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The Florida Association for the Treatment of Sexual Abusers

MAKING SOCIETY SAFER

The Association for the Treatment of Sexual Abusers (ATSA) is an international organization of mental health professionals who specialize in the treatment and management of individuals who engage in sexually assaultive or abusive behaviors (i.e., sex "offenders"). It is the aim of ATSA to make society safer by combating the problem of sexual aggression through whatever means are proven to be most effective. The Florida Association for the Treatment of Sexual Abusers (FATSA) is a state chapter of ATSA. Although members of the state chapter contributed to the development of this project, the present paper represents the views of the FATSA Board of Directors, as written by members of the board. As such it does not speak for ATSA. It does, however, incorporate various position statements promulgated by ATSA.

This position paper advocates for the following:

1. The differentiation and identification of true *sexual predators*:
    a. A clear and functional definition of the term "predator."
    b. Confinement and treatment of the most dangerous chronic sexual predators.
    c. Aggressive community notification for predators who do not meet criteria for confinement.

1. The creation of optimal circumstances for sexual offenders to gain control of their behavior. Our experience and research teach us that a large majority of sexual offenders are able and willing to learn to control their behavior. We believe these men should be *fully encouraged* in this endeavor and supported in seeking treatment.

2. The discriminating use of all available tools, including polygraphy, sentencing alternatives and medical interventions, to promote the most effective treatment and management of sex offenders.

3. The identification of sexual aggression as a pervasive public health problem that must be addressed proactively through *education and prevention* strategies. Reactive, punitive strategies alone will not significantly impact this problem. Mental and behavioral disorders are properly addressed through treatment. Although some sex offenders will not avail themselves of treatment, the opportunity for meaningful treatment must be provided to all.

Summary of Recommendations

Sexual Predators

Following the example of many other states, Florida should differentiate predatory sexual offenders from other types of offenders for purposes of civil commitment and community notification. "*Predatory"* means *an act is directed toward a stranger, a person of casual acquaintance with whom no substantial relationship exists, or an individual with whom a relationship has been established or promoted for the primary purpose of victimization*.

Civil Commitment

1. For a small group of sex offenders identified as *chronic sexual predators* civil commitment leading to confinement and treatment is appropriate and necessary. Florida should enact a law providing for civil commitment of this identifiable group of sexual predators.
2. In recognition of the imprecision inherent in identifying *any* group of human beings, we urge that every effort be made to safeguard the civil commitment process from arbitrary or abusive implementation. We recommend the California law (Welfare and Institutions Code, Sections 6600-6609.3) as a model law into which are built appropriate safeguards for the prevention of abuse.
3. Only combining a *history of predatory sexual offending* with the *ongoing presence of a mental disorder* will allow the identification of those offenders who are likely to commit future acts of sexual violence. A law stipulating that only those sexual predators with at least two victims be considered for civil commitment will appropriately target *repeat* offenders.
4. Civil commitment of sexual predators should be effected through a trial process. It is prudent and reasonable that the state prove that the individual is a dangerous sexual predator *beyond a reasonable doubt.*
5. A civil commitment law should allow no room for arbitrary or unnecessary confinement of individuals who have committed only non-contact or solicitation crimes. Crimes requiring civil confinement should involve either the use of "force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person," or, where the victim is under 14, "*substantial sexual conduct*." (California Welfare and Institutions Code, Sections 6600-6609.3)
6. Sexual predator assessments should be conducted using validated risk assessment screening instruments in a standardized assessment protocol.
7. Florida should reinstitute a contemporary, properly designed prison-based treatment program.
8. Treatment that follows release from incarceration, in cases of civil commitment, should be administered not by the Department of Corrections but by the Department of Health or the Department of Children & Families.

Community Notification

1. Notification requirements should be based on the likelihood that an offender remains a danger to the community. Offenders who meet the criteria for the definition of a *sexual predator* but who are determined not to be in need of civil commitment should be subject to public notification.
2. Information regarding non-predatory offenders should not be publicized. Aggressive, proactive public notification should be limited to those perpetrators who are defined as sexual predators.
3. Individuals currently on probation or parole should be evaluated according to the criteria for "predatory" offenses. Notification activities should be modified accordingly.
4. All sex offenders (regardless of predator status) who refuse treatment or fail to make suitable progress in treatment should be viewed as a threat to public safety and should be subject to public notification.
5. Public awareness campaigns promoting the prevention of child sexual abuse should become a priority in our communities.

Castration

1. Sexual predators living in the community should be evaluated by their sex offender treatment provider for referral to a medical practitioner. Those offenders deemed appropriate for medical intervention should then be evaluated by a physician to determine the type of medication management, if any, which will assist the offender to control his sexually assaultive behavior.
2. Anti-androgen therapy, surgical castration and/or psychotropic medication should be ordered by the court only after these interventions have been recommended by the treating sex offender therapist and consulting physician.
3. For some probationers, medical examination will create a financial hardship, and it is unlikely that courts can rescind probation based on inability to pay. To maximize community safety, therefore, and to ensure that all sex offenders will be subject to equal scrutiny, it is recommended that funding be made available for contracted psychiatric services for indigent offenders.

Polygraphy

1. Current legislation requires all sexual offenders sentenced after October 1997 to participate in polygraph examinations at their own expense. The law should be expanded to include all sexual perpetrators currently living in the community under supervision. Since polygraphy is not punitive, it should be a retroactive revision to the special conditions of all sex offenders.
2. Polygraph examination should be conducted only by examiners certified by the National Association of Polygraph Specialists in Sex Offender Testing (NAPS), a division of the American Polygraph Association.
3. Polygraph examination should be required 2-3 times per year as outlined in the NAPS guidelines (available upon request from Christopher Ballard, [904] 632-1233).
4. The current law requires offenders to bear the expense of polygraph examination. In general, FATSA supports the position that self-payment of the costs of treatment and supervision by sex offenders demonstrates commitment to change and the acceptance of responsibility. For some probationers, however, bearing the costs of regular polygraph examinations will create a substantial financial hardship, and it is unlikely that courts can rescind probation based on a probationer's inability to pay these costs. To maximize community safety, therefore, and to ensure that all sex offenders will be subject to equal scrutiny, it is recommended that funding be made available for contracted polygraph services for indigent offenders.

Treatment Standards

4. Sexual offenders be required to actively participate in and successfully complete a qualified sex offender program. (ATSA standards are attached at the end of this paper).
5. Sex offender treatment contracts with state agencies (e.g., Department of Corrections) be awarded with an emphasis on the bidder's experience, qualifications, and program description rather than with an emphasis on fees. Clearly fees need to be competitive and cost-effective for both the client and the Department of Corrections. The current contract award process is, however, weighted overwhelmingly in favor of those who exceedingly undervalue the cost of services. This is likely to result in the award of sex offender treatment contracts to unqualified practitioners, which will undoubtedly result in the compromise of quality treatment services for these dangerous clients.
6. Independent clinical experts should be utilized to review contract proposals to ensure that contracts are awarded only to qualified treatment programs.

Introduction

As our society has become more aware of the danger posed by sexually violent individuals, federal and state legislatures have introduced laws designed to contain this danger. It is the position of FATSA that legislative initiatives can help significantly to minimize sexual aggression, and that those laws that are the best informed are the most effective. Conversely, laws that fail to recognize the complex nature of sexual aggression, that neglect to clearly define terms, or that ignore what research shows regarding different types of sexual aggression, not only are less effective, but can inadvertently exacerbate the problem. It is the aim of the present paper to attempt to clarify, from a clinical standpoint, several of the many complex issues that arise in attempting to create laws to constrain sex offenders and to make recommendations regarding the most effective means of reducing sexual aggression.

