

3.000 STANDARDS OF PRACTICE FOR TREATMENT PROVIDERS

3.100 ♦ Sex Offense Specific Treatment

3.110 Sex offense specific treatment must be provided by a treatment provider listed at the full operating level or the associate level under these Standards.

DD3.110 In a situation where a client's developmental disability interferes with the provider's ability to meet the requirements of any section of 3.000, the Community Supervision Team must come to consensus about any modification to the Standards that is implemented. The modification must be documented in writing and signed by each CST member.

3.120 A provider who treats sex offenders under the jurisdiction of the criminal justice system must use sex offense-specific treatment. (See Definition Section.) This does not preclude participation in adjunctive treatment as clinically indicated and approved by the Community Supervision Team.

Discussion: A provider who chooses to begin treating an offender during the pre-conviction stage should provide treatment in compliance with these Standards.

DD3.120 When providing treatment to individuals with developmental disabilities who may exhibit sexually inappropriate behaviors but who have not been convicted of a sex offense, it is recommended that the Standards be used as guidelines. The treatment of non-convicted individuals does not fall under the purview of the Sex Offender Management Board.

3.130 Upon an offender entering treatment, a provider shall develop a written treatment plan based on the needs and risks identified in current and past assessments/evaluations of the offender. Treatment plans should evolve over the course of treatment as new information is discovered.

The treatment plan shall:

- Provide for the protection of victims and potential victims and not cause the victim(s) to have unsafe and unwanted contact with the offender
- Address the issue of ongoing victim input (will the victim be involved, in what manner, at what stage of treatment, etc.)
- Be individualized to meet the unique needs and risks of the offender
- Identify the issues to be addressed, the planned intervention strategies, and the goals of treatment
- Define expectations of the offender, his/her family (when possible), and support systems

3.140 Providers shall maintain clients' files in accordance with the professional standards of their individual disciplines and with Colorado state law and federal statutes on health care records. Client files shall:

- Document the goals of treatment, the methods used, the client's observed progress, or lack thereof, toward reaching the goals in the treatment plans.
- Record specific achievements, failed assignments, rule violations and consequences.
- Accurately reflect the client's treatment progress, sessions attended, and changes in treatment.

3.150 Approved providers shall participate in, and cooperate with, Board research projects related to evaluation or implementation of the Standards or sex offender management in Colorado in accordance with Section 16-11.7-103 (4) (d), C.R.S.

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

- A. The provider shall employ treatment methods that give priority to the safety of an offender's victim(s) and the safety of potential victims and the community.
- B. 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 F., below) and must contribute to the management of sex offenders. The sole use of individual therapy is not recommended with sex offenders, and should be avoided except when geographical—specifically rural—or disability limitations dictate its use.

Discussion: Group therapy may be supplemented by additional treatment modalities.

DD3.160.B. The modality of treatment for sex offenders with developmental disabilities needs to be determined on a case-by-case basis. Level of functioning, level of social skills, learning styles, receptive/expressive language and comprehension, and other relevant concerns need to be considered when choosing modalities. If, based on these considerations, the Community Supervision Team determines that the client is inappropriate for group treatment, the team shall consider the use of individual therapy, behavioral interventions coupled with external containment strategies, and/or other modalities.

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

Discussion: Many sex offenders have polarized views of men and women. As a result, it is beneficial to have male and female co-therapists conduct therapy groups. Therapists can model equal non-sexual relationships, assertive communication, and the value of multiple perspectives. Based on the offender's preexisting stereotypes, he/she may tend to discount information from a therapist of a specific gender. The gender of the therapist that the offender is most willing to listen to varies from offender to offender. Therapeutic feedback generally becomes more powerful and less likely to be discounted when it is expressed by both a male and female therapist. Use of male and female co-therapists also provides a catalyst for a diversity of issues to emerge, which can then be addressed in treatment.

- D. The ratio of therapists to sex offenders in a treatment group shall not exceed 1:8. Treatment group size shall not exceed 14 sex offenders.

DD3.160.D. It is likely that a group populated by sex offenders with developmental disabilities will require an even smaller client to therapist ratio. Ratios shall be determined based upon the needs of the group.

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

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

- E. Genders shall not be mixed in a sex offense specific treatment group.

