

ILLINOIS SEX OFFENDER MANAGEMENT BOARD

Standards and Guidelines for the
Evaluation, Treatment, and Monitoring
of Adult and Juvenile Sex Offenders

Acknowledgments

These Standards and Guidelines represent the collective effort from many dedicated professionals from a wide range of county and state agencies both in Illinois and other states. The Illinois Sex Offender Management Board has made every effort to balance the very real needs of the offender with the priority on public safety.

This collaborative effort would not have been possible without the input from those professionals. The Board would like to extend our gratitude and sincere thanks to all those professionals dedicated to increasing public safety. In particular, the Board wishes to acknowledge the staff of the Center for Sex Offender Management and Board Members, both past and present of the Colorado Sex Offender Management Board, which was the model for the Illinois Board. These professionals include:

Jean McAllister
Louise Esquibel
William Woodward
John Murphy
Peggy Heil
Kimberly English

This work would not have been possible without the help of non-Board members who assisted in working various subcommittees. These individuals include:

Robin McGinnis
Jana Fore
Harry Reed
Dr. Barry Leavitt
Dr. Phil Reidda
Dave Gasperin
Nancy Carlson
Kelly Collins
Kelly Van Overbeke
Jo Anne Smith
Loren Simmons
Betsy Goulet

A special thanks to Sheriff Tom Templeton, La Salle County, Billie Larkin, Ex. Director, McLean County Children's Advocacy Center, and the Naperville Police Department for their generous hospitality hosting Board and committee meetings.

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INTRODUCTION

Sex offenders pose an enormous challenge for policymakers. They can evoke unparalleled fear, and their offenses can result in lifelong consequences for victims. The most frequent victims of sexual attacks are the most vulnerable segment of our society – children. There is an urgent need for action.

The National Center for Missing and Exploited Children

In 1997, members of Illinois Attorney General Jim Ryan’s *Violence to Children Task Force* completed work on the draft legislation creating the Illinois Sex Offender Management Board. This legislation, modeled after a similar Colorado statute, focused on the critical need for uniform standards for the identification, evaluation, treatment, and monitoring of Illinois sex offenders. Task force members had discussed the challenges to developing such standards but felt that the Colorado legislation provided a framework for similar efforts in Illinois. In 1998 the Illinois General Assembly passed the SOMB legislation and the Governor and Attorney General Ryan began making appointments to the board.

While the Illinois SOMB statute acknowledges, and even emphasizes that sex offenders cannot be “cured,” it also recognizes that the criminal sexual behaviors of many offenders can be managed. The combination of comprehensive sex offenders treatment and carefully structured and monitored behavioral supervision conditions can assist many sex offenders to develop internal controls for their behaviors.

The Illinois Standards support and promote a coordinated, multidisciplinary approach for the management and treatment of sex offenders. The approach utilizes the “containment” model and greatly enhances the community’s ability to improve safety and reduce victimization.

The field of sex offender research is relatively new but emerging “best practices” were incorporated into the Illinois Standards. As research continues to increase and direct practices, the SOMB will evaluate the standards and make any necessary improvements. Professional organizations have also committed resources to this specialized field and their contributions will impact future modifications in the Standards.

Following the implementation of the Illinois Standards, the Sex Offender Management Board will remain dedicated to public safety and protection of Illinois’ citizens.

GUIDING PRINCIPLES FOR THE TREATMENT OF ADULT SEX OFFENDERS.

1. **Sex offending is a behavioral disorder which cannot be “cured” but risk can be reduced. Completion of treatment means risk is lowered, not that risk is eliminated.**

Sexual offenses are defined by law and may or may not be associated with or accompanied by the characteristics of sexual deviance which are described as paraphilias. Some sex offenders also have existing conditions such as mental disorders, organic disorders, or substance abuse problems.

Many offenders can learn through counseling to manage their sexual offending behaviors and decrease their risk of re-offense. Such behavioral management should not, however, be considered a “cure,” and successful treatment cannot permanently eliminate the risk that sex offenders may repeat their offenses.

2. **Sex offenders are dangerous.**

When a sexual assault occurs there is always a victim. Both the literature and clinical experience suggest that sexual assault can have devastating effects on the lives of victims and their families.

There are many forms of sexual offending. Offenders may have more than one pattern of sexual offending behavior and often have multiple victims. The propensity for such behavior is often present long before it is detected. It is the nature of the disorder that sex offenders’ behaviors are inherently covert, deceptive, and secretive. Untreated sex offenders also commonly exhibit varying degrees of denial about the facts, severity and/or frequency of their offenses.

3. **Community safety is paramount.**

The highest priority of these standards and guidelines is community safety. To achieve community safety, some sex offenders must be incarcerated or subject to civil commitment.

4. **Identification, evaluation and treatment of sex offenders is an on-going process. Progress in treatment and level of risk are not constant over time.**

The effective identification, evaluation and treatment of sex offenders is best seen as a process. Criminal sexual offenders must be first identified and referred for a comprehensive sex offense-specific evaluation. Evaluation of sex offenders should not however end at this point. Subsequent evaluations must occur at both the entry and exit points of all sentencing options, i.e. probation, parole, and prison.

In the management and treatment of sex offenders there will be measurable degrees of progress or lack of progress. Because of the cyclical nature of offense patterns and fluctuating life stresses, sex offender’s levels of risk are constantly in flux. Success in the management and treatment of sex offenders cannot be assumed to be permanent. For these reasons, monitoring of risk must be a continuing process as long as sex offenders are under criminal justice supervision. Moreover, the end of the period of court supervision should not necessarily be seen as the end of risk.

5. **Sex offenders assigned to community supervision must be completely accountable for their behaviors.**

Sex offenders on community supervision must agree to intensive and sometimes intrusive accountability measures which enable them to remain in the community rather than in prison. Offenders carry the

responsibility to learn and demonstrate the importance of accountability, and to earn the right to remain under community supervision.

6. **Sex offenders must waive confidentiality for evaluation, treatment, supervision, and case management purpose.**

All members of the team managing and treating each offender must have access to the same relevant information. Sex offenses are committed in secret, and all forms of secrecy undermine rehabilitation of sex offenders and threaten public safety.

7. **Victims have a right to safety and self-determination**

Victims have the right to be informed of an offender's status in the criminal justice system and if they choose, to provide input to the offender case management team. In the case of adolescent or child victims, custodial adults, and/or child advocates or guardians act on behalf of the child to exercise this right, in the best interest of the victim.

The Sex Offender Management Board recognizes that the behavior of sex offenders can be extremely damaging to victims and that their caregivers and that their crimes can have a long-term impact on victims' and their families' lives. Moreover, the level of violence, exploitation, and coercion involved in the offense does not necessarily determine the degree of trauma experienced by the victim.

- Under the provisions of Illinois' Constitutional Amendment for Crime Victims, victims and their caregivers may state whether they wish to be notified about any changes in the offender's status in the criminal justice system. The victim and their caregivers may determine the method (e.g. by phone, mail, etc.), and the channel (e.g. directly or through a person designated by the victim and their caregiver) in which they would like to be notified. These standards and guidelines also suggest that, only upon request, a victim and their caregiver should be informed about the offender's compliance with treatment and any changes in the offender's treatment status that might pose a risk to the victim (e.g. if the offender has discontinued treatment). In certain situations, the interagency containment team may communicate with a victim's therapist, advocate, or other person designated by the victim. Further, if a victim is willing he/she may be contacted for information during the pre-sentence investigation, in order to include additional victim impact information in the investigation report. If the victim and his/her caregiver respond that they do not want to be contacted for additional information, this decision will be respected by all agencies involved in the case to the extent allowed by law.

- Professionals in the criminal justice, evaluation and treatment systems should contact victims, or person designated by the victim and his/her family, to solicit their input, since victims may possess valuable information that is not available elsewhere. In particular, a victim's information about an offenders' offense patterns can assist evaluators, treatment providers and supervisors to develop treatment plans and supervision conditions that may prevent future offenses.

8. **When a child is sexually abused within the family, the child's individual need for safety, protection, developmental growth and psychological well-being outweighs any parental or family interests.**

All aspects of the community response and intervention system to child sexual abuse should be designated to promote the best interests of children rather than focusing primarily on the interests of adults. This

includes the child's right not to live with a sex offender, even if that offender is a parent. In most cases, the offender should be moved or inconvenienced to achieve a lack of contact, rather than further disrupting the life of the child victim.

9. **A continuum of sex offender management and counseling options should be available in each community in the state. Extended controls should remain in place until risk is reduced to ensure public safety.**

Many sex offenders can be managed in the community on probation or parole. It is in the best interest of public safety for each community to have a continuum of sex offender management and treatment options. Such a continuum should provide for an increase or decrease in the intensity of treatment and monitoring based on offenders' changing risk factors, treatment needs, compliance with supervision conditions, and use of objective testing (polygraph, etc.).

10. **Standards and guidelines for identification, evaluation, treatment and monitoring of sex offenders will be most effective if the entirety of the criminal justice and social services systems, not just sex offender treatment providers, apply the same principles and work together.**

It is the philosophy of the Sex Offender Management Board that setting standards for sex offender treatment providers alone will not significantly improve public safety. In addition, the process by which sex offenders are identified, evaluated, treated and monitored by the criminal justice and social services system should be coordinated and improved.

11. **Management of sex offenders requires a coordinated team response.**

All relevant agencies must cooperate in planning treatment and containment strategies of sex offenders for the following reasons:

- Sex offenders should not be in the community without comprehensive treatment, supervision, and behavioral monitoring.
- Each discipline brings to the team specialized knowledge and expertise.
- Open professional communication confronts sex offender's tendencies to exhibit secretive, manipulative, and denying behaviors.
- Information provided by each member of an offender case management team contributes to a more thorough understanding of the offender's risk factors and needs and to the development of a comprehensive approach to treating and managing the sex offenders.

12. **Sex offender identification, evaluation, treatment and behavioral monitoring should be non-discriminatory and humane, and bound law and the rules of ethics.**

Individuals and agencies carrying out the identification, evaluation, treatment, and behavioral monitoring of sex offenders should not discriminate based on race religion, gender, sexual orientation, disability or socioeconomic status. Sex offenders must be treated with dignity and respect by all members of the team who are managing and treating the offender regardless of the nature of the offender's crimes or conduct.

13. **Successful treatment and management of sex offenders is enhanced by the positive cooperation of family, friends, employers and members of the community who have influence in sex offenders' lives.**

Sexual issues are often not talked about freely in families, communities and other settings. In fact, there is often a tendency to avoid and deny sex offenses have occurred. Successful management and treatment of sex offenders involves an open dialogue about this subject and a willingness to hold sex offenders accountable for their behavior.

14. **Sex offenders must be identified at the earliest possible age.**

15. **Some sex offenders cannot or will not respond to counseling.**

The Board does not intend to imply that all sex offenders can be successfully treated.

16. **Treatment of sex offenders cannot be done successfully with medication alone.**

Best Practices indicate a need for a variety of treatment strategies in order to most effectively reduce risk of re-offending.

15. **Professionals making decisions regarding the management of sex offenders must have access to complete information.**

The information available to the professionals should include: police reports, victim statements, comprehensive sex offense-specific evaluation, and child protections reports when the victim is a child or when any child lives in the offender's residence.

DEFINITIONS

ACCOUNTABILITY: Accurate attributions of responsibility, without distortion, minimization, or denial.

BEHAVIORAL MONITORING: A variety of methods for checking, regulating and supervising the behavior of sex offenders.

BOARD: Illinois Sex Offender Management Board.

CASE MANAGEMENT: The coordination and implementation of the cluster of activities directed toward supervising, treating and managing the behavior of individual sex offenders. (see Containment Approach)

CLINICAL EXPERIENCE: Any activity directly related to providing evaluation and/or treatment to individual sex offenders, e.g. face to face therapy, report writing, administration, scoring and interpretation of tests; participation on case management teams of the type described in these standards and guidelines; and clinical supervision of therapists treating sex offenders.

CLINICAL POLYGRAPH: The employment of instrumentation, as defined by the Illinois Detection of Deception Examiners Act used for the purpose of detecting deception or verifying truth of statements of a person under criminal justice supervision and/or treatment for the commission of sex offenses. A clinical polygraph examination is specifically intended to assist in the treatment and supervision of convicted sex offenders. Clinical polygraphs include specific-issue, disclosure and periodic or maintenance examinations. Clinical polygraphs may also be referred to as post-conviction polygraphs. (See also Sex Offender Polygraph)

CONTAINMENT APPROACH: A method of case management and treatment that seeks to hold offenders accountable through the combined use of both offenders' internal controls and external control measures (such as the use of polygraph and relapse prevention plans). A containment approach requires the integration of a collection of attitudes, expectations, laws, policies, procedures and practices that have clearly been designed to work together. This approach is implemented through interagency and interdisciplinary teamwork.

DEFENSE MECHANISMS: Normal, adaptive self-protective functions which keep human beings from feeling overwhelmed and/or becoming psychotic, but which become dysfunctional when overused or overgeneralized.

DENIAL: A defense mechanism used to protect the ego from anxiety-producing information.

EVALUATION: Systematic collection and analysis of psychological, behavioral and social information; the process by which information is gathered, analyzed and documented.

In this document the term "comprehensive sex offense-specific evaluation" is used to describe the evaluation provided for sex offenders under the jurisdiction of the criminal justice system.

EVALUATOR: An individual who conducts comprehensive sex offense-specific evaluations of sex offenders according to the guidelines and standards contained in this document, and according to professional standards.

GUIDELINE: A principle by which to make a judgment or determine a policy or course of action.

INFORMED ASSENT: Compliance; a declaration of willingness to do something in compliance with a request; acquiescence; agreement. The use of the term “assent” rather than “consent” in this document recognizes that sex offenders are not voluntary clients, and that their choices are therefore more limited.

Informed means that a person’s assent is based on a full disclosure of the facts needed to make the decision intelligently, e.g. knowledge of risks involved, alternatives.

INFORMED CONSENT: Consent means voluntary agreement, or approval to do something in compliance with a request.

Informed means that a person’s consent is based on a full disclosure of the facts needed to make the decision intelligently, e.g. knowledge of risks involved, alternatives.

NON-DECEPTIVE POLYGRAPH EXAMINATION RESULT: A non-deceptive polygraph examination result must include a deceptive response to control questions. Any inconclusive or deceptive response to any relevant question disallows a non-deceptive examination result.

PAROLE: Refers to parole mandatory supervised release.

PLETHYSMOGRAPHY: In the field of sex offender treatment, plethysmography means the use of an electronic device for determining and registering variations in penile tumescence associated with sexual arousal. Physiological changes associated with sexual arousal in women are also measured through the use of plethysmography. Plethysmography includes the interpretation of the data collected in this manner.

POLYGRAPHY: The use of an instrument that is capable of recording, but not limited to recording, indicators of a person’s respiratory pattern and changes therein, galvanic skin response and cardiovascular pattern and changes therein. The recording of such instruments must be recorded visually, permanently and simultaneously. Polygraphy includes the interpretation of the data collected in this manner, for the purpose of measuring physiological changes associated with deception.

PROVIDER LIST: The list, published by the Board, identifies the treatment providers, evaluators, plethysmograph examiners and polygraph examiners who meet the criteria set forth in these Standards and Guidelines. The determination that the providers meet the criteria is made by the Board based on an application submitted by the provider, outlining his or her experience, training and credentials, a criminal history check and background investigation, written references and reference checks and a review of relevant program materials and products. Placement on the list must be renewed every three years.

SECONDARY VICTIM: A relative or other person closely involved with the primary victim, who is severely impacted emotionally or physically by the trauma suffered by the primary victim.

SEX OFFENDER: For purposes of this document a sex offender is defined pursuant to 20 ILCS 4026 10 (b)

SEX OFFENSE: For purposes of this document, a sex offense is pursuant to 201 ILCS 4026 10(c)

SEX OFFENDER POLYGRAPH: A polygraph examination of a suspected or convicted sex offender.

SEX OFFENSE-SPECIFIC TREATMENT: Consistent with current professional practices, sex offense- specif-

ic treatment means a long term comprehensive set of planned therapeutic experiences and interventions to change sexually abusive thoughts and behaviors. Such treatment specifically addresses the occurrence and dynamics of sexually deviant behavior and utilizes specific strategies to promote change. Sex offense-specific programming focuses on the concrete details of the actual sexual behavior, the fantasies, the arousal, the planning, the denial and the rationalizations. Due to the difficulties inherent in treating sex offenders and the potential threat to community safety, sex-offense specific treatment should continue for several years, followed by a lengthy period of aftercare and monitoring. Much more importance is given to the meeting of all treatment goals than the passage of a specific amount of time, since offenders make progress in treatment at different rates. The primary treatment modality for sex offense specific treatment is group therapy for the offenders. Adjunct modalities may include partner or couples therapy, psycho-education, and/or individual therapy. However, such adjunct therapies by themselves do not constitute sex offense-specific treatment.

STANDARD: Criteria set for usage or practices; a rule or basis of comparison in measuring or judging.

STANDARDS AND GUIDELINES: and behavioral monitoring of adult sex offenders.

SUPERVISING OFFICER: The probation, parole, or conditional release officer or case manager or supervisor who is responsible for the behavioral monitoring of sex offenders.

TREATMENT: Therapy, monitoring and supervision of any sex offender which conforms to the standards created by the Board (See also Sex Offense-specific treatment.)

TREATMENT PROVIDER: A treatment provider means a person who provides sex offense-specific treatment to sex offenders according to the standards and guidelines contained in this document.

VICTIM CLARIFICATION PROCESS: A process designed for the primary benefit of the victim, by which the offender clarifies that the responsibility for the assault/abuse resides with the offender. The process will clarify that the victim has no responsibility for the offender's behavior. It also addresses the damage done to the victim and the family. This is a lengthy process that occurs over time, including both verbal and written work on the part of the offender. Although victim participation is never required and is sometimes contraindicated, should the process proceed to an actual clarification meeting with the victim, all contact is victim centered and based on victim need.

1.000 GUIDELINES FOR PRESENTENCE INVESTIGATIONS

1.010

Before sex offenders are sentenced for felony sex offenses as outlined in the Illinois Compiled Statutes and all felony offenders whose criminal conduct includes some form of sexually motivated or deviant behavior (battery charges which were sexual, burglary with the theft of undergarments, criminal trespass which was peeping, etc.) shall be required to comply with a presentence investigation, including a comprehensive sex offense-specific evaluation, prior to sentencing, even when by statute it is otherwise acceptable to waive the presentence investigation. All misdemeanor offenders, including those in sex cases reduced to non-sex offense categories it is recommended that they undergo a presentence investigation, including a sex offense specific evaluation prior to sentencing.

Discussion: *The purpose of the presentence investigation is to provide the court with verified and relevant information upon which to base sentencing decisions. Sex offenders pose a high risk to community safety and have special needs. Therefore, presentence investigations on these cases differ from those in other types of cases, primarily by the inclusion of a comprehensive sex offense-specific evaluation. The evaluation establishes a baseline of information about the offender's risk, type of deviancy, amenability to treatment and treatment needs.*

The presentence investigation report, including the results of the comprehensive sex offense-specific evaluation, (including a polygraph) should follow the sex offender throughout the time the offender is under criminal justice system jurisdiction, whether on probation, parole, or in prison.

1.020

In cases of conviction, including plea agreements, supervision and sentences for non-sexual crimes, if the current offense has a factual basis of unlawful sexual behavior, the offender's case shall be assigned to a presentence investigator specially trained to assess sex offenders.

Discussion: *While it is preferable that sexual crimes not be plea bargained to non-sexual crimes, such plea bargains sometimes occur. However, this does not eliminate the need for the offender to be assessed based on the factual basis of the case. In addition, it is highly recommended that no Alford Pleas be entered on cases of a sexual nature.*

1.030

Presentence investigations on sex offender and sex offense related cases should be completed by probation officers specially trained to evaluate all data collected from comprehensive sex offense-specific evaluations, clinical interviews, objective and psychometric measures as well as criminal and social history information. At minimum, the officer shall meet the Hiring Guidelines of the Administrative Office of the Illinois Courts for Probation Officers. Probation officers assigned to sex offender presentence cases shall be required to have a minimum of 2 years active case supervision including sex offenders and shall complete a minimum of 40 hours training on the assessment of sex offenders.

1.040 PRESENTENCE INVESTIGATION REPORT FORMAT

OFFENSE

Summarize the circumstances of the offense(s), including when appropriate:

1. Date, time and place of offense(s).

2. Age, gender, and relationship of victim(s).
3. Details of offense, including any use of violence.
4. Date and circumstances of taking into custody.

Offender's Statement and Attitude Regarding Offense.

1. Summarize offender's version of offense. [Does he/she deny or minimize the offense, or take responsibility for his/her actions? What is the offender's opinion (or feelings) towards the victim(s) and his/her family?]
2. General attitude regarding self and his/her present situation.
3. Attitude toward legal process, detention and corrections personnel.
4. Cooperation/truthfulness.
5. Justification given by the offender for the offense.

HISTORY OF DELINQUENCY AND ADULT PRIOR CONVICTIONS

1. Chronological listing of all prior adjudications and convictions.
2. History of prior periods of probation or supervision, as juvenile or adult.
3. History of prior periods of incarceration, as juvenile or adult.
4. Specific identification of any sex-related criminal behavior.

FAMILY COMPOSITION

1. List names, ages, and addresses regarding spouse and children.
2. List names, ages, addresses of parent(s) (if living).
3. Summarizes information relating to siblings.
4. List any non-relatives presently residing with offender.
5. Note socio-economic status of family, including family income. [Indicate the type and amount of income; i.e., employment income, social security, welfare benefits, pension, etc. Note possibility of usage of assets for restitution or treatment.
6. Note any criminal history, mental illness, and other serious problems of family members, especially if there is a family criminal history of sexual offending.

FAMILY INTERACTION

1. Describe intra-family relationships and/or family attitude toward the offender. [Is there resentment directed at the offender due to his/her offense(s), especially if the victim resides in the same house, or is the family supportive of the offender and willing to help him/her deal with sex offending issues despite the victim(s) presence in the family unit? Is the family in denial about the subject's offending behavior?]
2. Describe offender's feelings toward family members, other members of the household and victim(s) (if applicable).

OFFENDER INFORMATION

1. Offender's place of birth; geographic movement of subject and family.
2. Living Situation. [Give a description of the residence and neighborhood. Expound on the safety plan at the residence if the offender is released after a court disposition, and the victim(s) resides in the same home. What steps are going to be implemented by the family to insure that the offender has no unsupervised contact with his/her victim(s) (if applicable)? Is it possible to have the offender live elsewhere instead of he/her home if the victim(s) also resides there? Explore the option of the court ordering a home-study.
3. Close associations or gang affiliations. [Inquire about the offender's keeping company with other known sex offenders (juvenile or adult).]

EDUCATION:

1. Years of education completed/present educational status.
2. Last school attended.
3. IQ and other relevant test results.
4. School grades and attendance record.
5. Department.
6. Special problems.
7. Any specialized training offender has received, including any placements.
8. School safety plan. [Expound on what steps are going to be taken by the offender and/or school officials to insure that he or she does not have victim access at the school. This particularly important if the subject is in a school setting with minors who are younger and/or smaller than he/she is.]

EMPLOYMENT:

1. List current employment status.
 - a. Name and address of employer.
 - b. Wages.
 - c. Duties.
 - d. Hours.
 - e. Work safety plan. [It is important, at the start, to determine where the subject is employed. If it is a place where he/she has victim access (particularly were small children associate), the subject should be discouraged from continuing to work there. Is the place of employment close to a public area where small children congregate? Should the investigation include a recommendation to the court that the subject not hold a particular job where there is victim access?]
2. List prior employment.
3. Indicate any special job skills possessed by the offender.

HEALTH:

1. Physical description.
 - a. Race.
 - b. Complexion.
 - c. Build.
2. Present health status.
3. Prescribed medication taken at present time.
4. History of any serious illnesses or injuries.
5. Physical handicaps.

MENTAL AND EMOTIONAL:

1. Comment on offender's mental and emotional appearance.
2. Indicate any past treatment or institutionalization for mental illness [Look for a history of organic brain disease, brain injury, depression or suicide attempts. Specifically, focus on past sex offender treatment or counseling (if applicable). Was the sex offender treatment administered by a qualified sex offender therapist, or just someone who is a "general counselor" (private counselor, family, counselor, religious-affiliated counselor, etc.)?]
3. A comprehensive sex offense-specific evaluation report (including a polygraph examination; is imperative, and should coincide with the social investigation.
4. Any prior evaluations (sex offense, psychological, psychiatric, drug/alcohol, etc.) should be attached to the report, and findings summarized.

ALCOHOL AND DRUG USE:

Indicate available information on offender's past and present use of alcohol and/or illegal drugs.

1. Source of information.
2. Degree of use.
3. Type and extent of drug involvement
4. History of treatment received, including dates and details of any placements.

RELIGION:

Indicate offender's religious preference and church membership, if any (name and address of church). Indicate degree of participation. [Also, as in the school safety plan, expound on what steps are going to be taken by the family, pastor and/or certain members of the congregation to insure that the offender does not have victim access?]

INTERESTS:

1. Hobbies.
2. Special interests.
3. Recreational preference.
4. Use of leisure time. [Determine what the offender most enjoys doing during his/her free time. Investigate various forms of media, especially videos, Internet, or magazines as the offender could very well be indulging in pornographic material with regard to these forms of media.]

FUTURE:

The subject's plans for his/her life in the future.

COMMUNITY ATTITUDE:

1. Statement of arresting officer.
2. Statement of school personnel (principal, teachers, counselors, etc.)
3. If the offender is employed, or has an employment history, an employer reference may be included here.
4. Any other reference letters submitted on behalf of the defendant may be inserted here.

VICTIM IMPACT

The probation officer, or whomever prepares the victim impact statement, should make contact with the victim/victims (if over 18) or the parents to verify if he/she was referred for victim services after the offense occurred. Was the victim physically injured requiring medical attention or attention or hospitalization? What mental and/or emotional trauma does the victim (or parents of the victim) report? Is the victim in counseling or does he/she plan to seek help? Has the victim had to move, change jobs or make other significant changes in his/her daily life or routine? Did the victim(or parents) have to pay medical expenses related to the investigation? If employed, how much time or pay was lost due to trauma and the legal process? What does the victim (or parents of the victim) believe is the appropriate sentence for the offender? If the victim does not reside in the same home as the subject, has the subject made contact, or attempted to make contact with him/her?]

SUMMARY AND SENTENCING ALTERNATIVES

1. Briefly summarize the most pertinent elements of the previous headings relative to the disposition of the case. Strengths and weaknesses may be discussed.
2. Present an analysis of the offender's problems and the factors related to the pattern of delinquent and/or sex offending behavior.

3. Consider alternatives for sentencing, treatment and placement.

If in local judicial practice the trial judge, in an exercise of discretion, may request formal recommendations, the presentence report should make recommendations about an offender's suitability for community supervision. This analysis, based on the gathered data, should include all the aggravating and mitigating information. It is an opportunity for the investigator to give, at the specific request of the court, opinions about the offender's amenability for treatment and his/her risk to the community.

If the offender is eligible to be placed on probation, the report should include all special conditions needed for effective supervision and treatment of the offender, and the safety of the victim and the community. The report should include recommendations restricting access to children as appropriate (specifically based upon recommendations in the comprehensive sex offense-specific evaluation).

SOURCES OF INFORMATION

ATTACHMENTS

Attached to the presentence investigation should be all the supportive documentation including the comprehensive sex offense-specific evaluation, polygraph results, previous presentence investigations, drug and alcohol evaluations, and treatment reports, victim impact statements, and any other pertinent documentation backing up the factual content of the report.

1.050

When referring an offender for a comprehensive sex offense-specific evaluation or treatment, presentence investigators should send to the evaluator, treatment provider and polygrapher the following as part of the referral packet:

1. The instant offense reports (police reports)
2. The victim impact statement
3. DCFS reports or investigation results and case records
4. A criminal history
5. Any completed risk assessment tools
6. Prior evaluations and treatment reports
7. Prior polygraph examinations
8. Any presentence investigation reports
9. Pertinent prior probation or supervision records
10. DOC records, both adult and juvenile
11. Other available information as required by the evaluator or polygrapher

1.060

At the time of the intake interview, the purpose of the presentence investigation should be explained to the offender by the presentence investigator/writer. All required release of information forms, including a copy of the required disclosure/advisement form, should be signed and dated.

Discussion: *This disclosure/advisement form notifies an offender and other concerned parties of the requirements the offender will have to meet should probation be granted.*

2.000 STANDARDS FOR COMPREHENSIVE SEX OFFENSE-SPECIFIC EVALUATIONS

2.010

In accordance with the Guidelines for Presentencing Standards, each sex offender shall receive a comprehensive sex offense-specific evaluation at the time of the presentence investigation.

Discussion: *Evaluations are conducted to identify individuals who are at low risk of re-offending as well as those who are highly likely to re-offend. Because of the importance of the information collected during an evaluation to subsequent sentencing, supervision, treatment, and behavioral monitoring, it is the Board's philosophy that each sexual offender should receive a thorough evaluation. In addition, it is important to recognize that evaluation is an ongoing processes and should continue through each state of supervision and treatment.*

2.020

The comprehensive sex offense-specific evaluation has the following purposes:

- To document the offense specific and/or mental health treatment needs identified by the evaluation (even if resources are not available to address adequately the treatment needs of the sexually abusive offender);
- To provide a written clinical evaluation of an offender's risk for re-offending and current amenability for treatment;
- To guide and direct specific recommendations for the conditions of treatment and supervision of an offender;
- To provide information that will help to identify the optimal setting, intensity of intervention, and level of supervision, and;
- To provide information that will help to identify offenders who should not be referred for community-based treatment

2.030

The evaluator must be certified by the Board. In addition, evaluators shall adhere to established ethical standards, practices and guidelines of their respective professions with regard to the administration of psychological tests.

2.040

The evaluator must obtain a waiver of confidentiality and the informed assent of the offender for the evaluation, and shall inform an offender regarding the evaluation methods (including use of polygraph), how the information will be used, and to whom it will be given. The evaluator shall respect an offender's right to be fully informed about the evaluation procedures. Results of the evaluation should be shared with the offender and any questions clarified.