It is time, we believe, to recognize that the problems of sexual assault against nonconsenting adults and sexual abuse of children in our society are pervasive and deeply rooted, and take an enormous toll on the most vulnerable of us. Sexual aggression is not a new problem, even though our understanding of its devastating effects, and our unwillingness as a society to tolerate those effects any longer, are new. Unfortunately, there will be no one-dimensional quick fix solutions to this problem. Sexual aggression is not merely a problem of criminal behavior that can be addressed simply by toughening sentencing guidelines or lengthening prison sentences. It is also a societal problem, a matter of public health that ultimately must be addressed using the same long-range educational and preventative measures that have been used successfully to address other public health problems, such as AIDS, drug use and smoking.

To date, we have seen an enormous outpouring of intense emotions. Fear and hatred have been fueled by sensational media coverage of gruesome sex crimes and by an absence of educational initiatives. Half-truths and myths about sex offenders are widely repeated. It is vitally important to recognize that all sex offenders are *not* the same. This fact is frequently lost in the panic felt when a horrific crime is publicized. For example, although less than one percent of sex offenders are murderers, it often appears as though all sexual abusers are actual or potential killers.

Most sex offenders can be successfully treated. Research (cited below) consistently shows that the vast majority of sex offenders who complete treatment do not reoffend. Clearly, helping sex offenders to overcome their aggressive behaviors *before* they act is preferable to ignoring their treatment needs and then punishing them after they have violated new victims. *Our ultimate aim must be to try to ensure the safety of women and children*. Achieving this end will necessitate putting aside our hatreds and fears and addressing the problem of sexual aggression through all available means.

We are proposing a multidimensional legislative approach to the problem of sexual aggression, including:

1. The differentiation and identification of true *sexual predators*:
    a. A clear and functional definition of the term "predator."
    b. Confinement and treatment of the most dangerous chronic sexual predators.
    c. Aggressive community notification for predators who do not meet criteria for confinement.

2. The creation of optimal circumstances for sexual offenders to gain control of their behavior. Our experience and research teach us that a large majority of sexual offenders are able and willing to learn to control their behavior. We believe these men should be *fully encouraged* in this endeavor and supported in seeking treatment.

3. The discriminating use of all available tools, including polygraphy, sentencing alternatives and medical interventions, to promote the most effective treatment and management of sex offenders.

4. The identification of sexual aggression as a pervasive public health problem that must be addressed proactively through *education and prevention* strategies. Reactive, punitive strategies alone will not significantly impact this problem. Mental and behavioral disorders are properly addressed through treatment. Although some sex offenders will not avail themselves of treatment, the opportunity for meaningful treatment must be provided to all.

Definition of a Sexual Predator

We believe it is essential to differentiate, to the extent possible, between types of sex offenses and types of sex offenders. In general sex offenders are difficult to classify because of their heterogeneity. For legislative purposes, however, several other states have constructed a simple but functional classification scheme by shifting the focus from the offender to the *offense*.

In Florida, the term "sexual predator" has undergone a series of redefinitions, none of which has incorporated the common understanding of the term "predatory." In fact, there exists a class of sex offenders who are "predators" in the common usage of the term, and it is precisely this group of offenders who represents the greatest threat to our society.

Men who *seek out* children to victimize, for example, can have *hundreds* of victims over the course of their lifetimes. Although such men may violate their own children, clearly they are also looking outside of their families to find new victims. They are a danger to their neighbors. They may spend their entire lives positioning themselves to have access to children by volunteering as youth leaders in sports, educational, religious, and scouting organizations.

Many states are using identical, or nearly identical, words to describe this most dangerous sex offender and the offenses he perpetrates. In the words of the Kansas Sexually Violent Predator Act, "predatory acts" are those "*acts directed towards strangers or individuals with whom relationships have been established or promoted for the primary purpose of victimization*." The state of California (Welfare and Institutions Code, Sections 6600-6609.3) states: "*'Predatory' means an act is directed toward a stranger, a person of casual acquaintance with whom no substantial relationship exists, or an individual with whom a relationship has been established or promoted for the primary purpose of victimization.*"

We strongly support the use of such wording to differentiate sexual predators and the offenses they perpetrate from other types of sexual offenses. Although all sexual offenders must, of course, be legally accountable for their actions, we argue that indiscriminate targeting of all sex offenders in public notification laws misses the heart of the problem, allowing the true predators to escape notice in the much larger group of less dangerous offenders. For purposes of civil commitment, the importance of precise definitions of terms becomes paramount.

Although in general sexual predators are more dangerous than non-predatory offenders, it must be noted that even within this dangerous group there will be a range of risk represented by individuals. All cases will need to be assessed for risk, manageability and compliance.

Although the term "predator" most commonly refers to those who perpetrate crimes against children, use of the term in this paper refers to rapists of adult victims as well.

Recommendations

Following the example of many other states, Florida should differentiate predatory sexual offenders from other types of offenders for purposes of civil commitment and community notification. *"Predatory" means an act is directed toward a stranger, a person of casual acquaintance with whom no substantial relationship exists, or an individual with whom a relationship has been established or promoted for the primary purpose of victimization.*

2 Civil Commitment of Sexual Predators

It is our experience that certain sexual predators, for a variety of reasons, will not utilize treatment and will not refrain from acting on their deviant impulses. Some men convince themselves that they can not control their urges to offend. Other men will not give up their distorted beliefs that children desire sex with them and are not harmed by it. For men whose primary sexual attraction is to children, they may feel that life would not be worth living if they could not abuse children.

Statement

Sexual predators will differ in the risk that they present to the community, and a range of legal and clinical options must be considered even within this group. FATSA holds that for a small, very specific group of *chronic sexual predators* who have rejected or failed to respond to treatment aimed at reducing their dangerousness, civil commitment may be appropriate and necessary. FATSA recommends that Florida consider the adoption of civil commitment procedures for chronic sexual predators. At the same time, we recognize that the confinement of individuals on the basis of mental disorders is an undertaking that can easily be abused, especially where civil procedures are to be used in addition to criminal sentencing.

Discussion

We note that the U.S. Supreme Court, in its 1997 decision in the case of *Kansas v. Hendricks* (95-1649), only narrowly approved the Kansas Sexually Violent Predator Act (after the act had been voided by the Kansas Supreme Court). Justice Breyer, however, writing for the minority, indicated that other states have implemented acts that he would have upheld. We would suggest that the minority opinion has illuminated some important issues for consideration in the construction of civil commitment legislation. Specifically, these issues include a) criteria sufficient to justify civil commitment; b) implementation of procedural safeguards adequate to insure the integrity of the civil commitment process; c) the ensuing obligations of the state to create genuine opportunities for rehabilitation of

affected individuals.

Criteria for Civil Commitment

There has been a lengthy discourse on the question of whether sexual deviancy meets the criteria of "mental illness" previously established by the courts to justify traditional civil commitment. Mental health professionals have themselves disagreed on this point. The American Psychiatric Association, for example, argued in its Amicus Curiae to the U.S. Supreme Court in *Kansas v. Hendricks* that sexual deviancy does not meet the "mental illness" criteria necessary for civil commitment. The Court itself, in both the majority and minority opinions in *Kansas v. Hendricks*, asserted that a civil commitment law need not conform to previously established criteria for mental illness and need not apply only to individuals who "lack capacity to make an informed decision concerning treatment" (Breyer). In so doing the Court established that civil commitment is permissible where a statute refers to an "irresistible impulse" (Breyer). Thomas, for the majority, wrote: "The Kansas Act…requires a finding of future dangerousness, and then links that finding to the existence of a 'mental abnormality' or 'personality disorder' that makes it difficult, if not impossible, for the person to control his dangerous behavior. …The precommitment requirement of a 'mental abnormality' or 'personality disorder' …narrows the class of persons eligible for confinement to those who are unable to control their dangerousness."

