members suffer job impact. Healthy teams can recognize when individual team members are struggling and can reach out to these individuals and help them through their difficulties. Healthy teams can also discuss different opinions about an offender's progress or different ideas for intervention without any individual member feeling discounted by team members who do not share the same viewpoint.

Better clinical decisions and containment can result from the ability of healthy teams to discuss differences in opinions without personalizing them. Healthy teams share knowledge and

can provide extra support when individual members are experiencing personal difficulties which make them more vulnerable in the work environment. Such team support lessens the chance that a vulnerable team member will receive validation and support from an offender, thereby compromising the containment approach.

While teams can be an important support system to help manage job impact, unhealthy teams can significantly increase the intensity of negative job impacts. As individuals experience negative job impacts, the team members often become the recipients of the manifestations of personal, negative job impacts. One manifestation of job impact which can affect teams is parallel process. McAllister (1997) describes parallel process as the usually unconscious recapitulation of traumatic dynamics or themes (not actual assault) by workers, teams, or organizations. In response to sexual assault trauma, she lists these themes as abuses of power, powerlessness, rage, secrecy, and boundary confusion. These symptoms can include: skeptical, negative attitude; irritability; cynicism; depression; apathy; and reacting to others on the team as if they are as dangerous as sex offenders (if they make one mistake they need to be fired!). In addition, symptoms may include changes in frame of reference, particularly in beliefs and actions regarding safety, trust, esteem, intimacy, or control. These manifestations can be devastating to teams.

This work is both demanding and very important. It is essential to find professionals who have a strong sense of self, who are not dependent on the offender for approval. Such a vulnerability is familiar to offenders, who use it to identify and groom their victims. For example, assigning a professional with a need to be liked to a sex offender management team is an invitation to meltdown.

It is inevitable that teams will go through cycles where they are supportive and cohesive and times when the team will break down. Some of the strengths professionals bring to this field can also be factors that contribute to team breakdown. To work with sex offenders, professionals need to hold strong beliefs to stand up to the sex offender's constant pressure to minimize his problems. When working within a team, these professionals' strong beliefs may clash with those of coworkers. Since professionals care so deeply about this work, they may personalize the criticisms. They may also be anxious to share their opinions and ideas in team discussions and, without meaning to, cut off a coworker's comments. The coworker on the receiving end of this behavior may feel ignored, further increasing these misunderstandings.

Another quality of most individuals who work in this field is the ability to identify and call attention to an offender's negative behaviors. This skill is important for containment, but when confrontation is carried into relationships with coworkers, it can be destructive. When teams become unhealthy, it is important to evaluate how job impact has contributed to this breakdown.

“Organizations often label the consequences of trauma and parallel process individual worker or supervisor problems. Many times negative organizational dynamics can be dramatically improved by addressing the issues openly as parallel process and discussing them as well as providing adequate support for individual providers who are impacted by the trauma at work.” ( McAllister, 1997:9).

## Symptoms of a Team Meltdown

If an unhealthy process is not interrupted and resolved, the team will move into a place where most of the energy of the team members is focused on interpersonal conflicts rather than

on the treatment of offenders. Sex offenders frequently pick up on the tension and conflict; they thrive on others engaging in conflict because it removes the focus from them. They are likely to feed the conflict by giving team members information that will tend to increase interpersonal problems among staff members.

The sex offender's involvement has two results: it encourages team members to scrutinize each other rather than the sex offender, and it can manipulatively engender good feelings and “trust” between the staff member(s) and the offender. *In effect, the offender is now part of the team, in a very destructive and subtle way.* The team is off-balance, with alliances occurring between staff and offenders rather than among staff members. Once this occurs, the meltdown accelerates.

The Colorado Department of Corrections Sex Offender Treatment and Monitoring Program (SOTMP) has experienced several team meltdowns over the years. Although the team members, supervisors, and location were completely different each time, the meltdown process was almost identical. Frequent steps contributing to a meltdown follow.

1. **Communication breaks down.** To hold sex offenders accountable, it is critical to have open and complete communication among team members. (Please see Chapter xxx, Collaboration). If information is not shared, there are gaps in individuals' knowledge, which the offender manipulates. As professionals get busy at their jobs or frustrated with coworkers they start sharing less information with each other.
2. **Differences in opinions are not accepted.** Sex offenders are excellent at hiding their problems, and the longer a staff member works with an offender, the more opportunities the offender has to manipulate the therapist. And the better the offender gets at manipulating the therapist. The larger the number of team members who are involved with the offender, the more likely it is that individual team members will see different sides of the offender. When all the information is shared, the team will have a more complete picture of the offender's issues. Staff who are at the developmental stage of over-confidence (see sidebar) may discount the input of others. Staff may also disagree on the methods for addressing offender issues once they are identified. When teams start to break down, staff may see different viewpoints as disagreements instead of different presentations of the offender. This sets the groundwork for further conflict, particularly when staff members are not communicating well.
3. **People recruit others who will value their opinions.** It is natural for people to find others who agree with them. During a meltdown, professionals actively seek out others who value their opinions. They may become frustrated or annoyed with those who hold a different opinion or others whom they perceive as challenging their opinion. Many times, those new to the team are particularly vulnerable to being recruited to support an opinion since they are still in the mode of active on-the-job training. They cannot yet discern a team meltdown from an offer for mentoring.
4. **People stop dealing directly with each other.** Team members who are in conflict talk about their conflicts with other team members, not with the person who is the object of concern. They talk about each other rather than to each other. This process prevents resolution and stirs people to take sides. It further alienates staff from one another and the mission of the program. Those involved feel alienated, isolated, hurt, and angry.
5. **In-groups and out-groups form.** The meltdown usually starts with one team member being made a scapegoat by two or more staff. The scapegoat is described as

- having fewer skills, having poor clinical judgment, being inconsistent in his/her approach to treatment, or being too harsh with offenders. Active recruiting occurs, which is designed to discount the scapegoat. Neutral team members are asked to join. If they do not, they are by default in the “out” group, along with those who believe the person is getting scapegoated. This process forms the core to the meltdown; all energy is now focused on co-workers. Supervisors are now dealing with pervasive staff anger and are not able to move the program forward or protect it. It is difficult at this point to shift the team into problem solving and away from blaming each other for what is now a massive team breakdown. People do not want to come to work.
6. **People do not check out their assumptions about others.** Since people are not dealing directly with each other, there is no way to correct faulty assumptions about other team members’ motivations or the meaning behind a comment or behavior. Staff can then build a case that another team member is incompetent to do the job and can use this assumption to maintain their own anger and fuel the anger of others. This unhealthy process is particularly vulnerable to sex offender manipulation; sex offenders will intentionally report false information or distort information to the angry professional, suggesting incompetent behavior, to increase the split in the team. If team members do not check out the information, the division among team members will be reinforced. Perhaps, more importantly, the offender’s manipulation goes unnoticed; and he or she is not held accountable for this lifelong pattern. Thus, treatment is compromised because the offender is encouraged to continue destructive behavior patterns.
  7. **People hold on to assumptions that maintain their anger and sense of danger about other team members.** Staff often begin to see only the negative aspects of their peers. They start treating each other as if they were as dangerous as sex offenders. They are suspicious of one another's motives and trust is lost. This black-and-white, good-versus-bad, thinking provides an easy answer: “fire the person I’m in conflict with!” This answer, with multiple assumptions (see #3 above) backing it up, provides significant relief in a job environment that offers challenging but complex clinical work with few clear-cut answers.

This meltdown process just described is completely destructive, and it drains all the energy staff need to manage sex offenders. Work becomes an unbearable place to be. Many staff members may quit, and the team may reform; but if steps are not taken to interrupt this cycle, eventually another meltdown will occur. When teams experience meltdown, it is crucial to recognize individual job impact as a contributor to this process. It is important to deal with splits early on to avoid team meltdowns. Meltdowns can be repaired, but immediate and rigorous steps must be taken to resolve the problem.

## Recommendations for Managing Job Impact

Following are some recommendations for preventing individual job impact from affecting the ability of teams to manage and treat sex offenders:

1. **Seek to hire individuals who are appropriate for the job.** No one should be assigned to do this work unless they voluntarily choose to do so (English, Pullen, and Jones 1996). Some desirable qualities include:

“...as good as I may be at protecting my children, the offender is even better at getting at them.” —victim’s mom
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*Reaffirm that everyone on the team is dedicated to the same goal.*

“People truly hurt and are fearful that they will not make a difference.” --Jan Hindman, Oregon, personal communication, 2000
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- Good self esteem
- Ability to set limits with clients
- Comfortable confronting clients and holding them accountable for their behavior
- Comfortable discussing sex
- Comfortable with their own sexuality
- Comfortable working with sex offenders and their offense behavior<sup>3</sup>
- Positive regard for men and women
- Comfortable challenging stereotyped beliefs about men and women
- Willing to work without developing a trusting relationship with the client
- Awareness that they can be duped
- Ability to deal with ambiguity and the fact that they cannot determine an offender’s level of dangerousness or range of manipulative behaviors
- Ability to remain assertive while being confronted with the client’s hostility
- Ability to avoid talking about personal information with clients

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<sup>3</sup>Sexual assault survivors who have not fully recovered from the assault(s) may find certain aspects of this job difficult to deal with. They may find themselves frequently triggered when reading descriptions of crimes, angered by offenders who minimize their crimes, and hurt by professionals who support the offender’s minimization. This work is very hard, even for those who have not experienced traumatic events. Survivors should not jeopardize their emotional well-being by doing this work before they are ready.



