Treatment Completion Guidelines

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California Sex Offender Management Board
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Treatment Completion Guidelines

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1. Introduction

The need for California-specific criteria to determine when sexual offense specific treatment has been "completed" for Penal Code 290 Registrants led the California Coalition On Sexual Offending (CCOSO) to create a Treatment Completion Criteria Work Group.

The CCOSO has generously made its Treatment Completion Guidelines available to CASOMB. The members of the CCOSO Treatment Completion Criteria Workgroup are, deservedly, acknowledged here:

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The CCOSO Work Group considered numerous treatment completion criteria and checklists utilized throughout the nation. There is no well-established model that meets California's needs, but there is considerable consistency in the treatment completion materials reviewed.

The CCOSO Work Group's goal in creating Treatment Completion Guidelines is to help sex-offender-specific treatment providers evaluate a client's progress and success in meeting the goals and objectives of his or her treatment plan - a treatment plan which is designed to identify and reduce risk factors for re-offense, increase lifestyle stability, and foster prosocial behaviors. This intention is identical to that of the Adult Practice Guidelines by the Association for the Treatment of Sexual Abusers (ATSA, 2014).

The result of these guidelines is a useful tool that will help treatment providers and others involved in sex offender management make good case management decisions that acknowledge the importance and benefit of successful treatment completion.

This tool will help California's systems of sex offender management achieve their ultimate goal: reduce sexual recidivism so that children, women and men do not become future victims of sexual abuse.

2. Application to California Statutes

California has implemented structures and requirements to reduce the re-offense risk of registered sex offenders. State law establishes that all registrants on state parole or county probation be managed within the "Containment Model" and required to enter and successfully complete a sex offender treatment program certified by CASOMB.

Much of this change was the result of Assembly Bill 1844, more commonly known as "Chelsea's Law." Enacted in 2010, created language in the California Penal Code which underscores the importance of determining whether an individual has successfully "completed treatment", *bold underline emphasis added*.

SELECTED PORTIONS OF THE CALIFORNIA PENAL CODE

1203.067. (b) (2) Persons placed on formal probation on or after July 1, 2012, **shall successfully complete** a sex offender management program, following the standards developed pursuant to Section 9003, as a condition of release from probation. The length of the period in the program shall be not less than one year, up to the entire period of probation, as determined by the certified sex offender management professional in consultation with the probation officer and as approved by the court.

3008. (d) (2) Persons placed on parole on or after July 1, 2012, **shall successfully complete** a sex offender management program*, following the standards developed pursuant to Section 9003, as a condition of parole. The length of the period in the program shall be not less than one year, up to the entire period of parole, as determined by the certified sex offender management professional in consultation with the parole officer and as approved by the court.

9003. (b) On or before July 1, 2011, the board [*CASOMB*] shall develop and update standards for certification of sex offender management programs, which shall include treatment, as specified, and dynamic and future violence risk assessments pursuant to Section 290.09. The standards shall be published on the board's Internet Web site.

("management program" in the above Penal Code sections is understood to mean the "treatment program.")

For purposes of the CASOMB Sex Offender Treatment Program Requirements the term "successful treatment completion" is defined as having "demonstrated sufficient progress in meeting the goals and objectives of an individualized treatment plan" at the time of release from treatment. When the client has successfully completed treatment he or she shall receive a statement of successful treatment completion. Provider agencies will submit a copy of the statement to CASOMB and to the supervising agency, if any.

Treatment completion does not mean that the client has successfully completed the sex offender management program. When active treatment ends, supervision and other elements of the Containment Model may continue. These elements may include, but are not limited to, monitoring, follow up sessions, aftercare meetings, polygraph testing, risk assessments, and other services which may be required as part of a sex offender management program, i.e. CASOMB Sex Offender Treatment Provider Agency Certification Requirements.

3. Guiding Principles

The following basic principles frame the assessment of successful treatment completion.

1. Appropriately-designed and well-delivered specialized sex offender treatment is widely accepted as an effective, evidence-based method for reducing the risk of future sexual offending of those who have committed a sexual offense.

