California Coalition On Sexual Offending

TREATMENT COMPLETION CONSIDERATIONS

Assessing "Treatment Completion"

2016

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Coalition members represent law enforcement, criminal justice, mental health, probation, parole, and other community services. Members are dedicated to addressing complex issues related to sex crimes and sexual deviance. If you are interested in joining CCOSO you may apply on our website:

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California Coalition On Sexual Offending – CCOSO

TREATMENT COMPLETION CONSIDERATIONS

Assessing "Treatment Completion"

INTRODUCTION

The need for California-specific criteria to determine when treatment has been "completed" for Penal Code (PC) 290 Registrants, who have participated in a sex offender treatment program, has led to the creation of the Treatment Completion Criteria Work Group under the auspices of the California Coalition On Sexual Offending (CCOSO). The efforts of the Work Group have resulted in this document.

The CCOSO Work Group took into consideration a sampling of treatment completion criteria and checklists used in numerous programs throughout the nation. Although no well-established and readily-adoptable model was identified which would meet California's needs, considerable consensus was found among the criteria reviewed.

The approach provided here is put forth as the recommended California model for adult community-based sex offender treatment programs when determining treatment completion.

The CCOSO Work Group's intention in providing guidelines is identical to that of the 2014 Adult Practice Guidelines published by the Association for the Treatment of Sexual Abusers (ATSA): to help sex-offender-specific treatment providers evaluate a client's progress in meeting the goals and objectives of his or her treatment plan - a treatment plan which is designed to reduce identified risk factors for re-offense and increase stability along with prosocial behaviors.

In developing these guidelines, the goal was to create 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.

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

CONTEXT

California has made substantial progress toward implementing structures and requirements to reduce the re-offense risk of registered sex offenders. State law has established that all registrants on parole or probation be managed within the "Containment Model" and be required to enter and complete a sex offender treatment program certified by the California Sex Offender Management Board (CASOMB).

Much of this change was the result of AB1844, commonly known as "Chelsea's Law," which was enacted in 2010 and which created the following language in the California Penal Code. (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.

(Note that "management program" in the above Penal Code sections is understood to convey the same meaning as "treatment program.")

Given these changes and the possibility that future changes to California's current universal lifetime registration policies (PC 290) may create a tiered registration system in which completion of treatment could become a factor for consideration in relief of registration, the determination regarding whether an individual has indeed "completed treatment" is increasingly important. Consequently, some common understanding of the meaning of "treatment completion" and agreement on the criteria for determining whether any particular individual has actually completed treatment are of utmost importance.

GUIDING PRINCIPLES AND ASSUMPTIONS

The following basic understandings frame the discussion of 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 by those who have committed a sexual offense.

2. Sex offender treatment, no matter how well delivered and well received, should not be seen as providing a guarantee that the treatment participant will never commit another sexual crime. Treatment should be 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. A determination that someone has "completed" treatment cannot be viewed as a guarantee that that person will never reoffend or has no risk of reoffending.

3. Some important research has clarified that simply being "in" a treatment program does not guarantee a beneficial outcome. There is a distinction between program participants who are successful in treatment (who "got it") and those who are not ("didn't get it"). This means that those who meaningfully engage in treatment change more than those who superficially participate in the treatment process. [Marques, J. K., Wiederanders, M., Day, D. M., Nelson, C., & van Ommeren, A. (2005)].

4. An individual has completed treatment when he or she has sufficiently attained the necessary skills and lifestyle changes to reduce the intensity of his or her risk factors and foster resiliencies and additional protective factors that lower the risk of recidivism. The body of 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, learning style, and unique criminogenic needs. Therefore, for low-risk offenders, with low levels of criminogenic needs, treatment should be much less intense and of shorter duration than that for high-risk offenders and those with high levels of criminogenic needs.

5. Universally-accepted, validated, evidence-based instruments, scales, and systems for determining treatment completion are not currently available within the entire field of sex offender treatment.

6. It is preferable for providers to organize their decisions around a set of criteria provided by a professional guild than to simply make such decisions independently with no generally-accepted guiding framework. Using a widely accepted method incorporating industry standards and guidelines assures providers they are adhering to best practice standards.

7. Following the research-based best practices in the area of sex offender risk assessment, it is better to provide a framework for a "structured" approach using agreed-upon criteria to guide decision making rather than relying on unstructured clinical judgment.

