

## **SECTION 7: GUIDELINES FOR SEX OFFENSE-SPECIFIC EVALUATIONS**

Evaluations are conducted to identify levels of risk and specific risk factors that require attention in treatment and supervision, and to assist the court in setting release conditions for offenders who are referred with sexually inappropriate behaviors. Each offender shall receive a thorough assessment and evaluation that examines risk to recidivate and the interaction of the offender's mental health, social/systemic functioning, family and environmental functioning, and offending behaviors. Sex offense specific evaluations are not intended to supplement comprehensive psychological or neuropsychological evaluations. Evaluators have an ethical responsibility to conduct evaluations in a comprehensive and factual manner regardless of the offender's status within the criminal justice system.

- 7.010 Sex offense specific evaluation is ongoing processes and should continue throughout supervision and treatment. The input of community supervision team members should occur on a regular basis to ensure recognition of changing levels of risk and progress.
- 7.020 Sex-offense specific evaluations should be completed at the time of pre-sentence or prior to the start of offense-specific treatment.
- 7.030 The Evaluator shall obtain the informed assent of the offender for the evaluation by advising the offender of the assessment and evaluation methods to be used, the purpose of the evaluation, and to whom the information will be provided. The Evaluator shall explain to the offender about the role the Evaluator fills with regard to the offender and the supervising criminal justice agency. Results of the evaluation should be shared with the offender and any questions addressed. The Evaluator shall explain the limits of confidentiality and the obligations regarding mandatory reporting of child abuse.
- 7.040 The Evaluator shall be sensitive to any cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues, or disabilities that become known during the evaluation.
- 7.050 To ensure the most accurate prediction of risk for sexual abusers, the following evaluation modalities are all required in performing a sex offense-specific evaluation:
- Use of instruments that have specific relevance to evaluating sexual abusers
  - Use of instruments with demonstrated reliability and validity
  - Examination and integration of criminal justice information and other collateral information, including:
    - The details of the current offense
    - Documents that describe victim trauma, when available
    - Scope of offender's sexual behavior other than the current offense that may be of concern

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- Structured clinical and sexual history interview
- Offense-specific psychophysiological testing (in compliance with the and standardized assessments/instruments. Protocol for Administering Plethysmograph Testing (Appendix --)
- Use of SOMT approved risk assessment instruments and/or validated risk instruments that were normed on a population most similar to the offender being evaluated.

Discussion: Evaluation instruments and processes will be subject to change as more is learned in this area. Because measurements of risk are imperfect at this time, evaluation and assessment must be done by collecting information through a variety of methods. Evaluation and assessment therefore currently involve the integration of physiological, psychological, historical, and demographic information to adequately assess a sexual abuser's level of risk and amenability to treatment. When the Evaluator is in doubt, s/he should err on the side of protecting community safety in drawing conclusions and making recommendations.

7.060 A sex offense-specific evaluation of a sexual abuser shall evaluate the following required areas:

- Cognitive Functioning
- Mental Health
- Medical/Psychiatric Health
- Drug/Alcohol Use
- Stability of Functioning
- Developmental History
- Sexual Evaluation
- Risk
- Motivation and Amenability to Treatment
- Impact on Victim

**REQUIRED AREAS OF SEX OFFENSE SPECIFIC EVALUATION**

Outlined in the following chart are the required areas of a sex offense-specific evaluation. The left hand column identifies the required areas to be evaluated. The right hand column identifies the required evaluation procedures that may be used. Evaluators shall keep current with evidence-based practices and use the most current versions of all standardized tests. All major categories identified in Standard 7.060 shall be addressed. Optional evaluation procedures for each of the required areas of sex offense-specific evaluation may be found at the end of this chapter. It is not the intent of this section to use only the below listed required evaluation procedures, but to allow Evaluators the flexibility to use additional evaluation procedures based on their educational and professional experience and expertise.

Evaluation Areas – Required	<ul style="list-style-type: none"> <li>• Required Evaluation Procedures</li> </ul>
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**Code for:**

- A – General use tests, no advanced training required**
- B – Screening test – graduate level training in test development and administration**
- C – Advanced test or procedures – advanced training required**
- D – Clinical procedure – clinical training required**
- E – Observational procedure**
- F – Collateral information source**
- R – Self report data**
- S – Specialist referral**

**COGNITIVE FUNCTIONING**

<i>Intellectual Functioning (Mental Retardation, Learning Disability, and Intelligence</i>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• History of Functioning and/or standardized tests</li> <li>• Observational Assessment (E)</li> <li>• Case File/Document Review (F)</li> <li>• Collateral Information/Contact/Interview (F)</li> </ul>
<i>Neuropsychological Functioning (fluid intelligence)</i>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> </ul>
<i>Academic Achievement (Literacy)</i>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> </ul>

**MENTAL HEALTH**

<i>Character/Personality Pathology</i>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• Collateral Information/Contact/Interview (F)</li> <li>• Observational Assessment (E)</li> <li>• Case File/Document Review (F)</li> </ul>
<i>Mental Illness</i>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• Collateral Information/Contact/Interview(F)</li> <li>• Clinical Mental Status Exam (D)</li> <li>• Observational Assessment (E)</li> <li>• Case File/Document Review (F)</li> </ul>
<i>Self Concept/Self Esteem</i>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• Observational Assessment (E)</li> <li>• Case File/Document Review (F)</li> <li>• Collateral Information/Contact/Interview (F)</li> </ul>

**MEDICAL/PSYCHIATRIC HEALTH**

<ul style="list-style-type: none"> <li>➤ Pharmacological Needs</li> <li>➤ Medical Condition Impacting Offending Behavior</li> <li>➤ History of Medication Use/Abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• Observational Assessment (E)</li> <li>• Case File/Document Review (F)</li> <li>• Collateral Information/Contact/Interview (F)</li> </ul>
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**DRUG/ALCOHOL USE**

<i>Use/Abuse</i>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• Collateral Information/Contact/Interview (F)</li> <li>• Observational Assessment (E)</li> <li>• Case File/Document Review (F)</li> </ul>
<i>Number of Relapses</i>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• Collateral Information/Contact/Interview (F)</li> <li>• Treatment History (F)</li> </ul>

<p><b>Marital/Family Stability</b></p> <ul style="list-style-type: none"> <li>➤ Past</li> <li>➤ Current</li> <li>➤ Familial Violence</li> <li>➤ Familial Sexual</li> <li>➤ Financial</li> <li>➤ Housing</li> <li>➤ Social Support Systems</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• Interview Attitudes</li> <li>• Collateral Information/Contact/Interview (F)</li> <li>• Observational Assessment (E)</li> <li>• Case File/Document Review (F)</li> <li>• History of Functioning (F)</li> </ul>
<p><b>Access to Children</b></p> <ul style="list-style-type: none"> <li>➤ Legal Relationship to Child</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview</li> <li>• Collateral Information</li> </ul>
<p><b>Employment/Education</b></p> <ul style="list-style-type: none"> <li>➤ Completion of Major Life Tasks</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• Collateral Information/Contact/Interview (F)</li> <li>• History of Functioning (F)</li> <li>• Case File/Document Review (F)</li> </ul>
<p><b>Social Skills</b></p> <ul style="list-style-type: none"> <li>➤ Ability to Form Relationships</li> <li>➤ Ability to Maintain Relationships</li> <li>➤ Courtship/Dating Skills</li> <li>➤ Ability to Demonstrate Assertive</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• Collateral Information/Contact/Interview (F)</li> <li>• Observational Assessment (E)</li> <li>• Case File/Document Review (F)</li> </ul>

**DEVELOPMENTAL HISTORY**

<ul style="list-style-type: none"> <li>➤ Disruptions in parent/child relationship</li> <li>➤ History of behavior problems in elementary school</li> <li>➤ History of special education services, learning disabilities, school achievement</li> <li>➤ Indicators of disordered attachments</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• History of Functioning (F)</li> <li>• Observational Assessment (E)</li> <li>• Case File/Document Review (F)</li> </ul>
<p><b>Sexual History</b> (<i>Onset, Intensity, Duration, Pleasure Derived</i>)</p> <ul style="list-style-type: none"> <li>➤ Age of Onset of Expected Normal Behaviors</li> <li>➤ Quality of First Sexual Experience</li> <li>➤ Age of Onset of Deviant Behaviors</li> <li>➤ Witnessed or Experienced Victimization (Sexual or Physical)</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• History of Functioning (F)</li> <li>• Observational Assessment (E)</li> <li>• Case File/Document Review (F)</li> <li>• Polygraph Examination (S)</li> </ul>

