County of San Diego

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To our Readers and Residents of San Diego County:

Over the past 15 years, our community has become increasingly aware of the prevalence of sexual abuse locally and nation-wide. Often the public portrays this type of offender as a stranger who stalks children from schools and parks. Research data, however, reminds us that the perpetrator is usually someone known to the victim. Frequently, the perpetrator is a close family member, relative or friend who takes advantage of their position of trust. As a community, we sometimes fail to recognize that youth are not only the victims in these cases but may also represent a group of perpetrators. We refer to these juvenile offenders as "sexually abusive youth." The San Diego County Probations Department's goal is to hold these youth accountable and decrease their risk of re-offending by providing an opportunity for rehabilitation. The Probation Department endorses the standards presented in this document, which constitute an effort to meet the challenges posed by this target population.

The Supervision Standards for Sexually Abusive Youth in San Diego were generated by a multi-agency collaborative effort. These agencies joined together as a task force under an Office of Justice Programs (OJP) Implementation Grant beginning in 2001. The Sex Offender Management Council (SOMC) coordinates this comprehensive plan to enhance sex offender management, and focuses on concern for community safety. This document outlines that concern in the form of protocols for monitoring sexually abusive juveniles. It is also consistent with the Mission Statement of the San Diego County Probation Department and our County's Strategic Initiatives. These Initiatives highlight the County's commitment to address needs in the areas of "kids, the environment, and safe and livable communities." The Probation Department strives to serve and protect the public, prevent further trauma to victims, and redirect offenders to a more productive lifestyle. The standards you are about to read provide the guidelines and model to effectively implement these objectives.

Sincerely,

LESLEY MCCLELLAND
DEPUTY CHIEF PROBATION OFFICER
JUVENILE FIELD SERVICES

STANDARDS FOR THE TREATMENT OF SEXUALLY ABUSIVE YOUTH

APPROVED BY THE SAN DIEGO SEX OFFENDER MANAGEMENT COUNCIL

THE RESPONSE OF CLINICIANS AND OTHER TREATMENT PROFESSIONALS

SECTION 1: QUALIFICATIONS FOR TREATMENT PROVIDERS

Levels of Providers

Certified Group Treatment Provider—Full Operating Level

STANDARD 1: A treatment provider at the Full Operating Level may treat sex offenders without supervision and may supervise a provider, or intern at the Associate Level. To qualify to provide juvenile sex offender group treatment at the Full Operating Level, an individual must meet all the following criteria:

1) The individual shall have attained the underlying credential of licensure and be in good standing as a physician, psychologist, clinical social worker, or marriage and family therapist.

2) The individual (a) shall be a TERM-approved provider with documented training and experience in providing face-to-face group therapy, and (b) shall have completed within the past five (5) years, a minimum of 3000 hours of clinical experience in the area of evaluation and treatment of sex offenses. At least half of those hours (1500 hrs) must have been face-to-face individual or group therapy for adult or juvenile convicted sex offenders. Such clinical experience may have been obtained while seeking licensure or after obtaining licensure; however, if it was obtained in part or in full after licensure, it is subject to the same requirements for supervision as required for all treatment providers under these Standards.

3) The individual shall have had, within the past five (5) years, at least 40 hours of documented training specifically related to the evaluation and treatment of sex offenders, including training in the area of victimology. The individual must demonstrate a balanced training history, having covered a wide or varied range of training topics. The training must directly relate to sex offender assessment/treatment/management and may include, but is not limited to:

- Statistics of offense/victimization rates
- Typologies
- Sex offender assessment
- Sex offender evaluation
- Sex offender treatment techniques, including:
    - Evaluating and reducing denial
    - Behavioral treatment techniques
    - Cognitive behavioral techniques
    - Relapse Prevention

    - Empathy training
- Offender/offense characteristics
- Sex offender risk
- Physiological techniques, including:
    - Polygraph
    - Plethysmograph
    - Abel Screen
- Victim issues
- Family reunification/visitations
- Legal issues regarding sex offenders
- Special sex offender populations, including:
    - Developmentally disabled
    - Juvenile
    - Female
- Pharmacotherapy with sex offenders
- Impact of sex offenders
- Assessing treatment progress
- Secondary and vicarious trauma
- Anger management
- Sex education
- Supervision techniques with sex offenders
- Philosophy & Principles of the Sex Offender Management Council
- Group therapy dynamics

4) In concert with the generally accepted Standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abuse (ATSA), shall demonstrate competency according to the individual's respective professional Standards, and shall conduct all treatment in a manner that is consistent with the reasonably accepted standard of practice in the sex offender treatment community.

Certified Group Treatment Provider—Associate Level

STANDARD 2: A treatment provider at the Associate Level may treat sex offenders under the supervision of a treatment provider approved at the Full Operating Level under these Standards. To qualify to provide juvenile sex offender group treatment that the Associate Level, an individual must meet all of the following criteria:

1) The individual shall have a Master's degree or above in a behavioral science and either (a) be a licensed provider who does not yet have sufficient experience and training to meet the level of a Full Operating Level Provider, or (b) meet the requirements of Registered Intern (Licensed Clinical Social Worker, Marriage and Family Therapist or Psychology Intern).

2) The individual (a) shall be a TERM-approved provider or TERM-approved intern with documented training and experience in providing face-to-face group therapy, and (2) shall have completed within the past five (5) years a minimum of 500 hours of clinical experience in the area of evaluation and treatment of sex offenses. At least half (250) of these hours must be in face-to-face individual or group therapy for convicted adult or juvenile sex offenders, and at least 160 of the 250 hours must have been as a group co-therapist, in the same room, with a treatment provider registered at the Full Operating Level.

3) Prior to commencing their clinical work, associates must complete 21 hours of balanced, documented training as identified previously in these Standards. These hours must have been completed within the past two years.

4) Associates must co-facilitate 72 hours of group therapy with a Full Operating Provider over a minimum of 6 months to be able to run sex offender groups on their own.

5) The individual must have received at least 50 hours of face-to-face clinical supervision by a treatment provider at the full operating level. The supervision must be reasonably distributed over the time in which the above clinical experience was being obtained (approximately 1 hour of supervision for each 10 hours of group supervision per week).

6) In concert with the generally accepted Standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abuse (ATSA), demonstrate competency according to the individual's respective professional Standards, and shall conduct all treatment in a manner that is consistent with the reasonably accepted standard of practice in the sex offender treatment community.