8. Considering the state of the art of sexual offender risk assessment, treatment completion can at best be viewed as lying along a continuum rather than existing as a dichotomous (YES or NO) variable. Yet, to meet the goal of making a statement regarding whether a particular individual has been sufficiently successful in the treatment process to merit a "completed" designation, the determination by the treatment provider must be either "Yes" or "No." The challenge posed by this expectation can be reasonably managed by use of a clear set of criteria rather than the idiosyncratic unstructured judgment of individual providers.

9. Guidance in developing criteria is found in the 2014 Adult Practice Guidelines developed by the Association for Treatment of Sexual Abusers (ATSA). Since those guidelines are framed in more general terms, they are not sufficiently specific for immediate practical use and they do not attempt, of course, to take into consideration issues raised by laws and regulations which must be followed in California. (See the excerpt from those Guidelines in the box below.)

10. Treatment completion criteria must take into account any parameters and requirements imposed by state law.

11. Each CASOMB Certified Treatment Program is currently required to have a statement in its Program Manual which addresses the issue of treatment completion. (cf. "Requirement 2. Basic Operating Policies and Practices – 6. Policies and criteria for program completion and graduation.) CASOMB has not further specified how this requirement is to be met but has left the articulation of such a statement to each program.

12. Completion criteria should take into account the expectations imposed by California's *State Authorized Risk Assessment Tools for Sex Offenders* (SARATSO) Committee which specified that certain dynamic risk assessment instruments be used to assess each individual directed to treatment. SARATSO has selected the STABLE-2007/ACUTE-2007 as the dynamic risk assessment tools specific to assessing risk of sexual recidivism and the Level of Service/Case Management Inventory (LS/CMI) for future violence risk assessment. Consequently, treatment completion criteria would be expected to take into consideration both of these instruments. [Adult Practice Guidelines developed by the Association for Treatment of Sexual Abusers (2014)]

13. A final determination regarding whether an individual has "completed" treatment should never come as a surprise to the client. Therefore it must be linked to regular reviews of progress in which the treatment provider and client have discussed the nature, goals, and objectives of treatment, in addition to the criteria used for assessing progress and determining treatment completion. The client's individual treatment plan should be used to guide treatment, should be developed in conjunction with the client, and should be regularly

reviewed with the client. The treatment plan should be used to track progress as measured by observable changes or lack of changes in factors associated with risk to recidivate.

14. Treatment "completion" is best viewed as a "protective factor." The presence of a recognized protective factor is viewed as associated with reduced risk. In the real world, many obstacles can emerge which make it very difficult for an individual to successfully acquire the desired protective factors attained by satisfactorily completing a treatment program. Such obstacles can include factors such as poor health, financial issues, distance from a certified program, low or impaired cognitive functioning, periods of incarceration which interrupt treatment participation, and similar obstacles to sufficient engagement in and successful completion of treatment. These types of issues are, in many cases, not the fault of nor in any way under the control of the individual whose treatment engagement is impacted by them. Nevertheless, they make it impossible for the impacted individual to successfully complete treatment. Therefore, despite the presence of challenges which may make it difficult for a particular individual to attain a "completed treatment" rating, such reasons for non-completion cannot be taken into account when assessing whether the protective factor resulting from successful treatment participation and completion is actually solidly in place. They cannot be viewed as excuses for failing to meet the standards for treatment completion. Either the individual being assessed has met the standards for treatment completion so that the protective factor can be judged to be in place or – for whatever reason – has not.

15. It is important to incorporate, on a routine basis, measures of criminogenic need factors, often referred to as stable risk factors or long term vulnerabilities. Such considerations should be based upon research-supported tools and inventories including state-mandated risk assessment instruments, specialized behavioral and psychophysiological tools, objective records, information obtained from the Containment Team, and information from collaterals as well as the client's self-report. Also, the client's individual treatment plan should be reviewed with the client on a regular and ongoing basis and treatment progress should be measured by observable changes or lack of change in treatment goals associated with risk to recidivate.

16. It could be argued that the only legitimate dimensions which should be considered in assessing treatment completion are the research-supported criminogenic needs identified in instruments such as the STABLE-2007, the Structured Risk Assessment-Forensic Version (SRA-FV), the Violence Risk Scale for Sex Offenders (VRS-SO), or the Sex Offender Treatment Intervention and Progress Scale (SOTIPS). A stronger argument could be made that these instruments identify considerations which are necessary but not sufficient factors for use in determining treatment completion. It should also be noted that, when each is analyzed separately, none of the accepted dynamic risk instruments (STABLE-2007, SRA-FV, VRS-SO, SOTIPS) actually consider <u>all</u> of the stable risk factors identified in the research. For example, neither the SRA-FV nor the STABLE-2007 include attitudes and cognitive distortions supportive of sexual offending.