2.050

The evaluator shall be sensitive to any cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues that may arise during the evaluation.

2.060

Because of the uncertainty of risk prediction for sex offenders, the Board recommends the following approaches to evaluation:

- Use of instruments that have specific relevance to evaluating sex offenders
- Use of instruments with demonstrated reliability and validity
- Integration of collateral information

- Use of multiple assessment instruments and techniques
- Use of structured interviews¹
- Use of interviewers who have been trained to collect data in a non-pejorative manner.

Discussion: *The Board recognizes that the field of evaluation of sex offenders is evolving. There is, however, a great deal of research currently being done to increase our ability to predict sex offenders' risk of re-offending. Undoubtedly evaluation instruments and processes will be subject to change as more is learned in this area. Evaluations must be done by collecting information through a variety of methods. An evaluation therefore currently involves the integration of physiological, psychological, historical, and demographic information to form a picture of a sex offender's likelihood for re-offending, and amenability to treatment. When the evaluator is in doubt, s/he should err on the side of protecting community safety.*

2.070

Unless otherwise indicated below, the following evaluation modalities are all required in performing a comprehensive sex offense specific evaluation:

- Examination of criminal justice information, including prior juvenile adjudications, the details of the current offense and documents that describe victim trauma, when available
- Examination of collateral information, including information from other sources on the offender's sexual behavior
- Structured clinical and sexual history and interview
- Offense-specific psychological testing
- Standardized psychological testing if clinically indicated
- Medical examination/referral for assessment of pharmacological needs if clinically indicated
- Testing of deviant arousal or interest through the use of the penile plethysmograph or standardized visual-reaction-time measurements
- Physiological testing of deception and denial through the use of polygraph examinations.
- Review of child welfare investigations and case records, where applicable

2.080

A comprehensive sex offense-specific evaluation of a sex offender shall consider the following:

- Sexual evaluation, including sexual developmental history and evaluation of a sexual arousal/interest, deviance and paraphilias
- Degree of psychopathology (including assessment for psychopathy)
- Level of deception and/or denial
- Mental and/or organic disorders
- Drug/alcohol use
- Stability of functioning
- Self-image/self-esteem
- Medical/neurological/pharmacological needs
- Level of violence and coercion
- Motivation and amenability for treatment

¹The use of the term "structured" is not meant to imply that there is only one acceptable format for clinical evaluation. Rather, it is used to emphasize the importance of structuring a clinical interview in such a way as to assure that all necessary areas of comprehensive sex offense-specific evaluation are covered in a systematic manner.

- Escalation of high-risk behaviors
- Risk of re-offense
- Treatment and supervision needs
- Impact on the victim, when possible
- Intellectual functioning
- Developmental history
- Level and quality of social-support systems

Discussion: *Outlined below are the required areas of a comprehensive sex offense-specific evaluation. The examples identify specific evaluation instruments/processes for each area. Use of any of these specific procedures is optional unless indicated as required in Section 2.070. However, it is minimally required that an evaluator do some type of offense-specific psychological testing. No single test should be seen as absolute or predictive; rather, results should be seen as contributing to the overall evaluation of the sex offender and his or her risk to the community. Effective evaluations must include multiple risk factors. The evaluator should be cognizant that an offender’s self-report is demonstrated by research to be the least reliable source of information during the evaluation, and shall take steps not to rely solely on self-report information.*

2.090

COMPREHENSIVE SEX OFFENSE-SPECIFIC EVALUATION - ADULT

The following evaluation instruments are recommended in conducting sex-offense evaluations of Adults.

Evaluation Areas - Required	Possible Evaluation Procedures
EVALUATE MENTAL AND/OR ORGANIC DISORDERS	
<i>IQ Functioning (Mental Retardation, Learning Disability, and Literacy)</i>	<ul style="list-style-type: none"> • History of Functioning and/or Standardized Tests. Examples: • WAIS III • WRAT-R • Revised Beta • TONI (Tests of Non-Verbal Intelligence) • Shipley Institute of Living Scale Revised • Kaufman IQ Test for Adults • Stanford Binet
<i>Organic Brain Syndrome (OBS)</i>	<ul style="list-style-type: none"> • History of Functioning and/or Standardized Tests. Examples: • WAIS-III • Weschler Memory Scale Revised • Limbic System Checklist • Structured Mental Status • Jacobs Cognitive Screening Test • Quick Neurological Screening Test • Medical Tests Necessary for Diagnosis

<i>Mental Illness</i>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • MMPI2 • MCMI-III • Beck Depression Scale
EVALUATE DRUG/ALCOHOL USE	
<i>Use/Abuse</i>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • MMPI2 • CAQ (Clinical Analysis Questionnaire) • PHQ (Personal History Questionnaire) • ADS • DAST-20 • Adult Substance Use Survey • Substance Use History Matrix • Collateral Information
<i>Number of Relapses</i>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • Treatment History • Collateral Information
EVALUATE DEGREE OF PSYCHOPATHOLOGY	
<i>Degree of Impairment</i>	<ul style="list-style-type: none"> • Hare PSYCHOPATHY CHECKLIST REVISED (PCLR OR PCLSC) • Structured Interview • MCMI-III • MMPI2 • History • Collateral Information
EVALUATE STABILITY OF FUNCTIONING	
<i>Marital/Family Stability</i>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • FES (Family Environment Scale) • DAS (Dyadic Adjustment Scale) • MSI (Marital Satisfaction Inventory) • SARA (Spousal Assault Risk Assessment) • Interview Attitudes • Collateral Information
Past	
Current	
Familial Violence	
Familial Sexual	
Financial	
Housing	
<i>Employment/Education</i>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • PHQ (Personal History Questionnaire)
Completion of Major Life Tasks	

<p><i>Social Skills</i> Ability to Form Relationships Ability to Maintain Relationships Courtship/Dating Skills Ability to Demonstrate Assertive Behavior</p>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • Collateral Information • IBS (Interpersonal Behavior Survey) • Social Avoidance and Distress Scale • Waring’s Intimacy Scale • UCLA Loneliness Scale • Tesch’s Intimacy Scale • Miller’s Social Intimacy Scale
DEVELOPMENTAL HISTORY	
<p>Disruptions in parent/child relationship History of bed wetting, cruelty to animals History of behavior problems in elementary school History of special education services, learning disabilities, school achievement Indicators of disordered attachments</p>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • Collateral Information
EVALUATION OF SELF-IMAGE AND SELF-ESTEEM	
<p>Self-image, Self Esteem</p>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • MPD (Measures of Psychological Development) • CAQ (Clinical Analysis Questionnaire) • CPI (California Personality Inventory)
MEDICAL SCREENING MEASURES	
<p>Pharmacological Needs Medical Condition Impacting Offending Behavior History of Medication Use/Abuse</p>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • Referral to Physician if indicated • Medical Tests
SEXUAL EVALUATION	
<p><i>Sexual History (Onset, Intensity, Duration, Pleasure Derived)</i> Age of Onset of Expected Normal Behaviors Quality of First Sexual Experience Age of Onset of Deviant Behavior Witnessed or Experienced Victimization (Sexual or Physical) Genesis of Sexual Information Age/Degree of Use of Pornography, Phone, Sex, Cable, Video, or Internet for Sexual Purposes Current and Past Range of Sexual Behavior</p>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • PSCI (Personal Sentence Completion Inventory—Miccio-Fonseca) • Wilson Sexual Fantasy Questionnaire • SONE Sexual History Background Form • SORI (Sex Offender Risk Instrument - in research stage) • Collateral Information

<p><i>Reinforcement Structure for Deviant Behavior</i> Culture Environment Cults Gangs</p>	<ul style="list-style-type: none"> • Structured Interview
<p><i>Arousal Pattern</i> Sexual Arousal Sexual Interest</p>	<ul style="list-style-type: none"> • Plethysmography • Abel Assessment for Sexual Interest
<p><i>Specifics of Sexual Crime(s) (Onset, Intensity, Duration, Pleasure Derived)</i> Detailed Description of Sexual Assault Seriousness, Harm to Victim Mood During Assault (Anger, Erotic, “Love”) Progression of Sexual Crimes Thoughts Preceding and Following Crimes Fantasies Preceding and Following Crimes</p>	<ul style="list-style-type: none"> • Structured Interview • History of Crimes • Review of Criminal Records • Contact with Victim Therapist • Polygraph • Collateral Information
<p><i>Sexual Deviance</i></p>	<ul style="list-style-type: none"> • Structured Interview • MSI (Multiphasic Sex Inventory) • SONE
<p><i>Dysfunction (Impotence, Priapism, Injuries, Medications Affecting Sexual Functioning, Etc.)</i></p>	<ul style="list-style-type: none"> • Structured Interview • MSI (Multiphasic Sex Inventory) • Sexual Autobiography
<p><i>Offender’s Perception of Dysfunction</i></p>	<ul style="list-style-type: none"> • Structured Interview • Sexual Autobiography • Bentler Heterosexual Inventory • History
<p><i>Perception of Sexual Functioning</i></p>	<ul style="list-style-type: none"> • Structured Interview • Sexual Autobiography • Plethysmography • Bentler Sexual Behavior Inventory
<p><i>Preferences (Male/Female; Age; Masturbation; Use of Tools, Utensils, Food, Clothing; Current Sexual Practices; Deviant as well as Normal Behaviors)</i></p>	<ul style="list-style-type: none"> • Structured Interview • Sexual Autobiography • Plethysmography • Abel Assessment for Sexual Interest • Collateral Information (such as from spouses or significant others)

<p><i>Attitudes/Cognition</i></p> <p>Motivation to Change/Continue Behavior</p> <p>Attitudes Toward Women, Children</p> <p>Sexuality in General</p> <p>Attitudes About Offenses (i.e. Seriousness, Harm to Victim)</p> <p>Degree of Victim Empathy</p> <p>Presence/Degree of Minimalization</p> <p>Presence/Degree of Denial</p> <p>Ego-Syntonic vs. Ego-Dystonic Sense of Deviant Behavior</p>	<ul style="list-style-type: none"> • Structured Interview • Burt Rape Myth Acceptance Scale • MSI (Multiphasic Sex Inventory) • Buss/Durkee Hostility Inventory • Abel and Becker Cognitions Scale • Attitudes Towards Women Scale • Socio-Sexual Knowledge and Attitudes Test (For use with sex offenders who have developmental disabilities)
<p>EVALUATE LEVEL OF DENIAL AND/OR DECEPTION</p>	
<p>Level of Denial</p> <p>Level of Deception</p>	<ul style="list-style-type: none"> • Structured Interview* • Polygraph** • Collateral Information (such as from victim, police, others)
<p>EVALUATE LEVEL OF VIOLENCE AND COERCION</p>	
<p>Level of Violence</p> <p>Overall Pattern of Assaultiveness</p> <p>Victim Selection</p> <p>Pattern of escalation of violence</p>	<ul style="list-style-type: none"> • Structured Interview • History • Review of Criminal Records • Collateral Information
<p>EVALUATE RISK</p>	
<p><i>Risk of Re-offense</i></p>	<ul style="list-style-type: none"> • Criminal History • Sex Offender Risk Scale (Colorado) <ul style="list-style-type: none"> • SOMB Checklist (Normed on Colorado Offenders from probation, parole and community corrections) • Oregon Risk Assessment Scale (Normed on Oregon offenders) • Violence Risk Assessment Guide (Normed on a psychiatric hospital sample) (Good predictor of violence recidivism but not of sexual recidivism) • Rapid Risk Assessment for Sex Offender Re-Arrest (Sample excludes incest offenders) • MnSOST-R (Normed on Minnesota Offenders in the Department of Corrections, excludes incest offenders) • Static 99 • SONAR

2.100

The evaluator shall consider the following factors when making recommendations relating to an offender's risk to re-offend and amenability to treatment:

- Admission of offenses
- Accountability (internal and external factors which control behavior)
- Cooperation
- Offense history and victim choice
- Escalating pattern of offenses, violence, and dangerous behaviors
- Sexual deviance, arousal patterns, and sexual interest
- Social interest
- Lifestyle characteristics
- Psychopathology
- Developmental markers
- History of childhood or adolescent delinquency
- Substance abuse
- Criminal history
- Social support systems
- Overall control and intervention
- Motivation for treatment and recovery
- Self-structure
- Disowning behaviors
- Prior treatment
- Impact on victim(s)
- Access to potential victims
- Availability of Treatment in the Community
- Availability of Supervision, including Surveillance agents, in the Community

Discussion: *Risk to re-offend and amenability to treatment must be considered together. It is important for evaluators to be conversant with the research that suggests that the presence of a number of these factors may increase or decrease treatment amenability and/or re-offense risk. In addition, some factors weigh more heavily than others. For example, a history of sexual offenses is currently considered one of the strongest predictors of re-offense. These factors may also be used as a guide to a structured interview for the purpose of assessing risk. However, no matter how carefully done, assessments cannot absolutely predict whether a given individual will or will not re-offend.*

2.110 The evaluator shall recommend:

- The level and intensity of offense-specific treatment needs
- Referral for assessment and/or treatment of co-existing conditions (e.g. substance abuse, mental illness, medical/pharmacological)
- Methods to lessen victim impact (e.g., no-contact orders, paying for counseling, involvement of non-offending spouse, etc.)
- Appropriateness of community placement with emphasis on the risks associated with the home, neighborhood, school or community.
- The level and intensity of behavioral monitoring needed

- The types of external controls which should be considered specifically for that offender (e.g. controls of work environment, access to children, leisure time, or transportation; life stresses, or other issues that might increase risk and require increased supervision)

The evaluator (if different from the treatment provider) shall also provide presentence investigations, sex offense specific evaluations, polygraph examinations, and other information to the case management team or prison treatment provider at the beginning of an offender's term of supervision or incarceration.

3.000 STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS FOR ADULT SEX OFFENDERS

3.100 Sex Offense-Specific Treatment

Discussion: Successful therapeutic outcomes require clinicians to be knowledgeable about dynamics of sex offending, the models of treatment that have proven successful and have experience in addressing the developmental issues that are common to adult sex offenders. Some offenders will remain at high risk of sex-offending despite the efforts of the treatment team and the criminal justice system to intervene.

3.110

Sex offense specific treatment must be provided by a treatment provider who is certified as defined by these Standards.

3.120

A provider who treats sex offenders under the jurisdiction of the Civil Commitment and criminal justice systems must use sex-offender specific treatment, as defined by these Standards.

3.130

A provider shall develop a written treatment plan with measurable goals based on the needs and risks identified in current and past assessments/evaluations of the offender.

3.140 The treatment plan shall:

- Provide for the protection of victims and potential victims and not cause the victims to have unsafe and/or unwanted contact with the offender;
- Be individualized to meet the unique needs of the offender;
- Identify the issues to be addressed, including multi-generational issues if indicated, the planned intervention strategies, and the goals of treatment;
- Define expectations of the offender, his/her family (when possible), and support systems;
- Address the issue of ongoing victim input.
- Describe the treatment provider's role in implementing the treatment plan.

3.150

A provider shall submit written quarterly progress reports.

3.160

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

Group therapy (with the group comprised only of sex offenders) is the preferred method of sex-offender specific treatment. 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. The sole use of individual therapy is not recommended with sex offenders and shall be avoided except when geographical—specifically rural—or disability limitations dictate its use or when it is clinically indicated. While group therapy is the preferred modality, individual therapy may be an appropriate adjunct treatment. Sex offender specific treatment may also be sup-

plemented with treatment for drug/alcohol abuse, marital therapy, and/or crisis intervention services;

- The use of male and female co-therapists in group therapy is highly recommended and may be required by the supervising agency;
- The ratio of therapists to sex offenders in a treatment group shall not exceed 1:8.
- Treatment group size shall not exceed 12 sex offenders;
- 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;
- The provider shall employ treatment methods that are based on recognition of the need for long-term, offense-specific treatment for sex-offenders. Self-help or time-limited treatment shall be used only as adjuncts to long-term, comprehensive treatment;

3.170

In order to achieve the goals of sex offense-specific treatment, the following elements shall be addressed in treatment:

Offense Disclosure

The offender discloses all of his or her sexual offenses, reducing denial and defensiveness and/or assisting the offender in assuming full responsibility for his or her sexual offending.

Completion Indicators

- The offender makes a disclosure of all sex offenses.
- The offender attends treatment sessions as ordered or required.
- Completes all assigned tasks as required.
- When available, the offender completes non-deceptive polygraphs on past and maintenance issues
- The offender consistently takes full responsibility for all of his or her actions including sex offenses, as indicated by polygraph.
- The offender holds himself/herself accountable for his/her behavior in general.

Offense Specific Cognitive Restructuring

Cognitive distortions refer to distortions in thinking, including thinking errors that enable sexually offending behaviors. Identifying and correcting or changing offenders' cognitive distortions that fuel sexual offending is the purpose of this element of treatment.

Completion Indicators:

- The offender identifies and restructures offense-specific cognitive distortions.
- The offender assumes responsibility for offending.

There is evidence that offense-specific distortions have been restructured or changed as indicated by the lack of using cognitive distortions and that the offender holds self fully accountable when discussing the offenses.

Assault Cycle and Intervention

The assault cycle is the repetitive patterns of sexual offending. This element of treatment is intended to:

- Identify the offender's patterns of offending, including risk factors.
- Teach sex offenders self-management methods, skills, and appropriate coping skills to eliminate a sexual re-offense.
- Educate offenders and individuals who are identified as the offender's support system and the containment team about the potential for re-offending and the offender's specific risk factors.
- Require offenders to learn specific relapse prevention strategies, including the development of a written, specific relapse prevention plan. This plan should identify antecedent thoughts, feelings, situations, social behaviors, and any other behaviors associated with sexual offenses along with specific interventions.

Completion Indicators:

- The offender demonstrates identification of his/her own assault cycle and how he/she applies it to his/her daily lifestyle.
- The offender demonstrates knowledge of relapse intervention concepts.
- The offender has consistently demonstrated the effective use of relapse prevention skills i.e. able to diffuse cycle behaviors, relapse processes, deviant arousal and other factors that contribute to sexual offending.
- The offender has disengaged from relationships that support his or her denial, minimization, and resistance to treatment.
- The offender is engaged in relationships that are supportive of treatment and seeks feedback from his/her support system.
- The offender has demonstrated consistently the ability to avoid high-risk environments.

Victim Empathy

Empathy is the capacity to understand and identify with another's perspective and experience the same emotions. The ability to develop victim empathy may vary from offender to offender and may have varying emphasis in treatment.

Completion Indicators:

- The offender verbalizes and demonstrates victim empathy, identifies feelings, recognizes victim impact, assumes ownership of offenses, understands and takes the perspective of others, demonstrates emotional regret, and expresses feelings of empathy and remorse.
- The offender demonstrates behaviors that indicate reduced risk of harm to victims.

CAUTIONARY NOTE: TREATMENT TO ASSIST IN THE DEVELOPMENT OF VICTIM EMPATHY IS CONTRA-INDICATED FOR PSYCHOPATHIC OFFENDERS.

Arousal Control

This element of treatment is intended to assess, identify, and decrease or replace deviant sexual desires, arousal, thoughts, and fantasies, replacing this deviancy with healthier sexual attitudes and functioning.

Completion Indicators:

- The offender discloses deviant and/or violent sexual fantasies.
- The frequency and intensity of deviant arousal, violent and/or sadistic fantasies, and masturbation to deviant fantasies are decreased.
- The offender develops behavioral/self management strategies to reduce deviant arousal and behavior patterns, including eliminating self-abusive sexual behaviors.
- The offender develops and maintains normal, non-victimizing fantasies.

Clinical / Core Issue Resolution

It is commonly assumed that offending involves multiple unresolved emotional issues and not just deviant sexual urges. Motivational dynamics that may fuel sexual offending or other victimizing or assaultive behaviors may arise from the effects of trauma or past victimization, key developmental events, or other unresolved problems or needs. It is critical for resolution of these core issues to occur without the offender assuming a victim stance. Offenders must still be held accountable for their offending when these issues are resolved.

Completion Criteria:

- The offender has identified and resolved or mostly resolved core issues that may facilitate sexual re-offense. Core issues may include anger, power, control, inferiorities, dependency, insecurity, rejection, jealousy, possessiveness, resentment, and inadequacies in terms of self-worth and self-esteem.
- The offender has identified and changed the effects of past trauma and past victimizations to decrease their impact on the risks of re-offending.

Social Skills and Interpersonal Restructuring

Social skills refer to specific communication skills and social behaviors. Interpersonal restructuring refers to redefining the way offenders form attachments or relate to others. Interpersonal deficits are frequently associated with attachment issues. The development of basic social skills replaces deficits and inappropriate attachments or relationships, diminishing the risk of sexual re-offending. This element of treatment is intended to:

Identify deficits in specific interpersonal skills and decrease the offender's deficits in social, and relationship skills, where applicable.

Assist offenders in developing and practicing social skills, improving the quality of their relationships with others.

Completion Indicators:

- Demonstrates appropriate social relationships.
- Demonstrates appropriate boundaries.
- Has the skills to manage interpersonal relationship issues.

Lifestyle Balancing and Restructuring

Lifestyle balancing and restructuring refers to assisting sex offenders in changing their existing lifestyles to lifestyle patterns that minimize sexual re-offending and maintaining this lifestyle. The focus of this element of treatment is to:

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

- Identify and treat offenders' personality traits, lifestyle, behaviors, patterns, and deficits that are related to their potential for re-offending.
- Maximize opportunities for the sex offender to develop a healthy self-esteem.

Completion Indicators:

- Demonstrates a change in personality traits, lifestyle behaviors, patterns, and deficits related to the potential for re-offending including:
 - Antisocial/ psychopathic behaviors
 - Narcissistic behaviors
 - Borderline characteristics of behavior
 - Schizoid behaviors
 - Obsessive-Compulsive/Passive Aggressive Behaviors
 - Demonstrates a healthy and balanced lifestyle.

Provision of Treatment Referrals

The provision of treatment referrals, as indicated, links sex offenders with other resources such as medical, pharmacological, mental, substance abuse, and/or domestic violence services.

Completion Indicators:

- Monitoring offenders' linkage with other referral resources.

Communication with others

Communication is a critical element in treatment, aftercare and supervision. This element of treatment maintains communication with significant persons in offenders support systems, when indicated, and to the extent possible to assist in meeting treatment goals.

3.180

Providers shall maintain clients' files in accordance with the professional standards of their individual disciplines and with Illinois 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.

3.200 Confidentiality

Discussion: *The primary mission of the Illinois Sex Offender Management Board is achieving and maintaining community safety. The rights of sex offenders to confidentiality do not supercede the rights of others in the community to be safe from sexual harm. The challenge is in achieving balance between these elements, ensuring that the safety of the larger community is not sacrificed in the interest of protecting the rights of a sex offender.*

The effectiveness of the containment team model of sex offender management depends upon open and ongoing communication between all professionals responsible for assessing, evaluating, treating, and monitoring sex offenders. The absence of open and ongoing communication compromises the purpose of the containment team, and may compromise the safety of the community.

3.210

Prior to accepting offender into treatment and as a condition of treatment, the treatment provider shall obtain signed waivers of confidentiality/release of information based on the informed consent of the offender. If the offender has more than one therapist or treatment provider, the waiver of confidentiality/release of information shall extend to all therapists treating the offender. The waiver of confidentiality/release of information should also extend to the victims' therapist. The waiver of confidentiality/release of information shall extend to the supervising officer and all members of the team and, if applicable, to the Department of Human Services and other individuals or agencies responsible for the supervision of the offender.

Waivers of confidentiality/release of information will be required of the offender by the conditions of:

- Probation and parole
- Sexually Violent Persons (SVP) case management team
- IDOC
- Treatment provider-client contract
- DHS
- Release from Civil Commitment

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

Waivers of confidentiality/release of information should also extend to the victim, or custodial parent or guardian of a child victim, particularly with regard to (1) the offender's compliance with treatment and (2) information about risk, threats, and possible escalation of violence.

3.220

A provider shall notify all clients of the limits of confidentiality imposed on therapists by the mandatory reporting law.

3.230

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.

3.240

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

3.250 A provider shall obtain specific releases, waiving confidentiality for communications with other parties in addition to those described in this standard unless emergency or safety considerations preclude obtaining a release.

3.300 Treatment Provider – Client Written Treatment Agreement

Discussion: *Written agreements between treatment providers and their clientele are common therapeutic tools and serve a variety of purposes. With sex offenders, they are particularly useful in establishing the sex offender's responsibility, accountability, and ownership in committing the offense, and document in writing that the sex offender is informed of the terms of treatment, and the consequences of breaching the terms. Highly specific written contracts help diminish the manipulation, minimization and denial that are characteristic of sex offenders.*

3.310

Prior to treatment and as a condition of treatment, a provider shall develop and utilize a written contract with each sex offender (hereafter called "client" in this section of the Standards) prior to the commencement of treatment. The contract shall describe the responsibilities of both the provider and the client and may be the basis of revocation of probation, recommendation to the Prisoner Review Board to revoke the parolee, or other community supervision.

3.320

The contract shall describe the role of the treatment provider in implementing the treatment plan as well as the responsibility of the provider to:

1. Define and provide timely statements of the costs of the assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations;
2. Describe the waivers of confidentiality/release of information which will be required for a provider to treat the client for his/her sexual offending behavior; describe the various parties with whom treatment information will be shared during the treatment; describe the time limits on the waivers of confidentiality; and describe the procedures necessary for the client to revoke the waiver;
3. Describe the right of the client to refuse treatment and/or to refuse to waive confidentiality, and describe the risks and potential risks and outcomes of that decision;
4. Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined;
5. Describe the limits of confidentiality imposed on the therapist by the mandatory reporting law.

3.330

The contract shall describe the responsibilities of the client (as applicable) to:

1. Pay for the cost of evaluation and treatment for him- or herself, and to his or her family, if applicable;
2. Pay for the cost of evaluation and treatment for the victim(s) and their family(ies), when ordered by the court, including all medical and psychological tests, physiological testing, and consultation;
3. the treatment provider, the client's family, and support system of the details of all past sexual offenses to ensure help and protection for past victims and/or as relevant to the development of the relapse prevention plan. Clinical judgment should be exercised in determining what information is provided to children;

4. Actively involve members of the offender's family and support system, as indicated in the relapse prevention plan;
5. Notify the treatment provider of any changes or events in the lives of the client, the members of the client's family, or support system;
6. Participate in polygraph testing as required in the Standards and Guidelines, and if indicated, plethysmographic testing as adjuncts to treatment;
7. Assent to be tested for sexually transmitted diseases and HIV, and assent for the results of such testing to be released to the victim by the appropriate person, and;
8. Comply with the limitations and restrictions placed on the behavior of the client, as described in the terms and conditions of probation, parole, or community corrections and/or in the contract between the provider and the client.

3.340

The contract shall describe the responsibility of and restrictions on the client to protect community safety by avoiding risky, aggressive, or re-offending behavior by avoiding high-risk situations, and by reporting any such behavior to the provider and supervising officer as soon as possible.

3.350

A. A provider shall develop and utilize a written contract with each sex offender (hereafter called "client" in this section of the Standards) prior to the commencement of treatment. The contract shall describe the responsibilities of both the provider and the client.

The contract shall explain the responsibility of the provider to:

- Define and provide timely statements of the costs of the assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations to the client as well as the parent or guardian.
- Describe the waivers of confidentiality that will be required for a provider to treat the client for his/her sexual offending behavior; describe the various parties with whom treatment information will be shared during the treatment; describe the time limits on the waivers of confidentiality; and describe the procedures necessary for the client to revoke the waiver;
- Describe the right of the client to refuse treatment and/or to refuse to waive confidentiality, and describes the consequences, risks and potential risks and outcomes of that decision, including the provider's right not to provide treatment if confidentiality is not waived.
- Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined.
- Describe the limits of confidentiality imposed on the therapist by the mandatory reporting law.
- Explain the terms of the contract to the client in language that the client understands.

3.400 Completion of Treatment

Discussion: *The most successful treatment outcomes for sex offenders are achieved when treatment, supervision, and*

placement are linked from the outset with the severity of the offense and the presenting level of risk. Participation by family members or members of the social support system is also a powerful determinant of the outcome of treatment.

It is the responsibility of the containment team to establish the individual benchmarks that will determine therapeutic progress and treatment completion for each juvenile sex offender.

Since levels of risk and the need for therapeutic intervention may fluctuate over time, anytime an adult or juvenile sex offender exhibits behaviors or attitudes that are indicative of relapse, levels of supervision and intensity of treatment should be immediately reviewed by the treatment provider and other members of the containment team. The recommendations of the containment team shall be forwarded to the juvenile court, parole, and/or probation

3.410

Completion of treatment should be understood as meaning the successful completion of treatment, and not as the cessation of court-ordered, offense-specific treatment or the completion of the sentence imposed by the court or the Prisoner Review Board. Successful completion of treatment may not end the offender's need for ongoing rehabilitation or elimination of risk to the community. If risk increases, treatment may be re-instated upon the request of the offender or the recommendation of the community supervision team. Treatment should be viewed as ranging from intensive to aftercare.

3.420

The sex offender community supervision team shall consult about the completion of treatment. The decision shall come after the evaluation and assessment, treatment plan, course of treatment sequence, and a minimum of a non-deceptive disclosure polygraph examination and two or more non-deceptive maintenance polygraph examinations, regarding compliance with court rules, compliance with supervision conditions, compliance with treatment contract provisions, including complete abstinence from grooming of victims and full, voluntary compliance with all conditions required to prevent re-offending behavior. The two or more non-deceptive polygraph examinations must be those most recent prior to termination of treatment. (See definitions for non-deceptive polygraph results.)

A failed polygraph examination should not be used as the sole reason to deny successful completion of treatment. The team should carefully consider termination of treatment based on maintaining community safety.