Certified Individual Treatment Provider—Full Operating Level

STANDARD 3: A treatment provider at the Full Operating Level may treat sex offenders without supervision and may supervise a provider or intern at the Associate Level. To qualify to provide juvenile sex offender individual treatment at the Full Operating Level, an individual must meet all of the following criteria:

1) The individual shall have attained the underlying credential of licensure and be in good standing as a physician, psychologist, clinical social worker, or a marriage and family therapist.

2) The individual (a) shall be a TERM-approved provider or TERM-approved intern with documented training and experience facilitating individual therapy, and (b) shall have completed within the past five (5) years a minimum of 200 hours of clinical experience in the area of evaluation and treatment of sex offenses. At least half of those hours (100 hrs)

must have been face-to-face individual or group therapy with convicted adult or juvenile sex offenders.

3) The individual must have had, within the past five (5) years, at least 40 hours of balanced, documented training as identified previously in these Standards.

4) In concert with the generally accepted Standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abuse (ATSA), shall demonstrate competency according to the individual's respective professional Standards, and shall conduct all treatment in a manner that is consistent with the reasonably accepted standard of practice in the sex offender treatment community.

Certified Individual Treatment Provider—Associate Level

STANDARD 4: A treatment provider at the Associate Level may treat sex offenders under the supervision of a treatment provider approved at the Full Operating Level under these Standards. To qualify to provide juvenile sex offender individual treatment that the Associate Level, an individual must meet all of the following criteria:

1) The individual shall have a Master's degree or above in a behavioral science and either (a) be a licensed provider who does not yet have sufficient experience and training to meet the level of a Full Operating Level Provider, or (b) meet the requirements of Registered Intern (Licensed Clinical Social Worker, Marriage and Family Therapist or Psychology Intern).

2) The individual shall be a TERM-approved provider or TERM-approved intern with documented training and experience in providing face to face individual therapy with juveniles. Licensed providers shall have provided, within the past five (5) years, a minimum of 100 hours of face-to-face individual or group therapy. Interns will have provided 350 hours of face-to-face individual or group therapy, 100 hours of which shall have been provided post-Master's degree.

3) Prior to commencing their clinical work, associates must complete 21 hours of balanced, documented training as identified previously. These hours must have been completed within the past two years.

4) Associate providers and interns must be supervised on a weekly basis with supervision to include videotape review of associate face-to-face client contact.

5) In concert with the generally accepted Standards of practice of the individual's mental health profession, the individual shall adhere to the Code of Ethics published by the Association for the Treatment of Sexual Abuse (ATSA), demonstrate competency according to the individual's respective professional Standards, and shall conduct all

treatment in a manner that is consistent with the reasonably accepted standard of practice in the sex offender treatment community.

Continued Placement on the Provider List

Continued Placement as a Licensed Group Treatment Provider on the Provider List

STANDARD 5: Treatment providers must apply for continued placement of the List every 3 years by the date provided by the Sex Offender Management Council. Requirements are as follows:

1) The treatment provider must demonstrate continued compliance with these Standards and Guidelines.

2) The individual shall accumulate a minimum of 600 hours of clinical experience every three years, 300 hours of which shall be face-to-face therapy with adult or juvenile convicted sex offenders.

3) Treatment providers shall complete a minimum of 40 hours of continuing education every three years in order to maintain a proficiency in the field of sex offender treatment and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Up to 10 hours of this training may be indirectly related to sex offender assessment/treatment/management.

4) Provide satisfactory references as requested by the Council. The Council may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the case management team.

5) Submit to a current background check.

6) Report any of your own practices that may be in significant conflict with the Standards and request a time limited waiver of the Standards with reasons to justify the waiver.

7) Comply with all of the requirements outlined in the Council policies.

Continued Placement as a Licensed Individual Treatment Provider on the Provider List

STANDARD 6: A treatment provider at the Individual level must apply for continued placement on the List every 3 years by the date provided by the Council. Requirements are as follows:

1) The individual must demonstrate continued compliance with these Standards and Guidelines.

2) The individual shall accumulate a minimum of 300 hours of clinical experience every three years, 150 hours of which shall be face-to-face therapy with adult or juvenile convicted sex offenders.

3) Treatment providers shall complete a minimum of 40 hours of continuing education within the past five years of application for placement and every three years in order to maintain a proficiency in the field of sex offender treatment and to remain current on any developments in the assessment, treatment, and monitoring of sexual offenders. Up to 10 hours of this training may be indirectly related to sex offender assessment/treatment/management.

4) Provide satisfactory references as requested by the Council. The Council may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the case management team.

5) Submit to a current background check.

6) Report any of your own practices that may be in significant conflict with the Standards and request a time limited waiver of the Standards with reasons to justify the waiver.

7) Comply with all of the requirements outlined in these STANDARDS.

SECTION 2: COLLABORATION

The Containment Team

STANDARD 7: Treatment of the sexually abusive youth requires an interagency approach in order to be effective. Provision of treatment alone, even specialized treatment, may not be sufficient without the legal support of the juvenile justice system. *Filing petitions and/or restrictive placements are insufficient without provision of treatment.* Monitoring sexually abusive youth and victim safety requires close coordination of treatment efforts with child protective services, educators, probation/parole and law enforcement agencies.

Interagency collaboration should be present in all settings. Probation officers, parole agents, protective services workers, law enforcement officers, and other professionals as necessary should be apprised of the sexually abusive youth's treatment status.

If a sexually abusive youth is moving up or down the continuum of care (see Appendix) all agencies must be advised immediately.

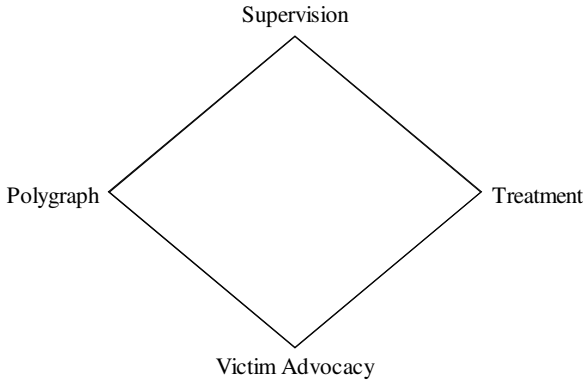
There must be a countywide commitment to making treatment affordable and available to all sexually abusive youth and their families, including those going through the juvenile courts. Treatment must be available for sexually abusive youth who are too young to be the subjects of delinquency petitions.