17. It is difficult to have a set of criteria which simultaneously takes into account two important dimensions: adequacy in a particular area vs. improvement in a particular area. An example sometimes used in the larger arena of goal attainment scaling and other progress measures is as follows. Two comparable people in a weight loss program may each lose 50 pounds. One ends up weighing a healthy 165 pounds. The other ends up weighing an unhealthy 265 pounds. Is it progress and change which is key, or absolute risk level? Good will, cooperation, effort, progress toward treatment goals are admirable and commendable but may leave some individuals with high levels of risk when they come to the "end" of treatment. There is much more work needed on their part to reduce their risk, even though they may not choose to or be able to do such work because their supervision period has ended or because they cannot afford the cost of treatment.

18. It is not the goal of the Work Group to create a set of criteria for treatment completion and then impose new requirements or tasks on any program. CCOSO has no direct authority to do so. The California Sex Offender Management Board, although it does have such authority, has been very restrained in setting specific programming requirements but requires that programs develop their own based on and supported by the research.

19. Programs are free to add any components or documentation requirements they wish in the manner they choose, but the determination of treatment completion is not the same as a "Discharge Summary" and should not require or expect narrative justifications or similar additional statements. 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 and not impose additional service requirements, program components, or documentation burdens on programs and providers.

20. The methods to assess treatment progress and completion should include measures of criminogenic needs incorporating structured, research-supported tools and inventories, specialized behavioral and psychophysiological tools, objective records, information obtained from the Containment Team and information from collaterals as well as the client's self-report.

PRACTICE GUIDELINES FOR THE ASSESSMENT, TREATMENT, AND MANAGEMENT OF MALE ADULT SEXUAL ABUSERS

Association for the Treatment of Sexual Abusers
2016

Treatment Progress and Completion

14.0 Members recognize and communicate that "successful completion" of a sexual abuser-specific treatment program/regimen indicates that a client has demonstrated sufficient progress in meeting the goals and objectives of an individualized treatment plan. Such a plan is designed to reduce the individual's risk to reoffend and increase stability and prosocial behaviors. Members recognize that treatment completion does not indicate that the individual's risk to reoffend has been eliminated completely.

14.1 Members ensure clarity and agreement between the provider and clients. Such agreement addresses, at a minimum, the following:

- The nature, goals, and objectives of treatment;
- The expected frequency and duration of treatment;
- Rules and expectations of treatment program participants;
- Rewards and incentives for participation and progress;
- Consequences of non-compliance with program rules and expectations; and
- Criteria used for assessing progress and determining program completion.

14.2 Members routinely utilize multiple methods in an effort to objectively and reliably gauge treatment progress, particularly with respect to dynamic risk factors. These methods include:

- Structured, research-supported tools and inventories;
- Specialized behavioral/psychophysiological tools;
- Client self-report; and
- Collateral reports.

14.3 Members routinely review the client's individual treatment plan and clearly document in treatment records the specific and observable changes in factors associated with the client's risk to recidivate, or the lack of such changes.

14.4 Members recognize that a client who has completed treatment has generally:

- Acknowledged treatment needs for which he was referred in sufficient detail for treatment staff to have developed a treatment plan that, if implemented properly, could be reasonably expected to reduce his risk to reoffend;
- Demonstrated an understanding of the thoughts, attitudes, emotions, behaviors, and sexual interests linked to his sexually abusive behavior and can identify these when they occur in his present functioning; and
- Demonstrated sufficiently sustained changes in managing these thoughts, attitudes, emotions, behaviors, and sexual interests and developed/ enhanced prosocial attitudes and skills such that it is reasonable to conclude that he has reduced his risk to reoffend.

14.5 Members evaluate a client's treatment progress within the context of a thorough understanding of the client's individual capacities, abilities, vulnerabilities, and limitations. Associated recommendations should reference these factors and aim to stay within the bounds of what is likely or possible for the individual client.

14.6 Members providing community-based treatment recommend more intensive treatment and/or supervision if a client experiences significant difficulties managing his risk for sexual abuse in a way that jeopardizes community safety and, conversely, recommend gradual reduction to the intensity and/or dosage of services as the client consistently demonstrates stability and positive gains.

