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Sex Offender Treatment Board

Practice Standards and Guidelines
for the Evaluation, Treatment and
Management of Juvenile Sex Offenders
January, 2010 Edition

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Regulation:

Effective March 15, 2010, and in accordance with ORS 675.400 and OAR 331-840-0070, all certified clinical and associate sex offender therapists as defined in ORS 675.365 and OAR 331-800-0010 must adhere to the following practice standards and guidelines for the evaluation, treatment and management of juvenile sex offenders.

Guiding Principles:

Safe and effective intervention and management approaches for juvenile sex offenders and youth with sexually abusive behaviors:

- Are victim centered with the primary emphasis on the safety and well-being of past and potential victims, the protection of the community and the protection of the rights of victims and their families.
- Recognize that juveniles who sexually abuse are different from adults who commit sex offenses. Responses to these youth must take into account these differences as well as their specific developmental needs.
- Recognize that juveniles who engage in sexual abuse are a heterogeneous group with diverse victim preferences, levels of risk, criminogenic needs, psychosocial deficits, health and behavioral health needs, strengths and assets.
- Require collaboration of all community agencies, law enforcement, juvenile courts, mental health, child welfare, schools, and an integrated system that recognizes the importance of diverse perspectives, shared resources and mutual commitment to work together.
- Ensure the protection of the rights of juveniles who have sexually abused by providing firm and fair treatment that protects the community and helps to develop hope and a sense of efficacy within the juvenile who has sexually abused for self management and rehabilitation.
- Provide and/or supervise services offered by appropriately credentialed and trained staff and uphold best practice standards of treatment.

SECTION I:

ASSESSMENT STANDARDS

A. Overview

A comprehensive assessment is imperative for the safety of the community, victim and juvenile offenders. Assessments should be specific for use with the juvenile population who are suspected of inappropriate sexual behavior (adjudicated or unadjudicated). Assessments provide reliable information regarding a juvenile's offense, specific risk factors, mental health status, social skills level, cognitive thought processes, family and environmental situation and general clinical needs.

Assessments should occur at periodic intervals to measure changes in the juvenile's individual, social, and environmental circumstances throughout the duration of their involvement with the treatment provider. Assessment recognizes the risk levels, needs, and circumstances of these youth and their change over time. The importance of ongoing assessment is critical so the supervision strategies, clinical interventions, and other management practices can be adjusted based on changes over time.

The goals of assessment are to provide data to guide and inform key stakeholders' decisions for working effectively with juvenile sex offenders and youth with sexually abusive behaviors. These stakeholders include:

- The family and community.
- Juvenile and family court judges who use the data to sentence youthful offenders appropriately and effectively.
- Treatment providers who use the assessment data to develop treatment plans that address juveniles' level of risk and needs, to monitor treatment progress over time, and to determine the appropriate end to treatment.
- Discharge planning staff responsible for releasing juveniles from residential facilities who use the data to determine when and under what conditions juveniles can transition back into their communities.
- Supervision officers and caseworkers who use the data to craft and modify management and supervision strategies to hold these youth accountable for their abusive behavior and to assist them to live healthier lives.

B. Evaluation

The evaluation of juveniles who have committed sexual offenses must be comprehensive. Recommendations for intervention should be included in the summary and the evaluation must be provided in written form to the referring agent. The evaluation of juveniles who have committed sexual offenses has the following purposes:

- To assess overall risk to the community
- To provide protection for victims and potential victims
- To provide written clinical assessment of a juvenile's strengths, risks and deficits

- To identify and document treatment and developmental needs
- To identify and document criminogenic risk and needs
- To determine amenability for treatment
- To identify individual differences, potential barriers to treatment, static and dynamic risk factors
- To make recommendations for the management and supervision of the juvenile
- To provide information to help identify the type and intensity of treatment needed
- To provide specific recommendations for community based treatment or the need for a more restrictive setting

Comprehensive evaluation and assessment of juveniles who have sexually offended is an ongoing process. Progress in treatment and level of risk are not constant over time and may not be directly correlated. As a result, risk and protective factors must be assessed on an ongoing basis.

Recommendations regarding intervention must be based on a juvenile's level of risk and needs rather than on resources currently or locally available. When resources are less than optimal this information must be documented.

The evaluation and subsequent assessments must be sensitive to the rights and needs of the victim and the client. The evaluator must be sensitive to any cultural, language, ethnic, developmental, sexual orientation, gender, gender identification, medical and/or educational issues that may arise during the evaluation. Evaluators must select evaluation procedures relevant to the individual circumstances of the case and commensurate with their level of training and expertise. It is recommended each phase of an evaluation address strengths, risks and deficits in the following areas:

- Cognitive functioning
- Personality, mental disorders and mental health
- Social and developmental history
- Developmental competence
- Current individual functioning
- Current family functioning
- Sexual evaluation
- Delinquency and conduct / behavioral issues
- Assessment of static and dynamic risk factors:
 - Criminogenic risks and needs
 - Community risks
 - Client's awareness of impact on victim
 - External protective factors including informed supervision
 - Amenability to treatment

Evaluation methods may include the use of clinical procedures, screening level tests, observational data, advanced psychometric measurements and special testing measures. Evaluation reports more than 6 months old should be regarded with caution.

It is recommended evaluation methodologies include:

- Examination of juvenile justice information and/or Department of Human Services reports.
- Details of the offense/factual basis and any victim statements including a description of harm done to the victim.
- Examination of collateral information including information regarding the juvenile's history of sexual offending and/or abusive behavior.
- A sex offense specific risk assessment protocol.
- Use of multiple assessment instruments and techniques.
- Structured clinical interviews including sexual history.
- Integration of information from collateral sources.
- Standardized psychological testing if clinically indicated.

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

If there is an admission of guilt and/or there is a voluntary request by the juvenile with the consent of a parent/guardian, evaluators may perform evaluations prior to, or in the absence of, filing of charges or adjudication. Such referrals for evaluation should be made only after the juvenile and parent/guardian have had the opportunity to consult with legal counsel concerning consequences, supervision and treatment expectations. Evaluations may be used to aid the court and should focus on placement and treatment recommendations. It is not the role of the evaluator to establish innocence or guilt. Recommendations should include the necessary level of supervision, management and placement and allow the following questions to inform decisions.