Discussion: It is understood that psycho-educational groups, informed supervision sessions, victim clarifications sessions and other modalities that do not require the same level of therapeutic work as a treatment group, may successfully contain, and sometimes require, a mix of genders to participate together.

It is also understood that in the event a treatment group cannot be found for an individual because of their gender, individual therapy may be warranted. In this situation, case notes should carefully document why individual therapy was chosen for the specific offenders.

- F. The provider shall employ treatment methods that are based on recognition of the need for long-term, comprehensive, offense-specific treatment for sex offenders. The provider shall use an evidence-based approach. Self-help or time-limited treatments shall be used only as adjuncts to long-term, comprehensive treatment¹.

DD3.160.F. Treatment planning and content shall take the needs of sex offenders who have developmental disabilities into consideration.

DD Discussion: *Progress in treatment and the ability to integrate material is generally slower for sex offenders with developmental disabilities than for the non-disabled population. The presence of concrete thinking, difficulty with concepts and abstraction and the need for frequent repetition and simple, direct instruction is common. For example, sex offenders who have developmental disabilities may not be able to*

¹ Evidence-based approach footnote:

conceptualize the sequential cycle portion of the traditional relapse prevention plan. In this case, the ability to identify risk situations or behaviors and appropriate interventions is a reasonable alternative.

- G. The provider, in consultation with the Community Supervision Team (CST), shall determine treatment intensity including frequency and duration of contact based on offender's needs and risk. The treatment provider shall consult with the CST regarding the need for referral to a program of different intensity if not offered in his/her program.

Discussion: The intensity of treatment (number of hours of treatment per week) should be based on the offender's evaluated risk and treatment needs. The majority of sex offenders have significant long- standing problems that have contributed to their sexual offending behavior. Therefore, most sex offenders will need intensive treatment for a long period of time in order to decrease their risk of re-offense. Research has suggested that treatment intensity and duration are significant factors in the effectiveness of treatment for sex offenders and substance abusers. Programs that cannot provide the level of intensity necessary to manage the offender's risk should refer the offender to a treatment team that can provide the necessary level of intensity. At a minimum, offenders should participate in weekly group session; many offenders may benefit from more than one treatment session per week.

- DD3.160.G.** Managing the client's risk to the community remains the primary goal of treatment. The fact that these clients may progress more slowly in treatment shall never be used as a reason for reducing monitoring and containment when risk continues to be present, or for accepting reduced compliance from the client.

- H. A treatment provider shall employ treatment methods that integrate the results of a polygraph, plethysmographs, visual reaction time assessments or other physiological testing, as indicated.

Discussion: Providers who utilize this data shall be aware of the limitations of these technologies shall recognize that this data is only meaningful within the context of a comprehensive evaluation and treatment process.

- DD3.160.H.** Use of some of these assessments and testing instruments with sex offenders with developmental disabilities is relatively new; employing these results for the purposes of assessing risk and planning for treatment should be done cautiously. Please see Section DD2.000 for additional Standards pertaining to evaluations. Wherever possible, materials appropriate for use with sex offenders with developmental disabilities shall be utilized instead of materials developed for a non-developmentally disabled population.

- I. Offense-specific treatment for sex offenders shall:
 - 1. Hold offenders accountable for their behavior and assist them in maintaining their accountability.
 - 2. Require offenders to complete a full sex history disclosure and to disclose all current sex offending behaviors;

3. Reduce offenders' denial and defensiveness;
4. Decrease and/or manage offenders' deviant sexual urges and recurrent deviant fantasies;
5. Educate offenders and individuals who are identified as the offenders' support systems about the potential for re-offending and an offender's specific risk factors, in addition to requiring an offender to disclose critical issues and current risk factors;
6. Teach offenders self-management methods to avoid a sexual re-offense;
7. Identify and treat the offenders' thoughts, emotions, and behaviors that facilitate sexual re-offenses or other victimizing or assaultive behaviors;
8. Identify and treat offenders' cognitive distortions;
9. Educate offenders about non-abusive, adaptive, legal, and pro-social sexual functioning;
10. Educate offenders about the impact of sexual offending upon victims, their families, and the community;
11. Provide offenders with training in the development of skills needed to achieve sensitivity and empathy with victims.
12. 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 and financial restitution for the victim(s);
13. Identify and treat offenders' personality traits and deficits that are related to their potential for re-offending;
14. Identify and treat the effects of trauma and past victimization of offenders as factors in their potential for re-offending. (It is essential that offenders be prevented from assuming a victim stance in order to diminish responsibility for their actions);
15. Identify deficits and strengthen offenders' social and relationship skills, where applicable;
16. Require offenders to develop a written plan for preventing a re-offense; the plan should identify antecedent thoughts, feelings, circumstances, and behaviors associated with sexual offenses;