- Strong sense of self that is not dependent on client praise or progress to feel good. Does not need acceptance from clients
  - Ability to separate own problem areas without discounting the necessity of the client to change in those same areas
  - Comfortable working with involuntary clients
  - Willing to work with limited confidentiality
  - Willing to monitor the clients behavior outside of treatment or office meetings
  - Not intimidated by lawsuits
  - Knowledge of child abuse reporting laws and duty to warn and willingness to adhere to these responsibilities
2. **Allow professionals to change their minds.** It may be a healthy decision for professionals to quit, rotate out for a while, or transfer when they feel they are too affected by the job, even after the first week of employment. *The organization should make it clear to employees that this job is not for everyone.* It is a positive situation when an employee is aware that the job is impacting them too severely. Inform employees that this awareness is important to act on, that they should tell the supervisor immediately and discuss other employment options. Please see “SOTP Philosophy Statement Regarding Trauma.” (attachment xxx)
3. **Provide initial and ongoing training on sex offenders, the job, and job impact.** Training can increase a professional's sense of competence and efficacy. This field is relatively new, and there is always something more to learn. Training helps professionals understand theories and interventions for working with sex offenders. Training that addresses job impact and team functioning will help professionals recognize when they are negatively affected by the job and give them options to manage that impact. Validating the struggle normalizes their experience and can help keep the focus on the larger public safety mission. It also gives team members time to be together outside the context of working with a specific offender. In addition, training provides a break from the daily exposure to abuse descriptions and to clients' hostility and manipulation.
4. **Use teams to manage sex offenders.** This is a containment mantra because there are so many reasons that effective management requires teamwork:
- The containment approach uses a team of professionals to manage sex offenders. This team can also provide an important emotional support for managing job impact.
  - Use co-therapists to conduct groups. It is preferable to utilize a male and female co-therapist team. Sex offenders' issues and group dynamics are complex. It is always helpful to have two therapists keeping track of all the issues and dynamics. The therapists should schedule time after each group to debrief. This practice can also be helpful to address job impact. If debriefing

results in avoidance or anger, it is not working, and the therapist should talk to the supervisor to consider other strategies.

- Use supervising officers' teams. Although each officer may have an assigned caseload, the team can provide backup and coverage for each other's caseload. This approach also makes it possible to debrief cases with the team.

5. **Maintain a supportive, cohesive team.** Remember to express positive responses, spend time with team members you do not know well, include everyone in the invitation to go to lunch, spend time talking to each other, say "hi," and acknowledge each other.

- Make it a team standard to help a staff person who is struggling instead of isolating that member and increasing his/her tendency to turn to offenders for support or validation.
- Make it clear to offenders that you support your coworkers. Do not let an offender's negative comment about a coworker go unaddressed. The offender will assume that you agree with the comment if you do not respond and support the coworker. If the offender believes you agree, he will work on creating a split.
- Develop trust in your co-workers. Remember that everyone is there because they want to prevent sex offenses even if they disagree on the methods to achieve the goal. Do not assume the negative in each other. If you do, it may be a sign of job impact.
- Develop methods as a team to identify when individuals feel hurt or discounted by a coworker's comments. Pick a word such as "ouch" that a co-worker can quickly say to immediately identify when a comment seems hurtful. The situation can be clarified and resolved instead of one member leaving a meeting with negative feelings and the other member unaware that someone is feeling injured by their comments. Many times co-workers do not realize when their statements hurt others.
- Develop regular times for the team to share information and be together as a team.
- Share positives as a regular part of team meetings.
- Develop the ability to disagree. Recognize that this work is complex and has no easy answers. All voices need to be heard. Make it safe to express opinions. See these as ideas and do not personalize differences in opinion. Convey feedback and ideas in a respectful manner.
- Hold job impact meetings with ground rules (see Box or Attachment xxx).

6. **Encourage seasoned staff to share the methods and attitudes they use to cope productively with job impact.** Some of the seasoned staff at the SOTMP use the following methods:

- Keep a clear distinction between sex and sex offending. Consenting sex between adults is not at all similar to sex offending.

- See sex offenders as different from most people you will meet in your personal life. Therefore, you do not need to treat coworkers or people in personal life with the same skepticism as you need to maintain with sex offenders.
- Talk to coworkers about how the job is personally impacting you.
- Accept your limitations in being able to help sex offenders change. Feel challenged to learn all that you can and be open to looking at new ways to address this problem. As long as you are learning and making an effort to help, you can feel good about what you are doing.
- When personally threatened by a sex offender, take the precautions you feel are necessary. Remember to keep threats in perspective, as sex offenders frequently threaten staff but rarely follow through on their threats.<sup>4</sup> None of our staff has ever had an offender carry out a threat after they were released. Although threats need to be taken seriously, offenders generally target individuals who are easily accessible to them at the time.
- Hold on to the belief that life is basically good. Since your beliefs affect how you feel, use positive beliefs to offset the negative material you are exposed to. The following statements are examples of messages you can give yourself:

—I am grateful for the caring people in my life.

—I will look for the good in all things.

—I will control what I can and let the rest go.

—I am safe.

- Use your knowledge and awareness to protect your children, but do not overreact. Teach your children to be aware, but do not teach them to be fearful. Allow them to participate in activities. If you are concerned about their safety, volunteer to help with the activity. Keep in mind that sex offenders frequently target children who are in need of attention. Become involved with your children and be the person who provides the attention they need.
- Find ways to nurture yourself and hold on to your optimism; suggestions include family activities, making time for mental processing to be able to leave work behind, and focusing on the goodness of people and life.
- Remember that we all have an important role in this program. We must strive to have faith that we are acting for the good.
- Maintain good health care, exercise, and be active.
- Socialize - have fun.

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<sup>4</sup>Any time another person is threatened by a sex offender, the professional has a legal obligation to warn the individual of this threat.

- Keep a good sense of humor.
  - Drive away at the end of the day and leave work behind.
  - Have a purpose.
  - Maintain balance in your life. Work at this--it is crucial. It is important to maintain relationships, friendships, and interests outside of work. This work is hard, and you will need to actively seek balance every day. Recognize and value the fact that most people care about other people and do not try to control and abuse them. Also provide balance by creating a lifestyle which includes a mix of work, time for relationships/friendships, time for recreation, time for exercise, proper sleep, and a healthy diet. Individuals who are healthy will have the strongest resilience to stress and trauma impact. Some of the individuals we know who have worked in this field a long time enjoy gardening and the beauty of a world with flowers. Another person who has worked in the field a long time enjoys horseback rides in the woods with the ensuing tranquility and peace. Celebrate kindness. Laugh often. Turn off the nightly news. Remember that most people are not sex offenders. (Also see Pullen and Pullen, 1996 and McAllister, 1997).
7. **Provide adequate supervision.** Supervision is a critical component of managing job impact and helping staff feel comfortable in the job. The supervisor can exacerbate or mitigate job impact on individuals and teams.
- *Define the value of the work and frequently remind employees of it.* Since success in this field is nebulous and professionals generally hear more about offenders who re-offend than about those who continue to manage their risk, it is easy to feel hopeless about the value of this work.
  - *Identify new measures of success for the work, such as:*
    - If my work results in one less victim, I have done something tremendous. (Of course, you may never know what harm you have prevented, but believe you have.)
    - I am gleaned information so that we all can learn more about sex offenders.
    - This work is humane. Helping people try to change and preventing victimization is valuable; helping people take responsibility for the pain they cause others is important work.
    - This work is hard; and I am continually learning how to be more effective.
    - I recognize that offenders will successfully manipulate me because many of them are experts! When I recognize I have been manipulated, I learn more about the offender.
    - My goal is information, and every day I get more information that helps me learn about the risk sex offenders pose to our communities and how to manage that risk. I can share what I am learning to help prevent or detect sex offenses.

–If a sex offender does not change, one of my skills is to recognize his or her failure to change and to increase containment.

–Working as part of a team that struggles to deal with job impact is challenging. I work to make the team healthy, and I provide support to my colleagues.

- *Develop clear program guidelines and procedures.* As much as possible, eliminate ambiguity in how the job is done. Clearly define jobs and authority. Set team members up for success. Allow employees to discuss their ideas for the program. Consider those ideas, but make clear whether they will be implemented. If changes are made, write out the procedures and define the research basis for those procedures. Programs can lose consistency and direction when everyone uses their own standards to perform their jobs. Offenders will take advantage of the inconsistency to avoid accountability, and staff will spend more time arguing. This situation sets up more possibilities for team divisiveness and increased job impact.
- *If the polygraph will be used as a component of the program, provide training to the staff on the use and effectiveness of the polygraph.* Staff need to understand what questions can be asked on the polygraph and what questions cannot. They also need to understand the validity of the polygraph, because offenders will try to convince staff that the results are wrong. Train staff how to respond to offenders who protest the polygraph procedure and results.<sup>5</sup>
- *Structure time for job impact meetings.* Set rules for these meetings (please see attachment xxx). The meetings should be designed for employees to talk about how the job impacts them personally, not about how other members of the team are affecting them. Supervisors need to lead by example and share how the job is affecting them. This creates a clear message that everyone needs to talk about job impact and that the team is a safe place to talk about it. Be sure to include all members of the team. Sometimes supervisors make the mistake of excluding support staff, but these staff members are exposed to the same material and also experience significant job impacts.
- *Provide strong direction and structure to employees.* Structure can clearly define some aspects of the job. Remember, positive feedback that recognizes good work is essential! To be most effective, feedback should be immediate and specific.
- *Brainstorm options to deal with complex clinical issues,* but provide a strong supervision direction during brainstorming sessions. Identify a menu of appropriate options that are consistent with the direction of the program, and let the professionals choose the option with which they feel most comfortable.

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<sup>5</sup>The SOTMP is considering making a video for offenders to explain how the polygraph helps them be more honest. The video would then also be used in new staff training.