- Is the victim(s) in the home?
- What was the level of intrusiveness of the sexual behavior?
- Did the juvenile use force, threats, intimidation, coercion or weapons during the alleged offense?
- Are the juvenile's parents/guardians minimizing or denying the seriousness of the alleged offense?
- Can the parent/guardian be reasonably expected to provide supervision in the home and the community as outlined in the Informed Supervision Protocol, at minimum?
- Does the juvenile have access to other vulnerable persons?
- What is the juvenile's history of delinquent or sexual offending behavior?

The evaluator must obtain the consent of the parent/guardian and the informed assent of the juvenile for the evaluation, unless the juvenile is 14 years of age or older in

which the juvenile has the right to consent to outpatient diagnosis or treatment of a mental or emotional disorder under to ORS 109.675. The juvenile and parent/guardian will be informed of the evaluation methods, how the information may be used and to whom it will be released. The evaluator must also inform the juvenile and parent/guardian about the nature of the evaluator's relationship with the juvenile and with the court. The evaluator must respect the juvenile's right to be fully informed about the evaluation procedures. Results of the evaluation may be reviewed with the juvenile and the parent/guardian upon request or as required by regulation. The mandatory reporting law requires certain professionals to report suspected or known abuse or neglect to the local department of social services or law enforcement. Evaluators are statutorily mandated reporters of child abuse or neglect.

SECTION II:

TREATMENT STANDARDS

A. Overview

Specialized treatment for juvenile sex offenders and youth with sexually abusive behaviors includes a continuum of services chosen for a particular youth based on several concerns: community safety, the victim's safety, the youth's assessed treatment needs, and, in so far as they can be identified, factors that enhance or reduce the risk for re-offense.

Specific treatment for juvenile sex offenders and youth with sexually abusive behaviors must promote accountability, increase positive coping skills in order to reduce the risk of recidivism, address criminogenic risk and needs, and is essential to rehabilitate these youth successfully. To achieve this end, interventions must employ cognitive behavioral methods and may include family treatment, parent training and a relapse prevention component. As research on this population of youth progresses, it should guide improvements to programming and treatment, to assessment tools and the application of data gathered and reflected in treatment planning.

Sex offense specific treatment for juveniles must be provided by persons who are specifically trained and competent in this specialty area. Traditional psychotherapy is not sufficient for sex offense specific treatment.

It is recommended these Standards and Guidelines be utilized with juveniles and families who are both adjudicated and those who are seeking intervention regarding sexually abusive behavior that has been disclosed through self-report or evaluation. Following a comprehensive evaluation, juveniles who have been adjudicated for non-sexual offenses, placed on diversion or those who are the subject of a dependency and neglect order may be included in the same programs as those developed for juveniles adjudicated for sexual offending behavior.

A written treatment plan must be developed based on the individualized evaluation and assessment of the juvenile. Specific treatment plans must be designed to address strengths, risks and deficits and all areas of need identified by the evaluation and must:

- Include treatment goals and interventions that are individualized to address the juvenile's therapeutic needs and concerns.
- Include treatment goals and interventions that are individualized to improve family functioning and enhance the abilities of support systems to respond to juvenile's needs and concerns.
- Implement interventions addressing the juvenile's need for pro-social peer relationships, activities and success in educational/vocational settings.

- Describe participation and supervision expectations for the juvenile, the family/caregivers, educators and support systems which exist.
- Describe relevant and measurable outcomes that will be the basis of determining successful completion of treatment.
- Develop detailed, long-term aftercare plans that support and maintain strengths, as well as address risks and deficits.
- The treatment plan must be reviewed at a minimum of every three months and at each transition point and revisions made as needed.

Sex offense specific treatment methods and intervention strategies shall be based on the individual treatment plan developed in response to the individual evaluation and ongoing assessments. It is recommended a combination of individual, group and family therapy be used unless contraindicated.

When a specific type of intervention is contraindicated, the issue(s) must be documented and alternative interventions listed.

If contra-indicators change and the modality is viable, the treatment plan must be amended accordingly.

B. Treatment Modalities

The primary treatment provider must make referrals for individual, family therapy or other adjunct services. Therapists must have a level of experience and knowledge of juvenile sexual offense dynamics to adequately provide services. The board is aware of a variety of factors that may contribute to difficulties for providers and programs to come into compliance with these standards. It is expected all individuals and agencies who make referrals and who provide services make a concerted effort to work within these Standards and Guidelines. It is recommended when a referring therapist has exhausted local options to come into compliance that person or entity must document the juvenile's needs, the circumstances that prevent compliance and the alternative solution.

- Individual therapy is used to address mental health issues, sex offender specific treatment and/or to support the juvenile in addressing issues in group, family or milieu therapy.
- Family therapy addresses family systems issues and dynamics. This model must address, at a minimum, informed supervision, therapeutic care, safety plans, relapse prevention, reunification and aftercare plans.
- Group therapy promotes the development of pro-social skills, provides positive peer support and/or is used for group process. It is recommended therapist/client ratios be no less than 1:6; 2:10.
- Multi-family groups provide education, group process and/or support for the parent and/or siblings of the juvenile. Inclusion of the juvenile is optional. The treatment provider monitors and supervises confidentiality. Staff to client ratios must be designed to provide safety for all participants.

- Milieu therapy is used to promote growth, development and relationship skills, to practice pro-social life skills, and to supervise, observe and intervene in the daily functioning of the juvenile. A combination of male and female role models is preferred in staffing milieus. Staff to client ratios must be designed to provide safety for all participants.
- Psycho-educational classes promote the development of specific knowledge and skills (e.g., the development of healthy sexuality and communication skills), and may take place within the context of group therapy or as an independent process.
- Self-help (e.g. 12-step programs) or time limited treatments are used as adjuncts to enhance goal oriented treatment. Adjunct treatments must be complementary to sex offense specific treatment.

Juveniles who commit sexual offenses present a complex set of challenges for group facilitators. Not only are the dynamics multifaceted, the safety of group members is of concern. The intensity of these groups requires a strong team approach; therefore, staff to client ratios may be higher than in other types of groups. It is understood occasional illness or absence of co-providers may affect ratios. Male and female co-therapists are preferred, when qualified individuals are available.

Treatment providers must monitor and manage groups to minimize exposure to deviance, deviant peer modeling and to provide for the safety of all group members.

