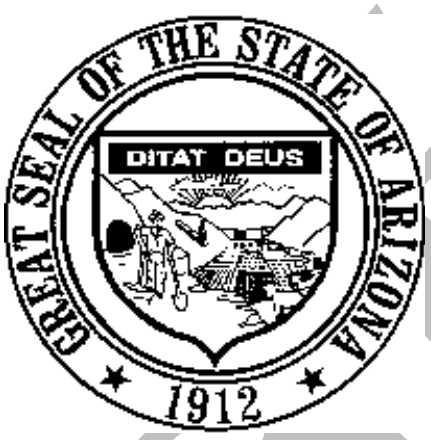
ARIZONA



STANDARDS AND GUIDELINES

FOR THE

EFFECTIVE MANAGEMENT

OF

ADULT SEX OFFENDERS ON PROBATION

May 1999

TABLE OF CONTENTS

PURPOSE

Through the enactment of the Arizona Revised Statutes, the Legislature has determined that some individuals convicted of certain sex offenses can be effectively managed in the community through appropriate supervision, assessment and treatment and do not require imprisonment.

The Arizona Judiciary, through its commitment to building trust and confidence in Arizona Courts, places a high priority on the protection of children, families and communities.

These Standards and Guidelines for the Effective Management of Adult Sex Offenders on Probation are intended to facilitate the effective management of convicted sex offenders while emphasizing and increasing the protection of the community. They apply to all adult convicted sex offenders placed by court order on standard or intensive probation supervision and residing in the State of Arizona.

The standards and guidelines were developed through the Administrative Office of the Courts by Arizona adult probation personnel specializing in the supervision of sex offenders, service providers experienced in treating this unique population, and a victim advocate.

GUIDING PRINCIPLES

1. *Community safety is paramount.*

   The highest priority of these standards and guidelines is to promote community safety by preventing further victimization.

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

   Victims have a constitutional right to determine the extent to which they will be informed of an offender's status in the criminal 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 and/or guardians ad litem on behalf of the child exercise this right, in the best interest of the victim.

3. *Sexual offending is a behavioral disorder which can often be managed but not "cured."*

   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 co-existing conditions such as mental disorders, personality disorders, medical conditions, substance abuse problems, or other non-sex related criminal tendencies.

   Many offenders can learn through treatment to manage their sexual offending behaviors and decrease their risk of reoffense. 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.

4. *Sex offenders are dangerous.*

   When a sexual assault occurs there is always a victim. Both 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.

Prediction of the risk of reoffense for sex offenders is in the early stages of development. Therefore, it is difficult to predict the likelihood of reoffense or future victim selection.

Some offenders may be too dangerous to be placed in the community. Other offenders may be managed within the community so long as lengthy monitoring, up to and including lifetime, is utilized to minimize the risk. Even after serving a prison commitment, some offenders may need lifetime monitoring.

5. *In cases of child sexual abuse, all aspects of community response should be designed to promote the best interests of the children involved.*

The vast majority of sexual offenders who offend against children are members of the same family unit. When a child is sexually abused by a family member or by a person close to the family, the child's individual rights to safety and psychological well-being supersede any claim of parental or family rights. This includes a 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 ensure no contact between the offender and all minors within the family, rather than further disrupting the life of the child victim.

Similarly, decisions regarding other aspects of offender management (e.g., community notification, work furlough, visitation) should be made with an emphasis upon both community safety and victim welfare.

6. *Assessment and evaluation of sex offenders is an ongoing process. Progress in treatment and level of risk are not constant over time.*

The effective assessment and evaluation of sexual offenders is best seen as a process. Ideally, sexual offenders are first assessed and referred for a mental health sex offense-specific evaluation during the presentence investigation conducted by the probation department. Assessment of sex offenders' risk and amenability to treatment should not, however, end at this point. Subsequent assessments should occur at both the entry and exit points of all sentencing options (i.e., probation, prison). In addition, assessment and evaluation should be an ongoing practice in any program providing treatment for sex offenders.

In the management and treatment of sex offenders there will be measurable degrees of progress. Because of the cyclical nature of offense patterns and fluctuating life stresses, sex offenders' levels of risk are likely to change. 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 the supervision of the criminal justice system. Moreover, the end of the period of court supervision should not necessarily be seen as the end of dangerousness.

7. *Probation supervision is a privilege and sex offenders must be completely accountable for their behaviors.*

   Sex offenders on probation 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.

8. *Sex offenders must waive confidentiality for evaluation, treatment, supervision and case management purposes.*

   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 the rehabilitation of sex offenders and threaten public safety.

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

   Many sex offenders can be managed under court-ordered supervision. It is in the best interest of public safety and victim recovery 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 and compliance with supervision conditions.

10. *Standards and guidelines for assessment, evaluation, treatment and behavioral 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.*

    Setting standards for sex offender treatment providers alone will not significantly improve public safety. In addition, each criminal justice and social service agency involved in the management of sex offenders should become knowledgeable about each other's purpose, practices and funding, and collaborate on efforts to create a coordinated, improved system.

11. *The management of sex offenders requires a coordinated team response to ensure community protection and full reparation to the victims.*

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 offenders' 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 offender, thereby enhancing public safety.

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

Individuals and agencies conducting the assessment, 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 that 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. *Coexisting substance abuse and/or mental illness may be significant contributors to, but not the cause of, sex offender's behavior.*

Abstinence from substances of abuse and mandatory treatment of mental disorders may be necessary for some offenders to maintain community placement.

VICTIMS/SURVIVORS
IMPACT ON SEX OFFENDER SUPERVISION

The behavior of sex offenders can be extremely damaging to victims and their crimes can have a long-term impact on victims' lives. Every effort should be made to be sensitive to the needs of the victim and to ensure they are provided an opportunity for appropriate treatment. Moreover, the level of violence and coercion involved in the offense does not necessarily determine the degree of trauma experienced by the victim.

- Victims' involvement in the criminal justice process can be either empowering or revictimizing. These standards are based on the premise that victims have the option to decide their level of involvement in the process, especially after the offender had been convicted and sentenced.

- Pursuant to the Constitution of the State of Arizona Article 2 § 2.1, Arizona Revised Statutes § 13-4415 and Supreme Court Administrative Order 94-16, victims may request to be notified of an offender's rearrest on a probation violation warrant, any revocation disposition proceedings, requests to terminate probation, and requests to modify the conditions of probation that affect restitution or the incarceration status of the offender, or that substantially affect the offender's contact with the victim or the victim's safety. These standards and guidelines also suggest that upon request a victim should also 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).

- Every effort will be made to contact the victim during the presentence investigation in order to obtain victim impact information for the presentence investigation report. Whenever possible, a victim trauma assessment should be included as a component of victim impact information.

- Since victims may possess valuable information that is not available elsewhere, with their permission, professionals in the criminal justice, evaluation and treatment systems may contact the victim concerning the offender's offense patterns, which can assist in the development of treatment plans and supervision conditions that may prevent or detect future offenses. Unnecessary, unrepeated questioning of the victim shall be avoided. Previous victim statements should always be reviewed first and the questions should be carefully preplanned.

1.000 - GUIDELINES FOR PRESENTENCE INVESTIGATIONS

1.001 Each sex offender should be the subject of a presentence investigation prior to sentencing, even when by statute it is otherwise acceptable to waive the presentence investigation. Ideally, this presentence investigation should include a mental health sex offense-specific evaluation.

The purpose of the presentence investigation is to provide the court with verified and relevant information upon which to base sentencing decisions, and afford the victim an opportunity to be heard. 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 mental health 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 result of the mental health sex offense-specific evaluation, should follow the sex offender throughout the time the offender is under criminal justice system jurisdiction, whether on probation, parole, community corrections or in prison to assist in future decisions concerning classification, release, etc..

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

While it is preferable that prosecutors not plea bargain sexual crimes 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.

1.003 Probation officers conducting presentence investigations on sex offenders during should receive as much training specific to sex offenders as possible. Such training should be consistent with section 5.217.

1.004 A presentence investigation report should address the following:

- ♦ impact of the offense on the victim and their position concerning sentencing;
- ♦ protection of children, families and the community;

- criminal history;
- education/employment;
- financial status;
- assaultiveness;
- residence;
- leisure/recreation;
- companions;
- alcohol/drug problems;
- emotional/personal problems;
- attitude/orientation;
- family, marital and relationship issues;
- offense patterns and victim grooming behaviors; and
- mental health sex offense-specific evaluation report.

If authorized by probation department policy, the information gathered during the presentence investigation should be used to make recommendations to the court concerning the offender's suitability for probation supervision. If probation supervision is recommended, special conditions for sex offender treatment and supervision should be included.

1.005 When referring an offender for a mental health sex offense-specific evaluation, presentence investigators should assist the evaluator in obtaining pertinent information on the offender such as:

- police reports;
- victim impact statement;
- child protection reports;
- criminal history;
- risk assessment materials;
- prior supervision records, if available; and
- prior mental health and sexual evaluations and treatment reports.

1.006 At the time of the intake interview, the presentence investigation writer shall provide the sex offender with a copy of the disclosure/advisement form and shall have the offender sign for receipt of the form. 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 MENTAL HEALTH SEX OFFENSE-SPECIFIC EVALUATIONS

2.001 Each sex offender shall receive a mental health sex offense-specific evaluation. Ideally, it shall occur at the time of the presentence investigation.

Evaluations are conducted to identify individuals who are at low risk of reoffending as well as those who are highly likely to reoffend. Because of the importance of the information collected during an evaluation to subsequent sentencing, supervision, treatment and behavioral monitoring, each sexual offender should receive a thorough assessment and evaluation. In addition, it is important to recognize that assessment and evaluation are ongoing processes and should continue through each stage of supervision and treatment. Reevaluation should occur on a regular basis to ensure recognition of changing levels of risk for many offenders.