FATSA agrees that some sexual predators appear to be unable to control their dangerousness due to a mental disorder. For the sake of clarity, however, we note that the preamble to the Kansas Sexually Violent Predator Act is only partly accurate. Specifically, the act reads: "sexually violent predators generally have antisocial personality features...." In fact, although rapists do frequently exhibit antisocial personality features, many dangerous child molesters do not (outside of their criminal sexual offenses). Predatory molesters do, however, frequently suffer the mental disorder of *pedophilia*, which involves having a sexual attraction toward children. Thus, it would be more accurate to state: "sexually violent predators generally have pedophilic disorders and/or antisocial personality features…"

At the same time, it is important to recognize that the fact of an individual having a pedophilic disorder (or antisocial personality features) does not in itself make him a predator or a danger to society. That is, the existence of a particular sexual attraction or orientation does not mean that an individual can not resist that attraction and choose not to act on it. Thus, only combining a *history of predatory sexual offending* with the *ongoing presence of a mental disorder* will identify those offenders who are likely to commit future acts of sexual violence. California has stipulated that only those sexual predators with at least two victims be considered for civil commitment. We believe that this law appropriately targets *repeat* offenders.

Procedural Safeguards

In order to preclude the possibility of arbitrary, unnecessary (and expensive) confinement of individuals who do not constitute an imminent risk to the community, appropriate safeguards should be incorporated into the law. In all states, civil commitment of sexual predators is effected through a trial process. In California, Arizona, Illinois,

Kansas, Washington and Wisconsin, the state must prove that the individual is a dangerous sexual predator *beyond a reasonable doubt*. We believe that this standard of proof is prudent and reasonable and will not impede the appropriate application of the law to truly dangerous offenders.

In defining the nature of the sexual offenses that may subject an individual to commitment as a sexual predator, several states have simply included every type of sexual offense. True sexual predators, however, are highly unlikely to engage only in non-contact crimes or solicitation crimes. Moreover, to include, as Kansas has, "any act which has been determined …to have been sexually motivated," is to introduce the possibility of confusion and arbitrary confinement.

California, we believe, has constructed a more properly targeted law by defining "sexually violent offenses" as including either "force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person," or, where the victim is under 14, "substantial sexual conduct," including "penetration of the vagina or rectum of either the victim or the offender by the penis of the other or by any foreign object, oral copulation, or masturbation of either the victim or the offender." We support the adoption of such wording in a civil commitment statute.

With regard to the proper assessment of sexual predators, we submit that there are inherent limitations in any attempt to classify human beings. Where the consequences of that classification are so profound as are here contemplated, no effort should be spared in attempting to ensure accuracy. Professionals who are trained and experienced in the field of sexual deviancy and who are familiar with the use of standardized risk assessment instruments are best able to provide accurate information. California has stipulated that sexual predator assessments "shall be conducted in accordance with a structured screening instrument" and "shall evaluate the person in accordance with a standardized assessment protocol … [which] shall require assessment of diagnosable mental disorders, as well as various factors known to be associated with the risk of reoffense among sex offenders. Risk factors to be considered shall include criminal and psychosexual history, type, degree, and duration of sexual deviance, and severity of mental disorder."

Obligations of the State

U.S. Supreme Court Justice Breyer, in his dissenting opinion in the case of *Kansas v. Hendricks*, suggested that Kansas' law was "disingenuous." He wrote: "Kansas …concedes that Hendricks' condition is treatable; yet the Act did not provide Hendricks (or others like him) with any treatment until after his release date from prison and only inadequate treatment thereafter. …when a State believes that treatment does exist, and then couples that admission with a legislatively required delay of such treatment until a person is at the end of his jail term (so that further incapacitation is therefore necessary), such a legislative scheme begins to look punitive."

Not only for legal reasons, but, more importantly, for public health reasons, *we urge the state of Florida to assume responsibility for promoting effective treatment of sexual aggressor*s. Punishment of sexual offenders by the criminal justice system is appropriate and necessary. Punishment alone, however, has not and will not stem the tide of sexual aggression. We strongly recommend that legislators consider taking corrective, *preventative*

measures now, by reinstituting a contemporary, properly designed prison-based treatment program. As we discuss later in this paper, such programs are meeting with success in other states.

Treatment that follows release from incarceration, in cases of civil commitment, should be conducted not by the Department of Corrections but by the Department of Health or the Department of Children & Families. With the exception of Illinois, all states with sexual predator commitment provisions have removed participation by the Department of Corrections in order to clearly differentiate treatment from punishment. California provides for the implementation of a model treatment program in its statute. *We strongly recommend that Florida explore the treatment initiatives designed and implemented by California.*

Recommendations

1. For a small group of chronic or violent sexual predators civil commitment leading to confinement and treatment is appropriate and necessary. Florida should enact a law providing for civil commitment of this identifiable group of sexual predators.
2. In recognition of the imprecision inherent in identifying *any* group of human beings, we urge that every effort be made to safeguard the civil commitment process from arbitrary or abusive implementation. We recommend the California law (Welfare and Institutions Code, Sections 6600-6609.3) as a model law into which are built appropriate safeguards for the prevention of abuse.
3. Only combining a *history of predatory sexual offending* with the *ongoing presence of a mental disorder* will identify those offenders who are likely to commit future acts of sexual violence. A law stipulating that only those sexual predators with at least two victims be considered for civil commitment will appropriately target *repeat* offenders.
4. Civil commitment of sexual predators should be effected through a trial process. It is prudent and reasonable that the state prove that the individual is a dangerous sexual predator *beyond a reasonable doubt.*
5. A civil commitment law should allow no room for arbitrary or unnecessary confinement of individuals who have committed only non-contact or solicitation crimes. Crimes requiring civil confinement should involve either the use of "force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the victim or another person," or, where the victim is under 14, "substantial sexual conduct," including "penetration of the vagina or rectum of either the victim or the offender by the penis of the other or by any foreign object, oral copulation, or masturbation of either the victim or the offender." (California Welfare and Institutions Code, Sections 6600-6609.3)
6. Sexual predator assessments should be conducted using validated risk assessment screening instruments in a standardized assessment protocol.
7. Florida should reinstitute a contemporary, properly designed prison-based treatment program. (Such programs are meeting with success in other states.)
8. Treatment that follows release from incarceration, in cases of civil commitment, should be conducted not by the Department of Corrections but by the Department of Health or the Department of Children & Families. *We strongly recommend that Florida explore*

the treatment initiatives designed and implemented by California.

3 Community Notification

In May 1996, President Clinton signed into law a mandate for community notification to be instituted in every state. The law states that a mechanism must be established which would allow law enforcement personnel to disseminate information about high risk sex offenders to the public while protecting the identity of victims. Most states have already implemented their own process for notification, although some states are experiencing challenges to the constitutionality of the community notification laws. President Clinton has also charged the Department of Justice with writing guidelines for individual states to use in implementing community notification. As of this writing, the crafting of the guidelines is still in process. Once completed, the guidelines will be published in the Federal Register and will be available for public comment.

Statement

Sexual predators will differ in the risk that they present to the community, and a range of legal and clinical options must be considered even within this group. The Florida Association for the Treatment of Sexual Abusers does not oppose notification of the public regarding the presence of those truly *predatory* sex offenders who pose a danger to our communities. We view community notification, however, as only one component of society's commitment to reduce sexual violence. Appropriate community notification can contribute to a larger societal strategy for preventing sexual abuse, but does not, in itself, constitute a strategy. If community notification is allowed to appear as a solution to the problem of sexual aggression, it will create a dangerous illusion of safety. We believe that for community notification policies to have a significant effect on reducing sexual aggression, they must be supplemented by ongoing community education programs.

We believe that the current law allowing public notification of *all sex offenders* in "any manner deemed appropriate" is arbitrary and *counterproductive*. We advocate for a more discriminating approach to the disclosure of sex offender information. Community notification should be made only on those offenders who are sexual predators as defined in Section 1, as determined by the evaluation process described in Section 2. Genuine sexual predators who are determined through the trial process to be inappropriate for civil commitment should be the subjects of aggressive community notification. These are the offenders of whom parents need to be aware.

Discussion

<u>The Value of Community Notification</u>

At best, the value of community notification is limited. While society would like to believe in the dangers of strangers and take comfort in the idea that children are safe at home, statistics clearly show a different reality. The vast majority of sexual assaults against

children are perpetrated by someone the child knows and trusts, and most of these assaults occur right in the child's own home. Community notification, then, even if it were highly effective, could protect the society from only a minority of child molestations.