C. Treatment Content

The content of sex offense specific treatment must focus on decreasing deviance and dysfunction and improving overall health with the goal of decreased risk. Treatment planning must be formulated to set measurable outcomes and include, but not be limited to:

- The role of sexual arousal in sexual offending or abusive behaviors.
- The definition of healthy and respectful sexual fantasy and behaviors.
- Reduction and disruption of deviant sexual thoughts and arousal.
- Awareness of victim impact without objectification or stereotyping of the victim.
- Recognition of harm done to victim(s).
- Impact of sexual offending on victim(s), families, community and self.
- Restitution/reparation to victims (including victim clarification) and others impacted by the offense including the community.
- Recognition of victim(s) experience through role taking and perspective taking.
- Define abusive behaviors: abuse of self, others, property, physical, sexual and verbal abuse.
- Acceptance of responsibility for offending and abusive behaviors, past and present, without minimization or externalization of responsibility or blame.

- Identification of patterns (cycle) of thoughts, feelings and behaviors associated with offending and abusive behaviors.
- Identification of cognitions supportive of antisocial or violence themed attitudes.
- Disinhibiting influences such as stress, substance use, impulsivity, peer influence.
- Anger management, conflict resolution, problem solving, stress management, frustration tolerance, delayed gratification, cooperation, negotiation and compromise.
- Recognition and management of risk factors.
- Skills for safety planning, risk management, strength-based aftercare strategies.
- Identification of physical health and safety needs.
- Accurate information about human sexuality; positive sexual identity.
- Intervention strategies to effectively address developmental deficits, delays, and skills for successful functioning.
- Relationship skills such as assessment of personal trustworthiness and basic trust of others and interpersonal communication skills.
- Locus of control, i.e. internal sense of mastery, control, competency.
- Family dysfunction and/or deviance including intimacy and boundaries, attachment disorders, role reversals, sibling relationships, criminality and psychiatric disorders.
- Recognition of how attitudes of family, peer group, community and culture influence tolerance of offending/abusive behavior.
- Experiences of victimization, trauma, maltreatment, loss, abandonment, neglect, exposure to violence in the home or community.
- Legal parameters and consequences relevant to sexual offending.
- Diagnostic assessment, stabilization, pharmacological treatments and management of concurrent psychiatric disorders.

Sex offense specific treatment must be designed to maximize measurable outcomes relevant to the dynamic functioning of the juvenile in the present and future by decreasing risk of sexual and non-sexual deviance, dysfunction and offending. Outcomes relevant to decreased risk include (but are not limited to):

- Juvenile consistently defines all types of abuse (self, others, property).
- Juvenile acknowledges risks and uses foresight and safety planning to moderate risk.
- Juvenile consistently recognizes and interrupts patterns of thought and/or behavior associated with his/her abusive behavior.
- Juvenile consistently demonstrates emotional recognition, expression and empathic responses to self and others (empathy).
- Juvenile demonstrates functional coping patterns when stressed.
- Juvenile makes accurate attributions: takes responsibility for own behavior and does not try to control or take responsibility for other's behavior (accountability).
- Juvenile has demonstrated the ability to manage frustration and unfavorable events, anger management and self-protection skills.
- Juvenile rejects abusive thoughts.

- Juvenile improves overall health, strengths, skills and resources relevant to successful functioning.

Outcomes relevant to increased overall health include (but are not limited to):

- Juvenile demonstrates pro-social relationship skills and is able to establish closeness, trust, and assess trustworthiness of others and to establish healthy sexual attitudes, boundaries and behaviors.
- Juvenile has improved/positive self-image and is able to be separate, independent and competent.
- Juvenile is able to resolve conflicts and make decisions; is assertive, tolerant, forgiving, and cooperative and is able to negotiate and compromise.
- Juvenile is able to relax, play, and is able to celebrate positive experiences.
- Juvenile seeks out and maintains pro-social peers.
- Juvenile has the ability to plan for and participate in structured pro-social activities.
- Juvenile has identified family and/or community support systems.
- Juvenile is willing to work to achieve delayed gratification, persists in pursuit of goals, respects reasonable authority and limits.
- Juvenile is able to think and communicate effectively, demonstrates rational cognitive processing, adequate verbal skills, and is able to concentrate.
- Juvenile has an adaptive sense of purpose and future.

Sex offense specific treatment providers shall continue to advocate for treatment until the outcomes in the individual treatment plan have been achieved. Offense prevention and aftercare planning must be elements of the treatment plan and developed based on risk and the ongoing needs of the juvenile.

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

D. Documentation

It is considered best practice to have records as complete as possible. The complete case record must provide information obtained in all areas of a juvenile's life impacted by the offense and subsequent interventions. When services are not available it must be noted and the alternative plan delineated. Client files must include, but are not limited to:

- Evaluations, assessments, present tense investigations and treatment plans
- Documentation of treatment goals and interventions
- Documentation of clarification assignments and progress
- Documentation of progress (or lack of) toward measurable outcomes
- Critical incidents occurring during treatment
- Impediments to success and/or lack of resources and systemic response to the issue
- Non-compliance by juvenile, family, or support system
- Discharge criteria, risk assessment, safety plan and recommendations for aftercare
- Availability (or lack of) of family and/or community resources to support aftercare

E. Confidentiality

Best practices recommend treatment professionals facilitate open communication amongst all professionals involved in the intervention of the juvenile sex offenders and youth with sexually abusive behaviors. This waiver of confidentiality must be based on complete informed consent of the parent/legal guardian and voluntary assent of the juvenile. The juvenile and parent/guardian must be fully informed of alternative dispositions that may occur in the absence of consent/assent.

The collaborating professionals involved in the treatment and supervision of the client must obtain the required signed waivers of confidentiality with the informed consent of the parent/guardian and the assent of the juvenile who has committed a sexual offense.

Providers must notify all clients of the limits of confidentiality imposed by the mandatory reporting law. Disclosure regarding alleged acts against other minors may generate a mandatory report to designated agencies including but not limited to Department of Human Services.

Providers must ensure that a juvenile who has committed a sexual offense and the parent/guardian understand the scope and limits of confidentiality in the context of his/her situation, including collateral information that previously may have been confidential.

Providers must inform all persons participating in any group that participants must respect the privacy of other members and agree to maintain confidentiality regarding shared information and the identity of those in attendance.

Providers must be in compliance with all federal and state statutes and regulations governing confidentiality.

F. Treatment Agreements

The purpose of treatment agreements is to convey information to the juvenile and the parent/guardian regarding treatment program expectations and policies, unless the juvenile is 14 years of age or older in which the juvenile has the right to consent to outpatient diagnosis or treatment of a mental or emotional disorder under ORS 109.675. Treatment agreements may also take the form of acknowledgements, agreements, or disclosures. Issues such as the juvenile's developmental stage, level of cognitive functioning and the purpose of the document should be taken into account. These documents may be useful with juveniles to foster accountability and responsibility.