- *Provide immediate intervention* when staff display problematic behaviors or when conflicts occur between coworkers. When someone complains about another coworker, talk to both individuals before deciding on the intervention. Reframe the issue to focus on the work that needs to be done, moving the discussion away from personalities.
- *Use discussions with staff who are in conflict to decrease hostility, negative feelings, and misunderstandings between the colleagues.* Help them develop a better understanding of each other and a more positive view about their work.
- *Recognize that a professional who is experiencing job impact may have needs to over-control his or her environment.* This can result in a poor response to supervision. The supervisor can best respond by increasing structure and emphasizing consistency in work performance.
- *Help employees by discouraging any tendency to isolate* with others in the same profession when they are experiencing job impact. This work is only effective when all of the options are available to manage sex offenders. If treatment providers see treatment as the only option to change sex offenders, they will feel like failures when offenders do not use treatment to change. They may forget that they can depend on other containment options. Help them see the importance of staying connected to the interdisciplinary team to activate other containment options besides treatment.
- *Set regular structured supervision time with each employee.* These meetings need to be more frequent with new staff. The meetings can help identify issues that need to be addressed early before they can become major issues that contribute to team breakdown.
- *Help professionals be comfortable with the fact that they can always be manipulated.* This is not a negative attribute—it is *positive* to acknowledge how skillful offenders are at manipulating others. When a staff member realizes they have been manipulated, he or she must acknowledge it to the offender and point out to the offender how the manipulation is a continuation of a destructive behavior pattern.
- *Set structured times with each staff member to discuss difficult situations or difficult cases.* This is especially important with new staff, but it is also valuable for experienced staff.

- *Remind professionals that a sex offender's failure is not the professional's failure.* The professional is doing a good job when he or she identifies that an offender has not changed. This concept is especially important when using the polygraph as a treatment and monitoring tool.
- *Set a standard on how staff conflicts should be handled.* Have staff members talk directly to the person they are upset with instead of talking about him/her to other co-workers. If the situation cannot be resolved at that level, the next meeting should include the supervisor. Hold employees to this expectation. This practice can help prevent a team meltdown.
- *Monitor team members and the team environment for early signs of job impact and team distress.* Early recognition of symptoms and intervention can prevent full team meltdowns. Meltdowns make the job unbearable. Once a meltdown occurs, it takes a much more rigorous intervention to get the team back on track. Some members of the team may quit in the process.

#### **8. Provide modified team building when a team melts down.**

- *When a team does melt down, step up efforts* to pull the team back together and provide clear direction. This may be difficult and unpleasant for the supervisor, since much of the anger and frustration may be vented on the supervisor.
- *Identify a facilitator.* Most professional facilitators are unfamiliar with job impact and how it can affect the team dynamics. In many cases, it is better to have the supervisor lead the team building sessions. It is also possible to use a therapist from another program whom you and your team would trust to help with team building. Victim therapists may be able to help by presenting information on job impact. This may not be a one-time event, but may take several sessions with a few monthly "check-ins" after the meltdown has passed. Administrators of the agency must be educated about the importance of taking time during the work week to rebuild a cohesive team.
- *Keep in mind that traditional team building can further divide the team.* Exercises that allow team members to blame each other exacerbate distrust and painful feelings. Many professional team builders may not understand the nature of the work, including how job impact affects teams.
- *Set firm rules* for the team building (see example). The goal of team building is to facilitate healing.
- *Instead of exclusively focusing on conflict, try to pull people together by spending time discussing what everyone has in common and agrees on.* For example, most people on the team have a strong commitment

to trying to prevent sex offenses. Identify the positives and what is working well.

- *Set a clear direction for the program.* Many team disagreements begin with differences in how to handle clinical situations. As part of team building, give employees a thorough understanding of why the program direction was selected. Emphasize the need for a consistent approach. Make it clear that employees are free to express their disagreement with the program direction, but they still must consistently follow it and support the program to offenders.
  - *Follow up team building by providing open, honest, and constructive feedback to employees.* Supervise employees regarding their behavior with each other and compliance with the program direction.
9. **Focus on solutions.** Use multiple methods to achieve the goal and stay focused on the goal and stay focused on it! The goal should not depend exclusively on the offender changing, since that is out of your control. Create systems that help offenders get caught if they do not choose to manage their risk.

The goal of the SOTMP is “public safety with no more victims.” The following methods are used to achieve that goal:

- The program contributes to the general knowledge of sex offenders through research and community services projects that offenders complete in treatment (please see attachment, xxx list of comm. service projects). These projects describe how others might identify sex offenders, how they set up their offenses to make their victims seem non-credible, how they manipulated and groomed victims and families, etc. This information can contribute to prevention efforts, victim treatment, and offender identification and apprehension.
- The program learns more information on the offending patterns of specific inmates and utilizes that information to recommend specialized conditions of community supervision. These conditions will allow supervisors to revoke sex offenders if they engage in high-risk behaviors prior to a reoffense. This information is also entered into a statewide ViCAP (FBI Violent Crime Apprehension Program Modus Operandi) database so the offenders can be caught more quickly if they reoffend.
- The program provides therapy to offenders to help them change their lifestyle and manage their risk.
- The program offers a support/education program to family members of the offender to help them understand the changes the offender will need to make and help them identify risk behaviors and how to respond.



10. **Find peers with whom you can debrief.** Managing job impact responsibly requires supervisors to be watchdogs for indications of job impact and then vigilant in their response to it. Supervisors must respond to individuals *and* the larger group. Supervisors need to debrief their experiences with trusted colleagues for support, advice, and guidance. This is important because professionals will inevitably be impacted by the job and the team will occasionally enter meltdown periods.

In sum, take good care of yourself and your staff and co-workers. This is important work, and you need to stay healthy.

#### SIDEBAR

##### SOTMP Rules for Team Building

- 1) Demonstrate common courtesy — Treat others as you would like to be treated.
- 2) No personal attacks on anyone — No derogatory comments — No blaming.
- 3) One person speaks at a time — No private conversations, side comments, or eye rolling.
- 4) Allow others to complete their thoughts — Listen for the intent of what they are saying.
- 5) Use I-statements owning your feelings, wants, and needs, not I-statements placing blame on others — speak about what you would like to see in the future
- 6) Focus on solutions — What will make this team function more positively and productively?
- 7) If you are angry and start to place blame, take a few moments and rethink what it is you need and how you would like things to be in the future — take personal responsibility for positive problem solving.
- 8) We can agree to disagree without being disagreeable and still respect the other person's right to disagree.

#### SIDEBAR

VanderKolk, McFarlane and Weisaeth have reviewed the literature on secondary trauma resulting from war, disasters, and crises. They identified these prevention strategies that are also useful in the context of job impact:

**TRAINING** can be used to decrease surprise and prepare for the unexpected, to maximize the sense of mastery and optimal performance, and to decrease the sense of hopelessness and defeat. Training can attribute meaning to the experience. Important components of training include peer support, ongoing stress management techniques, education about stress and ways to manage it, and evaluation and monitoring of training effectiveness.

**EXPERIENCE** The degree of anticipated stress among body handlers working during a natural disaster was significantly lower among those with experience. Experience seems to have an “inoculating” effect.

**GROUP/ORGANIZATIONAL LEADERSHIP** Leaders direct others to accomplish a common goal and insure adequate training. They direct the meaning of the work. Important parts of organization leadership include providing regular feedback, pairing more experienced workers with less experienced

workers, encouraging cohesion among coworkers, providing information about the organization, and encouraging exercise and sleep.

**MANAGEMENT OF MEANING** Reinforcing the importance and meaning of the work; recognition by valued authorities.

**MANAGEMENT OF EXPOSURE** Rotating schedules, providing a sense of predictability—for disaster workers, this meant providing a sense of safety through providing housing, food, resources, assurance of employment (a future).

**MANAGEMENT OF FATIGUE, SLEEP, AND EXHAUSTION** Over-dedication can be a serious risk factor for individuals in terms of psychological outcomes and performance errors. This finding is based on research on disaster workers and victims, as well as military personnel in chemical/biological warfare environments. The organization and group leaders should do what they can to prevent additional stresses.

**BUDDY CARE** Research on victims of terrorist acts has found that high levels of support is very important. Since leaders found that direct caretakers fail to take care of themselves, they assigned consultants who had not been exposed to the trauma to debrief the debriefers.

**NATURAL SOCIAL SUPPORTS AND CARETAKERS** Formal and informal networks of family members, friends and professionals are a key component to preventing and intervening in episodes of secondary trauma. According to research conducted during large-scale disasters, naturally occurring support systems represent a fundamental protective influence. Education of spouses may facilitate the natural recovery process. Outreach education programs are considered important.

**SCREENING** Performance criteria (e.g. training) may be the best screening tools. In a study of 469 firefighters, those who displayed a pattern of adversity before the event and had a tendency to avoid thinking about problems did worse after prolonged exposure to a large brush fire.

From *Traumatic Stress* (p. 452).

Contributors to the ideas and concepts discussed in these two chapters include:

- Jean McAllister, Former manager of the Colorado Sex Offender Management Board.
- The staff at the Sex Offender Treatment and Monitoring Program at the Colorado Department of Corrections that participated in the job impact survey in November 1996;
- The staff at the SOTMP TC team building session held in January 2000;
- The SOTMP staff who attended the May 19, 2000 job impact meeting;
- Burl McCullar, TC Manager, Judy Smith, Coordinator of the TC and Family Support Program.

### **Team Commandments**

1. Help each other be right, not wrong.
2. Look for ways to make new ideas work, not for reasons they won't.
3. If in doubt, check it out. Don't make negative assumptions about each other.