Even with the small group of predatory offenders, one must question how much protection is truly afforded by community notification laws. Knowing that a sexual predator lives in your neighborhood does allow parents to take the precaution of warning their children about that individual. But a predatory offender can, of course, venture to another neighborhood (or venture to your neighborhood from elsewhere) if he is intent upon finding a victim. Additionally, it is difficult to see how notification of rapists can enhance community safety.

The state of Washington has tracked sexual offense rates since the inception of its community notification procedures and has and found that the process has had little measurable impact. FATSA supports implementing research efforts to determine the effectiveness of existing community notification procedures.

<u>The Dangers of Community Notification</u>

The federal legislation governing public notification of sex offenders specifically addresses the importance of *protecting the identity of sexual abuse victims*. Identification of an offender who has abused a family member leads to relatively easy identification of his victim by anyone familiar with the family. Such inadvertent identification of child sexual abuse victims risks stigmatizing these victims, thus revictimizing them.

Men who are engaging meaningfully in treatment and are working to change their lifestyles need to be encouraged, not scorned and harassed. Offenders in treatment have been evicted from their homes, have lost their jobs, and have been threatened with violence after being publicly identified as a sexual offender. Probation officers report that their sex offender probationers are more difficult to supervise because they can see no hope for rebuilding their lives. *Subjecting offenders to public humiliation and the threat of vigilantism can have the effect of overwhelming them with stress and making them more likely to lose control and reoffend—which makes all our children less safe.*

Even while having little sympathy for sexual offenders, we have little justification for ignoring the plight of members of the offender's family. Distribution of notices in public schools result in the stigmatization of the children of offenders and has led to harassment and ostracizing of these children.

In some instances, legislation requiring community notification includes juvenile offenders who have been tried as adults. Where such notification is concerned, consideration must be given to the developmental stage of the juvenile and the effect notification will have on his ability to develop healthy peer relationships and redirect his life. Juveniles who have made impulsive decisions to sexually exploit another may not be inveterate sexual deviants. When they are tagged with stigmatizing labels, however, they may be ostracized and inadvertently pushed toward deviant and criminal lifestyles. Again, only a juvenile offender who meets the criteria for a sexual predator, and who is clearly a danger to the community should be subjected to notification.

<u>To Be Effective, Community Notification Must Be Linked with Education</u>

In November of 1996 a ghastly crime occurred in Fort Lauderdale. A sexual predator named Howard Ault murdered two young girls. Ault was on the predator list. Just a few months before he committed this crime he had been publicly identified in a local

newspaper as a predator. Perhaps the mother of the two victims had not seen the newspaper. If she had seen it, she still might have thought that such a nice man who was so attentive to her children could not be dangerous. She did not recognize the danger he posed. She did not understand the modus operandi of the sexual predator.

In the long run, posting the names and pictures of sex offenders without community involvement and education on how and why these men are dangerous may not provide much help to parents in protecting their children. But the notification process can also provide a forum for discussion and explanation. Community meetings, such as have been organized already in several areas, could involve standardized educational presentations that present accurate information to assist parents in making informed decisions.

Notification should also be combined with community education regarding sexual abuse *prevention*. Informed, aware parents who make it their business to communicate with their children and with the people who come in contact with their children are best able to protect their children from sexual abuse. All parents should be familiar with the fundamental warning signs of potentially dangerous situations.

Recommendations

1. Notification requirements should be based on the likelihood that an offender remains a danger to the community. Offenders who meet the criteria for the definition of a *sexual predator* but who are determined not to be in need of civil commitment should be subject to public notification.
2. Information regarding non-predatory offenders should not be publicized. Aggressive, proactive public notification should be limited to those perpetrators who are defined as sexual predators.
3. Individuals currently on probation or parole should be evaluated according to the criteria for "predatory" offenses. Notification activities should be modified accordingly.
4. All sex offenders (regardless of predator status) who refuse treatment or fail to make suitable progress in treatment should be viewed as a threat to public safety and should be subject to public notification.
5. Public awareness campaigns promoting the prevention of child sexual abuse should become a priority in our communities.

4 Castration

Utilizing hormonal agents, anti-androgens and surgical castration in the management of sexual abusers continues to be an area of interest and concern for many, including researchers, clinicians, program administrators, legislators, sexual abusers, victims of sexual abuse, and the general public. Last year legislation was enacted in Florida allowing for chemical or surgical castration of sexual offenders and requiring "chemical castration" for repeat sexual offenders.

Statement

Chemical or surgical castration may be an appropriate supplement to supervision and treatment for some offenders. It is not appropriate or necessary for the majority of sex offenders, and should not, under any circumstances, be considered an adequate substitute for comprehensive sex-offender specific cognitive-behavioral therapy or for correctional supervision.

Discussion

Organic treatments have been used to reduce the sexual drive of some sexually aggressive males and other paraphiliacs whose inability to control their behavior leads to repeated occurrences of sexually deviant behavior. The importance of sexual motivation in the attraction to sexual offending, however, varies widely among abusers; therefore, the simple reduction of sexual drive is of limited usefulness for many abusers.

Sexual offending is driven only in part by sexual desire. For most offenders, sex becomes a vehicle with which to exercise perceived emotional needs, such as a desire for power and control or the expression of anger. Equally importantly, distorted thinking justifies, rationalizes, and reinforces the offender's behavior. Simply reducing sexual desire does not address the cognitive and emotional issues involved in offending behavior. Since most sexual offenses involve not penetration, but fondling, it is easy to see how perpetrators could continue to offend even if sexual functioning is impaired.

Generally, those predatory pedophiles and rapists described in sections 1 and 2 above are the offenders most likely to be highly motivated by sexual desire, and therefore are those most likely to benefit from organic therapy. At the same time it must be noted that these are the offenders least motivated to control their deviancy, and thus least likely to adhere to a prescribed medication regimen.

<u>Anti-androgen Therapy</u>

It is important to develop ordered and reasonable criteria for anti-androgen therapy based on diagnosis, history, motivation and risk. A referral to a physician for anti-androgen therapy should occur only after an extensive sex-offense specific mental health evaluation has been completed and a medical evaluation recommended by the treating mental health professional. Since anti-androgen medication carries some clear medical risks, it should only be administered under ongoing medical supervision. As with any treatment

intervention, appropriate informed consent must be obtained when anti-androgen therapy is implemented.

Anti-androgen treatment should be coupled with appropriate correctional monitoring and counseling within a comprehensive treatment plan. For the medical intervention to be effective the abuser must be involved in concurrent cognitive-behavioral treatment designed to address other aspects of the deviant behavior in addition to sexual interests. No medication should ever be used as the sole method of treatment.

Surgical Castration

The effect of surgical castration is to reduce the availability of androgen by removing the testes, where approximately 95% of testosterone is produced. European studies of castrates indicate that surgical castration does reduce (though it does not eliminate) paraphiliac fantasies and behaviors. FATSA is opposed to surgical castration procedures, however, where there are alternative and less invasive treatments available. Specifically, anti-androgen medications can achieve the same, if not better, results.

A substantial percentage of surgical castrates retain sexual functioning. Moreover, replacement androgens can restore testosterone to pre-castration levels, thus nullifying the effects of the surgical castration.

Selective Serotonin Reuptake Inhibitors

SSRIs (commonly known as antidepressant medications) have been found to be extremely useful in controlling obsessive, intrusive thoughts and compulsive behaviors. In many cases, antidepressants may be a more appropriate medical intervention for helping to manage sexual deviancy than anti-androgens. Again, a referral to a physician for antidepressant therapy should occur only when recommended by the treating mental health professional. No medication will be effective as the sole, or even primary, treatment intervention for sexual deviance.