Providers must develop and utilize a written treatment agreement with each juvenile who has committed a sexual offense prior to the commencement of treatment. Treatment agreements must address public safety and be consistent with the conditions of the supervising agency. The treatment agreement must define the specific responsibilities and rights of the provider, and be signed by the provider, parent/guardian(s) and the juvenile.

At minimum, the treatment agreement must explain the responsibility of a provider to:

- Define and provide timely statements of the applicable costs of evaluation, assessment and treatment, including all medical and psychological testing, physiological tests and consultations.
- Describe the waivers of confidentiality, describe the various parties, including the multidisciplinary team with whom treatment information will be shared during the course of treatment and inform the juvenile and parent/guardian that information may be shared with additional parties on a need to know basis.
- Describe the right of the juvenile or the parent/guardian(s) to refuse treatment and/or to refuse to waive confidentiality, and describe the risks and the potential outcomes of that decision.
- Describe the procedure necessary for the juvenile or the parent/legal guardian(s) to revoke the waiver and describe the relevant time limits.
- Describe the type, frequency and requirements of treatment and outline how the duration of treatment will be determined.
- Describe the limits of confidentiality imposed on providers by the mandatory reporting law as it applies to each licensed professional in the State of Oregon.

At a minimum, the treatment agreement must explain the responsibilities of the juvenile and his/her parent/guardian(s) and must include but is not limited to:

- Compliance with the limitations and restrictions placed on the behavior of the juvenile as described in the terms and conditions of diversion, probation, parole, Department of Human Services, community corrections or the Department of Corrections, and/or in the agreement between the provider and the juvenile.

- Compliance with conditions that provide for the protection of past and potential victims, and that protect victims from unsafe or unwanted contact with the juvenile.
- Participation and progress in treatment
- Payment for the costs of assessment and treatment of the juvenile and family
- Notification of third parties (i.e. employers, partners, etc.).
- Notification of the treatment provider of any relevant changes or events in the life of the juvenile or the juvenile's family/support system.

G. Completion or Termination of Sex Offense Specific Treatment

Successful completion of treatment should be understood as the cessation of mandated sex offense specific treatment. It may not be an indication of the end of the juvenile's management needs or the elimination of risk to the community. The multidisciplinary team must carefully consider victim and community safety before making a determination of completion of treatment.

Successful completion of sex offense specific treatment requires the following:

- Accomplishment of the goals identified in the treatment plan.
- Demonstrated application in the juvenile's daily functioning of the principles and tools learned in sex offense specific treatment.
- Consistent compliance with treatment conditions.
- Consistent compliance with supervision terms and conditions.
- Completed written aftercare and safety plan addressing remaining risks and deficits, and that has been reviewed and agreed upon by all professionals involved in the treatment and supervision of the client, the family and the community support system.

Any exception made to any of the requirements for successful completion must be made in consultation with all professionals involved in the treatment and supervision of the client. In this case, all professionals involved in the treatment and supervision of the client must document the reasons for the determination of why treatment has been completed without meeting all of the Standard's requirements and note the potential risk to the community.

The treatment completion decision must follow the evaluation, assessment and treatment plan. In making this determination, all professionals involved in the treatment and supervision of the client must:

- Consider all sources of collateral information in making transition, discharge or termination decisions.
- Assess and document evidence the treatment plan goals have been met; the actual changes that have been accomplished regarding the juvenile's potential to re-offend; and which risk factors remain, particularly those effecting the emotional and physical safety of the victim(s) and potential victims.
- Repeat, when indicated, those assessments showing changes in the juvenile's level of risk and functioning.
- Seek input from others who are aware of the juvenile's progress and current level of functioning.
- Assess the viability of support and resources in the juvenile's transitional environment if aftercare includes transition as part of the living environment.
- Develop a treatment summary with aftercare plan recommendations.

Expectations regarding outcomes must consider the assessment of developmental stages and functional impairments. Younger, lower functioning or developmentally delayed juveniles cannot be expected to have the same competencies as older, higher functioning juveniles. In such cases, evidence the juvenile is aware of risks and is able to manage them may be demonstrated by his/her willingness to ask for help, cooperate with adult caregivers, and comply with legitimate authority. Aftercare and long-term relapse prevention for juveniles who are still highly dependent or cannot reasonably master relevant outcomes will require commitment from their support systems.

H. Denial

Denial is a common defense mechanism that protects individuals from being overwhelmed by unmanageable stress. Denial may also be a conscious action to avoid internal or external consequences associated with one's behavior. Initial denial of allegations of a sexual offense is not uncommon, and it is not always clear whether it is a conscious ploy to avoid consequences or a defensive coping mechanism. Therefore, assessment of the nature and extent of denial must be part of each sex offense specific evaluation.

Some level of denial is common among juveniles who commit sexual offenses and their families, and may be reduced through intervention. The existence of some level of denial regarding sexual offending behaviors does not in itself exclude the juvenile from treatment, but may be a factor in determining the level of structure for the juvenile along the continuum of care.

Through evaluation it may be determined the juvenile's level of denial is such that continued evaluation or sex offense specific treatment may be contraindicated. The evaluator must document the rationale for a recommendation to postpone further evaluation or treatment and provide a recommendation for appropriate intervention.

The level of denial and defensiveness must be assessed during the initial sex offense specific evaluation. While some level of denial and/or defensiveness may be expected initially, high levels of denial may be a factor for consideration of a more restrictive placement. In cases where the level of denial is assessed as high, evaluators and providers shall make recommendations based on individual needs rather than availability of resources.

I. Penile Plethysmography

Physiological data may be useful in assessing progress and risk for some juveniles. Providers who utilize penile plethysmography must recognize the data should be interpreted in the context of a comprehensive evaluation and/or treatment process. Deviant sexual arousal or interest is not a component of many juvenile's risk profile. Physiological data cannot determine whether an individual has committed or is going to

commit a specific sexual act. Research has not been conducted to assess the arousal patterns of juveniles in the general population; therefore, there is no normative data. Research using samples of college age males (older teens and young adults) has shown that even as older teens and young adults, many males in this culture experience a wide range of sexual interests and arousal. There is no research available regarding penile plethysmography with females.

Penile plethysmography is an assessment of a juvenile's sexual arousal patterns using non-pornographic audio and/or visual stimuli. The clinician should consult with a penile plethysmograph examiner and should consider a referral for penile plethysmography when a juvenile is post-pubescent, at least 14 years of age, and any of the following indicators are evidenced through legal history, an evaluation or an individual's risk profile.