4. Help each other win, and take pride in each others' victories.
5. Speak positively about each other and about your organization at every opportunity.
6. Maintain a positive mental attitude no matter what the circumstances.
7. Act with initiative and courage, as if it all depends on you.
8. Do everything with enthusiasm; it's contagious.
9. Whatever you want, give it away.
10. Don't lose faith
11. Keep your sense of humor. Have some fun!

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## **Appendix 21**

### **Sample Phased Treatment Program Description Obtained from the Colorado Department of Corrections**

#### **SEX OFFENDER TREATMENT AND MONITORING PROGRAM COLORADO DEPARTMENT OF CORRECTIONS**

##### **CRITERIA FOR TREATMENT**

In light of the depth and seriousness of the problem addressed, a major intervention is needed. In order to accomplish this, the inmate must acknowledge having this problem and be willing to actively participate in a major intervention program. Sex offenders will be accepted for the Sex Offender Treatment and Monitoring Program when they meet the following requirements:

- 1) The inmate must have 8 years or less to PED (Parole Eligibility Date). The only exception to this rule will be inmates with court documentation that they will be eligible for reconsideration if they participate in sex offender treatment.
- 2) The inmate must have successfully completed the Core Curriculum Group.
- 3) The inmate must admit to sexually abusive behavior and be willing to discuss it.
- 4) The inmate must acknowledge that he has a current problem in the area of sexual abuse.
- 5) The inmate must be motivated to work on his problems as demonstrated by: a) a willingness to acknowledge and discuss problems; b) a willingness to participate in group; c) a willingness to address problematic patterns of behaviors; and d) a willingness to acknowledge the risk of reoffense.
- 6) The inmate must comply with the conditions of the group contract. This contract will explain expectations, responsibilities, and termination criteria.

##### **SEX OFFENDER TREATMENT PHASES**

The SOTMP is designed to utilize the most extensive resources with those inmates who have demonstrated a desire and motivation to change. Therapists are responsible for assessing the offender's treatment needs and making treatment recommendations based on the therapist's clinical judgement of the offender's eligibility and progress in treatment.

The Sex Offender Treatment and Monitoring Program is cognitive behavioral in orientation and has strict requirements for participation. The requirements are designed to convey the inmate's responsibility for change and the depth of the commitment that must be made.

The following groups are currently offered to inmates:

**CORE CURRICULUM:** This group is a prerequisite for participation in Phase I of the Sex Offender Treatment and Monitoring Program. The focus of the group is on thinking

errors, anger management, and stress management. The group meets for a minimum of 18 hours. The time may vary depending on the progress of the group.

**PHASE I:** Phase I is a time-limited therapy group focusing on the following common problem areas of sex offenders: Why people commit sex offenses, developing victim empathy, cognitive restructuring, sex offense cycles, relapse prevention, sex education, sex roles, social skills, and relationships. At FCF, SCF, YOS and CTCF the group meets four times a week and lasts approximately 6 months.

**PHASE IB:** This group covers the same components as the regular Phase I group, but it is designed for inmates who have low intellectual functioning. The group meets once a week.

**PHASE IC:** This group covers the same components as the regular Phase I group, but it is designed for sex offenders who are chronically mentally ill. The group meets twice a week and is open-ended.

**PHASE IE:** This group covers the same components as the regular Phase I group, but is designed for sex offenders who are Spanish speaking. The group meets once a week and is open-ended.

## **CRITERIA FOR PHASE II**

Inmates must have successfully completed Phase I and demonstrate motivation to participate in Phase II.

**PHASE II:** Phase II focuses on changing the inmate's distorted thinking and patterns of behavior as well as helping the inmate develop a comprehensive personal change contract (relapse prevention plan). Participants must keep a daily interactions journal and maintain appropriate behavior. This phase will be offered as an outpatient program and as a therapeutic community treatment program. The therapeutic community treatment program will house sex offenders together in a therapeutic milieu operating 24 hours per day, 7 days a week. This phase of the program is open-ended. Offenders remain in treatment until they progress to the community.

SOTMP recommends inmates for progression to the community and RAM supervision when they meet the following criteria:

1. Actively participating in treatment and applying what he or she is learning.
2. Completed a non-deceptive polygraph assessment of his or her deviant sexual history - any recent monitoring polygraph exams must also be non-deceptive.
3. Completed a comprehensive personal change contract (relapse prevention plan) which is approved by the SOTMP team
4. Identified, at a minimum, one approved support person who has attended family/support education and has reviewed and received a copy of the offender's personal change contract

5. Practicing relapse prevention with no institutional acting out behaviors within the past year
6. Compliant with any DOC psychiatric recommendations for medication which may enhance his or her ability to benefit from treatment and or reduce his or her risk of reoffense.
7. Able to be supervised in the community without presenting an undue threat

### **Community Transition Recommendations**

Offenders must meet the following requirements in order to receive a recommendation for parole:

1. Actively participating in treatment and applying what he or she is learning.
2. Completed a non-deceptive polygraph assessment of his or her deviant sexual history - any recent monitoring polygraph exams must also be non-deceptive.
3. Completed a comprehensive personal change contract (relapse prevention plan) which is approved by the SOTMP team
4. Identified, at a minimum, one approved support person who has attended family/support education and has reviewed and received a copy of the offender's personal change contract
5. Practicing relapse prevention with no institutional acting out behaviors within the past year
6. Compliant with any DOC psychiatric recommendations for medication which may enhance his or her ability to benefit from treatment and or reduce his or her risk of reoffense.
7. Able to be supervised in the community without presenting an undue threat

**FAMILY EDUCATION ON RELAPSE PREVENTION:** Family education meetings are offered periodically for families of the inmates participating in the relapse prevention group. This program is offered to educate the family on the dynamics involved in sex offenses and the offense cycle. The inmate's specific relapse prevention plan is reviewed with the inmate and family prior to parole in order to help the family become a support system for the offender in monitoring his thoughts, feelings, and behaviors for indications of high risk.






## Appendix 22

Procedure for approving community treatment providers:  
Colorado DOC



<u>ADMINISTRATIVE REGULATION</u>    COLORADO DEPARTMENT OF CORRECTIONS		REGULATION NUMBER	PAGE NUMBER
		250-23	1 OF 9
		CHAPTER: Adult Parole, Community Corrections, and Youthful Offender System	
		SUBJECT: Procedure for Approving Community Mental Health Treatment Providers	
RELATED STANDARDS: ACA Standards NONE		EFFECTIVE DATE: June 15, 2007	
		SUPERSESSION: 08/01/06	
		Aristedes W. Zavaras Executive Director	
OPR: PCY	REVIEW MONTH: March		

## I. POLICY

The Department of Corrections (DOC) recognizes that specialized mental health treatment providers are an essential component to successful reintegration of offenders returning to the community. No one treatment agency can meet these specialized needs statewide. It is, therefore, necessary to utilize treatment providers who are skilled in offender treatment and are willing to coordinate with supervising officers for the enhancement of public safety.

## II. PURPOSE

The purpose of the administrative regulation is to establish procedures for the approval of providers, evaluation of quality of services sanctioning, and reimbursement of community mental health treatment providers.

## III. DEFINITIONS

- A. ADAD: Department of Human Services, Alcohol, and Drug Abuse Division.
- B. Approved Treatment Provider (ATP): An individual, group, or agency who, after applying to the review board, is determined qualified to provide mental health or substance abuse treatment, or assessment, to DOC offenders.
- C. Approved Treatment Provider Coordinator: A person who functions as the coordinator for the Approved Treatment Provider (ATP) program and supports the operation of the board and its members.
- D. Approved Treatment Provider Criteria: Standards set by the ATP Review Board for providing mental health treatment, or assessment services, to DOC offenders and sets the standards for treatment and assessment.

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- E. Approved Treatment Provider Review Board: This board will consist of the ATP coordinator and appointees from each of the following areas: Adult Parole, Community Corrections, Youthful Offender System, Correctional Programs, and Contract Management. The ATP Review Board meets monthly.
- F. Community Corrections Center: Any private or public facility under contract to the Department of Public Safety or the Department of Corrections to provide residential treatment and transitional services for DOC offenders.
- G. Contract Worker: Any person employed under contractual arrangement to provide services to the DOC: any person employed by private or public sector agencies who is serving under DOC special assignment to provide services or support to DOC programs. The employee/employer relationship lies with the contractor. All Department agreements are for a specified period and are renewable.
- H. DOC Employee: Someone who occupies a classified, full or part-time, position in the State Personnel System in which the Department has affect over pay, tenure, and status.
- I. Mental Health Authorization Form: A written form referring offenders to an Approved Treatment Provider (ATP) and authorization for reimbursement for services.

#### IV. PROCEDURES

- A. ATP Personnel and Review Board Member Determination
  - 1. The members of the ATP Review Board are appointed by the director of the Division Adult Parole, Community Corrections, and Youthful Offender System and the assistant director of Clinical Services for the Department of Corrections. Each member is a DOC employee and is eligible to service as board chairperson. The board chairperson will rotate among board members and the term will be for one year. Board members will make every effort to attend meetings to ensure a quorum. The ATP Review Board will meet once a month.
  - 2. The appointed members of the ATP Review Board will include at a minimum:
    - a. Associate director from the Division of Adult Parole, Community Corrections and YOS.
    - b. Manager from the Division of Adult Parole, Community Corrections and YOS.
    - c. Mental health treatment representative from Clinical Services.
    - d. Supervisor from the Community Parole Sex Offender Program.
    - e. Assistant director of Legal Affairs from the Division of Adult Parole, Community Corrections and YOS.
    - f. Mental health manager from the Division of Adult Parole, Community Corrections and YOS.