3.430

Those offenders who pose an ongoing threat to the community require supervision, even while demonstrating progress in treatment, and may require ongoing supervision and treatment to manage their risk, including revocation as authorized and approved in writing by the Prisoner Review Board when on parole. Any exception made to any of the requirements for treatment completion must be made by the consensus of the community supervision team. In this case, the team must document the reasons for the determination that treatment completion is appropriate without meeting all of the standard requirements and note the potential risk to the community.

3.440

To determine the recommendations for the termination of treatment, the provider shall:

- Assess actual changes in a client's potential to re-offend prior to recommending treatment termination;
- Attempt to repeat, where indicated, those evaluations that might show changes in the client;
- Assess and document how the goals of the treatment plan have been met, what actual changes in a client's re-offense potential have been accomplished, and what risk factors remain, particularly those affecting the emotional and physical safety of the victim(s);

- Seek input from others who are aware of a client's progress as part of the decision about whether to terminate treatment;
- Report to the supervising officer regarding a client's compliance with treatment and recommend any modifications in conditions of community supervision and/or termination of treatment;
- At the end of this evaluation process, inform the client regarding the recommendation to end or continue court-ordered treatment.

3.450

Prior to terminating offense-specific treatment, a provider shall, in cooperation with the community supervision team, 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 risks of re-offense.

3.500 Additional Standards for Sex Offense-Specific Treatment of Sex Offenders in IDOC

Discussion: The first priority for the use of resources is the evaluation and treatment of those sex offenders who are motivated to participate in treatment and are eligible for release and/or present an unusually high risk to the community.

3.510

A comprehensive sex-offender specific evaluation shall be completed as a part of the pre-sentence investigation, which shall accompany the offender to prison.

3.520

A sex offender who has been sentenced to the Department of Corrections (DOC), and who is being paroled or being released and who did not receive a comprehensive sex-offender specific evaluation within a year of admission to DOC at the time of the presentence investigation shall receive a comprehensive-offense specific evaluation document outlined in this document. The evaluation may occur prior to or during the course of sex-offense specific treatment in the prison or prior to release to the community or on parole if the offender has not been in treatment.

3.540

Treatment for sex offenders in prison shall conform to the standards for offense-specific sex offender treatment.

3.550

The DOC treatment provider shall employ treatment methods that are based on recognition of the need for long-term, comprehensive, offense-specific treatment of sex offenders. Self-help or time limited treatments shall be used only as an adjunct to long-term, comprehensive treatment.

3.560

DOC treatment providers are encouraged to utilize a team approach similar to that described in Section (9.100). Specifically, the polygraph examiner and the treatment provider should work closely together, and other professionals should be included on the team as indicated.

3.570

In addition to general conditions imposed on all offenders, including those who have not participated in or received treatment, the following special conditions should be imposed on sex offenders who are incarcerated unless a treatment provider submits approval in advance and in writing:

1. Sex offenders shall have no contact with their victim(s) including correspondence, telephone contact, or communication through third parties;
2. Sex offenders shall have no contact with children, including their own children;
3. Sex offenders shall not access or loiter near children in the visiting room or participate in any volunteer activity that involves contact with children;
4. Sex offenders should not possess any pornographic, sexually oriented or sexually stimulating materials, including visual, auditory, telephonic, or electronic media, and computer programs or services that are relevant to offenders deviant behavior/ pattern. Sex offenders shall not patronize any place where such material or entertainment is available. Sex offenders shall not utilize "900" or adult telephone numbers or any other sex-related telephone numbers;
5. DOC, as approved by the Prisoner Review Board, may impose other special conditions that restrict sex-offenders from high-risk situations and limit access to potential victims;

3.570

The duration of time in treatment in DOC shall not offset the need for the offender's continued treatment upon his/her supervised release to the community.

3.580

All sex offenders require supervision upon release from DOC, and to have their participation in treatment monitored by the containment team.

3.590

Prior to the offender's release, DOC treatment providers shall prepare a detailed treatment report of the offender's participation in treatment, their institutional behavior, modus operandi, and risk of re-offending. This report shall be provided to the prison review board prior to a hearing. If paroled, the report shall be submitted to the parole supervisor as well as the treatment provider in the community and other members of the containment team.

A parole plan shall be completed prior to an offender's beginning parole supervision. The purpose of the parole plan is:

1. Assess the resources that will be available to an offender who will live and work in the community and;
2. Make recommendations for conditions of supervision, including the offender's treatment.

A discharge summary should also be completed for sex offenders who will be released directly into the community without a period of parole. The report should provide information on the offender's institutional behavior, including treatment goals and progress toward them, modus operandi, and risk of re-offending. Such discharge data shall be forwarded to the parole supervisor and to the Division of Parole for potential dissemination to law enforcement agencies.

3.600 Community Placement and Treatment of Sex Offenders Who Are in Denial

Discussion:

Secrecy, denial, and defensiveness are part of the sex offender's disorder. Almost all offenders fluctuate in their level of accountability or "denial" of the offense. Although most are able to admit responsibility for the act soon after conviction, some offenders do not. An offender's continued denial of the act after plea-bargaining or conviction may threaten community safety and may be highly distressing and emotionally damaging to the victim.

3.610

Level of denial and defensiveness shall be assessed during the comprehensive sex offender specific evaluation. In some cases, denial alone may be regarded as a sufficient fact to eliminate an offender from a recommendation for community-based treatment. Continued strong or severe denial of the offense during the course of the evaluation as opposed to fluctuating or moderate denial and/or continued strong defensiveness in general suggests a level of risk that may rule out an offender's eligibility for community-based treatment.

3.620

When a sex offender in strong or severe denial must be in the community (e.g. parole), the maximum level of supervision shall be provided. Sex offense-specific treatment should begin immediately with an emphasis on denial and defensiveness. Such offense-specific treatment for denial should not be provided for an indefinite period of time when offenders continue to deny the offense.

3.630

Although offense-specific treatment typically begins by addressing denial and defensiveness, treatment for strong or severe denial may occur separately from regular group therapy that is provided for offenders who have, at a minimum, admitted the crime of conviction. Treatment for such denial may include a variety of modalities specifically designed to reduce denial and resistance to treatment.

3.640

Sex offenders in strong or severe denial require maximum levels of supervision and monitoring during an initial treatment phase. Home detention, electronic monitoring, field supervision, and/or stringent restrictions on offenders' time are examples of additional conditions that should be recommended by the evaluator that may be indicated during treatment for denial.

3.650

Offenders who continue to deny the facts of their sexual offenses cannot benefit from treatment and may not be suitable candidates for community placement. After a period of time specified by the therapist, consideration should be given to termination of the offender from treatment and referral back to court, if offender is on probation. Other increased levels and types of supervision, such as home detention, electronic monitoring, polygraph etc., should be pursued if revocation is not an option.

3.660

Only treatment providers who also meet the requirements to provide sex-offense specific treatment, as defined in these standards, may provide treatment for denial.

3.670

Progress in treatment for denial is reflected by the offender's decreased resistance to treatment, decreased defensiveness and denial, and increased accountability for the behavior. This progress should be documented by:

- The offender's compliance with the conditions of offense-specific denial treatment;
- The offender's verbal disclosures during treatment that document changes in denial;
- Changes in the offender's responses on standardized tests;
- The timely and competent completion of homework and in-session assignments;
- The offender's willingness to schedule and undergo polygraph testing;
- Non-deceptive polygraph.
- Compliance with Court conditions

3.680

Treatment providers and containment teams must establish specific and measurable goals and tasks for offenders in denial. These measurable goals will establish whether or not offenders have reached the threshold for eligibility for referral to standard offense-specific treatment, continued treatment, or referral for revocation proceedings. It is especially important to document measures of offenders' acceptance of responsibility for their offenses.

3.690

Use of the polygraph is important in reducing an offender's denial but the timing of its use should be flexible. In cases with highly resistant offenders, use of the polygraph before adequate preparation might increase the resistance.

3.700 Treatment Providers' Use of the Polygraph, Plethysmograph, and ASI

Discussion:

Physiological data can be useful in assessing a client'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 ASI and shall recognize that this physiological data is only meaningful within the context of a comprehensive evaluation and/or treatment process.

3.710

A treatment provider may employ treatment methods that integrate the results of polygraph, plethysmography, the Abel Assessment for Sexual Interest or other physiological testing, as indicated. If plethysmography is used, the examiner must meet the standards for plethysmography as defined in the ATSA Practitioner's Handbook (2001 Edition) and described in these standards. If the Abel Assessment for Sexual Interest (ASI) is used, the treatment provider or evaluator must be trained and licensed to utilize the instrument.

3.720

It is recommended that a provider employ plethysmography as a means of gaining information regarding the sexual arousal patterns of sex offenders or the ASI as a means of gaining information regarding the sexual interest patterns of sex offenders.

3.730

In cooperation with the supervising officer, the provider shall employ treatment methods that incorporate the results of polygraph examinations, including issue specific polygraphs, disclosure polygraphs, and maintenance polygraphs. Exceptions to the requirement for use of the polygraph may be made only by the community supervision team or by a prison treatment provider.

3.740

The containment team shall determine the frequency of polygraph examinations, and the team shall review the results. The results of such polygraphs shall be used to identify treatment issues and for behavioral monitoring.

Discussion:

Because of the epidemic nature of sexual assault, there is a need for more and better methods to accurately assess, treat, and monitor sex offenders. Polygraph testing is an effective tool for informing the community supervision team 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.

GUIDING PRINCIPLES FOR JUVENILE SEX OFFENDERS

These principles apply to any minor found guilty of a sex offense in the juvenile court. Minors must be held accountable for their sex crimes and as necessary, be institutionalized until satisfactory completion of an appropriate treatment program.

1. **Juvenile sexual offending is a complex behavioral disorder.**

Sex offenses are defined by law and may or may not be associated with or accompanied by the characteristics of sexual deviance, which are described as paraphilias. Some sex offenders also have co-existing conditions such as mental disorders, organic disorders, or substance abuse problems. Clinical intervention and treatment do not always eliminate the risk that sex offenders may repeat their offenses. Many juvenile offenders can learn through treatment to manage their sexual offending behaviors and decrease their risk of re-offense.

2. **Juvenile sex offenders commit sexual offenses that are harmful to the victim and the family and are potentially dangerous to the community and self.**

When a sexual assault occurs, there is always a victim. Both the literature and clinical experience suggest that sexual assault can have devastating effects on the lives of victims and their families.

There are many forms of sexual offending. Offenders may have more than one pattern of sexual offending behavior and often have multiple victims. The propensity for such behavior is often present long before it is detected. It is the nature of the disorder that adolescent sex offenders' behaviors are inherently covert, deceptive, and secretive. Untreated adolescent sex offenders also commonly exhibit varying degrees of denial about the facts, severity, and/or frequency of their offenses.

3. **Community safety is paramount.**

The highest priority of these guidelines and standards is community safety. Community safety means that juvenile sexual offenders are held accountable for their behavior, and depending on the level of risk, may be incarcerated, placed in a residential treatment facility, or supervised on probation in the home. All components of the system (the court, law enforcement, parole, probation, corrections, child welfare, and treatment providers) must be trained and educated to promote community safety.

4. **Evaluation of juvenile sex offenders is an ongoing process. Progress in treatment and level of risk are not constant over time.**

The evaluation of all sex offenders is best seen as a process. Best practice requires that adolescent sexual offenders are first evaluated and referred for a court-ordered comprehensive sex-offender specific evaluation during the social investigation. Subsequent evaluations must occur at both entry and exit of all sentencing options i.e. probation, parole, and prison. In addition, evaluation should be an ongoing practice in any program providing treatment for juvenile sex offenders.

In the management and treatment of juvenile sex offenders, there will be measurable degrees of progress or lack of progress. Because of the cyclical nature of offense patterns and fluctuating life stresses, sex

offenders' levels of risk are constantly in flux. Success in the management and treatment of sex offenders cannot be assumed to be permanent. Monitoring of risk must be a continuing process as long as the juvenile offender is under court supervision or in treatment. The end of court supervision should not be understood as the end of risk or the end of ongoing rehabilitative needs.

5. Whether incarcerated or not, juvenile sex offenders must be held completely accountable for their behaviors.

The placement of juvenile sex offenders should depend on the presenting level of risk and amenability to treatment. For those juvenile sex offenders placed in a correctional facilities or in a residential treatment program, risks of re-offense may increase at the point of discharge. Recommended is the transition of juvenile sex offenders from the highly structured, supervised correctional or treatment setting to a setting that permits a gradual reduction in structure and supervision as the juvenile demonstrates an increasing ability to manage his or her behavior in a community setting.

6. Juvenile sex offenders must waive confidentiality for evaluation, treatment, supervision, and case management purposes.

All members of the team managing and treating each adolescent sex offender must have access to the same relevant information. Sex offenses are committed in secret, and all forms of secrecy potentially undermine the rehabilitation of sex offenders and threaten public safety.

7. Victims have a right to safety and self-determination.

Consistent with the provisions of the Juvenile Court Act, victims have the right to determine the extent to which they will be informed of an offender's status in the juvenile justice system and the extent to which they will provide input through appropriate channels to the offender management and treatment process. In the case of adolescent or child victims, custodial adults, guardians, and/or guardian ad litem act on behalf of the child to exercise this right in the best interest of the victim.

8. When a child is sexually abused within the family, the victim's individual needs for safety, protection, developmental growth, and psychological well-being is paramount.

All aspects of the community response and intervention system to child sexual abuse should be designed to promote the best interest of children rather than focusing primarily on the interests of adults. In most cases, the offender should be moved to achieve a lack of contact, rather than further disrupting the life of the child-victims. Family reunification is not always a goal.

9. A continuum of juvenile sex offender management and treatment options should be available in each community in the state.

Many adolescent sex offenders can be managed in the community on probation or parole. It is in the best interest of public safety for each community to have a continuum of sex offender management and treatment options for juveniles. Such a continuum should provide for an increase or a decrease in the intensity of treatment and monitoring based on the history of offending, changing risk factors, treatment needs, and compliance with the conditions of supervision. Such a continuum assures the most effective use of resources by providing juveniles with the highest risk of re-offending, intensive treatment in a residential setting that restricts access to victims or potential victims.

The components of a continuum of services for juvenile sex offenders shall provide for the following:

- Outpatient sex offense specific treatment and community supervision for minors with little or no previous history of sexual offending, and are typically at low risk of re-offending.
- Day treatment, instead of a traditional school setting, for juveniles who have an emerging pattern of repetitious offenses and a broader range of behavioral, emotional, and environmental problems. Minors at this level of treatment and supervision are often opportunistic in offending, presenting an unacceptable level of risk in traditional school settings.
- Community-based residential treatment for minors who have displayed predatory or fixed patterns of offenses, or those who have used force or weapons in committing their offenses. Juvenile sex offenders in this group typically have other maladaptive social, behavioral, and emotional difficulties and require maximum non-secure supervision and intensive clinical intervention.
- Psychiatric treatment in a community-based facility that is semi-secure. The most significant features of juveniles at this level of care is the presence of a significant mental illness. The offender may display psychotic processes, self-destructive behaviors, and/or severe aggression. Because of their psychiatric problems, they are not able to benefit from treatment in a less secure setting or one that is less psychiatrically oriented. The population of six offenders within such a setting must be segregated from non-offending populations.
- Treatment, behavioral intervention, levels of supervision, and residential settings for juvenile offenders who, as a result of a developmental disability, require treatment and intervention strategies tailored to their level of functioning. The severity of offending behaviors of juveniles within this group range from low-risk to extremely high-risk. They are unable to benefit from more traditional models of treatment and these models will not reduce their risks of sexual harm to others.
- Secure confinement / correctional placement and treatment for minors who sex offenses are patterned, repetitive, predatory, and involve the use of force or weapons, and tend to act out sexually with even with same age peers. At this level of treatment and supervision, most juveniles have a history of previous treatment. This group presents an extreme risk to the community.

10. **Standards and guidelines for evaluation, treatment, and behavioral monitoring of juvenile sex offenders will be most effective if the entirety of the juvenile justice and social services systems, not just sex offender treatment providers, apply the same principles and work together.**

It is the philosophy of the Illinois sex Offender Management Board that setting standards for sex offender treatment providers alone will not significantly improve public safety. In addition, the process by which juvenile offenders are evaluated, treated, managed by juvenile justice, corrections, and social services systems should be coordinated and improved.

11. **The management of juvenile sex offenders requires a coordinated team response.**

All relevant agencies must cooperate in planning treatment and containment strategies of sex offenders for the following reasons:

- Sex offenders should not be in the community without comprehensive treatment, supervision, and behavioral monitoring.
- Each discipline brings to the team specialized knowledge and expertise.
- Open professional communication confronts the tendency of adolescent offenders to exhibit secretive, manipulative, and denying behaviors.
- Information provided by each member of an offender containment team contributes to a more thorough understanding of the juvenile offender's risk factors and needs, and to the development of a comprehensive approach to treating and managing the juvenile sex offender.

12. Sex offender evaluation, treatment, and behavioral monitoring of juvenile offenders shall be non-discriminatory and humane and bound by the rules of ethics and law.

Individuals carrying out the evaluation, treatment, and behavioral monitoring of sex offenders shall not discriminate based on race, religion, gender, sexual orientation, disability, or socioeconomic status. Sex offenders must be treated with dignity and respect by all members of the team who are managing and treating the offender regardless of the nature of the offender's crimes or conduct.

13. Successful treatment and management of juvenile sex offenders are enhanced by the positive cooperation of family, friends, employers, and members of the community who have influence in sex offenders' lives.

Sexual issues are often not talked about freely in families, communities, and other settings. In fact, there is often a tendency to avoid and deny sex offenses have occurred. Successful management and treatment of juvenile sex offenders involves an open dialogue about this subject and a willingness to hold juvenile offenders accountable for their behavior.

4.000 JUVENILE SEX OFFENDER SOCIAL INVESTIGATIONS

Discussion: *The purpose of the social investigation is to provide the court with verified and relevant information upon which to base sentencing decision even when a plea bargain reduces the charges to a non-sexual offense. Sex offenders pose a high risk to community safety and have special needs. Therefore, social investigations on these cases differ from those in other types of cases, primarily by the inclusion of a comprehensive sex offense-specific evaluation (including a polygraph). The evaluation establishes a baseline of information about the offender's risk, type of deviancy, amenability to treatment and treatment needs.*

The social investigation report, including the results of a recent (i.e., generally within one year) comprehensive sex offense-specific evaluation (including a polygraph), should follow the sex offender throughout the time the offender is under juvenile justice system jurisdiction, whether on probation, parole, or in prison.

4.010

Before sex offenders are sentenced for felony sex offenses as outlined in the Illinois Compiled Statutes and all felony offenders whose delinquency includes some form of sexually motivated or deviant behavior (battery charges which were sexual, burglary with the theft of undergarments, criminal trespass which was peeping, etc.) shall be required to comply with a social investigation, including a comprehensive sex offense-specific evaluation (including a polygraph), prior to sentencing, even when by statute it is otherwise acceptable to waive the social investigation. All misdemeanor offenders, including those in sex cases reduced to non-sex offense categories, it is recommended that they undergo a social investigation, including a comprehensive sex offense-specific evaluation (including a polygraph) prior to sentencing.

4.020

In cases of a finding of guilt, including plea agreements, continuance under supervision and sentences for non-sexual crime, if the current offense has a factual basis of unlawful sexual behavior, the offender's case should be assigned to a social investigator specially trained to assess sex offenders.

Discussion: *While it is preferable that sexual crimes not be plea-bargained to non-sexual crimes, such plea bargains sometimes occur. However, this does not eliminate the need for the offender to be assessed based on the factual basis of the case. In addition, it is highly recommended that no Alford Pleas or deferred judgments be entered on cases of a sexual nature.*

Juveniles with a known history of sexual offending behaviors, but who have not been adjudicated for a sexual offense may benefit from these Standards for treatment, e.g. those placed on diversion, deferred adjudication or subject of dependency and neglect proceedings. These juveniles may receive treatment for sexual offending behaviors in the same programs as those who have been adjudicated. Such juveniles should acknowledge their history of sexual offending behavior, be held accountable for participation in treatment, and be supervised by caregivers in a manner congruent with these Standards.

4.030

Social investigations on sex offender and sex offense related cases should be completed by probation officers specially trained to evaluate all data collected from comprehensive sex offense-specific evaluations (including a polygraph), clinical interviews, objective and psychometric measures, as well as delinquency and social history, information including hospital and school records. At minimum, the officer should meet the Hiring Guidelines of the Administrative Office of the Illinois Courts for Probation Officers. Probation officers assigned to complete juvenile sex offender social investigations should be required to have a minimum of 2 years active case supervision including juvenile sex offenders and should complete a minimum of 40 hours training on the management of

juvenile sex offenders.

4.040

At the time of the intake interview, the purpose of the social investigation should be explained to the offender and parent/guardian by the social investigator. All required release of information forms, including a copy of the required disclosure/advisement form, should be signed and dated.

Discussion: *This disclosure/advisement form notifies an offender and other concerned parties of the requirements the offender will have to meet should probation be granted.*

4.050 JUVENILE SEX OFFENDER SOCIAL INVESTIGATION REPORT FORMAT

A. Offense

1. Summarize the circumstances of the offense(s), including when appropriate:

- a. Date, time and place of offense or delinquent act.
- b. Ages, gender, and relationship of victim(s).
- c. Details of offense, including victim's statement.
- d. Date and circumstances of taking into custody.
- e. If there were any station adjustment not brought to adjudication.

2. Juvenile's Statement and Attitude:

- a. Summarize juvenile's version of offense. Does he/she deny or minimize the offense, or take responsibility for his/her actions? What is the juvenile's opinion (or feelings) towards the victim(s) and his/her family?
- b. General attitude regarding self and his/her present situation.
- c. Attitude toward legal process, detention and probation.
- d. Cooperation/truthfulness.
- e. What justification does the juvenile give of the sex offense?

B. History of Delinquency

1. Chronological listing of all prior police contacts. Include the type of contact, date and action taken.
2. Juvenile probations/supervisions granted, adjustment and present status. [Include informal supervision and home detention.]
3. Dates of detention including, but not limited to records of behavior while in custody.

C. Family Composition

1. List names, ages, addresses and occupations of parent (s), and/or guardian, foster parents or relative care givers.
2. Summarize information relating to siblings; any non-relatives living in the home. [If the minor is or has been married and/or has any children, include this information.]

3. Socio-economic status of family, including family income. Indicate the type and amount of income; i.e., employment income, social security, welfare benefits, pension, etc.
4. Note any criminal history, mental illness, and other serious problems of family members, especially if there is a family criminal history of sexual offending. Note any involvement with the Illinois Department Children and Family Services.
5. Indicate if and when subject moved from family residence. [This should primarily pertain to the minor leaving on his/her own, staying with friends or relatives, foster placements, residential placements or any out-of-home placement.
6. Information on cultural and ethnic demographics.

D. Family Dynamics

Discussion: *The victim and the offender should not reside in the same home. It is preferable to remove the offender from the home.*

1. Describe intra-family relationships and/or family attitude toward the subject. Is there resentment directed at the minor due to his/her sex offense(s) or is the family supportive of the subject, and willing to help him/her deal with sex offending issues despite the victim(s) presence in the family unit? Is the family in denial about the subject's offending behavior?
2. Describe juvenile's feelings toward family members, other members of the household and victim(s) (if applicable).
3. Describe the disciplinary / behavioral measures used in the home with the minor.

E. Juvenile Information

1. Juvenile's place of birth; geographic movement of subject and family.
2. Living Situation. Give a description of the residence and neighborhood. Expound on the safety plan at the residence if the juvenile is released back to his or her parents/guardians after a court disposition, and the victim(s) resides in the same home. What steps are going to be implemented by the parents/guardians to insure that the minor has no unsupervised contact with his/her victim(s) and potential victim(s) (if applicable)? Is it possible to have the minor placed with a relative (aunt, uncle, grandparent, etc.) instead of his/her home if the victim(s) also resides there? Explore the option of the court ordering a home study.
3. Close associations or gang affiliations. Inquire about the juvenile keeping company with other known sex offenders, juvenile or adult.

F. Education

Discussion: *Describe the school safety plan. Describe the steps that are going to be taken by the juvenile and/or school officials to insure that he or she does not have victim access at the school. [This is particularly important if the subject is in a school setting with other minors who are younger and/or smaller than he/she is.]*

1. Years of education completed/present educational status. Including class placement (i.e., special education, learning disabled, mainstreamed)
- 2 Last school attended.
3. IQ and other relevant test results.
4. School grades and attendance record.
5. Special problems, including disciplinary history.
6. Indicate any specialized training juvenile has received, including any placements.
7. Strengths
8. Relationships with peers and adults in authority, school interaction.

G. Employment

Division: *It is important, at the start, to determine where the subject is employed. If it is a place where he/she has victim access (particularly where small children associate), the subject should be discouraged from continuing to work there. Juvenile sex offenders should not be employed in facilities or institutions in which they have child-care responsibilities or in places of employment close to a public area where small children congregate. The social investigation report should include a recommendation to the court that the subject not hold any job where there is a victim access.*

1. List current employment status or volunteer or community work.
 - a. Name and address of employer/volunteer coordinator/organization.
 - b. Wages.
 - c. Duties.
 - d. Hours.
2. List prior employment.
3. Indicate any special job skills possessed by the subject

H. Physical Health

1. Present Health Status
 - a. Current health problems or diagnosis, including STD's.
 - b. Prescribed medication taken at present time.
 - c. Physical handicaps
2. History of any serious illnesses or injuries.

I. Mental Health

1. Comment on subject's mental and emotional status, including intellectual functioning (i.e. IQ).
2. Indicate any past treatment or institutionalization for mental illness (look for a history of organic brain disease, brain injury, depression or suicide attempts, fire setting, homicidal ideation, aggression and personal violence, substance abuse). Specifically, focus on past sex offender treatment or counseling (if applicable).
3. Include past and current psychiatric medications.
4. Is there a history of physical, emotional and/or sexual abuse and/or exposure to domestic violence?
5. A comprehensive sex offense-specific evaluation report (including a polygraph examination; see standards section 2.000) is imperative, and should coincide with the social investigation.
6. Any prior evaluations (sex offense, psychological, psychiatric, drug/alcohol, etc.) should be attached to the report, and the findings summarized.

J. Alcohol and Drug Use

1. Obtain information on subject's present use of alcohol and/or illegal drugs.
 - a. Source of information.
 - b. Degree of use.
 - c. Type and extent of drug involvement, drug(s) of choice, frequency, age of onset.
 - d. Attitudes toward drugs/alcohol usage.
2. History of alcohol/ illegal drug usage, treatment received, including dates and details of any placements.
3. Attach copies of any assessments and evaluations.

K. Religion

1. Indicate subject's religious preference and church membership, name and address of church, if applicable, and degree of participation.
2. Describe the measures that will be taken by the family, pastor and/or certain members of the congregation to insure that the minor does not have unsupervised contact with children or access to victims, including in such settings as child care centers, day camps, or sleepovers.

L. Interests

1. Hobbies.
2. Special interests.
3. Recreational preference.
4. Use of leisure time. Determine what the subject most enjoys doing during his/her free time.

5. Investigate various forms of media, especially videos, Internet or magazines.

M. Community Attitude

Discussion: Interviews with others who know the juvenile or are familiar with the offense committed often provide critical knowledge and perspectives that would otherwise be unavailable within the course of a social investigation. This information contributes to sound decisions about treatment strategies, placement settings, and the level of supervision required to ensure community safety and supports the efforts of the containment team.

Interviews should be conducted with the following persons:

1. Arresting or juvenile officer.
2. School personnel (principal, teachers, counselors, etc.).
3. Employer, if the minor is employed, or has an employment history.
4. Clergy.
5. Neighbors or other community members.
6. Any other references may be inserted here.

N. Victim Impact

Contact should be made with the victim/victims (if over 18) or the parents to verify if he/she was referred for victim services after the offense occurred. Information about the impact on the victim and family should include the following:

1. Physical injuries sustained by the victim, medical attention and/or hospitalization.
2. Mental and/or emotional trauma reported by the victim (or parents of the victim).
3. Whether or not the victim is receiving mental health services such as counseling or plans to seek help.
4. Whether or not the victim had to move, change jobs or make other significant changes in his/her daily life or routine.
5. Medical expenses paid by the victim or victim's parents as a result of the sex offense.
6. Any time off work or pay that was lost due to trauma and/or the legal process?
7. What the victim (or parents of the victim) believe is the appropriate sentence for the offender.
8. If the victim does not reside in the same home as the subject, whether or not the offender has made contact, or attempted to make contact with him/her?

O. Summary and Sentencing Recommendations if Requested

Discussion: *Based on an analysis of all the information gathered, the investigator completing the social investigation report should make recommendations about an offender's suitability for treatment and level of care (i.e. community supervision, residential placement, incarceration.) This analysis based on the gathered data should include all the aggravating and mitigating information and is an opportunity for the investigator to give opinions about the offender's amenability for treatment and his/her risk to the community. When and if possible, as much of the perpetrator's cycle should be exposed for review.*

1. Briefly summarize the most pertinent elements of the previous headings relative to the disposition of the case. Strengths and weaknesses may be discussed.
2. Present an analysis of the subject's problems and the factors related to the pattern of delinquent and/or sex offending behavior.
3. Present recommendations for sentencing, treatment and placement.
4. If the offender is placed on probation, the report should include all special conditions or events that are a violation of community supervision or probation and that offer the safety of the victim and the community.
5. The report should include recommendations restricting access to children as appropriate (specifically based on the comprehensive sex offense-specific evaluation).

P. Sources of Information/Attachments

All supporting documentation should be attached to the social investigation report, including the comprehensive sex offense-specific evaluation, polygraph results, previous social investigations, drug and alcohol evaluations, mental health assessments and treatment reports, victim impact statements (if available), and any other pertinent documentation backing up the factual content of the report, police report.