14.7 Members prepare their clients for treatment completion, which may include a gradual reduction in frequency of contacts over time as treatment gains are made, booster sessions to reinforce and assess maintenance of treatment gains, and consultation to any future service providers.

14.8 Members are clear when communicating with clients, other professionals, and the public that some clients may require ongoing management of their risk and treatment needs.

Members provide the client, support persons, and appropriate professionals involved in ongoing case management with written information that includes follow-up recommendations for maintaining treatment gains.

(Cited with the permission of the Association for the Treatment of Sexual Abusers.)

IMPORTANT ADDITIONAL PRELIMINARY NOTES:

1. The items to be reviewed when determining whether treatment has been completed are intended to be seen only as an organized collection or list of research-supported "considerations." What is offered here is not a scorable instrument, scale or tool. No suggestions are made regarding how the listed considerations are to be rated, scored, or weighted by the treatment provider. At this time the research does not support the use of any type of formal scoring system.

2. Future research may provide evidence that some of the considerations listed are not as important as they are thought to be at the time this paper is published. New research may identify other areas which deserve consideration. The user of this list of considerations is responsible for making any needed corresponding changes so that the considerations which are relied upon continue to be supported by solid research.

SPECIFIC FACTORS TO BE CONSIDERED IN DETERMINING SEXUAL OFFENDER TREATMENT COMPLETION

The following outline provides a system for applying “structured clinical judgment” to the determination regarding whether treatment has or has not been “completed.”

Using structured clinical judgment is viewed as being better than using clinical judgment which is not structured. “Structured” here means breaking down the global final judgment about treatment completion into a number of components (referred to as Factors or Dimensions), each of which can be considered separately.

It is essential to note that the approach offered here does not provide, offer, or suggest the use of any formal “scoring” system.

While having some structured way to combine the clinician’s judgments on all of the elements recommended for consideration here might be desirable, at this time the research basis which would support such a system simply does not exist.

What can be provided is a list of areas and factors which should be considered. This information is intended to assist a clinician with providing a “structured clinical judgment.” It must be left to the clinician to determine how these multiple considerations and determinations are best combined into a specific final decision about whether the individual being evaluated has “completed” treatment.

At the end of this document is a form which might be used to help organize the clinician’s thinking. Each user can include any type of “NOTES” which will help keep track of the determinations for each of the factors. A review of these notes can then help guide the final determination. The notes can also be helpful should the determination be questioned or challenged at a later time.

CONDENSED OVERVIEW OF THE FACTORS TO BE CONSIDERED

	SECTION ONE: FOUNDATIONAL CONSIDERATIONS
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 agreed-upon treatment goals
	SECTION TWO: STABLE DYNAMIC RISK FACTOR CONSIDERATIONS
6	**I. Self-management Domain**
7	**II. Social Involvement Domain**
8	**III. Sexuality Domain**
9	**IV. Attitudes, Schemas and Beliefs Domain**
10	**V. General Criminality Domain**
	SECTION THREE: ADDITIONAL CONSIDERATIONS
11	Other Possible Considerations
12	Absolute Risk Level
13	Individual Factor
14	Predicted Trajectory
15	Containment Team Judgment
16	**Override**

TREATMENT COMPLETION CONSIDERATIONS

	FACTOR OR DIMENSION	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: **FOUNDATIONAL CONSIDERATIONS**	The following considerations 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 might be difficult to justify a determination 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 in arriving for treatment sessions, 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 acceptance of the framework and rules around treatment and satisfactorily followed program rules?
2	Duration of Treatment	Has the individual clearly met the requirements of California State Law (PC 1203.067) which requires "*not less than one year up to the entire period of probation…*" and, for parole, cf. the similarly worded PC 3008. (d) (2)? (Note that the duration requirements do not specify any treatment intensity or frequency levels but leave that consideration to the judgment of the Containment Team and treating clinician.)
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; completes homework without special prompting; offers useful feedback to others in a group setting. Does the individual consistently demonstrate evidence of satisfactory and sufficient effort 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 most cases this would include taking responsibility for the 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 a 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.")
5	Attainment of agreed-upon treatment goals	It may be useful to differentiate overall progress in attaining a variety of identified treatment goals from the more narrowly focused success in making progress in the Domains described below in 6, 7, 8, 9, 10. This is so because not all legitimate treatment goals fall clearly into one or another of those Domains. For example, some valuable goals may address "Individual Responsivity" themes or similar topics.
	SECTION TWO: **DYNAMIC RISK FACTOR CONSIDERATIONS**	In accord with the "Need Principle," the focus of specialized sex offender treatment should be to reduce recidivism risk by addressing and changing aspects of the participant's life which have been identified as dynamic risk factors for reoffending in the research literature and by accepted dynamic risk assessment instruments. Although a large number of different dynamic risk factors (criminogenic need areas) have been identified, it is generally accepted that nearly all of them can be classified within four overarching "Domains." ** These are: **I. The Self-Management or Self-Regulation Domain** **II. The Social Involvement Domain** **III. The Sexuality Domain** **IV. 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 must be included. **V. General Criminality Domain** *[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 on the last page of this document.]* **WITHIN EACH DOMAIN, EVIDENCE FOR SUCCESS AND PROGRESS IN REDUCING RISK 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 outside daily life dimension – actions in group and individual sessions show that efforts to