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- g. Division of Adult Parole, Community Corrections and YOS supervisors (two supervisors on six month rotations).

Other members may be appointed at the discretion of the director of the Division Adult Parole, Community Corrections, and Youthful Offender System and the assistant director of Clinical Services for the Department of Corrections. These positions may include voting members or non-voting advisory members.

- 3. The ATP coordinator will support the board and other personnel as deemed appropriate by the director of the Division Adult Parole, Community Corrections, and Youthful Offender System.

**B. Assignment of responsibilities for ATP**

- 1. The ATP Review Board will be responsible for the following:
  - a. Approving provider and treatment criteria.
  - b. Approving set time frames for applications and review.
  - c. Approving providers and therapists as ATP.
  - d. Reviewing service audits.
  - e. Reviewing and resolving complaints against ATP providers and/or therapists.
  - f. Developing and maintaining policies on the ATP program.
  - g. Maintaining and adjusting as necessary service rates.
- 2. The ATP coordinator is responsible for:
  - a. The documentation and implementation of the decision and policies established by the ATP Review Board.
  - b. Establishing ATP Review Board meeting dates, creating meeting agendas and posting on website, maintaining minutes of meetings, and recording all decisions.
  - c. Operations of DOC employees and contract workers assigned to the ATP program.
  - d. Distributing meeting minutes to board members and division directors and posting on CDOC website.
- 3. The ATP Review Board and ATP coordinator will be accountable to the director of Adult Parole, Community Corrections, and Youthful Offender System, or designee.

**C. Process of Becoming an ATP**

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1. General Provisions:

- a. The ATP Review Board will accept applications throughout the year from agencies and/or individuals seeking to become an ATP.
- b. An ATP application (Attachment “A”) must be completed by an agency and by each therapist who is seeking to treat Adult Parole, Community Corrections, and YOS offenders. In addition, each applying therapist must complete a copy of the pre-employment supplemental application, for submission for background check.
- c. Completion and submittal of an application constitutes only an application to become an Approved Treatment Provider in the DOC ATP program. It does not constitute an offer by the DOC to enter into a contract and receipt of the application form by DOC will not constitute nor will be deemed to constitute acceptance of an offer to contract with the DOC.
- d. An ATP application is to be completed and approved by the review board prior to providing treatment services to DOC offenders.
- e. A DOC background investigation of applicants must be completed and result in a pass prior to providing treatment services to DOC offenders.
- f. The applicant may not be considered for referrals by the DOC and/or may have its approval revoked, contract terminated, and referrals withdrawn if it is found that information on the application is falsified. Further, as falsification of credentials is a criminal act, the Colorado Attorney General will be notified of all such situations.

2. Application Criteria:

- a. The applicant must be qualified to deliver the services they identify as wishing to deliver to offenders.
- b. The applicant must submit a complete and legible application to include attachments.
- c. The applicant must submit a complete and legible pre-employment supplemental application.
- d. Applicant cannot be currently employed by the State of Colorado.

3. Application Process:

- a. Treatment provider(s) may apply to the ATP program by requesting an Approved Treatment Provider Application from the ATP program coordinator or designee.
- b. Applicant must submit a completed and legible application and pre-employment supplemental application to the ATP program coordinator. Any questions or requests should be directed toward the ATP program coordinator.

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- c. The ATP program coordinator will prescreen the application for any incomplete or missing information. Any information needed or that appears to be unclear or missing will be requested in writing from the applicant.
- d. The ATP program coordinator will forward the completed pre-employment supplemental application to the doc investigations unit for processing and shall document this action.
- e. All applicants are required to submit a pre-employment supplemental application and Release of Information for a background investigation to be performed.
- f. Results of investigation are pass or fail.
- g. The pass or fail results of the investigation are forwarded to the ATP program coordinator, however; the details of the investigation are kept confidential and are not forwarded to the ATP program coordinator.
- h. The ATP coordinator shall screen and forward all completed applications and background investigations to the Review Board.
- i. At a minimum, two members of the ATP Review Board shall meet annually to:
  - 1) Review completed applications.
  - 2) Approve or deny treatment programs.
  - 3) Approve or deny therapists.

The reviewing members shall document their approval/denial on the applications.
- j. Applicants will be notified in writing of acceptance or denial by the ATP program coordinator or designee. Providers who are approved will be listed as an ATP.
- k. Any questions by the applicant concerning the background investigation results will be redirected to the division in DOC responsible for performing them.
- l. Treatment providers will be reviewed annually and must provide current proof of licensure and a letter of supervision, if required, proof of insurance, and release of information. Providers cannot provide services outside their approved areas of expertise.

4. Additional Treatment and New Hires Services:

- a. Approved treatment providers may apply to have additional treatment services added to their areas of expertise. The following steps need to be completed:

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- 1) A detailed program description of new treatment(s).
- 2) List of ATP therapist that will be providing new treatment service with their qualification to provide such treatment.
- b. Approved treatment providers may hire additional or replacement therapists to provide treatment for DOC offenders.
- c. All proposed therapists must complete an ATP application and a pre-employment supplemental application, and have a DOC background investigation performed prior to treating DOC offenders.
- d. A list of ATP treatment services that the new hire will be providing to DOC offenders.
5. Exceptions:
  - a. All requests for waiver of any ATP criteria shall be reviewed and responded to by the ATP Review Board.
  - b. Treatment providers may request applications for becoming an ATP from the ATP coordinator. Completed and submitted applications will be reviewed by the ATP coordinator, or designee, for complete data and to ensure that required background checks have been completed successfully.
  - c. The ATP coordinator will submit the completed applications to the review board for review and subsequent approval or denial. Applicants will be notified, in writing, of acceptance or denial by the ATP coordinator, or designee. Applications will be evaluated against criteria set forth by the ATP Review Board in their policies and procedures.

D. ATP Tier System

An ATP shall be assigned to a specific level within the ATP Tier system in order to provide direction to the CPO as to the usage of the treatment provider. The ATP Tier system is based on the contractual/non-contractual relationship between CDOC and the treatment provider.

1. The ATP Tier is constructed as follows:
  - a. Tier One – The ATP has a competitive contract with the CDOC.
  - b. Tier Two – The ATP has a discretionary contract with the CDOC.
  - c. Tier Three – The ATP has no contract with the CDOC.
  - d. Tier Four – The ATP has no contract with the CDOC but does allow for another third-party payer to fund the referred offender's treatment due to a unique status of the offender.



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2. All ATP may receive referrals for self-pay offenders. The commitment of state funds by a CPO through the ATP program for reimbursement of an ATP's service delivery to an offender can only occur if the ATP has a contract, competitive or discretionary, with the CDOC. This would be a Tier 1 or 2 ATP only. Tier 3 ATP may refer self-pay offenders only. Tier 4 ATP require that the offender have a unique status that the Tier 4 ATP recognizes and thus will provide subsidized treatment to that offender.

E. ATP Usage Process

1. The supervising CPO will identify those offenders who are required to receive mental health evaluation and/or participate in treatment to meet the conditions or directives of community placement or parole. Offenders with these conditions or directives shall receive treatment services only from ATP and not from non-ATP. Services received from non-ATP do not meet the conditions and directives placed on the offender by community placement or parole.
2. The supervising CPO will review the status of the offender who is so identified and subsequently determine what resources the offender may have to pay for their own treatment services and make every effort to utilize those resources first (self pay, insurance, Medicaid, etc.) before moving to commit state funds.
3. If the supervising CPO finds that the offender can pay for his/her own treatment services, the CPO will refer the offender to any of the Tier 1,2, or 3 listed ATP who deliver the desired specific treatment services and identify the offender to the referred ATP as self-pay only.
4. If the supervising CPO finds that the offender can receive treatment services from a Tier 4 due to having a unique status that a specific Tier 4 ATP recognizes, the CPO will refer the offender to that Tier 4 ATP for those services.
5. The supervising CPO, after determining the lack of any other funding and thus the need to commit state funds to subsidize an offender's required treatment, will submit the appropriate data as structured on the existing divisional database requesting a treatment referral and submit it to the ATP. Following notification from the ATP of the submitted referral transmitted to the requested vendor, the CPO will direct and/or assist the offender to schedule an appointment with the vendor.
6. When the supervising CPO determines ongoing support of an offender's treatment is needed and commitment of additional state funds is needed, the referral process is repeated on a two month basis. State funding of offender's treatment should be removed as soon as feasible and the offender be made responsible for payment.

- F. Substance abuse treatment providers are licensed by ADAD and funded by the DOC Office of Alcohol and Drug Services. These services are governed by the applicable portions of CRS 16-11.5-102.
- G. Approved treatment providers will submit the ATP Mental Health Monthly Services Report (Attachment "B") to the appropriate office monthly.

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- H. Any CPO, or supervisor, who has reason to believe an ATP is not complying with the terms of ATP approval shall complete an ATP Review Board Complaint Form (Attachment “C”) and forward it to the ATP coordinator.

Upon receipt of a complaint, the ATP coordinator will review the complaint and determine if the review board should address the matter or offer the provider an opportunity to respond before taking further action to the review board. The review board will review and evaluate all relative information and determine if the complaint is substantial. If warranted, the review board may administer the following actions:

1. Meet with the provider, discuss the concerns and resolve the complaint.
2. Notify the provider, in writing, of placement on probationary status for a specific period of time. Such notice shall include the reasons for said placement and set time of probationary status and what steps must be taken by the provider to be removed from probationary status.
3. Notify the provider, in writing, that their status as an approved treatment provider has been terminated and the reasons for the termination.

In the event action is taken under Section IV.H.2 or 3, outlined above, if the approved treatment provider has a current contract with the State of Colorado, they may appeal the decision of the review board, to the DOC purchasing director, under Colorado Revised Statute 24-109-102.

