Behavioral Health and Sexual Offenders

BACKGROUND

Sexual violence is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work." Sexual violence is a widespread problem that affects not just the victim, but the offender and the families and communities around both of them. Criminal justice and related systems offer deterrence, incarceration, rehabilitation, and restitution, however, efforts to foster community safety are often implemented after the detection and commission of a crime. An interdisciplinary treatment focus has the potential to diminish the number of sexual offenders (SO) in the general population and to diminish sexual victimization in the community.[1]

RISK ASSESSMENT

Risk assessment is the use of various tools or instruments typically based on scientific evidence, to estimate an offenders' potential for reoffending or causing harm to others and potential causes or sources of that risk. This component is essential to treatment of sexual offenders and informs participants in the criminal justice system (from police to treatment providers) of the future likelihood of certain individuals to cause harm. The assessment informs decisions on the level of supervision police provide certain individuals, the length and type of sentence a person might receive, supervision requirements, and the type and intensity of treatment. Risk assessment involves: [2]

- Analyzing static factors (e.g., historical items, not amenable to change)
- Dynamic risk factors (e.g., criminogenic needs, amenable to change)
- Gathering and verifying information
- Interviewing offenders and collaterals
- Applying standardized and validated tools to summarize an offender's risk level
- Giving informed risk prediction, case management, and treatment targets and/or options

Risk assessment has two distinct purposes - risk prediction and risk management.[3]

- ***Risk prediction*** is the science of estimating the likelihood of recidivism over a period of years. The most accurate and useful estimations of risk come from objective, empirically based, scientifically validated tools that enhance the ability of providers to identify subgroups of offenders who pose a high risk to re-offend.
- ***Risk management*** is the process (undertaken by probation/parole officers, treatment providers, police officers, victim advocates, etc.) of recognizing and responding to ongoing, short-term (hourly, daily, or weekly) changes in sex offender risk. This process is premised on the understanding that every sex offender has a unique set of dynamic factors that are related to the immediate risk they pose.

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Initial and subsequent risk 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. Each phase of an evaluation shall address strengths, risks and deficits in the following areas:[4]

- 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, psychometric measurements and special testing measures. Gathering collateral information from a broad base of resources allows the provider to evaluate SOs with intellectual and other developmental disabilities. Collateral information may be more reliable and valid than self-report data, but self-report information should be also be included.

SEX OFFENDER RISK APPRAISAL GUIDE (SORAG)

The Sex Offender Risk Appraisal Guide (SORAG)[5] is a 14-item tool to generate level of risk; items include:

- Living with biological parents until age 16
- Elementary school maladjustment (behavior or attendance issues [e.g., truancy, expulsion, suspension])
- History of alcohol problems (parent, self)
- Evidence of sustained intimate relationship
- Nonviolent criminal activity (Cormier-Lang system)
- Violent criminality (Cormier-Lang system)
- Previous sexual contact convictions
- Sexual convictions against girls under 14 only
- Failure on prior conditional release (e.g., probation violation, revocation, new arrests, etc.).
- Age at index offense
- Diagnosis of a personality disorder as specified by the DSM criteria
- Diagnosis of schizophrenia as specified by the DSM criteria
- Evidence of deviant sexual preferences (phallometric testing)
- Hare Psychopathy Checklist Revised (PCL-R) or Childhood and Adolescent Taxon Scale (CATS) score

An individual can score between -23 and +47. The SORAG Category of Risk tells you the SORAG category for the offender. The SORAG categories range from Low to High however if the score is a 17, 18, or 19, the risk would be categorized as “medium high” instead of “medium” to indicate the risk is at the high range of the Medium scale.