The Containment Model

STANDARD 8: San Diego County utilizes the Containment Model in the Management of Sex Offenders. The Containment Model is a method of case processing and case management that focuses on holding offenders accountable for past and present behaviors, while providing the offender an opportunity to develop the tools necessary to avoid re-offense. This system requires that "the justice system (court) must identify and implement limitations or barriers to foreseeable high-risk behavior in order to provide the highest level of public safety and offender accountably. This is accomplished with the use, monitoring and enforcement of specialized conditions of supervision." (Bullens, ed. 2002) Coupled with this element of external control, these offenders must also be required to participate in specialized treatment focused on the identification of high-risk situations and behaviors and the development of an appropriate relapse prevention plan. The offender's activities and compliance are then monitored routinely with the use of polygraph examinations to verify the offender's compliance to both

supervision and treatment goals, in addition to reducing the offender's denial mechanisms. This model requires that professionals working with sex offenders collaborate at all stages of the case management system to ensure that decisions are appropriate, informed and victim focused, "what is best for the victim". The focus on accountability also extends beyond the offender: to those professionals responsible for supervision, treatment, polygraph and others monitoring—"containment" tools. Thus, the containment model focuses on "containing" offenders in a tight supervision and treatment network with active monitoring and enforcement of rules and expectations.

CONTAINMENT MODEL



SECTION 3: ASSESSMENTS AND PLACEMENT

Comprehensive Clinical Assessments

STANDARD 9: Clinical assessment/re-assessment is an on-going multi-disciplinary, interactive process. *Clinical expertise should include knowledge of risk determinants, appropriate treatment options, a comprehensive education in the sex disorders, (Paraphilia Disorder) the paraphiliac type of behaviors and dynamics, and sensitivity to any possible cultural issues. Determining "risk level" should be the immediate focus of the evaluation due to its impact on court dispositions, placement decisions, treatment decisions, and after-care decisions.* Risk level should be considered in both the specific and general sense (i.e. victim[s] and the community at large).

STANDARD 10: In addition to determining risk level, an equally important task of clinical assessment is to identify long term needs and suggested intervention remedies. These should be comprehensive and prioritized. In this way, a continuum of treatment is developed that will provide the best short-term response as well as enhance clinical progress via continuing, goal-oriented reassessment.

STANDARD 11: A comprehensive assessment should be performed before entry into any level of treatment, as well as when the sexually abusive youth is being considered for less secure supervision. This assessment can be accomplished by the treatment provider. The first treatment recommendation/needs assessment should be done prior to juvenile court disposition, and updated at least annually during treatment.

Assessment requires multiple sessions with the sexually abusive youth and should also include review of victim statements, all collateral data, and interviews with all significant systems including the family, schools, and others who interact with the youth or who understand the cultural context in which the abuse occurred.

Risk Assessment

STANDARD 12: In assessing the probability of future sexually offending behavior, past behavior must be considered. Risk assessments should be comprehensive and ongoing, and may consider (Order does not reflect prioritization):

- Victim statements and other collateral reports
- The sexually abusive youth's history, including family, extended family, cultural norms and values, education, sexual victimization, physical or psychological abuse, neglect, medical, psychological, psychosocial, psychosexual (deviant sexual fantasies and masturbatory

patterns), and law enforcement
- Progression of sexually aggressive behavior development over time
- Dynamics/process of victim selection
- Intensity of sexual arousal prior to, during, and after offense
- Use of force, violence, weapons; history of assaultive behavior
- Spectrum of injury to victim, i.e. fear, physical injury, violation of trust
- Sadism
- Abuse experienced within organized groups
- Deviant nonsexual interests
- Chronic/situational factors
- Behavioral warning signs
- Identifiable triggers
- Current functioning and perceptions about offense:
    - Thinking errors (irrational thinking)
    - Ability to accept responsibility
    - Denial or minimization
    - Understanding of wrongfulness
    - Concern for injury to victim
    - Victim empathy/capacity for empathic thought
    - Substance abuse
    - Mental status/retardation/developmental disability
    - Organicity (predisposition)
    - Neuropsychological factors
    - Learning disability
- Family's denial, minimization, response
- Family level of function and dysfunction
- Level or degree of self-governance, impulse control
- Homicidal/suicidal Ideation—assess levels of lethality

Treatment Needs Assessment

STANDARD 13: Identification of treatment needs is based on assessment of specific problem areas, strengths and weaknesses, cultural factors, skills, knowledge, and especially identification of the precedents and antecedents of the sexually abusive behavior. Needs assessment should include consideration of thought processes, behavior and organicity. The level of intervention needed should initially be based on a needs assessment and should be re-evaluated periodically as knowledge of the individual's needs change.

Recommendations for Therapeutic Intervention

STANDARD 14: The assessment should identify specifically, and in detail, the optimal setting for treatment of the sexually abusive youth. It is important to document the needs, even when resources are not available, to most

appropriately address the needs of sexually abusive youth.

Treatment recommendations for sexually abusive youth should designate offense-specific treatment in a peer based group and should include recommendations for court support (i.e. supervision, detailed orders, probation, judicial review, etc.), as well as expectations for supervision by family at home or workers in community placements.

Adjunct treatment components to the peer-based group should be individualized in the treatment plan and may include:

- Individual therapy
- Family therapy
- Physiological arousal assessment treatment (i) (ii)
- Biomedical interventions (i)
- Substance abuse interventions
- Sex education (i)
- Educational assessment (for remedial or special education referrals)
- Acculturation
- Social skills training
- Assertiveness training
- Anger management
- Victimization issues
- Counseling for parental loss issues
- Cognitive restructuring
- Values clarification
- Stress management

(i) Parent/Guardian permission is necessary.
(ii) Currently this procedure is used little in San Diego, but is used throughout the nation.

STANDARD 15: Denial is an issue with most sexually abusive youth. Working through denial is a gradual process achieved in treatment and, therefore, the existence of denial should not preclude a sexually abusive youth entering into placement. The degree of denial is, however, a factor in the placement decision. Continuing long-term treatment may not be appropriate for an adjudicated sexually abusive youth who remains in complete denial.