Recommendations

1. Sexual predators living in the community should be evaluated by their sex offender treatment provider for referral to a medical practitioner. Those offenders deemed appropriate for medical intervention should then be evaluated by a physician to determine the type of medication management, if any, which will assist the offender to control his sexually assaultive behavior.
2. Anti-androgen therapy, surgical castration and/or psychotropic medication should be ordered by the court only after these interventions have been recommended by the treating sex offender therapist and consulting physician.
3. For some probationers, medical examination will create a financial hardship, and it is unlikely that courts can rescind probation based on inability to pay. To maximize community safety, therefore, and to ensure that all sex offenders will be subject to equal scrutiny, it is recommended that funding be made available for contracted psychiatric services for indigent offenders.

5 Polygraphy

Due to the consistent unreliability of self-report among sexual abusers, the use of polygraphy has become nationally endorsed in the identification, treatment, and management of offenders. Several studies have linked the history of sexually deviant behavior and deviant sexual arousal to risk and recidivism. Therefore, instruments that promote the collection of data in these areas are deemed to have significant clinical value.

Statement

All sexual perpetrators (regardless of predator status) who are allowed to remain in the community should be required to submit to any means available to verify their ability and willingness to live safely in society. FATSA endorses the use of regular polygraph examinations as part of a comprehensive sex offender evaluation and treatment program. We believe that the polygraph examination is a vital supplement to the clinical process in evaluating and monitoring treatment progress, compliance with supervision restrictions and treatment recommendations, and the existence of current deviant thoughts, fantasies, and behavior.

Discussion

Polygraphy is not used primarily to determine guilt or innocence related to a specific crime. Rather, it is used in conjunction with other data such as police reports and victim statements to assess and confront an offender who denies deviant sexual behavior, fantasies, or arousal. Polygraph assessment is also useful in monitoring supervision compliance and treatment progress.

The potential usefulness of polygraphy is illustrated by a highly publicized Fort Lauderdale case from 1996 in which a sex offender on probation murdered two young girls after having sexually abused one of them. The offender claimed after his arrest that he was easily able to circumvent the special conditions of his community control order to gain access to these vulnerable children. Has this offender been subjected to periodic polygraphing it is possible that these violations of his court orders, as well as his violent fantasies, would have been revealed. The treatment provider and probation officer may have been alerted to the need for more restrictive alternatives.

Polygraphy assists the therapist to collect a thorough sexual history, which supplements the psychosexual assessment. Only when the therapist knows the true extent of an offender's deviant history can effective treatment procedures be implemented. Where polygraphy reveals that an offender in treatment is having ongoing deviant sexual fantasies, the treatment provider may, on that basis, recommend intensified supervision or referral for anti-androgen or antidepressant medication.

FATSA recommends testing by polygraph examiners certified by the National Association of Polygraph Specialists in Sex Offender Testing (NAPS), a division of the American Polygraph Association. Examiners certified by NAPS are specifically trained in the testing of sexual offenders.

Recommendations

1. Current legislation requires all sexual offenders sentenced after October 1997 to participate in polygraph examinations at their own expense. The law should be expanded to include all sexual perpetrators currently living in the community under supervision. Since polygraphy is not punitive, it should be a retroactive revision to the special conditions of sex offenders.
2. Polygraph examination should be conducted only by examiners certified by the National Association of Polygraph Specialists in Sex Offender Testing (NAPS), a division of the American Polygraph Association.
3. Polygraph examination should be required 2-3 times per year as outlined in the NAPS guidelines (available upon request from Christopher Ballard, [904] 632-1233).
4. The current law requires offenders to bear the expense of polygraph examination. In general, FATSA supports the position that self-payment of the costs of treatment and supervision by sex offenders is an integral component of effective treatment, as it demonstrates commitment to change and the acceptance of responsibility. For some probationers, however, bearing the costs of regular polygraph examinations will create a substantial financial hardship, and it is unlikely that courts can rescind probation based on a probationer's inability to pay these costs. To maximize community safety, therefore, and to ensure that all sex offenders will be subject to equal scrutiny, it is recommended that funding be made available for contracted polygraph services for indigent offenders.

6 Treatment Standards

In the absence of a coordinated effort to accurately educate the public on the realities of sexual aggression, destructive myths and half-truths about sex offenders have been widely circulated, creating confusion and unnecessary anxiety in many people. When a consensus holds, for example, that "all sex offenders are the same" and that "sex offenders can't be treated," it is little wonder that the fires of fear and hatred rage in our society. Indeed, there appears no solution to the problem—just at the time that we are beginning to understand how pervasive the problem is!

It must be admitted that one unfortunate contributor to public confusion is the tendency of sex offender specialists themselves not to carefully explain their statements. For instance, it is not unusual to hear knowledgeable clinicians state: "There is no cure for sexual deviancy" or "once a sex offender, always a sex offender." Such remarks are easily misinterpreted. In reality, there is no "cure" for most of the emotional and mental disorders people suffer (nor, for that matter, is there a cure for many physical diseases). Just as psychotherapy helps people to control and manage the painful symptoms of depression, anxiety and phobias, so does sex offender therapy help offenders to *control* their behavior. A depressed person who feels better following therapy may feel "cured," but soon learns that managing his or her depression will call for an ongoing commitment to following treatment prescriptions. A sex offender who is free of deviant urges following successful treatment understands that those urges can always return and that he must be prepared to control them.

The expression "once a sex offender, always a sex offender," holds exactly the same meaning as "once an alcoholic, always an alcoholic." No one in this day fails to recognize that most alcoholics learn to control their self-destructive urges and abstain from drinking. The "always an alcoholic" warning implies only that the *propensity* for abusing alcohol will remain with the person. Alcoholics frequently warn themselves that they are not "cured," even when they have controlled their drinking for many years, lest they forget to use the tools they have learned to control their problem.

Although the destructive consequences of sexual deviancy are far more serious than those of alcoholism, from a psychological standpoint the conceptualization and treatment of the disorders is similar. Sex offenders will always have the *propensity* to reoffend; most offenders will learn to control their deviant tendencies. As with any type of problematic human behavior, *sex offenders must want to change for treatment to help them.*

Sex offender treatment is a relatively new undertaking, dating only from the 1960s. Early treatment approaches were not effective and outcome studies demonstrated that. As research in the field has advanced, so has treatment effectiveness. During this decade outcome studies have demonstrated a consistently growing treatment effect. Most recently, a study conducted by the Minnesota Department of Corrections dated August, 1997, shows that for all sex offenders treated in prison, 12% of treatment completers, compared to 17% of those receiving no treatment and 28% of those who dropped out of treatment, were

rearrested for sex offenses over the following 4.5 years. The same study shows only 3% of first time offenders who completed treatment being rearrested for a sex crime over the same follow-up period.

If we insist on guarantees that no one who has ever committed a sex offense will ever offend again, we will have to imprison or hospitalize for life an astounding number of men. Even then, unfortunately, we would still make only a small dent in the overall scope of the problem, since less than 10% of sex offense cases are ever prosecuted. Ultimately, we have little choice but to accept that we must seek to prevent sex crimes before they happen and treat those who offend to the best of our ability. We must accept that treatment is not perfect and will never guarantee any individual's safety, but that it has improved and with the support of the legal-justice system and the community it will continue to improve. With laws that mandate appropriate confinement and/or management strategies for chronic sexual predators and treatment for all offenders, the community can be better protected.

The membership of the Florida Association for the Treatment of Sexual Abusers is committed to constantly improving its strategies for enhancing public protection from sexual aggression. Toward that end, we annually sponsor a research and treatment conference, featuring top name researchers and treatment experts from around the nation. We regret that there continue to be clinicians who, failing to recognize that the effective treatment of sexual deviance requires highly specialized training, continue to hold themselves out as sex offender therapists without seeking that training.

The following discussion defines the role of treatment in the management of sex offenders. Sex offender treatment is frequently viewed as a "soft" response that minimizes the harm the offender has caused. On the contrary, treatment providers often take the lead in identifying high-risk individuals and in recommending more intensive or restrictive management strategies. *More than anyone*, sex offender treatment providers recognize the danger potential of treatment failures. Unlike psychotherapists generally, they are not averse to collaborating with corrections personnel, nor are they reluctant to recommend incarceration when they believe it necessary to protect the community.