SORAG Category of Risk	
2 through -17	*Low*
3 through 19	*Medium*
20 through 34	*High*

Assessment available online at http://www.fotres.ch/index.cfm?&content=9030&spr=en

TREATMENT

Sex Offender Treatment is defined as specialized treatment to prevent reoccurring sexually abusive/aggressive behavior by (a) helping offenders identify and change thoughts, feelings, and actions that may lead to sexual offending, (b) developing strategies and plans to avoid, control, or productively address risk factors before a re-offense may occur, and (c) developing offender strengths and competencies to address needs appropriately.[6]

Sex Offender Management involves an interdisciplinary approach that may include mental health professionals, treatment providers, law enforcement officers, probation or parole agents, child welfare caseworkers, and victim advocacy groups. It incorporates psychological assessment and treatment, polygraph monitoring, criminal sanctions, and social policies. [6]

Treatment and behavior management programs include cognitive behavioral therapy, relapse prevention, behavior modification, harm-reduction, self-regulation, principles of risk, need and responsivity, and medical intervention. Although treatment for sexual offending is based in part upon traditional therapeutic models, there are significant differences, such as a focus on the harm caused to the victims, the protection of future victims and the prevention of re-victimization. Group treatment is a common modality, as it offers group confrontation, as well as support and encourages offenders to model for each other ways to overcome denial, minimization, thinking errors, and manipulation. In addition to group treatment, adjunct individual and family treatment are also commonly used. Research studies indicate that successful completion of treatment included the following: [6]

- Lower levels of recidivism (the commission of a subsequent offense) through assisting sexual offenders with housing, employment opportunities, and transportation;
- Supportive environments that address mental health, developmental, and behavioral issues; and
- Improved relationships and stability, and positive support increase successful reintegration.

Initial Intake Assessments[7]

Initial intake assessments should combine sound and empirically guided clinical assessment with the appropriate assessment protocols and measures. Intake assessment procedures should include, but are not limited to:

- Empirically guided, structured clinical interviews
- Collateral interviews
- Assessment of the offender-client's current learning and communication ability
- Psycho-physiological measurements of sexual interest/arousal
- Actuarial instruments (e.g., Static-99R, Static-2002R, and MnSOST-R, etc)

The intake assessment produces a formal statement about:

1. A particular offender-client's potential risk that he/she presents during community placement and treatment
2. A treatment plan for reducing risk which would include:
    - Specific deficits related to sexual offending
    - Individual and environmental strengths and resources available for managing and mitigating deficits
    - Measurable goals related to managing and mitigating the deficits
    - Interventions used to enhance strengths and reduce deficits
    - Treatment completion criteria

Treatment Goals and Progress Assessments[7]

Sexual offender therapy aims to achieve specific goals which can be tailored to the specific issues of the member.

- Increased community safety through reduced risk of re-offense;
- Improved capacity for a responsible lifestyle and healthier relationships;

- Accountability –full disclosure of the offense(s) is a basic requirement for successful completion of therapy. Exceptions must be reviewed with, and approved by, the treatment team (the offender, treatment provider, the supervising agent, and/or a court representative);
- Any resolution of issues related to the offender-client's sexual, physical and emotional victimization;
- Reparations to victim(s) and community;
- Offender-client determined goals allow the offender to participate in their own treatment planning maintained a greater sense of mastery and were more likely to successfully complete treatment.

An assessment of the member's risk and progress should be ongoing and conducted at a minimum of every six months. Updated assessments should utilize empirically validated and reliably supported measures regarding:

- Monitoring SOs progress;
- Adjustment of goals and plans;
- Monitoring sex offender compliance with the supervising agency and treatment program requirements;
- Monitoring compliance via periodic polygraph examinations; and
- Polygraph utilized in a manner consistent with the American Polygraph Association (APA) standards

Treatment completion is never based on time spent/number of sessions in therapy – instead, treatment completion is based on the reduction of risk of re-offense. Sexual offender completion is based on an evaluation of:

- Goal attainment
- Member's strengths, residual deficits, and continuing risk to the community
- Member's lifestyle and support system (e.g., friends, family, community contacts)
- Ability to continue self-imposed prohibitions against abusive behavior and participate in self-maintenance (e.g., coping skills, ongoing promotion of healthy attitudes) and the willingness to seek help when needed