2. Treatment is viewed as a set of structures, tools, and procedures to support, motivate, and guide each offender's self-change process so that the risks of reoffending are reduced. Thus, a determination that someone has "completed" treatment is not a guarantee that that person will never reoffend, has no risk of reoffending, or will not have an increase in such risk in the future.

3. Research clarifies that simply attending a treatment program does not elicit the beneficial outcome. Program participants who are successful in meeting treatment objectives (those who "got it") reoffend less frequently and less severely than those who are not successful in meeting objectives (those who "didn't get it"). This highlights the importance of treatment engagement [Marques, J. K., Wiederanders, M., Day, D. M., Nelson, C., & van Ommeren, A. 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*, Jan. 2005, V. 17, 1, 79–107].

4. Collaboration, consistent terminology, and understanding the larger framework within which treatment completion is considered are essential to effectively intervene in the problem of sexual offending. Treatment is one component of the Containment Model. Readers are referred to Requirement 10 in the CASOMB Sex Offender Treatment Provider Agency Requirements.

5. "Successfully completing treatment" means the client has sufficiently attained the identified skills and lifestyle changes necessary to adequately manage his or her risk factors and foster resiliencies and additional protective factors that lower the risk of recidivism. The larger body of general offender outcome research, summarized as the Risk-Needs-Responsivity principles, indicates that treatment length and intensity should take into account the individual offender's degree of risk, unique "criminogenic needs" (risk factors), and learning style. Therefore, for high-risk offenders and those with high levels of criminogenic needs, treatment will be more intense and of longer duration than that delivered to low-risk offenders, with low levels of criminogenic needs.

6. Validated, evidence-based, applicable instruments or scales for determining treatment completion are not currently available within the field of sexual offender treatment.

7. In the absence of a sufficiently validated empirically based instrument, research suggests it is better to rely upon a framework for "structured clinical judgment" using agreed-upon criteria to guide decision making rather than relying on unstructured clinical judgment.

8. Treatment completion is most appropriately viewed as lying along a continuum rather than existing as a dichotomous variable. Yet, the determination by the treatment provider must be either yes or no. The challenges posed by this expectation are managed by use of a clear set of structured clinical judgment criteria.

9. The 2014 Adult Practice Guidelines developed by the Association for Treatment of Sexual Abusers (ATSA) represent general consensus among experts in the field of sexual offender treatment and are a useful guide in developing treatment completion guidelines.

10. California Treatment Completion criteria must take into account parameters and requirements imposed by California state law.

11. Using a widely-accepted method incorporating industry standards and guidelines assures providers they are adhering to best practice standards.

12. The items to be reviewed when determining whether treatment has been completed are an organized list of profession and research-supported factors that can guide structured clinical judgment. What is offered here is not a scorable instrument, scale or tool. No suggestions are made regarding exactly how the listed considerations are to be rated, scored, or weighted by the treatment provider.

13. Future research may identify new factors and provide evidence that some of the items listed are not as important as thought to be at the time of this paper. The provider is responsible for incorporating contemporary research in determining treatment completion, without changing the items on the worksheet (Appendix A).

14. Completion criteria should take into account the expectations imposed by California's *State Authorized Risk Assessment Tools for Sex Offenders* (SARATSO) Committee which specifies that certain dynamic risk assessment instruments be used to assess each individual directed to treatment. SARATSO has selected dynamic risk assessment tools specific to assessing risk of sexual recidivism and for future violence risk assessment. Consequently, treatment completion criteria would be expected to take into consideration these instruments.

15. Discharge planning starts at intake. The final determination regarding whether an individual has "completed" treatment should never come as a surprise to the client. Regular reviews of progress in which the treatment provider and client collaborate about the nature, goals, and objectives of treatment along with the criteria for assessing progress and completion are necessary.