Placement Issues

STANDARD 16: If victim safety and treatment options are not compatible and cannot be reconciled, victim safety is the highest consideration.

STANDARD 17: Sexually abusive youth should be placed in the least restrictive environment

that allows for community safety. *When there is a question regarding community safety, a youth should be placed in the most restrictive environment until a less restrictive environment is deemed appropriate.*

In cases of sibling incest, the sexually abusive youth, not the victim, should be removed from the home until the victim's and sexually abusive youth's therapists clinically facilitate conjoint sessions and a reunification plan is established.

STANDARD 18: Placement decisions should also consider the safety of the sexually abusive youth who may be vulnerable or who may face retaliation in the family, community or placement.

STANDARD 19: Placement for sexually abusive youth should be sex offender (offense-specific) treatment.

- Maximum security with sex offender (offense-specific) treatment
- Inpatient psychiatric hospital units with sex offender (offense-specific) treatment
- Secure residential treatment center (or secure group home, if any exist) with sex offender (offense-specific) treatment
- Medium security training schools with sex offender (offense-specific) treatment
- Offense-specific group home
- Residential group home with sex offender (offense-specific) day treatment
- Residential group home while attending sex offender (offense-specific) outpatient treatment programs
- Specialized foster care while attending sex offender (offense-specific) day treatment
- Specialized foster care while attending sex offender (offense-specific) outpatient treatment
- Home-based while attending sex offender (offense-specific) day treatment
- Home-based while attending sex offender (offense-specific) outpatient treatment
- Short-term sex offender (offense-specific) psycho-educational programs (Low risk sexually abusive youth only)
- Post-treatment support systems

STANDARD 20: Treatment programs <u>should</u> operate on the continuum based on progress or regression to stated goals.

Treatment providers would like to include a treatment option in every placement, but the sexually abusive youth who exercises his/her right to refuse treatment may require maximum security without treatment and should not be in placement with those who are in treatment.

Upon successful completion of a sex offender (offense-specific) treatment, continuing support, after care or follow up, and monitoring are essential.

SECTION 4: STANDARDS OF PRACTICE

Sex Offense Specific Treatment

STANDARD 21: Sex Offense-specific Treatment must be provided by a treatment provider registered at the full operating level or the associate level under these Standards.

Goals of Sex Offender Specific Treatment

STANDARD 22: The goals of sexual offense-specific treatment are 1) to stop all sexually offending behavior, 2) to protect members of society from further sexual victimization, and 3) to prevent other aggressive or abusive behaviors, which the sexually abusive youth may manifest. The methods required for implementing these goals may vary, but rest upon certain common assumptions.

Sexually abusive/aggressive behavior is illegal. Therefore, intervention with sexually abusive youth should involve the justice system. The sexually abusive youth must be held accountable for the offending behavior. Criminal investigation, petition filing, and orders for treatment can be components of effective interventions.

Treatment control should come externally from the juvenile courts. Treatment practitioners may be supported by the court's ability to impose appropriate sanctions upon sexually abusive youth who refuse to participate in treatment. Treatment providers retain the right to discharge sexually abusive youth from their programs for noncompliance.

STANDARD 23: Mandating treatment for this population is necessary because most sexually abusive youth are not sufficiently uncomfortable with their behavior to follow through in treatment without external motivation to do so. No sexually abusive youth should be allowed to terminate treatment prematurely without immediate notification to the appropriate agencies, such as CPS and Probation.

STANDARD 24: Intervention should begin as soon as possible after disclosure of the sexually abusive behavior.

STANDARD 25: Sexually abusive youth require a specialized offense-specific treatment approach.

STANDARD 26: Treatment in specialized sexual offense-specific peer groups is the primary treatment of choice, but may also include other treatment modalities. Clinical experience indicates that insight-oriented, individual psychotherapy is insufficient when used alone to change sexually abusive behaviors and is

both contra-indicated and may be potentially detrimental to the sexually abusive youth and the community if used exclusively. Sex offense-specific treatment must address aggressive and exploitive behaviors.

Intake Risk Assessment

STANDARD 27: At the onset of treatment, all sex offenders shall undergo an intake and risk assessment. This shall include:

- Admission of Offenses
- Accountability
- Cooperation
- Offense History and Victim Choice
- Sexual deviancy and arousal patterns
- Lifestyle characteristics
- Psychopathy
- Developmental markers
- Substance abuse and other addictive patterns
- Criminal history
- Prior treatment history
- Social support system
- Overall control and intervention
- Motivation for treatment and recovery
- Self-structure
- Disowning beliefs

STANDARD 28: At the onset of treatment, the provider shall receive a copy of the following documents, if available, from the supervising agency:

- Psychological evaluations
- Police and/or probation reports
- Victim evaluation reports
- Child Protective Services
- Department of Social Services reports
- Condition of probation orders
- Polygraph results

STANDARD 29: A provider who treats sex offenders under the jurisdiction of the criminal justice system must use sex offense-specific treatment.

Treatment Plans

STANDARD 30: A provider shall develop a written treatment plan based on the needs and

risk assessment functions identified on Risk Assessment and on current and past assessments/evaluations of the offender.

The treatment plan shall:

- Be individualized to meet the unique needs of the offender
- Identify the issues to be addressed, including multi-generational issues in indicated, the planned intervention strategies, and the goals of treatment
- Address the issue of ongoing victim input
- Address the issues of victims and families
- If necessary, be supplemented by treatment for drug/alcohol abuse, marital therapy and individual crisis intervention.

Treatment Group Design and Size

A provider shall employ treatment methods that are supported by current professional research and practice:

STANDARD 31: Group therapy (with the group comprised only of sex offenders) is the preferred method of sex offense-specific treatment, unless when otherwise determined by the treatment provider. At a minimum, any method of psychological treatment used must conform to the Standards for content of treatment and must contribute to behavioral monitoring of sex offenders.

STANDARD 32: The use of co-therapists in a group may be recommended by the treating agency.

STANDARD 33: The treatment group size shall not exceed 10 sex offenders.

STANDARD 34: The provider shall employ treatment methods that give priority to the safety of an offender's victim(s) and the safety of potential victims and the community.

STANDARD 35: The provider shall employ treatment methods that are based on recognition of a need for long-term, comprehensive, offense-specific treatment for sex offenders. Self-help or time-limited treatments shall be used only as adjuncts to long-term, comprehensive treatment.