		change behaviors in this domain are succeeding
6	**DYNAMIC RISK FACTORS** **I. 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.
7	**DYNAMIC RISK FACTORS** **II. 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; Employment Instability; Residence; Finances; Mental Health Stability.
8	**DYNAMIC RISK FACTORS** **III. 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; Sexual Behavior; Sexual Attitudes; Sexual offending cycle.
9	**DYNAMIC RISK FACTORS** **IV. 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.
10	**DYNAMIC RISK FACTORS** **V. 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 may and sometimes should be entertained in determining whether treatment has been “completed.”
11	Other Possible Considerations	Has the individual recently (within the past year) taken and passed a Polygraph – ordinarily a Maintenance Test)? (Note that there may be a variety of reasons why the individual did not take or did not pass a polygraph examination, not all of which need be related to deception or 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"? Does this individual have a realistic plan for "aftercare"?
12	Absolute 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)? [See Guiding Principle 17 above.]
13	Individual Factor	EXAMPLES Is there a particular handicap of some sort that this individual has addressed and overcome which might have proved a barrier to successful treatment but for which has been significantly modified or compensated? 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 some sort of prelude to sexual offending? Is there something about this individual and his or her history in treatment which should be considered as an additional factor?
14	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?
15	Containment Team Judgment	Do other members of the Containment Team support the determination that treatment has or has not been successfully completed?
	Override	This case-specific consideration allows a place for a possible override. It would be viewed as different from #13 in that it might potentially outweigh <u>all</u> the others.

** Given the context and nature of sex offender treatment, it is very often the case 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 the following determinations if the individual has given good evidence of having subsequently moved beyond early resistance behaviors.*

******* *Although there appears to be agreement that the majority of the research-generated dynamic risk actors can be clustered under these five broad Domains, it is important, when applying these guidelines to a particular individual, to 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 delineated in the individual's Treatment Plan.*

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

"TREATMENT COMPLETION" REVIEW – CONSIDERATIONS AND NOTES

The following grid may be helpful to the clinician as a worksheet and a record when each factor is considered and the final determination about treatment completion is made.

NAME OF INDIVIDUAL BEING REVIEWED: _____

OTHER IDENTIFYING INFORMATION AS NEEDED (e.g. DOB): _____

CLINICIAN NAME: _____ **DATE:** _____

	AREA FOR CONSIDERATION	NOTES
SECTION ONE: FOUNDATIONAL CONSIDERATIONS		
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 agreed-upon treatment goals	
SECTION TWO: DYNAMIC RISK FACTOR CONSIDERATIONS		
6	**I. Self-management Domain**	
7	**II. Social involvement Domain**	
8	**III. Sexuality Domain**	
9	**IV. Attitudes, Schemas and Beliefs Domain**	
10	**V. General Criminality Domain**	
SECTION THREE: ADDITIONAL CONSIDERATIONS		
11	Other Possible Considerations	
12	Absolute Risk Level	
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14	Predicted Trajectory	
15	Containment Team Judgment	
16	**Override**	

LIST OF RESEARCH-SUPPORTED DYNAMIC RISK FACTORS AND THEIR SOURCES
(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 of 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 Heath 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 Offence planning (VRS-SO)
Cooperation w Community Supervision (SOTIPS)
Co-operation with Supervision (STABLE-2007)
D 14 Compliance w community supervis.(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 the Mann, Hanson, Thornton article in SAJRT

(P) = Promising