#### V. RESPONSIBILITY

- A. The director of Adult Parole, Community Corrections, and Youthful Offender System shall be responsible for the overall implementation of this administrative regulation.
- B. The review board shall be responsible to evaluate treatment providers and establish the criteria for evaluation and approval. The review board shall approve or deny approved treatment provider status, review complaints, and take appropriate action to resolve said complaints. The review board will be accountable to the director of Adult Parole, Community Corrections, and Youthful Offender System.
- C. The ATP coordinator shall be responsible to track all treatment provider applications and to notify applicants of acceptance or denial.
- D. The community parole officer shall be responsible to refer offenders to approved treatment providers and shall utilize the ATP referral system as directed.
- E. The Adult Parole, Community Corrections, and Youthful Offender System supervisor shall be responsible to review the mental health referrals made by community parole supervising officers to ensure compliance with this administrative regulation.

#### VI. AUTHORITY

- A. CRS 16-11.5-102. Substance abuse assessment - standardized procedure.

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- B. CRS 17-1-103. Duties of the executive director.
- C. CRS 17-22.5-303. Parole.
- D. CRS 24-60-303. Compact approved and ratified.
- E. CRS 24-109-102. Protested solicitations and awards.

VII. HISTORY

July 1, 2006  
 July 1, 2005  
 July 1, 2004  
 December 15, 2003  
 December 15, 2002  
 December 15, 2001 (supersedes AR 1250-03)  
 December 15, 2000

- ATTACHMENTS:
- A. AR Form 250-23A, Approved Treatment Provider Application
  - B. AR Form 250-23B, Mental Health Monthly Services Report
  - C. AR Form 250-23C, Approved Treatment Provider Review Board Complaint Form
  - D. AR Form 100-01A, Administrative Regulation Implementation/Adjustments

**COLORADO DEPARTMENT OF CORRECTIONS  
APPROVED TREATMENT PROVIDER PROGRAM APPLICATION**

The Division of Adult Parole Supervision and Community Corrections with the Colorado Department of Corrections will be referring offenders to approved treatment providers for mental health services. Completion and submittal of this form constitutes only an application to become an approved treatment provider in the Department of Corrections Approved Treatment Provider (ATP) Program. This form does not constitute an offer by the Department of Corrections to enter a contract and receipt of the application form by the Department of Corrections will not constitute nor will be deemed to constitute acceptance of an offer to contract with the Department of Corrections. To apply please fill out the enclosed forms and mail them to:

**Approved Treatment Provider (ATP) Program Office  
Adult Parole, Community Corrections, and Youthful Offender System  
Colorado Department of Corrections  
12157 W. Cedar Dr.  
Lakewood, CO 80228**

Your application will be evaluated by the ATP Review Board. You will be informed of your status in writing after committee review of your application and the completion of a background check.

AGENCY/NAME: \_\_\_\_\_

TYPE OF AGENCY:    \_\_\_\_\_ CORPORATION                      \_\_\_\_\_ PROPRIETOR  
                                 \_\_\_\_\_ INDIVIDUAL                      \_\_\_\_\_ OTHER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

PHONE: \_\_\_\_\_ FIN OR SS#: \_\_\_\_\_

CLINICIANS: (Enclose contractor's supplemental application, releases, and Background Information Form on all clinicians. Complete this page 1 for each clinician separately).

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SS#: \_\_\_\_\_ DEGREE \_\_\_\_\_ LICENSE #: \_\_\_\_\_

If not licensed in the mental health field, please submit additional information regarding supervision arrangements, license eligibility or other qualifications.

Attachment "A"  
Page 1 of 10

## Treatments / Services Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please review this list of treatments / services. Check the one(s) for which you are applying.

<b>Adult</b>	<b>YOS (i.e. Juvenile Offenders)</b>
<b>Treatment Programs</b>	<b>Treatment Programs</b>
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Anger Management
<input type="checkbox"/> Crisis Intervention	<input type="checkbox"/> Crisis Intervention
<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Domestic Violence
<input type="checkbox"/> General Mental Health	<input type="checkbox"/> Family (of Origin) Therapy
<input type="checkbox"/> Marriage & Family	<input type="checkbox"/> Gang Intervention
<input type="checkbox"/> Developmentally Disabled	<input type="checkbox"/> General Mental Health
<input type="checkbox"/> General Offenders Group	<input type="checkbox"/> Marriage & Family
<input type="checkbox"/> Parenting	<input type="checkbox"/> Developmentally Disabled
<input type="checkbox"/> Serious Mental Illness	<input type="checkbox"/> General Offenders Group
<input type="checkbox"/> Sex Offender	<input type="checkbox"/> Parenting
<input type="checkbox"/> Women Offenders Group	<input type="checkbox"/> Serious Mental Illness
	<input type="checkbox"/> Sex Offender
	<input type="checkbox"/> Women Offenders Group
<b>Evaluations</b>	<b>Evaluations</b>
<input type="checkbox"/> Medication Management	<input type="checkbox"/> Medication Management
<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Psychological	<input type="checkbox"/> Psychological
<input type="checkbox"/> Psychosexual	<input type="checkbox"/> Psychosexual
<input type="checkbox"/> Psychosocial	<input type="checkbox"/> Psychosocial
<b>Examinations</b>	<b>Examinations</b>
<input type="checkbox"/> Abel Screen	<input type="checkbox"/> Abel Screen
<input type="checkbox"/> Plethysmograph	<input type="checkbox"/> Plethysmograph
<input type="checkbox"/> Polygraph	<input type="checkbox"/> Polygraph
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Psychological Testing
<b>Addiction Treatment</b>	<b>Addiction Treatment</b>
<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Substance Abuse

Attachment "A"

Page 2 of 10

Applicant Name: \_\_\_\_\_

List three professionals who are not related to you and who have definite knowledge of your treatment program and professional qualifications.

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Agency: \_\_\_\_\_

Address: \_\_\_\_\_

**Please submit the following information along with your application: Incomplete applications or those lacking details will result in delay in processing.**

\$ A brief description of your organization and length of operation (no brochures).

\$ Details on type of experience treating offenders and number of clinical hours treating offenders.

\$ Very detailed description of treatment program: TX approach, crime specific elements, length of program certification documents if applicable.

\$ Fee schedules for therapy, evaluations, etc.

\$ Treatment times (what times offered, how often it starts, etc.)

- Proof of professional liability insurance (minimum \$600,000).
- Signed Authorization for Release of Information Form, Background Information Form, Certification Form, and initialed Requirements Form (all attached).
- If unlicensed, your supervisor must also apply and provide a plan outlining your supervision under them.

## ATP REQUIREMENTS FORM For Mental Health Services

I agree to the following requirements while providing services to Department of Corrections offenders and will further communicate and require such requirements to any and all employees of my agency.

- 1) All offenders shall sign a waiver of confidentiality allowing the therapists, supervising officers and past treatment providers at DOC to communicate regarding the client and his/her therapy.
- 2) A copy of the offender's intake evaluation and treatment contract shall be sent to the supervising officer. The intake evaluation shall include information on therapeutic issues, therapy recommendations, treatment plans and costs.
- 3) Monthly DOC reports will be sent to the supervising officer. Staffings will be held when requested by the supervising officer in order to share information and impressions of the offender.
- 4) Whenever an offender fails to attend a therapy appointment, the supervising officer shall be notified the following working day.
- 5) The supervising officer shall be notified immediately whenever the therapist perceives instability, deterioration, negative attitude changes, or suspected danger of re-offenses in the offender.
- 6) A "discharge summary" shall be sent to the supervising officer whenever an offender is expelled or the therapist anticipates expulsion from treatment or successfully completes treatment.
- 7) The therapist shall write a certified report on the offender upon request for parole/administrative adjustment hearings.
- 8) The therapist shall be willing to testify as a material witness in parole/administrative adjustment hearing concerning the offender.
- 9) In sex offender treatment the offender's "cycle of relapse" shall be identified and shall be part of the focus of treatment. High-risk situations, which can lead to re-offense, will be identified and the supervising officer shall be given a copy.
- 10) The therapeutic approach must be consistent with the DOC therapeutic approach which embraces community safety above the rights of the offender. Treatment must be offense specific and address the antecedent behavior, high-risk signs and situations, and relapse prevention techniques. The provider must disclose to the supervising officer any behavior on the part of the offender which increases the offenders level of risk or dangerousness, including but not limited to: assaultive behavior, unwanted touching of others, associating with potential victims, increasing levels of deviant fantasies, missing treatment sessions and or failure to meet treatment requirements.
- 11) Sex offender treatment providers must maintain compliance with the Colorado Sex Offender Treatment Board Standards.
- 12) Approved Treatment Providers will be reviewed at least yearly. Quality assurance procedures may include review of evaluations, on site visits and observation of therapy, video tapes or audio tapes of therapy and client records. These reviews will result in renewal, probation, or termination of ATP status.
- 13) Any failure to provide complete, timely information or any misrepresentation of facts, past or present, to the supervising officer, hearing officer, parole board or a DOC agent will result in termination or denial of ATP status.

---

Applicant Signature

---

Date

**ATP SEX OFFENDER EXAMINERS REQUIREMENT FORM**

I agree to the following requirements while providing services to Department of Corrections offenders and will further communicate and require such requirements to any and all employees of my agency.