- Pre-pubescent male and/or female victims(s)
- Three or more known victims
- Pairing of aggression and physiological arousal
- Self-report of deviant arousal
- Offense history indicative of a persistent pattern of deviant sexual behavior

Uses for penile plethysmograph examination:

- To compare the juvenile's relative physiological arousal to his own self-report in order to assess his self-awareness and enhance his understanding of his own sexuality.
- To compare the juvenile's relative physiological arousal to a variety of stimulus cues.
- To compare the juvenile's measured physiological response to known pattern of deviant sexual history.
- To assess for the presence or absence of sexual arousal response to appropriate sexual stimuli.
- To discern change in the juvenile's patterns of arousal over time, e.g. to measure increased arousal to non-problematic stimuli and/or decreased arousal to problematic stimuli.
- To assess the effectiveness of conditioning processes and suppression techniques the juvenile has learned in treatment, e.g. to measure the juvenile's ability to suppress unwanted and problematic arousal.
- To carefully control the administration of and monitor the effects of more intrusive conditioning techniques and/or the efficacy of psycho-pharmaceutical intervention.

Penile plethysmograph examiners must meet the standards for penile plethysmography as defined in the Association for the Treatment of Sexual Abusers Practitioner's Handbook and have training specific to the assessment and treatment of juveniles. If an examiner uses visual stimuli in addition to or in place of audio stimuli, it should not be

used with persons under the age of 14. Visual and auditory stimuli should be non-pornographic.

Penile plethysmograph testing must be used as an adjunct tool; it does not replace other forms of monitoring. Information and results obtained from penile plethysmograph examinations should never be used in isolation when making treatment or supervision decisions. Information and results obtained through penile plethysmograph examination, shall be considered, but must not become, the sole basis for decisions regarding transition, progress and completion of treatment.

J. Visual Reaction Time instruments

Visual reaction time data may be useful in assessing sexual interest and risk for some juveniles. Providers who utilize visual reaction time instruments must recognize the data should be interpreted in the context of a comprehensive evaluation and/or treatment process. Deviant sexual interest can be a component of many juveniles' risk profiles. visual reaction time data cannot determine whether an individual has committed or is going to commit a specific sexual act. Research has not been conducted to assess the sexual interests of juveniles in the general population; therefore, there is no normative data. There is no research available regarding visual reaction time data with females.

A visual reaction time instruments examiner must demonstrate competency according to professional standards and conduct visual reaction time examinations in a manner consistent with the reasonably accepted standard of practice for this instrument. Uses for visual reaction time instrument include the ability to compare the juvenile's self-awareness and acknowledgement of sexual interest to an objective measure and to facilitate disclosure and discussion of sexual interest with the juvenile. Generally, it is recommended visual reaction time instruments be considered only for a juvenile who is post-pubescent and at least 14 years of age.

The results of visual reaction time instruments cannot be interpreted as indicators of guilt or innocence regarding any specific sexual act. visual reaction time instruments can be used as an adjunct assessment tool. Information and results obtained from visual reaction time instruments should never be used in isolation when making treatment or supervision decisions. Information and results obtained through visual reaction time instruments can be considered, but should not become the sole basis for decisions regarding transition, progress and completion of treatment.

Before commencing any visual reaction time examination with any juvenile who has committed a sexual offense, the visual reaction time examiner must document that each juvenile at each examination has been provided a thorough explanation of the visual reaction time assessment process and the potential relevance of the procedure to the juvenile's treatment and/or supervision. Review and documentation of informed assent will include information regarding the juvenile's right to terminate the examination at any time, and speak with his or her attorney if desired. The examinee

must also sign a standard waiver/release of information statement. The language of the statement should be coordinated prior to the visual reaction time examination with the multidisciplinary team.

The examiner must elicit relevant biographical and medical history information from the examinee prior to administering any visual reaction time instrument. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination. Test results must be reviewed with the examinee.

K. Polygraphs

Polygraph testing must be used as an adjunct tool; it does not replace other forms of monitoring. Information and results obtained from polygraph examinations should never be used in isolation when making treatment or supervision decisions.

Information and results obtained through polygraph examination shall be considered, but must not become, the sole basis for decisions regarding transition, progress and completion of treatment. The findings of polygraph tests, as well as the juvenile's compliance or refusal to comply with requests for polygraph testing, should not be used as the sole source in making treatment and supervision decisions.

The treatment and supervision team must respond to polygraph testing results in order to maintain the efficacy of the tool for maximum therapeutic benefit. Treatment and supervisory team responses shall be in the form of sanctions, additional restrictions, rewards or follow-up through the treatment and safety plans commensurate with the information obtained in the results.

The treatment and supervision team must determine and document in the case files the rationale for and type of polygraph testing used, frequency of testing, and the use of results in treatment, behavioral monitoring and supervision.

Polygraphers will be fully licensed in the state of Oregon, in good standing, adhere to their professional ethics and to the sex offender specific standards of practice of the American Polygraph Association.

At the time of testing, the polygraph examiner must make the final determination of suitability for polygraph examination and not conduct polygraph examinations with juveniles when clear indicators exist that results would be invalid.

No juvenile shall be referred for polygraph examinations without the full, informed consent of the parent/legal guardian and the informed assent of the juvenile. The potential consequences of compliance or non-compliance with the procedure should be fully explained including legal consequences.

The following types of polygraph examinations should be used with juveniles who have committed sexual offenses:

- **Sexual history polygraph examination**-The treatment and supervision team shall refer juveniles determined to be suitable for polygraph examination. When employed, it is recommended the sexual history polygraph examination be initiated within three to nine months following the onset of treatment to allow for sufficient preparation and follow-up on the information and results. The completion and verification of the juvenile's sexual history should be given reasonable priority as it is the basis for much of the treatment planning process.

When necessary, the treatment and supervision team may accelerate or delay referral for sexual history polygraph examination and the reasons for this decision must be documented in the juvenile's clinical and supervision records.

Test questions must focus on issues that are clinically relevant to risk assessment, treatment issues and transition planning. Care must be given to minimize the focus on detail which may be sexually arousing.

- **Maintenance/monitoring polygraph examination**-The treatment and supervision team shall refer juveniles determined to be suitable for polygraph examination according to criteria for maintenance polygraph examination prior to transition to less restrictive placement settings in the community.

When indicated in accordance with suitability criteria, it is recommended the treatment and supervision team refer juveniles for maintenance polygraph examination approximately every four to six months or as deemed necessary.

Test questions must focus on issues clinically relevant to the assessment of safety and/or risk, compliance with the conditions of treatment and supervision and progress in treatment.