2.002 The evaluator shall obtain the informed consent of the offender for the evaluation, and shall inform an offender of the assessment and evaluation methods, how the information will be used, and to whom it will be given. The evaluator shall also inform the offender about the nature of the evaluator's relationship with the offender and with the court. 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.

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

2.004 The mental health sex offense-specific evaluation has the following purposes:

- ♦ to document the treatment needs identified by the evaluation (even if resources are not available to adequately address the treatment needs of the sexually abusive offender);
- ♦ to provide a written clinical evaluation of an offender's risk for reoffending and current amenability for treatment;
- ♦ to guide and direct specific recommendations for the conditions of treatment and supervision of the 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.

2.005 A mental health sex offense-specific evaluation of a sex offender shall consider the following:

- sexual evaluation, including sexual developmental history and evaluation for sexual arousal, interest, fantasy, deviance and paraphilias;
- character pathology;
- level of deception and/or denial;
- mental and/or personality disorders;
- offender's level of education;
- drug/alcohol use;
- stability of functioning;
- self-esteem and ego-strength;
- medical/neurological/pharmacological needs;
- level of violence and coercion;
- motivation and amenability for treatment;
- escalation of high-risk behaviors;
- risk of reoffense;
- treatment and supervision needs; and
- impact on the victim utilizing a professional assessment of victim trauma.

2.006 The following evaluation modalities should be included in performing a mental health sex offense-specific evaluation:

- examination of criminal justice information, including the details of the current assault and documents that describe victim trauma;
- examination of collateral information, including information from other sources on an 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; and
- testing of deviant arousal or interest through the use of the penile plethysmograph, Abel Screen, or other evaluation tool recognized by the Association for the Treatment of Sexual Abusers.

2.007 Qualifications for evaluators and treatment providers are outlined in Section 4.000. In addition, evaluators shall adhere to established ethical standards, practices and guidelines set forth by the Association for the Treatment of Sexual Abusers and by their respective professions with regard to the administration of psychological and physiological tests.

2.008 In the prediction of risk for sex offenders, the following approaches to evaluation are recommended:

- 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 interviews;
- use of interviewers who have been trained to collect data in a non-pejorative manner;
- offender self reports of sexual history and behavior should be externally verified to the extent possible.

There is a great deal of research currently being done to increase the ability to predict sex offenders' risk of reoffending. Undoubtedly, evaluation instruments and processes will be subject to change as more is learned in this area. Because measures of risk are still being developed, evaluation and assessment must be done by collecting information through a variety of methods. Evaluation and assessment therefore currently involve the integration of physiological, psychological, historical and demographic information to form a picture of a sex offender's dangerousness, likelihood of reoffending and amenability to treatment.

2.009 Physiological testing through the use of polygraph examinations can be useful in understanding an offender's level of deception and denial and is recommended in the evaluation process. If this option is not used, other means for measuring deception must be part of the assessment.

2.010 Risk to reoffend 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 factors may increase or decrease treatment amenability and/or reoffense 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 reoffense. The

following factors may 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 reoffend.

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

- admission of offense;
- accountability; internal and external factors which control behavior;
- cooperation;
- offense history and victim choice;
- escalating pattern of offenses, violence and dangerous behaviors;
- sexual deviancy and arousal patterns;
- impulsiveness;
- social interest;
- lifestyle characteristics;
- psychopathology;
- developmental markers;
- history of childhood or adolescent delinquency;
- coexisting mental disorder;
- substance abuse;
- criminal history;
- social support systems;
- overall control and intervention;
- motivation for treatment and recovery;
- self-structure;
- disowning behaviors/level of denial;
- prior treatment;
- impact on victim(s); and
- access to potential victim pool.

2.011 Based on assessments and evaluations, the evaluator shall recommend:

- the level and intensity of offense-specific treatment needs;
- referral for medical/pharmacological treatment if indicated;
- treatment of coexisting conditions;
- 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, leisure time or transportation; life stresses, or other issues that might increase risk and require increased supervision; and/or the special sex offender conditions of supervision);

- ♦ methods to lessen victim impact; and
- ♦ appropriateness and extent of community placement

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

3.000 - STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS

3.100 - SEX OFFENSE-SPECIFIC TREATMENT

3.101 Sex offense specific treatment must be provided by an individual or agency certified by the Arizona Board of Behavioral Health Examiners or licensed by the Arizona Board of Psychologist Examiners, Arizona Board of Osteopathic Examiners, Board of Medical Examiners, or the Office of Behavioral Health Licensure.

3.102 A provider who treats sex offenders under the jurisdiction of the criminal justice system must use sex offense-specific treatment. (See definition, page 66).

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

The treatment plan shall:

- ♦ address the protection of victims and potential victims and not cause the victim(s) 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; and

- ♦ address the issue of ongoing victim input, if available and when appropriate.

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

a. Group therapy (with the group comprised only of sex offenders) is the preferred method of sex offense-specific treatment. At a minimum, any method of psychological treatment used must conform to the standards for content of treatment (see g. below) and must contribute to behavioral monitoring of sex offenders. The sole use of individual therapy is not recommended with sex offenders. However, individual therapy can be an important part of a comprehensive treatment regime and may be appropriate when geographical, specifically rural, cultural, religious, gender or disability limitations dictate its use.

b. Group therapy may need to be supplemented by treatment for drug/alcohol abuse, marital therapy or individual crisis intervention. However, group sex-offense specific treatment should remain the primary modality utilized with sex offenders.

c. The use of male and female co-therapists in group therapy is recommended.

d. An on-going primary treatment group should not exceed twelve members, unless geographical, specifically rural, limitations necessitate a larger group.

The treatment of sex offenders is sufficiently complex and the likelihood of reoffense sufficiently high to necessitate a fairly small ratio and group size.

e. The provider shall employ treatment methods aimed at ensuring the safety of an offender's victim(s), reduce the risk of future victimization and protects the community.

f. The provider shall employ treatment methods that are based on a recognition of the need for long-term, comprehensive, offense-specific treatment for sex offenders and incorporate lapse/relapse prevention. Self-help or time-limited treatments shall be used only as adjuncts to long-term, comprehensive treatment.

g. The content of offense-specific treatment for sex offenders shall be designed to:

1. Reduce offenders' defensiveness and denial of all stages of the sexual offense process;

2. Decrease and/or manage offenders' deviant sexual urges and recurrent deviant fantasies through prescribed counter-conditioning techniques;

3. Educate offenders (and individuals who are identified as the offenders' support system) about the potential for reoffending and an offender's specific risk factors;

4. Teach offenders self-management methods to avoid a sexual reoffense;

5. Identify and treat the offenders' thoughts, emotions and behaviors that facilitate sexual reoffenses or other victimizing or assaultive behaviors;

6. Identify and correct offenders' cognitive distortions;

7. Educate offenders about non-abusive, adaptive, legal and pro-social sexual functioning and, when appropriate, use conditioning techniques to increase appropriate sexual arousal;

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

9. Provide offenders with an environment that encourages the development of empathetic skills needed to achieve sensitivity and empathy for victims;

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

11. Identify and treat deficits in the offenders' personality traits that are related to the offenders' potential for reoffending;

12. Identify and treat the effects of trauma and past victimizations on offenders as factors in their potential for reoffending. It is essential that offenders be prevented from assuming a victim stance in order to diminish responsibility for their actions;

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

14. Require offenders to develop a written relapse prevention plan for preventing a reoffense; the plan should identify replacement behaviors and/or activities to be initiated upon recognition (by self or others) of antecedent thoughts, feelings and behaviors associated with the sexual offense cycle. The antecedent behaviors should be disclosed to the probation officer and/or offender therapist;

15. Encourage development of an informed support network;

16. Provide treatment referrals, as indicated, for offenders with co-existing medical, pharmacological, mental, substance abuse and/or domestic violence issues or other disabilities;

17. Maintain communication with other significant persons in offenders' support systems when indicated, and to the extent possible, to assist in meeting treatment goals. The provision of educational and support services to the families of sex offenders enhances the possibility of meeting treatment, supervision and community safety goals;

18. Evaluate cultural, language, developmental disabilities, sexual orientation and/or gender factors that may require special treatment arrangements;

19. Identify and address issues of gender role socialization;

20. Identify and treat issues of anger, power, control and other inappropriate behaviors.

3.105 Providers shall maintain clients' files in accordance with the professional standards of their individual disciplines. Client files shall:

a. Document the assessments, goals of treatment, methods used and the client's observed progress, or lack thereof, toward reaching the goals in the treatment records. Specific achievements, failed assignments, and rule violations and sanctions imposed shall be recorded.

b. Accurately reflect the client's treatment progress, sessions attended, changes in treatment and fee status.

c. Provide necessary data for evaluation of the program.

3.200 - CONFIDENTIALITY

3.201 A treatment provider shall obtain signed waivers of confidentiality based on the informed consent of the offender. If an offender has more than one therapist or treatment provider, the waiver of confidentiality shall extend to all therapists treating the offender. The waiver of confidentiality should also extend to the victim's therapist, supervising probation officer and other individuals or agencies responsible for the supervision of the offender.

3.202 A provider shall notify all clients of the limits of confidentiality imposed on therapists by Arizona Revised Statutes § 13-3620.

3.203 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 be confidential.

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

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

3.300 - TREATMENT PROVIDER-CLIENT CONTRACT

3.301 A provider shall develop and utilize a written treatment contract with each sex offender (hereafter referred to as "client") prior to the commencement of treatment. The treatment contract shall define the specific responsibilities of both the provider and the client.

