

California Coalition on Sexual Offending (CCOSO)

Guidelines for Outpatient Treatment of Adult Sexual Offenders

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Guidelines for Outpatient Treatment of Adult Sexual Offenders

Philosophy

Sex offender treatment is fundamentally different from traditional psychotherapy, in that:

1. Traditional patients arrive by their own volition, seeking change for themselves. Sex offender patients arrive by decision of a court and its supervising agency. These agencies, acting as agents of the court and on behalf of the community, advocate change for these patients, regardless of the patients' desire for change.
2. In traditional therapy, therapists are primarily responsible to their patients. In sex offender treatment, therapists are responsible to community agencies that refer these patients. Responsibility to the sex offender patient is limited to fiduciary responsibility for ethical and competent services.
3. In traditional therapy, patient well-being and satisfaction are the therapist's primary concern. In sex offender treatment, patient well-being may, at times, be secondary to public safety.

Education

Therapists providing sex offender treatment ("therapists") should hold a degree that meets or exceeds a Masters level, PsyD or PhD in social work, psychology or related discipline, or MD with psychiatric training.

Training

In addition to the above educational requirements, therapists should have and be able to demonstrate significant knowledge about

1. The criminal justice and corrections systems:
2. Treatment techniques
3. Psychosocial diagnosis
4. Risk assessment
5. Normal and aberrant human sexual development
6. Psychological and psycho-physiological testing relevant to appropriate sexuality and sexual deviance

7. Neurobiology
8. Psychopathology
9. Character development and disorders
10. Cognitive therapy
11. Behavioral therapy
12. Pharmacological interventions
13. Social skills training
14. Sex offender relapse prevention
15. Victim empathy
16. The Containment Model
17. Developmental disorders
18. Collateral issues
 - a. Substance abuse
 - b. Domestic violence

Therapists should obtain 100 hours of sex offender continuing education within these subject areas every 5 years, with a minimum of seven hours each year.

Experience

A qualified therapist responsible for the treatment of a sex offender shall have at least 2000 hours of face-to-face clinical experience in the assessment and/or treatment of sex offenders.

Therapists with less than the above-delineated education and experience shall not have primary responsibility for a patient, but may provide psychotherapy and other services to sex offenders under supervision of a therapist who has such education and experience.

Licensing

Therapists shall be state licensed in a discipline that allows psychotherapy as part of their scope of practice or be pre-licensed, having met their degree requirements and being in the process of accumulating supervised hours in preparation for taking their licensing examination.

Containment Model

A thorough understanding of the Containment Model is essential to public safety and essential to externally motivated change. This model includes active monitoring, supervision, and interventions designed to produce behavioral changes, supported by modifications in the offender's daily lifestyle and psychological condition. For further information on the Containment Model see the position paper by the California Coalition on Sexual Offending (<http://www.ccoso.org/papers/containment.html>).

Assessment

Initial assessments combine sound clinical judgment with research knowledge to produce a formal statement about

1. The risk a particular sex offender presents during community placement and treatment
2. A treatment plan for reducing said risk, which shall include
 - a. Specific deficits related to sexual and other offending
 - b. Individual and environmental strengths and resources available for managing/mitigating identified deficits
 - c. Interventions utilizing specified strengths to address said deficits
 - d. Measurable goals related to mitigating the deficits
 - e. Community safety

Assessment of sex offenders should be an ongoing process. Additional assessments should utilize empirically supported measures and shall occur

1. Initially, as outlined above in number 1 and 2
2. Periodically during treatment, to
 - a. Monitor progress
 - b. Adjust goals and plans
 - c. Monitor sex offender compliance with legal and program requirements and treatment protocols
 - d. Periodic clinical polygraph examinations are a crucial tool for monitoring compliance.

3. When nearing treatment discharge, to
 - a. Assess strengths, residual deficits and continuing risk to the community
 - b. Offer lifestyle recommendations to sex offenders, their friends and families, and community supervisors

Assessment procedures should include, but are not limited to

1. Review of all available records
2. Clinical interviews
3. Collateral interviews
4. Psycho-physiological measurements of sexual interest/arousal
5. Actuarial instruments
6. Clinical polygraphy utilized in a manner consistent with standards supported by the California Association of Polygraph Examiners (CAPE) (<http://www.californiapolygraph.com>)

Treatment

Goals

1. Increased community safety through reduced risk of re-offense
2. Reparations to victim(s) and community
3. Improved capacity for a responsible lifestyle and healthier relationships

Interventions

Therapists must be knowledgeable and skilled in the application of appropriate treatment interventions. Interventions currently supported in professional literature as having significant treatment value include:

1. Victim impact awareness and empathy development
2. Sex offender relapse prevention
3. Education related to appropriate and healthy sexual functioning
4. Full disclosure of sexual offenses
5. Relationship skills

6. Anger management skills training
7. Social skills training
8. Identifying and correcting distorted thinking (cognitive restructuring)
9. Arousal management/urge control
10. Behavior modification addressing sexual arousal control
11. Identifying and changing behavior patterns and offense cycles
12. Medication evaluation relevant to conditions affecting treatment compliance and arousal control

Not all sex offenders need intervention in every one of these domains. Interventions should be focused on individual deficits identified by evaluation.

Modalities

Empirical research has not established the comparative efficacy of group, family and individual therapy. It seems likely that varying modalities work best for addressing particular issues with particular patients. At present, when to use which modality remains a question of clinical judgment. Nonetheless, group therapy is presently the most widely used modality, and there is consensus that a significant group therapy experience is advisable for most sex offenders, unless individual clinical assessment counter-indicates group therapy in a specific case.

Family Resolution

Issues related to impact on the family must be resolved as part of sex offender treatment. Family resolution may take many paths. Family disruption and family reunification are among the many possible outcomes. The specific course of treatment will depend on the family resolution pathway chosen by the family, the sex offender, and representatives of the court.

When integrating sex offenders into families, CCOSO members shall adhere to guidelines set forth in CCOSO's Position Paper on Family Resolution.

Confidentiality

Patients must know what information will and will not be communicated to others, how it will be communicated, and to whom it will be communicated. This is accomplished through the appropriate use of written waivers of confidentiality, and informed consent prior to commencing treatment. Patients should be reminded on a regular basis of the conditions that impact confidentiality.