<ul style="list-style-type: none"> <li>➤ Age/Degree of Use of Pornography, Phone Sex, Cable, Video, or Internet for Sexual Purposes</li> <li>➤ Current and Past Range of Sexual Behavior</li> <li>➤ Genesis of Sexual Information</li> <li>➤ Behavior</li> </ul>	
<p><b><i>Reinforcement Structure for Deviant Behavior</i></b></p> <ul style="list-style-type: none"> <li>➤ Culture</li> <li>➤ Environment</li> <li>➤ Cults</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> </ul>
<p><b><i>Arousal/Interest Pattern</i></b></p> <ul style="list-style-type: none"> <li>➤ Sexual Arousal or Sexual Interest</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> </ul>
<p><b><i>Specifics of Sexual Crime(s)</i></b> <i>(Onset, Intensity, Duration, Pleasure Derived)</i></p> <ul style="list-style-type: none"> <li>➤ Detailed Description of Sexual Assault</li> <li>➤ Seriousness, Harm to Victim</li> <li>➤ Mood During Assault (Anger, Erotic, “Love”)</li> <li>➤ Progression of Sexual Crimes</li> <li>➤ Thoughts Preceding and Following Crimes</li> <li>➤ Fantasies Preceding and Following Crimes</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• History of Crimes (F)</li> <li>• Collateral Information (F)</li> <li>• Review of Criminal Records (F)</li> <li>• Review of Victim Impact Statement, if available (F)</li> <li>• Polygraph (S)</li> </ul>
<p><b><i>Sexual Deviance</i></b></p>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• Polygraph Examination (S)</li> </ul>
<p><b><i>Dysfunction (Impotence, Priapism, Injuries, Medications Affecting Sexual Functioning, Etc.)</i></b></p>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> </ul>

<p><b><i>Offender's Perception of Sexual Functioning</i></b></p>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> <li>• History</li> </ul>
<p><b><i>Preferences (Male/Female; Age; Masturbation; Use of Tools, Utensils, Food, Clothing; Current Sexual Practices; Deviant as well as Normal Behaviors)</i></b></p>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> </ul>
<p><b><i>Attitudes/Cognition</i></b></p> <ul style="list-style-type: none"> <li>➤ Motivation to Change/Continue Behavior</li> <li>➤ Attitudes Toward Women, Children, Sexuality in General</li> <li>➤ Attitudes About Offense (i.e., Seriousness, Harm to Victim)</li> <li>➤ Degree of Victim Empathy</li> <li>➤ Presence/Degree of Minimalization</li> <li>➤ Presence/Degree of Denial</li> <li>➤ Ego-syntonic vs. Ego-dystonic Sense of Deviant Behavior</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical Interview (D)</li> </ul>

**RISK**

<p><b><i>Risk of Re-offense</i></b></p>	<ul style="list-style-type: none"> <li>• Criminal History</li> <li>• STATIC-99</li> <li>• STABLE-2007 (to be conducted on offenders within the community only)</li> </ul>
<p><b><i>Risk of Failure in Treatment and Supervision</i></b></p>	<ul style="list-style-type: none"> <li>• Clinical Interview</li> <li>• Criminal History</li> </ul>

**MOTIVATION AND AMENABILITY TO TREATMENT**

	<ul style="list-style-type: none"><li>• Clinical Interview (D)</li><li>• Observational Assessment (E)</li><li>• Case File/Document Review (F)</li><li>• History of Functioning (F)</li><li>• Review of Criminal Records</li><li>• History of Compliance with Treatment and Supervision</li></ul>
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**IMPACT ON VICTIM**

<i>Evaluate impact on victim and the offender's perception of impact on victim</i>	<ul style="list-style-type: none"><li>• Clinical Interview of Offender (D)</li></ul>
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Discussion: No single test should be seen as absolute or predictive; rather, results should be seen as contributing to the overall evaluation of the sexual abuser and his or her risk to the community. An offender's self-report is an unreliable source of information during the evaluation, and the Evaluator shall take steps not to rely solely on self-report information.

7.070 The Evaluator shall make recommendations or findings regarding:

- Level of risk
- Amenability for treatment
- Appropriateness for community placement
- Type of placement (e.g. outpatient, secured housing)
- Intensity of offense-specific treatment (i.e. frequency of treatment contact)
- Multi axial diagnoses
- Treatment of co-existing conditions and further assessments needed to address areas of concern
- The need for medical/pharmacological treatment, if indicated
- Expectations for involvement in treatment of offender's family
- Specific risk factors that require management and potential interventions
- Access to, contact with and /or restrictions against contact with children and victims

Upon request, the Evaluator (if different from the treatment provider) shall also provide information to the case management team or prison treatment provider at the beginning of an offender's term of supervision or incarceration.

- 7.080 In the evaluation process, physiological testing through the use of polygraph examinations can be useful in understanding an offender's level of deception and denial and is recommended in the evaluation process. The polygraph should not be used to determine guilt or innocence or as the primary finder of facts for legal purposes. (See Sections 12.000 for standards on the use of the polygraph.)
- 7.090 Evaluators shall follow the Protocol for Administering Plethysmograph Testing (Appendix --) prior to administering a plethysmograph test. If the offender has an assigned community supervision officer, the Evaluator shall work with the community supervision team.

*Note: The Hawaii Sex Offender Management Team recognizes the importance of thorough and comprehensive assessments for both public safety as well as successful treatment strategies for the offender. SOMT also recognizes the multitude of diagnostic tools available when conducting assessments as well as for their use during treatment. In consideration of the nature of these tests<sup>1</sup> as well as the additional resources required for the administration of these tests to both the State and the client these tests are not mandatory components of evaluations. The protocol shall be followed for Plethysmograph Testing.*

- 7.110 Evaluators have an ethical responsibility to conduct evaluation procedures in a manner that ensures the integrity of testing data and the humane and ethical treatment of the offender, and compliance with mental health statutes. Evaluators should use testing instruments in accordance with their qualifications and experience. Uninterpreted raw data from any type of testing should never be released to those not qualified to interpret.
- 7.120 Any required evaluation areas that the Evaluator did not address or any required evaluation procedures that the Evaluator did not perform shall be specifically noted. In addition, the Evaluator must state the limitations of the evaluation's results, conclusions or recommendations. When there is insufficient information to evaluate one of the required areas, then no conclusions shall be drawn nor recommendations made concerning that required area.
- 7.130 When conducting an evaluation prior to an admission or finding of guilt, the Evaluator must obtain all information the Evaluator would have received if the referral for the evaluation had been from a criminal justice agency. If an evaluation conducted prior to an admission or finding of guilt does not address all required evaluation areas, recommendations and findings should be correspondingly limited and the evaluation must be referred to an Evaluator to be completed in accordance with the Standards prior to sentencing.

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<sup>1</sup> United States v. Weber, 451 F.3d 552, 556 (9<sup>th</sup> Cir. 2006).

**OPTIONAL AREAS OF SEX OFFENSE SPECIFIC EVALUATION**

Outlined in the following chart are the optional evaluation procedures within the required areas of a sex offense-specific evaluation, in the left hand column. The left hand column identifies the required areas to be evaluated. The right hand column identifies the optional evaluation procedures that may be used in addition to the required evaluation procedures outline in Section 7.060. These optional evaluation procedures may be used at the discretion of the Evaluator. The most current versions of all standardized tests should be used.

Evaluation Areas – Required	o Optional Evaluation Procedures
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**Code for:**

- A – General use tests, no advanced training required**
- B – Screening test – graduate level training in test development and administration**
- C – Advanced test or procedures – advanced training required**
- D – Clinical procedure – clinical training required**
- E – Observational procedure**
- F – Collateral information source**
- R – Self report data**
- S – Specialist referral**

**COGNITIVE FUNCTIONING**

<i>Intellectual Functioning (Mental Retardation, Learning Disability, and Literacy)</i>	<ul style="list-style-type: none"> <li>o WAIS (C)</li> <li>o TONI (Test of Non-Verbal Intelligence) (B)</li> <li>o Shipley Institute of Living Scale Revised (B)</li> <li>o Kaufman IQ Test for Adults (C)</li> <li>o <u>Woodstock-Johnson Psychoeducational Battery, Revised (C)</u></li> <li>o Stanford Binet (C)</li> <li>o Slosson Intelligence Test – Revised (B)</li> <li>o Slosson Full-Range Intelligence Test (B)</li> <li>o Kaufman Brief Intelligence Test (B)</li> <li>o Universal Nonverbal Intelligence Test (C)</li> </ul>
<i>Neuropsychological Functioning (fluid intelligence)</i>	<ul style="list-style-type: none"> <li>o Observational Assessment (E)</li> <li>o Case File/Document Review (F)</li> <li>o Collateral Information/Contact/Interview (F)</li> <li>o Test of Memory and Learning (C)</li> <li>o K-SNAP (B)</li> <li>o Cognistat – Neurbehavioral Cognitive Status Exam (B)</li> <li>o Boston Naming Test (B)</li> <li>o Boston Diagnostic Aphasia Test (C)</li> <li>o Luria-Nebraska Screening Test (B)</li> <li>o Weschler Memory Scale Revised (C)</li> </ul>