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

1. Define and provide timely statements of the costs of treatment;

2. Describe the waivers of confidentiality 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 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 therapists by the mandatory reporting law.

b. The treatment contract shall explain any responsibilities of a client to, if applicable:

1. Pay for the cost of assessment and treatment for him or herself, and his/her family;

2. Pay restitution for the cost of assessment and treatment for the victim(s) and their family(ies), when ordered by the court;

3. Provide reparation to the community through the completion of community work service, when ordered by the court;

4. Inform the client's family and support systems of details of past offenses which are relevant to ensuring help and protection for past victims and/or relevant to the relapse prevention plan. Clinical judgement should be exercised in determining what information is provided to children;

5. Actively involve relevant family and support system, as indicated by the treatment team;

6. Notify the treatment provider of any changes or events in the lives of the client and members of the client's family or support system;

7. Participate in polygraphic, psychological and physiological testing as adjuncts to treatment;

8. Comply with the limitations and restrictions placed on the behavior or the client, as described in the terms and conditions of probation and/or in the treatment contract between the provider and the client.

c. The treatment contract shall reinforce the limitations and prohibitions of the conditions of probation, including;

1. Providing instructions and describing limitations regarding the client's contact with victims, secondary victims and children;

2. Describing limitations or prohibitions on the use or viewing of sexually explicit or violent material;

3. Describing the responsibility of the client to protect community safety by avoiding risky, aggressive or reoffending behavior, by avoiding high risk situations and by reporting any such forbidden behavior to the provider and the supervising probation officer as soon as possible;

4. Describing limitations or prohibitions on the use of alcohol or drugs not specifically prescribed by medical staff;

5. Describing limitations or prohibitions on employment or recreation.

6. Describing sanctions which may be applied for failure to abide by the conditions of the treatment contract.

3.400 - TRANSITIONS BETWEEN PRIMARY AND MAINTENANCE PHASES OF SEX OFFENDER TREATMENT

3.401 Prior to moving from primary to maintenance treatment, a provider shall in cooperation with the case management team, develop a maintenance and relapse prevention plan that includes ongoing behavioral monitoring, such as periodic polygraph examinations. Such monitoring is intended to motivate the offender to avoid high risk behaviors related to increased risk of reoffense. If risk increases, any phase of treatment may be reinstated.

3.500 - COMMUNITY PLACEMENT AND TREATMENT OF SEX OFFENDERS IN DENIAL

3.501 Sex offenders who continue to deny the conviction offense or continue to be highly defensive should not be placed on or remain on probation supervision.

Secrecy, denial and defensiveness are part of the sex offenders' 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 relatively soon after conviction, some offenders do not. An offender's continued denial of the act after plea bargaining or conviction threatens community safety and is highly disempowering and emotionally damaging to the victim.

3.502 Level of denial and defensiveness shall be assessed during the mental health sex offense-specific evaluation.

In assessing an offender's risk and amenability to treatment during the mental health sex offense-specific evaluation, it is important to take into

account the offender's continued denial and defensiveness. In some cases, denial alone may be regarded as a sufficient factor to eliminate an offender from a recommendation for community-based treatment. Continued strong or severe denial of the instant offense (as opposed to fluctuating or moderate denial) and/or continued strong defensiveness in general (as opposed to fluctuating or moderate defensiveness), suggest a level of risk that should rule out an offender's eligibility for community-based treatment.

3.503 When a sex offender in strong or severe denial must be in the community, offense-specific treatment shall begin with addressing denial and defensiveness. Such offense-specific treatment for denial shall not exceed six months and is regarded as preparatory for the remaining course of offense-specific treatment.

3.504 Supervision and behavioral monitoring of sex offenders in strong or severe denial should be maximized during this initial treatment phase. Home detention, electronic monitoring, field supervision and/or stringent restrictions on offenders' time are examples of additional conditions that may be indicated during treatment of denial.

3.505 Offenders who are still in strong denial or severe denial and/or are strongly resistant after this six month phase of treatment shall be terminated from treatment and the court notified. If appropriate, revocation proceedings should be initiated. Other sanctions and increased levels and types of supervision, such as home detention, electronic monitoring, etc., should be pursued if revocation is not an appropriate option. In no case should a sex offender in continued denial of the facts of the offense remain indefinitely in offense-specific treatment.

It is important that community safety be supported by proceeding with revocations for those sex offenders whose continued denial and/or resistance make treatment impossible.

3.506 Treatment for denial may be provided only by treatment providers who also meet the requirements to provide sex offense-specific treatment, as defined in this document.

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

- ♦ 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, psychological and physiological testing.

3.508 Treatment providers and case management teams must establish specific and measurable goals and tasks for all offenders, especially those in denial. These measurable goals will establish whether offenders have reached the threshold of eligibility for referral to the next phase of offense-specific treatment at the end of six months. It is especially important to document measures of offenders' acceptance of responsibility for their offenses.

In the event that an offender fails to make sufficient progress in the attainment of those goals and is therefore terminated from treatment, documentation is imperative for future revocation proceedings.

3.509 Use of the polygraph is important in reducing an offender's denial, but the timing of its use should be flexible.

3.600 - TREATMENT PROVIDERS' USE OF POLYGRAPHIC AND PHYSIOLOGICAL TESTING

3.601 A treatment provider should employ treatment methods that integrate the results of plethysmography or other physiological testing, as indicated. If plethysmography is used, the examiner must meet the standards for plethysmography as defined in the Association for the Treatment of Sexual Abusers (ATSA) Practitioner's Handbook and described in Section 7.00.

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

Plethysmographic 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 shall recognize that plethysmographic data is only meaningful within the context of a comprehensive evaluation and/or treatment process.

3.603 In cooperation with the supervising probation officer, the provider shall employ treatment methods that incorporate the results of polygraph examinations, including specific issue polygraphs, disclosure/confirmation polygraphs and maintenance polygraphs. Exceptions to the requirements for use of the polygraph may be made only by the case management team.

3.604 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.

Because of the serious 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 suggesting necessary levels of supervision and treatment. In addition, polygraph testing can improve treatment outcomes by shortening the denial phase. It is recommended that polygraph exams occur at least every six months, and more frequently as necessary.

4.000 QUALIFICATIONS OF TREATMENT PROVIDERS

4.001 Treatment Provider - Full Operating Level. Individuals in the field of sex offender management must have a combination of education, training and experience in the evaluation and treatment of sexual deviance. To qualify to provide sex offender treatment/evaluation at the full operating level, an individual must meet **all** the following criteria:

a. Education. The treatment provider shall possess an advanced degree (masters or above) in one of the behavioral sciences including but not limited to, psychology, sociology, human sexuality, social work, criminology, counseling, psychiatry or medicine from a fully accredited institute of higher education.

b. Licensure or Certification. While there is currently no certification specifically for sex offender treatment providers in the state of Arizona, individuals shall be state licensed by the Board of Behavioral Health Examiners, Board of Psychologist Examiners, Board of Medical Examiners, or Board of Osteopathic Examiners.

c. Experience. At the full operating level, the treatment provider must have demonstrated competency in providing a minimum of 2,000 hours of clinical service specifically in the areas of evaluation and treatment of sex offenders. At least 1,000 of these hours shall have been within the last five years and shall have been face-to-face contact with clients who have perpetrated sexual offenses. Licensed doctorate level individuals who have passed nationally recognized competitive certification examinations in forensic psychiatry or psychology within the past five years may be allowed credit for up to 500 hours toward meeting these requirements.

d. Competency Areas. The treatment provider shall have completed training courses and/or gained significant experience in a majority of the following topics as they pertain to the evaluation and treatment of sex offenders and their victims:

- counseling and psychotherapy;
- personality theory and disorders;
- individual, group, couple and family therapy;
- etiology of sexual deviance;
- psychometric assessment;
- risk assessment;
- sexual arousal assessment and reconditioning;
- physiological measurements;
- human sexuality;
- victimology;
- relapse prevention;
- behavior modification;
- cognitive restructuring therapy;
- culturally specific treatment needs;
- treatment of special needs clients;
- pharmacological therapy;
- social competency training;
- family unification;
- ethics and professional standards;
- federal and state sexual abuse statutes; and

- ♦ federal and state statutes concerning sex offender registration and community notification.

e. Continuing Education. Treatment providers shall continually update their education and professional training in order to remain familiar with current literature on sex offender management, including the focus and direction of research, evaluation and treatment techniques. Within any given two-year period, the provider shall have completed at least 30 hours of documented training specifically related to the competency areas listed above. The provider shall have documentation of such training available for review by referring agencies.