- **Specific Issue polygraph examination**-The treatment and supervision team may, at its discretion, refer juveniles for a specific issue polygraph examination.

It is appropriate to employ specific issue polygraph examinations under the following conditions:

- Substantial denial of offense
- Significant discrepancy between the account of the juvenile who committed a sexual offense and the victim's description of the offense
- To explore specific allegations or concerns

APPENDIX:

DEFINITIONS

Accountability: Quality of being responsible for one's conduct, being responsible for causes, motives, actions and outcomes.

Aftercare: Aftercare commences at the point when the treatment provider and juvenile probation officer approves completion of primary treatment and readiness for accountability through a less restrictive supervision plan. Aftercare often requires continued input by those who have been part of the juvenile's treatment and supervision team.

Aftercare Plan: Developed by the juvenile client's treatment and supervision team prior to the juvenile's completion of treatment; addresses strengths, risks and deficits relative to the release/completion and follow-up stage of treatment and supervision.

Amenability to Treatment: A sincere willingness, even if minimal, to participate in treatment to address changes in thoughts, feelings and behaviors.

Assessments: Standardized measurements, developed for juvenile populations, used to test various levels of functioning including: cognitive, neuropsychological, psychiatric, psychological (DSM Axis II), memory and learning, social and emotional, social stability, family dynamics, academic, vocational/career, sexual, accountability, offense characteristics and level of risk.

Board: Oregon Sex Offender Treatment Board

Caregivers: Parents or other adults who have a custodial responsibility to care for the juvenile. Care giving is broadly defined as providing the nurturance, guidance, protection and supervision that promotes normal growth and development and supports competent functioning.

Caregiver Stability: Consistency of a caregiver's relationship with the juvenile across the continuum of care. Caregiver consistently participates in the juvenile's treatment and supervises appropriately.

Coercion: Exploitation of authority, use of pressure through actions such as bribes, threats or intimidation to gain cooperation or compliance.

Commitment: A statutory process by which a person is placed in the custody of a public or private agency, i.e. committed to the State Department of Human Services or the Oregon Youth Authority.

Community Supervision: When a juvenile is residing in any unlocked location (home, foster placement, RTC placement, etc.), he/she is considered to be under community supervision. Community supervision is the responsibility of either the appropriate juvenile authority or the Department of Human Services in consultation with any engaged treatment providers.

Complete Record: A working file which includes the legal history, reformation plan or social history report, initial evaluations, all ongoing assessments, all case plans, all interventions, sanctions and contact information of all professionals, parents/guardians and others identified as significant in a juvenile's case.

Consent: Agreement including all of the following: 1) understanding what is proposed based on age, maturity, developmental level, functioning and experience; 2) knowledge of societal standards for what is being proposed; 3) awareness of potential consequences and alternatives; 4) assumption that agreement or disagreement will be respected equally; 5) voluntary decision; and 6) mental competence.

Contact: Any verbal, physical, written or electronic communication that may be indirect or direct, between a juvenile who has committed a sexual offense and a victim or potential victim.

Continuing Care and Services: The various levels and locations of care are based on the juvenile's individual needs and level of risk; include treatment intensity and approach, and restrictiveness of setting. For the purpose of these Standards, the continuum is not unidirectional.

Criminogenic Risk/Needs: Factors that contribute to the likelihood a youth will engage in further criminal behavior.

Dependency and Neglect: A juvenile court finding that a child is in need of care and/or protection beyond that which the parent is, or has been, able or willing to provide. Dependency and neglect cases are often referred to as "D&N" cases. Such cases may result in court ordered treatment for parents, children and families, without any family member having been charged, convicted or adjudicated for a crime. Court orders may include directives for the juvenile to participate in sex offense specific treatment and/or directives regarding familial participation in the juvenile's treatment. At times these orders are put in place to ensure residential treatment for juveniles.

Developmental Competency: Having the acquired skills for optimal human functioning at each developmental stage.

Deviance: Significant departure from the norms of society; behavior which is not normative, differing from an established standard.

Direct Clinical Contact: Includes intake, face-to-face therapy, case/treatment staffing with the juvenile, treatment plan review with the juvenile, crisis management, and milieu intervention.

Dyadic Therapy: Two people engaged in a therapeutic setting facilitated by a provider.

Dynamic Risk Factors: For the purpose of these Standards, dynamic risk factors are considered changeable and must be addressed in sex offense specific treatment. The juvenile is held accountable and responsible for managing dynamic risk factors that are not based in the environment.

Evaluation: The scope of various assessments and information gathered collaterally constitutes an evaluation. The systematic collection and analysis of the data is used to make treatment and supervision decisions. Evaluations, as a whole, are not likely to be ongoing since the subsequent assessments can be done on an as-needed basis.

Guideline: A principle by which judgments to determine a policy or course of action is made. Guidelines are identified by the terms, "should," "may," and in some cases, "it is recommended..."

Incidental: Unplanned or accidental; by chance.

Informed Assent: Juveniles give assent, whereas adults give consent. 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 juveniles who have committed sexual offenses are not voluntary clients and that their choices are therefore more limited. Informed means that a person's assent is based on a full disclosure of the facts needed to make the decision intelligently, e.g. knowledge of risks involved, alternatives.

Informed Consent: Consent means voluntary agreement, or approval to do something in compliance with a request. Informed means that a person's consent is based on a full disclosure of the facts needed to make the decision intelligently, e.g. knowledge of risks involved, alternatives.

Informed Supervision: Specific to these Standards, informed supervision is the ongoing, daily supervision of a juvenile who has committed a sexual offense by an adult who:

- Is aware of the juvenile's history of sexually offending behavior;
- Does not deny or minimize the juvenile's responsibility for, or the seriousness of sexual offending;
- Can define all types of abusive behaviors and can recognize abusive behaviors in daily functioning;
- Is aware of the laws relevant to juvenile sexual behaviors;

- Is aware of the dynamic patterns (cycle) associated with abusive behaviors and is able to recognize such patterns in daily functioning;
- Understands the conditions of community supervision and treatment;
- Can design, implement and monitor safety plans for daily activities;
- Is able to hold the juvenile accountable for behavior;
- Has the skills to intervene in and interrupt high risk patterns;
- Can share accurate observations of daily functioning;
- Communicates regularly with members of the multidisciplinary team.

Collaborative Team of Professionals: All other professionals involved in the treatment decisions such as supervising probation or parole officer, primary treatment provider and ancillary treatment providers, educators or victim advocates.