Discussion Point: this plan shall be shared with the offender's identified support system.

17. Provide treatment or referrals for offenders with co-existing treatment needs such as medical, pharmacological, psychiatric needs, substance abuse, domestic violence issues, or disabilities;
18. Maintain communication with other significant persons in offenders' support systems to the extent possible to assist in meeting treatment goals;
19. Evaluate existing treatment needs based on developmental or physical disabilities, cultural, language, sexual orientation, and gender identity that may require different treatment arrangements;
20. If clinically indicated, every effort should be made to provide services in the client's primary language using professional interpretive and translation resources as needed.

Discussion Point: Individuals who have an existing relationship with the offender, such as family members, shall not be used as interpreters in order to avoid dual relationships and conflict of interest.

21. Identify and address issues of gender role socialization; and,
22. Identify and treat issues of anger, power, and control.

DD3.160.I. Achieving success in the above listed content areas for the sex offender with developmental disabilities may require modifications based on the needs of the individual such as using pictures instead of written assignments, or using a data collection system by the treatment provider to document skills learned by the client.

- J. A treatment provider shall model empathy and respect to the offender.

Discussion Point: Disrespectful behavior includes but is not limited to: labeling the person not the behavior, unnecessary volume when speaking to the offender, and name calling..

- K. In cooperation with the supervising officer, the provider shall address the results of polygraph examinations. The treatment provider shall collaborate with the Community Supervision Team to schedule polygraph examinations and review the results and admissions in accordance with Section 6.000. Results and admissions of the polygraph shall be used to identify treatment and behavioral monitoring needs.
- L. Recognizing the importance that the continuum of treatment intensity is dependant on offender progress, providers shall offer phases of reduced treatment intensity following an offender successfully addressing all applicable issues and concepts contained in Standards 3.160 (I) 1 –22. This phase of treatment shall include regular polygraph examinations. The main focus of this reduced intensity "maintenance treatment" shall be to:
 - Enhance application of those concepts learned in Standards 3.160 (I) 1 –22 in the client's current lifestyle, including internalizing, integrating and consolidating these concepts;

- Refine re-offense prevention skills. As offenders apply concepts it is possible that they will have lapses, which shall be addressed during the maintenance treatment.
- Return offenders to a more intensive phase of treatment if clinically indicated.

M. An offender can be moved to a maintenance phase of treatment when the community supervision team reaches consensus that the sex offender has:

- Satisfactorily addressed all applicable issues listed in Standards 3.160 (I) 1 – 22;
- Completed the non-deceptive sexual history disclosure polygraph process;
- Yielded non-deceptive results on the two most recent and consecutive maintenance polygraphs and they are absent any information not previously disclosed to the containment team;
- Produced an objective sexual arousal or interest measure demonstrating management of deviance;
- Demonstrated consistent compliance with treatment and supervision conditions;
- Modified his/her lifestyle to actively manage his/her risk and consistently applies the concepts learned in treatment. In addition, he/she discloses and addresses ongoing risk factors in treatment;
- Accepted s/he needs ongoing treatment and external support irrespective of required supervision conditions.

In assessing offender progress, teams shall look for external, objective and behaviorally measurable evidence.

DD3.160.M In assessing progress of the offender with developmental disabilities, teams should remain mindful that not all sex offenders with developmental disabilities are appropriate for polygraph and/or for some sexual arousal or interest measurements. Please see DD.2.000 for further discussion.

3.200 ♦ Successful Completion of Legally Mandated Treatment

3.210 In certain cases it may be appropriate to end legally mandated, offense-specific treatment. However, most offenders will need ongoing treatment at some level. Completion of treatment is not the end of offenders' rehabilitative needs or the elimination of all risk to the community. Successful completion of legally mandated treatment prior to an offender's supervision termination date shall only be considered upon the unanimous agreement of the Community Supervision Team.