	<ul style="list-style-type: none"> <li>o Jacobs Cognitive Screening Test (B)</li> <li>o Quick Neurological Screening Test (B)</li> <li>o Bilingual Verbal Abilities Test (B)</li> <li>o Referral to Neuropsychologist if necessary (S)</li> <li>o WAIS (C)</li> <li>o <u>CPT (C)</u></li> <li>o <u>Trails (B)</u></li> <li>o Bender – Gestalt (C)</li> </ul>
<b><i>Academic Achievement</i></b>	<ul style="list-style-type: none"> <li>o Observational Assessment (E)</li> <li>o Case File/Document Review (F)</li> <li>o Collateral Information/Contact/Interview (F)</li> <li>o Woodcock-Johnson Psychoeducational Battery, Revised (C)</li> <li>o Wide Range Achievement Test (B)</li> <li>o Referral to Educational Diagnostic if necessary (S)</li> <li>o Referral to Vocational Specialist if necessary (S)</li> <li>o <u>Tabc (B)</u></li> </ul>

**MENTAL HEALTH**

<b><i>Character/Personality Pathology</i></b>	<ul style="list-style-type: none"> <li>o Hare Psychopathy Checklist Revised (C)</li> <li>o Psychopathy Checklist – Screening Version (B)</li> <li>o MCMI (C)</li> <li>o MMPI-2 (C)</li> <li>o Jessnes Inventory (C)</li> <li>o Rorschach Test (C)</li> <li>o Sentence Completion Series (B)</li> <li>o State-Trait Anger Inventory (B)</li> <li>o State-Trait Anxiety Inventory (B)</li> <li>o Social/Developmental History (D)</li> <li>o <u>PAI (C)</u></li> </ul>
<b><i>Mental Illness</i></b>	<ul style="list-style-type: none"> <li>o MCMI (C)</li> <li>o MMPI-2 (C)</li> <li>o Jessnes Inventory (C)</li> <li>o Rorschach Test (C)</li> <li>o Sentence Completion Series (B)</li> <li>o Symptom Checklist 90 (B)</li> <li>o Brief Symptom Inventory / Symptom Assessment 45 (B)</li> <li>o Trauma Symptom Checklist (C)</li> <li>o Beck Depression Inventory (A)</li> <li>o Positive and Negative Syndrome Scale (B)</li> <li>o Brief Psychiatric Rating Scale (B)</li> </ul>

<b><i>Self Concept/Self Esteem</i></b>	<ul style="list-style-type: none"> <li>o MPD (Measures of Psychological Development) (B)</li> <li>o CAQ (Clinical Analysis Questionnaire) (D)</li> <li>o CPI (California Personality Inventory) (C)</li> <li>o MCMI (C)</li> <li>o MMPI-2 (C)</li> <li>o Jessnes Inventory (C)</li> </ul>
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**MEDICAL/PSYCHIATRIC HEALTH**

<ul style="list-style-type: none"> <li>➤ Pharmacological Needs</li> <li>➤ Medical Condition Impacting Offending Behavior</li> <li>➤ History of Medication Use/Abuse</li> </ul>	<ul style="list-style-type: none"> <li>o Referral to Physician, if indicated (S)</li> <li>o Referral to Psychiatrist, if indicated (S)</li> <li>o Referral for Medical Tests (S)</li> <li>o Referral to Psychiatric Mental Health Nurse Practitioner, if indicated (S) (Joseph)</li> </ul>
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**DRUG/ALCOHOL USE**

<b><i>Use/Abuse</i></b>	<ul style="list-style-type: none"> <li>o <u>Referral to Certified Substance Abuse Counselor (S)</u></li> <li>o MCMI-III (C)</li> <li>o MMPI-2 (C)</li> <li>o Clinical Analysis Questionnaire (D)</li> <li>o Personal History Questionnaire (B)</li> <li>o SASSI – III (B)</li> <li>o Adult Substance Use Survey (B)             <ul style="list-style-type: none"> <li>o Substance Use History Matrix (B)</li> <li>o Polygraph Examination (S)</li> </ul> </li> </ul>
<b><i>Number of Relapses</i></b>	<ul style="list-style-type: none"> <li>o Observational Assessment (E)</li> <li>o Case File/Document Review (F)</li> </ul>

**STABILITY AND FUNCTIONING**

<b><i>Marital/Family Stability</i></b> <ul style="list-style-type: none"> <li>➤ Past</li> <li>➤ Current</li> <li>➤ Familial Violence</li> <li>➤ Familial Sexual</li> <li>➤ Financial</li> <li>➤ Housing</li> <li>➤ Social Support Systems</li> </ul>	<ul style="list-style-type: none"> <li>o Personal History Questionnaire (B)</li> <li>o Family Environment Scale (B)</li> <li>o Dyadic Adjustment Scale (B)</li> <li>o Marital Satisfaction Inventory (B)</li> </ul>
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<p><b>Access to Children</b></p> <ul style="list-style-type: none"> <li>➤ Legal Relationship to Child</li> </ul>	<ul style="list-style-type: none"> <li>o PRA (Parental Risk Assessment)</li> </ul>
<p><b>Employment/Education</b></p> <ul style="list-style-type: none"> <li>➤ Completion of Major Life Tasks</li> </ul>	<ul style="list-style-type: none"> <li>o Clinical Mental Status Exam (D)</li> <li>o Observational Assessment (E)</li> <li>o Personal History Questionnaire (B)</li> </ul>
<p><b>Social Skills</b></p> <ul style="list-style-type: none"> <li>➤ Ability to Form Relationships</li> <li>➤ Ability to Maintain Relationships</li> <li>➤ Courtship/Dating Skills</li> <li>➤ Ability to Demonstrate Assertive</li> </ul>	
<p><b>Behavior</b></p>	<ul style="list-style-type: none"> <li>o Interpersonal Behavior Survey (B)</li> <li>o Social Avoidance and Distress Scale (B)</li> <li>o Miller's Social Intimacy Scale (A)</li> </ul>

**DEVELOPMENTAL HISTORY**

<ul style="list-style-type: none"> <li>➤ Disruptions in parent/child relationship</li> <li>➤ History of bed wetting, cruelty to animals</li> <li>➤ History of behavior problems in elementary school</li> <li>➤ History of special education services, learning disabilities, school achievement</li> <li>➤ Indicators of disordered attachments</li> </ul>	<ul style="list-style-type: none"> <li>o Collateral Information/Contact/Interview (F)</li> </ul>
<p><b>Reinforcement Structure for Deviant Behavior</b></p> <ul style="list-style-type: none"> <li>➤ Culture</li> <li>➤ Environment</li> <li>➤ Cults</li> </ul>	
<p><b>Arousal/Interest Pattern</b></p> <ul style="list-style-type: none"> <li>➤ Sexual Arousal or Sexual Interest</li> </ul>	<ul style="list-style-type: none"> <li>o Plethysmograph (S) or Able Assessment (S)</li> </ul>

<p><b><i>Specifics of Sexual Crime(s)</i></b>  <i>(Onset, Intensity, Duration, Pleasure Derived)</i></p> <ul style="list-style-type: none"> <li>➤ Detailed Description of Sexual Assault</li> <li>➤ Seriousness, Harm to Victim</li> <li>➤ Mood During Assault (Anger, Erotic, "Love")</li> <li>➤ Progression of Sexual Crimes</li> <li>➤ Thoughts Preceding and Following Crimes</li> <li>➤ Fantasies Preceding and Following Crimes</li> </ul>	<ul style="list-style-type: none"> <li>o Contact with Victim Therapist (F)</li> </ul>
<p><b><i>Sexual Deviance</i></b></p>	<ul style="list-style-type: none"> <li>o SONE Sexual History Background Form (R)</li> <li>o Multiphasic Sex Inventory II (C)</li> <li>o Hanson Sexual Attitudes Questionnaire (B)</li> <li>o Wilson Sex Fantasy Questionnaire (B)</li> <li>o Abel and Becker Card Sort (B)</li> <li>o Sexual Projective Card Sort (B)</li> <li>o Sexual Autobiography (R)</li> <li>o Attitudes Toward Women Scale (B)</li> <li>o Burt Rape Myth Acceptance Scale (B)</li> <li>o Abel and Becker Cognition Scale (B)</li> </ul>
<p><b><i>Dysfunction (Impotence, Priapism, Injuries, Medications Affecting Sexual Functioning, Etc.)</i></b></p>	<ul style="list-style-type: none"> <li>o Multiphasic Sex Inventory II (C)</li> <li>o SONE Sexual History Background Form (R)</li> <li>o Medical tests (S)</li> </ul>
<p><b><i>Offender's Perception of Sexual Functioning</i></b></p>	<ul style="list-style-type: none"> <li>o Bentler Heterosexual Inventory (B)</li> <li>o Abel and Becker Card Sort (B)</li> <li>o Plethysmograph (S) or Abel Assessment (S)</li> <li>o Bentler Sexual Behavior Inventory (R)</li> <li>o MSI II(A)</li> </ul>
<p><b><i>Attitudes/Cognition</i></b></p> <ul style="list-style-type: none"> <li>➤ Motivation to Change/Continue Behavior</li> <li>➤ Attitudes Toward Women, Children, Sexuality in General</li> </ul>	<ul style="list-style-type: none"> <li>o Burt Rape Myth Acceptance Scale (B)</li> <li>o Multiphasic Sex Inventory II (C)</li> <li>o Buss/Durkee Hostility Inventory (R)</li> <li>o Abel and Becker Cognitions Scale (B)</li> </ul>