Treatment Curriculum

STANDARD 36: The content of offense-specific treatment for sex offenders shall be designed to:

- Reduce offenders' deviant sexual urges and recurrent deviant fantasies.

- Educate offenders (and individuals who are identified as the offenders' support systems) about the potential for re-offending and an offender's specific risk factors.

- Teach offenders self-management methods to avoid a sexual re-offense.

- Identify and treat the offenders' thoughts, emotions and behaviors that facilitate sexual re-offenses or other victimizing or assaultive behaviors.

- Identify and correct offenders' cognitive distortions.

- Educate offenders about non-abusive, adaptive, legal, and pro-social sexual functioning.

- Educate offenders about the impact of sexual offending upon victims, their families, and the community.

- Provide offenders with an environment that encourages the development of empathic skills needed to achieve sensitivity and empathy for their own victim(s).

- Provide offenders with guidance to prepare, when applicable, written explanation or clarification for the victim(s) that meets the goals of: establishing full perpetrator responsibility, empowering their victim(s), and promoting emotional restitution for their victim(s).

- Identify and treat offenders' personality traits and deficits that are related to their potential for re-offending.

- Identify and treat the effects of trauma and past victimizations of offenders as factors in their potential for re-offending. (It is essential that offenders be prevented from assuming a victim stance in order to diminish responsibility for their actions).

- Identify and decrease offenders' deficits in social and relationship skills, where applicable.

- Require offenders to develop a written relapse prevention plan for preventing a re-offense; the plan should identify antecedent thoughts, feelings, circumstances, and behaviors associated with sexual offenses.

- Provide referrals and collaborate with adjunct treatment providers in the community on an ongoing basis throughout treatment for offenders with co-existing medical, pharmacological, mental, substance abuse and/or domestic violence issues, or other disabilities.

- Maintain communication with significant persons in offenders' support systems when indicated, and to the extent possible, assist in meeting treatment goals.

- Evaluate cultural, language, developmental disabilities, sexual orientation and/or gender factors that may require special treatment arrangements. *The treatment should match the youth's learning ability.*

- Identify and address issues of gender role socialization.

- Identify and treat issues of anger, power and control.

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

Issues to be addressed in Treatment

STANDARD 37: Certain definable issues have been identified as a result of clinical experience and should be addressed in the treatment process of every sexually abusive youth (The order in which issues are listed does not indicate their relative importance.):

- Accept responsibility for behavior without minimization or externalizing blame.

- Identify pattern or cycle of offense behavior.

- Improve ability to self-govern and interrupt cycle before an offense occurs.

- Resolve victimization in the history of the sexually abusive youth. (For example, history of generic abuse, neglect, physical, emotional, and sexual abuse. Also included are any traumatic events in the sexually abusive youth's background.)

- Develop victim awareness or empathy to a point where potential victims are seen as people rather than objects.

- Understand the dynamics of power and control and helplessness and lack of control.

- Understand the role of sexual fantasy and sexual arousal in sexually abusive behavior and how to better self-govern these.

- Understand the role of neuropsychological factors, for example, the altered states, dissociative reactions, amnesic states and fugue states found in paraphilia syndromes.

- Understand the consequences of offending behavior for himself/herself, his/her family, and the victim and the victim's family.

- Involve family in treatment. Identify family issues or dysfunctional patterns which support or trigger sexually offending behavior.

- Identify cognitive distortion, irrational thinking or "thinking errors" which support or trigger sexually offending behaviors.

- Improve the ability to identify and express feelings.

- Improve social skills and relationships with peers. This would include developing a positive sexual identity.

- Provide sexual education -- should be broad and should not exclusively cover heterosexuality, safer sex practices and birth control alternatives.

- Identify issues regarding trust of and by others, be it peers, family, or adults.

- Identify addictive and compulsive variables contributing to the reinforcement of deviance.

- Identify the possible role of substance use and abuse by the sexually abusive youth or within the family system.

- Identify and improve skill deficits which interfere with successful functioning.

- Make available relapse prevention or other treatment modalities, as indicated.

- Provide psychopharmacological maintenance where indicated.

- Identify options for restitution/reparation to victims and community.

Treatment Provisions

STANDARD 38: Each sexually abusive youth should have an individualized treatment plan that identifies the issues to be covered, intervention strategies, and goals. *This plan should be re-assessed and revised periodically and should not be time-limited, since treatment is frequently life-long.*

STANDARD 39: The treatment of sexually abusive youth should consider all needs of the individual and utilize existing resources wherever possible to enhance his/her overall pro-social functioning.

Treatment Concerns of the Provider

STANDARD 40: A sexually abusive youth should be accepted for treatment, if appropriate, even if such treatment is not court mandated, as long as the sexually abusive youth holds himself or herself accountable and cooperates in the same

manner as mandated clients.

STANDARD 41: There may be instances when the clinician needs to refuse to treat because there are insufficient resources to provide the appropriate supervision/control or levels of intervention. The clinician should not jeopardize community safety or the credibility of Offense-Specific Treatment by accepting clients into treatment under these conditions. (Lack of sufficient resources, resulting in the inability to give appropriate treatment, should be reported to the court or other referring agency.)

STANDARD 42: A male and female co-therapy team with a peer group is the ideal recommended facilitation model.

STANDARD 43: Groups facilitated by a single practitioner are strongly discouraged and should be used only when options are limited.

STANDARD 44: Ideally there should be an agency specialist who has a primary and consistent relationship with the sexually abusive youth. Consistent case management through the courts, probation, parole, or other agency is the model of choice so that the same individual can provide both support and sanctions.

STANDARD 45: Sex Offender (offense-specific) treatment should be structured, and may include written guidelines, treatment contracting, community and instructional safeguards, monitoring of risk situations, verification when appropriate, and other concrete, external components. The accountability of sexually abusive youth in treatment is crucial.

STANDARD 46: Adequate sex offender treatment most often requires long-term treatment, a minimum of 12 to 24 months. Treatment providers should make every effort to ensure that the mandating agency sets a realistic time frame. Time-limited programs may endanger the credibility of all treatment programs for sexually abusive youth.