The decision to end treatment shall be based on:

- A determination by the team that the offender would not pose an undue risk to victim and community safety without treatment;
- A reexamination of the offender's progress over an extended period of time in the maintenance phase of treatment.
- A determination that the offender is low risk on criminogenic factors as defined by all information gained over the course of treatment and supervision.

DD Discussion: Because some sex offenders with developmental disabilities have difficulty learning to generalize behaviors and/or memorize information without subsequent behavioral change, the Community Supervision Team should, in these cases, also base its decision to end treatment on the client's actual demonstration of new skills.

3.220 Prior to discontinuing offense-specific treatment, a provider shall, in cooperation with the Community Supervision Team, make recommendations for an aftercare plan that may include a variety of self-management skills/techniques and support systems.

3.300 ♦ Confidentiality

3.310 When enrolling an offender in treatment, a provider shall obtain signed waivers of confidentiality based on the informed assent of the offender. This waiver shall explain that written and verbal information will be shared between all team members. The waiver of confidentiality shall, if applicable, extend to the Department of Human Services, other individuals or agencies responsible for the supervision of the offender, and the Board for the purpose of research related to evaluation or implementation of the Standards or sex offender management in Colorado.

Discussion: Waivers of confidentiality should be required of the sex offender by the conditions of probation, parole, and community corrections and shall be part of the treatment provider-client contract.

DD3.310 The information shall be provided in a manner that is easily understood, verbally and in writing, in the native language of the person, or through other modes of communication as may be necessary to enhance understanding.

(A) The provider shall obtain the informed assent of the legal guardian, if applicable, and the informed assent of the offender with developmental disabilities for treatment. The guardian will be informed of the treatment methods, how the information may be used and to whom it will be released. The provider shall also inform the offender with developmental disabilities and the guardian about the nature of the provider's relationship with the offender and with the court. The provider shall respect the offender's right to be fully informed about treatment procedures.

(C) If informed assent cannot be obtained after consulting with the third party, then the provider shall refer the case back to the Community Supervision Team or the court

3.320 Waivers of confidentiality shall extend to the victim, the victim advocate/therapist, the guardian ad litem of a child victim, the caseworker, the approved supervisor(s), the offender's current partner, the guardian, or other individuals involved in the case. This is especially important with regard to, but not limited to, offender non-compliance with treatment, information about risk, threats, and possible escalation of violence, and decisions regarding clarification or reunification of the family, and an offender's contact with past or potential child victims.

3.330 A provider shall notify all clients in writing of the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304, C.R.S.

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

3.400 ♦ Treatment Provider-Client Contract

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

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

1. Define and provide timely statements of the costs of assessment, evaluation, and treatment, including all medical and psychological tests, physiological tests, and consultations;
2. Describe the waivers of confidentiality and the limits of confidentiality pursuant to Standards, Section 3.300, which will be required for a provider to treat the client for his/her sexual offending behavior and describe the procedures necessary for the client to revoke the waiver.
3. Describe the right of the client to refuse treatment and to refuse to waive confidentiality, and describe the risks and potential outcomes of that decision;
4. Describe the limits of confidentiality imposed on therapists by the mandatory reporting law, Section 19-3-304, C.R.S.
5. Describe the type, frequency, and requirements of the treatment and outline how the duration of treatment will be determined, and;

B. The contract shall explain any responsibilities of a client (as applicable) to:

1. Pay for the cost of assessment and treatment for him or herself, and his or her family,
2. Comply with all requirements to pay for the cost of assessment and treatment for the victim(s) and their family(ies), including all medical and psychological tests, and consultation;
3. Inform the client's family and support system of details of past offenses, which are relevant to ensuring help and protection for past victims and relevant to the re-offense plan. Clinical judgment should be exercised in determining information provided to children;
4. Actively involve relevant family and support system;
5. 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;
6. Participate in polygraph testing and sexual arousal/interest testing as prescribed in the Standards and Guidelines (including DD3.160.K);