Sex offender therapists have an ethical obligation to help their clients, the offenders. It is fully understood by the offenders, however, that that obligation never extends past the point where the client represents an imminent danger to society. Treatment is a privilege and an opportunity; those who fail to utilize it and who threaten the community must be dealt with by whatever means necessary.

We recognize that the natural revulsion sex offenses elicit in most people makes it difficult for them to accept the role of treatment. For those who would only punish offenders and withhold treatment, we submit that treatment is not, after all, only for the offender, but primarily for the safety of those who would be victimized.

Statement

The Florida Association for the Treatment of Sexual Abusers (FATSA) is committed to reducing sexual aggression and increasing public safety. Qualified sex offender treatment is a valuable tool in meeting that commitment. Our understanding of sex offenders has grown steadily in recent years. It will only be through the continued research and treatment of sex offenders that we will fully understand the etiology of sexual offending and move toward eliminating the sexual abuse of children and adults.

FATSA does not propose that treatment of sex offenders should replace a criminal justice response. Treatment is only one of several tools society can use in designing effective management strategies for offenders. Treatment should be used in conjunction with incarceration, community monitoring and probationary supervision. The purpose of treatment and the manner in which treatment is instituted can vary.

Discussion

Who is Included in the Category of Sex Offenders?

It is important to begin by understanding that sex offenders are not all the same. On the contrary, researchers consistently note the surprising and perplexing heterogeneity they display. Offenders span socioeconomic groupings and vary widely in age, personality characteristics, and history of offending. The vast majority of offenders are male. Studies indicate that males commit approximately eighty percent of sex offenses against children and females commit approximately twenty percent.

Public awareness of sex offenders has been largely formed by media descriptions of the most serious offenders, frequently offenders who have also murdered their victims. Certainly these offenders have committed heinous acts and merit society's attention and harshest censure. It is important to recognize, however, that this type of offender does not represent the typical sex offender.

Based on victim surveys from the general population, the offender is known to the victim or victim's family in eighty to ninety-five percent of the cases. The offenders are family members in less than fifty percent of all offenses and are identified as acquaintances (neighbors, coaches, teachers, and religious leaders) in the remaining cases. (As indicated earlier, a small percentage of predatory offenders, who may have hundreds of victims, account for a much larger percentage of offenses). Adults are the identified abusers in two-thirds of the assaults; the remaining one-third of abusers is under the age of eighteen.

Sex offenders differ greatly in terms of level of impulsiveness, persistence, the risks they pose to the public and their desire to change their behavior. Most people recognize the significant differences between a violent rapist with multiple identified victims and a teenager who has sexually abused a sibling. Effective public policy needs to be cognizant of the differences among offenders rather than applying a "one size fits all" approach.

During the evaluation process, it is necessary to screen individuals carefully for conditions that may interfere with successful sex offender treatment. Before treatment of the sexually deviant behavior can be initiated, untreated mental illness or ongoing substance addiction must be addressed. Once these conditions are in remission, and the offender's level of functioning is assessed to be adequate, sex offender therapy can proceed. Although a dual disorder may exacerbate the sexually abusive behavior, the condition should not be presumed to cause the abusive behavior. Treatment of a concurrent disorder cannot substitute for offense specific treatment.

Community-based sex offender treatment is not appropriate for mentally disabled individuals or mentally ill individuals who are not receiving appropriate psychiatric treatment or who are not responsive to psychiatric interventions. Clients who have a history of psychotic or organic mental illnesses should be referred for psychiatric consultation and medication management. While medication regimens can be utilized effectively to prevent

decompensation, some clients will be unlikely to benefit from outpatient psychotherapy and may require a more restrictive setting.

How Frequently Do Sex Offenders Re-offend?

Many people ask this question with the expectation that there is a typical reoffense rate for sex offenders and, based on many media reports, expect the answer to be near one hundred percent. Actually, for a variety of reasons related to the ways in which sex offenses are reported, investigated and prosecuted, reoffense rates vary widely from study to study. And because sex offenders are not a homogeneous group, generalizing with a single reoffense rate is misleading and inaccurate. Rather, it is more accurate to examine reoffense patterns for the different categories of sex offenders. At present, the research literature indicates that reoffense rates for untreated sex offenders who choose victims from within the family unit range from four to ten percent. Reoffense rates for untreated sex offenders who primarily target unrelated children range from ten to forty percent. Rates for untreated sex offenders who target adult women range from seven to thirty-five percent.

What Role Does Treatment Play in the Management of Sex Offenders?

Treatment is a powerful component in the *prevention* of future sex offenses. Effective prevention involves, among other things, teaching offenders to identify the components of their offense patterns. As the types of situations, stimuli and stressors that trigger offenses in a particular individual are identified, along with his modus operandi for finding and courting ("grooming") victims, treatment providers are better able to recognize when an offender may be nearing a relapse. When treatment providers able to relay this information to probation officers, they too can improve their ability to monitor the offender's ability to remain offense-free. More generally, as treatment providers garner a growing body of knowledge regarding the cognitive and behavioral patterns exhibited by sex offenders, this information can be incorporated into probationary supervision strategies, as well as into education and prevention programs.

What Kind of Treatment is Effective with Sex Offenders?

Treatment for sexual aggression is still a developing field. Because sex offenses were kept hidden for so many years, until recently the problem received little attention or funding. Over the past decade, however, sufficient progress has been made to provide clear indicators of the treatment approaches most likely to be successful.

The core therapeutic approach recognized as essential to effective treatment is cognitive-behavioral, which incorporates a specialized behavioral self-control model called "relapse prevention." With training in relapse prevention techniques, offenders learn to identify the chains of thoughts and behaviors that culminate in their commission of a sex offense. Once they can identify their offense patterns, offender work on mastering alternative coping strategies with which to intervene in the chain and stop the progression of behaviors. Augmenting the relapse prevention centerpiece of treatment is work on understanding the emotional factors that underlie and infuse sexual deviancy with its compulsive power, and training in social skills, communication and intimacy, anger management, and self-esteem.

Behavioral conditioning techniques are used to directly counter deviant fantasies and urges.

Where Should Treatment Occur?

Treatment can occur in a variety of settings and at various stages in the criminal justice process. Currently, most offenders in Florida are treated in an outpatient, community-based setting following release from incarceration or as a sentencing alternative to incarceration. Typically, the offender is supervised by corrections' personnel during a mandated period of treatment. If the offender does not make a good faith effort in treatment, is unwilling to give up his denial of his crimes and address his problem, or is not adhering to the treatment plan, cases are returned to court to be reviewed by the judge for alternative disposition.

Although Florida has had an unsuccessful experience with an early, unsophisticated prison based treatment program, there is no reason not to expect a contemporary program to meet with greater success. Many states now are offering treatment programs and, in fact, the statistics cited earlier in this section from the Minnesota Department of Corrections refer to a prison-based program. Following the prison term, a correctional officer supervises and monitors the individual in the community. This post-prison monitoring includes additional community-based treatment and is an important part of the total management program.

What Are the Costs of Treatment?

Treatment costs vary depending on the treatment setting, intensity and duration of treatment. In most cases, the offender is required to cover the cost of the outpatient court mandated treatment program, but state funding is available to contracted treatment providers for indigent offenders. It is strongly recommended that offenders, whenever possible, be required to pay for their own treatment. Payment for treatment services demonstrates an acceptance of responsibility, a commitment to prevention, and an investment in the outcome of the therapy.

Is Treatment Sufficient To Reduce A Sex Offender's Risk to the Community?

Because offenders represent a heterogeneous group, some offenders will respond well to treatment interventions and others will not take advantage of the treatment offered. A formal risk assessment conducted by a qualified professional offers the best method of estimating the risk posed by a particular sex offender. An appropriate evaluation incorporates a review of the offender's history, clinical impressions, and risk assessment testing utilizing instruments that have established reliability and validity.