STANDARD 47: Refusal or willingness to treat cases with insufficient legal mandates will depend upon the seriousness of the offense, client age, whether parents or an involved agency can provide a workable mandate, and the sexually abusive youth's own attitude.

STANDARD 48: Not all sexually abusive youth should be treated together in the same group. Considerations in serving sexually abusive youth in different groups include:

- Number of sexually abusive youth to be served
- Concrete versus abstract thinking ability

- Age/maturity factors
- Potential for violence
- Demonstrated sexually deviant behaviors
- Treatment setting
- Gender
- Developmental disabilities

STANDARD 49: Although it can be beneficial to have sexually abusive youth with different deviant sexual behavior in the same group, this should be evaluated carefully.

STANDARD 50: Family involvement may have a primary and significant impact on the treatment process. Parents should be held responsible as much as possible for having a beneficial impact on treatment. When juvenile court is involved, the court should be notified if a parent's behavior undermines treatment and the court should be responsible for intervening to either engage them or to prevent the youth from having contact with them. Parental interference or lack of cooperation should be well documented.

STANDARD 51: Conjoint sessions are necessary in cases where victims and sexually abusive youth are to be reunited and should occur prior to any contact. Adequate precautions must be taken to assure the victim's physical and psychological safety. Victim/sexually abusive youth sessions should not be attempted until both the victim's and the sexually abusive youth's therapists are confident that safety can be maintained and the session will be beneficial to the victim's treatment. Victim/sexually abusive youth sessions should always be at the victim's discretion and entirely voluntary, based on a therapeutic decision that the sessions are in the best interest of both the victim and the sexually abusive youth.

STANDARD 52: Any youth who engages in offensive behavior should, during the treatment process, clearly identify specific problem behaviors in which he has engaged.

Treatment Progress/Removal/Completion

STANDARD 53: Sexually abusive youth must be required to actively participate in treatment rather than merely attend sessions. Treatment progress, or lack thereof, is determined by accomplishment of specific goals and objectives, cooperativeness in treatment, maintaining control and self-responsibility, changes in thinking, and measures of behavior over time.

Indicators of Progress include:

- Acknowledgement of responsibility for offenses without denial, minimization
- or projection of blame;
- Behavioral indications of work toward treatment goals;
- Ability to discern contributing factors to offending cycle;
- Positive changes in contributing factors to sexual assault behavior;
- Capacity for victim empathy/demonstration of empathic thinking;
- Improvement in self-esteem;
- Increase in positive sexuality; decrease attitudes that support sexually offensive behaviors;
- Pro-social interactions;
- Positive family interactions;
- Openness in examining thoughts, fantasies, and behavior;
- Ability to counter irrational thinking/thinking errors;
- Ability to interrupt cycle and seek help when destructive or risk-behavior pattern begins;
- Assertiveness and communication;
- Resolution of personal victimization or loss issues;
- Ability to experience pleasure in normal activities;
- Decrease in disturbances of altered states i.e., sleepwalking, talking, daydreaming, etc.

STANDARD 54: Assessment of progress should not rely heavily on self-report by sexually abusive youth, but should include external forms of observation, verification, and consideration of treatment goals. All progress, or lack thereof, should be clearly documented in the sexually abusive youth's record, and outline specific achievements or failures.

STANDARD 55: While the sexually abusive youth is in treatment, violations such as refusal to participate, missed sessions, and high-risk behaviors should be immediately reported to the mandating agency and a higher level of care should be considered or recommended.

Completion of Treatment

STANDARD 56: Completion of treatment must be based on accomplishment of specific, measurable objectives, observable changes, and demonstrated ability to apply changes in current situations. Successful completion requires multiple measures of change including:

- Behavioral
- Emotional
- Attitudinal
- Social
- Cognitive

and should measure increased understanding of the offense cycle, victim empathy, and demonstrated ability to seek appropriate help.

STANDARD 57: A specific assessment procedure should be followed before discharge from

treatment.

Treatment Violations and Termination

STANDARD 58: Treatment providers shall document in writing all violations of the client contract. This documentation shall be provided to the proper referring agency within three (3) business days utilizing the SEXUAL OFFENDER TREATMENT PROGRAM REPORT form. (See Appendix). Following termination, a new court order or written referral from the Probation Department, or other referring source, will be required prior to re-admission into the treatment program.

Sex Offender Treatment Provider Collaboration

Treatment providers shall not exist in isolation.

STANDARD 59: Treatment providers should seek opportunities to network with other providers about current and evolving interventions and research.

STANDARD 60: It is the responsibility of the program to obtain the information and implementation changes as necessary they shall maintain cooperative working relationships with other providers and the criminal justice programs. Treatment providers must keep available a list of treatments that the provider as well as referrals to other programs.

Interprogram Transition and Communication

STANDARD 61: When clients move from one treatment program to another, a cooperative effort shall be made on the part of each provider to assist in effecting the client's transfer. In creating procedures to guide client transfers, the primary goal will be to encourage the clients' personal responsibility to their victims and to the court that has ordered them into counseling. Additional goals are to discourage manipulation of the criminal justice system by clients, and to prevent the loss of therapeutic/educational benefits that may be caused by "program hopping".

The following procedures shall be used to assure uniform treatment of transferring clients:

- At the time of the initial interview, all clients shall be asked if they have attended another program previously.

- If a client admits to having attended a different program at either the intake or at any time during their program, the client shall be required to sign a release authorizing contact between the two programs.

- Depending on individual program policies, intake providers may complete the enrollment process, but keep the client from attending sessions or not issue credit for sessions attended, until pertinent information has been exchanged between programs (e.g., reason(s) for termination, unpaid balance, non-compliance with previous program, etc.).
    - The client shall be informed that contact with, and arrangements for payment of any outstanding balance to, the previous provider will be required before he/she may enroll in the current program.

STANDARD 62: A program's request for information from another program shall be made using the INTERPROGRAM COMMUNICATION FORM.

STANDARD 63: Attendance information will be documented and made available to the receiving program utilizing the INTERPROGRAM COMMUNICATION FORM.

STANDARD 64: The provider receiving the INTERPROGRAM COMMUNICATION FORM will complete it and respond to the requesting provider within three (3) business days.

Crisis Response Plans

STANDARD 65: Within the client contract, treatment providers must provide a crisis response plan for clients who are unable to cope or are a danger to self or others. Treatment providers shall also be knowledgeable about community resources and will make this information available to clients as needed. If a crisis response plan is implemented, there must be coordination with the probation department as soon as possible.