Needs: Issues to be addressed therapeutically or by specific intervention through the treatment and supervision plan.

On-Site Treatment: Treatment provided in a therapeutic milieu, residential or day-treatment setting which is specifically not an outpatient program.

Overall Health: Consists of personal and ecological aspects of a juvenile's life including: physical, emotional, intellectual, social, relational, spiritual, educational and vocational aspects.

Polygraph: An instrument that records certain physiological changes in a person undergoing questioning in an effort to verify truth or detect deception.

Potential Victim: Any individual who fits the juvenile's victim selection profile, whether opportunistic or predatory, or who the juvenile intends to harm. Animals have been harmed by juveniles who sexually offend and must be considered potential victims.

Purposeful: A planned experience with an identified potential outcome.

Relapse Prevention: An element of treatment designed to address behaviors, thoughts, feelings and fantasies that were present in the juvenile's offense, abuse cycle and consequently, part of the relapse cycle. Relapse prevention is directly related to community safety. Risk assessment must be used to develop safety plans and determine the level of supervision.

Recidivism: Return to offending behavior after some period of abstinence or restraint. A term used in literature and research which may be measured by self-reported re-offenses, convicted offenses or by other measures. The definition must be carefully identified especially when comparing recidivism rates as an outcome of specific therapeutic interventions.

Safety Planning: Recognition/acknowledgement of daily/circumstantial/dynamic risks and purposeful planning of preventive interventions which the juvenile and/or others can use to moderate risk in current situations.

Secondary Victim: A relative or other person closely involved with the primary victim who is impacted emotionally or physically by the trauma suffered by the primary victim.

Sex Offense Specific Treatment: A comprehensive set of planned therapeutic experiences and interventions to reduce the risk of further sexual offending and abusive behavior by the juvenile. Treatment focuses on the situations, thoughts, feelings and behaviors that have preceded and followed past offending (abusive cycles) and promotes changes in each area relevant to the risk of continued abusive, offending and/or sexually deviant behaviors. Due to the heterogeneity of the population of juveniles who commit sexual offenses, treatment is provided on the basis of individualized evaluation and assessment. Treatment is designed to stop sexual offending and abusive behavior, while increasing the juvenile's ability to function as a healthy, pro-social member of the community. Progress in treatment is measured by the achievement of change rather than the passage of time. Treatment may include adjunct therapies to address the unique needs of individual juveniles, yet always includes offense specific services by listed sex offense specific providers.

Sexual Abuse Cycle: A theoretical model of understanding the sequence of thoughts, feelings, behaviors and events within which sexual offending and abusive behavior occur. Also referred to as "offense cycle," or "offense chain"

Sexual Paraphilias / Sexual Deviance:

Sexual paraphilias/sexual deviance means a sub-class 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 non-consenting persons that occur over a period of at least 6 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 non-consenting partner in a way that may be injurious to the partner... The individual may be subject to arrest and incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal acts" (DSM-IV-TR, pages 566-567). 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.

Special Populations: Any group of juveniles, who commit sexual offenses, who have needs which significantly differ from the majority of juveniles in this population. Special populations might include (but are not limited to) juveniles who are female, are

developmentally disabled, have co-occurring psychiatric disorders or those who have learning disabilities.

Standard: Criteria set for usage or practices; a rule or basis of comparison in measuring or judging. Standards are identified by directive wording such as "shall," "must," or "will".

Static Risk Factors: For the purposes of these Standards, static risk factors refer to those characteristics that are set, are unchangeable by the juvenile and may be environmental, or based upon other observable or diagnosable factors.

Supervising Officer/Agent: A professional in the employ of the probation, parole or state/county department of human services who is the primary supervisor of the juvenile and who maintains the complete case record.

Termination: Removal from or stopping sex offense specific treatment due to 1)completion; 2)lack of participation; 3) increased risk; 4) re-offense; or, 5)cessation of mandated sex offense specific treatment without completion (without accomplishing treatment goals).

Therapeutic Care: Intervention and nurturance, beyond normal parenting, which address treatment goals. Remediation of special needs and/or developmental deficits identified in the individualized evaluation which focuses on increasing juveniles' potential and competencies for successful, normative functioning. Standards for therapeutic care apply to care in both in and out-of home living settings, yet such care may also be provided by parents who are active participants in the treatment process.

Therapeutic Caregivers: Responsible for implementing interventions to address goals to be accomplished in a therapeutic care setting.

Therapeutic Milieu: The setting in which caregivers provide therapeutic care in out-of-home, residential and day-treatment environments.

Transition Points: Planned movement from one level of care to another.

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Sex Offender Treatment Board

Practice Standards and Guidelines
for the Evaluation, Treatment and
Management of Sex Offenders with
Intellectual and Other Developmental
Disabilities

January, 2010 Edition

Regulation:

Effective March 15, 2010, and in accordance with ORS 675.400 and OAR 331-840-0070, all certified clinical and associate sex offender therapists as defined in ORS 675.365 and OAR 331-800-0010 must adhere to the following practice standards and guidelines for the evaluation, treatment and management of sex offenders with intellectual and other developmental disabilities.

SECTION I:

STANDARDS FOR SEX OFFENSE-SPECIFIC EVALUATIONS

A. Conducting Evaluations

Evaluations are conducted to identify levels of risk and specific risk factors that require attention in treatment and supervision, and to assist the court in determining the most appropriate sentence for offenders. Each sex offender must receive a thorough assessment and evaluation that examines the interaction of the offender's intellectual or other developmental disabilities, mental health, social/systemic functioning, family and environmental functioning, and offending behaviors because of the importance of the information to planning subsequent sentencing, supervision, treatment, placement and housing, day programming, and behavioral monitoring. Specialized experience and training is needed to conduct a sex offense specific evaluation with clients who experience intellectual or other developmental disabilities.

Evaluators have an ethical responsibility to conduct evaluations which are within the scope of their training, education, and experience. Clinicians without sufficient training and experience with special needs clients should either obtain the needed training and supervision or refer such clients to another evaluator with the requisite training and experience for such evaluations. All evaluations of special needs clients need to be conducted in a comprehensive and factual manner, regardless of the offender's status within the criminal justice system. Such evaluations are not intended to supplant more comprehensive psychological or neuropsychological evaluations.

When conducting evaluations with special populations:

- The information must be provided in a manner that is easily understood, verbally and in writing, or through other modes of communication as may be necessary to enhance understanding.