<ul style="list-style-type: none"> <li>➤ Attitudes About Offense (i.e., Seriousness, Harm to Victim)</li> <li>➤ Degree of Victim Empathy</li> <li>➤ Presence/Degree of Minimalization</li> <li>➤ Presence/Degree of Denial</li> <li>➤ Ego-syntonic vs. Ego-dystonic Sense of Deviant Behavior</li> </ul>	<ul style="list-style-type: none"> <li>○ Attitudes Towards Women Scale (B)</li> <li>○ Socio-Sexual Knowledge and Attitudes Test (For use with sexual abusers who have developmental disabilities) (B)</li> </ul>
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**RISK**

<p><i>Risk of Re-offense</i></p>	<ul style="list-style-type: none"> <li>○ Violence Risk Assessment Guide (Normed on a psychiatric hospital sample)</li> <li>○ Sex Offense Risk Assessment Guide</li> <li>○ Rapid Risk Assessment for Sex Offender Re-arrest (Sample excludes incest offenders)</li> <li>○ MnSOST-R (Normed on Minnesota offenders in the Department of Corrections, excludes incest offenders)</li> <li>○ CARAT</li> <li>○ HCR 20</li> </ul>
<p><i>Risk of Failure in Treatment and Supervision</i></p>	<ul style="list-style-type: none"> <li>○ PCL-R</li> <li>○ STABLE-2007</li> </ul>

**MOTIVATION AND AMENABILITY TO TREATMENT**

	<ul style="list-style-type: none"> <li>○ DCJ Checklist</li> <li>○ <u>BTPI (C)</u></li> <li>○ <u>MSI II(A)</u></li> </ul>
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**IMPACT ON VICTIM**

<p><i>Evaluate impact on victim and the offender's perception of impact on victim</i></p>	<ul style="list-style-type: none"> <li>○ Case File/Document Review (F)</li> <li>○ Review Victim Impact Statement</li> <li>○ Contact Victim Therapist/Advocates, when available</li> <li>○ Interview Family Members</li> </ul>
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## **SECTION 8.000 STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS**

### **8.100 Sex Offense-specific Treatment**

An essential component of sex offender management involves sex offense-specific treatment. Sex offense-specific treatment is designed to promote offender accountability and enhance skills and competencies that may reduce the likelihood of sexual re-offending. Sex offense-specific treatment programs that include cognitive-behavioral and relapse prevention components incorporating individual interventions appear to have the most favorable effect on reducing recidivism<sup>1</sup>. Treatment should draw on an offender's personal strengths to replace abusive behavior with prosocial alternatives. The aim of sex offender treatment should be to:

“equip the offenders with the skills, values, attitudes and resources necessary to lead a different kind of life, one that is meaningful and satisfactory and does not involve inflicting harm on children or adults.”<sup>2</sup>

- 8.101 Sex offense-specific treatment must be provided by a treatment provider registered at the full operating level or the associate level under these Standards (see Qualifications of Treatment Providers).
- 8.102 A provider who treats sexual offenders must use sex offense-specific treatment (See Definition Section) and incorporate evidence-based best practices.
- 8.103 A provider shall employ treatment methods that are supported by current professional research and practice:
- A. Group therapy (with the group comprised only of sexual offenders) is the preferred method of sex offense-specific treatment. At a minimum, any method of therapeutic treatment must conform to the standards for content of treatment (see F., below) and must contribute to behavioral monitoring of sexual offenders. The sole use of individual therapy is not recommended with sexual offenders, and shall be avoided except when geographical—specifically rural—or individual needs dictate its use, or when treating females (see C below).

*Discussion: Group therapy may need to be supplemented by treatment for drug/alcohol abuse, marital therapy, mental health treatment, psychotropic*

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<sup>1</sup> Marshall, W. L., and D. R. Laws. 2003. A brief history of behavioral and cognitive behavioral approaches to sexual offender treatment: Part 2. The modern era. *Sexual Abuse: A Journal of Research and Treatment*, 15, 93-120.

<sup>2</sup> Ward, T., Mann, R. E., and T.A. Gannon. 2007. The good lives model of rehabilitation: clinical implications. *Aggression and Violent Behavior*, 12, 208-228.

*medication intervention, and individual crisis intervention. However, group sex offense-specific treatment should remain the primary modality utilized with sexual offenders.*

- B. Where possible, therapists shall separate sub-populations of sexual offenders (i.e. offenders who target adult victims and those who target children).
- C. Where possible, therapists shall separate high-risk offenders from lower risk offenders<sup>3</sup>.
- D. Male and female sexual offenders shall be treated in separate groups. The treatment of females may require individual therapy solely, when the number of female offenders does not constitute a group and when treatment targets, such as trauma issues, may be better addressed in individual sessions.
- E. Group sessions should be a minimum of once per week and may extend to one additional session per week.
- F. Group sessions shall be a minimum of 1.5 hours and maximum of 3 hours.

*Note: As offenders progress in treatment by obtaining treatment goals, increasing protective factors, decreasing risk factors, etc., the frequency of group sessions may be reduced upon consensus of the treatment team. Upon making such changes to the treatment plan, written justification for such changes shall be maintained within the offender's file.*

- G. Group sessions shall be facilitated by two therapists. The use of male and female co-therapists in group therapy is highly recommended and may be required by the supervising agency.
- H. The ratio of therapists to sexual offenders in a treatment group shall not exceed 1:8. Treatment group size (should) not exceed 12 sexual offenders.

*Discussion: It is understood that the occasional illness or absence of a co-therapist may occur, which will cause the treatment group to exceed this ratio. It is also understood that a particular treatment program may be structured in such a way that specific didactic modules of psycho-educational information are presented to larger groups of sexual offenders at one time. Such psycho-educational information is a component of, but not a substitute for sex offense-specific treatment. These circumstances constitute occasional exceptions to the standard described in E. above. The test of compliance with this standard will be the regularity with which the ratio of therapists to sexual*

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<sup>3</sup> Andrews, D.A., and J. Bonta. 2003. *The psychology of criminal conduct*, 3<sup>rd</sup> ed., Cincinnati, OH: Anderson Publishing, Fernandez, Y.M. and W.L. Marshall. 2000. Contextual issues in relapse prevention treatment. In *Remaking Relapse Prevention with Sex Offenders*, ed. D.R. Laws, S.M. Hudson, and T. Ward, 225-35. Thousand Oaks, CA: Sage Publishing.

*offenders is congruent with E. above. It is also understood that circumstances within a prison setting may result in treatment groups exceeding this ratio. Such circumstances must be approved by the contracting agency.*

*The Sex Offender Management Team believes that the treatment of sexual offenders is sufficiently complex and the likelihood of re-offense sufficiently high that the offender to therapist ratio and group size should be fairly small.*

- I. The provider shall employ treatment methods that give priority to the safety of the offender's victim(s) and the safety of potential victims and the community.
  - J. The provider shall employ treatment methods that are based on the recognition of the need for long-term, comprehensive, offense-specific treatment for sexual offenders. Self-help or time-limited treatments shall be used only as adjuncts to long-term, comprehensive treatment.
  - K. The provider shall employ treatment methods that target assessed sexual and general criminogenic risk factors. These factors should be addressed during treatment sessions.
  - L. The provider shall, whenever practicable, match the offender's risk, needs and personal characteristics with appropriate treatment interventions, intensity, and staff.
  - M. The provider shall employ methods of positive reinforcement by targeting a 4:1 ratio of positive to negative reinforcement.
- 8.104 The provider shall agree to quality assurance measurements, program assessments, and feedback. These may include an assessment of the provider's treatment program as it relates to effective programming and/or validation of research.<sup>4</sup>

## **8.200 Confidentiality**

In the treatment of sexual offenders, safety issues must override the usual rights of confidentiality<sup>5</sup>.