Q. Collateral Information

When referring an offender for a comprehensive sex offense-specific evaluation (including a polygraph) or treatment, social investigators should send to the evaluator, treatment provider and polygrapher the following as part of the referral packet:

- The instant offense reports (police reports)
- The victim impact statement
- DCFS reports or investigation results and case records
- A criminal history
- Any completed risk assessment tools
- Prior evaluations and treatment reports, including psychiatric / psychological evaluations
- Prior polygraph examinations
- Any social investigation reports
- Pertinent prior probation or supervision records
- Juvenile DOC records
- Other available information as required by the evaluator or polygrapher
- Family history
- Health records, as available
- School/educational records
- Sex Offense specific evaluations

5.000 STANDARDS FOR COMPREHENSIVE SEX-OFFENSE-SPECIFIC EVALUATIONS- JUVENILES

5.010

The definition of “juvenile” for purposes of these standards shall be “any minor charged with a sex offense under the jurisdiction of the juvenile court.”

5.020

In accordance with this section, each sex offender shall receive a comprehensive sex offense-specific evaluation.

Discussion: *Evaluations are conducted to ascertain a juvenile’s risk of sexual offending. Because of the importance of the information collected during an evaluation to subsequent sentencing, supervision, treatment, and behavioral monitoring, it is the Board’s philosophy that each sexual offender should receive a thorough assessment and evaluation. In addition, it is important to recognize that evaluation is an ongoing process and should continue through each level of supervision and treatment.*

5.030

The comprehensive sex offense-specific evaluation (including a polygraph) has the following purposes:

- To document the offense specific and/or mental health treatment needs identified by the evaluation (even if resources are not available to address adequately the treatment needs of the offender);
- To provide a written clinical evaluation of an offender’s risk for re-offending and current amenability for treatment;
- To guide and direct specific recommendations for the conditions of treatment and supervision of an offender;
- To provide information that will help to identify the optimal setting, intensity of intervention, and level of supervision, and;
- To provide information regarding family/guardian supervision and support needed to help maintain community safety.

5.040

The evaluator shall meet the all requirements set forth in these standards and be certified by the Illinois Sex Offender Management Board. In addition, evaluators shall adhere to established ethical standards, practices and guidelines of their respective professions.

5.050

The evaluator shall inform the offender and his or her parents/guardian of the purposes of the evaluation, the evaluation methods (including use of polygraph), how the information will be used, and to whom it will be given. A consent waiver must be obtained.

The evaluator shall also inform the offender and his or her parents/guardian about the nature of the evaluator’s relationship with the offender and the court. The evaluator shall respect the rights of these individuals to be fully informed about the evaluation procedures. Results of the evaluation should be shared with the offender and his or her parents/guardian and any questions clarified.

5.060

The evaluator shall be sensitive to any cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues that may arise during the evaluation.

COMPREHENSIVE SEX OFFENSE-SPECIFIC EVALUATION - JUVENILE

The following evaluation instruments are recommended in conducting sex-offense evaluations of juveniles:

Evaluation Areas - Required	Possible Evaluation Procedures
EVALUATE MENTAL AND/OR ORGANIC DISORDERS	
<p><i>IQ Functioning (Mental Retardation, Learning Disability, and Literacy)</i></p>	<ul style="list-style-type: none"> • History of Functioning and/or Standardized Tests. Examples: • WAIS III • WRAT-R • WISC-R • TONI (Tests of Non-Verbal Intelligence) • Kaufman IQ Test • Stanford Binet • BASC
<p><i>Organic Brain Syndrome (OBS)</i></p>	<ul style="list-style-type: none"> • History of Functioning and/or Standardized Tests. Examples: • WAIS-III • Weschler Memory Scale Revised • Structured Mental Status • Quick Neurological Screening Test • Medical Tests Necessary for Diagnosis
<p><i>Mental Illness</i></p>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • MMPI-A • MACI • Beck Depression Scale • Symptom Checklist (SCL-90-R) • Achenbach Childhood Behavior Checklist • Jesness Inventory • Child Depression Inventory • Rorschach • Storytelling Tests (TAT, CAST, Roberts)
EVALUATE DRUG/ALCOHOL USE	
<p><i>Use/Abuse</i></p>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • MMPI-A • DAST-A • SSI-AOD • CAGE-AA • MACI • Collateral Information

<p><i>Number of Relapses</i></p>	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • Treatment History • Collateral Information
<p>EVALUATE DEGREE OF PSYCHOPATHOLOGY</p>	
<p><i>Degree of Impairment</i></p>	<ul style="list-style-type: none"> • Structured Interview • Jesness Inventory • MACI • MMPI- A • History • Collateral Information • PCLR-JV
<p>EVALUATE STABILITY OF FUNCTIONING</p>	
<p><i>Marital/Family Stability</i></p> <ul style="list-style-type: none"> • Past • Current • Familial Violence • Familial Sexual • Financial • Housing <p><i>Employment/Education</i></p> <ul style="list-style-type: none"> • Completion of Major Life Tasks <p><i>Social Skills</i></p> <ul style="list-style-type: none"> • Ability to Form Relationships • Ability to Maintain Relationships • Courtship/Dating Skills • Ability to Demonstrate Assertive Behavior 	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • FES (Family Environment Scale) • FACESII • Family of Origin Scale • Parenting Stress Inventory • Interview Attitudes • Collateral Information <ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • PHQ (Personal History Questionnaire) <ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • Collateral Information • IBS (Interpersonal Behavior Survey) • Index of Personality Characteristics • Teenage Inventory of Social Skills • Melson Evaluation of Social Skills • Social Skills Rating System
<p>DEVELOPMENTAL HISTORY</p>	
<ul style="list-style-type: none"> • Disruptions in parent/child relationship • History of bed wetting, cruelty to animals • History of behavior problems in elementary school • History of special education services, learning disabilities, school achievement • Indicators of disordered attachments 	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • Collateral Information

EVALUATION OF SELF-IMAGE AND SELF- ESTEEM	
<ul style="list-style-type: none"> • Self-image, Self Esteem 	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • Piers-Harris Self-Concept Scale • Rosenberg Self-Esteem Scale • Tennessee Self-Concept Scale
MEDICAL SCREENING MEASURES	
<ul style="list-style-type: none"> • Pharmacological Needs • Medical Condition Impacting Offending Behavior • History of Medication Use/Abuse 	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • Referral to Physician if indicated • Medical Tests
SEXUAL EVALUATION	
<p><i>Sexual History (Onset, Intensity, Duration, Pleasure Derived)</i></p> <ul style="list-style-type: none"> • Age of Onset of Expected Normal Behaviors • Quality of First Sexual Experience • Age of Onset of Deviant Behavior • Witnessed or Experienced Victimization (Sexual or Physical) • Genesis of Sexual Information • Age/Degree of Use of Pornography, Phone, Sex, Cable, Video, or Internet for Sexual Purposes • Current and Past Range of Sexual Behavior 	<ul style="list-style-type: none"> • History of Functioning and/or Structured Interview • PSCI (Personal Sentence Completion Inventory-Miccio-Fonseca) • Adolescent Cognition Scale • PHASE • Sentence Completion • Math Tech Sex Test • MSI-J • Adolescent Modus Operandi Questionnaire • Polygraph <ul style="list-style-type: none"> • Abel Assessment for Sexual Interest • ERASOR Bremer Protective Factor Scale • Collateral Information
<p><i>Reinforcement Structure for Deviant Behavior</i></p> <ul style="list-style-type: none"> • Culture • Environment • Cults • Gangs 	<ul style="list-style-type: none"> • Structured Interview
<p><i>Arousal Pattern</i></p> <ul style="list-style-type: none"> • Sexual Arousal • Sexual Interest 	<ul style="list-style-type: none"> • Plethysmography • Abel Assessment for Sexual Interest
<p><i>Specifics of Sexual Crime(s) (Onset, Intensity, Duration, Pleasure Derived)</i></p> <ul style="list-style-type: none"> • Detailed Description of Sexual Assault • Seriousness, Harm to Victim • Mood During Assault (Anger, Erotic, “Love”) 	<ul style="list-style-type: none"> • Structured Interview • History of Crimes • Review of Criminal Records • Contact with Victim Therapist • Polygraph

<ul style="list-style-type: none"> • Progression of Sexual Crimes • Thoughts Preceding and Following Crimes • Fantasies Preceding and Following Crimes 	<ul style="list-style-type: none"> • Collateral Information
<p><i>Sexual Deviance</i></p>	<ul style="list-style-type: none"> • Structured Interview • MSI-J
<p><i>Dysfunction (Impotence, Priapism, Injuries, Medications Affecting Sexual Functioning, Etc.)</i></p>	<ul style="list-style-type: none"> • Structured Interview • MSI-J • Sexual Autobiography
<p><i>Offender's Perception of Dysfunction</i></p>	<ul style="list-style-type: none"> • Structured Interview • Sexual Autobiography • History
<p><i>Perception of Sexual Functioning</i></p>	<ul style="list-style-type: none"> • Structured Interview • Sexual Autobiography • Plethysmography
<p><i>Preferences (Male/Female; Age; Masturbation; Use of Tools, Utensils, Food, Clothing; Current Sexual Practices; Deviant as well as Normal Behaviors)</i></p>	<ul style="list-style-type: none"> • Structured Interview • Sexual Autobiography • Plethysmography • Abel Assessment for Sexual Interest • Collateral Information (such as from parents or significant others)
<p><i>Attitudes/Cognition</i></p> <ul style="list-style-type: none"> • Motivation to Change/Continue Behavior • Attitudes Toward Women, Children • Sexuality in General • Attitudes About Offenses (i.e. Seriousness, Harm to Victim) • Degree of Victim Empathy • Presence/Degree of Minimalization • Presence/Degree of Denial • Ego-Syntonic vs. Ego- Dystonic Sense of Deviant Behavior 	<ul style="list-style-type: none"> • Structured Interview • Burt Rape Myth Acceptance Scale • MSI-J • Buss/Durkee Hostility Inventory • ABEL for Sexual Interest • Bumby Cognitions Scale • Abel, Becker, Kaplan, Adolescent Cognitions Scale, Revised
<p>EVALUATE LEVEL OF DENIAL AND/OR DECEPTION</p>	
<ul style="list-style-type: none"> • Level of Denial • Level of Deception 	<ul style="list-style-type: none"> • Structured Interview* • Polygraph** • Collateral Information (such as from victim, police, others)

EVALUATE LEVEL OF VIOLENCE AND COERCION	
<ul style="list-style-type: none"> • Level of Violence • Overall Pattern of Assaultiveness • Victim Selection • Pattern of escalation of violence 	<ul style="list-style-type: none"> • Structured Interview • History • Review of Criminal Records • Collateral Information
EVALUATE RISK	
<i>Risk of Re-offense Criminal History</i>	

*The use of the structured interview may assist in evaluation of deception on the part of offender. However, it is not adequate on its own as an indicator of denial or deception.

**Required

5.080

Discussion: *Risk to re-offend and amenability to treatment must be considered together. It is important for evaluators to be conversant with the research that suggests that the presence of a number of these factors may increase or decrease treatment amenability and/or re-offense risk. In addition, some factors weigh more heavily than others. For example, a history of sexual offenses is currently considered one of the strongest predictors of re-offense. These factors may also be used as a guide to a structured interview for the purpose of assessing risk.*

The evaluator shall consider the following factors when making recommendations relating to an offender's risk to re-offend and amenability to treatment:

- Admission of offenses
- Accountability (internal and external factors which control behavior)
- Cooperation
- Offense history and victim choice
- Escalating pattern of offenses, violence, and dangerous behaviors
- Sexual deviance, arousal patterns, and sexual interest
- Social interest
- Lifestyle characteristics
- Psychopathology
- Developmental markers
- History of childhood or adolescent delinquency
- Substance abuse
- Criminal history
- Social support systems
- Overall control and intervention
- Motivation for treatment and recovery
- Self-structure

- Disowning behaviors
- Prior treatment
- Impact on victim(s)
- Access to potential victim(s)
- Availability of treatment in the community
- Availability of supervision, including surveillance agents, in the community

5.090

Discussion: *In developing the recommendations that conclude sex offender specific evaluations, the evaluator summarizes the information gathered about the juvenile sex offenders, including the specific features, characteristics, or circumstances that may increase the risk of re-offense, and/ or enhance or diminish treatment outcomes for this individual.*

The evaluator shall address all of the following areas in developing recommendations:

- The level and intensity of offense-specific treatment needs
- Referral for assessment and/or treatment of co-existing conditions (e.g. substance abuse, mental illness, medical/pharmacological)
- Methods to lessen victim impact (e.g., no-contact orders, paying for counseling, involvement of non-offending family member.)
- Appropriateness of community placement with emphasis on the risks associated with the juvenile in the home, school, and neighborhood or community
- The level and intensity of behavioral monitoring needed
- The types of external controls which should be considered specifically for that offender (e.g. controls of work environment, access to children, leisure time, or transportation; life stresses, or other issues that might increase risk and require increased supervision)

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

6.000 STANDARD OF PRACTICE FOR TREATMENT PROVIDERS FOR JUVENILE SEX OFFENDERS

Discussion: *One of the distinctions between juveniles who commit sex-offenses and their adult counterparts is the amenability of juveniles to treatment. However, treatment of either juveniles or adults who commit sex offenses is vastly different from other therapies. Successful therapeutic outcomes require clinicians to be knowledgeable about the dynamics of sex offending, the models of treatment that have proven successful and have experience in addressing the developmental issues that are common to adolescents. Some juvenile sex offenders will remain at high risk of sex-offending despite the efforts of the treatment team and the juvenile justice system to intervene.*

6.010

Sex offense-specific treatment must be provided by a treatment provider who is certified, as defined in Section 4.000 of the Standards of the Illinois Sex Offender Management Board.

6.020

A provider who treats sex offenders under the jurisdiction of the juvenile justice system must use the model of sex-offender specific treatment described in these standards.

6.030

A provider shall develop a written treatment plan with measurable goals based on the needs and risks identified in current and past evaluations of the offender. The treatment plan shall:

- Provide for the protection of victims and potential victims and not cause the victims to have unsafe and/or unwanted contact with the offender.
- Be individualized to meet the unique needs of the offender.
- Identify the issues to be addressed, including multi-generational issues if indicated, the planned intervention strategies, and the goals of treatment.
- Define expectations of the offender, his/her family (when possible), and support systems.
- Address the issue of ongoing victim input.
- Describe the treatment provider's role in implementing the treatment plan.

6.040

Group therapy (with the group comprised only of age and developmentally appropriate sex offenders) is the preferred method of sex-offender specific treatment. The sole use of individual therapy is not recommended with sex offenders and shall be avoided except when geographical-specifically rural-or disability limitations dictate its use or it is clinically indicated.

Discussion: *Group therapy may be supplemented by other treatment modalities, including but not limited to marital/family, drug/alcohol treatment, individual, and crisis intervention. Group therapy should remain the primary modality utilized with juvenile sex offenders*

1. The use of male and female co-therapists in group therapy is highly recommended and may be required by the supervising agency.
2. The optimal ratio of therapists to sex offenders in a treatment group is 1:8. Treatment group size will not exceed ten (10) sex offenders.

3. It is understood that the occasional illness or absence of a co-therapist may occur, which will cause the group to exceed this ratio.

4. Some particular treatment programs may be structured in such way that specific didactic modules of psycho-educational information are presented to larger groups of sex offenders at one time. Such psycho-educational information is a component of, but not a substitute for, sex-offense specific treatment.

5. The test for compliance for this standard will be the regularity with which the ratio of therapists to sex offenders is congruent with #2 above.

6.050

The provider shall employ treatment methods that give priority to the safety of the offender's victim(s), the safety of potential victims and the community, and recognize the juvenile sex offender's need for long-term, offense-specific treatment. Self-help or time-limited treatment for juveniles shall be used only as an adjunct to long-term, comprehensive treatment.

The content of offense specific treatment for juvenile sex offenders shall be based on the needs identified in the initial and ongoing offender-specific evaluation.

6.060

Culture, language, developmental disabilities, sexual orientation, and/or gender actors that may require special treatment considerations must be considered.

6.070

Whenever possible, parents, foster parents, or caretakers shall participate in psycho-educational and support groups relevant to sexual offending and relapse prevention.

6.080

Caretakers, or potential caretakers, shall be sufficiently informed about the offender's history of offense and potential risks to others to give informed consent for placement.

6.090

From a strengths perspective, treatment for juvenile offenders must address and consider all issues pertaining to the individual's functioning including environmental, developmental, familial, and social, as well as those that relate to sexual offending such as anger, control, and power.

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

6.100 Treatment Methods

A provider shall employ treatment methods that are supported by current professional research and practice. In order to achieve the goals of sex offense-specific treatment, the following elements shall be addressed in treatment:

A. Offense Disclosure

The offender discloses all of his or her sexual offenses, reducing denial and defensiveness and/or assisting the offender in assuming full responsibility for his or her sexual offending.

Completion Indicators:

- The offender makes a disclosure of all sex offenses.
- The offender attends treatment sessions as ordered or required.
- Completes all assigned tasks as required.
- When available, the offender completes non-deceptive polygraphs as described in Section 3.700 on past and maintenance issues.
- The offender consistently takes full responsibility for all of his or her actions including sex offenses, as indicated by polygraph.
- The offender holds himself/herself accountable for his/her behavior in general.

B. Offense Specific Cognitive Restructuring

Cognitive distortions refer to distortions in thinking, including thinking errors that enable sexually offending behaviors. Identifying and correcting or changing offenders' cognitive distortions that fuel sexual offending is the purpose of this element of treatment.

Completion Indicators:

- The offender identifies and restructures offense-specific cognitive distortions.
- The offender assumes responsibility for offending.
- There is evidence that offense-specific distortions have been restructured or changed as indicated by the lack of using cognitive distortions and that he/she holds self fully accountable when discussing his or her offenses.

C. Assault Cycle and Intervention

The assault cycle is the repetitive patterns of sexual offending. This element of treatment is intended to:

- Identify the offender's patterns of offending, including risk factors.
- Teach sex offenders self-management methods, skills, and appropriate coping skills to eliminate a sexual re-offense.
- Educate offenders and individuals who are identified as members of the offender's support system and the containment team about the potential for re-offending and the offender's specific risk factors.
- Require offenders to learn specific relapse prevention strategies, including the development of a written, specific relapse prevention plan. This plan should identify antecedent thoughts, feelings, situations, social behaviors, and any other behaviors associated with sexual offenses along with specific interventions.

Completion Indicators:

- The offender demonstrates an understanding of the general concept of an assault cycle.
- The offender demonstrates identification of his/her own assault cycle and how he/she applies it to his/her daily lifestyle.
- The offender demonstrates knowledge of relapse intervention concepts.
- The offender has consistently demonstrated the effective use of relapse prevention skills i.e. able to diffuse cycle behaviors, relapse processes, deviant arousal and other factors that contribute to sexual offending.
- The offender has disengaged from relationships that support his or her denial, minimization, and resistance to treatment.

- The offender is engaged in relationships that are supportive of treatment and seeks feedback from his/her support system.
- The offender has demonstrated consistently the ability to avoid high-risk environments.

D. Victim Empathy

Empathy is the capacity to understand and identify with another's perspective and experience the same emotions. As a part of treatment, juvenile sex offenders, their parents or caregivers and their social support system should be provided with education about the impact of sex offending on victims, their families, and the community. The ability to develop victim empathy may vary from offender to offender and may have varying emphasis in treatment.

This aspect of treatment should assist the offender in developing a written explanation or clarification for the victim(s) that demonstrates respect for the victim and the victim's right to self determination. This explanation may be sent only with the prior approval of the victim, if over 18, or the victim's parents/guardian and where applicable, the approval of the therapist for the victim.

Completion Indicators:

- The offender verbalizes and demonstrates victim empathy, identifies feelings, recognizes victim impact, assumes ownership of offenses, understands and takes the perspective of others, demonstrates emotional regret, and expresses feelings of empathy and remorse.
- The offender demonstrates behaviors to avoid further harm to the victim.

CAUTIONARY NOTE: TREATMENT TO ASSIST IN THE DEVELOPMENT OF VICTIM EMPATHY IS CONTRA-INDICATED FOR PSYCHOPATHIC OFFENDERS.

E. Arousal Control

This element of treatment is intended to assess, identify, and decrease or replace deviant sexual desires, arousal, thoughts, and fantasies, replacing this deviancy with healthier sexual attitudes and functioning.

Completion Indicators:

- The offender discloses deviant and/or violent sexual fantasies.
- The frequency and intensity of deviant arousal, violent and/or sadistic fantasies, and masturbation to deviant fantasies are decreased.
- The offender develops behavioral/self management strategies to reduce deviant arousal and behavior patterns, including eliminating self-abusive sexual behaviors.
- The offender develops and maintains normal, non-victimizing fantasies.

F. Clinical / Core Issue Resolution

It is commonly assumed that offending involves multiple unresolved emotional issues and not just deviant sexual urges. Motivational dynamics that may fuel sexual offending or other victimizing or assaultive behaviors may arise from the effects of trauma or past victimization, key developmental events, or other unresolved problems or needs. It is critical for resolution of these core issues to occur without the offender assuming a victim stance. Offenders must still be held accountable for their offending when these issues are resolved.

Completion Indicators:

- The offender has identified and resolved or mostly resolved core issues - thoughts, emotions, and behaviors - that may facilitate sexual re-offense. Core issues may include anger, power, control, inferiorities, dependency, insecurity, rejection, jealousy, possessiveness, resentment, and inadequacies in terms of self-worth and self-esteem.
- The offender has identified and changed the effects of past trauma and past victimizations to decrease their impact on the risks of re-offending.

G. Social Skills and Interpersonal Restructuring

Social skills refer to specific communication skills and social behaviors. Interpersonal restructuring refers to redefining the way offenders form attachments or relate to others. Interpersonal deficits are frequently associated with attachment issues. The development of basic social skills replaces deficits and inappropriate attachments or relationships, diminishing the risk of sexual re-offending. This element of treatment is intended to:

- Identify deficits in specific interpersonal skills and decrease the offender's deficits in social, and relationship skills, where applicable.
- Assist offenders in developing and practicing social skills, improving the quality of their relationships with others.

Completion Indicators:

- Demonstrates appropriate social relationships.
- Demonstrates appropriate boundaries.
- Has the skill to manage interpersonal relationship issues.

H. Lifestyle Balancing and Restructuring

Lifestyle balancing and restructuring refers to assisting sex offenders in changing their existing lifestyles to lifestyle patterns that minimize sexual re-offending and maintaining this lifestyle. The focus of this element of treatment is to:

- Educate offenders about non-abusive, adaptive, legal, and pro-social sexual functioning.
- Identify and treat offenders' personality traits, lifestyle, behaviors, patterns, and deficits that are related to their potential for re-offending.
- Maximize opportunities for the sex offender to develop a healthy self-esteem.

Completion Indicators:

- Demonstrates a change in personality traits, lifestyle behaviors, patterns, and deficits related to the potential for re-offending including:
 - Antisocial/ psychopathic behaviors
 - Narcissistic behaviors
 - Borderline characteristics of behavior
 - Schizoid behaviors
 - Obsessive-Compulsive/Passive Aggressive Behaviors
- Demonstrates a healthy and balanced lifestyle.

I. Provision of Treatment Referrals

The provision of treatment referrals, as indicated, links sex offenders with co-existing medical, pharmacological, mental, substance abuse, and/or domestic violence issues, or other disabilities.

Completion Indicators:

- Monitoring offenders' linkage with other referral resources.

J. Communication with Others

Communication is a critical element in treatment, aftercare and supervision. This element of treatment maintains communication with significant persons in the offenders' support systems, to assist the offender in meeting treatment goals.

6.110

Providers shall maintain clients' files, including content and order, in accordance with the professional standards of their individual disciplines, the requirements of any accrediting bodies, and Illinois state law on health care records. Client files shall:

- Contain an individual treatment plan that lists measurable goals, interventions and expected outcomes.
- Describe specific achievements, contacts with collaterals or members of the juvenile justice system, failed assignments, rule violations, and consequences given should be recorded.
- Accurately reflect the client's treatment progress, sessions attended, and changes in treatment.
- List the names of all persons involved with the child, including family members, relatives, caregivers, treatment providers, attorneys, or other members of the juvenile justice system.

6.200 Confidentiality

Discussion: *The primary mission of the Illinois Sex Offender Management Board is achieving and maintaining community safety. The rights of sex offenders to confidentiality do not supercede the rights of others in the community to be safe from sexual harm. The challenge is in achieving balance between these elements, ensuring that the safety of the larger community is not sacrificed in the interest of protecting the rights of a sex offender.*

The effectiveness of the containment team model of sex offender management depends upon open and ongoing communication between all professionals responsible for assessing, evaluating, treating, and monitoring sex offenders. The absence of open and ongoing communication compromises the purpose of the containment team, and may compromise the safety of the community.

6.210

A treatment provider shall obtain signed waivers of confidentiality based on the informed assent of the offender. If the offender has more than one therapist or treatment provider, the waiver of confidentiality shall extend to all therapists treating the offender. The waiver of confidentiality shall extend to the supervising officer and all members of the team and, if applicable other individuals or agencies responsible for the supervision of the offender. The waiver of confidentiality should extend to the victim's therapist(s).

Discussion: *Waivers of confidentiality will be required of the offender by the (1) Conditions of probation, parole, and/or community corrections, or the prison Treatment program, and (2) the treatment provider-client contract.*

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

Waivers of confidentiality should also extend to the victim, or custodial parent or guardian ad item of a child victim, particularly with regard to (1) the offender's compliance with treatment and (2) information about risk, threats, and possible escalation of violence.

6.220

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

6.230

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.

6.240

When indicated and consistent with the informed assent 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).

6.250

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

6.300 Treatment Provider - Client Written Treatment Agreements

Discussion: *Written agreements between treatment providers and their clientele are common therapeutic tools and serve a variety of purposes. With sex offenders, they are particularly useful in establishing the sex offender's responsibility, accountability, and ownership in committing the offense, and document in writing that the sex offender is informed of the terms of treatment, and the consequences of breaching the terms. Highly specific written contracts help diminish the manipulation, minimization and denial that are characteristic of sex offenders.*

6.310

A provider shall develop and utilize a written contract with each sex offender (hereafter called "client" in this section of the Standards) prior to the commencement of treatment. The contract shall describe the responsibilities of both the provider and the client.

1. The contract shall explain the responsibility of the provider to:

- Define and provide timely statements of the costs of the assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations to the client as well as the parent or guardian.

- Describe the waivers of confidentiality that will be required for a provider to treat the client for his/her sexual offending behavior; describe the various parties with whom treatment information will be shared during the treatment; describe the time limits on the waivers of confidentiality; and describe the procedures necessary for the client to revoke the waiver;
- Describe the right of the client to refuse treatment and/or to refuse to waive confidentiality, and describes the consequences, risks and potential risks and outcomes of that decision, including the provider's right not to provide treatment if confidentiality is not waived.
- Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined.
- Describe the limits of confidentiality imposed on the therapist by the mandatory reporting law.
- Explain the terms of the contract to the client in language that the client understands.

2. The contract shall describe the responsibilities of the client (as applicable) to:

- Be made aware of the cost of assessment and treatment for him/herself, and to his or her family, if applicable, or be assigned responsibility for some portion or all of the payment if prescribed in the treatment plan.
- To comply with any orders for restitution issued by the court.
- Inform the treatment provider, the client's family, and support system of the details of all past sexual offenses to ensure help and protection for past victims, potential victims, and the community and to assist in the development of an effective relapse prevention plan. Clinical judgment should be exercised in determining what information is provided.
- Actively involve members of the offender's family and support system and members of the containment team as indicated in the relapse prevention plan.
- Notify the treatment provider and members of the containment team of any changes or events in the lives of the client, the members of the client's family, or support system.
- Participate in polygraph testing as required in the Standards and Guidelines as an adjunct to treatment.
- To be tested for HIV, if medically necessary. (Consent is not required when such tests are court-ordered.)

3. The contract shall require the juvenile sex offender to comply with the limitations and restrictions placed on the behavior of the client, as described in the terms and conditions of probation, parole, or community corrections and/or in the contract between the provider and the client, including:

- Provide instructions and describe limitations regarding the client's contact with victims, secondary victims, and children;
- Describe prohibitions on the client's use of viewing sexually explicit or violent material, including audio, visual, or printed media, "900" telephone calls, or the use of the Internet to access such materials.
- Describe the responsibility of the client, family, caregivers, or members of the support system 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 supervising officer as soon as possible.
- Describe limitations or prohibitions on the use of alcohol or drugs not specifically prescribed by medical staff.
- Describe prohibitions on employment or recreations.
- Abide by state and local curfew laws.

6.400 Treatment of Juvenile Sex Offenders in Prison and on Parole

Discussion: Sex offender specific treatment when juveniles are in prison or are on parole must utilize all available evaluation tools and outcomes as outlined in these Standards. The DOC or community containment team will benchmark

an individual sex offender's progress prior to release from prison or parole. A transitional treatment plan should be developed prior to release from prison or discharge from parole.

6.410

A juvenile offender who has been sentenced to the Department of Corrections- Juvenile Division (DOC), and who is being paroled or being released to community corrections, and who did not receive a comprehensive sex-offender specific evaluation at the time of the social investigation shall receive a comprehensive sex-offense specific evaluation (including a polygraph) as outlined in this document. The evaluation may occur prior to or during the course of sex-offense specific treatment in the prison or prior to release into a community setting or parole if the offender has not been in treatment.

6.420

At the discretion of the treatment provider at DOC, offenders who received a comprehensive sex-offense specific evaluation one year or more prior to entering treatment at DOC, or offenders who in the opinion of DOC treatment providers received a partial or inadequate evaluation should receive a comprehensive sex-offense specific evaluation comparable to that outlined in these standards.

Discussion: *The first priority for the use of resources is the evaluation and treatment of those sex offenders who are motivated to participate in treatment and are eligible for release, and/or present an unusually high risk to the community.*

6.430

Treatment for sex offenders in prison or on parole shall conform to the standards for offense-specific sex offender treatment described in the standards of the Illinois sex Offender Management Board.

6.440

Prison treatment providers are encouraged to utilize a team approach. The treatment team should meet on an ongoing basis in order to evaluate the offender's progress and to facilitate cohesion within the team. The polygraph examiner and the treatment provider should work closely together, and other professionals should be included in the team as indicated.