CHALLENGES IMPACTING TREATMENT SUCCESS

Challenges that impact successful completion of treatment and decrease the change of re-offense include:[6,8]

- Unemployment
- Lack of housing / homelessness
- Lack or loss of support and social relationships
- Harassment / discrimination / ostracism
- Poor access to specialized treatment and probationary supervision
- Loss of constitutional rights (e.g., the ability to possess a firearm or vote)
- Feelings of shame, diminished self-worth

The *Comprehensive Approach* to treatment of sexual offenders involves a framework that encourages a strategic, deliberate, and integrated response to managing sex offenders and reducing recidivism. Questions addressed:[3]

1. What are the activities that are central to effective sex offender management practices?
2. Who are the stakeholders that need to be involved in these efforts in order for them to be effective?
3. How should professionals approach the sex offender management process (e.g., underlying philosophies about how this should be done)?

The first two questions center on an effective approach to sex offender management includes: investigation, prosecution, and disposition; assessment; treatment; supervision; re-entry; and registration and community notification. The third question addresses the:

- Critical nature of collaboration in response to the problem at the case management and policy levels;
- Primary goal (shared by all stakeholders) of preventing future sexual victimization and a victim-centered approach to sex offender management;

- Need for specialized training and knowledge for those working with sex offenders;
- Emphasis on educating the public; and
- Importance of monitoring and evaluating sex offender management practices.

Key Issues of Concern

Securing safe, affordable and legal housing is a problem encountered by the sexual offender population and increase the likelihood of repeat offenses and incarceration. Laws have strengthened in recent years, further increasing the distance a sexual offender must be from places where children reside or gather (e.g., schools, day care centers, parks, and bus stops. Some cities limit or prohibit sex offenders' access to homeless shelters or other residential settings (including treatment centers) where more than one sex offender might reside. Such limitations increase homelessness. In addition, some sex offenders who have served their maximum term are denied conditional release from confinement as a result of an inability to secure housing. These offenders are released to the community without a period of community supervision or treatment, eliminating oversight by the justice system professionals in the critical months following release from confinement when re-offense is most likely to occur.[9]

SPECIAL POPULATIONS

Developmental Disabilities[4]

When conducting evaluations with members who have a developmental disability, information must be provided that is easy to understand via the form of communication that works best for the member (e.g., verbal, written). The clinician should be trained in areas specific to their clients. The clinician should also understand characteristics of a member with developmental disabilities such as impaired cognitive functioning, communication styles, mental health issues, vocabulary and language skills, and other significant limitations.

PROFESSIONAL TRAINING

A variety of factors should be considered by the clinician when developing a member's treatment plan. Considerations include, but are not limited to: sexual deviancy, past behavior, current environment, psychosexual functioning, socialization, and co-occurring mental health issues. Further, clinicians should be current on research for treating this population and in turn provide treatment that is evidence based. Providing therapy is highly specialized and requires special training. Clinicians adhere to their licensing agency (e.g., psychiatry, psychology, social work, or marriage and family therapy). Clinicians treating sexual offenders should have proper training in applying treatment interventions that are currently supported in professional literature such as:[7]

- Cognitive restructuring
- Sex offender relapse prevention
- Self-regulation
- Education regarding victim impact awareness
- Empathy development
- Education related to appropriate and healthy sexual functioning
- Full disclosure/accountability for all past sexual offenses
- Relationship skills
- Parenting classes
- Anger management skills training
- Social skills training
- Arousal management/urge control
- Behavior modification addressing sexual arousal control
- Medication for mood disorders and/or arousal control
- Substance abuse management
- Life enhancement training (Good Lives Model)
- Vocational training

CMS STAR METRIC / NCQA HEDIS STANDARD

CMS has not published a metric for this condition. NCQA has not published a metric for this condition.

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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

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