- 8.201 A treatment provider shall obtain signed waivers of confidentiality and releases of information based on the informed consent of the offender. Waivers of confidentiality and releases of information are only valid while the offender is in treatment with the provider and while under the jurisdiction of the supervising

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<sup>4</sup> Quality assurance and program evaluations support the State's ongoing efforts towards implementing evidence-based programs and services.

<sup>5</sup> Except where state and federal laws prevent specific information from being released.

agency. If either of these two conditions cease, both the waiver of confidentiality and releases of information will no longer be in effect.

8.202 The waiver/release shall include the following relevant components:

- State that all reports generated by the treatment provider will be shared with future therapists and supervising officers in the interest of community safety.
- Extend to all therapists treating the offender.
- Extend to the victim's therapist except where prohibited by law.
- 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.
- Extend to the supervising officer and all members of the treatment team (see 5.200) and, if applicable, to the contracting agency and any other individuals or agencies responsible for the supervision of the offender.

*Notwithstanding such waivers of confidentiality, treatment providers shall safeguard the confidentiality of offender information from those for whom waivers of confidentiality have not been obtained.*

8.203 These waivers of confidentiality do not allow treatment therapist/provider to release any information directly received from the supervision agency. All records provided by the supervising agency, shall be returned or destroyed.

8.204 A provider shall notify all offenders of the limits of confidentiality imposed on therapists by the mandatory reporting law, H.R.S. 350-1.1.

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

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

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

**8.300 Treatment Provider-Offender Contract**

8.301 A provider shall develop and utilize a written contract with each sexual offender prior to the commencement of treatment. The contract shall define the specific responsibilities of both the provider and the offender.

A. The contract shall explain the responsibility of a provider to:

1. Define and provide timely statements of the costs of assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations;
2. Describe the waivers of confidentiality which will be required for a provider to treat the offender for his/her sexual offending behavior; describe the various parties (i.e. probation/parole officer, polygraph examiner) with whom treatment information will be shared during the treatment; describe the time limits on the waivers of confidentiality; describe the procedures necessary for the offender to revoke the waiver, and describe what will be done with the information that has already been provided;
3. Describe the right of the offender to refuse treatment and/or to refuse to waive confidentiality, and describe the risks and potential outcomes of that decision;
4. Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined; and
5. Describe the limits of confidentiality imposed on therapists by the mandatory reporting law, H.R.S. 350-1.1.

B. The contract shall explain an offender's responsibility (as applicable) to:

1. Participate satisfactorily in his/her assessment and treatment, and comply with treatment and case planning activities;

*Note: Repeated unexcused absences, disruptive behavior, etc. should be stated so that offender is aware that such behavior may be grounds for termination.*

2. Pay for the cost of assessment and treatment for him or herself, and his or her family, if applicable;
3. Pay for the cost of assessment and treatment for the victim(s) and their family(ies), when ordered by the court and through the supervising officer,

including all medical and psychological tests, physiological testing, and consultation;

4. Inform the offender's family and support system of details of past offenses that are relevant to ensuring help and protection for past victims and/or relevant to the relapse prevention plan. Clinical judgment should be exercised in determining what information is provided to children;
5. Actively involve relevant family, support system and group members as indicated in the relapse prevention plan;
6. Notify the treatment provider of any changes or events in the lives of the offender and members of the offender's family or support system;
7. Participate in polygraph examinations as required by the treatment team and, if indicated, plethysmograph testing and/or Abel Screening as adjuncts to treatment;
8. Comply with the limitations and restrictions placed on the behavior of the offender, as described in the terms and conditions of probation, parole, or community corrections and/or in the contract between the provider and the offender.
9. Break patterns of secrecy by reporting the behavior of other group members involved in risky behavior.
10. Bring in family members and support system at treatment milestones<sup>6</sup>.
11. Notify both the treatment provider and supervising officer of any changes in treatment or supervision status.

*Note: While all members of the treatment team are in continuous communication, it is the responsibility of the offender to inform all members of any changes in status. At no time, should the offender assume communication has occurred between team members.*

C. The contract shall also (as applicable):

1. Provide instructions and describe limitations regarding the offender's contact with victims, secondary victims, and children;
2. Describe limitations or prohibitions on the use or viewing of sexually explicit or violent material;

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<sup>6</sup> English, K., Pullen, S. and L. Jones. 1996. Managing Adult Sex Offenders: A Containment Approach. Colorado Division of Criminal Justice, American Probation and Parole Association.

3. Describe the responsibility of the offender to protect community safety by avoiding risky, aggressive, or re-offending behavior, by avoiding high risk situations, and by reporting any such forbidden behavior to the provider and the supervising officer as soon as possible;
4. Describe limitations or prohibitions on the use of alcohol or drugs not specifically prescribed by medical staff;
5. Describe limitations or prohibitions on employment or recreation; and
6. Describe limitations or prohibitions on the use of electronic devices and internet.

**8.400 Treatment Goals and Behavioral Targets**

- 8.401 To reduce recidivism, the provider shall employ risk assessment instruments approved by SOMT that measure both general and sex offending risk using static, dynamic and protective variables. The administering of these instruments shall be set at intervals determined by SOMT.
- 8.402 Treatment shall focus on the top three dynamic criminogenic factors related to the offenders' risk of sexual offending
- 8.403 The provider shall employ recidivism reduction interventions in addressing the primary goals of treatment:
- A. Recognize and enhance strengths in order to increase resilience;
  - B. Motivate and enhance engagement to leading a prosocial lifestyle;
  - C. Decrease and/or manage deviant sexual urges and recurrent deviant fantasies;
  - D. Decrease criminal thinking, attitudes and beliefs;
  - E. Develop or increase victim empathy;
  - F. Increase cognitive, emotional and behavioral self-regulation skills;
  - G. Decrease intimacy and attachment deficits that relate to problematic cognitive, emotional and behavioral responses;
  - H. Develop prosocial relationships and ongoing support in the community, while decreasing negative social influences.

8.404 The content of sex offense-specific treatment should be delivered in a strength-based approach designed to overcome resistance and increase intrinsic motivation for change, and shall be designed to:<sup>7 8</sup>

1. Teach offenders the skills to intervene in their thinking through coaching, modeling, role rehearsal and assignments, and the relationship between thoughts, feelings, attitudes/beliefs, and behavior.
2. Reduce the offenders' denial and defensiveness;
3. Decrease and/or manage offenders' deviant sexual urges and recurrent deviant fantasies;
4. Educate offenders (and individuals who are identified as the offenders' support systems) about the potential for re-offending and about the offenders' specific risk factors;
5. Teach offenders self-management methods to avoid a sexual re-offense;
6. Identify and treat the offenders' thoughts, emotions, attitudes/beliefs, and behaviors that facilitate criminal thinking and behaviors;
7. Identify and correct offenders' cognitive distortions;
8. Educate offenders about non-abusive, adaptive, legal, and pro-social sexual functioning;
9. Educate offenders about the impact of sexual offending upon victims, their families, and the community;
10. Provide offenders with an environment that encourages the development of empathetic skills needed to achieve sensitivity and empathy for victims;
11. Provide offenders with guidance to prepare, when applicable, written explanation or clarification for the victim(s) that meets the goals of: establishing full perpetrator responsibility, empowering the victim, and promoting emotional restitution for the victim(s);
12. Identify the offender's personality traits and deficits that contribute to his/her risk, and provide offenders with strategies for intervention;
13. Identify the effects of trauma and past victimizations on offenders as factors that may interfere with their treatment, and potential for re-offending. If

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<sup>7</sup> Marshal, W.L., L. Marshall, G. Serran, and M. O'Brian 2011. *Rehabilitating Sexual Offenders: A Strength-Based Approach*. American Psychological Association, Washington D.C.

<sup>8</sup> Ward, T. et al. 2007. page 6.

serious trauma and victimization issues exists, consideration should be given to how these issues shall be addressed.

14. Identify and decrease offenders' deficits in social and relationship skills and reinforce positive coping skills, where applicable;
15. 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;
16. Provide assessment referrals, , for offenders with co-existing medical, pharmacological, mental, substance abuse and/or domestic violence issues, or other disabilities, so appropriate treatment can be initiated;
17. Maintain communication with other significant persons in offenders' support systems when indicated, and to the extent possible, to assist in meeting treatment goals;
18. Evaluate cultural, language, developmental disabilities, sexual orientation and/or gender factors that may require special treatment arrangements;
19. Identify and address issues of gender role socialization; and
20. Identify and treat issues of anger, power, and control.