4.002 Treatment Provider - Associate Level. A treatment provider at the associate level may evaluate/treat sex offenders under the supervision of treatment provider approved at the full operating level. To qualify to provide sex offender treatment at the associate level, an individual must meet all the following criteria:

a. Education. The treatment provider shall possess a minimum of a bachelor's degree in one of the behavioral sciences and completed at least 40 hours of documented training during the past 3 years specifically related to the competency areas listed below.

b. Experience. The treatment provider shall have completed within the past 5 years a minimum of 1,000 hours of supervised clinical experience specifically in the area of sex offender treatment. At least half (500) of those hours must be in face-to-face therapy with sex offenders. In addition, at least 200 of those face-to-face hours must have been in co-therapy, in the same room, with a treatment provider at the full operating level.

c. Supervision. The treatment provider must have received at least 50 hours of clinical supervision outside of the group setting by a treatment provider at the full operating level. The supervision must be reasonably distributed over the time in which the above clinical experience was being obtained.

d. Competency Areas. The treatment provider shall have completed training courses and/or gained significant experience in a majority of the following topics as they pertain to the evaluation and treatment of sex offenders and their victims:

- ♦ counseling and psychotherapy;
- ♦ personality theory and disorders;
- ♦ individual, group, couple and family therapy;
- ♦ etiology of sexual deviance;
- ♦ psychometric assessment;
- ♦ risk assessment;
- ♦ sexual arousal assessment and reconditioning;
- ♦ physiological measurements;
- ♦ human sexuality;
- ♦ victimology;
- ♦ relapse prevention;
- ♦ behavior modification;
- ♦ cognitive restructuring therapy;
- ♦ culturally specific treatment needs;
- ♦ treatment of special needs clients;
- ♦ pharmacological therapy;
- ♦ social competency training;
- ♦ family unification;
- ♦ ethics and professional standards;
- ♦ federal and state sexual abuse statutes; and
- ♦ federal and state statutes concerning sex offender registration and community notification.

e. Continuing Education. Treatment providers shall continually update their education and professional training in order to remain familiar with current literature on sex offender management, including the focus and direction of research, evaluation and treatment techniques. Within any given two year period, the provider shall have completed at least 30 hours of documented training specifically related to the competency areas listed above. The provider shall have documentation of such training available for review by referring agencies.

Associate level treatment providers wishing to move to full operating level status must meet the education, licensure, experience, competency and continuing education requirements outlined in section 4.001. Documentation of direct supervision for evaluation and treatment of sexual offenders during the associate period is the preferred method for meeting the experience requirements.

4.003 All treatment providers at full operating and associate levels shall supplement their educational and professional experience with ongoing consultation with other mental health professionals experienced in the evaluation and/or treatment of sexual abusers.

5.000 - THE MANAGEMENT OF SEX OFFENDERS ON PROBATION

5.100 - ESTABLISHMENT OF AN INTERAGENCY SUPERVISION TEAM

5.101 As soon as possible after the conviction and placement of a sex offender on probation, the supervising officer shall develop a case plan and identify individuals to assist in the management of the offender during his/her term of supervision.

a. The supervising officer shall use the presentence investigation, mental health sex offense-specific evaluation (as soon as available), and community notification risk assessment as a starting point for decisions related to risk assessment, treatment, behavioral monitoring, identifying the members of the supervision team and the management of each offender.

b. Supervision and behavioral monitoring is a joint, cooperative responsibility of the supervising officer(s), local law enforcement and the treatment provider (which may include the polygraph, psychological, psychiatric or physiological examiner).

c. 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.

d. 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 offense is incest (intra familial sexual misconduct), the child protection worker is also a team member if the case is still open.

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

a. The members of the team who should attend any given staffings;

b. The frequency of staffings (at least once each quarter);

c. The content of the staffings with input from other team members;

d. The types of information required to be released.

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

5.104 The team should demonstrate the following behavioral norms:

a. There is an ongoing flow of information among all members of the team.

b. Each team member participates in the management of each offender.

c. Team members are committed to the collaborative approach and seek assistance with conflicts or alignment issues that occur.

d. Team members settle among themselves conflicts and differences of opinions that might make them less effective in presenting a unified response. The final authority rests with the supervising officer and their supervisor.

5.105 Supervising officers are encouraged to periodically (i.e., once every other month) attend group and/or individual treatment sessions to monitor sex offenders under their supervision. Treatment providers are encouraged to allow attendance of a supervising officer. Preparation should include notification to group members of the supervising officer's attendance and execution of the 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 of the group process.

5.200 - RESPONSIBILITIES OF THE SUPERVISING OFFICER FOR TEAM MANAGEMENT

5.201 The supervising officer shall refer sex offenders for sex offender evaluation and treatment only to treatment providers who meet these standards.

Supervising officers have a responsibility to ensure that the offender is engaged in appropriate treatment with a provider and that the treatment program is consistent with these standards and guidelines. It is the supervising officer's responsibility to refer sex offenders to evaluators and treatment providers who will best meet the sex offender's treatment/evaluation needs and the need for community safety.

5.202 The supervising probation officer should request that sex offenders sign releases for at least the following individuals:

- ♦ treatment providers, including the Department of Corrections;
- ♦ case management team members, including collateral sources such as the child protection agency, polygraph examiner, victim's therapist, and any other professionals involved in the treatment and/or supervision of the offender or victim; and
- ♦ guardian ad litem, custodial parent, guardian, caseworker or other involved professional, as indicated.

5.203 The supervising probation officer, in cooperation with the treatment provider and polygraph examiner, shall 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.

It is the supervising probation officer's responsibility to refer to polygraph examiners who will best meet the sex offender's treatment/evaluation needs and the need for community safety.

Although deceptive findings on a polygraph test are not in and of themselves a violation of probation, they can be considered in determining the intensity and conditions of supervision. Admissions of conduct constituting a violation of probation, however, may be used in a revocation hearing. An offender's failure to submit to a polygraph as directed shall be considered a violation of probation.

5.204 The supervising probation officer shall require sex offenders to provide a copy of any written plan developed in treatment for preventing a relapse, signed by the offender and the therapist, as soon as it is available. The supervising probation officer shall utilize the relapse prevention plan in monitoring offenders' behavior.

5.205 The supervising probation officer shall document in the probationer case file contacts with the treatment provider concerning the offender's progress, attendance, participation in treatment, change in risk factors and changes in the treatment plan. Documentation should occur within 24 working hours of contact.

5.206 At a minimum, the supervising probation officer shall retain in the case file records of the offender's:

- mental health sex offense-specific evaluation;
- risk and screening assessments;
- treatment progress;
- successful or unsuccessful completion of treatment;
- auxiliary treatment;
- fulfillment of restitution to the victim;
- compliance with supervision plan and conditions of probation;
- residence; and
- completion of community service.

5.207 The supervising probation officer shall work with the supervision team to increase behavioral monitoring and supervision for offenders in denial. Increased behavioral monitoring and supervision may include placing limitations on offenders' use of free time and mobility.

5.208 When probation conditions prohibit contact between an offender and minors, prior to authorizing such contact, the supervising probation officer shall consult with the supervision team (e.g., offender's therapist, victim's therapist, custodial parent(s) or foster parent(s), guardian ad litem).

5.209 In the development of a supervision plan and officer-offender contact standards, the supervising probation officer shall consider the offender's risk assessment, the sex offender's offending cycle, physiological results, the offender's progress in treatment, and the offender's social support network and environment.

On a regular basis, the supervising probation officer shall review with the supervision team each offender's specific conditions of probation and assess the offender's compliance, needs, risk and progress to determine the necessary level of supervision and the need for additional conditions.

5.210 Recognizing that sex offenders present a high risk to community safety, probation officers shall base their field work on the supervision plan, relapse prevention plan and offense cycle of the offender.

5.211 The supervising probation officer should not request early termination of sex offenders from supervision except when exigent circumstances exist (i.e., the offender possess a debilitating or terminal illness).

5.212 The supervising probation officer shall notify sex offenders that they must register with local law enforcement, submit to DNA testing, and be subject to community notification in compliance with Arizona Revised Statutes §§13-3821, 13-3822 , 13-4438 and 13-3825.

5.213 The supervising probation officer shall discuss treatment issues/progress with offenders during office visits and other contacts.

5.214 The supervising probation officer should discourage movement among treatment providers by offenders, unless recommended by the supervision team.

5.215 The supervising probation officer should impose or request criminal justice sanctions for offenders' unsatisfactory termination from sex offender treatment, up to and including revocation of probation.

5.216 The supervising probation officer shall require sex offenders who are transferred from other states through an Interstate Compact Agreement to agree in advance to participate in offense-specific treatment, specialized conditions of supervision contained in these standards and all statutory requirements for sex offenders in Arizona, including, but not limited to, registration, community notification and DNA testing.

5.217 Supervising probation officers assessing or supervising sex offenders should initially successfully complete a minimum of 30 hours of training specific to sex offender issues and victimology within the first year.

Such training shall include, but is not limited to, 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; and
- cultural and ethnic awareness.

It is also desirable for agency supervisors of officers managing sex offenders to complete such training.

5.218 On an annual basis, supervising probation officers should, at a minimum, obtain 12 hours of continuing education/training specific to sex offenders.

5.300 - RESPONSIBILITIES OF THE TREATMENT PROVIDER WITHIN THE TEAM

5.301 A treatment provider shall establish a cooperative professional relationship with the supervising probation officer of each offender and with other relevant supervising agencies.

a. A provider shall within 72 hours report to the supervising probation officer all violations related to specific conditions of probation.

b. A provider shall immediately report to the supervising probation officer evidence or likelihood of an offender's increased risk of reoffending so that behavioral monitoring may be increased. If the supervising probation officer is not available and if a clear and present danger exists, the provider shall immediately contact local law enforcement and advise them of the situation.

c. Prior to any change in an offender's treatment plan the provider should consult with the supervising probation officer.

d. At least quarterly a provider shall provide to the supervising probation officer written progress reports which include, but are not limited to, the offenders' attendance, participation in treatment, change in risk factors, changes in the treatment plan and treatment progress.

e. If a Petition to Revoke probation is filed by the supervising probation officer, upon request and within the time frame specified, the provider shall furnish to the supervising probation officer, 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. The treatment provider shall testify in court if necessary.

f. Providers shall not initiate or develop any plans for contact between the offender and any child without the expressed approval of the supervising probation officer. Any plans for family unification must also be approved by the supervising probation officer.

g. A provider shall discuss with the supervising probation officer potential chaperones for an offender's contact with children, if such contact is to be allowed.