16. Treatment "completion" is conceptualized as a "protective factor". Protective factors are associated with reduced risk. In the real world, many obstacles emerge which can make it difficult for an individual to successfully acquire the protective factor "successful treatment completion". These obstacles include, but are not limited to, circumstances such as ill health, infirmity, financial issues, impediments to travelling to the treatment setting, cognitive disabilities, mental illness, physical disabilities, and periods of incarceration or other interruptions in treatment participation. In many cases, these circumstances are not caused by or under the control of the individual whose treatment engagement is impacted by them. In some circumstances obstacles make it impossible for the impacted individual to successfully complete treatment, and may require on-going maintenance treatment.

17. It is important to routinely incorporate measures of criminogenic needs, variably referred to as stable risk factors, psychological risk factors and long term vulnerabilities, using research-supported tools and inventories, specialized behavioral and psychophysiological tools, objective records, and information obtained from the Containment Team, collateral contacts, and the client's self-report.

18. When assessing for treatment completion, do not rely solely on one assessment instrument. Refer to Appendix B for common tools assessing known criminogenic needs.

19. Criteria strive to simultaneously take into account two important dimensions: adequacy and improvement in a particular area. Progress and change are necessary, but reduction in an acceptable risk level is the ultimate goal. Some individuals with high levels of risk may cease treatment without having "successfully completed". For example because their supervision period has ended or because they cannot afford the cost of treatment they might discontinue treatment prior to "successful completion".

20. Although provider agencies are free to add any components or documentation requirements they wish in the manner they choose, the determination of treatment completion is not the same as a "Discharge Summary." The goal is to provide a tool to structure and guide a clinician's thinking in order to arrive at a YES-or-NO conclusion about whether treatment has been completed. The intent is not to impose additional service requirements, program components, or excessive documentation burdens on programs and providers.

21. CASOMB has the authority to conduct audits of certified provider agencies. One focus of such audits will be the provider agency's decision process for determining treatment completion and the provider agency's outcomes using that process.

5. Structured Clinical Approach

The Treatment Completion Guidelines list the components of a system for applying a "structured clinical judgment" approach to determine whether treatment has been "completed."

Structuring clinical judgment according to professional guidelines is a more reliable method of making clinical determinations than unstructured clinical judgment. "Structured" in this case means determining the global final judgment about treatment completion by considering a number of previously determined components (referred to as Factors or Dimensions).

Note that the approach suggested here does not provide, offer, or indicate the use of any numerical, "scoring," or weighting system of factors listed.

Provided is a list of areas and factors that shall be considered when determining successful treatment completion. Clinician's rate the factor as not met, partially met, or met. This information structures the clinician's professional judgment, leaving it to the clinician to determine how these multiple considerations are best combined into a specific final decision about whether the individual being evaluated has "completed" treatment. For example, one factor might not be met, but it is not relevant to the client at hand, whereas another factor might be met that is more salient than other factors met. In short, there are no rules to rating, weighting, or combining factors.

At the end of this document, in Appendix A, is the Treatment Completion Worksheet form to help organize the clinician's professional determination of successful treatment completion. The clinician can include "NOTES" to help track the determinations for each of the factors. The notes can also be helpful should the determination be questioned at a later time.

Section One: Cooperation with Treatment

1. Attendance and External Compliance with Treatment Expectations *
2. Duration of Treatment
3. Effort and Active Participation in Treatment **
4. Ownership of Actions
5. Attainment of Treatment Goals

Section Two: Criminogenic Needs

6. Self-Management Domain
7. Social Involvement Domain
8. Sexuality Domain
9. Attitudes, Schemas and Beliefs Domain
10. General Criminality Domain