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

8.405 A provider shall develop a written treatment plan based on the needs and risks identified in current and past assessments/evaluations of the offender, and focus on the highest three criminogenic factors.

- A. The treatment plan shall:
  1. Be individualized to meet the unique needs of the offender.
  2. Identify the issues to be addressed, including multi-generational issues if indicated, the planned intervention strategies, the goals and objectives of treatment and tasks to be completed.
  3. Incorporate cognitive-behavioral interventions with role rehearsal.
  4. Incorporate strengths and protective factors.

5. Define expectations of the offender, his/her family (when possible), and support systems.
6. Identify measurable outcomes. (include more direction at to what type of outcomes; i.e. behavioral, emotional, financial, employment?)
7. Identify necessary precautions for the protection of victims and not cause the victim(s) to have unsafe and/or unwanted contact with the offender.
8. Address the issue of ongoing victim input, when applicable.

- B. The treatment plan shall be updated regularly to reflect the current risk/needs of the offender and shall be provided to the supervising officer.

*Note: Treatment plans shall be based on criminogenic risk/needs identified through assessments and revised according to the offender's achievement of treatment plan goals. The primary therapist shall meet with the offender to establish the treatment plan goals collaboratively. Both the therapist and the offender shall sign treatment plans.*

*Note: Treatment plans shall be developed in consultation with the community supervision officer to ensure consistency in developing behavioral management goals.*

- 8.406 A provider shall assess each offender's progress in treatment on a minimum quarterly basis utilizing a SOMT-approved form and provide the completed form to the supervising officer.

*Note: More frequent progress reports may be optimal for some offenders in some situations.*

- A. The progress report shall:
1. Address the offender's progress in meeting the goals and objectives of the treatment plan.
  2. Identify changes in the offender's previously identified protective factors.
  3. Identify changes in the offender's dynamic risk factors and how they are being addressed in treatment.
  4. Identify issues and changes in the offender's situation.

5. Provide recommendations to the community supervision officer.

8.407 Providers should maintain face-to-face contact a minimum of once per month, with the supervising officer or designee, and provide updates to progress in treatment and/or any concerns. Electronic communications are encouraged when decisions require prompt attention and shall abide by HIPAA regulations.

*Note: Any violations of the treatment contract shall be reported to the supervising officer immediately, but no later than twenty-four (24) hours after the violation becomes known to the provider.*

8.408 Providers shall maintain offenders' files in accordance with the professional standards of their individual disciplines and with state and federal laws on health care records. Offender files shall:

- A. Document the goals of treatment, the methods used, the offender'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.
- B. Accurately reflect the offender's treatment progress, the dates of treatment sessions attended, and changes in treatment.
- C. Include copies of evaluations and risk assessment instruments completed on the offender.

### **8.500 Completion of Court-Ordered Treatment**

8.501 Discharge from treatment requires the concurrence of the supervising officer. Successful completion of treatment is not the end of offenders' rehabilitative needs or the elimination of all risk to the community.

The decision to discharge the offender from treatment shall be based on:

- A risk assessment and a determination by the provider, and with the concurrence of the supervising officer, that the offender would not pose an undue risk to the victim and the community without further treatment;
- The goals of treatment have been met;
- An examination of multiple factors over an extended period of time in the maintenance phase of treatment, including but not limited to: a non-deceptive disclosure polygraph examination, two or more consecutive non-deceptive

maintenance polygraph examinations, demonstration of pro-social skills and behaviors, and positive input from the offender's community network regarding the offender's adjustment;

8.502 Prior to discontinuing treatment, a provider shall, in cooperation with the supervising officer, develop an aftercare plan that includes ongoing behavioral monitoring, such as periodic polygraph examinations. Such monitoring is intended to motivate the offender to avoid high-risk behaviors that might be related to increased risk of re-offense. The plan shall also recommend the offender be reassessed for additional treatment needs should the offender later be found to engage in high risk behaviors.

8.503 Exceptions made to any of the requirements for treatment completion requires the concurrence of the supervising officer. The therapist shall document the reasons for the determination that treatment completion is appropriate without meeting all of the standard requirements, and note the potential risks to the community.

Note: an example of this may be when an offender's cognitive impairments restrict him/her from obtaining the full benefits of treatment.

#### **8.600 Termination from Treatment**

8.601 Violence or threats of violence shall warrant immediate termination. This may include violent actions in treatment sessions or threats of violence against the therapists, group members, self, or is perceived as presenting as an imminent threat to self or others.

8.602 Termination from treatment may be appropriate due to continued non-compliance of the signed treatment contract.

8.603 The treatment provider shall provide the offender with a minimum of two written warnings prior to termination from treatment. A photocopy of the written warning notices shall be provided to the supervising officer within forty eight (48) hours.

8.604 The decision to terminate from treatment may be based on:

- Repeated unexcused absences from treatment sessions
- Disruptive behavior in group
- Failure to abide by the signed treatment contract

- 8.605 A therapist shall not terminate an offender from treatment without due cause. Termination from treatment without due cause may be considered by the treatment team. The decision to terminate without due cause shall be the consensus of the treatment team. Upon such termination, a written notice and alternative treatment plan shall be provided to the offender.
- 8.606 Upon termination from treatment, the therapist will provide the offender with a written notice of termination. This letter shall document the previous warnings given to the offender and documentation of the offender's failure to take corrective action to prevent the termination.
- 8.607 Upon termination from treatment, the provider shall provide a recommended plan of action to the supervising officer.
- 8.608 There may be exceptions to these standards given the unique needs of individual situations. Any exceptions should be in collaboration with the supervising officer.

**8.700 Treatment Providers' Use of the Polygraph and Plethysmograph and Abel Assessment**

- 8.701 In cooperation with the supervising officer, the provider ~~may~~ shall employ treatment methods that integrate the results of polygraph examinations, including specific issue polygraphs, disclosure polygraphs, and maintenance polygraphs. Exceptions to the requirement for use of the polygraph may be made only by the supervision officer or by the contracting agency.
- 8.702 When polygraph is used, the examiner must meet the standards for post-conviction sex offender polygraph testing as defined in Section 12 of these standards and by Association for the Treatment of Sexual Abusers (ATSA).
- 8.703 Maintenance polygraphs should be conducted at least every six months; specific issue polygraphs should be conducted as the need arises. The result of such polygraphs shall be used to identify treatment issues and for behavioral monitoring.

*Discussion: Because of the epidemic nature of sexual abuse, there is a need for more and better methods to accurately assess, treat, and monitor sexual offenders. Polygraph testing is an effective tool for informing the provider and supervising officer about the type and severity of abusive behavior patterns, and compliance with treatment and supervision conditions, and can assist in suggesting necessary levels of supervision and treatment. In addition, polygraph testing can improve treatment outcomes by shortening the denial phase. It is recommended that polygraph exams occur at least every six months, and more frequently as necessary.*

- 8.704 A provider may employ treatment methods that integrate the results of plethysmography, the Abel Assessment or other physiological testing, as indicated.

If plethysmography is used, the examiner must meet the standards for plethysmography as defined in Appendix (TBD): Protocol for Administering Plethysmograph (PPG) Testing and the Association for the Treatment of Sexual Abusers (ATSA)<sup>9</sup> and described in Section 13.000 of these standards. If the Abel Assessment is used, the treatment provider or evaluator must be trained and licensed as an Abel site to utilize the instrument.

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

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

### **8.800 Exemptions**

- 8.801 Exemptions to any of the standards within Section 8.000 may be made to the supervising or contracting agency. Exemptions must be applied for in writing. The supervising or contracting agency must reply to the requesting provider in writing within a reasonable amount of time.
- 8.802 A copy of all approved and denied exemptions must be submitted to the Sex Offender Management Team to keep on file.

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<sup>9</sup> "Guidelines for the Use of the Penile Plethysmograph," from The ATSA Practitioner's Handbook, published by the Association for the Treatment of Sexual Offenders. 1993.