Treatment Admission and Reporting

STANDARD 66: Treatment providers must provide admission to therapy within 21 days of contact by a client.

- If this condition cannot be met, the treatment provider will be required to notify the original referral source as to the reason for the delay or refer the client to another treatment provider.
- If a client is deemed inappropriate or unsuitable for the program, the treatment provider must notify the referral source within three (3) business days.

STANDARD 67: Treatment providers must report to the referral agent a minimum of one time every 90 days or at times stipulated by the Court regarding clients' progress using the appropriate reporting form. (See Appendix).

Treatment Client Files

STANDARD 68: Providers shall maintain clients' files in accordance with the professional Standards of their individual disciplines and with California state law on health care records. Client files shall:

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

- Accurately reflect the client's treatment progress, sessions attended, and changes in treatment;

- Have ongoing assignment of risk.

STANDARD 69: Treatment providers shall maintain a contact log in each client's individual case file documenting a record of all phone calls, communications, violations, collateral contacts with other relevant involved professionals, including the Court, Probation, Attorneys, and other involved therapists. (Refer to Appendix)

STANDARD 70: Treatment providers must label case notes and contact logs in such a way that the certification representative can monitor the charts with ease. A Chart Order Checklist must be provided to the certification representative upon applying for re-certification of their program.

STANDARD 71: Treatment providers shall read and sign, under penalty of perjury, an acknowledgement stating that they will abide by these STANDARDS.

Contact with a Victim's Treatment Provider

STANDARD 72: If a victim of a perpetrator is also attending counseling, treatment providers, with the victim's written authorization, shall consider any information provided by the victim's therapist as it relates to the perpetrator.

- Obtaining this information is highly recommended within the ethical guidelines of confidentiality.

Victim Safety

STANDARD 73: Treatment providers shall make a reasonable effort to ensure that victims' safety is never compromised.

- If the victim contacts the provider at any time during the sex offender treatment program, that information is not confidential, and the victim must be informed of these limits of confidentiality at the onset of the conversation.

Family Reunification

STANDARD 74: The family reunification process should follow the procedures and protocols outlined in the CCOSO "Position Paper for Family Resolution"—Draft 7/1/02. (See Appendix)

Ethical Issues

STANDARD 75: Failure to report to law enforcement and/or protective services any sexually abusive behavior regardless of the age of the youth may endanger the community.

- Such failure could result in re-victimization or further abuse against others. (See Penal Code Section 11166).

STANDARD 76: Laws of confidentiality between the therapist and the client apply. Releases of information, obtained with informed consent, should be encouraged in order to permit treatment providers to exchange relevant information.

STANDARD 77: Use of sexually explicit treatment materials should be carefully considered in the context of the sexually abusive youths' history, in order to avoid exposure to inappropriate material to which s/he has not already been exposed.

- When sexually explicit materials are used in an educational context, the material should be carefully screened to eliminate stereotyping and exploitive depictions, and should demonstrate egalitarian relationships.

STANDARD 78: The use of sexually explicit materials in any context that does not specifically deal with eliminating or reducing arousal to illegal sexual behaviors or modeling sexual responses to legal behaviors should be viewed as counter- productive.

Confidentiality

STANDARD 79: A treatment provider shall obtain signed waivers of confidentiality (signed releases of information) based on the informed consent of the offender. If an offender has more than one therapist or treatment provider, the waiver of confidentiality shall extend to all therapists and mental health professionals who are treating the offender. The waiver of confidentiality shall extend to the supervising officer and to all members of the team and, to any and all individuals and/agencies responsible for the supervision of the offender.

- When indicated and consistent with the informed consent of the offender, the treatment provider shall obtain a waiver of confidentiality (signed releases of information) in order

to communicate with the victim's therapist, guardian ad litem, custodial parent, guardian, pastor, caseworker and/or any and all professionals involved in making decisions regarding reunification of the family or an offender's contact with past or potential child victim (s).

- The treatment provider shall obtain specific releases that waive confidentiality for communications with other parties in addition to those described in this STANDARD.

Discussion: Waivers of confidentiality (signed releases of information) will be required of the sex offender by the (1) conditions of probation, parole, and/or community corrections, and (2) the treatment provider-client contract.

STANDARD 80: Notwithstanding such waivers of confidentiality (signed releases of information), treatment providers shall safeguard the confidentiality of client information from those for whom waivers of confidentiality have not been obtained.

STANDARD 81: Waivers of confidentiality (signed releases of information) shall also extend to the victim, or custodial parent or guardian ad litem, of a child victim, particularly with regard to (1) the offender's compliance with treatment, and (2) information about risk, threats and/or possible escalation of violence.

STANDARD 82: The treatment provider shall notify all clients of the limits of confidentiality imposed on therapists by the mandatory reporting law.

- The treatment provider shall ensure that an offender understands the scope and limits of confidentiality in the context of his/her particular situation, including the collection of collateral information, which may or may not be treated as confidential. This will be done by a signed document that states that the offender has understanding of the scope and limits of confidentiality.

SECTION 5: SPECIAL POPULATIONS

Cultural Sensitivity

The culturally insensitive counselor or program can hinder the therapeutic relationship by misinterpreting cultural expressions. Culture is an important variable to account for in the understanding of sexually abusive youth, their families, and communities. The ability to communicate with the youth and their families in their predominant language is critical. *However, cultural sensitivity does not equate with acceptance of abusive behaviors.* We are concerned with cultural sensitivity as it relates to the acceptability and effectiveness of treatment, not the acceptance of abusive behavior.

STANDARD 83: Treatment and education interventions should support culture and ethnicity as positive factors. When working with minority youth and their families, it is important to be aware of cultural, ethnic, linguistic, and attitudinal issues which heighten or diminish sensitivity and efficacy. Treatment experiences provide education for clinicians and clients simultaneously.

Treatment issues for sexually abusive youth are similar for both minority and non-minority youth. Cross-cultural treatment is required--not treating different cultures. Culture and ethnicity must be directly addressed in any program that intervenes with minority youth.

STANDARD 84: Interventionists at all levels of the juvenile justice system need to be aware of ethnic, cultural, and/or racial myths, and take responsibility for obtaining education about ethnic and cultural issues. Participation in cultural/ethnic sensitivity training enhances personal world views, as well as a greater understanding of culturally diverse clients.