Section Three: Additional Considerations

11. Risk Level
12. Individual Factor(s)
13. Predicted Trajectory
14. Containment Team Judgment

6. Treatment Completion Guidelines

Item	Description [Only brief statements are provided. It is assumed that treatment providers and programs will be sufficiently familiar with the following domains and dimensions and their discussion in the literature to be able to apply them to the case being evaluated.]
Section One: **Cooperation with Treatment**	These factors focus on the individual's basic stance toward and performance in the treatment program. Unless there is good evidence that these basic elements are solidly in place, it would be difficult to determine that treatment has been "completed."
1. Attendance and External Compliance with Treatment Expectations *	After a period of settling into treatment, has the individual been regular in attendance, generally punctual, and responsible in handling acceptable absences with advance notification? After a period of settling into treatment, have there been few or no instances of needing parole or probation supervisor support in enforcing attendance? After a period of settling into treatment, has the individual demonstrated sufficient acceptance of the framework and rules around treatment and satisfactorily followed program rules?
2. Duration of Treatment	Has the individual completed a treatment program of not less than one year, or up to the entire period of supervision? (PC 1203.067 and 3008. (d) (2))
3. Effort and Active Participation in Treatment *	Does the individual take an active role in his or her own treatment? Examples: speaks up in sessions without prompting; offers statements of self-disclosure; focuses on relevant issues; completes homework without special prompting; offers useful feedback to others in a group setting. Does the individual consistently demonstrate sufficient effort, meaningful treatment engagement, directed toward meeting treatment goals and changing problematic patterns of thought and behavior?
4. Ownership of Actions	Does the individual clearly and consistently demonstrate a sense of "agency," and responsibility for his or her own personal decisions and behaviors in the treatment setting and in his or her current life? In most cases this would include taking responsibility for offending behavior. Does the individual accept having a set of problems, issues, and criminogenic treatment "needs?" Is he or she generally able to identify and take ownership of corresponding treatment goals? (Such an "ownership" or "agency" stance is in contrast with client statements such as "it just happened" or "circumstances or the actions of others are what really led to my problems.") However, criminogenic factors can be addressed in treatment without an individual acknowledging the full extent of which the person was accused.
5. Attainment of Treatment	Has the individual made sufficient progress with the goals on his or her treatment plan?

SECTION TWO: **Criminogenic Needs** *[A condensed list of the research-supported factors which should be considered when evaluating progress and current status in each of the five Domains can be found in Appendix B.]*	In accord with the "Need Principle," the focus of specialized sex offender treatment is to address the changeable aspects of the participant's life that have predisposed him/her to sexual offending. These are summarized in the research literature by accepted dynamic risk assessment instruments. A large number of different criminogenic needs have been identified, that can be classified within four overarching "Domains."** These are: • The Self-Management or Self-Regulation Domain • The Social Involvement Domain • The Sexuality Domain • The Attitudes or Belief System Domain In addition, because there is an expectation that specialized sex offender treatment will also address and reduce general criminal recidivism, a fifth domain is included: • General Criminality Domain **Within Each Domain, Evidence For Success And Progress Should Be Evaluated Along Four Dimensions. ***** 1. Understanding dimension – understands the key concepts related to this domain. 2. Acceptance dimension – accepts the values and desired core attitudes related to this domain. 3. Behaviorally-evidenced in sessions dimension – actions in group and individual sessions show that efforts to change behaviors in this domain are succeeding. 4. Behaviorally-evidenced in daily life dimension – disclosures in group and individual sessions along with information from outside sources show that efforts to change behaviors in this domain are succeeding.
Criminogenic Needs 6. Self-Management Domain	General self-regulation problems; Lifestyle Impulsiveness; Impulsivity; Recklessness; Dysfunctional Coping; Sexualized Coping; Poor Problem Solving Skills; Emotional Control; Emotion Management; Negative Emotionality; Dysfunctional Self-Evaluation; Substance Abuse; Insight; Sexual Risk Management.
Criminogenic Needs 7. Social Involvement Domain	Social Involvement; Social Influences; Community Support; Relationships with Adults; General Social Rejection; Negative Social Influences; Lack of Emotionally Intimate Relationships with Adults; Intimacy Deficits; Capacity for Relationship Stability; Conflicts in intimate Relationships; Emotional Congruence with Children; Employment Instability; Residence; Finances; Mental Health Stability.
Criminogenic Needs 8. Sexuality Domain	Sexual Preoccupation; Sexual Compulsivity; Sex Drive; Sex as Coping; Any Deviant Sexual interest; Multiple Paraphilias; Sexually Deviant lifestyle; Sexual Preference for Children; Sexualized Violence; Persistence and Rapidity of Sexual Offending; Sexual Behavior; Sexual Attitudes; Sexual Offending Cycle.
Criminogenic Needs 9. Attitudes, Schemas and Beliefs Domain	Acceptance of Responsibility; Cognitive Distortions; Offense-supportive Attitudes; Child Abuse Supportive Beliefs; Excessive Sense of Entitlement; Lack of Concern for Others; Callousness; Machiavellianism; Adversarial Sexual Attitudes; Hostility Toward Women; Deceitful Women; Emotional Congruence with Children; Externalizing; Grievance/hostility; Grievance Thinking.