## 2.000 EVALUATION AND ONGOING ASSESSMENT

*A comprehensive evaluation should be completed prior to disposition or prior to the onset intervention services are provided. Ongoing assessments should be completed to monitor changes over time, progress in treatment and adherence to conditions of release. Level of risk, needs and protective factors must be assessed at transition points (i.e. disposition, admission to treatment, prior to family/community visits, prior to discharge, transitions in school, home or community, at change in level of treatment or care). Measurements and testing instruments should be utilized as clinically indicated and/or adopted by the contracting agency.*

2.100 Evaluators shall comply with the following:

- A. Adhere to the ethical principles and codes, and any and all practice standards and guidelines, for the person's respective discipline/area of professional licensure as promulgated by the licensing body;
- B. Conduct testing in accordance with the person's licensing body, qualifications and experience. Outside sources should be utilized to interpret required testing that is beyond the person's training and expertise.
- C. Adhere to current professional code of ethics established by the Association for the Treatment of Sexual Abusers (ATSA). Although membership in ATSA is not required, it is strongly recommended.
- D. Be knowledgeable of statutes and scientific data relevant to specialized sex offender evaluation;
- E. Be committed to community protection and safety; and
- F. Conduct evaluation procedures in a manner that ensures the integrity of testing data, and the humane and ethical treatment of the youth.

2.200 The evaluation of youth who have engaged in a sexual offense shall be comprehensive<sup>1</sup>. The evaluation of youth who have committed a sexual offense has the following purposes:

- A. To assess overall static and dynamic risk to the community;
- B. To assess safety for victims and potential victims;
- C. To provide written clinical assessment of a youth's strengths, risks and deficits;

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<sup>1</sup> Quinsey, V.L., Harris, G.T., Rice, M.E., Cormier, C.A. (1998). *Violent Offenders: Appraising and Managing Risk*. American Psychological Association, 55-72.

- D. To identify and document treatment and developmental needs;
- E. To determine amenability for treatment;
- F. To identify individual differences, potential barriers to treatment, and static and dynamic risk factors; and
- G. To make recommendations for the management and supervision of the youth.
- H. To provide recommendations that identify the type and intensity of community based treatment, or the need for a more restrictive setting.

*Comprehensive evaluation and assessment is an ongoing process. Client needs change over time and circumstances; progress in treatment and level of risk are not constant over time and may not be directly correlated; risk and protective factors must be assessed on an ongoing basis.*

2.300 The evaluator shall be sensitive to any cultural, language, ethnic, developmental, sexual orientation, gender, gender identification, medical and/or educational issues that may arise during the evaluation. Evaluators shall select evaluation procedures relevant to the individual circumstances of the case and commensurate with their level of training and expertise.

2.400 Recommendations regarding intervention shall be made and based on a youth's level of risk and needs rather than on resources currently or locally available. When resources are less than optimal this information shall be documented and an alternative recommendation should be made.

2.500 Each stage of an evaluation shall address strengths, risks, and deficits in the following areas:

- A. Cognitive and emotional functioning
- B. Personality, mental disorders, mental health
- C. Social/developmental history
- D. Developmental competence
- E. Current individual functioning
- F. Current family functioning
- G. Trauma history and exposure
- H. Sexual development and knowledge

- I. Delinquency and conduct/behavioral issues
- J. Assessment of risk - community risks and protective factors
- K. Awareness of victim impact – understanding into behavior
- L. External relapse prevention systems including informed supervision
- M. Amenability to treatment.

2.600 Evaluation methodologies must include the use of clinical procedures, screening level tests, self-report or observational data, advanced psychometric measurements, specialized testing, and measures. Due to of the complexity of evaluating youth who have committed a sexual offense, methodologies should be guided by the use of instruments that have specific relevance to the evaluation of youth, and the use of instruments with demonstrated reliability and validity (when possible) which are supported by research in the mental health and youth sex offender treatment fields.

2.700 Evaluation must include a combination of clinical procedures, screening level testing, self-report or observational measurements, advanced psychometric measures, specialized testing and measurement.

2.800 In keeping with best practice, evaluation reports more than 6 months old should be regarded with caution.

2.900 The evaluator shall obtain the consent of the parent/legal guardian and the informed assent of the youth for evaluation and assessment. The youth and parent/guardian will be informed of the evaluation methods, how the information may be used and to whom it will be released. The evaluator shall also inform the youth and parent/guardian about the nature of the evaluator's relationship with the youth and with the court. The evaluator shall respect the youth's right to be fully informed about the evaluation procedures. Results of the evaluation may be reviewed with the youth and the parent/guardian upon request or as required by regulation.

The mandatory reporting law (HRS 350-1.1) requires certain professionals to report suspected or known abuse or neglect to the local department of social services or law enforcement. Evaluators are statutorily mandated reporters.

## **3.000 STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS**

### **3.100 Treatment providers shall comply with the following:**

- A. Adhere to the ethical principles and codes, and any and all practice standards and guidelines, for the person's respective discipline/area of professional licensure as promulgated by the licensing body;**
- B. Conduct testing in accordance with the person's licensing body, qualifications and experience. Outside sources should be utilized to interpret required testing that is beyond the person's training and expertise;**
- C. Adhere to current professional code of ethics established by the Association for the Treatment of Sexual Abusers (ATSA). Although membership in ATSA is not required, it is strongly recommended.**
- D. Adhere to the current practice standards established by the Association for the Treatment of Sexual Abusers (ATSA);**
- E. Adhere to the State of Hawaii's Master Plan.<sup>1</sup>**
- F. Remain apprised of contemporary research and engage in professional development activities in order to provide contemporary research-supported and evidence-based treatment;**
- G. Be committed to community protection and safety; and**
- H. Collaborate with other professionals who are involved in the management of clients to further the goals of specialized treatment and management and promote the guiding principles of these standards.**

**3.110 Treatment providers shall develop a comprehensive written document that details the treatment program being offered and guides delivery of services. This document shall be made available to the SOMT and any agency contracting treatment services.**

**3.120 Providers treating youth for a sexual offense shall be sensitive to any cultural, language, ethnic, developmental, sexual orientation, gender, gender identification, medical and/or educational issues that may arise during the treatment.**

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<sup>1</sup> State of Hawaii (2014). Master Plan: Strategies to Effectively Management Sexual Offenders, Sex Offender Management Team.

### **3.200 Treatment Plans**

**Treatment Providers shall develop written treatment plans based on the individualized evaluation and assessment of the youth. The treatment plans shall:**

- 1. Provide for the protection of past and potential victims, and protect victims from unsafe or unwanted contact with the youth;**
- 2. Outlines appropriate targets of treatment;**
- 3. Include clear and specific measureable treatment goals and interventions that are individualized and consistent with the results of a current psychosexual evaluation or risk assessment;**
- 4. Favor consistency in caregiver relationships;**
- 5. Implement interventions that address the youth's need for pro-social peer relationships, activities and success in educational/vocational settings; and**
- 6. Be reviewed and updated routinely to evaluate progress and documented in accordance with this section.**

**3.210 Sex offense specific treatment methods and intervention strategies shall be based on the individualized treatment plan and in response to the youth's individual risk and intervention needs.**

**3.220 Research supports intervention that addresses trauma a youth may have experienced, including their own history of having been sexually abused and/or assaulted. In some cases a placing a hold on offense specific work may be justified so that the youth may direct his/her energy towards working through an acute symptom of his/her abuse (i.e. PTSD issues, flashbacks, other invasive thoughts, etc.).<sup>10,11</sup>**

**Trauma work should be incorporated into every youth's treatment plan when there is a history of abuse. Trauma work does not preclude entry into sex offense treatment, however careful evaluation must be done to determine the youth's current level of functioning (Section 2.000).<sup>12</sup>**

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<sup>10</sup> Robinson, S. (2006). Adolescent females with sexual behavior problems. In R.E. Longo & D.S. Prescott, (Eds), *Current Perspectives: Working with sexually aggressive youth and youth with sexual behavior problems* (pp. 273-324). Holyoke, MA: NEARI Press.

<sup>11</sup> Prescott, D.S. (2007). *Assessing Youth Who Have Sexually Abused: A Primer* (p. 59). Holyoke, MA: NEARI Press.

<sup>12</sup> Fannif, A. & Becker, J. (2006). Developmental considerations in working with juvenile sex offenders. In R.E. Longo & D.S. Prescott, (Eds), *Current Perspectives: Working with sexually aggressive youth and youth with sexual behavior problems* (pp.119-141). Holyoke, MA: NEARI Press.