Upon hearing that a sexual abuser has reoffended during or after treatment, many people find it easy to dismiss treatment as ineffective or worthless. Treatment, however, is not something that a therapist does to a client; as with any psychotherapy, the client must be motivated to change his behavior in order to benefit from treatment. Accordingly, treatment will not be equally helpful to all offenders. Some men will not choose to give up their deviant sexual behavior even after intensive treatment. Others might be unlikely to reoffend even with no treatment at all. Most offenders fall somewhere in between; those who desire to change are helped to accomplish that end through treatment.

Clients who have a substance abuse history must abstain from the use of drugs and

alcohol and attend 12-step or other appropriate programs. Those who are assessed to have a current substance abuse problem that interferes with the ability to benefit from outpatient psychotherapy should be referred to an appropriate treatment facility. When possible, offenders should resume sex offender treatment at the earliest opportunity after detoxification has been completed and addiction rehabilitation is well under way. Since the use of drugs and alcohol impairs judgment and lowers inhibition, substance use is considered a high risk factor for sexual offenders. All offenders in treatment are strongly encouraged to abstain completely from the use of intoxicants. Those who refuse to abstain from intoxicants may not be amenable to outpatient treatment.

Just because an offender is exposed to treatment for some period of time does not imply that the treatment has been successful and that the offender will not again offend. When "treated" offenders recidivate, one should carefully consider the following questions in order to determine if a treatment failure has indeed occurred.

Was the offender really receiving sex offender specific treatment? Sexual offender evaluation and treatment is a highly specialized area and requires an approach unfamiliar to most mental health professionals. An advanced degree and a license to practice psychotherapy do not imply an expertise in the area of sexual deviancy. We take it for granted that not all physicians are equally qualified to treat all medical problems and that special problems necessitate specialized treatment. We would be foolish, of course, to allow a general practitioner to treat a brain tumor. So it is with sexual deviancy.
If treatment standards and professional performance are not closely monitored and subjected to peer review, dangerous predators will fall through the cracks. Substandard treatment damages the credibility of sex offender specialists, undermines the public's confidence, and leaves the community at risk.

Did the offender successfully complete treatment? Attendance at a treatment facility should *not* be interpreted as successful completion. Offenders successfully complete only when they are able to demonstrate competency at the many skills required to prevent a future offense. Half-treated offenders are only half-prepared to prevent reoffense. If an offender drops out of treatment, completes probation prior to graduating from treatment, or is dismissed from the program for any reason, he should not be considered a "treated" offender.

Were the treatment professional's recommendations followed? Sex offender treatment specialists are specifically trained to evaluate the extent of the sexual deviancy and to assess the risk of future offense. Often, however, due to legal limitations and/or a lack of collaboration in the case, conclusions regarding the offender's risk to the community and recommendations regarding his supervision or management are disregarded. If a treatment provider assesses that an individual's risk for reoffense is high and recommends increased restrictions, it is usually up to others (probation officers and judges) to follow through with implementing the recommendations. When recommendations are not followed, a systemic failure has occurred, *not* a treatment failure.
Successful treatment of sexual offenders requires a very high degree of collaboration and cooperation among community agencies and the court. Consider the following cases which

exemplify the need for collaboration. These are all true Florida cases in which clients were in treatment in sex offender programs that conform to ATSA standards.

A sex offender has been arrested for molesting a neighborhood child. His 11-year-old granddaughter is living in his home, even though the man is court-ordered not to have contact with children. The evaluating psychologist recommends that this living arrangement is inappropriate and warns that the child may be at risk. The judge, in response, changes the order to read "no contact with children except the granddaughter." A polygraph later reveals that the man does, indeed, have sexual fantasies of molesting his granddaughter.

A predatory pedophile who has molested hundreds of children has an additional diagnosis of schizophrenia. He displays intermittent psychotic symptoms when he is not taking his anti-psychotic medication and sometimes hears voices telling him to hurt children. He is frequently hospitalized under the Baker Act, but is usually released within days. His treatment provider advises the probation officer that he is not an appropriate candidate for outpatient treatment, as he is an extremely high risk to community safety. A more intensive treatment setting is recommended. Due to limited resources, the probation officer cannot locate an appropriate inpatient facility. Frustrated that the FATSA provider cannot ethically continue to treat the client, she moves him to a different community-based program which does not comply with ATSA guidelines (and is therefore willing to accept the client into the program). A few months later he is arrested for exposing himself.

A man in treatment denies that he molested his granddaughter despite having pleaded guilty to sexual battery and despite clear medical evidence of sexual abuse. He admits, however, to having molested his daughter for several years when she was growing up, which suggests a pattern of sexual deviancy. When the offender is repeatedly harassed by neighbors following community notification of his address, the granddaughter suddenly recants her allegations (as children often do). The offender petitions the court to dismiss the case. Without even consulting the sex offender treatment provider, the State Attorney's Office supports him. The judge voids the conviction based on a psychiatrist's testimony that the child's recantation indicates the sexual abuse never occurred.

A rapist is unsuccessfully terminated from treatment because he has maintained his denial even after 5 months in a sex offender program. The judge, at the violation hearing, orders the client to a program that does not require him to admit that he committed a crime.

A man who has been in treatment for over two years is requesting to be reunited with his family. He is told that prior to reunification, his wife should attend a sexual abuse education program, he and his wife must develop a family safety plan, and that he must take a polygraph exam to confirm a reduction in deviant sexual arousal and to verify compliance with court-ordered restrictions and treatment recommendations. He refuses to take the polygraph exam, stating that he cannot afford it. His probation

officer allows him to transfer to a program that does not require polygraph examination or family reunification therapy.

A man is court-ordered to seek treatment after pleading no contest to sexually abusing his 5 year old daughter. He attends individual treatment for two years with a psychologist unfamiliar with the treatment of sexual offenders. He requests that the psychologist treat him for depressive symptoms that result from having been "falsely" accused of the sexual abuse. The psychologist finds his denial convincing, and after two years reports that he has "successfully completed" his counseling requirement. His probation officer later refers him to sex offender specific treatment, where, after a few weeks in a treatment group, the man admits that he abused his daughter and deceived his previous therapist. Meanwhile, he has petitioned the court to release him from treatment. Based on the first therapist's "successful completion" letter, and without consulting the sex offender specialist, the judge rescinds the treatment order. The client is now seeking unsupervised visitation with his daughter (the victim).

Recommendations

1. Offenders should be required to actively participate in and successfully complete a qualified sex offender program. (ATSA standards are attached on the following pages).
2. Sex offender treatment contracts with state agencies (e.g., Department of Corrections) should be awarded with an emphasis on the bidder's experience, qualifications, and program description rather than with an emphasis on fees. Clearly fees need to be competitive and cost-effective for both the client and the Department of Corrections. The current contract award process is, however, weighted overwhelmingly in favor of those who exceedingly undervalue the cost of services. This will likely result in the award of sex offender treatment contracts to unqualified practitioners, which will undoubtedly result in the compromise of quality treatment services for these dangerous clients.
3. Independent clinical experts should be utilized to review contract proposals to ensure that contracts are awarded only to qualified treatment programs.

7 Ethical Standards and Principles for the Management of Sexual Abusers

FATSA Position

The effective evaluation, treatment and supervision of sexual abusers require a multi-disciplinary approach that recognizes the unique features of this population. The Association for the Treatment of Sexual Abusers (ATSA) has published a document: Ethical Standards and Principles for the Management of Sexual Abusers. The section below will incorporate some of the national standards regarding the educational and professional experience of service providers and suggested guidelines for sex offender evaluations and sex offender treatment. Again, this paper reflects the position of FATSA's Board of Directors and does not necessarily imply endorsement by the national Association.

Sexually assaultive or sexually abusive behavior is a learned or acquired behavioral disorder. It is not a disease that can be cured. Treatment is focused on helping offenders control deviant sexual behavior through recognizing and altering the distorted attitudes that promote abuse. Treatment success is measured by the offender's ability to learn and apply how to maintain control of their sexually abusive or sexually assaultive behaviors throughout their lifetime. FATSA holds that without the proper treatment, many abusers will continue to commit sexual offenses. Without court orders to enter and successfully complete sex offender treatment, most sex offenders will avoid specialized treatment.