6.450

The duration of time in treatment in prison shall not offset the need for the offender's continued treatment upon his/her supervised release to the community. Ongoing treatment aimed at relapse prevention and minimizing the risks of re-offense is mandatory.

6.460

Prison treatment providers shall prepare a release summary of the offender's participation in treatment and their institutional behavior, including copies of evaluations. This summary, which is provided to the parole board prior to a hearing, should also be provided to the parole officer at the time of the pre-parole investigation.

6.470

A pre-parole investigation should be completed prior to an offender's beginning parole supervision. The purpose of the pre-parole investigation is:

- To assist the containment team in assessing risks, and the level of monitoring that is consistent with these risks;
- Assess the resources that will be available to an offender who will live and work in the community and;
- Make recommendations for conditions of supervision, including the offender's treatment.

6.480

The prison treatment provider or the community treatment provider for juveniles on parole shall impose special conditions that restrict sex-offenders from high-risk situations and limit access to potential victims:

- Sex offenders should have not contact with their victim(s) including correspondence, telephone contact, or communication through third parties; including e-mail.
- Sex offenders should have no contact with children, including their own children unless they are supervised.
- Sex offenders shall not access or loiter near children in the visiting room.
- Sex offenders shall not possess any pornographic, sexually oriented or sexually stimulating materials, including visual, auditory, telephonic, or electronic media, and computer programs or services] that are relevant to offenders deviant behavior/ pattern. Sex offenders shall not patronize any place where such material or entertainment is available. Sex offenders shall not utilize “900” or adult telephone numbers or any other sex-related telephone numbers.
- Sex offenders will be required to undergo blood, saliva, and DNA testing as required by statute.

6.500 Community Placement and Treatment of Juvenile Sex Offenders Who are in Denial

Discussion: *Secrecy, denial, and defensiveness are part of both juvenile and adult sex offender’s disorder. Almost all offenders fluctuate in their level of accountability or “denial” of the offense. Although most are able to admit responsibility for the act soon after the finding of guilt, some offenders do not. An offender’s continued denial of the act after the finding of guilt may threaten community safety and may be highly distressing and emotionally damaging to the victim. All procedures must comply with the standards of the Illinois Sex Offender Management Board for juvenile offenders who are in prison or parole.*

6.510

Level of denial and defensiveness shall be assessed during the sex offender specific evaluation. In some cases, denial alone may be regarded as a sufficient fact to eliminate an offender from a recommendation for community-based treatment. Continued strong or severe denial of the offense during the course of the assessment as opposed to fluctuating or moderate denial and/or continued strong defensiveness in general suggests a level of risk that may rule out an offender’s eligibility for community-based treatment.

6.520

When a sex offender in strong or severe denial *must* be in the community (e.g. parole), the maximum level of supervision shall be provided. Sex offense-specific treatment should begin immediately with an emphasis on denial and defensiveness. Such offense-specific treatment for denial should not be provided for an indefinite period of time when offenders continue to deny the offense.

6.530

Although offense-specific treatment typically begins by addressing denial and defensiveness, treatment for strong or severe denial may occur separately from regular group therapy that is provided for offenders who have, at a minimum, admitted the crime of conviction. Treatment for such denial may include a variety of modalities specifically designed to reduce denial and resistance to treatment.

6.540

Sex offenders in strong or severe denial require maximum levels of supervision and monitoring during an initial treatment phase. Home detention, electronic monitoring, field supervision, and/or stringent restrictions on

offenders' time are examples of additional conditions that should be recommended by the evaluator.

6.550

Offenders who continue to deny the facts of their sexual offenses cannot benefit from treatment and may not be suitable candidates for community placement. After a period of time specified by the therapist, consideration should be given to termination of the offender from treatment and referral back to court, if the offender is on probation or the parole board if the offender is on parole. Increased levels and types of supervision, such as home detention, electronic monitoring, polygraph, etc., should be pursued if revocation is not an option.

6.560

Only treatment providers who are certified in accordance with the standards of the Illinois Sex Offender Management Board may provide treatment for denial.

6.570

Progress in treatment for denial is reflected by the offender's decreased resistance to treatment, decreased defensiveness and denial, and increased accountability for the behavior. This progress should be documented by:

- The offender's compliance with the conditions of offense-specific denial treatment;
- The offender's verbal disclosures during treatment that document changes in denial;
- Changes in the offender's responses on standardized tests;
- The timely and competent completion of homework and in-session assignments;
- The offender's willingness to schedule and undergo polygraph testing;
- Non-deceptive polygraph.
- Compliance with court-ordered conditions.

6.580

Treatment providers and containment teams must establish specific and measurable goals and tasks for offenders in denial. These measurable goals will establish whether or not offenders have reached the threshold for eligibility for referral to standard offense-specific treatment, continued treatment, or referral for revocation proceedings. It is especially important to document measures of offenders' acceptance of responsibility for their offenses.

6.590

Use of the polygraph is important in reducing an offender's denial but the timing of its use should be flexible. In cases with highly resistant offenders, use of the polygraph before adequate preparation might increase the resistance. In some cases, the polygraph can be used as a "last resort" to lessen denial.

6.600 Treatment Providers' Use of the Polygraph, and Abel Assessment for Sexual Interests with Juvenile Sex Offenders

Discussion: Physiological data can be useful in assessing a client'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 physiological assessments, including the Abel screen and shall recognize that this physiological data is meaningful only within the context of a comprehensive evaluation and/or treatment process.

6.610

STANDARDS AND GUIDELINES

A treatment provider may employ treatment methods that integrate the results of the *Abel Assessment for Sexual Interests* (ASI), polygraph, or other physiological testing, as indicated. If the Abel screen is used, the treatment provider or evaluator must be trained and licensed to utilize the instrument.

6.620

The age and developmental level of the juvenile offender must be taken into account in making a decision to use polygraph. It is recommended that a provider employ the ASI as a means of gaining information regarding the sexual interest patterns of sex offenders.

6.630

The treatment provider shall employ methods that incorporate 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 containment team or by a prison treatment provider.

6.640

The containment team shall determine the frequency of polygraph examinations, and the team shall review the results. The results of such polygraphs shall be used to identify treatment issues, changes in the level of risk, and to monitor the juvenile offender in the community.

Discussion: *Because of the epidemic nature of sexual assault, there is a need for more and better methods to accurately evaluate, treat, and monitor sex offenders. Polygraph testing is an effective tool for informing the containment team 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 once every six months, and more frequently as necessary.*

6.700 Completion of Treatment and Accompanying Changes in the Level of Supervision

Discussion: *The most successful treatment outcomes for juvenile sex offenders are achieved when treatment, supervision, and placement are linked from the outset with the severity of the offense and the presenting level of risk. Participation by family members or members of the social support system is also a powerful determinant of the outcome of treatment.*

Since levels of risk and the need for therapeutic intervention may fluctuate over time, anytime a juvenile sex offender exhibits behaviors or attitudes that are indicative of relapse or progress, levels of supervision and intensity of treatment should be immediately reviewed by the treatment provider and other members of the containment team. The recommendations of the containment team shall be forwarded to the juvenile court, parole, and/or probation.

6.710

Completion of treatment should be understood as meaning the successful completion of treatment, and not as the cessation of court-ordered, offense-specific treatment or the completion of the sentence imposed by the court.

Successful completion of treatment may not end the offender's need for ongoing rehabilitation and supervision or eliminate risk to the community. If risk increases, treatment may be re-instated and the level of supervision by the parole or probation officer increased upon the request of the offender or the recommendation of the containment team.

6.720

The sex offender containment team shall consult about the discharge or termination of treatment for a juvenile offender and any changes in the level of supervision, including discharge from probation or parole. Staff from the juvenile court, parole, probation, corrections, and members of the offender's family or support system become a part of the containment team and participate in the decision.

6.730

Decisions shall come after the evaluation, treatment plan, course of treatment sequence, and a minimum of :

- non-deceptive disclosure polygraph examination and two or more non-deceptive maintenance polygraph examinations regarding the juvenile's compliance with court rules
- compliance with supervision conditions
- compliance with treatment contract provisions, including complete abstinence from grooming of victims
- full, voluntary compliance with all conditions required to prevent re-offending behavior. The two or more non-deceptive polygraph examinations must be those most recent prior to termination of treatment.

A failed polygraph examination should not be used as the sole reason to deny successful completion of treatment. The level of supervision being provided to a sex offender who fails a polygraph exam must be re-evaluated by the containment team in terms of risks to the community. The recommendations of the team shall be submitted in writing to the court, parole board, and/or the Prison Review Board.

The team should carefully consider termination of treatment, a decrease in the level of supervision, and/or discharge of the sex offender from parole or probation based on maintaining community safety.

6.740

Those offenders who pose an ongoing threat to the community require supervision, even while demonstrating progress in treatment, may require ongoing supervision and treatment to manage their risk, including revocation.

6.750

Any exception made to any of the requirements for treatment completion must be made by consensus of the community supervision team. In this case, the team must document the reasons for the determination that treatment completion is appropriate without meeting all of the standard requirements and note the potential risk to the community.

6.760

Prior to recommending an offender's discharge or termination from treatment or changes in the level of supervision including revocation, the treatment provider shall:

- Assess actual changes in a client's potential to re-offend prior to recommending treatment termination;
- Attempt to repeat, where indicated, those assessments that might show changes in the client;
- Assess and document how the goals of the treatment plan have been met, what actual changes in a client's re-offense potential have been accomplished, and what risk factors remain, particularly those affecting the emotional and physical safety of the victim(s);
- Seek input from others who are aware of a client's progress as part of the decision about whether to terminate treatment;
- Report to the supervising officer regarding a client's compliance with treatment and recommend any modifications in conditions of community supervision and/or termination of treatment;
- At the end of this re-assessment process, inform the client and the parent/guardian regarding the recommenda-

tion to end or continue court-ordered treatment and supervision.

6.770

Prior to terminating offense-specific treatment or releasing a sex-offender from probation or parole, the provider shall, in cooperation with the containment team, 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 risks of re-offense.

7.000 QUALIFICATIONS OF TREATMENT PROVIDERS/EVALUATORS

Discussion point: The Board recognizes that treatment and evaluations of adults are significantly different than for juveniles. Therefore, placement on the provider lists will be based upon area of specialty. If a provider seeks to serve both populations, they must request placement on each list. In addition, providers who seek to treat or evaluate juveniles will be required to have the specified training in areas unique to juveniles. However, if a provider wishes to treat or evaluate adults and juveniles, the total hours in the training portion of the qualifications need not be doubled.

7.010 TREATMENT PROVIDER - Full Operating Level: A treatment provider at the full operating level may treat sex offenders without supervision and may supervise a treatment provider operating at the associate level. To qualify to provide sex offender treatment at the full operating level as either an adult provider or a juvenile provider, an individual must meet all the following criteria:

1. The individual shall have attained the underlying credential of licensure or certification and be in good standing as a physician, psychologist, clinical social worker, clinical professional counselor, marriage and family therapist, or clinical psychiatric nurse specialist;
2. The individual shall have completed within the last four (4) years a minimum of one thousand (1000) hours of clinical experience specifically in the areas of evaluations and treatment of sex offenders, at least half of which shall have been face-to-face therapy with adult 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 treatment providers under these standards;
3. The individual shall have at least eighty (80) hours of documented training specifically related to evaluation and treatment methods within the last four years. The individual must demonstrate a balanced training history, having covered a wide or varied range of training topics. This training must directly relate to sex offender evaluation, treatment, and management and may include but is not limited to:
 - Statistics on offensive/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 assessment
 - Victim Issues
 - Family reunification/visitation

- Legal issues regarding sex offenders
- Special sex offender populations including:
 - Sadists
 - Developmentally disabled
 - Compulsive
 - Juvenile
 - Female
- Pharmacotherapy with sex offenders
- Impact of sex offenses
- Assessing treatment Progress
- Secondary and vicarious trauma
- Anger management
- Human sexuality
- Supervision techniques with sex offenders
- Philosophy and principles of the Sex Offender Management Board
- Group therapy dynamics
- Cycle of sexual abuse
- Thinking errors
- Deviant sexual fantasies
- Sexual arousal
- Techniques for sexual arousal treatment
- Understanding the psychiatric disorders
- Safety planning

Additional training on child growth and developemnt is recommended for providers/evaluators who work with juvenile offenders.

To receive credit for training not identified on this list, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender evaluation,treatment, and management as described in these standards;

In Concert with 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 Abusers and shall demonstrate competency according to the individual's respective professional standards and conduct all treatment in a manner that is consistent with the reasonably accepted standard of practice in the sex offender treatment community.

1. All treatment must have measurable goals for the individual / group and will be monitored by the SOMB board.
2. Providers must submit to a current background check.
3. Providers must submit satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the case management team;

7.020 Continued Placement on the Provider List:

Treatment providers must apply for continued placement on the List every 3 years by the date provided by the Board. Requirements are as follows:

1. The treatment provider must demonstrate continued compliance with the 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 sex offenders. This must be from the population in which the placement is sought (ie juvenile or adult)
3. Treatment providers shall complete a minimum of forty (40) hours of continuing education every three years in order to maintain proficiency in the field of sex offender treatment and to remain current on any developments in the evaluation, treatment, and monitoring of sexual offenders. This must be from the population in which the placement is sought (ie adult or juvenile)
4. Report any practice that is in conflict with the Standards;
5. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies .

Failure to comply with any of the above conditions may result in state removal from the provider list..

7.030 EVALUATOR - Full Operating Level:

An evaluator at the full operating level may evaluate sex offenders without supervision and may supervise an evaluator operating at the associate level. To qualify to provide sex offender evaluations 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 or certification and be in good standing as a physician, psychologist, clinical social worker, clinical professional counselor, marriage and family therapist, or clinical nurse specialist;
2. The individual must be registered as a treatment provider at the full operating level for the population in which the placement is sought ;
3. An evaluator shall have completed a minimum of 40 health sex-offense specific evaluations as defined in section 2.000 of these Standards within the last four years,. These must be from the population in which the placement is sought;
4. The individual shall have had at least eighty (80) hours of documented training specifically related to evaluation and treatment methods , and including training in the area of victimology, within the last four years. The individual must demonstrate a balanced training history, having covered a wide or varied range of training topics. Training must be in the area in which placement is sought This training will be identified as directly related to sex offender evaluation , treatment, and management and may include but is not limited to:
 - Statistics on offense/victimization rates
 - Typologies

- Sex offender assessment
- Sex offender evaluation
- Sex offender treatment techniques including:
 - Evaluating and reduce denial
 - Behavioral treatment techniques
 - Cognitive behavioral techniques
 - Empathy training
 - Offender/offense characteristics
 - Sex offender risk
 - Physiological techniques including:
 - Polygraph
 - Plethysmograph
 - Abel assessment
 - Victim Issues
 - Family reunification/visitation
 - Legal issues regarding sex offenders
 - Special sex offender populations including:
 - Sadists
 - Developmentally disabled
 - Compulsive
 - Juvenile
 - Female
 - Pharmacotherapy with sex offenders
 - Impact of sex offenses
 - Assessing Treatment Progress
 - Secondary and vicarious trauma
 - Anger management
 - Human sexuality
 - Supervision techniques with sex offenders
 - Philosophy and principles of the Sex Offender Management Board
 - Group therapy dynamics
 - Cycle of sexual abuse
 - Thinking errors
 - Deviant sexual fantasies
 - Sexual arousal
 - Techniques for sexual arousal treatment
 - Understanding the psychiatric disorders
 - Safety planning

Additional training on child growth and development is recommended for providers/evaluators working with juvenile offenders.

To receive credit for training not identified on this list, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/treatment/management as described in these standards;

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 Abusers (ATSA), which is contained in Appendix D and shall demonstrate competency according to the individual's

respective professional standards and conduct all evaluations in a manner that is consistent with the reasonably accepted standard of practice in the sex offender evaluation community.

1. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the standards and guidelines. These references shall include other members of the case management team;
2. Submit to a current background check;

7.040 Continued Placement on the Evaluator List: Evaluators must apply for continued placement on the List every 3 years by the date provided by the Board. Requirements are as follows:

1. The evaluator must demonstrate continued compliance with the Standards and Guidelines;
2. The individual may maintain registration as a treatment provider and evaluator at the full operating level in the area of specialty, adult or juvenile. In this case, the individual shall accumulate a minimum of 600 hours of clinical experience every three years, 300 hours or which shall be face-to-face therapy with sex offenders. This evaluator shall complete a minimum of 20 health sex-offense specific evaluations in the three (3) year period;

Or

The evaluator may discontinue their listing as a treatment provider at the full operating level and be placed on the Provider List as an evaluator only. Evaluators re-registering as evaluators only shall complete a minimum of 20 sex offense-specific evaluations in the three (3) year period;

4. Evaluators shall complete a minimum of forty (40) hours of continuing education in area of specialty (adult or juvenile) every three years in order to maintain proficiency in the field of sex offender evaluation and to remain current on any developments in the evaluation , treatment, and monitoring of sexual offenders. Up to ten(10) hours of this training may be indirectly related to sex offender evaluation /treatment/management but must be from the area in which placement is sought. In order to receive credit for training that is indirectly related, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender evaluation, treatment and management as described in these standards. The remaining thirty (30) hours must be directly related to sex offender evaluation, treatment and management.
5. Report any practice that is in conflict with these standards;
6. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies.
7. Failure to comply with the requirements stated above may result in removal from the provider list as an evaluator.

7.050 TREATMENT PROVIDER - Associate Level:

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 stan-

dards. To qualify to provide sex offender treatment at the associate level; an individual must meet all the following criteria:

1. The individual shall have a baccalaureate degree or above in behavioral science;
2. The individual shall have completed within the last four (4) years a minimum of five hundred (500) hours of supervised clinical experience specifically in the area of specialty (adult or juvenile)of treatment of sex offenders. At least half (250) of these hours must be face to face therapy with sex offenders. In addition, at least one hundred sixty (160) of these face to face hours must have been in co-therapy, in the same room, with a treatment provider registered at the full operating level;
3. The individual must have received at least fifty (50) hours of face-to-face clinical supervision by a treatment provider at the full operating level. in the area of specialty (adult or juvenile) 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 clinical experience);
4. The individual shall have had at least forty (40) hours of documented training from the area of specialty (adult or juvenile)specifically related to evaluation and treatment methods , and including training in the area of victimology, within the last four years. The individual must demonstrate a balanced training history, having covered a wide or varied range of training topics. This training will be identified as directly related to sex offender assessment /treatment/management and may include but not limited to:

- Statistics on offensive/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 assessment
- Victim Issues
- Family reunification/visitation
- Legal issues regarding sex offenders
- Special sex offender populations including:
 - Sadists

- Developmentally disabled
- Compulsive
- Juvenile
- Female
- Pharmacotherapy with sex offenders
- Impact of sex offenses
- Assessing treatment Progress
- Secondary and vicarious trauma
- Anger management
- Sex education
- Supervision techniques with sex offenders
- Philosophy and principles of the Sex Offender Management Board
- Group therapy dynamics

To receive credit for training not identified on this list, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender evaluation/treatment/management as described in these standards;

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 Abusers (ATSA) and shall demonstrate competency according to the individual's respective professional standards and conduct all evaluations in a manner that is consistent with the reasonably accepted standard of practice in the sex offender evaluation community.

1. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the Standards and Guidelines. The references shall include other members of the case management team;

2. Submit to a current background check;

Movement to Full Operating Level: Associate level treatment providers wishing to move to full operating level status must complete and submit documentation of a total of 1000 hours of supervised clinical experience, 100 hours of clinical supervision, at least half of which must be face to face, 80 hours of training and submit a letter from their supervisor indicating their readiness to become a full operating level provider.

7.060 Continued Placement: Associate level treatment providers must apply for continued placement on the list every three years by the date provided by the Board. Requirements are as follows:

1. The Associate level treatment provider must demonstrate continued compliance with the Standards and Guidelines;

2. He 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 convicted sex offenders. If the provider seeks placement on the provider list as a juvenile provider, then that provider must have the experience w juveniles.

3. The individual shall obtain a minimum of one hour face to face supervision, from an individual registered at the full operating level under these Standards, for every 30 hours of clinical contact with sex offenders. This

supervision must be from a provider who is from the area of specialty (adult or juvenile) This standard pertains both to those seeking licensure who have not yet met the licensing requirements of the state and to those who intend to provide treatment at the associate level for an indefinite amount of time;

4. Associate level treatment providers shall complete a minimum of forty (40) hours of continuing education every three years from their area of specialty in order to maintain 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 treatment/assessment/management. In order to receive credit for training that is indirectly related, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/treatment/management as described in these standards. The remaining thirty (30) hours must be directly related to sex offender evaluation/treatment/management.

5. Report any practice that is in conflict with these standards;

6. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies.

7. Failure to comply with the conditions stated above may result in de-certification as an associate treatment provider.

7.070 EVALUATOR - Associate Level:An evaluator at the associate level may evaluate sex offenders under the supervision of an evaluator approved at the full operating level. An evaluator at the associate level is an individual who has completed fewer than 40 sex-offense specific evaluations in the last four years. To qualify to provide sex offender evaluations at the associate level under an individual must meet the following criteria:

1. The applicant must be listed as a treatment provider at the associate level or the full operating level;

2. The individual must have received at least fifty (50) hours of face-to-face clinical supervision by a treatment provider at the full operating level, in the area of specialty (adult or juvenile) 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 clinical experience);

3. The associate level evaluator must have a clinical supervisor at the full operating level in the area of specialty (adult or juvenile) level sign off on each evaluation they conduct as the associate level;

4. The individual shall have had at least forty (40) hours of documented training specifically related to evaluation and treatment methods, in the area of specialty (adult or juvenile) and including training in the area of victimology, within the last four years. The individual must demonstrate a balanced training history, having covered a wide or varied range of training topics. This training will be identified as directly related to sex offender evaluation/treatment/management and may include but not limited to:

- Statistics on offensive/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 assessment
- Victim Issues
- Family reunification/visitation
- Legal issues regarding sex offenders
- Special sex offender populations including:
 - Sadists
 - Developmentally disabled
 - Compulsive
 - Juvenile
 - Female
- Pharmacotherapy with sex offenders
- Impact of sex offenses
- Assessing treatment Progress
- Secondary and vicarious trauma
- Anger management
- Sex education
- Supervision techniques with sex offenders
- Philosophy and principles of the Sex Offender Management Board
- Group therapy dynamics

To receive credit for training not identified on this list, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender evaluation/treatment/management as described in these standards;

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 Abusers (ATSA), which is contained in Appendix D and shall demonstrate competency according to the individual's respective professional standards and conduct all evaluations in a manner that is consistent with the reasonably accepted standard of practice in the sex offender evaluation community.

1. Provide satisfactory references as requested by the Sex Offender Management Board. The Sex Offender Management Board may also solicit such additional references as necessary to determine compliance with the standards and guidelines. These references shall include other members of the case management team;
2. Submit to a current background check;

7.080 Continued Placement -Evaluator: Associate level evaluators must apply for continued placement on the list every three years by the date provided by the Board. Requirements are as follows:

1. The evaluator must demonstrate continued compliance with the Standards and Guidelines;

2. The evaluator at the associate level may maintain registration as a treatment provider at the associate level or the full operating level and shall complete a minimum of 20 sex offender specific evaluations in the three year (3) year period.

3. Evaluators shall complete a minimum of forty (40) hours of continuing education every three years in the area of specialty (adult or juvenile in order to maintain 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 treatment/evaluation /management. In order to receive credit for training that is indirectly related, it is incumbent on the trainee to write a justification demonstrating relevance to sex offender assessment/treatment/management as described in these standards. The remaining thirty (30) hours must be directly related to sex offender assessment/treatment/management.

4. Report any practice that is in conflict with these standards;

5. Comply with all other requirements outlined in the Sex Offender Management Board administrative policies

Failure to comply with the conditions stated above may result in removal from the provider list as an associate evaluator.

Period of Compliance: Individuals currently listed on the Provider List as treatment providers and/or evaluators or polygraphers who do not meet one or more of the the Standards under qualifications have a period of compliance not to exceed one year from the effective date of the these revised Standards to meet the Standard. It is incumbent upon the provider to complete an affidavit of his/her intent to comply with the standards within the specified period.

- Any new applicants must be in compliance when they apply.

- All providers/evaluators must provide adequate liability insurance as required by state law.

7.090 Revocation, Denial, or Non-Renewal of Registration. The SOMB board shall have the right to revoke a registration , refuse to accept a registration , and/or refuse to renew a registration upon proof that the treatment provider , associate treatment provider, evaluator , or associate evaluator has :

1) been convicted of any felony or a misdemeanor involving a sexual offense;

2) had licensure placed on inactive status , not renewed, revoked , canceled, suspended, or placed on probationary status by any professional licensing body ;

3) been determined by any professional licensing body to have engaged in any unprofessional or unethical conduct ;

4) been determined by the SOMB board to have engaged in deceit or fraud in connection with the delivery of services , supervision, or documentation of registry requirements or registry eligibility;

5) violated any act adopted by the SOMB board;

8.000 STANDARDS FOR USE OF POLYGRAPH

8.010

Treatment Providers' Use of Polygraph and Plethysmograph and ASI

8.020

In cooperation with the supervising officer, the provider shall employ treatment methods that incorporate 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 case management team or by a prison treatment provider.

8.030

The case management team shall determine the frequency of polygraph examinations, and the results shall be reviewed by the team. The results of such polygraphs shall be used to identify treatment issues and for behavioral monitoring.

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

8.040

*Responsibilities of the Polygraph Examiner within the Team

8.050

The polygraph examiner shall participate as a member of the post-conviction case management team established for each offender.

8.060

The polygraph examiner shall submit written reports to each member of the community supervision team for each polygraph examination as required in section (6.190). Reports shall be submitted in a timely manner, no longer than two (2) weeks post testing.

8.070

Attendance by the polygraph examiner at team meetings shall be on an as-needed basis, at the discretion of the supervising officer.

8.100 *QUALIFICATIONS OF POLYGRAPH EXAMINERS

8.110

Polygraph Examiner - Full Operating Level

1. The individual shall be licensed under the Detection of Deception Examiner's Act in Illinois and had conferred upon him/her an academic degree, at the baccalaureate level, from an accredited college or university.
2. The individual shall have graduated from a polygraph school accredited by the American Polygraph Association (APA).
3. The individual shall have completed 40 hours of specialized clinical sex offender training for polygraph examiners which has been approved by the American Polygraph Association.
4. The individual shall have conducted at least one hundred fifty (150) criminal specific issue examinations, including a minimum of fifty (50) clinical sexual offender polygraph examinations, including specific issue, disclosure and maintenance examinations. The total clinical examinations shall include at least ten (10) disclosure polygraphs and ten (10) specific sexual issue polygraphs. Twenty (20) of the fifty required clinical examinations shall have been conducted in the previous 12 months.
5. The individual shall provide satisfactory references as requested by the Sex Offender Management Board and shall allow the Board to solicit any additional necessary references to determine compliance with the standards and guidelines.
6. The individual shall submit to a background check.
7. The individual shall adhere to the code of ethics and bylaws of the American Polygraph Association and shall conduct all examinations in a manner that is consistent with those listed ethics and bylaws.

8.120

Polygraph Examiner-Associate Level:

1. The examiner shall be licensed under the Detection of Deception Examiner's Act in Illinois and possess a baccalaureate degree from an accredited college or university.
2. The examiner shall have graduated from a polygraph school accredited by the American Polygraph Association (APA).
3. The examiner shall have completed 40 hours of specialized clinical sex offender training for polygraph examiners which has been approved by the American Polygraph Association.
4. The examiner shall have completed at least 30 specific issue examinations (at least 15 shall be real life examinations and the other 15 may be specific issue mock examinations).
5. The associate level examiner shall obtain supervision from a SOMB approved clinical polygraph examiner, at the full operating level, to conduct the necessary clinical polygraphs to achieve the 50 examinations required at the full operating level. The supervision agreement must be in writing and the supervising examiner must review each clinical polygraph conducted to satisfy the 50 clinical polygraph examination requirement.

The supervisor of an associate level clinical polygraph examiner shall review samples of videotapes and /or actually observe the examiner during the examinations and provide supervision and consultation on question formulation for clinical polygraph exams, report writing, and other issues related to conducting clinical polygraph exams. Supervisors must review each clinical polygraph report used to meet the 50 clinical polygraph examinations requirement and sign off that such review has been completed.

8.130 Continued Registration on the Provider List

1. The polygraph examiner must demonstrate continued compliance with the SOMB Standards and Guidelines.
2. Clinical polygraph examiners shall complete a minimum of forty (40) hours of relevant continuing education every three years to help maintain proficiency in the polygraph field and to remain current on developments in the assessment, treatment and monitoring of sexual offenders.
3. The examiner shall have conducted a minimum of 75 clinical polygraph examinations in the three years immediately prior to re-registration.
4. It is recommended that the examiner has engaged in periodic peer review by other registered full operating level clinical polygraph examiners, especially in cases where there are conflicting results with another registered examiner.
5. The examiner shall provide any satisfactory references as requested by the Sex Offender Management Board.
6. The examiner shall submit to a current background check.
7. There shall be no evidence that the examiner has been convicted of a felony or has committed any criminal sexual offenses.
8. The examiner shall comply with all requirements outlined in the Sex Offender Management Board administrative practices and shall report any practice which is in significant conflict with the Standards of Practice.

8.140 Use of the Polygraph

1. The supervising officer should ensure that the polygraph examiner conducting the current examination has full background information, including PSIR, police reports, mental health evaluations, reports from all prior polygraphs, including sex history disclosure and any prior maintenance examinations.
2. Polygraph examinations should not be conducted by anyone serving as the supervising officer or therapist.
3. Opinions of the polygraph examiner should be based upon all information gathered during the examination process. The computer algorithm should never be the sole determining factor in reporting the examination results. Numeric scores should be considered raw data and not disclosed in written examination reports.
4. The maximum number of relevant test questions in any examination should not exceed four, however three or fewer relevant questions is ideal.