### **3.300 Treatment Modalities**

**Treatment shall utilize research-supported methods of intervention, to the extent that such research is available. Treatment modalities shall match the youth's individual intervention needs and responsivity factors. Such modalities include, as appropriate:**

#### **A. Group therapy –**

**i. Ideally should be co-facilitated<sup>13,14</sup>**

**ii. Provider:Client ratios shall be no less than 1:6; 2:10.**

*Discussion: In group therapy sessions where there is one therapist, there shall be no more than six clients in the group. In group therapy sessions where there are two therapists, there shall be no more than ten clients.*

**iii. Therapy groups shall be gender specific, male and female youth shall not be treated within the same group.<sup>10,13</sup>**

*Discussion: Due to the unique needs of LGBT youth, they shall not be placed into regular therapy groups. Treatment plans shall be determined by the MDT on an individual case-by-case basis. Group therapy may be contraindicated and not required under Section 3.141.*

**iv. Youth shall be placed into therapy groups that meet both their developmental and individual needs as well as risk identified through evaluation.<sup>13</sup>**

*Discussion: Developmental stages of youth are fluid and dependent upon relationships in their treatment experience and in their own environment . The potential for predatory behavior on the part of an older, more experienced group member against a younger member cannot be overlooked.<sup>15</sup> Thus, it is incumbent upon the treatment provider to select group members who are in like stages of development for optimum group dynamics.*

*Discussion: In group therapy where there is only one therapist, a visiting therapist, member of the MDT, or a contract agency representative, should observe the group sessions a minimum of once every two months, or six sessions annually.*

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<sup>13</sup> Carpentier, M., Silovsky, J. and Chaffin, M. (2006). *Treating Children: Results from a 10-year follow up*. The Forum, Association for the Treatment of Sexual Abusers, Fall.

<sup>14</sup> Marshall, W.L., & Barbaree, H.E. (1990). Outcome of Comprehensive Cognitive-Behavioral Treatment Programs. In W.L. Marshall, D.R. Laws, H.E. Barbaree (Eds.) *Handbook of Sexual Assault: Issues, Theories & Treatment of the Offender*, New York, New York: Plenum Press, pp 363-385.

<sup>15</sup> Hunter, J. (2006). Understanding diversity in juvenile sex offenders: implications for assessment, treatment and legal management. In R.E. Longo & D.S. Prescott (Eds.), *Current perspectives: Working with sexually aggressive youth and youth with sexual behavior problems* (pp. 63-77). Holyoke, MA: NEARI Press.

**v. Male and female co-therapists are preferred.**<sup>14</sup>

*Discussion: Youth who have engaged in a sexual offense present a complex set of challenges for group facilitators. Not only are the dynamics multifaceted, the safety of group members is of concern. The intensity of these groups requires a strong team approach; therefore, staff to client ratios may be higher than in other types of groups. It is understood that occasional illness or absence of co-providers may affect ratios.*

**B. Individual therapy**

**C. Family therapy**

**3.310** The primary treatment provider shall, as needed, make referrals for individual, family therapy or other adjunct services. The provider shall also refer youth to other treatment providers or agencies when they cannot provide an adequate and appropriate level of intervention.

**3.320** Treatment providers shall strive to engage youth in treatment and promote internal motivation to change. This shall be facilitated by:

- a. Conducting treatment in a respectful, directive, and humane manner;
- b. Creating a therapeutic climate that is conducive to trust and openness; and
- c. Involving clients/or their parents/legal guardian in the development of their treatment plans and identifying realistic goals, objectives and timeframes for achieving goals.

**3.330** Treatment shall focus primarily on research-supported dynamic risk factors that are linked to sexual and non-sexual recidivism. These include:

**A. General Self-Regulation.**

- a. Managing emotional states that support or contribute to the client's potential to engage in problem behavior;
- b. Learning and practicing problem-solving and impulse control skills;
- c. Managing mental health and substance abuse difficulties; and
- d. Medication management as necessary.

**B. Sexual Self-Regulation.**

- a. Developing healthy sexual interest and arousal, fantasies, and behaviors oriented toward age-appropriate and consensual partners;
  - b. Improving management and control of sexual impulses; and
  - c. Modifying thinking patterns that serve to support age-inappropriate and/or non-consensual sexual interests, arousal and behavior.
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**C. Attitudes Supporting Criminality.**

- a. Increasing attitudes, beliefs, and values that support prosocial sexual behaviors; and
- b. Managing or decreasing attitudes, beliefs, and values that support sexually abusive and other antisocial behavior.

**D. Close Interpersonal Relationships.**

- a. Developing skills for establishing and maintaining prosocial, healthy relationships with family members and peers (as applicable and appropriate);
- b. Developing age appropriate/healthy sexuality; and
- c. Building on strengths in the client's existing relationships.

**E. Social and Community Supports.**

- a. Identifying appropriate, prosocial individuals who can act as positive support persons;
- b. Engaging family members and other support persons to actively participate in the treatment process; and
- c. Developing and maintaining stability in housing, employment, school, and leisure.

**F. Family Reunification/Victim Contact (in consultation with the MDT).**

- a. Victim clarification;
- b. Client reunification with family;
- c. Recommendations for informed parental or guardian supervision.

**G. Ancillary treatment targets may include factors not clearly linked to recidivism, but may enhance the therapeutic relationship, engagement in treatment, and responsiveness to treatment include:**

- a. Denial and minimization;
- b. Victim empathy; and
- c. Self-esteem.

**3.340 A treatment provider shall assess each youth's progress in treatment on a minimum quarterly basis and provide a completed written progress report to the supervising officer.**

*Note: More frequent progress reports may be optimal for some offenders in some situations.*

**A. The progress report shall:**

- 1. Address the youth's progress in meeting the goals and objectives of the treatment plan.**

- 2. Identify changes in the youth's previously identified protective factors.**
- 3. Identify changes in the youth's dynamic risk factors and how they are being addressed in treatment.**
- 4. Identify issues and changes in the youth's situation.**
- 5. Provide recommendations to the community supervision officer.**

### **3.400 Client Files**

**Sex offense specific treatment providers shall maintain client files in accordance with the professional standards of their individual disciplines and with Hawaii state law on health care records.**

#### **3.410 Client files should include, at a minimum:**

- A. Informed consent;**
- B. Treatment agreements;**
- C. Evaluations and assessments, including any treatment progress reports;**
- D. Treatment plans, goals and interventions; and**
- E. Discharge summaries when the client has successfully completed or otherwise discontinued treatment.**

### **3.500 Confidentiality**

**Youth who have engaged in, and have been adjudicated of, a sexual offense must waive confidentiality for purposes of evaluation, treatment, supervision, and case management to obtain the privileges attached to community supervision. This waiver of confidentiality must be based on complete informed consent of the parent/legal guardian and voluntary assent of the youth. The youth and parent/guardian must be fully informed of alternative dispositions that may occur in the absence of consent/assent.**

**Effective supervision and treatment of youth who have engaged in a sexual offense is dependent upon open communication among the multidisciplinary team members.**

#### **3.510 The multidisciplinary team shall obtain the required signed waivers of confidentiality with the informed consent of the parent/guardian and the assent of**

**the youth who have engaged in a sexual offense (Sections 3.300 and 5.301 of these Standards).**

**3.520 Treatment providers shall notify all clients of the limits of confidentiality imposed by the mandatory reporting law, HRS 350-1.1.**

**3.530 Treatment providers shall ensure that youth offense and the parent/guardian understand the scope and limits of confidentiality in the context of his/her situation, including collateral information that may have been previously confidential.**

**3.540 Treatment providers shall inform all persons participating in any group that participants shall respect the privacy of other members and shall agree to maintain confidentiality regarding shared information and the identity of those in attendance.**

**3.600 Treatment Contracts and Agreements**

**Treatment Providers shall develop and utilize a written treatment contract/agreement with each client and/or their parent/legal guardian. At a minimum, the treatment contract/agreement shall address:**

- a. The nature, goals, and objectives of treatment;**
- b. The expected frequency and duration of treatment;**
- c. Rules and expectations of treatment program participants;**
- d. Incentives for participation and progress;**
- e. Consequences of noncompliance with treatment program rules and expectations; and**
- f. Criteria used to gauge treatment progress and determine treatment completion.**

**3.700 Successful Completion of Sex Offense Specific Treatment should be understood as the cessation of mandated sex offense specific treatment. It may not be an indication of the end of the youth's management needs or the elimination of risk to the community. The multidisciplinary team shall carefully consider victim and community safety before making a determination of completion of treatment.**

**A. Treatment providers shall recognize and communicate that successful completion of a specialized treatment program:**

- 1. Indicates that the client has met the specified series of goals and objectives of an individualized treatment plan designed to reduce the individual's risk to reoffend and increase stability and prosocial behaviors;**

2. **The client has demonstrated the goals and objectives of treatment have been achieved as demonstrated by their behavior while in treatment and under supervision; but**
  3. **Does not indicate that the client's risk to reoffend has been eliminated completely.**
- B. The treatment provider shall take reasonable steps to prepare the client for treatment completion. These may include:**
1. **A gradual reduction in frequency of contacts over time as treatment gains are made;**
  2. **Aftercare/maintenance sessions to reinforce and assess treatment gains; and**
  3. **Providing written information that includes follow up recommendations for maintaining treatment gains to the client, family, support persons, and appropriate professionals involved in ongoing case management, with the confidentiality parameters established.**