Criminogenic Needs 10. General Criminality Domain	Criminal and Rule-Breaking Attitudes; Criminal and Rule-Breaking Behavior; Criminal Personality; Interpersonal Aggression; Offence Planning; Cooperation with Supervision; Compliance with Community Supervision; Resistance to Rules and Supervision; Cooperation with Treatment; Treatment Compliance; Stage of Change; Admission of Offense Behavior; Substance Abuse; Any other LS/CMI factors.

Section Three: **Additional Considerations**	Other justifiable considerations should be utilized in determining whether treatment has been "completed."
11. Risk Level	What is the level of risk as determined by an administration of the STABLE-2007 (or equivalent instrument) within the last six months (or at least within the last year) and with consideration of his Static-99R risk score? [See Guiding Principle 17 above.]
12. Individual Factor(s)	Examples: Is there a particular risk-related barrier that this individual has addressed and sufficiently overcome? Has there been a new arrest or charge for a sex offense within the last year or has there been a violation of supervision conditions or an incident of other behavior which appears related to or suggests active interest in sexual offending? Is there something about this individual and his or her history in treatment which should be considered as an additional factor? Has the individual's prosocial and compliant behavior been corroborated recently (within the past year) by a passed Polygraph (e.g., Maintenance Test)? There may be reasons why the individual did not take or pass a polygraph examination, that may not be related to risk. Has the individual created a satisfactory Safety Plan? Has the individual identified, accepted, made use of and built upon areas in which he or she demonstrates relevant "Strengths" and/or "Resiliencies"? Does this individual have a realistic plan for "aftercare"?
13. Predicted Trajectory	Is there sufficient evidence to support the belief that this individual will, after treatment ends, continue to make changes in his life in the desired direction? How long has the individual been in the community without reoffense?
14. Containment Team Judgment	Do other members of the Containment Team support the determination that treatment has been successfully completed? Refer to the process described in the CASOMB Provider Agency Requirements on page 24.

** Given the context and nature of sex offender treatment, it is common that a referred individual initially exhibits resistance and non-compliance. Behaviors during that initial period of understanding and accommodating to treatment expectations should not be heavily weighed when making overall ratings*

******* *When applying these guidelines to a particular individual, identify and focus on those particular dynamic risk factors within each Domain which are salient for the individual being evaluated. It is to be expected that those factors will have been previously identified in the individual's Treatment Plan.*

**** Derived from McGrath's "Sex Offender Treatment Intervention and Progress Score" (SOTIPS) system.*

Appendix A.

Treatment Completion Worksheet

The following document is the treatment completion worksheet, which has been provided to aid clinicians with the organization of their professional determination of successful treatment completion.

Treatment Completion Worksheet

Client Name:	Client DOB:
Client CII #:	Client SSN:
Clinician Name:	Assessment Date:

AREA FOR CONSIDERATION		NOTES
Section One: Cooperation With Treatment		
1. Attendance & External Compliance with Treatment Expectations	☐ Not Met ☐ Partially Met ☐ Met	
2. Duration of Treatment	☐ Not Met ☐ Partially Met ☐ Met	
3. Effort and Active Participation in Treatment	☐ Not Met ☐ Partially Met ☐ Met	
4. Ownership of Actions	☐ Not Met ☐ Partially Met ☐ Met	
5. Attainment of Agreed-upon Treatment Goals	☐ Not Met ☐ Partially Met ☐ Met	
Section Two: Criminogenic Needs		
6. Self-management Domain	☐ Not Met ☐ Partially Met ☐ Met	
7. Social Involvement Domain	☐ Not Met ☐ Partially Met ☐ Met	
8. Sexuality Domain	☐ Not Met ☐ Partially Met ☐ Met	
9. Attitudes, Schemas and Beliefs Domain	☐ Not Met ☐ Partially Met ☐ Met	
10. General Criminality Domain	☐ Not Met ☐ Partially Met ☐ Met	
Section Three: Additional Considerations		
11. Risk Level Initial Level/Current Level (Static-99R & Stable-2007 Combined)	Initial Risk Level ☐ I – Very Low Risk ☐ II – Below Average Risk ☐ III – Average Risk ☐ IVa – Above Average Risk ☐ IVb – Well Above Average Risk	Current Risk Level ☐ I – Very Low Risk ☐ II – Below Average Risk ☐ III - Average Risk ☐ IVa – Above Average Risk ☐ IVb – Well Above Average Risk
12. Individual Factor(s)		
13. Predicted Trajectory		
14. Containment Team Judgment		

With consideration of the results of this Treatment Completion Worksheet has the person completed treatment? ☐ **Yes, Successful Completion** ☐ **No, Treatment was Not Completed**

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Appendix B.

Research-Supported Criminogenic Needs For Sex Offender

The following table includes items from several common need assessment instruments and also the meta-analysis on need factors categorized by domain. The table will assist users of any of these instruments in identifying which treatment completion domain individual instrument items correspond.

SRA: Structured Risk Assessment-Forensic Version

VRS-SO: Violence Risk Scale Sex Offender Version

SOTIPS: Sex Offender Treatment Intervention and Progress Scale

Stable-2007: Stable, 2007 version

MHT: Mann, Hanson, & Thornton meta-analysis

Research-Supported Criminogenic Needs for Sex Offenders

(Grouped into five major "Domains")

I. Self-Regulation – Self-Management Domain

General self-regulation problems (MHT *)
Lifestyle Impulsiveness (SRA)
D 13 Impulsivity (VRS-SO)
Impulsivity (SOTIPS)
Impulsive (STABLE-2007)
Impulsivity, recklessness (MHT)
(P) Dysfunctional coping (MHT)
Dysfunctional Coping (SRA)
(P) Sexualized coping (MHT)
Poor Problem Solving Skills (STABLE-2007)
Problem Solving (SOTIPS)
Poor cognitive problem solving (MHT)
D7 Emotional control (VRS-SO)
Emotion Management (SOTIPS)
Negative Emotionality (STABLE-2007)
Dysfunctional Self-Evaluation (SRA)
Substance Abuse (SOTIPS)
D9 Substance abuse (VRS-SO)
D8 Insight (VRS-SO)
Sexual Risk Management (SOTIPS)

II. Social Involvement Domain

Social Involvement (SOTIPS)
Social Influences (SOTIPS)
Significant Social Influences (STABLE-2007)
D10 Community support (VRS-SO)
Relationships with Adults (SRA)
General Social Rejection (STABLE-2007)
Negative social influences (MHT)
Adult Love Relationship (SOTIPS)
Lack of Emotionally Intimate (SRA)
Lack emotionally intimate relationships w adults (MHT)
D 17 Intimacy deficits (VRS-SO)
Conflicts in intimate relationships (MHT)
Emotional congruence with children (MHT)
Employment (SOTIPS)
Employment Instability (MHT)
Residence (SOTIPS)
Finances (SOTIPS)
Mental Health Stability (SOTIPS)
Capacity for Relationship Stability (STABLE-2007)

III. Sexuality Domain

Sexual Preoccupation (SRA)
D2 Sexual compulsivity (VRS-SO)
Sexual preoccupation (MHT)
Sex Drive - Sex Preoccupation (STABLE-2007)
Sex as Coping (STABLE-2007)
Any deviant sexual interest (MHT)
Multiple paraphilias (MHT)
D 16 Deviant sexual preference (VRS-SO)
Deviant Sexual Preference (STABLE-2007)
D I Sexually deviant lifestyle (VRS-SO)
Child Preference (SRA)
Sexual preference for children (PPG) (MHT)
Sexual Interests (SOTIPS)
Sexualized violence (MHT)
Sexualized Violence (SRA)
Sexual Behavior (SOTIPS)
Sexual Attitudes (SOTIPS)
D 12 Sexual offending cycle (VRS-SO)