5. Prior to the examination the general nature of the procedure can be discussed with the offender, but the specific issues to be addressed will be determined by the team. The supervising officer and treatment provider should defer any questions or information about the mechanics and actual operation of the polygraph to the polygraph examiner. The team should emphasize the importance of being honest and making full disclosure.
6. If the offender is in full or partial denial of the facts of the instant offense, a specific issue examination is the most appropriate type of initial examination. This type of examination should be conducted as early as possible in the supervision/treatment process.
7. Sex history disclosure polygraphs should be completed after the offender has provided a written sex history, which has been reviewed in their treatment program. The supervising officer or treatment provider should provide the examiner with a copy of the offender's written sex history and any disclosure questionnaire prior to the examination.
8. Only the supervision team can waive the requirement for a non-deceptive sex history disclosure polygraph.
9. Maintenance examinations should cover a wide variety of offending behavior as well as compliance with treatment and supervision conditions. An ongoing dialogue between team members is crucial to identify issues to be explored. For offenders who remain in denial, the frequency of maintenance testing should be accelerated due to the possibility of increased risk.
10. Unresolved issues should be re-examined as soon as possible and sanctions should be imposed for continued deceptive responses. These re-examinations are not considered to be a substitute for scheduled maintenance examinations.
11. Post test admissions to deceptive polygraph responses should result in further testing to verify if the offender has failed to disclose additional offenses.
12. Disclosure test questions and maintenance test questions should not be mixed in any single examination.
13. Single issue polygraph examinations provide the best opportunity for identification of offender deception, however the examiner may utilize multiple issue examinations at his/her discretion and while considering the goals of the team.
14. If the offender is deceptive or inconclusive to one or more issues in a multiple issue examination, a re-examination over all issues should be considered, once the results have been reviewed with the offender by the team.
15. (Regarding the reporting on Split Call reporting, further discussion is needed here)
16. Offenders should not be tested on fantasy, intentions or thoughts. Questions regarding arousal should be tied to behaviors: e.g. "Have you masturbated to deviant sexual fantasies?"
17. Test questions should not contain emotionally laden, psychological or legal terminology.
18. Test questions should be based upon actual behavior, and not on written statements about behavior, ie. Sexual History Disclosure Questionnaires.

19. Relevant test questions should not ask for estimates of offenses/victims for those offenders who report large numbers of those behaviors. Questions about victims may be broken down into separate categories for which the offender has no disclosures, ie. male, female, relative, stranger, etc.
20. Examiners should communicate with the team any concerns and recommendations for further testing of an offender. If the examiner suspects the offender has used countermeasures, it is appropriate for the team to use appropriate sanctions with the offender. Likewise, if the supervising officer or treatment provider has any questions about the polygraph results, they should communicate with the examiner.
21. If conflicting polygraph results are reported between two separate examiners, using similar test questions and time frames, a meeting of both examiners with the supervising officer and treatment provider should be convened as soon as possible. Each examiner should bring all relevant test materials to the meeting to help explore the possible causes for the differing results. The team members should work to develop a consensus on the results and the subsequent response to the offender. If consensus cannot be reached the team should consult with a third, independent SOMB approved full operating level examiner to offer an opinion regarding the issue. If the conflict still remains unresolved, a new examination by a third party should be conducted.
22. V.If an offender claims significant differences in the results or information disclosed in the examination from that provided in the examiner's report, the examiner should be contacted to seek clarification and to mitigate offender splitting. If the procedure was recorded, a review of the recording is appropriate.
23. In preparation for reviewing polygraph reports with the offender, the supervising officer and treatment provider should be familiar with both the current and prior polygraph reports. They should review the entire current report and identify critical issues to discuss with the offender. In meeting with the offender, efforts should be made to have the offender repeat and document any relevant statements and to solicit additional information. After reviewing the report with the offender, the case should be staffed by the team and appropriate sanctions should be imposed for reported deception and any statements of problem behavior. (*The use of the polygraph with convicted sex offenders is most effective when relevant sanctions to high risk behaviors or deceptive responses are imposed quickly.)
24. Treatment providers and supervising officers should not offer the offender explanations or excuses for deceptive responses, other than dishonesty. Team members should not allow splitting and should discuss with the team any information the offender provides about another team member.
25. If any team member has concerns regarding an offender's emotional state, or mental health related symptoms, which may affect the polygraph, the entire team should staff the case.
26. If the members of the team have concerns about what they consider to be excessive inconclusive results reported by the examiner, a staffing of all members is appropriate to explore how to resolve this problem.
27. If the offender is not fluent in English, an interpreter should be used who is fluent in speaking and writing both English and the language used during the examination. The interpreter should not be a relative or a friend and must have prior approval by the examiner. The interpreter should serve only to interpret the communication between the subject and the examiner. For further details on conducting proper polygraph examinations, see the appropriate appendix in "Truth and Deception" by John E. Reid and Fred E. Inbau.
28. There may be value in occasionally changing polygraph examiners to avoid familiarization between a particular examiner and the offender.

9.000 STANDARDS AND GUIDELINES FOR MANAGEMENT OF SEX OFFENDERS ON PROBATION/PAROLE

9.100 Establishment of an Interagency Containment Team

9.110

As soon as possible after a sex offender is placed on probation or parole, the supervising officer/agent should convene a team to manage the offender during his/her term of supervision:

A. The purpose of the team is to staff cases, share information, and make informed decisions related to risk assessment, treatment, behavioral monitoring, and management of each offender. The team should use the comprehensive sex offense-specific evaluation and pre-sentence investigation as a starting point for such decisions;

B. Supervision and behavioral monitoring is a joint, cooperative responsibility of the supervising officer/agent, the treatment provider, and the polygraph examiner .

9.120

Each team, at a minimum, should consist of:

- the supervising officer/agent
- the offender's treatment provider and
- the polygraph examiner

Each team is formed around a particular offender and is flexible enough to include any individuals necessary to ensure the best approach to managing and treating the offender. Team membership may therefore change over time.

The team may include individuals who need to be involved at a particular stage of management or treatment (e.g., the victim's therapist or victim advocate). When the sex offender is a family member of the victim, the child protection worker is also a team member if the case is still open.

9.130

The team is coordinated by the supervising officer/agent, who determines:

- A. The members of the team, beyond the required membership, who should attend any given meeting;
- B. The frequency of team meetings;
- C. The content of the meetings, with input from other team members;
- D. The types of information required to be released.

9.140

Team members should keep in mind the priorities of community safety and risk management when making decisions about the management and/or treatment of offenders.

9.150

The team should demonstrate the following behavioral norms:

- A. There is an ongoing, completely open flow of information among all members of the team;
- B. Each team member participates fully in the management of each offender;
- C. Team members settle among themselves conflicts and differences of opinion that might make them less effective in presenting a unified response. The final authority rests with the supervising officer/agent;
- D. Team members are committed to the team approach and seek assistance with conflicts or alignment issues that occur.

Discussion: *Supervising officers/agents are encouraged to periodically attend group and/or individual treatment sessions to monitor sex offenders under their supervision. Treatment providers are encouraged to allow attendance of supervising officers/agents and prepare sex offenders in the group in advance for the attendance of a supervising officer/agent. Preparation should include notification of the supervising officer's/agent's attendance and execution of appropriate waivers of confidentiality if necessary. The visiting supervising officer shall be bound by the same confidentiality rules as the treatment provider and should sign a statement to that effect. It is understood that treatment providers may set reasonable limits on the number and timing of visits in order to minimize any disruption to the group process.*

9.160

Team members should communicate frequently enough to manage and treat sexual offenders effectively, with community safety as the highest priority.

9.200 Responsibilities of the Supervising Officer/agent for Team Management

9.210

Sex offenders shall only be referred for evaluation and treatment to treatment providers who meet these standards.

Discussion: *Supervising officers/agents or indicated IDOC facility staff have a responsibility to ensure that the offender is engaged in appropriate treatment with a provider who is listed on the Sex Offender Management Board's Provider List and that the treatment program is consistent with Sex Offender Management Board Standards. It is the supervising officer's/agent's responsibility to refer to evaluators and treatment providers who will best meet the sex offenders treatment/evaluation needs and the need for community safety.*

9.220

Sex offenders shall sign releases for at least the following types of information:

- Releases of information to treatment providers, including information from any treatment program in which the offender participated at the Department of Corrections;
- Releases of information to case management team members, including collateral information sources, as indicated, such as the child protection agency, the treatment provider, the polygraph examiner, the victim's therapist, and any other professionals involved in the treatment and/or supervision of the offender;
- Releases of information to the victim's therapist, the guardian ad litem, custodial parent, guardian, caseworker, or other involved professional, as indicated. Such information may be used in the victim's treatment and/or in

making decisions regarding reunification of the family or the offender's contact with the victim.

9.230

The supervising officer/agent or indicated IDOC facility staff, in cooperation with the treatment provider and polygraph examiner, should utilize the results of periodic polygraph examinations for treatment and behavioral monitoring. Team members should provide input and information to the polygraph examiner regarding examination questions. The information provided by the team should include date and results of last polygraph examination.

Discussion: *Supervising officers/agents or indicated IDOC facility staff have a responsibility to ensure that the offender receives polygraph examinations from a polygraph examiner who is listed on the Sex Offender Management Board's Provider List and that the examinations are consistent with Sex Offender Management Board Standards. It is the supervising officer's responsibility to refer to polygraph examiners who will best meet the sex offenders' treatment and evaluation needs and the need for community safety.*

9.240 Written Treatment Agreements

The supervising officer/agent or indicated IDOC facility staff should require sex offenders to provide a copy of the written plan developed in treatment for preventing a relapse, signed by the offender and therapist, as soon as it is available. The supervising officer/agent should utilize the relapse prevention plan in monitoring offenders' behavior.

9.250

The supervising officer/agent or indicated IDOC facility staff should require sex offenders to obtain the officer's/agent's written permission (and if required, court approval) to change treatment programs.

9.260 Supervision

The supervising officer/agent or indicated IDOC facility staff should ensure maximum behavioral monitoring and supervision for offenders in denial. The officer/agent should use supervision tools that place limitations on offenders' use of free time and mobility and emphasize community safety and containment of offenders.

9.270

1. The supervising officer/agent or indicated IDOC facility staff should require treatment providers to keep monthly written updates on sex offenders' status and progress in treatment.

2. The supervising officer/agent or indicated IDOC facility staff should discuss with the treatment provider, the victim's therapist, custodial parent or foster parent, and guardian ad litem specific plans for any and all contracts of an offender with a child victim and plans for family reunification.

3. The supervising officer/agent or indicated IDOC facility staff should develop a supervision plan and contact standards based on a risk assessment of each sex offender, the sex offender's offending cycle, physiological monitoring results, and the offender's progress in treatment.

4. Recognizing that sex offenders present a high risk to community safety, supervising officers/agents should base their field work on the supervision plan, relapse prevention plan, and offense cycle of an offender.

5. The supervising officer/agent or indicated IDOC facility staff should not request early termination of sex offenders from supervision.

6. On a regular basis, the supervising officer/agent or indicated IDOC facility staff should review each offender's specific conditions of probation/parole, and assess the offender's compliance, needs, risk, and progress to determine the necessary level of supervision and the need for additional conditions.
7. If contact is allowed, the supervising officer/agent or indicated IDOC facility staff should limit and control the offenders' authority to make decisions for minors or to discipline them.
8. If necessary and possible, the supervising officer/agent or indicated IDOC facility staff should request an extension of supervision to allow an offender to complete treatment.
9. The supervising officer/agent or indicated IDOC facility staff should notify sex offenders that they must register with local law enforcement, in compliance with the Sex Offender Registration Act (730 ILCS 150).
10. The supervising officer/agent or IDOC facility staff should discuss treatment issues and progress with offenders during office visits and other contacts.
11. The supervising agency should impose or request criminal justice sanctions for offenders' unsatisfactory termination from sex offender treatment, including revocation of probation or parole.

9.280

The supervising officer/agent or indicated IDOC facility staff should require sex offenders who are transferred from other states through an Interstate Compact Agreement to agree in advance to participate in offense-specific treatment and specialized conditions of supervision contained in these Standards.

9.290

The supervising officer/agent or indicated IDOC facility staff should not allow a sex offender who has been unsuccessfully discharged from a treatment program to enter another program unless the new treatment program and case management arrangement will provide *greater* behavioral monitoring and *increased* treatment in the areas the sex offender "failed" in the previous program.

Discussion: *The purpose of this standard is to discourage movement among treatment providers by offenders as a way of avoiding doing the work of therapy.*

9.300 Training for Supervising Agents

Supervising officers/agents or indicated IDOC facility staff assessing or supervising sex offenders should successfully complete training programs specific to sex offenders. Such training shall include information on:

- Prevalence of sexual assault
- Offender characteristics
- Assessment/evaluation of sex offenders
- Current research
- Community management of sex offenders
- Interviewing skills
- Victim issues
- Sex offender treatment
- Choosing evaluators and treatment providers
- Relapse prevention

- Physiological procedures
- Determining progress
- Offender denial
- Special populations of sex offenders
- Cultural and ethnic awareness

It is also desirable for agency supervisors of officers/agents or indicated IDOC facility staff managing sex offenders to complete such training, as well as appropriate management training in the development of policy and procedure for the supervision of sex offenders in the community.

9.310

On an annual basis, supervising officers/agents or indicated IDOC facility staff should obtain continuing education/training specific to sex offenders.

9.400 Responsibilities of the Treatment Provider within the Team

9.410

A treatment provider shall establish a cooperative professional relationship with the supervising officer/agent of each offender and with other relevant supervising agencies. This includes but may not be limited to:

1. A provider shall immediately report to the supervising officer/agent all violations of the provider/client contract, including those related to specific conditions of probation/parole;
2. A provider shall immediately report to the supervising officer/agent evidence or likelihood of an offender's increased risk of re-offending so that behavioral monitoring activities may be increased;
3. A provider shall report to the supervising officer/agent any reduction in frequency or duration of contacts or any alteration in treatment modality that constitutes a change in an offender's treatment plan. Any permanent reduction in duration or frequency of contacts or permanent alteration in treatment modality shall be determined on an individual basis by the provider and the supervising officer/agent.
4. On a timely basis, and no less than monthly, a provider shall provide to the supervising officer/agent progress reports documenting offender's attendance, participation in treatment, increase in risk factors, changes in the treatment plan, and treatment progress.
5. If a revocation of probation or parole is filed by the supervising officer/agent, a provider shall furnish, when requested by the supervising officer/agent, written information regarding the offender's treatment progress. The information shall include: changes in the treatment plan, dates of attendance, treatment activities, the offender's relative progress and compliance in treatment, and any other material relevant to the court at the hearing. The treatment provider shall be willing to testify in court if necessary.
6. A provider shall discuss with the supervising officer/agent, the victim's therapist, custodial parent, foster parent and/or guardian ad litem specific plans for any and all contact of the offender with the child victim and plans for family reunification.
7. A provider shall make recommendations to the supervising officer/agent about visitation supervisors for an offender's contact with children, if such contact is allowed.

9.500 Responsibilities of the Polygraph Examiner within the Team.

9.510

The polygraph examiner shall participate as a member of the containment team established for each sex offender, and shall routinely consult with the supervising officer/agent and the treatment provider concerning the conduct and the content of each examination.

9.520

The polygraph examiner shall submit written reports to each member of the containment team for each polygraph exam. Reports shall be submitted in a timely manner, no longer than two (2) weeks post testing.

9.530

Attendance at team meetings shall be on an as-needed basis. At the discretion of the supervising officer/agent, the polygraph examiner may be required to attend only those meeting preceding and/or following an offender's polygraph examination, but the examiner is nonetheless an important member of the team.

9.600 Conditions of Community Supervision

9.610

In addition to general conditions imposed on all offenders under community supervision, the following special conditions shall be imposed on sex offenders under community supervision by the court or Prisoner Review Board. The court or Prisoner Review Board can identify specific conditions, on a case by case basis, which are not deemed to apply to a sex offender.

1. Sex offenders shall have no contact with their victim(s), including correspondence, telephone contact, or communication through third parties except under circumstances approved in advance and in writing by the supervising officer/agent in consultation with the community supervision team. Sex offenders shall not enter onto the premises, travel past, or loiter near the victim's residence, place of employment, or other places frequented by the victim;
2. Sex offenders shall have no contact, nor reside with children under the age of 18, including their own children, unless approved in advance and in writing by the supervising officer/agent or indicated IDOC facility staff consultation with the community supervision team. The sex offender must report all incidental contact with children to the treatment provider and the supervising officer/agent, as required by the team;
3. Sex offenders who have perpetrated against children shall not date or befriend anyone who has children under the age of 18, unless approved in advance and in writing by the supervising officer/agent or indicated IDOC facility staff in consultation with the community supervision team;
4. Sex offenders shall not access or loiter near school yards, parks, arcades, playgrounds, amusement parks, or other places used primarily by children unless approved in advance and in writing by the supervising officer/agent in consultation with the community supervision team;
5. Sex offenders shall not be employed in or participate in any volunteer activity that involves contact with children;

6 Sex offenders shall not possess any pornographic, sexually oriented or sexually stimulating materials, including visual, auditory, telephonic, or electronic media, computer programs or services. Sex offenders shall not patronize any place where such material or entertainment is available. Sex offenders shall not utilize any sex-related telephone numbers. The community supervision team may grant permission for the use of sexually oriented material for treatment purposes;

7. Sex offenders shall not consume or possess alcohol or the illegal use of controlled substances or marijuana;

8. The residence and living situation of sex offender must be approved in advance by the supervising officer/agent in consultation with the community supervision team. In determining whether to approve the residence, the supervising officer/agent will consider the level of communication the officer/agent has with others living in the residence, and the extent to which the offender has informed household members of his/her conviction and conditions of probation/parole/community corrections, and the extent to which others living in the residence are supportive of the case management plan;

9. Sex offenders will be required to undergo DNA testing as required by statute;

10. Other special conditions that restrict sex offenders from high-risk situations and limit access to potential victims may be imposed by the supervising officer/agent in consultation with the containment team;

11. Sex offenders shall sign information releases to allow all professionals involved in assessment, treatment, and behavioral monitoring and compliance of the sex offender to communicate and share documentation with each other;

12. Sex offenders shall not hitchhike or pick up hitchhikers;

13. Sex offenders shall attend and actively participate in evaluation and treatment approved by the supervising officer/agent and shall not change treatment providers without prior approval of the supervising officer/agent.

14. Sex offenders shall not access the Internet or communicate with any individual or entity via the use of a computer, without explicit authorization from the containment team.

15. Sex offenders shall be subject to a warrantless search or unannounced visit by the community containment team.

16. When in public view, sex offenders shall be attired in appropriate clothing which is not sexually provocative.

9.700 Behavioral Monitoring of Sex Offenders in the Community

9.710

The monitoring of offenders' compliance with treatment and sentencing requirements shall recognize sex offenders' potential to re-offend, to re-victimize, to cause harm, and the limits of sex offenders' self reports:

A. Responsibility for behavioral monitoring activities shall be outlined under explicit agreements established by the supervising officer/agent. Some or all members of the team described in these standards will share monitoring responsibility. At a minimum, the provider, the supervising officer/agent, and the polygraph examiner shall take an active role in monitoring offenders' behaviors;

For purposes of compliance with this standard, behavioral monitoring activities shall include, but are not limited to the following:

1. The receipt of third-party reports and observations;
2. The use of disclosure and maintenance polygraphs; measures of arousal or interest including sexual and violent arousal or interest;
3. The use and support of targeted limitations on an offenders' behavior, including those conditions set forth in these standards;
4. The verification (by means of observation and/or collateral sources of information in addition to the offender's self report) of the offender's:
 - (a) Compliance with sentencing requirements, supervision conditions and treatment directives;
 - (b) Cessation of sexually deviant behavior;
 - (c) Reduction of behaviors most likely to be related to a sexual re-offense;
 - (d) Living, work and social environments, to ensure that these environments provide sufficient protection against offenders' potential to re-offend;
 - (e) Compliance with specific conditions of the relapse prevention plan;
5. The direct involvement of individuals significant in the offenders' life in monitoring offenders' compliance, when approved by the community supervision team.

B. Behavioral monitoring should be increased during times of an offender's increased risk to re-offend, including, but not limited to, such circumstances as the following:

1. The offender is experiencing stress or crisis;
2. The offender is in a high-risk environment;
3. The offender will be having visits with victims or potential victims, as recommended by the provider and approved by the supervising officer/agent, victim treatment provider, custodial parent, and/or guardian ad litem;
4. The offender demonstrates a high or increased level of denial.
5. The offender works with computers or is on the Internet.

9.800 The Role of Victims/Survivors in Sex Offender Evaluation and Treatment

The Sex Offender Management Board recognizes that the behavior of sex offenders can be extremely damaging to victims and that their caregivers and that their crimes can have a long-term impact on victims' and their families' lives. Moreover, the level of violence, exploitation, and coercion involved in the offense does not necessarily determine the degree of trauma experienced by the victim.

9.810

For purposes of compliance with this standard, supervising officer/agents and providers shall:

RE: ADULT VICTIMS

1. Respect the victim's wishes regarding contact with the offender
2. With the consent of the victim, collaborate with the victim's therapist and/or advocate in making decisions regarding communication and contact between the victim and offender.
3. Place the safety of the victim first, if it is therapeutically indicated, and the victim wishes to have contact with the offender. When assessing safety, both psychological and physical well-being will be evaluated.
4. Any recommended contact with the victim or potential victim shall be in compliance with the following:
 - Any court orders such as orders of protection
 - Recommendations from the offender's individual and group therapist.
 - Work with the offender's therapist who shall consider the following prior to recommending contact between a victim and an offender:
 - The offender is able to utilize cognitive and behavioral interventions to interrupt sexual deviant fantasies.
 - The offender is able to cooperate with supervised visitation and is able to respect and follow a safety plan.
 - The offender accepts responsibility for the abuse.
 - Significant differences between the offender's statements, the victim's statements, and corroborating information about the abuse have been resolved.
 - The offender has a cognitive understanding of the impact of the abuse on the victim and the family.
 - The offender is able to put the victim's needs first and is willing to respect the victim's verbal and non-verbal boundaries and need for privacy.
 - Results of any polygraph examinations (if available).
 - Complete training addressing sexual offending, understand the deviant cycle and the possibility of re-offense, the dynamics of incestuous families, and learn how to facilitate a visit between a victim and offender with safety being paramount.
 - Closely supervise and monitor the process and content of the visit if contact is approved:
 - Victim's and potential victims' emotional and physical safety shall be assessed on a continuing basis and visits shall be terminated immediately if any aspect of safety is jeopardized. Any behavior indicating risk shall result in visits being terminated immediately.
 - There must be provisions for monitoring, documenting, and giving both positive and negative feedback to the offender.
 - Indirect contact (e.g. mail, sending gifts) shall also be monitored and may be prohibited.

RE: VULNERABLE VICTIMS (Any person 17 years old and younger, or any person who is developmentally disabled, cognitively impaired, or unable to give consent)

1. Ensure consultation with custodial parents or guardians of the victim, the victim's guardian ad litem, and the victim's treatment provider prior to authorizing contact and the contact is in accordance with court directives.
2. Ensure that the custodial parent or guardian shall not place the victim at risk.
3. Consider the victim's wishes regarding contact with the offender.
4. Whenever possible, collaborate with the victim's therapist and/or advocate in making decisions regarding communication and contact between victim and offender.
5. If the victim and her/his family/guardian wishes, and contact with the offender is therapeutically indicated, safety of the victim and potential victims must be paramount. Safety, both psychological and physical well being, must be evaluated and continually monitored.
6. . Any recommended contact with the victim or potential victim shall be in compliance with the following:
7. Any court orders such as orders of protection
8. Recommendations from the offender's individual and group therapist.
9. Work with the offender's therapist who shall verify the following progress in therapy prior to recommending contact between a victim and an offender:
 - The offender is able to utilize cognitive and behavioral interventions to interrupt sexual deviant fantasies.
 - The offender is able to cooperate with supervised visitation and is able to respect and follow a safety plan.
 - The offender accepts responsibility for the abuse.
 - Significant differences between the offender's statements, the victim's statements, and corroborating information about the abuse have been resolved.
 - The offender has a cognitive understanding of the impact of the abuse on the victim and the family.
 - The offender is able to put the victim's needs first and is willing to respect the victim's verbal and non-verbal boundaries and need for privacy.
 - Results of any polygraph examinations, if available.
10. Complete training addressing sexual offending, understand the deviant cycle and accept the possibility of re-offense, the dynamics of incestuous families, and learn how to facilitate a visit between the victim and offender with safety being paramount.
11. Closely supervise and monitor the process and content of the visit if contact is approved.
 - Victim's and potential victims' emotional and physical safety shall be assessed on a continuing basis, and visits will be terminated immediately if any aspect of safety is jeopardized. Any behavior indicating risk shall result in visits being terminated immediately.
 - There must be provisions for monitoring, documenting, and giving both positive and negative feedback to the offender.
12. Indirect contact (e.g. mail, sending gifts) will also be monitored and may be prohibited.

13. Consider family reunification:

- Only after a multidisciplinary staffing has occurred with all therapists and supervising officers present.
- Never recommend family reunification if the safety of any former or potential victims is still at risk.

15. If family reunification is indicated by all therapists and supervising agents:

- This team will closely supervise and monitor the process with safety plans in place.
- Continued treatment shall be mandatory through this process and over an extended period of time.
- Periodic polygraph examinations shall be mandatory (if available) throughout this process. The examiner shall determine that the results of the offender's polygraphs be nondeceptive during these examinations.
- An ongoing, comprehensive, assessment shall be made of all of the different social contexts in which the offender participates.

Appendix A: Philosophy Regarding Restricted Contact with Children

The Illinois Sex Offender Management Board has set the following standard:

Sex offenders shall have no contact, nor reside with children under the age of 18, including their own children, unless approved in advance and in writing by the supervising officer in consultation with the community supervision team. The sex offender must report all incidental contact with children to the treatment provider and the supervising officer as required by the team.

Illinois Sex Offender Treatment Board applicable principles:

1. Sexual offending is a behavioral disorder which cannot be “cured.”
2. Sex offenders are dangerous.
3. Community safety is paramount.

Research in support of the “no contact” condition:

1. Gene Abel et. al. Conducted a breakthrough study in 1983 which gave us information on the frequency and variety of sexual offending behaviors sex offenders have committed. He received a federal certificate of confidentiality to study sex offenders. Individuals in this study could admit to current offending behaviors without fear that the information would be reported to law enforcement. He studied 411 sex offenders and found that on average over a twelve year period each offender had attempted 581 crimes, completed 533 crimes, had 366 victims and committed an average of 44 crimes a year. These crimes included hands off sex offenses such as exposing, peeping and obscene phone calls. Additionally, he found that 50.6% of the rapists involved in the study had also molested children. (Restraining Adult Sex Offenders: Methods and Models, Safer Society Press, by Fay Honey Knopp)
2. In 1985, Rob Freeman-Longo reported on a group of 23 rapists and 30 child molesters involved in an institutional forensic comprehensive sex offender program. Arrest records indicated rapists had an average of 1.9 offenses each for a group total of 43 arrests for sex offenses. The 23 rapists as a group admitted committing a total of 5090 various incidents of sex offending behaviors which included 319 child molestations and 178 rapes. Arrest records indicated child molesters had an average of 1.5 arrests each. While in treatment, the 30 child molesters as a group admitted 20,667 offenses which included 5891 sexual assaults on children and 213 rapes on adult women. (Sexual Abuse in America: Epidemic of the 21st Century, by Freeman-Longo and Blanchard, 1998, Safer Society Press, Brandon, VT)
3. Illinois Department of Corrections Sex Offender Treatment Program has found similar patterns to those reported by Gene Abel with the sex offenders participating in treatment and polygraph assessment. The program collected data in 1998 on the number of known victims of the first 36 sex offenders to participate in two polygraph evaluations. On average, for each offender there were 2 known victims documented in official records. After the first polygraph exam inmates disclosed on average 165 victims per offender. By the second polygraph exam the same inmates, on average, disclosed 184 victims per offender. These crimes included hands-on sex offenses such as exhibitionism, voyeurism and obscene phone calls. Approximately 80% of these offenders were still deceptive on their polygraph examinations, suggesting that even more offenses were committed. (The Impact of Polygraphy on Admissions of Victims and Offenses of adult Sex Offenders; Ahlmeyer, Heil, McKee, English, in press)
4. In 1988, Kim English analyzed a sample of 87 sex offenders who had participated in polygraph evaluations

at the Colorado Department of Corrections. The sample included inmates and parolees. She determined that 48% of the offenders had crossed over in either age (36%) or the gender (25%) of the victims they offended against—they had committed offenses with either victims of different ages (adults and children) or victims of different sexes (males and females). Again, 80% of this sample were still scoring deceptive on their polygraph evaluations. (Presentation at the Association for the Treatment of Sexual Abusers 17th Annual Research and Treatment Conference, Maximizing the Use of the Polygraph with sex Offenders: Policy Development and Research Findings, Vancouver 1998)

5. In 1999, Sean Ahlmeyer analyzed a larger scale of 117 inmates who participated in polygraph evaluations at the Colorado Department of Corrections. In this sample 74% of the inmates self reported that they had committed offenses with either victims of different ages (adults and children) and/or victims of different sexes (males and females). It was determined that 69% of the sample acknowledged crossing over in the age of the victims they assaulted. Of the offenders who were only known to have child victims in official records, 79% later admitted to also having adult victims. Of the offenders who were only known in official records to have adult victims, 50% later admitted to having child victims during the process of polygraph examination.

It was also determined that 32% of the sample acknowledged crossing over in the sex of the victims they assaulted. Of the offenders who were only known to have male victims in official records, 58% later admitted to having female victims. Of the offenders who were only known to have female victims, 22% later admitted to having male victims. Again the majority of the individuals in this sample were still scoring deceptive on some areas of their polygraph evaluations, indicating that the percent of cross over may be higher than the numbers self reported by these offenders.

6. In 1983, Abel et. al. studied incest offenders who had involved themselves sexually with female children. He found that 44% of these offenders had offended against unrelated female children 11% had offended against unrelated male children. 18% had committed rapes, 18% had committed exhibitionism, 9% had engaged in voyeurism, 5% had engaged in frottage, 4% had engaged in sadism, and 21% had other paraphilias. In this study it was determined that 59% of the child molesters developed deviant sexual interest during adolescence. (Information reported in an article by Judith Becker and Emily Coleman in the Handbook of Family Violence.)