STANDARD 85: It is important to discuss the impact of oppression and mistrust in the psychological functioning of ethnic minority groups and to infuse this cultural knowledge in the context of treatment programs for sexually abusive youth.

STANDARD 86: In addition to being presented in their primary language, education and information provided to families and the community to enhance awareness of sexual abuse and promote the prevention of perpetration among youth must acknowledge and address cultural values and expectations that minimize, allow, or encourage abusive attitudes and/or behavior. However, cultural sensitivity does not equate with acceptance of abusive behaviors, which might be common or prevalent in a particular cultural group whether it is the majority culture or a minority subgroup. Objective definition of what constitutes abusive behavior cannot be subject to redefinition due to individual or cultural value judgments or customs, which excuse or allow abuse.

Pre-Pubescent Children

Professional, paraprofessional, and lay child care providers and educators must be trained to define and report sexually abusive behavior of children that has victimized another child.

STANDARD 87: Evaluation is needed for children who are engaging in problematic or sexually abusive behaviors, and specialized intervention may be indicated. Specialized treatment for sexually abusive behavior in childhood must be respectful of children's developmental needs and address developmental deficits.

STANDARD 88: It is not yet possible to know which children who exhibit sexually abusive behavior may cease these behaviors either spontaneously or as a result of treatment and which are most at risk to continue abusive behaviors over time. Treatment providers may therefore be reluctant to label the very young child; however, early interventions should clearly label the behaviors as sexually abusive.

STANDARD 89: Treatment of the younger child must convey the illegal nature of the behavior in the same sense that other behaviors (e.g., stealing) would be.

STANDARD 90: Current practice in treating sexually abusive behavior in childhood includes individual, group, and family components, which include specialized education, group process, and directive play therapy modalities.

STANDARD 91: Therapeutic interventions with sexually abusive children must limit access to vulnerable children and provide adequate supervision to prevent abusive interactions.

STANDARD 92: The full continuum of treatment services and placements should be available to all children who engage in sexually abusive behaviors, regardless of their age. (Note: Some programs are exclusive to specific age/gender groups).

Female Youth

STANDARD 93: All treatment should be gender-sensitive and explore issues of femininity and masculinity regardless of client gender and/or offense. Female sex offenders are distinctly different than male offenders and putting male and females together in treatment groups is not a general consensus in the field. A developmental approach may be useful in understanding the status of identity formation and needs of each specific group.

STANDARD 94: Treatment goals for sexually abusive female youth, in some areas are similar or identical to those suggested identified previously in these Standards (i.e., accountability, empathy, and behavior management), and many specific

treatment tools such as the sexual abuse cycle, victim empathy development, and relapse prevention plans are the same. Consideration should be given to gender issues, and treatment adaptations may be indicated by individual assessment, as is the case in appreciating the unique needs of every client (male or female).

STANDARD 95: The risks posed to children and other vulnerable persons by the untreated female perpetrator of sexual abuse appear to be as great as the risks posed by the male perpetrator. Therefore, equal attention must be given to the management of risk as is described throughout this report, whether the youth is male or female. The tendency to deny female perpetration, combined with greater access and opportunity factors requires great vigilance in case management decisions regarding placement, supervision, and relapse prevention planning.

STANDARD 96: Self reports of female clients must be viewed with the same reservations typical in treatment with male clients.

STANDARD 97: The full continuum of treatment services and placements should be available for the sexually abusive female youth.

Developmentally Disabled Youth

STANDARD 98: To prevent sexual abuse among and/or by developmentally disabled persons, specialists treating sexually abusive youth must work together with generalists whose expertise is in working with these populations. *The eventual aim should be to develop treatment providers who have expertise in both fields.*

STANDARD 99: Specialists are currently treating developmentally disabled youth who exhibit sexually abusive behaviors in residential and outpatient settings, utilizing the same theory and methods demonstrated with non-disabled sexually abusive youth. Adjustments must be made to accommodate the individual's level of cognitive ability and method of learning, and to manage impulsivity. Education relating to sexuality, relationship skills, and impulse control are especially indicated.

STANDARD 100: The full continuum of treatment services and placements should be available for developmentally disabled sexually abusive youth.

SECTION 6: APPENDIX

Inter-program Communication Form

This document is used for exchanging information between different treatment programs—such as when an offender is transferred from one program and placed into another program. This document will be available online in Phase 3 of the Sex Offender Management Information Technology system.

Treatment Referral Cover Sheet

This cover sheet will accompany all treatment referrals from probation.

Progress Report

The quarterly progress report is submitted to probation by the treatment provider to document treatment goals and progress. This document is submitted at the time of treatment enrollment, each quarter, and at the time of discharge.

Case Staffing Protocol

The Case Staffing Protocol outlines the bi-weekly collaboration between supervision officers and the treatment team.

Polygraph Forms

Evaluation for Indigent-Contract Polygraph Referrals: This document is used at the time of a polygraph referral to determine eligibility for "contract" cases. "Contract" refers to polygraph referrals paid by the Probation Department. If under contract, the fees paid by probation are later added to the probation fees incurred by the probationer. It should be noted that ability to pay should be evaluated at the time of each polygraph referral.

Probation Polygraph Referral Form and Examinee Instructions: This referral document is used by probation at the time of a polygraph referral. It outlines the issues to be addressed by the polygraph and resources that must be provided to the polygraph examiner prior to the examination. It also notes that a Sexual History Full Disclosure Test may not be referred by the Probation Department. The Examinee Instructions should be signed by the Examinee at the time of Referral.

Treatment Polygraph Referral Form: This document is used by probation at the time of a polygraph referral. It outlines the issues to be addressed by the polygraph and resources that must be provided to the polygraph examiner prior to the examination. It is the treatment provider's discretion to refer for a polygraph examination. If a Sexual History Full Disclosure Test is requested, the treatment provider must provide the Special Notice to the offender at the time of the

referral.

Special Notice about Sexual History Disclosure Polygraphs: This document must be provided to offenders at the time of a referral by a Treatment Provider for a Sexual History Disclosure Polygraph. This type of examination is for treatment assessment purposes only.

CCOSO "Position Paper for Family Resolution"

This document outlines the County's acceptance of the CCOSO Position on Family Re-Unification issues.