5.400 - RESPONSIBILITIES OF THE POLYGRAPH EXAMINER WITHIN THE TEAM

5.401 The polygraph examiner is a member of the case management team established for each sex offender.

5.402 The polygraph examiner should be available for consultation preceding and/or following an offender's polygraph examination.

5.403 The polygraph examiner shall submit, within two weeks of testing, a written report to the supervising probation officer for each polygraph exam.

5.404 The polygraph examiner shall, within 72 hours, contact the supervising probation officer if there are new disclosures of victims and/or violations of the conditions of probation.

5.500 - CONDITIONS OF PROBATION

5.501 In addition to general conditions imposed on all offenders under probation supervision, the supervising agency should impose the following special conditions on sex offenders:

a. Sex offenders shall have no contact with their victim(s), including correspondence, telephone contact, or communication through third parties or electronic media except under circumstances approved in advance and in writing by the supervising probation officer. 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.

b. 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 probation officer. The sex offender must report within 72 hours all incidental contact with children to the treatment provider and the supervising probation officer.

c. Sex offenders shall not date or befriend anyone who has children under the age of 18, unless approved in advance and in writing by the supervising probation officer.

d. Sex offenders shall not go near school yards, parks, arcades, playgrounds, amusement parks, swimming pools or other places used primarily by children under the age of 18 unless approved in advance and in writing by the supervising probation officer.

e. Sex offenders shall not be employed in or participate in any volunteer activity that involves children or access to them, except under circumstances approved in advance and in writing by the supervising probation officer.

f. If the sex offender applies for a job or volunteer position working with children, the sex offender must notify that business or organization of the conviction and notify the supervising probation officer of the application.

g. Sex offenders shall not possess or view any sexually oriented or sexually stimulating materials, including visual, auditory, telephonic or electronic media, and computer programs or services unless authorized to do so by the supervision team for treatment purposes. Sex offenders shall not frequent or patronize establishments whose primary business pertains to such material or entertainment. Sex offenders shall not utilize any sex-related telephone numbers.

h. The residence and living situation of sex offenders must be approved in advance by the supervising probation officer.

i. Sex offenders shall undergo blood, saliva and DNA testing as required by A.R.S. § 13-4438.

j. 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.

k. Sex offenders shall not hitchhike or pick up hitchhikers.

l. Sex offenders shall attend and actively participate in evaluation and treatment, including but not limited to, psychological, psychiatric and physiological assessments, and/or the polygraph, approved by the supervising probation officer and shall not change treatment providers without prior approval of the supervising probation officer.

m. Sex offenders shall abide by any curfew imposed by the supervising probation officer.

n. Sex offenders shall be responsible for their appearance at all times. They must wear appropriate clothing, including undergarments, in the home or places where others might be expected to view them.

o. Sex offenders shall abide by all conditions and restrictions of the family unification/reunification process.

p. Other special conditions that restrict sex offenders from high-risk situations and limit access to potential victims may be imposed by the supervising probation officer.

q. Sex offenders shall annually obtain a nonoperating identification or driver license from the motor vehicle division of the department of transportation pursuant to A.R.S. § 13-3821.

5.600 - BEHAVIORAL MONITORING OF SEX OFFENDERS IN THE COMMUNITY

5.601 The monitoring of offenders' compliance with treatment and sentencing requirements shall recognize sex offenders' potential to reoffend, revictimize, deny and minimize, and to limit information in their self-reports.

The probation officer is the primary manager of the case who enforces court conditions and monitors behavior and environment, with community and victim safety being paramount. Conditions of probation shall be described and reinforced by the supervising probation officer.

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

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 of an offenders' behavior, including the special conditions of probation outlined in Section 5.500;

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. intervention into behaviors most likely to be related to a sexual reoffense;

d. living, working and social environments, to ensure that these environments provide sufficient protection against offenders' potential to reoffend; and

e. compliance with specific conditions of the relapse prevention plan.

5. The direct involvement of individuals significant in the offender's life in monitoring offender compliance, when approved by the supervision team.

Behavioral monitoring should be increased during times of an offender's increased risk to reoffend, 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 treatment provider and approved by the supervising probation officer, victim treatment provider, custodial parent and/or guardian ad litem; and

4. The offender demonstrates a high or increased level of denial.

5.700 - SEX OFFENDERS' CONTACT WITH VICTIMS AND POTENTIAL VICTIMS

5.701 For purposes of compliance with this standard, supervising probation officers, in collaboration with treatment providers, shall:

a. collaborate with an adult victim's therapist or advocate, or a child victim's therapist, guardian, custodial parent, foster parent, and/or guardian ad litem, in making decisions regarding communication, visits and unification;

a. after sentencing, contact the victim or victim advocate and advise them of the supervising probation officer's name, address and telephone number;

c. support the victim's wishes when the victim does not wish to have contact with the offender or the judicial system;

d. arrange contact in a manner that places child/victim safety first. When assessing safety, both psychological and physical well-being shall be considered;

e. ensure consultation with custodial parents or guardians of a child victim and the child's guardian ad litem and treatment provider prior to authorizing contact and that contact is in accordance with court directives;

f. before recommending contact with a child victim or any potential victims, 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). In addition, the following criteria must 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, victim's statements and collaborating 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 victim's needs first.

7. The offender has willingly disclosed all relevant information related to risk to all others.

8. The offender is actively participating in the clarification process.

9. Victim posturing has been evaluated.

10. The potential visitation supervisor has completed training provided by the supervising probation officer and/or the treatment provider addressing sexual offending and how to participate in visitation safely. The level of training may vary with the nature and frequency of the contact.

11. The offender and the potential visitation supervisor understand the deviant cycle and accept the possibility of reoffense. The offender should also be able to recognize thinking errors.

12. The offender has completed non-deceptive polygraphs on the sentencing offense(s), sexual history and maintenance. Any exception to the requirement must be made by a consensus of the supervision team.

13. The offender understands and is willing to respect the victim's verbal and non-verbal boundaries and need for privacy.

14. The offender accepts that others will decide about visitation, including the victim, spouse and supervision team.

g. If contact is approved, the treatment provider and 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 are known to have been against children, and most of all during visitation with any child previously victimized by the offender. Any behavior indicating risk shall result in visits being terminated immediately.

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 supervision team.

5.702 Family Unification

The goal of family unification shall never take precedence over the safety of any former or potential victim. If unification is indicated, after careful consideration of all the potential risks, supervising probation officers and providers shall closely supervise and monitor the process. Even when indicated, family unification is a process that is potentially dangerous and should be approached with great consideration and over an extended period of time.

Any move toward family unification should be avoided until after disposition of the criminal case. Child sexual abusers who are convicted shall not be allowed to live with the victim (or any other place where children reside) without advanced written approval from the supervision team. When a child protective agency is involved in a case in which the offender is on probation, family unification, if any, should be carefully coordinated with the supervision team. Sex offense-specific treatment providers and supervision teams are in the best position to assess offender's

risk when unification is being considered. Agencies or providers who fail to consider the recommendations of the supervision team members are at increased risk of liability if the safety of any victim or potential victim is jeopardized by a unification effort.

6.000 - STANDARDS FOR POLYGRAPHY

6.100 - STANDARDS OF PRACTICE FOR SEX OFFENDER CLINICAL POLYGRAPH EXAMINERS

6.101 Examiners shall use a computerized polygraph system or a late model (1980's to present) state-of-the-art, four or five channel polygraph instrument that will simultaneously record the physiological phenomena of abdominal and thoracic respiration, galvanic skin response and the cardiovascular system.

6.102 If the examiner employs a computerized polygraph system, a recognized scoring software must be used (e.g., the Johns Hopkins Applied Physics Laboratory scoring algorithm). Computerized charts must also be independently hand scored by the examiner.

6.103 The duration of each examination (including the pre-test, in-test and post-test phases) shall be a minimum of 90 minutes. Time begins when the examinee enters the examination room with the examiner and ends when the examinee departs after the conclusion of the polygraph examination.

6.104 Examiners shall use a recognized Control Question Technique (CQT), plus a Peak of Tension test when necessary. The Directed Lie Technique does not meet standards of care for reliability and validity.

6.105 Examiners shall adhere to the established ethics, standards and practices of the American Polygraph Association (APA). In addition, clinical polygraph examiners shall demonstrate competency according to professional standards and conduct all polygraph examinations in a manner that is consistent with the reasonably accepted standards of practice in the clinical polygraph examination community.

6.106 Examiners shall use the following specific procedures during the administration of each examination:

a. The examinee shall agree in writing or on video tape to a standard waiver/release statement. The language of the statement should be agreed upon prior to the polygraph examination with the therapist and probation officer.

b. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual polygraph examination.

c. The testing process shall be completely explained to the examinee, including an explanation of the instrumentation used and causes of general nervous tension.

d. Examiners shall conduct a thorough pre-test phase, including a detailed discussion of each relevant issue. There shall be an open dialogue with the examinee to confirm his/her version of the issues.

e. Examiners shall review and explain all test questions to the examinee. Examinees must demonstrate that they comprehend the meaning of each question.

f. Surprise or trick questions are forbidden during the administration of primary test charts.

g. All test questions must be formulated to allow only Yes or No answers.

h. An optional acquaintance/practice test may be run.

i. A minimum of three primary test charts shall be administered on the primary issue(s).

j. Test results shall be reviewed with the examinee.

k. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination.

6.107 Videotaping of polygraph examinations is recommended. If videotaped, the tape shall be maintained by the examiner for a minimum of three years from the date of the examination. Videotaping greatly enhances the validity of the polygraph record, is an effective tool for confronting sex

offender denial and creates a useful record to be used in disagreements about the content or report of the polygraph.