7. In a 1996 study by Gary Davis, Laura Williams and James Yokley, 142 child molesters were polygraphed to determine if they were having deviant fantasies and masturbating while thinking about a known minor. Only 3% of offenders who were not permitted contact with children were having deviant fantasies and masturbating while thinking about a known minor. Only 3% of offenders who were not permitted contact with children were having deviant fantasies and masturbating while thinking about a known minor. Of the child sex offenders who were permitted supervised contact with children, 59.5% were having deviant fantasies and masturbating while thinking about a known minor. (An Evaluation of Court-Ordered contact Between Child Molesters and Children: Polygraph Examination as a Child Protective Service by Gary Davis, Laura Williams, and James Yokley. Paper presented at 15th Annual ATSA Conference, November 1996)

8. William Marshall has reported findings from an unpublished project conducted within child protective agencies in Ontario in the mid-1970's. The project was unsystematic in the sense that some, but not all, victims of incest over approximately a three year period were contacted. A child protective services caseworker located a number of children who had reported molestation by a relative. She found that many cases were recanted when the family did not believe the victim, or when the victim was believed but was poorly treated by family members. Once the children had been located, the caseworker asked the children if they would report the incident if they were molested again. Almost 100% answered "no." The reasons they gave included the following: Practically no one believes them when they tell, or if they do believe, they become hostile to the victim for getting the perpe-

trator in trouble and removing him from where he was needed: the child held him/herself responsible for the father's absence from the family; or the outcome almost always ended up being more devastating to the child than to the perpetrator. (Information presented at the Association for the Treatment of Sexual Abusers annual research and treatment conference; personal communication with William Marshall 11/6/98)

9. In 1985, Marshall reported that family reunification provides the following risks; Victims may not want the family to reunify, but may feel pressured into it; even after treatment 80% of families separate within 5 years; there is an increased chance the victim will not report if victimized again; or the victim may get the impression that the family is important and that he/she is not (Wisconsin Sex Offender Treatment Network, Inc. training tapes; personal communication with William Marshall 11/6/98)

10. In 1998, Jim Tanner conducted a research study on the polygraph results of 128 sex offenders who were participating in offense specific treatment in the community. Each of the offenders had participated in one baseline and at least on maintenance polygraph examination. The study looked at the offender's behavior between the time period of the baseline polygraph and maintenance polygraph. Based on the polygraph examination results, 31% of the offenders had sexual contact with a minor, 25 % had unauthorized contact with a minor, and 12% of the offenders had forced someone to have sex since the baseline examination. Overall, 86% of this sample were engaging in new high risk behaviors and/or new crimes. On average, each offender were engaging in 2.5 different high risk behaviors. This would indicate that many offenders continue their patterns of perpetration while participating in sex offender treatment (Incidence of Sex Offender Risk Behavior During Treatment, Research Project Final Report, by Jim Tanner, funded by Teaching Humane Existence, Inc. 2/4/99)

11. In 1997, Karl Hanson and Andrew Harris conducted research on dynamic predictors of sexual reoffense. The following factors were significantly associated with reoffense: General excuses/ justifications/low victim empathy, sexual entitlement, attitudes tolerant of rape, attitudes tolerant of child molesting, sees self as no risk, sexual risk factors (polygraphy, excessive masturbation, deviant sexual fantasies, preoccupation with sex), access to victims, negative social influences. (Dynamic Predictors of Sexual Reoffense Project 1997 presented at The Association for the Treatment of Sexual Abusers 16th Annual Conference, October 16 1997, Arlington, Virginia).

Appendix B: Special Populations

From the Ethical Standards and Principles for the Management of Sexual Abusers, the Association for the Treatment of Sexual Abusers.

There is a growing awareness of the importance of designing and implementing specific treatment programs sensitive to diverse populations. Many of the evaluation and treatment procedures currently being used have been developed by the majority culture and do not reflect awareness or sensitivity to differences within minority populations. It is incumbent upon the service providers in this field to modify and adapt the generally accepted treatment techniques, standards, and principles to those special populations that they serve.

(a) Where differences of age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, language or socioeconomic status significantly differ from the service provider's experience and/or orientation it is imperative that the treatment provider obtain the training and/or supervision necessary to ensure the adequacy of the services provided.

(b) If it is not feasible to obtain training and/or supervision to adequately provide services to a special clientele, referral to a service provider who does possess the necessary knowledge and skills is necessary.

(c) Emphasis should be placed on the development of specific programs and treatment plans that address the sexually deviant behavior within the context of the minority group culture.

(d) Service providers must acknowledge and educate themselves about their own ethnic, cultural, racial and/or professional biases and assumptions.

(e) Special care and attention should be given to the environment in which the abuser will spend most of his or her time, both during and following treatment intervention.

Appendix C: Ethical Principles

The Philosophical Foundation

The Association for the Treatment of Sexual Abusers (ATSA) represents professionals committed to the welfare of their clientele, the community, and their professional colleagues. Based upon a foundation of theory and research, knowledge and skill, professions are self-regulating. An inherent assumption in this process is the adoption and adherence to a set of standards or code of ethics that facilitates the evaluation of each professional act as to its positive or negative impact on its constituents. This Code of Ethics is intended to reflect scientifically informed and professionally accepted beliefs regarding professional behavior and conduct. At the same time, such a Code must also satisfy the prevailing community standards.

Standards for professional conduct are developed based on a consensus of members of a profession and, as such, are particularly relevant to the investigation of grievances. The public nature of an organization's code of ethics and the uniform application of these principals are integral to sustaining community confidence. Ethical standards are maintained through individual member's reflection and self-discipline, through collegial input and guidance, and as a result of more formal discipline provided by professional associations. Since association membership is highly valued and contributes to professional success, the potential for formal disciplinary action represents a powerful force in encouraging adherence to ethical conduct.

As members of ATSA, a voluntary association whose members accept its ethical standards as part of their choice to affiliate, the membership has both expected duties to perform as well as rights to be protected. ATSA has the right to become involved in areas of concern to its members and the profession and an obligation to protect its members and the public. As a professional association, ATSA has a duty to inquire into the conduct of its membership.

Ethical principles reflect a code of behavior consistent with the performance of professional duties at the highest level of integrity, within a professional's areas of competence, and maintaining the best interests of their Client, the Client's victims, and the community at large. These principles are intended to complement ATSA's Standards and Guidelines and offer clarification regarding professional conduct, relationships and confidentiality.

1. DEFINITIONS

(a)**Client** - Any person who enters into a therapeutic or consulting relationship with a member for the purpose of receiving treatment or consulting services.

(b)**Professional Services** - Services that can only be performed by a member in the course of providing treatment or consulting services to a Client.

(c)**Professional Tasks** - Tasks that may be performed by, or under the supervision of, a member in the course of rendering treatment or consulting services to a Client.

(d)**Professional Relationship** - A therapeutic or consulting relationship that a Client has with a member, and persons under the member's supervision, in connection with the Client receiving treatment or consulting services.

(e)**Confidential Information** - Any information gained in a Professional Relationship on condition, whether express or implied, that the information shall be held inviolate or the disclosure of which would be embarrassing or would likely be detrimental to a Client, Client's family member(s), or research participant.

(f)**Confidential Relationship** - Any Professional Relationship in which a person entrusts information to a member under terms or circumstances where the member understands, or should understand, that the information in Confidential Information.

2. PROFESSIONAL CONDUCT

(a)Members will not allow personal feeling related to a Client's crimes or behavior to interfere with professional judgment and objectivity. When a therapist cannot offer the highest quality of professional service to a Client for any reason, he or she will make a proper referral.

(b)Members shall not engage in discrimination based on age, gender, race, ethnicity, national origin, religion, sexual orientation, political affiliation, social or economic status, disability, on any basis proscribed by law.

(c)Members shall not engage in conduct that demonstrates a lack of good moral character. Conduct reflecting upon a lack of moral character shall include acts or conduct that reflect moral turpitude or acts or conduct which would cause a reasonable person to have substantial doubts about the individual's honesty, fairness and respect for the rights of others and for the laws of the state and nation. The conduct or acts in question should be rationally connected to the member's fitness to provide Professional Services or Tasks.

(d)Members will not engage in behaviors that are harassing, exploitative or demeaning to persons with whom they interact as a part of their work.

(e)Members will not engage in sexual harassment. Sexual harassment is unlawful discrimination within a Professional Relationship on the basis of gender and includes

i)Unwelcome sexual advances, requests for sexual favors, or other conduct of a sexual nature when such conduct is directed toward an individual because of the individual's gender.

ii)Any unwelcome verbal or physical conduct that is sufficiently severe or pervasive to have the purpose or effect of unreasonably interfering with a Professional Relationship or creating a hostile, intimidating or offensive professional environment.

iii)The standard for determining whether harassment based on an individual's gender is sufficiently severe or pervasive to create a hostile, intimidating or offensive professional environment is whether a reasonable person in the circumstances of the complaining individual would so perceive it.

(f)No member shall have a felony conviction and no member shall engage in illegal behavior that rationally reflects adversely upon the member's fitness to provide Professional Services or Tasks.

(g)Each member is responsible for becoming fully aware of all statutes that pertain to the conduct of his or her professional practice.

(h)Members are responsible for familiarizing themselves with the ATSA Standards and Guidelines.

(i)ATSA recognizes that members must exercise their professional judgment when interpreting and applying the ATSA Guidelines (published in the ATSA Standards and Guidelines document) to their own work.

(j)Any deviation from the ATSA Standards (published in the ATSA Standards and Guidelines document) shall

be considered an ethical violation, except to the extent that a Standard conflicts with applicable law or professional regulations that pertain to a member's practice.

3. PAYMENT FOR SERVICES

(a) Other than customary fees, members will refrain from using Professional Relationships relating to the assessment or treatment of a Client, to further personal, religious, political or economic interests.

(b) Bartering for services can result in a multiple relationship and therefore is considered unethical. (See Section 8 for discussion of multiple relationships)

(c) If a Client does not pay for services as agreed and if the member wishes to use a collection agency to collect the fees, the member must first give written notice to the Client that a collection agency will be employed, but that the Client will first be allowed a reasonable opportunity to make prompt payment. The written notice shall specify a date by which the collection agency will be employed if prompt payment is not received. The member shall limit information provided to the collection agency only to that which is essential to recover the member's fees.

4. MEMBER'S TRAINING AND EXPERTISE

(a) Members have an obligation to engage in continuing education and professional growth activities on a regular basis to assure an awareness of advances in the field.

(b) Members will refrain from diagnosing, treating or giving advice about problems outside the recognized boundaries of his or her discipline or training.

(c) Members interested in developing new areas of competency shall attend a sufficient number of training sessions that address the newly adopted area of interest before offering or providing treatment or consultation services in that area. Members shall also seek and receive appropriate supervision as they begin to practice in a new area of competency.

5. PERSONAL PROBLEMS AND CONFLICTS

(a) Members recognize that their personal problems and conflicts may interfere with their effectiveness with Clients. In keeping with this awareness, they shall avoid undertaking an activity where it can be reasonably foreseen that such activity will result in harm to a Client, colleague, student, research participant, or other person to whom they owe a professional or scientific obligation.

(b) Members are obligated to be alert to signs that a personal difficulty will, or may, adversely impact their professional behavior and seek professional assistance to address this concern.

(c) In instances where personal difficulties impact professional behavior to a significant extent, members shall consider limiting, suspending, or terminating their work-related duties until these problems are resolved.

6. SUPERVISORY RELATIONSHIPS

(a) A Member shall only delegate responsibilities to people, such as employees, supervisees, and research assistants, who the member reasonably believes have the competency to perform the delegated Professional Tasks with the

supervision the member provides or arranges to provide. Such delegation shall be made based upon the training, education or experience of the person to whom a task is delegated. Consideration can also be given to the frequency, extent and duration of supervision being provided.

(b) A Member shall provide appropriate supervision to anyone whom the member delegates a professional task. The frequency, extent and duration of supervision shall be adequate to allow competent professional work.

(c) Supervision arrangements for trainees and research assistants shall be agreed upon in writing and shall specify: (1) expected supervisee duties; (2) the scope and focus of the supervision; and (3) the frequency and duration of meeting between the supervisee and the member to review the supervisee's professional performance.

(d) Members shall provide proper training and supervision to persons to whom they delegate Professional Tasks and take reasonable steps to see that such person perform services responsibly, completely, and ethically.

(e) Members shall not engage in sexual relationships with students, supervisees or others over whom the member has evaluative or direct authority, as such relationships are likely to impair judgment or be exploitative.

7. CLIENT RELATIONSHIPS

(a) A Member, while offering dignified and reasonable support to Clients, shall not exaggerate the efficacy of his or her services.

(b) Members shall address the following financial matters with Clients:

i) The member's fees for services shall be described to the Client either prior to or at the time of the initial appointment.

ii) Payment arrangements for fees shall be settled at the beginning of an assessment or a therapeutic relationship.

iii) If there is a change in fees, or if a service is to be provided for which the fees have not been discussed, the Client shall be informed of the change in fees prior to the provision of the service. In the case of emergency, the Client shall be informed of any fees as soon as is practical after the service is rendered.

iv) If the Client is a juvenile, the parent or legal guardian shall be informed of all fees in the manner outlined above. (c) Informed consent is an essential component of the provision of any professional service. At the time of the initial appointment, each Client (adult and juvenile) and the parent or guardian of a juvenile Client, shall be informed verbally or in writing of:

- The types of services proposed.
- Reasonable expectation of outcome.
- Alternatives to the type of services proposed.
- Potential benefits and risks involved in the services.
- The limits of privilege and confidentiality.

(d) Members shall engage in supervisory or peer-based consultation under circumstances where a reasonable practitioner would recognize that a Professional Relationship might be non-therapeutic for a Client.

(e) Sexual intimacy with Clients or former Clients is unethical. A member shall not engage in a sexual relationship with any Client who is receiving or has received Professional Services, regardless of whether payment for the services was involved.

(f) Sexual intimacy with a Client's, or former Client's, family members is also unethical. Such situations constitute multiple relationships and may compromise confidentiality.

(g) Members shall not withdraw services from a Client in a precipitous manner. When considering termination of services, each member shall give careful consideration to all factors involved in the situation and take care to minimize possible adverse effects on the Client.

(h) If a member anticipates the termination or disruption of services to a Client, he or she shall notify the Client promptly and, when possible, provide for transfer or referral to another service provider.

(i) Members who serve a Client of a colleague during a temporary absence or emergency will serve that Client with the same consideration afforded to their own Clients.

8. MULTIPLE RELATIONSHIPS

(a) Members will avoid engaging in multiple relationships with a Client.

i) A multiple relationship occurs whenever a member and a Client have a relationship with one another in one context (e.g., social or business relationships) that conflicts with and/or compromises the primary Professional Relationship.

ii) Multiple relationships may impair professional judgment and pose a significant risk for Client exploitation.

iii) It may not be possible or reasonable for a member to avoid other nonprofessional contact with Clients. Any foreseeable non-professional contact with a Client shall take place only after all other possible options are exhausted.

(b) A member shall refrain from accepting professional or scientific obligations when any pre-existing relationship may foreseeably impair the member's professional judgment or create a risk of harm.

(c) If a potentially harmful multiple relationship develops, due to unforeseen circumstances, the member shall attempt to resolve it as quickly as possible, with due regard for the best interest of Clients, supervisees, and other persons relying upon the member in his or her professional capacity, and in keeping with the ATSA Code of Ethics.

9. CONFIDENTIALITY

(a) Members are responsible for insuring that Clients, consultation parties, family members, research participants, organizations/agencies, and all other work related Clients fully understand issues related to confidentiality. This includes, but is not limited to:

- i)informing Clients of the limits of confidentiality;
- ii)informing Clients of any circumstances that may cause an exception to the agreed upon confidentiality;
- iii)specifically informing Clients about mandatory reporting requirements; and
- iv)clarifying issues of confidentiality where multiple parties are involved.

(b)Members shall clarify issues of confidentiality in cases involving minors in a manner that the minor Client is capable of understanding with respect to requirements for sharing information with parents, guardians, and/or agencies that may have custody of the minor.

(c)When a member agrees to provide service to several persons who have a relationship (such as husband and wife or family), the member shall clarify at the outset how confidentiality will apply among participants and to any external party (e.g., criminal justice agency).

(d)Members shall comply with mandated reporting laws and statutes. No part of this ethical code shall be construed as releasing members from such obligations. If the circumstances allow, members shall inform Clients that they will comply with mandated reporting requirements.

(e)Members shall ensure that a Client is informed when an individual under the member's supervision is providing services to the Client, such that the Client is informed of the name of the member or members who are responsible for providing supervision and how this impacts confidentiality.

(f)In instances where persons are legally incapable of giving informed consent, members must obtain written informed consent from a legally authorized person or agency for providing services, for participation in research and in video-taping for educational purposes.

(g)When working with Clients incapable of giving informed consent, including minors, the member is still responsible to (1) inform those Clients about any proposed assessments an/or interventions in a manner commensurate with the persons' psychological or developmental capabilities, (2) seek their help and participation in such interventions, and (3) consider such persons' preferences and best interest.

(h)Live demonstrations of treatment techniques with current or former Clients or their family members is considered exploitative and compromises confidentiality beyond what can be justified relative to educational benefits.

(i)Unless reporting is mandated, written permission shall be required before any data may be divulged to persons beyond a member's staff. The Client shall be informed of the reason for the release of information.

(j)Client information is not communicated to others without the written and informed consent of the Client, unless the following circumstances apply:

- The Client presents a clear and immediate danger to another individual or individuals.
- The Client presents a clear and immediate danger to him/herself.

•There is an obligation to comply with specific governmental statutes or regulations requiring reporting to authorities. (k)When consulting with colleagues, a member shall not share Confidential Information that might

reasonably lead to the identification of a Client, research participant, or other person or organization with whom the member has a Confidential Relationship unless the member first obtained prior written and informed consent to do so, or if the disclosure cannot be avoided. If disclosure cannot be avoided in the course of a professional consultation, then the only information disclosed shall be limited to that which is necessary to achieve the purpose of the consultation.

(l) While providing training or workshops, a member shall not share Confidential Information that might reasonably lead to the identification of a Client, research participant or other person or organization with whom the member has a Confidential Relationship.

(m) When utilizing audio tape and/or video tape information in the context of training, workshops or research studies, members shall protect the confidentiality of participants. Such tapes shall be used only with the written and informed consent of all individuals portrayed on the tapes for that particular use (i.e., training/workshops, research studies).

(n) A Member providing services within criminal justice settings shall inform all parties (including the Client) of the level of confidentiality that applies.

10. PROFESSIONAL RELATIONSHIPS

(a) Members will refrain from knowingly offering services to a Client who is in treatment with another professional without consultation between the professionals involved.

(b) At the time of the initial appointment, a Client shall be asked to provide information about treatment received from other service providers and a release of information shall be required in order to consult with that service provider. If the Client refuses to comply, the member shall discontinue the therapeutic relationship.

(c) If, after involving a Client in therapy, a member discovers that the Client was in treatment with another service provider, the release of information shall be signed immediately and consultation with the other service provider shall occur in a timely fashion.

(d) In cases where a member agrees to provide services to a person, agency or organization at the request of a third party, the member shall clarify at the outset of the service, the nature of the relationship with each party, including the role of the member, the potential use of the services to be provided and any information obtained, as well as any limits to confidentiality.

(e) A member shall not accept or continue employment if the exercise of the member's professional judgment on behalf of the member's Client will be, or reasonably may be, affected by

i) the member's own financial business, property, or personal interests;

ii) the member's treatment of another or existing Client; or

iii) any commitment or relationship the member has, or may have, with any third party or entity.

(f) A member will neither offer nor accept payments for referrals.

11. RESEARCH AND PUBLICATIONS

(a) Members shall plan and conduct research in a manner consistent with applicable federal, state and provincial laws and regulations, as well as professional standards governing the conduct of research. For example, US members shall comply with the U.S. Department of Health and Human Services' regulations for the protection of human subjects.

(b) The practice of informed consent applies to all research projects.

(c) The research participant shall have full freedom to decline to participate in or withdraw from research at any time without any prejudicial consequences.

(d) The research subject shall be protected from physical and mental discomfort to the greatest degree possible.

(e) Publication credit is assigned to those who have contributed to a publication in proportion to their contribution and in accordance with customary publication practices.

12. PUBLIC INFORMATION AND ADVERTISING

(a) All professional presentations shall be based upon accurate information and, whenever possible, supported by scientific literature.

(b) Information that appears in advertising shall include:

i) Office or agency identifiers (name, group name, names of professional associates, address, telephone and fax number, e-mail address second languages, office hours).

ii) Professional degrees, state licensure and/or professional certification.

iii) Specific experience and training in their specialization and services offered.

iv) Fee information, including methods of payment accepted.

(c) Members shall refrain from public presentations and/or advertising that produce unrealistic expectations, bring about a lack of confidence in the profession or are harmful to the community.

(d) Members shall refrain from the use of a name or credential that could mislead referral sources or the public.

(e) A member must indicate any limitations in his or her practice, including any requirements for the member's supervision.

(f) A member shall not represent his or her affiliation with any organization or agency in a manner that falsely implies sponsorship or certification by that organization.

Rules and Procedures

Proceedings Relating to Unethical Conduct

Ultimately, Complaints regarding members' conduct under the Code of Ethics for the Association for the Treatment of Sexual Abusers (ATSA) are measured against the privilege of continued membership in ATSA.

Membership is conditioned, in part, on members' assent to ATSA's rules and regulations. ATSA members indicate their consent to be governed by the *Code of Ethics*, as well as the obligatory items covered in the ATSA Standards and Guidelines when they sign the membership application.

ATSA requires its members to exhaust their remedies within the organization before resorting to a court for review. An Ethics decision by the Board is considered to be final and binding upon the parties, with the exception that a court of competent jurisdiction may review an Ethics decision by the Board for procedural compliance with these rules and procedures. A court will not retry the matter by instituting a new fact-finding effort, nor will it substitute itself for ATSA's Ethics Committee or Board of Directors in the interpretation of ATSA's Code of Ethics. **Ethical Conduct**

ATSA's Code of Ethics is reviewed, revised, and amended on a periodic basis to respond to changing needs and developments in the field of sexual abuse. As a condition of ATSA membership, members are bound to uphold the Code of Ethics in all respects of professional practice. ATSA has established procedures to interpret the meaning of its Code of Ethics to the community and practitioners, to protect its members from irresponsible accusations of unethical behavior, and to discipline members who violate the Code based on objective evidence weighed judiciously by peers. These procedures serve a concomitant purpose for ATSA providing the machinery for unifying concepts of professional values through the examination of specific behavior in professional practice. Moreover, in a time when professions generally are under public scrutiny, it is increasingly important that members be held to high standards of professional conduct.

Rules and Procedures

1. DEFINITIONS

(a) "**Committee**" shall mean the Ethics Committee.

(b) "**Board**" shall mean ATSA's Board of Directors.

(c) "**Code of Ethics**" shall mean ATSA's Code of Ethics.

(d) "**Complaint**" shall mean an ethics complaint.

(e) "**Complainant**" shall mean the person who files a Complaint.

(f) "**Subject Member**" shall mean the person who is the subject of a Complaint. The person may be a current or prior member. **2. PURPOSE AND RESPONSIBILITY OF THE ETHICS COMMITTEE**

(a) **Maintain Standards.** The objectives of the Ethics Committee shall be to promote ethical conduct by ATSA members at the highest professional level.

(b) General Operating Rules and Nature of Authority

i) **Power to Investigate.** The Committee has the power to investigate allegations of unethical scientific and professional conduct that may be in violation of the Code of Ethics.

ii) Failure to Follow these Rules and Procedures. Failure to follow these Rules and Procedures by the Committee is not a reason to set aside any action taken by the committee, unless the failure resulted in demonstrable prejudice to the Complainant or the Subject Member.

iii) Relationship to ATSA Board of Directors. The Committee is responsible to the Board. Decisions of the Committee may be superseded by the Board.

iv) Committee Membership. The Committee shall consist of ATSA members appointed by the ATSA President subject to the approval of the Board

v) Chair. The Chair is to be appointed as a member of the Committee by the ATSA President from among the Board members with the approval of the Board.

vi) Frequency of Meetings and Quorum. The Committee shall meet at reasonable intervals as needed. A quorum shall consist of a majority of the appointed members of the Committee, including the Chair.

vii) Relationship to ATSA Board of Directors. The Chair of the Committee shall make regular reports of Committee activity to the Board.

viii) Jurisdiction over Individuals. The Committee has jurisdiction only over ATSA members.

ix) Litigation. Civil, administrative, or criminal litigation pending against members shall not bar the consideration of Complaints by the Committee. It shall be within the sole discretion of the Committee whether to proceed during the course of litigation or wait until its completion. At the Committee's discretion, investigations by the Committee may be deferred when another body, such as a state licensing board, is involved in the matter. Delay in conducting the investigation by the Committee during pending litigation shall not constitute a waiver of jurisdiction by the Committee.

x) Confidential Sessions. Committee deliberations are confidential and any attendance beyond the Committee's membership shall be at the Committee's discretion. The deliberations of the Committee are considered to be peer review functions by a professional Association.

3. PROCEDURAL STEPS INVOLVED IN FILING AN ETHICAL COMPLAINT AND INVESTIGATION BY THE COMMITTEE

(a) **Submitting A Complaint Alleging Violations of the Code of Ethics.** Complaints may only be submitted by ATSA members or by a Special Advocate (as described in Section 11) regarding other ATSA members. A Complaint must contain a precise description of the behavior constituting the alleged ethics violation, including the specific sections(s) of the Code of Ethics that the Subject Member is alleged to have violated. The Complaint's allegation must cover conduct during the period of time the Subject Member was an ATSA member, but in no event shall the Complaint cover violations alleged to have occurred more than one year prior to the Complaint being received by the ATSA Executive Director's office. This description shall include the name of the Subject Member as well as any other individual(s) who may have witnessed the behavior, been involved in the behavior or to whom the behavior was directed. The only exception to this rule is that the Complainant may choose not to divulge the name(s) of a Client if doing so will violate Client confidentiality. All Complaints shall be submitted in writing to the attention of the "ATSA Ethics Committee Chair" and delivered to the ATSA business office.

(b) Determining Subject Member Membership Status & Acknowledging the Complaint. “Upon receiving the complaint, the ATSA Executive Director will determine

i) if the Complainant is a current ATSA member as of the date the Complaint is received by the Executive Director’s office;

ii) whether the Subject Member was an ATSA member during the time the ethics violations are alleged to have occurred in the Complaint; and

iii) whether the ethics violation is alleged to have occurred within one year prior to the date the Executive Director’s office received the Complaint.

If the Executive Director determines that the Complaint satisfies the membership and time limitation requirements, then the Executive Director will notify the Complainant in writing that the Complaint has been referred to the Committee. If the Executive Director determines that the membership and time limitation requirements have not been met, then the Executive Director will send written notification to the Complainant that ATSA cannot take any action on the Complaint, giving the reasons why.

The Executive Director’s determinations as to the membership and time limitation requirements shall not be final, and are subject to review by the Committee and the Board. If the Complainant or Subject Member disagree with any of the Executive Director’s determinations as to membership or time, they may request a review by the committee. The Committee’s determination shall only be subject to review by the Board.

In any case, within 10 business days from the date the Executive Director’s office receives the Complaint, it will provide the Complainant with written acknowledgment of its receipt of the Complaint, which will include the date it received the Complaint. **(c) Subject Member Request for Reply.** The Committee Chair shall send the Subject Member a copy of the complaint within 10 business days after the Executive Director’s office sends the acknowledgment of the complaint to the Complainant. The Complaint will be accompanied by a copy of the Code of Ethics, including these rules and procedures and a letter requesting the Subject Member to provide the Chair with a response within twenty-one (21) days of the date on the letter. Failure by the Subject Member to file a timely response is grounds for suspension and possible dismissal from ATSA.

(d) Lack of Cooperation. Failure or delay in responding, or lack of cooperation in the investigation shall not prevent continuation of any proceedings and in itself may constitute a violation of the Code of Ethics or these rules and procedures.

(e) Action of the Committee. Within a reasonable time, the Chair shall provide Committee members with copies of the Complaint, as well as a copy of the Subject Member’s response. The committee may determine that additional information is required from the Complainant, the Subject Member, and/or a third party that may have pertinent information. Based upon the type of information required, the Committee will make a written request of the individual or individuals it deems to have relevant information to respond within a particular period of time. Failure of a member to respond to the Committee is grounds for suspension and possible dismissal from ATSA. Once the Committee determines that it has sufficient information, it will deliberate and render a recommendation to the board regarding the allegations in the Complaint. Such a recommendation shall be agreed upon by a majority vote of the Committee’s members.

(f) Case Closure. After the receipt of a written response from the Subject Member, the Committee may determine that the complaint has no basis in fact, or is insignificant, and may dismiss the complaint without further action. **(g) Information from Other Sources.** The committee may request additional information from persons

or witnesses involved, including Boards, Committees, or Ethics Committees or professional licensing boards or other relevant entities.

(h)Action of the ATSA Board of Directors. The Committee Chair shall present the recommendations of the Committee to the Board during the next regularly scheduled Board meeting after the Committee has agreed upon a recommendation. Final decision by the board regarding disposition of the Complaint shall be determined through discussion and a formal resolution by the Board. The resolution shall describe the sanctions, if any, to be imposed against the Subject Member. The board's action shall not be subject to review by any court of law or other forum, except for procedural compliance with these rules.

(i)Notification of Parties Involved. The ATSA office staff, in coordination with the Chair of the Committee, will notify the Complainant and Subject Member regarding the Board's final resolution.

(j)Monitoring of Sanctions. The Chair of the Committee will coordinate and monitor any sanctions that are decided upon by the Board.