7. Comply with the limitations and restrictions placed on the behavior of the client, as described in the terms and conditions of probation, parole, or community corrections and in the contract between the provider and the client.
- C. Failure to comply with the terms of the contract may result in termination from treatment. The contract shall also, (as applicable):
- Provide instructions and describe limitations regarding the client's contact with victims, secondary victims, and children;
 - Describe limitations or prohibitions on the use or viewing of sexually stimulating, violent material and material related to deviant sexual interest;
 - Describe the responsibility of the client to protect community safety by avoiding risky, aggressive, or re-offending behavior, avoiding high risk situations, and reporting any such forbidden behavior to the provider and the supervising officer as soon as possible;
 - Describe limitations or prohibitions on the use of alcohol or drugs not specifically prescribed by medical staff;
 - Describe limitations or prohibitions on employment and recreation

3.500 ♦ Managing Sex Offenders in Denial

3.510 Levels of Denial

The following is a description of different levels of denial as it relates to the conviction. This classification is similar to those proposed by Salter (1988)¹, Leflen and Sturn (1993)², Winn (1993)³, and Brake and Shannon (1995)⁴. These levels should be used in conjunction with the rest of 3.500.

Level 1: Low Denial

This level consists of attitudes that reflect low or occasional avoidance of responsibility. Most offenders present with Level 1 denial at one time or another. Offenders presenting with Level 1 denial are considered to be “admitters of fact”.

Level 2: Moderate to High Denial

This level consists of offenders who a) admit to some of the behavior involved in the offense, but justify its occurrence or minimize its importance, b) offenders who admit the facts of the offense, but deny the sexually abusive aspect of the offense, and/or c) offenders who do not admit committing the current sexual offense, but admit to engaging in less harmful sexual behaviors.

Level 3: Severe Denial

This level consists of offenders who deny committing the current offense and refuse to acknowledge responsibility for even remotely similar behaviors. Offenders may also

¹ Salter, A. (1988). *Treating Child Sex Offenders & Victims*, Newbury Park, CA: Sage Publications.

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⁴ Brake, S. C. & Shannon, D. (1997). *Using PreTreatment to Increase Admission in Sex Offenders*. In *The Sex Offender: New Insights, Treatment Innovations and Legal Developments*, BK Schwartz and HR Cellini (Eds.), Civic Research Institute: Kingston, N.J.

appear excessively hostile or defensive. These types of denial are most resistant to change.

- 3.520** Sex offenders who are in Level 3 Denial shall not be recommended for community based treatment and supervision.

Discussion: Secrecy, denial, and defensiveness are part of sex offenders' pathology. Almost all offenders fluctuate in their level of accountability or minimization of the offenses. Although most are able to admit responsibility for the sexual offense relatively soon after conviction, some offenders do not. As denial impedes treatment engagement and progress⁵, an offender's continued denial of the sexual offense after conviction threatens community safety. Offender denial is highly distressing and emotionally damaging to victims.

- 3.530** When a sex offender in severe denial is placed in the community, despite the requirements of 3.520, (e.g. on mandatory parole), a Denier Intervention shall specifically address the sex offender's denial and defensiveness as it relates to preventing the sex offender from successfully participating in sex offender treatment. Denier Intervention shall not exceed three months and shall be regarded as preparatory for offense-specific treatment.

Discussion: Although all offense-specific treatment programs usually begin by addressing minimization and defensiveness, Denier Intervention for those in Level 3 Denial, typically occurs separately from regular group therapy that is provided for offenders who have, at a minimum, admitted the crime of conviction. Level 3 deniers are not considered amenable to offense specific treatment. They do not admit sex offenses and therefore do not acknowledge a need to work on issues that contribute to their offending behavior or re-offense plans. Since severe denial prevents therapists from obtaining critical information from the offender, they are unable to develop effective interventions to address the offending behavior. Further, including deniers in regular groups may disrupt the group's focus on treatment tasks and encourage other offenders to deny their crimes and can increase their level of denial. Denier Intervention for Level 3 Denial may include a variety of modalities specifically designed to reduce denial and resistance to treatment and supervision.