When the evaluator is evaluating a sex offender with intellectual or other developmental disabilities the evaluator must obtain informed assent. The evaluator should be familiar with characteristics of persons with developmental disabilities such as impaired cognitive functioning, communication styles, mental health issues, vocabulary and language skills,

and other significant limitations. If the evaluator feels that informed assent could not be acquired at the time of the evaluation, the evaluator shall obtain assistance from a third party who is not a practitioner from within the same agency. A third party may be an individual or group of individuals who understands the definition of informed assent and who has had significant knowledge of the person's unique characteristics.

- The evaluator shall obtain the assent/consent of the legal guardian, if applicable, and the informed assent/consent of the offender with developmental disabilities for the evaluation and assessments. The legal guardian needs to be informed of the evaluation methods, how the information may be used and to whom it will be released. The evaluator shall also inform the offender with developmental disabilities and the legal guardian about the nature of the evaluator's relationship with the offender and with the court. The evaluator shall respect the offender's right to be fully informed about the evaluation procedures. Results of the evaluation may be reviewed with the offender and the legal guardian upon request.

The mandatory reporting law ORS 675.390 requires certain professionals to report suspected or known abuse or neglect to the local department of social services or law enforcement. Evaluators need to be aware of the laws pertaining to their licensed discipline and function accordingly.

- If informed assent/consent cannot be obtained after consulting with the third party, then the evaluator shall refer the case back to the referring agent, agency, or court.
- The evaluator shall be sensitive to any cultural, ethnic, developmental, sexual orientation, gender, medical and/or educational issues, or disabilities that become known during the evaluation.

B. Evaluation Methodology Concerns

Due to the complex issues of evaluating sex offenders with intellectual and other developmental disabilities, methodologies are to be applied individually and their administration will be guided by the following:

- When possible, instruments should be used that have relevance and demonstrated reliability and validity which are supported by research in the mental health and sex offender treatment fields as they relate to persons with intellectual or other developmental disabilities.
- If a required procedure is not appropriate for a specific client, the evaluator must document in the evaluation why the required procedure was not done.

Evaluators must carefully consider the appropriateness and utility of using a plethysmography assessment, or VRT assessment with sex offenders who have developmental disabilities. For these assessments to be effective with this population, evaluators must assess whether the offender has a sufficient level of cognitive functioning to be able to adequately discriminate between stimulus cues and/or respond appropriately to instructions and questions.

Evaluators shall address the level of adaptive functioning and any neuropsychological concerns for sex offenders with intellectual or other developmental disabilities. Evaluators also need to make appropriate recommendations regarding treatment modalities and any need for additional behavioral interventions or containment and supervision requirements.

SECTION 2:

ADDITIONAL EVALUATION AREAS FOR SEX OFFENDERS WITH DEVELOPMENTAL DISABILITIES

The evaluation and any subsequent assessments must be sensitive to the rights and needs of the victim and the client. The evaluator shall be sensitive to any cultural, language, ethnic, developmental, sexual orientation, gender, gender identification, medical and/or educational issues that may arise during the evaluation. Evaluators shall select evaluation procedures relevant to the individual circumstances of the case and commensurate with their level of training and expertise. Each phase of an evaluation shall address strengths, risks and deficits in the following areas:

- Psycho-social history, including sexual history
- Cognitive functioning
- Adaptive functioning (e.g., independent living skills, social judgment and competencies, impulse control, treatment amenability and/or ability to participate in group settings)
- Sexual information and comprehension level
- Expressive and receptive language skills
- Developmental /social level of functioning
- History of trauma and reactivity
- Family and community support systems
- Assessment of static and dynamic risk factors
- Specific intervention recommendations
- Feasibility of polygraph testing or similar surveillance techniques

Evaluation methods may include the use of clinical procedures, screening tests, observational data, advanced psychometric measurements and special testing measures. The gathering of collateral information from a broad base of resources needs to be emphasized when evaluating clients with intellectual and other developmental disabilities. Collateral information may be more reliable and valid than self-report data, but all self report information should be included in the evaluation.

SECTION 3:

QUALIFICATIONS OF TREATMENT PROVIDERS, EVALUATORS AND WORKING WITH SEX OFFENDERS

Clinical level treatment providers and evaluators who want to provide evaluation and/or treatment services to sex offenders with developmental disabilities must demonstrate education, training and experience specifically relevant to the assessment and treatment of intellectually or developmentally disabled sex offenders as identified in the in section 3.

Associate level providers, who do not have a graduate degree in social sciences with specific training in evaluation of persons who are developmentally disabled, should not be involved in the clinical evaluation of special needs populations. Associate level providers must provide treatment for developmentally disabled clients only when under the direct supervision of a Clinical level treatment provider who has the requisite training and experience to evaluate and/or treat developmentally disabled clients.

Developmental disabilities specific training may include but is not limited to trainings from these areas:

- Treatment, evaluation and monitoring considerations for the sex offender with intellectual or other developmental disabilities
- Assessment tools and procedures for persons with intellectual and other developmental disabilities
- Impact of developmental disability on the individual
- Healthy sexuality and sex education for the sex offender with developmental disabilities
- Statutes, rules and regulations pertaining to individuals with developmental disabilities
- Co-occurring mental health issues
- Co-occurring family and other support systems
- The role of the regional center/department of developmental disabilities services in the lives of these clients

APPENDIX:

DEFINITIONS

Developmental Disability: A disability that is manifested before the person reaches 22 years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 6000 et seq., will apply.

This definition is further explicated as follows: Impairment of general intellectual functioning means the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error measurement of the instrument should be considered when determining the intellectual quotient equivalent.

Adaptive behavior means the person has overall adaptive behavior which is significantly limited in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment and administered and clinically determined by a qualified professional.

"Similar to that of a person with mental retardation" means that a person's adaptive behavior limitations are a direct result of or are significantly influenced by impairment of the person's general intellectual functioning and may not only be attributable to a physical impairment or mental illness.

Some sexual offenders have intellectual and/or functional deficits that indicate a need for revised assessment, evaluation, treatment or behavioral monitoring even though they do not meet the federal definition for developmental disabilities. Evaluators, treatment providers, polygraph examiners, and supervising officers shall provide services appropriate to each sex offender's developmental level.

Special Populations: Persons subject to federally mandated protections and accommodations under the Americans with Disabilities Act (1990), Section 504 of the Rehabilitation Act (1973), or who were subject to the Education of All Handicapped Act (1975) and the subsequent Individuals with Disabilities Education Act (1990) and Individuals with Disabilities Education Improvement Act (2004), are clearly identified as special populations according to those legislative guidelines.