- 1) All offenders shall sign a waiver of confidentiality allowing the polygraph examiners, therapists, supervising officers and past treatment providers at DOC to communicate regarding the client and his/her therapy.
- 2) Polygraph examination reports will be sent to the supervising officer. Staffings will be held when requested by the supervising officer in order to share information and impressions of the offender.
- 3) Whenever the offender fails to attend an appointment, the supervising officer shall be notified the next working day. The offender is responsible for payment of any missed appointments.
- 4) The polygraph examiner shall be willing to testify as a material witness in parole/administrative adjustment hearings on the offender.
- 5) The polygraph examination report or videos of the offender will be made available upon request for parole/administrative adjustment hearings.
- 6) The polygraph examination must support the DOC therapeutic approach, which embraces community safety above the rights of the offender. Treatment must be offense specific and address the antecedent behavior, high-risk signs and situations, and relapse prevention techniques. The polygraph examiner must disclose any behavior on the part of the offender which increases the offenders level of risk or dangerousness, including but not limited to: assaultive behavior, unwanted touching of others, associating with potential victims, increasing levels of deviant fantasies, missing treatment sessions and/or failure to meet treatment requirements.
- 7) Approved Treatment Providers will be reviewed at least yearly. Quality assurance procedures may include review of evaluations, on site visits and observation of therapy, video tapes or audio tapes of therapy and client records. These reviews will result in renewal, probation, or termination of ATP status.
- 8) Any failure to provide complete, timely information or any misrepresentation of facts, past or present, to the supervising officer, hearing officer, parole board or DOC agent will result in termination or denial of approved treatment provider status.
- 9) Polygraph examiners must maintain compliance with the Colorado Sex Offender Treatment Board Standards.

---

Applicant Signature

Date



**COLORADO DEPARTMENT OF CORRECTIONS**  
**Approved Treatment Provider Certification Form**

Applicant Name: \_\_\_\_\_

I certify that I have fully disclosed each of the following items:

1. Any previously successful or currently pending challenge to my licensor, certification or registration.
2. The voluntary relinquishment of my licensor, certification, or registration or the voluntary or involuntary termination of any mental health treatment/referral privilege membership.
3. The voluntary or involuntary limitation reduction or the loss of clinical privileges.
4. Any pending professional liability or malpractice action and final judgments or settlements involving my professional practice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Request for Insurance Statement**

\_\_\_\_\_(Date)

\_\_\_\_\_(Agency Name)

\_\_\_\_\_(Address)

\_\_\_\_\_

To Whom It May Concern: \_\_\_\_\_  
(Insurance Company)

Please forward insurance statement verifying my malpractice insurance coverage and other policy terms, including the naming of the Colorado Department of Corrections as an “Additional Insured.”  
Please mail the insurance statement to the following address:

**ATP Office  
Adult Parole and Community Corrections  
12157 W. Cedar Dr.  
Lakewood, CO 80228**

Thank you for your timely assistance in this matter.  
Sincerely,

\_\_\_\_\_  
\_\_\_\_\_(Phone #)

**ATP STANDARD REIMBURSEMENT RATES**

**Mental Health Services**

**INTAKE = \$75.00 (per intake)**

- Includes a review of case material and an interview with the offender to provide a written summary of resulting recommendations.

**GROUP TREATMENT = \$50.00 (per session)**

- Therapy provided in a group setting with more than one client.
- Time frame is up to and including two (2) hours.
- This is the preferred type of treatment service.

**INDIVIDUAL TREATMENT =**  
**\$25.00 (10-15 minutes)**  
**\$50.00 (16-30 minutes)**  
**\$75.00 (31-60 minutes)**  
**\$100.00 (61-90 minutes)**

- Therapy provided on a one on one (1:1) setting with the therapist.
- Time frame is between 10 minutes up to and including a maximum of 90 minutes.
- This type of treatment should be utilized infrequently and be time-limited.

**PSYCHOSOCIAL EVALUATION= \$75.00 (per evaluation)**

- Evaluation of an offender provided by a licensed mental health professional. Requires interview with offender, review of all available case material and results in a written report that identifies specific intervention needs by the offender and treatment recommendations.
- Used to determine or verify an offender's intervention needs.
- This type of evaluation should be utilized infrequently.

**PSYCHOLOGICAL EVALUATION =**  
**\$25.00 (10-15 minutes)**  
**\$50.00 (16-30 minutes)**  
**\$75.00 (31-60 minutes)**  
**\$100.00 (61-90 minutes)**

- Evaluation of an offender provided by a licensed Psychologist. Requires interview with offender, review of all available case material and results in a written report that identifies a diagnosis and treatment recommendations.
- Used to determine or verify if offender has a serious mental illness.
- Time frame is between 10 minute up to and including a maximum of 90 minutes.
- This type of evaluation should be utilized infrequently.

**PSYCHOLOGICAL TESTING= \$100.00 (per hour)**

- Administration, scoring, interpretation of a battery of psychological assessment tools by a licensed Psychologist resulting in a detailed report that contained a diagnosis with treatment recommendations.

- Evaluation of an offender provided by a licensed Psychiatrist. Requires face-to-face interview with offender, review of all available case material and results in written recommendations.
- Used to determine if offender could benefit from psychotropic medications, a change in existing medications, or to follow-up on medications that the offender was prescribed while in the institution.
- This type of treatment should be used infrequently.

## Sex Offender Services

**TESTIMONY/WITNESS FEE=** **\$ 100.00** (per hour)

- For testifying in court or at a Parole Board hearing.

**GROUP TREATMENT=** **\$35.00/ single therapist; \$75.00/ co-therapists.**

- Therapy provided in a group setting with more than one client.
- Time frame is up to and including two (2) hours.
- This is the preferred type of treatment service for sex offenders.
- ATP/DOC highly recommends co-therapists, preferably one male and one female, in all group therapy sessions for sex offenders.

**The Provider may not bill the state or any offender for services which exceed these established reimbursement rates. Similarly, the provider may not bill the DOC and an offender in combination for services, nor "split" the bill for services which exceed these established reimbursement rates.**

**STATE OF COLORADO  
DIVISION OF ADULT PAROLE SUPERVISION AND COMMUNITY CORRECTIONS  
AND YOUTH OFFENDERS SYSTEM**

**MENTAL HEALTH MONTHLY PROGRESS & TERMINATION  
REPORT**

(TYPE OR PRINT CLEARLY)

Offender Name: \_\_\_\_\_ DOC #: \_\_\_\_\_ DOB: \_\_\_\_\_

DOC Supervising Agent/Officer: \_\_\_\_\_

Approved Treatment Provider Agency: \_\_\_\_\_

Number of sessions during report period: \_\_\_\_\_

Session dates during reporting period: \_\_\_\_\_

1. **Type** of treatment currently provided: \_\_\_\_\_

2. List **Treatment Objectives** during the past month:

3. In what areas has the offender demonstrated **progress or lack thereof** toward treatment objectives during this report period:

Attachment "B"  
Page 1 of 2

4. Describe other **concerns** pertaining to issues of relapse and/or risk to the community. This may include lack of participation, disruptive behavior, non compliance with required medications(s), etc.
  
5. List **recommendations** for other treatment or services needed:
  
6. What are the **treatment objectives** for the upcoming month:  
Complete previously listed objectives and move on to next goal (identified below)
  
7. **Staffing** requested with supervising Agent/Officer within 2 weeks Yes \_\_\_\_\_ No \_\_\_\_\_
  
8. **COMMENTS:**

---

ATP Therapist

---

Date

---

Print Name

Attachment "B"  
Page 2 of 2

**APPROVED TREATMENT PROVIDER REVIEW BOARD****> COMPLAINT FORM <**

Department of Corrections  
 Adult Parole, Community Corrections, and YOS  
 12157 W. Cedar Dr, Lakewood, CO 80228  
 phone: 303-763-2420 fax: 303-763-2445

This form is be used by any individual who has reason to believe that a Colorado Department of Corrections Approved Treatment Provider (ATP) or ATP employee not complying with the terms of the ATP Program or has complaints and/or ethical concerns.

Please complete this form to make sure the Review Board has all relevant information. Incomplete or illegible information will result in the delay of processing your complaint.

Upon receipt of this completed form (and any supporting documentation), your complaint will be scheduled to be reviewed through the Review Board=s formal complaint process. An acknowledgment of our receiving your complaint will be sent to you. Please be aware that your complaint may take a period of time to completely process.

**Individual(s) or Agency Making Complaint:**

**Address:**

**City:**

**State:**

**Zip:**

**Phone:**

**Fax:**

**Email:**

**Individual(s) or Agency Complaint is Being Made About:**

**Address:**

**City:**

**State:**

**Zip:**

**Phone:**

**Fax:**

**Email:**

**Nature of Your Complaint:** Please provide any specific information that would assist the ATP Review Board toward a resolution. For example names of individuals involved, the problem behavior, frequency or time frame the behavior occurred or any other relevant details. Continue on a separate sheet if needed. Please include all related attachments supporting your complaint.

**Incomplete or illegible information will result in the delay of processing your complaint.**

Attachment "C"

Page 1 of 2



**Nature of Your Complaint (continued):**

**Your Suggested Resolution:** Please identify what you believe to be the best resolution to this complaint. Continue on a separate sheet if needed. Please feel free to include attachments.

After completing this form, mail, fax or e-mail the form and any supporting documentation to the ATP Review Board at the below address and number(s) provided. It is recommended that you keep a copy of your submitted complaint.

Department of Corrections  
Adult Parole, Community Corrections, and YOS  
c/o ATP Coordinator  
12157 W. Cedar Dr., Lakewood, CO 80228  
phone: 303-763-2420 Fax: 303-763-2445  
e-mail: [chris.kesterson@doc.state.co.us](mailto:chris.kesterson@doc.state.co.us)

Thank you for addressing your concerns to the ATP Review Board.