6.108 Examiners shall use an effective quality control process that allows for periodic independent review of all documentation, polygraph charts and reports.

Quality control requires the periodic review of clinical polygraph examinations by other active examiners. The review should cover numerical chart analysis, technique and question formulation and the inspection of instrumentation used in the examination, as well as reports submitted to referral sources.

6.109 Examiners shall issue a written report. The report must include factual, impartial and objective accounts of the pertinent information developed during the examination, including statements made by the subject. The examiner's professional conclusion shall be based on the analysis of the polygraph chart readings and the information obtained during the examination process. All polygraph examination written reports must include the following:

- ♦ date of test of evaluation;
- ♦ name of person requesting exam;
- ♦ name of examinee;
- ♦ location of examinee in the criminal justice system (probation);
- ♦ reason for examination;
- ♦ date of last clinical examination;
- ♦ examination questions and answers;
- ♦ any additional information deemed relevant by the polygraph examiner (e.g., examinee's demeanor, reasons for inability to complete exam, information from examinee outside the exam, etc.); and
- ♦ results of pre-test and post-test examination, including answers provided by the examinee.

6.110 In order to design an effective polygraph examination and adhere to standardized and recognized procedures the relevant test questions should be limited to no more than four and shall:

a. Be simple, direct and as short as possible.

b. Not include legal terminology that allows for examinee rationalization and utilization of other defense mechanisms.

c. Not include mental state or motivation terminology.

d. The meaning of each question must be clear and not allow for multiple interpretations.

e. Each question shall contain reference to only one issue under investigation.

f. Never presuppose knowledge on the part of the examinee.

g. Use language easily understood by the examinee and all terms used by the examiner should be fully explained to the examinee.

h. Be easily answered Yes or No.

i. Avoid the use of any emotionally laden terminology (such as rape, molest, murder, etc.) and use language that is behaviorally descriptive.

6.200 - QUALIFICATIONS OF POLYGRAPH EXAMINERS

6.201 Full Operating Level

a. The individual shall have graduated from an accredited American Polygraph Association (APA) school and shall have a baccalaureate degree from a four year college or university or five years experience as a private investigator or law enforcement officer.

b. The individual shall have conducted at least 150 criminal specific-issue examinations. In addition, the examiner shall have conducted a minimum of 50 clinical polygraph examinations of which 20 must be disclosure polygraph examinations and 20 more must be either maintenance or disclosure polygraph examinations within a twelve month period.

c. The individual shall have completed 40 hours of a specialized clinical sex offender polygraph examiner training program recognized and approved by the American Polygraph Association.

This training program shall focus on polygraph examination of convicted sex offenders and on sex offender assessment, evaluation, treatment and behavioral monitoring, as follows:

Twenty-four hours of specialized polygraph training in any of the following areas:

- pre-test interview procedures and formats;
- valid and reliable examination formats;
- post-test interview procedures and formats;
- reporting format (i.e., to whom, disclosure content, forms);
- recognized and standardized polygraph procedures;
- participation in sex offender case management teams;
- use of polygraph results in the treatment and supervision process;
- professional standards and conduct;
- expert witness qualifications and courtroom testimony;
- interrogation techniques; and
- periodic/compliance examinations.

Sixteen of these hours must be of specialized training in any of the following areas:

- behavior and motivation of sex offenders;
- trauma factors associated with victims/survivors of sexual assault;
- overview of assessment and treatment modalities for sex offenders; and
- sex offender denial.

If an examiner wishes to substitute any training not listed, it is incumbent on the examiner to provide written justification demonstrating the relevance of the training to this standard.

d. In concert with the generally accepted standards of practice of the polygraph 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 treatment in a manner that is consistent with the reasonably accepted standard of practice in the clinical polygraph community.

6.202 Associate Level

a. A clinical polygraph examiner at the associate level is an individual who otherwise meets the standards for full operating level but who does not have a baccalaureate degree from a four year college or university or five years experience as a private investigator or law enforcement officer and who has not yet completed 50 clinical polygraph examinations within a 12-month period as specified in standard 6.201.

The examiner shall obtain supervision from a clinical polygraph examiner at the full operating level under these standards for each remaining clinical polygraph examination up to the completion of 50 clinical polygraph exams. The supervision agreement must be in writing. Supervision must continue for the entire time an examiner remains at the associate level.

The supervisor of a clinical polygraph examiner shall review samples of videotapes of clinical polygraphs and/or otherwise observe the examiner; and provide supervision and consultation on question formulation for clinical polygraph exams, report writing and other issues related to the provision of clinical polygraph exams. Supervisors must review and sign off on each polygraph examination report completed by an associate level polygraph examiner under their supervision.

If the associate level polygraph examiner has met all the requirements for full operating level status expect for obtaining a bachelor's degree, the supervision requirement that supervisors sign off on each exam may be waived if the examiner is able to provide documentation:

- that all other criteria for full operating level status has been met;
- of continuing work toward obtaining the bachelor's degree;
- that the examiner is continuing to conduct clinical polygraph exams; and
- from the examiner's supervisor indicating their proficiency and their willingness to lower the intensity of supervision to one hour per month.

b. The individual shall have completed 40 hours of specialized clinical sex offender polygraph examiner training.

This training shall focus on polygraph examination of convicted sex offenders, and on sex offender assessment, evaluation, treatment and behavioral monitoring, as follows:

Forty hours of specialized polygraph training in any of the following areas:

- ♦ pre-test interview procedures and formats;
- ♦ valid and reliable examination formats;
- ♦ post-test interview procedures and formats;
- ♦ reporting format (i.e., to whom, disclosure content, forms);
- ♦ recognized and standardized polygraph procedures;
- ♦ participation in sex offender case management teams;
- ♦ use of polygraph results in the treatment and supervision process;
- ♦ professional standards and conduct;
- ♦ expert witness qualifications and courtroom testimony;
- ♦ interrogation techniques; and
- ♦ periodic/compliance examinations.

Sixteen of these hours must be of specialized training in any of the following areas:

- ♦ behavior and motivation of sex offenders;
- ♦ trauma factors associated with victims/survivors of sexual assault;
- ♦ overview of assessment and treatment modalities for sex offenders; and
- ♦ sex offender denial.

If an examiner wishes to substitute any training not listed here, it is incumbent on the examiner to write a justification demonstrating the relevance of the training to this standard.

c. Provide satisfactory references as requested by any potential contractor. These references shall include, but not be limited to, other members of the supervision team.

d. In concert with the generally accepted standards of practice of the polygraph 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 treatment in a manner that is consistent with the reasonably accepted standard of practice in the clinical polygraph examiner community.

6.203 Individuals who (1) have been substantially engaged in the provision of sex offender polygraph examinations for at least one year prior to the effective date of these standards, and (2) who do not meet one or more of the standards for clinical polygraph examiner may request a period of compliance not to exceed one year from the effective date of these standards.

7.000 - STANDARDS FOR PLETHYSMOGRAPHY

7.100 - STANDARDS OF PRACTICE FOR PLETHYSMOGRAPH EXAMINERS

7.101 A plethysmograph examiner shall adhere to the "Guidelines for the Use of the Penile Plethysmograph" published by the Association for the Treatment of Sexual Abusers (ATSA) and shall demonstrate competency according to professional standards and conduct plethysmograph examinations in a manner that is consistent with the reasonably accepted standard of practice in the plethysmograph examination community.

7.102 A plethysmograph examination shall only be administered to offenders 18 years of age or older.

7.103 Plethysmograph examiners shall adhere to the following specific procedures during the administration of each examination:

a. The examiner shall obtain the informed consent of the offender for the plethysmograph examination, and shall inform an offender of the examination methods, how the information will be used, and to whom it will be given. The examiner shall also inform the offender about the nature of the evaluator's relationship with the offender and the court. The examiner shall respect an offender's right to be

fully informed about the examination procedures, and results of the examination should be shared with the offender and any questions clarified.

b. The examinee shall also sign a standard waiver/release of information statement. The language of the statement should be coordinated prior to the plethysmograph examination with the therapist and probation officer.

c. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual plethysmograph examination.

d. The testing process shall be completely explained to the examinee, including the explanation of the instrumentation used and causes of general nervous tension.

e. Test results shall be reviewed with the examinee.

f. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination.

7.104 Plethysmograph examiners shall complete a minimum of 40 hours of continuing education every 3 years in order to maintain proficiency in the field of plethysmography and to remain current on any developments in the assessment, treatment and behavioral monitoring of sexual offenders. 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 and/or management and may include but is not limited to:

- statistics on offense/victimization rates;
- typologies;
- sex offender assessment;
- sex offender treatment techniques including:
  - evaluating and reducing denial,
  - behavioral treatment techniques,
  - cognitive behavioral treatment,
  - relapse prevention,
  - empathy training;
- offender/offense characteristics;

- physiological techniques including:
  - polygraph,
  - plethysmograph,
  - screening techniques;
- victim issues;
- family unification/visitation;
- legal issues regarding sex offenders;
- special sex offender populations including:
  - sadists,
  - developmentally disabled,
  - compulsive,
  - 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; and
- 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 assessment/treatment/management as described in these standards.

7.105 Plethysmograph examinations should never be used in isolation. The results must be utilized in conjunction with other evaluative measures or as part of a treatment program to effectively predict risk.

7.200 - QUALIFICATIONS OF PLETHYSMOGRAPH EXAMINERS

7.201 A plethysmograph examiner must have a baccalaureate degree from a four year college or university and demonstrate that s/he has received credible training in the use of the plethysmograph.