IV. Attitudes, Schemas and Beliefs Domain

Acceptance of Responsibility (SOTIPS)
D5 Cognitive distortions (VRS-SO)
Offense-supportive attitudes (MHT)
Child Abuse Supportive Beliefs (SRA)
Excessive Sense of Entitlement (SRA)
Lack of Concern for Others (STABLE-2007)
(P) Callousness/lack of concern for others (MHT)
Callousness (SRA)
Machiavellianism (SRA)
(P) Machiavellianism (MHT)
Adversarial Sexual Attitudes (SRA)
(P) Hostility toward women (MHT)
Hostility toward Women (STABLE-2007)
Deceitful Women (SRA)
Emotional Congruence with Children (SRA)
Emotional ID with Children (STABLE-2007)
(P) Externalizing (MHT)
Grievance/hostility (MHT)
Grievance Thinking (SRA)

V. General Criminality Domain

Criminal and Rule-Breaking Attitudes (SOTIPS)
Criminal and Rule-Breaking Behavior (SOTIPS)
D4 Criminal personality (VRS-SO)
D6 Interpersonal aggression (VRS-SO)
D3 Offense planning (VRS-SO)
Cooperation with Community Supervision (SOTIPS)
Co-operation with Supervision (STABLE-2007)
D 14 Compliance w community supervision (VRS-SO)
Resistance to rules and supervision (MHT)
Cooperation with Treatment (SOTIPS)
D15 Treatment compliance (VRS-SO)
Stage of Change (SOTIPS)
Admission of Offense Behavior (SOTIPS)

* "MHT" Refers to Mann, R., Hanson, R.K., Thornton, D., [2010] Assessing Risk for Sexual Recidivism: Some Proposals on the Nature of Psychologically Meaningful Risk Factors. *Sexual Abuse: A Journal of Research and Treatment.* 22: 191-217 (P) = Promising

Appendix C.

Statement of Successful Treatment Completion

The following document is the statement of successful treatment completion, which has been provided to aid clinicians with the organization of their professional determination of successful treatment completion.

Statement of Successful Treatment Completion

This document verifies that the individual named below successfully completed the requirements of treatment at the California Sex Offender Management Board Certified Provider Agency named below.

Client Name:	Client Date of Birth: MM/DD/YYYY
Client CII #:	Client SSN:
Provider Agency Name:	
Provider Agency City:	Provider Agency Zip Code:
Independent Provider Name:	Provider Cert #:

Treatment was completed on:

Click here to enter a date.

_____

CASOMB Certified Independent Provider Signature

One original signed, and Two (2) copies of this document should be completed and a copy is to be provided to the following: One (1) original to the Supervising Agency, One (1) copy to the Client, One (1) copy to the Provider Agency File.

Note: For purposes of the CASOMB Sex Offender Treatment Provider Agency Requirements the term “successful treatment completion” is defined as having “demonstrated sufficient progress in meeting the goals and objectives of an individualized treatment plan” at the time of release from treatment. When the client has successfully completed treatment he or she shall receive a statement of successful treatment completion. Provider agencies will submit a copy of the statement to the supervising agency, if any. Treatment completion does not mean that the client has successfully completed the sex offender management program, or that the client will never reoffend. When active treatment ends, supervision and other elements of the Containment Model may continue. These elements may include, but are not limited to, monitoring, follow up sessions, aftercare meetings, polygraph testing, risk assessments, and other services which may be required as part of a sex offender management program, i.e., CASOMB Sex Offender Treatment Provider Agency Certification Requirements.

KEEP THIS DOCUMENT
The client is required to keep this document until such time that he or she is no longer required to register.