Signature:

Date:

**Incomplete or illegible information will result in the delay of processing your complaint.**

ATP Complaint Form; revised 1/30/03

Attachment "C"  
Page 2 of 2

**ADMINISTRATIVE REGULATION  
IMPLEMENTATION/ADJUSTMENTS**

AR Form 100-01A (11/15/05)

CHAPTER	SUBJECT	AR #	EFFECTIVE
Adult Parole, Community Corrections, and Youthful Offender System	Procedure for Approving Community Mental Health Treatment Providers	250-23	06/15/07

(FACILITY/WORK UNIT NAME) \_\_\_\_\_  
WILL ACCEPT AND IMPLEMENT THE PROVISIONS OF THE ABOVE ADMINISTRATIVE REGULATION:

☐ AS WRITTEN    ☐ NOT APPLICABLE    ☐ WITH THE FOLLOWING ADJUSTMENTS TO MEET  
LOCALIZED OPERATIONS/CONDITIONS

(SIGNED) \_\_\_\_\_ (DATE) \_\_\_\_\_  
Administrative Head

Attachment "D"  
Page 1 of 1

## **Appendix 23**

### **POLYGRAPH SANCTIONS GRID**

**And**

### **INTERMEDIATE SANCTIONS GRID**

# **POLYGRAPH SANCTIONS GRID (USE A NEW FORM FOR EACH POLYGRAPH EXAM)**

ID# \_\_\_\_\_ NAME \_\_\_\_\_ Poly Exam Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Sex Offender Treatment Date (Start) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Number of Poly Exam(s) 1 2 3 4 5 6 7 8 9 10 11 12 13 14

(Please circle)

Number of Treatment Sessions per Week (Currently) \_\_\_\_\_

## **DURING THE POLYGRAPH EXAM**

### **ADMISSIONS DURING POST TEST**

	<b>Admissions During Pretest<sup>1</sup></b>	<b>Admissions to Non-deception / Post test<sup>2</sup></b>	<b>Admissions to Deception / Post test<sup>3</sup></b>	<b>No Admissions to Deception<sup>4</sup></b>
<b>Past Behavior: Offenses / High Risk<sup>A</sup></b> Behavior that occurred Before being placed under Community supervision And/or Treatment	Behavior(s):  None	Behavior(s):  None	Behavior(s):  Low	Behavior(s):  Low
<b>New High Risk Behaviors &amp; Behavior Lapses<sup>B</sup></b> New offense cycle behavior that occurs after placement in comm. Superv. Or treatment	Behavior(s):  Low	Behavior(s):  Low	Behavior(s):  Moderate	Behavior(s):  Moderate
<b>New Major Violations<sup>C</sup></b> New behavior. That violates the rules after being placed on comm. Superv. Or Treat.	Behavior(s):  Moderate	Behavior(s):  High	Behavior(s):  High	Behavior(s):  Moderate/High
<b>New Offenses (or refused exams)<sup>D</sup></b> Fel. Or Misd. Offenses after Being placed on comm. Superv. And/or treat.	Behavior(s):  Severe	Behavior(s):  Severe	Behavior(s):  Severe	Behavior(s):  High/Severe

\*\* IF SANCTIONING AT A HIGHER LEVEL THAN INDICATED ON THE GRID, PLEASE FILL OUT THE SANCTIONS OVERRIDE SECTION ON PAGE 4

## **FAILED POLYGRAPH SANCTIONS**

**Purposeful** non-cooperation will result in a re-test paid by the offender within 30 days with the same polygrapher unless deemed otherwise by the polygrapher or the supervision team.

---

Please check the sanction(s) employed:

**LOW:**

<input type="checkbox"/>	POLYGRAPH IN 3 TO 6 MONTHS – OFFENDER PAYS
<input type="checkbox"/>	ADDITIONAL HOMEWORK
<input type="checkbox"/>	CURFEW OR GEOGRAPHICAL RESTRICTIONS
<input type="checkbox"/>	ADDITIONAL COLLATERAL CONTACTS
<input type="checkbox"/>	CONTACT WITH OFFENDER'S SUPPORT NETWORK TO DISCUSS EXAM
<input type="checkbox"/>	START UA'S OR INCREASE FREQUENCY
<input type="checkbox"/>	ANTABUSE AND / OR SOBRIETER
<input type="checkbox"/>	INCREASE TREATMENT CONTACTS (INDIVIDUAL OR FAILED POLY GROUP)
<input type="checkbox"/>	OTHER: _____

**MODERATE:**

<input type="checkbox"/>	WEEKLY SCHEDULE
<input type="checkbox"/>	POLYGRAPH RE-TEST FREQUENCY INCREASED (OFFENDER PAYS)
<input type="checkbox"/>	INCREASED TREATMENT CONTACTS
<input type="checkbox"/>	INCREASED PROBATION VISITS
<input type="checkbox"/>	STAFFING WITH PO, THERAPIST AND OFFENDER (OFFENDER PAYS)
<input type="checkbox"/>	ADDITIONAL HOMEWORK
<input type="checkbox"/>	COMMUNITY SERVICE
<input type="checkbox"/>	DRUG / ALCOHOL TREATMENT, DV, OR ANGER MANAGEMENT
<input type="checkbox"/>	SEARCH RESIDENCE (IF REASONABLY RELATED TO INFORMATION GENERATED BY THE POLY REPORT OR OFFENDER'S ADMISSIONS)
<input type="checkbox"/>	NO TRAVEL PERMITS FOR VACATION
<input type="checkbox"/>	NO COMMUNITY ACTIVITIES
<input type="checkbox"/>	SPECIFIC SAFETY PLANS FOR COMMUNITY ACTIVITIES
<input type="checkbox"/>	ELECTRONIC MONITORING (EHM OR GPS)
<input type="checkbox"/>	ACCOUNTABILITY & CONTACT LOGS
<input type="checkbox"/>	CURFEW
<input type="checkbox"/>	INCREASE MONITORING & FIELD CONTACTS
<input type="checkbox"/>	NO DRIVING
<input type="checkbox"/>	I.D. SELF—CLOTHES / CAR
<input type="checkbox"/>	CONTRIBUTION TO VICTIM PROGRAM
<input type="checkbox"/>	DAY REPORTING
<input type="checkbox"/>	TECHNICAL VIOLATION BOARD
<input type="checkbox"/>	OTHER: _____

\*\* IF SANCTIONING AT A HIGHER LEVEL THAN INDICATED ON THE GRID, PLEASE FILL OUT THE SANCTIONS OVERRIDE SECTION ON PAGE 4

HIGH:

	WEEKLY SCHEDULE
	POINT TO POINT CALL INS
	TOTAL ACCOUNTABILITY (THROUGH TREATMENT PROGRAM)
	MORE INTENSIVE TREATMENT PROGRAM
	INCREASE SUPERVISION LEVEL OR REGRESSION
	INCREASE SUPERVISION TO SOISP WITH COURT ORDER
	CONTACT LAW ENFORCEMENT FOR SURVEILLANCE
	TECHNICAL VIOLATION BOARD
	POLYGRAPH RE-TEST FREQUENCY INCREASED (OFFENDER PAYS)
	COMMUNITY SERVICE
	WORKENDERS
	ELECTRONIC MONITORING (EHM OR GPS)
	CURFEW WITH DAILY SCHEDULE CALL IN
	I.D. SELF—CLOTHES/CAR
	NO TRAVEL PERMITS
	NO DRIVING
	COMBINATION OF LOW AND MODERATE SANCTIONS
	OTHER:

SEVERE

	POINT TO POINT CALL INS
	TOTAL ACCOUNTABILITY
	MOVE FROM HOME (WITH COURT ORDER)
	ELECTRONIC MONITORING (EHM OR GPS)
	MORE INTENSIVE TREATMENT/ACCOUNTABILITY PROGRAM
	DAY REPORTING
	HOME LOCKDOWN
	COMBINATION OF LOW, MODERATE & HIGH SANCTIONS
	OTHER:

Therapist: \_\_\_\_\_

Polygrapher: \_\_\_\_\_

Probation Officer: \_\_\_\_\_

Date form Complete: \_\_\_\_/\_\_\_\_/\_\_\_\_

Probationer: \_\_\_\_\_

\*\* IF SANCTIONING AT A HIGHER LEVEL THAN INDICATED ON THE GRID, PLEASE FILL OUT THE SANCTIONS OVERRIDE SECTION ON PAGE 4

**SANCTIONS OVERRIDE:** \_\_\_\_\_ Multiple similar violations and / or deceptions to high risk behaviors or offenses. (OVERRIDE TO NEXT HIGHEST SANCTION)  
(Please Mark Only One Result)

\_\_\_\_\_ History of sadistic or lethal behavior / offenses.  
(OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

\_\_\_\_\_ Sabotage exam. (OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

\_\_\_\_\_ Other:  
\_\_\_\_\_ (OVERRIDE TO THE NEXT HIGHEST SANCTIONS)

**EXAM QUESTIONS:**

Question1: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Non-deceptive / Deceptive / Inconclusive / Sabotage

Question2: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Non-deceptive / Deceptive / Inconclusive / Sabotage

Question3: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Non-deceptive / Deceptive / Inconclusive / Sabotage

Question4: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Non-deceptive / Deceptive / Inconclusive / Sabotage

**Follow-up Questions:**

Question1: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Question2: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\* IF SANCTIONING AT A HIGHER LEVEL THAN INDICATED ON THE GRID, PLEASE FILL OUT THE SANCTIONS OVERRIDE SECTION ON PAGE 4

Question3: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Question4: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\* IF SANCTIONING AT A HIGHER LEVEL THAN INDICATED ON THE GRID, PLEASE FILL OUT THE SANCTIONS OVERRIDE  
SECTION ON PAGE 4