7.202 A plethysmograph examiner shall be proficient in the use of stimulus materials:

a. Determination of type of stimuli to be utilized for each assessment;

b. Use of specialized stimuli; and

c. Familiarity with local, state and federal codes regulating possession, storage, use and transportation of pornographic materials.

7.203 Interpretation of test data shall consider the following:

a. Differential responses to various stimuli categories;

b. Required minimum response levels;

c. Maximum response, latency, area under the curve;

d. Base rates for responses;

e. Client's self-estimates of response;

f. Detecting faking/suppression attempts; and

g. Data validity/reliability.

7.204 A plethysmograph examiner shall have received manufacturer's and/or other supervised training on equipment operation and shall be trained in:

a. Types and selection of available gauges; and

b. Gauge size determination for each client.

7.205 A plethysmograph examiner shall be knowledgeable about and familiar with the uses of plethysmograph data for:

a. Assessment/evaluation;

- ♦ assessing cross-over of deviant interests;
- ♦ assessing reliability of self-report;
- ♦ determining existence of deviant arousal; and
- ♦ determining baseline data for treatment of deviant arousal reduction/control.

b. Treatment;

- ♦ providing objective measure of treatment progress in terms of deviant arousal; and
- ♦ providing recommendations based on knowledge of treatment methodologies.

c. Offenders in denial;

- ♦ understanding limitations; and
- ♦ understanding proper/improper use.

d. Validity/Reliability;

- ♦ familiarity with current and historical research;
- ♦ client's ability/potential to control arousal patterns during assessment;
- ♦ as a variable for recidivism prediction; and
- ♦ habituation as a potential contaminating factor.

8.000 - RETENTION OF PROBATION CASE FILE

8.001 The entire case file of a sex offender should be retained indefinitely.

9.000 - GRIEVANCE PROCEDURE

9.001 Any sex offender or their family member wanting to express a complaint specific to sex offender treatment is encouraged to first discuss the complaint directly with the treatment provider.

9.002 If the complainant does not feel the issue is adequately resolved in this manner, the complainant is encouraged to discuss the issue with the sex offender's supervising probation officer. The probation officer will address the concern with the treatment provider and, if appropriate, arrange a staffing including the complainant, supervising probation officer, and treatment provider. The probation officer will document in the case file all conversations and actions taken.

9.003 If at the conclusion of the staffing the complaint is still not resolved to the satisfaction of the complainant, the probation officer shall immediately advise the complainant of the Sex Offender Treatment Grievance Procedure and provide a copy of the Sex Offender Treatment Grievance Form.

9.004 Should the complainant wish to proceed with the grievance process, they must complete a Sex Offender Treatment Grievance Form detailing their concerns and submit it to the supervising probation officer within ten (10) working days following the staffing. **The filing of the Grievance Form in no way absolves the complainant (if the probationer) from their treatment responsibility or obligation to adhere to the conditions of probation.**

9.005 Within five (5) working days of receipt of the Grievance Form, the supervising probation officer shall document their findings on the Grievance Form and provide it to their immediate supervisor. Copies shall be provided to the complainant and the probationer's case file.

9.006 Within ten (10) working days of receipt of the Grievance Form, the supervisor shall conduct an investigation into the complainant's concerns, documenting in the case file all contacts with involved parties and all actions taken. If deemed appropriate, the supervisor may confer with their immediate supervisor before determining the action to be taken. The supervisor shall record their findings on the Grievance Form and advise the complainant. The supervisor shall also inform the complainant of the basis for their decision and, if appropriate, provide the complainant with the Court Ombudsman Officer Contact Form or the State Licensing Agency Contact Form. If referral to the Court Ombudsman Officer is recommended, the supervisor shall staff the matter with the Chief Probation Officer.

9.007 On the Grievance Form the complainant shall acknowledge receipt of the supervisor's response to their grievance and acknowledge their responsibility to pursue the recommended action. The original Grievance Form is forwarded to the supervising probation officer for placement in the case file and copies provided to the complainant and treatment provider. A copy should also be forwarded to the Court Ombudsman Officer if this is the recommended action.

SEX OFFENDER TREATMENT
GRIEVANCE FORM

COMPLAINANT:_____ TELEPHONE:_____

ADDRESS:_____

PROBATIONER: _____ CAUSE NUMBER:_____
(If different than Complainant)

TREATMENT PROVIDER:_____

ADDRESS:_____ TELEPHONE:_____

PROBATION OFFICER:_____ TELEPHONE:_____

COMPLAINANT CONCERNS:

_____ _____
Complainant Signature Date

PROBATION OFFICER FINDINGS:

_____ _____
Probation Officer Signature Date

SUPERVISOR FINDINGS:

Based upon my investigation of the circumstances surrounding this grievance I recommend the following:

☐ The matter be referred to the Superior Court as the complaint involves a violation of a court order (i.e. conditions of probation) and modifications must be approved by the sentencing court.

☐ The matter be referred to the appropriate Arizona state licensing agency as the complaint alleges unethical or inappropriate behavior on the part of the treatment provider.

☐ The matter be referred to the Arizona Probation Mediation Specialist for remediation.

This action is recommended for the following reasons:

_____
_____
_____
_____
_____
_____

_____ _____
Supervisor Signature Date

I ACKNOWLEDGE RECEIPT OF THE SUPERVISOR'S RECOMMENDATION AND UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PURSUE THE RECOMMENDED ACTION.

_____ _____
Complainant Signature Date

ARIZONA STATE LICENSING AGENCY
CONTACT FORM

You must contact the appropriate licensing agency for information concerning how to file a complaint against a licensed/certified sex offender treatment provider.

Board of Behavioral Health Examiners
1400 W. Washington, Suite 350
Phoenix, Arizona
(602) 542-1882

Office of Behavioral Health Licensure
1647 E. Morten
Phoenix, Arizona
(602) 255-1127

Arizona Board of Psychologist Examiners
1400 W. Washington, Suite 235
Phoenix, Arizona
(602) 542-8162

Board of Medical Examiners
1651 E. Morton Avenue, Suite 210
Phoenix, Arizona
(602) 255-3751

Board of Osteopathic Examiners
9535 E. Doubletree Ranch Road
Scottsdale, Arizona
657-7703

ARIZONA COURT OMBUDSMAN OFFICER
CONTACT FORM

In order to begin the process of mediating your grievance concerning sex offender treatment, you must contact the Court Ombudsman Officer within ten (10) working days.

Mr./Ms. Court Ombudsman Officer
Arizona Supreme Court
Administrative Office of the Courts
1501 West Washington
Phoenix, Arizona 85007
(602) 542-XXXX

10.000 - REVISION OF STANDARDS AND GUIDELINES

10.001 The *Standards and Guidelines for the Effective Management of Adult Sex Offenders on Probation* shall be periodically reviewed and updated. This process shall include the review and solicitation of comments from Arizona professionals involved in the evaluation, treatment and management of adult sex offenders.

APPENDIX

DEFINITIONS

ACCOUNTABILITY: The accurate assignment and understanding of responsibility, without distortion, minimization, or denial.

ASSESSMENT: The collection of facts to draw conclusions which may suggest the proper course of action. Although the term "assessment" may be used interchangeably with the term "evaluation," in this document assessment generally has the broader usage, implying the collection of facts by a variety of agencies or individuals (e.g. presentence investigators), while evaluation is generally used to mean the mental health sex offense-specific evaluation conducted by a therapist.

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

CASE MANAGEMENT: The coordination and implementation of all activities directed toward supervising, treating and managing the behavior of individual sex offenders.

CLINICAL EXPERIENCE: The background, knowledge and time involved in those activities directly related to the 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 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 both specific-issue and periodic examinations.

COGNITIVE BEHAVIORAL TREATMENT: The cognitive behavioral approach to treatment assumes that people are able to compensate for their difficulties by assuming responsibility for changing their behavior. It intends to teach people to become an agent of change.

COMMUNITY NOTIFICATION: Pursuant to Arizona Revised Statutes § 13-3825, the process by which the community may be notified by local law enforcement of a convicted sex offender's presence in the community according to the community notification guidelines.

COMMUNITY NOTIFICATION GUIDELINES: Guidelines established pursuant to Arizona Revised Statutes §13-3826 for notification of the community of the presence of a convicted sex offender. Each sex offender is categorized by local law enforcement into one of three notification levels. Local law enforcement is required to maintain information on all Level One offenders and may disseminate that information to those individuals with whom the offender resides. For Level Two offenders, notification may be made to immediate neighbors, schools, appropriate community groups and prospective employers which may include a flyer with a photograph and general address of the offender, as well as a brief general summary of the offender's status and criminal background. For those offenders categorized as Level Three, notification must be made to the surrounding neighborhood, area schools, appropriate community groups and prospective employers and shall include a flyer with a photograph and exact address of the offender as well as a summary of the offender's status and criminal background.

CONTACT: Any verbal, nonverbal, or physical contact, including those occurring through a third party.

CONTAINMENT APPROACH: A method of case management and treatment that seeks to hold offenders accountable through combined use of both offenders' internal controls and external control measures (such as the use of the polygraph and relapse prevention plans). A containment approach requires the integration 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 can become dysfunctional when overused or overgeneralized.

DENIAL: In psychological terms, a defense mechanism used to protect the ego from anxiety-producing information.

DEOXYRIBO-NUCLEIC ACID TESTING: Pursuant to Arizona Revised Statutes § 13-4438 persons convicted of a sexual offense must submit a blood sample for deoxyribonucleic (DNA) testing by the department of public safety.

DSM IV: The Diagnostic Statistical Manual of Mental Disorders; provides a common language for mental health clinicians and researchers to communicate about the disorders for which they have professional responsibility.