During the time an offender is attending Denier Intervention, the CST should work closely together to ensure maximum containment, supervision and accountability measures are enforced for the offender. Intermediate sanctions should also be used during the course of Denier Intervention to reduce denial and encourage disclosure. In addition to requiring the offender to undergo an instant offense polygraph regarding the offense of conviction, the CST shall also require the offender to undergo Maintenance polygraph testing to monitor current behavior and enable the CST to respond to concerns quickly.

- 3.540** Use of the polygraph is important in reducing an offender's denial. Deniers shall be referred for an instant offense polygraph examination. Documentation is imperative for

⁵ Denial was found to be inversely associated with treatment engagement and progress (Levenson & MacGowan, 2004). Further, the Division of Criminal Justice, Office of Research and Statistics, found that denial measured early in treatment using the SOMB Checklist significantly correlated with treatment failure/revocation (see English, Kleinsasser and Retzlaff, 2002, "The Colorado Sex Offender Risk Scale" in the *Journal of Child Sexual Abuse*, Vol. 11, No. 2).

future revocation proceedings, in the event that an offender fails to make sufficient progress and is therefore terminated from Denier Intervention.

- 3.550** Offenders who are still in Level 3 Denial and are strongly resistant after this three (3) month phase of Denier Intervention shall be terminated from treatment and 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 a revocation does not occur. In no case should a sex offender in continuing denial of the sexual offense remain indefinitely in Denier Intervention.

Discussion: It is important to support victim recovery and community safety by proceeding with revocations for those sex offenders whose continued denial for resistance make treatment ineffective.

- DD3.550** An exception may be made for sex offenders with developmental disabilities who are in Level 3 Denial and are strongly resistant after this three (3) month phase. If revocation and termination from treatment are not clearly indicated for a specific client, then a Community Supervision Team review shall occur at this 3 month mark to determine whether an extension of this pre-treatment phase following by a second case review shall occur. Other options may be explored at this time and shall always consider the client's current risk of sexual re-offending and availability of community supervision.

- 3.560** Denier Intervention shall only be provided by treatment providers who also meet the requirements to provide sex offense-specific treatment, as defined in this document.
- 3.570** Progress in Denier Intervention is reflected by the offender's decreased resistance to treatment, decreased defensiveness and denial, and increased accountability for offense behavior.
- 3.580** Treatment providers and community supervision teams must establish specific and measurable goals and tasks for offenders in denial. These measurable goals will establish whether offenders have reached the threshold of eligibility for referral to offense-specific treatment at the end of three months or earlier. It is especially important to document offenders' accountability for their offenses.

3.600 ♦ Treatment of Sex Offenders Within the Department of Corrections

- 3.610** During incarceration and parole a continuum of treatment services shall be available to sex offenders.
- 3.620** Unless otherwise noted in this section, treatment for sex offenders in prison shall conform to these Standards for sex offense specific treatment described in Section 3.000 and shall be provided by therapists who meet the qualifications for treatment providers described in Section 4.000.

The prison treatment provider shall employ treatment methods that are based on recognition of the need for long-term, comprehensive, sex offense specific treatment. Self-help or time-limited treatments shall be used only as adjuncts to long-term, comprehensive treatment. Offenders who have been removed from the community are

presumed to have a higher risk level and longer-term intensive treatment is warranted. The duration of treatment in prison will be based on the assessment by the clinical team. This shall be followed by community based sex offense specific treatment upon the offender's release.

A sex offender who has been sentenced to the Department of Corrections (DOC), and who is participating in the treatment program, and who did not receive a sex offense-specific evaluation at the time of the pre-sentence investigation shall receive a sex offense-specific evaluation.

3.630 It is highly recommended that Treatment in prison should be provided by male/female co-therapy teams.

3.640 Prison treatment providers shall utilize a modified team approach similar to that described in Section 5.000. Specifically, the polygraph examiner and treatment provider shall work closely together, and other professionals should be included in the team as indicated.

3.650 Treatment providers shall:

- A. Prepare a summary of offenders' progress and participation in sex offender treatment and their institutional behavior. This summary shall be provided to the parole board prior to a hearing.
- B. Prepare a summary for pre-parole investigation with recommendations regarding ongoing treatment needs, living arrangements and conditions of supervision related to the offender's rehabilitative needs, and;
- C. Forward pertinent documents including any pre-sentence investigation reports to outpatient treatment providers upon request and with a valid release.