(k)Notification of ATSA Members. If the Board finds that the Subject Member violated the code of Ethics, it shall publish in the next scheduled issue of the ATSA newsletter the Subject Member's name; the circumstances of the violation; the Code of Ethics section(s) violated; the corrective action, directive and/or sanction(s) imposed; and the status of the Subject Member's ATSA membership.

(l)Waive Right to Subpoena. Membership in ATSA constitutes a member's agreement to waive any right to subpoena from ATSA, its officers, directors, and other members, any documents or information in connection with a Complaint, including Committee investigations and recommendations and Board materials, for any purpose, including private civil litigation. **4. CONFIDENTIALITY**

(a)Correspondence. All case material mailed from the ATSA office relating to a specific Complaint shall be designated as confidential both on the envelope and on the face of the material enclosed.

(b)Disclosure of Information During Investigations. All information concerning Complaints against members shall be confidential except that the Committee may disclose such information when compelled under a validly issued subpoena or court order or when otherwise required by law. The Committee in its sole discretion may divulge such information as it deems necessary to complete its investigation.

(c)Disclosure of Information in Cases Closed by the Committee. If the Committee dismisses a Complaint without further action, it shall so notify the Complainant and the Subject Member in writing of its Action. The Committee's action shall be final and binding upon the parties and shall not be subject to review by any court of law or other forum, except for procedural compliance with these rules.

(d)Disclosure of Corrective Action, Directives and/or Sanctions. If the disposition of a case results in a corrective action, directive, and/or sanction, a description of the corrective action, directive and/or sanction can be released to any individual upon that individual's written request. ATSA will respond to the written request by providing the name of the Subject Member, the Code of Ethics sections violated, and the corrective action, directive and/or sanctions imposed against the Subject Member. **(e)Requirement of Confidentiality.** Except as otherwise provided within these rules and procedures, all information concerning Complaints against members shall be confidential. Notwithstanding the confidential nature of Complaint materials, such information may be released when the Chair and the Board in their discretion agree that the release of that information is necessary to protect the interests of: a) the Complainant or Subject Member; b) other investigative bodies; c) ATSA; d) the

public; or e) a Client, and that the release will not unduly interfere with ATSA's interest in respecting the legitimate confidentiality interests of participants in the ethics review process, the interests of Clients, and ATSA's interest in safeguarding the confidentiality of internal peer review deliberation.

(f)**Communication for Investigation.** Nothing in this section shall be construed as preventing the Committee from communicating with the Complainant, witnesses, potential member of other fact-finding committees, or other sources of information necessary to enable the Committee to carry out its investigative function.

5. RECORDS

(a)**Confidential Permanent Files.** Permanent files of the Committee shall be confidential according to these rules and procedures. The files shall be maintained at the main ATSA office, and shall be available only to those specifically authorized by the Committee. These records are the property of ATSA.

(b)**Files for Loss of Membership.** Files of individuals whose membership has been terminated because of an ethical violation shall be maintained for five years.

(c)**Files for Non-Violation.** Except for cases closed for insufficient evidence, personally identifiable information concerning Subject Members who have been found not to have committed an ethical violation shall be destroyed five years after the Committee has closed the case. (d)**Files for Insufficient Information.** In cases where the Committee has closed a case due to evidence insufficient to sustain a Complaint, records containing personally identifiable information shall be maintained for five years after the Committee has closed the case.

(e)**Files for Lesser Sanctions.** In cases where the Committee has found an ethical violation but where the sanction is less than termination of membership, records containing personally identifiable information shall be maintained for five years after the Committee has closed the case.

(f)**Records for Educational Purposes.** Nothing in this section shall preclude the Committee from maintaining records in a form that prevents identification of the parties involved so that the records may be used for remediation, education, or other legitimate purposes.

6. RECOMMENDATION DEVELOPMENT

(a)**Focus of Recommendations.** Since the purpose for investigation Complaints is to improve the profession and instill confidence from the community, any corrective action, directive and/or sanction recommended by the Committee and resolved by the Board shall be fashioned with an aim to instruct whenever possible.

(b)**Form of Recommendations.** The Committee has the latitude to suggest a broad array of corrective actions, directives, and/or sanctions. Its final written recommendations shall, however, include: (1) a synopsis of its findings regarding each of the alleged Code of Ethics violations; (2) details describing its rationale for the conclusions drawn; (3) specific corrective actions, directives, and/or sanctions to be imposed upon the Subject Member; (4) the impact of these recommendations on current and future membership in ATSA; and (5) a specific time-frame for any recommended corrective actions, directive and/or sanction. (c)**Sanctions for Non-Compliance With Requests for Information from Members Pertaining to An Ongoing Investigation of an Ethical Violation.** The Committee may immediately impose temporary suspension of membership privileges for any member who does not fully comply with informational or investigatory requests from the Committee. Other sanctions may be considered with consultation from the ATSA Executive Committee or the Board. Membership will be fully reinstated upon compliance with Committee's requests. Reinstatement will include, but is not limited to, the for-

warding of back issues of the Journal and newsletter.

(d)**Sanctions for Non-Compliance With Approved Final Recommendations.** The Committee may recommend additional and more severe consequences for members who do not comply with corrective actions, directives, and/or sanctions approved by the Board as a result of findings of ethical violations.

7. TYPES OF RECOMMENDATIONS FOR SANCTIONS, CORRECTIVE ACTIONS AND DIRECTIVES

(a)**Cease and Desist Order.** This directive requires the member to cease and desist specified unethical behaviors.

(b)**Education, Training, or Tutorial Requirement.** This corrective action requires that the member engage in education, training, or tutorials specified and approved by the Committee.

(c)**Supervision or Clinical Consultation Requirement.** This corrective action requires that the member engage in supervision or clinical consultation by a supervisor or consultant recommended and approved by the Committee. The Committee may stipulate the type, frequency, duration, goals, and content of the supervision or consultation.

(d)**Reprimand.** This sanction requires that a written statement of censure for unethical or unprofessional behavior be sent to the Subject Member clarifying the inappropriate nature of the Subject Member's conduct.

(e)**Evaluation and/or Treatment.** This directive requires that the Subject Member be evaluated to determine the possible need for treatment and/or, if a dysfunction has been established, to obtain remedial treatment approved by the Committee and the Board.

(f)**Suspension.** Suspension is an immediate change in status that ends membership until a specified period of time elapses or until the Board allows reinstatement.

(g)**Termination.** Termination constitutes expulsion from current and future membership on a permanent basis (usually the result of a particularly egregious ethical violation and/or non-cooperation in the Committee's investigation).

8. MEMBERSHIP

(a)**Application for Membership.** The Chair of the Committee shall review applications for membership. After such review, the Chair may recommend to the Board through the Membership Committee that an application for a membership be denied or voided because of past or current ethical violations.

(b)**Voided Membership.** The Committee may recommend to the Board that it void the membership of any person who obtained membership on the basis of false or fraudulent information.

(c)**The Effect of Resignation.** A Subject Member's resignation shall have no effect upon the investigation and resolution of a Complaint, so long as the Code of Ethics violation(s) alleged in the complaint took place during the term of the Subject Member's membership with ATSA.

(d)**Application for Readmission.** The Committee shall automatically review all applications for readmission received by the Membership Committee from persons who have been expelled or suspended from membership.

(e)**Procedures for Readmission.** The Chair of the Committee shall submit to the Committee for consideration a summary of the application for readmission, including copies of any statements submitted by sponsors of the application and any available record of the previous case against the former member. The Committee shall make one of the following recommendations to the Membership Committee:

- **Readmission.** Recommend to the Membership Committee that the former member be readmitted;
- **Denied Readmission.** Recommend to the Membership Committee that readmission be denied; or
- **Deferred Decision.** Recommend to the Membership Committee is deferred pending the results of further investigation.

9. PROCEDURES FOR COMMENCING AN INVESTIGATION ON THE COMMITTEE'S OWN MOTION

The committee, on its own motion or by referral to the Special Advocate, may commence an investigation according to these rules and procedures under the following circumstances:

(a)**Felony or Other Illegal Offense.** When the Committee learns that a member has been convicted of a felony or other illegal behavior that rationally reflects adversely upon the Subject Member's fitness to provide Professional Services or Tasks and the Committee determines that an investigation is necessary for protection of the public or the profession, and such felony conviction is not under appeal.

(b)**Expulsion, Suspension, Delicensure, or Decertification.** When the Committee learns that a member has been expelled or suspended from a state, regional, or national psychological association, or delicensed or decertified, or had a certificate or license revoked or suspended by a State or Local Board, and the action is not under appeal.

(c)**Public Information.** When the Committee learns of publicly available information indicating unethical conduct and the Committee determines that commencing an investigation is necessary for the protection of the public or the profession.

(d)**Multiple Complaints.** The committee may take into consideration previous Complaints, regardless of outcome, and may elect to commence an investigation under these rules and procedures if the committee determines that there has been a pattern of ethically questionable behavior.

(e)**Notice to the Subject Member.** The committee shall provide notice to the Subject Member that it has commenced an investigation on its own motion with the same specificity required as if a Complaint were filed, and the Subject Member shall have the same time period to respond as if responding to a Complaint.

10. GENERAL CONSIDERATIONS

(a)**Time Requirements.** Any failure to adhere to the time requirements specified in these rules and procedures shall not prevent an investigation from proceeding to final resolution by the Board unless the Committee of the Subject Member can show that such failure was willful or prejudicial.

(b)**Clarification by the Committee on Client Responsibility.** If the Subject Member believes there is a conflict between responsibility to Clients and the Committee's request for information, the Subject Member may seek

advice from the Committee to resolve the conflict.

(c)**Release of Information.** The Complainant, upon submitting a Complaint, is deemed to have consented that the complaint and all associated materials submitted with the Complaint will be provided to the Subject Member and to other people, as provided in these rules and procedures.

(d)**Telephone Inquiries about Potential Complaints.** Telephone inquiries shall not be considered as Complaints.

(e)**Previous Remedy.** The Complainant may be required to inform the Committee of previous steps, if any, that have been taken to remedy the situation.

11. SPECIAL ADVOCATE

(a)**Situations Requiring Special Advocates.** Ideally, complaints against ATSA members are filed by ATSA members who are personally affected by or who have first-hand knowledge of the alleged misconduct. However, in some instances, violations of the Code of Ethics may come to the attention of members of the Committee indirectly through the media, from second hand communication with other individuals, or from a member who is not willing to follow through with filing a Complaint. In such cases, the need for ATSA to respond is no less critical. A surrogate Complainant or “Special Advocate,” can serve as a substitute for a Complainant.

(b)**Appointing Special Advocates.** A special advocate can be any ATSA member appointed by the Chair of the committee. Appointments shall be in writing and shall include a copy of the Code of Ethics and sufficient information for the Special Advocate to consider drafting a formal Complaint.

(c)**Role of the Special Advocate.** The role of the special advocate is to review existing information and seek additional materials sufficient to write a formal Complaint to the Committee against the member identified in the letter from the Chair of the Committee. The Special Advocate may also be called upon to participate in the Committee’s investigation as the investigatory process continues. In an instance where the Special Advocate feels that sufficient information is not available to write a formal Complaint, he/she shall first consult with the Committee Chair in an attempt to clarify what information is missing. If this does not provide resolution, the Special Advocate shall indicate his/her inability to proceed in the form of a letter to the Chair of the Committee. The Committee may then choose to drop the case or appoint a successor Special Advocate to review the matter.

(d)**Conflict of Interest.** The initial appointment letter shall be preceded by a telephone conversation with the potential Special Advocate to ensure that there is no conflict of interest or appearance of conflict. Conflicts may include professional or personal relationships. A Special Advocate can, at any time, declare a conflict of interest. For example, as the Special Advocate obtains additional information regarding the case, he/she may discover that the Advocate’s relationship with a third party involved in the case may cause a conflict. Special Advocates shall be warned of this potential problem when they are appointed. Questions of a potential conflict shall be addressed by the Chair of the Committee and copied to the ATSA Board President.

(e)**Submitting a Complaint.** The steps required and the form of the Complaint filed by the Special Advocate are identical to Complaints filed by any other member. Details are provided in Section 3 of these rules and procedures.

12. EVALUATION OF COMPLAINTS

(a)**Evaluation by the Committee.** The Committee shall review each completed Complaint and take action as outlined in these Rules and Procedures.

- (b)**Immediate Referral.** The Committee may immediately refer the matter to the appropriate professional licensing board for action prior to action by the Committee.
- (c)**Impaired Members.** The Committee Chair may determine that the alleged violation may have resulted from a member's substance abuse, mental and/or emotional problems. Such a determination will not preclude the Committee from proceeding with the process outlined in these rules and procedures and may, in fact, form the basis of the Committee's recommendations to the Board. (d)**Violations with Potential for Harm to Public.** If the Committee determines that the alleged violation has potential for harm to the public, the Chair shall immediately consult with ATSA's legal counsel, who may recommend that the case be referred to the appropriate jurisdiction of law enforcement.
- (e)**Conflict of Interest.** The Committee must first determine that there is no conflict of interest precluding the Committee from proceeding with the complaint (e.g., Complaints against ATSA officers Committee member, ATSA Board members, etc.). If a conflict of interest is deemed present, the Committee Chair shall immediately notify ATSA's President and the ATSA Executive Director. If the Complaint involves either the President or the Executive Director, the Committee Chair shall notify the other individual and the ATSA Past President. If the conflict involves the Chair of the Committee, the President shall appoint another member of the Board, subject to the Board's approval, to chair Committee matters involving this Complaint. If the conflict involves any member of the Committee, that member shall recuse him/herself from Committee discussions and decisions pertaining to the case. If the conflict involves an ATSA Board member, that member shall not participate in discussions or decisions regarding the case. In all other situations where there is a conflict of interest, the ATSA President and the Committee Chair shall take such action as deemed prudent to resolve the conflict.
- (f)**Request for Further Information.** If the Committee determines that there is insufficient information from which to make a recommendation to the Board, the Committee may request further information from the Complainant or others. If a request is made to the Complainant, the Complainant shall have twenty-one (21) days to respond. Failure to respond to this request may result in a recommendation by the Committee to dismiss the Complaint for lack of evidence. Continued refusal by a member to provide the Committee with information within that member's control may constitute grounds for an ethics violation and can result in discipline including dismissal from ATSA. (g)**Multiple-Category Complaints.** A single Complaint may include allegations about individual ethics violations and violations of the obligatory sections of the ATSA Standards and Guidelines.
- (h)**Anonymous Complaints.** The Committee shall not act upon anonymous complaints except when information in the public domain is of sufficient weight that the Committee determines there is adequate cause to refer the matter to a Special Advocate.
- (i)**Complaints about Non-Members.** Complaints about non-members will not be considered.
- (j)**Counter Complaints.** The Committee will not accept formal Complaints from a Subject Member against a Complainant member during the course of an investigation or the initial Complaint. Rather, the Committee shall indicate that all sides of the matter leading to the Complaint will be considered and that a countercharge will not be considered until after the initial Complaint is resolved.
- (k)**Capricious Complaints.** The Committee may recommend that a Complaint be filed against a Complainant if the Committee determines that the initial Complaint is capricious or intended primarily to harm the Subject Member rather than to uphold professional standards.

13. LEGAL REPRESENTATION

(a)**Involvement of Legal Representation.** The ATSA investigation procedures do not allow for “legal representation” of a Subject Member before the Committee or the Board in the investigation process or with respect to any deliberations. ATSA’s rationale for precluding active participation by attorneys in this process is that an ethics investigation is a peer review and the members of ATSA are best able to conduct the professional review process.

(b)**Communications.** Attorneys may be present to serve as advisors to a Complainant, Subject Member or witness only if they are ATSA members and are present solely in a membership capacity. In furtherance of the policy of peer review, ATSA Board members and Committee Members shall communicate solely with Complainants, Subject Members and witnesses on substantive matters rather than with attorneys or advisors. Responses to general inquiries or procedural questions may be permissible exceptions. Exceptions shall be considered on a case-by-case basis.

(c)**ATSA’s Access to Legal Counsel.** ATSA, including the Committee and the Board, will retain the right to consult with its own attorney at any point in this process.

Appendix D: Sex Offender Management Board Administrative Policies

ILLINOIS SEX OFFENDER PROVIDER CERTIFICATION ACT

1) Declaration of Public Policy

No person shall engage in the evaluation, treatment, polygraph examination, and/or plethysmograph examination of sex offenders as defined by the Illinois Sex Offender Management Board Act [20 ILCS 4026/1 et. seq.] unless they are on the Certified Provider List of the Illinois Sex Offender Management Board. In order to qualify for placement on the Certified Provider List, a person must meet the certification requirements contained in the Illinois Sex Offender Management Board's Standards.

An applicant shall be allowed a one time waiver of the standards regarding the requirement of licensure or certification for treatment providers and evaluators until three years from the effective date of the standards. All applicants who have received the waiver must go through the application process for continued placement on the Certified Provider List.

An applicant shall be allowed a one time waiver of the standards regarding the minimum number of criminal and sex offender specific examinations required for a full operating level polygraph examiner until three years from the effective date of the standards. All applicants who have received the waiver must go through the application process for continued placement as a full operating level polygraph examiner.

Any procedure under this act shall be in accordance with the Standards of the Illinois Sex Offender Management Board.

2) Administrative Procedure

The procedures governing hearings authorized by this Act shall be in accordance with the Illinois Administration Procedure Act [5 ILCS 100/1-1 et seq.] which is expressly adopted and incorporated herein as if all of the provisions of such Act were included in this Act, except that in the case of a conflict between the two Acts the provisions of this Act shall control.

3) Application

An application for placement on the Certified Provider List shall be made in writing to the Illinois Sex Offender Management Board Application Review Committee.

Upon receipt of the application, the Board's Application Review Committee shall review the application and shall make a recommendation as to whether the applicant will be granted placement on the certified provider list.

In assessing references for applicants for placement on the Provider List provided to and solicited by the Sex Offender Management Board, the Application Review Committee shall weigh many factors, including the following:

- The evidence of compliance or lack thereof with the standards;
- References for the applicant and the degree to which there is a difference of opinion among references;

- Apparent reasons for differences of opinion;
- How recently the reference has had contact with the applicant and the extent of contact with the applicant;
- Whether the reference has had direct contact with the applicant or is reporting third hand information;
- Whether the applicant has recently changed a particular practice to conform with the standards and guidelines;
- The motivation of the reference.

Any applicant who is denied placement on the Provider List will be supplied with a letter from the Board outlining the reasons for the denial and notifying them of their right to an appeal.

Any provider who is denied placement on or removed from the Provider List shall not provide any services to convicted adult sex offenders in Illinois without written permission from the Board.

No listed provider shall use any provider denied placement on or removed from the Certified Provider List to provide any services to convicted adult sex offenders in Illinois without written permission from the Board.

Any applicant who is denied placement on the Provider List by the Application Review Committee may appeal the decision to the full Board. Appeals will be conducted in the following manner:

- The applicant must submit an appeal in written form within 30 days after receiving notification of the denial of placement on the Provider List.
- The applicant may request either a hearing or a conference call with the Board in addition to the submission of the written appeal. The request must be made in writing at the time the written appeal is submitted.
- The Board will consider appeals in open hearing and audio record the proceedings for the record.
- The applicant will be notified in writing of the Board's decision regarding the appeal.

4) Complaints

When a complaint is made to the Sex Offender Management Board about a treatment provider, evaluator, plethysmograph examiner or polygraph examiner, the complaint shall be made in writing to the Board.

Complaints appropriate for Sex Offender Management Board intervention are those complaints against sex offender treatment providers, evaluators, plethysmograph examiners and clinical polygraph examiners who are listed on the Certified Provider List when the complainant alleges that the standards developed by the Sex Offender Management Board have been violated. These complaints will be addressed in the following manner:

- The Application Review Committee in conjunction with the vice chair of the Board, or other Board member identified by the chair, will have the responsibility for reviewing and responding to complaints.
- When the vice chair and the Application Review Committee determine that a complaint is appropriate for Sex Offender Management Board intervention the complainant will be notified in writing that their complaint has been received and the identified provider will be notified that a complaint against them has been received.

- As a part of the investigation of the complaint the Board may:
 - (a) Request more information from the complainant;
 - (b) Request a response from the identified provider;
 - (c) Indicate and carry out or cause to be carried out an investigation of the complaint either directly or through staff, investigators, or consultants; or
 - (d) Hold a hearing before the committee requesting both parties to appear.

The committee will consider complaints in executive session.

The following are possible findings and actions by the Sex Offender Management Board regarding complaints:

- Dismissal of the complaint, identifying it as unfounded and taking no action.
- Finding a complaint valid and placing a letter of admonition in the provider's file. The Board may recommend changes in the provider's services or additional training or supervision. The letter of admonition and the provider's response to the Board's suggestions will be taken into consideration when the provider is reviewed for placement on the Provider List.
- Finding a complaint valid and removing a provider from the Provider List. In these cases, referral sources will be notified of the provider's removal from the Provider List.
- Written notice of the Committee's findings and the reasons for those findings will be provided to the complainant and the identified provider along with a notice of the right to file a written appeal within 30 days.
- Any complaint or identified provider who wishes to appeal a finding on a complaint may appeal the decision to the full Board. Appeals regarding findings on complaints will be conducted in the following manner:
 1. The applicant must submit their appeal in writing within 30 days after receiving notification of the finding of the Board.
 2. The Board will consider only information that addresses the reasons for the finding outlined by the Board in their letter.
 3. Either the party requesting the appeal or the other party may request either a hearing with the Board or a conference call with a group of Board Members identified by the Board as part of their appeal. The request must be made in writing at the time of the appeal. Hearings or conference calls will be scheduled in conjunction with regular Board meetings. Either party may bring one representative with them. Hearings or calls will be 45 minutes long; 15 minutes for a verbal presentation by each party and 15 minutes for questions from the Board.
 4. The Board will consider appeals in open hearing and audio record the proceedings for the record.
 5. The Board will notify both parties of its decision in writing.

F) In the event that the Board denies the appeal, this decision may be judicially reviewed. The provisions of the Administrative Review Law [735 ILCS 5/3-101 et. seq.] and the rules adopted pursuant thereto shall apply to and govern all proceedings for the judicial review of administrative decisions of the Department hereunder. The term “administrative decisions” is defined as in Section 3-101 of the Code of Civil Procedure [735 ILCS 5/3-101].

Appendix E: The Role of Victims/Survivor in Sex Offender Evaluation, and Treatment

The Sex Offender Management Board recognizes that the behavior of sex offenders can be extremely damaging to victims and their caregivers and that their crimes can have long-term impact on victims' and their families' lives. Moreover, the level of violence, exploitation, and coercion involved in the offense does not necessarily determine the degree of trauma experienced by the victim and their family.

Victims' involvement in the criminal justice process can be experienced as empowering at times, and re-victimizing at other times. These standards are based on the premise that victims should have the option to decide their level of involvement in the process, especially after the offender has been convicted and sentenced.

Under the provisions of Illinois' Constitutional Amendment for Crime Victims, victims and their caregivers may state whether they wish to be notified about any changes in the offender's status in the criminal justice system. The victim and their caregivers may determine the method (e.g. by phone, mail etc.), and the channel (e.g. directly or through a person designated by the victim and their caregiver) in which they would like to be contacted. These standards and guidelines also suggest that only upon request, a victim and their caregiver should be informed about the offender's compliance with treatment and any changes in the offender's treatment status that might pose a risk to the victim (e.g. If the offender has discontinued treatment.) In certain situations, the inter-agency team may communicate with a victim's therapist, advocate, or other person designated by the victim. Further, if a victim is willing, s/he may be contacted for information during the pre-sentence investigation, in order to include additional victim impact information in the investigation report. If the victim and his/her caregiver respond that they do not want to be contacted for additional information, this decision should be respected by all agencies involved in the case.

Professionals in the criminal justice, evaluation, and treatment systems should contact victims, or person designated by the victim and their family, to solicit their input, since victims may possess valuable information that is not available elsewhere. In particular, a victim's information about an offender's offense patterns can assist evaluators, treatment providers and supervisors to develop treatment plans and supervision conditions that may prevent future offenses.

Appendix F: Recommendations for Management and Information Sharing on Alleged Sex Offenders Prior to Conviction

Discussion: *Following are recommendations for the management of alleged sex offenders prior to conviction. Although the Sex Offender Management Board has no authority to set standards for alleged sex offenders prior to conviction, the Board strongly recommends that these guidelines be followed in order to establish both the data and practices to support the later assessment, treatment, and behavioral monitoring of convicted sex offenders.*

1. Investigation of reports to law enforcement and child protection services.

Information that will contribute to the future assessment of an alleged sexual offender and preserve evidence is best obtained through a thorough and objective investigation in which the well being of the alleged victim is of primary importance.

Investigations that preserve the well-being of the alleged victim include such approaches as:

- Providing immediate medical referral
- Minimizing the number of interviews of children
- Using a child advocacy center to interview children; increasing the comfort level as much as possible of the adult alleged sexual assault victim being interviewed
- Removing the alleged perpetrator, rather than the child alleged to be a victim of sexual abuse from the home
- Using forensic medical examinations
- Providing emotional support (and victim advocacy services) to the alleged victim
- Using community based protocols for the response to alleged victims of sexual abuse

2. Documentation of sexual abuse

Complete documentation will assist in developing future treatment and supervision plans and in protecting the alleged victim and the community. Both child protection and law enforcement investigative reports should provide detailed information on the behavior of the alleged perpetrator related to and including the sexual offending behavior.

Investigative reports should include information that describes:

- The dynamics of the alleged abuse
- Alleged offender patterns of grooming (preparing) the victim
- The ways in which the alleged offender discouraged disclosure
- Presence of child pornography
- Amount of violence and/or coercion
- Any direct or indirect corroboration of the offense
- Evidence of other sexual assault

Such information will not only assist in the prosecution of the case but will also contribute to assessment by the pre-sentence investigator, the judge, and the treatment provider/evaluator who will conduct a comprehensive sex offense-specific evaluation. Such documentation can assist in confronting offender denial and can establish a modus operandi in the event of future crimes by the offender.

3. Specialized job duties and training.

Whenever possible, investigation and prosecution of sexual assault cases should be assigned to individuals specifically trained to work in this area. Trained individuals are least likely to cause trauma to the alleged victim and their investigations are most likely to result in a prosecutable case.

4. Teamwork among law enforcement, child protection services and prosecution

A team approach to the investigation, review, and case management of sexual abuse reports is vital to the successful prosecution of alleged sexual offenders. Regular meetings of the team enhance community safety and increase the effectiveness of the team. Information should be routinely updated on the status of dependency/neglect petitions, which cases are being criminally filed, and the status of placement decisions.

5. Removal of the perpetrator from the home in intra-familial sexual abuse cases.

Whenever possible, the perpetrator, not the alleged victim should be removed from the home.

6. Family Reunification should be cautiously approached.

In child sexual abuse cases, family reunification is dangerous. When family reunification is a goal of the child protection agency, family reunification should be avoided until after disposition of the criminal case. Before recommending contact with a child victim or any potential victims, responsible parties shall assess the offender's readiness and ability to refrain from revictimizing, i.e. to avoid coercive and grooming statements and behaviors, to respect the child's personal space, and to recognize and respect the child's indication of comfort or discomfort.

A. In addition, the following criteria be met before visitation can be initiated:

1. Sexually deviant impulses are at a manageable level and the offender can utilize cognitive and behavioral interventions to interrupt deviant fantasies;
2. The offender is willing to plan for visits, to develop and utilize a safety plan for all visits and to accept supervision during visits;
3. The offender accepts responsibility for the abuse;
4. Any significant differences between the offender's statements, the victims' statements and corroborating information about the abuse have been resolved;
5. The offender has a cognitive understanding of the impact of the abuse on the victim and the family;
6. The offender is willing to accept limits on visits by family members and the victim and puts the victims' needs first.
7. The offender has willingly disclosed all relevant information related to risk to all necessary others;
8. The clarification process is complete;

9. Both the offender and the potential visitation supervisor have completed training addressing sexual offending and how to participate in visitation safely;

10. The offender and the potential supervisor understand the deviant cycle and accept the possibility of re-offense. The offender should also be able to recognize thinking errors;

11. The offender has completed a non-deceptive sexual history disclosure polygraph and at least one non-deceptive maintenance polygraph. Any exception to the requirement for a non-deceptive sexual history disclosure polygraph must be made by a consensus of the community supervision team;

12. The offender understands and is willing to respect the victim's verbal and non-verbal boundaries and need for privacy;

13. The offender accepts that others will decide about visitation, including the victim, the spouse and the community supervision team.

B. If contact is approved, the treatment provider and the supervising officer shall closely supervise and monitor the process;

1. There must be provisions for monitoring behavior and reporting rule violations to the supervising officer;

2. Victims' and potential victims' emotional and physical safety shall be assessed on a continuing basis and visits shall be terminated immediately if any aspect of safety is jeopardized.

3. Supervision is critical when any sex offender visits with any child; supervision is especially critical for those whose crimes

4. Special consideration should be given when selecting visitation supervisors. The visitation supervisor shall have some relationship with the child, be fully aware of the offense history including patterns associated with grooming, coercion, and sexual behaviors and be capable and willing to report any infractions and risk behaviors to the community supervision team members. If the supervisor is not known to the child, then the child's current care giver should be available. The potential supervisor must complete training addressing sexual offending and safe and effective visitation supervision;

7. Referrals for comprehensive sex offense-specific evaluations.

When an alleged sexual offender is referred for evaluation and assessment, the referral should be an evaluator/provider who meets the standards for the evaluation of sex offenders. However, such an evaluation often will not take the place of the comprehensive sex offense-specific required at the pre-sentence investigation, if the individual is convicted in a criminal case.

8. Forwarding of child protection services reports to the presentence investigator.

In cases where the report of an intra-familial sexual assault results in a conviction, the child protection agency should provide the probation department, upon request with a signed release of information by the offender, with copies of the intake report and the comprehensive sex offense-specific evaluation in time for the court date.

9.Pre-trial conditions.

With the exception of offense-specific treatment requirements, bond supervision conditions should be similar to the specialized conditions of probation or parole, particularly the prohibition of contact with the alleged victim and, if the victim is a child, with the alleged victim and all other children.