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

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

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

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

INFORMED ASSENT: Assent means 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 CONSENT: Voluntary agreement or approval to do something in compliance with a request; includes an understanding of what is being requested.

NON-DECEPTIVE POLYGRAPH EXAMINATION RESULT: Must include a deceptive response to control questions and only non-deceptive responses to all relevant questions. Any inconclusive or deceptive response to any relevant question disallows a non-deceptive examination result.

PLETHYSMOGRAPHY: In the field of sex offender treatment, 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 instrumentation that is capable of recording, but not limited to recording, indicators of a person's respiratory pattern and changes therein, galvanic skin responses 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.

REPARATION: Payment for an injury; redress for a wrong done.

RESTORATION: The return of something to its original state. To give back or make restitution.

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: Any (adult) person convicted of a sex offense as defined in Arizona Revised Statutes Chapter 14;

Any person under the age of 18 who has been transferred or remanded to the Superior Court and subsequently been convicted of a sex offense as defined in Arizona Revised Statutes Chapter 14;

Any (adult) person convicted of any criminal offense who has previously been convicted of a sex offense in Arizona;

Any (adult) person who has previously been convicted in any other jurisdiction of any offense which would constitute a sex offense in Arizona;

Any (adult) person for whom the court has imposed sex offender conditions of probation.

A sex offender is also referred to as an “offender” in the body of this document; a sex offender is also referred to as a “client” and an “examinee” in sections relating to treatment and polygraph examinations respectively.

SEX OFFENSE: Pursuant to Arizona Revised Statutes a sex offense is:

Indecent exposure;
Public sexual indecency, public sexual indecency to a minor;

Sexual abuse;
Sexual conduct with a minor;
Sexual assault;
Sexual assault of a spouse;
Molestation of a child;
Commercial sexual exploitation of a minor;
Sexual exploitation of a minor

SEX OFFENDER POLYGRAPH: A criminal specific-issue polygraph examination of a suspected or convicted sex offender.

SEX OFFENDER REGISTRATION: Pursuant to Arizona Revised Statutes § 13-3821 persons convicted of certain sex offenses are required to register with the sheriff of the county in which they reside and provide subsequent notice of change of address.

SEX OFFENSE-SPECIFIC TREATMENT: A long term comprehensive set of planned therapeutic experiences and interventions to change/manage 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, arousal, planning, denial and 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 varying rates. The primary treatment modality for sex offense-specific treatment is group therapy. 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.

SEXUAL PARAPHILIAS/ SEXUAL DEVIANCE: A subclass of sexual disorders in which the essential features are "recurrent intense sexually arousing fantasies, sexual urges, or behaviors generally involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one's partner, or (3) children or other nonconsenting persons that occur over a period of at least six months.... The behavior, sexual urges or fantasies cause clinically significant distress or impairment in social, occupational or other important areas of functioning. Paraphiliac imagery may be acted out with a nonconsenting partner in a way that may be injurious to the partner.... The offending individual may be subject to arrest or incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal sex acts." (DSM IV, pages 522-523). This class of disorders is also referred to as "sexual deviations." Examples include pedophilia, exhibitionism, frotteurism, fetishism, voyeurism, sexual sadism, sexual masochism and transvestic fetishism. This classification system includes a category labeled "Paraphilia Not Otherwise Specified" for other paraphilias which are less commonly encountered.

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

STANDARDS AND GUIDELINES: The standards and guidelines for the effective management of adult sex offenders on probation.

SUPERVISING OFFICER: The probation officer to whom the offender's case is assigned.

TREATMENT: Therapy, monitoring and supervision of any sex offender which conforms to the standards and guidelines contained in this document.

TREATMENT PROVIDER: A person who provides sex offense-specific treatment to sex offenders according to the standards and guidelines

contained in this document. A treatment provider is also referred to as a "provider" in this document.

UNIFICATION: The process through which an offender is permitted to reside with the victim or any minor.

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.

RECOMMENDED EVALUATION AREAS AND POSSIBLE PROCEDURES

Outlined on the following pages are recommended areas of a mental health sex offense-specific evaluation. All areas should be examined in terms of history of functioning and, if indicated, standardized testing should be utilized. The examples provided identify specific evaluation instruments/processes for each area and are not meant to be exhaustive. 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. Evaluations must include multiple measures of multiple factors.

The clinical interview is the primary basis of offender evaluation. However, the examiner should be cognizant that an offender's self report is demonstrated by research to be unreliable. All data should be verified through external sources to the greatest extent possible. Similarly, standardized tests, structured interviews and polygraphs are subject to distortion by the offender and should not be taken as definitive.

Recommended Evaluation Area	Possible Evaluation Procedures
I. Mental and/or Organic Disorders IQ Functioning	WAIS-III WRAT-R GAMA Revised Beta TONI (Test of Non-Verbal Intelligence) Shipley Institute of Living Scale (Revised) Kaufman IQ Test for Adults
Organic Brain Syndrome	WAIS-III Jacobs Cognitive Screening Test Weschler Memory Scale (Revised) Limbic System Checklist Structured Mental Status Exam Quick Neurological Screening Test Thails A & B Medical Tests Necessary for Diagnosis Categories Test
Mental Illness	MMPI-II MCMI-II Mental Health Status Exam Checksheet
II. Drug/Alcohol Use Use/Abuse	MMPI-II CAQ (Clinical Analysis Questionnaire) PHQ (Personal History Questionnaire) ADS DAST-20 Adult Substance Use Survey (ASUS) Substance Use History Matrix MAST (Michigan Alcohol Screening Test) SASSI (Substance Abuse Subtle Screening Inventory)
Number of Relapses	Treatment History Collateral Information

Recommended Evaluation Area	**Possible Evaluation Procedures**
III. Character Pathology Degree of Impairment	CATS SORAG Hare Psychopathy Checklist Structured Interview MCMI-II History Collateral Information
IV. Stability of Functioning Marital/Family Stability Past/Current Housing Familial Violence/Sexual Financial Employment/Education Social Skills Ability to Form Relationships Ability to Maintain Relationships Courtship/Dating Skills	FES (Family Environment Scale) DAS (Dyadic Adjustment Scale) Interview Attitudes MSI (Marital Satisfaction Survey) Collateral Information PHQ (Personal History Questionnaire) 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 Collateral Information
V. Developmental History Disruptions in Parent/Child Relationship Length of time with biological parents History of Bedwetting History of Cruelty to Animals History of Behavior Problems (Elementary School) History of Special Education Services, Learning Disabilities, School Achievement Indicators of Disordered Attachments	Collateral Information CATS

Recommended Evaluation Area	Possible Evaluation Procedures
VI. Evaluation of Self Self-image, Self Esteem Ego Strength	MPD (Measures of Psych. Develop.) CAQ (Clinical Analysis Questionnaire) CPS (California Personality Inventory) MMPI-II MCMI
VII. Medical Screening Measures Pharmacological Needs Medical Condition Impacting Offending Behavior History of Medication Use/Abuse	Referral to Physician if Indicated Medical Tests
VIII. Sexual Evaluation **A. Sexual History** Age of Onset of Expected Normal Behaviors Quality of First Sexual Experience Age of Onset of Deviant Behaviors 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	Collateral Information PSCI (Personal Sentence Completion Inventory --- Miccio-Fonesca) Wilson Sexual Fantasy Questionnaire SONE Sexual History Background Form SORI (Sex Offender Risk Instrument) Clarke Questionnaire Cavanaugh/Johnson Checksheet for Normative Sexual Behavior
B. Reinforcement Structure for Deviant Behavior Culture Environment Cults	Structured Interview

Recommended Evaluation Area	Possible Evaluation Procedures
C. Arousal Pattern Sexual Arousal/Interest	Plethysmograph Abel Screen Adult/Adolescent Sexual Interest Card Sort
D. Specifics of Sexual Crimes 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	History of Crimes Collateral Information Review of Criminal Records Review of Victim Impact Statement Polygraph
E. Sexual Deviance	MSI (Multiphasic Sex Inventory) SONE Clarke
F. Dysfunction Impotence, Priapism, Injuries, Medications Affecting Sexual Functioning	MSI Sexual Autobiography
G. Offender's Perception of Dysfunction	Structured Interview Sexual Autobiography Bentler Heterosexual Inventory Abel and Becker Card Sort History Abel Questionnaire
H. Perception of Sexual Functioning	Structured Interview Sexual Autobiography Plethysmograph Bentler Sexual Behavior Inventory

Recommended Evaluation Area	Possible Evaluation Procedures
I. Preferences Male/Female, Age, Masturbation, Use of Tools, Utensils, Food, Clothing, Current Sexual Practices, Deviant as well as Normal Behaviors	Structured Interview Sexual Autobiography Plethysmograph Abel Questionnaire
J. Attitudes/Cognition Motivation to Change/Continue Behavior Attitudes Toward Women, Men, Children Sexuality in General Attitudes About Offense (i.e., Seriousness, Harm to Victim) Degree of Victim Empathy Presence/Degree of Denial Presence/Degree of Minimalization Ego-syntonic vs. Ego-dystonic Sense of Deviant Behavior	Structured Interview Burt Rape Myth Acceptance Scale MSI Buss/Durkee Hostility Inventory Abel and Becker Cognitions Scale Attitudes Towards Women Scale Abel Questionnaire
IX. Level of Denial and/or Deception Level of Denial Level of Deception	Structured Interview Collateral Information Polygraph
X. Level of Violence and Coercion Level of Violence Overall Pattern of Assaultiveness Victim Selection Pattern of Escalation of Violence	Structured Interview History Collateral Information Review of Criminal Records