Research has clearly shown that ***no reliable psychological "profile" of a sexual offender exists.*** On standardized psychological tests, sex offenders show no greater prevalence of psychopathology than the general population. Consequently, a traditional psychological testing battery will not provide any information regarding the subject's propensity to have committed the sex offense in question or the need for specialized treatment. It is the responsibility of the Courts, not the mental health system, to determine an individual's guilt or innocence.

An advanced degree and a license to practice psychotherapy do not imply expertise in the area of sexual deviancy. The educational and professional experiences of service providers in this field are diverse and multi-disciplinary.

Sex offender treatment specialists are trained in the evaluation of sexual abusers. The Psychosexual Assessment is focused on reviewing prior criminal history, sexual history, mental health/substance abuse history, social history, current mental status and risk factors present in daily lifestyle. Specialized sex history questionnaires and testing instruments that measure sexual deviance and psychopathy are often utilized to gather pertinent information and identify treatment needs.

The sex offender evaluation should provide specific recommendations regarding: **1)**

the need for specialized treatment, **2)** risk factors to be considered for supervision and **3)** recommendations regarding contact with the victim and others that may be at risk of future sexual abuse.

Group therapy is endorsed in the professional literature as the most effective and best evaluated treatment method.

Sexual offenders almost always deny their crimes. Because of the shame they feel, as well as the potential legal and social consequences of their behavior, they become practiced at deception and can often convince others of their innocence. Sex offender treatment specialists are experienced at penetrating the multiple levels of denial that are common among offenders.

Most offenders enter the criminal justice and child welfare systems with varying degrees of denial. FATSA believes that the existence of denial should not preclude an offender entering appropriate treatment, but that the program should have some pre-designated time frame by which offenders must admit to their sex offense. ***Treatment will not be effective unless the offender admits his behavior, accepts his problem, and acknowledges a need to learn to control his behavior in the future. Sex offenders cannot "successfully complete" treatment while in denial.***

Ethical Standards and Guidelines as promulgated by the ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS (ATSA)

1. **GENERAL PRINCIPLES:**

General principles published by ATSA are as follows:

2.01 Community safety takes precedence over any conflicting consideration and ultimately is in the best interest of the abuser and his or her family.

2.02 Inadequate or unethical treatment damages the credibility of all treatment and presents an unnecessary risk to the community.

2.03 Without external pressure most sexual abusers will not successfully complete treatment or abide by treatment and probation/parole requirements.

2.04 Internal motivation improves the prognosis for completing treatment, but in and of itself, is not a guarantee of success.

2.05 Criminal investigation, prosecution and a court order requiring specialized sexual abuser treatment can be important components of effective intervention and management.

2.06 It is imprudent to release an untreated sexual abuser into the community without providing an offense-specific evaluation, treatment and/or specialized supervision.

2.07 Clinicians should establish cooperative working relationships with each other, as

well as with other social and criminal justice agencies in order to facilitate effective and quality evaluation, treatment and management of sexual abusers.

2.08 When feasible, clinicians should actively involve correctional officers, child protection workers and victim therapists in case management.

2.09 Although sexual abusers are treatable, there is no known cure. Management of the abusive behavior is a life-long task for the abuser.

2. **SEX OFFENDERS:**

ATSA developed the following standards on denial:

4.20 Treatment is unlikely to be effective until a client acknowledges the abusive behavior and accepts responsibility for that behavior.

4.21 The majority of clients enter the system with varying degrees of denial related to sexually abusive behavior.

4.22 Denial may be impacted by the status of the client's legal proceedings or other external variables.

4.23 The existence of some degree of denial should not preclude a client from entering treatment.

4.24 Diminishing the degree of denial is a gradual process and that process must be incorporated into the client's individualized treatment plan.

4.25 Community-based treatment is not appropriate for a client who continues to demonstrate complete denial.

4.26 Groups for clients who exhibit a high degree of denial may be used as preparation for therapy. These groups should not be substituted for, referred to, or identified as treatment devised to address the primary issues of sexual abuse.

3. **SEX OFFENDER THERAPISTS:**

ATSA Standards for service providers are as follows:

1.01 The service provider should possess an advanced degree in psychology, sociology, human sexuality, social work, criminology, counseling or psychiatry from a fully accredited institute of higher education. However, if the provider has not completed graduate studies, at minimum, he or she must hold a bachelor's degree in social sciences, demonstrate competence in specialized professional experience and work under the supervision of a

licensed mental health professional.

1.02 Relevant work experience is essential to supplement educational achievement.

1.03 The service provider must have demonstrated competence in providing a minimum of 2000 hours of face to face contact with clients who have perpetrated sexual abuse.

1.04 Service providers are expected to continually update their education and professional training in order to remain familiar with current literature, including the focus and direction of both research and evaluation/treatment techniques.

1.05 The service provider should have completed graduate studies, training courses and/or gained significant experience in a majority of the following topics:

- **Counseling and psychotherapy**
- **Personality theory and disorders**
- **Etiology of sexual deviance**
- **Psychometric assessment**
- **Risk assessment**
- **Sexual arousal assessment and reconditioning**
- **Physiological measurements**
- **Human sexuality**
- **Individual, dyad, group, couple and family therapy**
- **Social competency training**
- **Relapse prevention**
- **Behavior modification**
- **Cognitive restructuring therapy**
- **Culturally specific treatment needs**
- **Treatment of special needs clients**
- **Pharmacological therapy**
- **Victimology**
- **Federal, state or provincial sexual abuse statutes**
- **Ethics and professional standards**

1.08 Failure to evaluate the performance and qualifications of service providers jeopardizes the credibility of all sexual abuse providers and programs.

4. **SEX OFFENDER EVALUATIONS**

Some of the most important ATSA Standards on evaluation are as follows:

3.01 There is no known set of personality characteristics that can differentiate the sexual abuser from the non-abuser.

3.02 Psychological profiles cannot be used to prove or disprove an individual's propensity

to act in a sexually deviant manner.

3.06 A thorough review of written documentation and collateral interviews should include gathering and reviewing information from all available and relevant sources, including:

- **Criminal investigation records**
- **Child protection service investigations**
- **Previous evaluations and treatment progress reports**
- **Mental health records and assessments**
- **Medical records**
- **Correctional system reports**
- **Probation/parole reports**
- **Offense statements from abuser**
- **Offense statements from victim**

3.07 When possible, interviews with the client's significant other and/or family of origin should be conducted.

3.08 Any evaluation conducted without collateral information should be interpreted cautiously.

3.09 In addition to evaluation procedure summaries, conclusions and recommendations, all collateral reports and interviews should be listed an acknowledged in the written evaluation report.

3.10 Victims should not be re-interviewed for the purpose of gathering information for the abuser's evaluation.

3.11 The clear preference is to keep the abuser and victim interview and evaluation processes separate. If that is not possible, the evaluator must be extremely vigilant to avoid bias.

3.14 Specific to the evaluation of sexual abusers is the comprehensive assessment of the client's sexually deviant behavior.

3.18 It is important to note the degree of similarity or disparity between the abuser and the victim's statements.

3.19 The client's explanations for false allegations should be documented.

3.21 Both community safety and the degree to which an abuser is capable and willing to manage risk should be considered when generating recommendations.

3.23 An evaluator should never recommend an inadequate treatment program or level of risk management because existing resources limit or preclude adequate or appropriate services.

5. **SEX OFFENDER TREATMENT:**

ATSA provides the following general description of treatment.

Sexual deviance is a complicated, multi-determined behavioral disorder. Treatment intervention is focused on assisting the individual to accept responsibility, increase recognition, institute change and manage sexually deviant thoughts, attitudes and behavior. The focus of contemporary treatment is on techniques designed to assist sexual abusers in maintaining control of their sexual deviance throughout their lifetime. Therefore, treatment should include simple, practical techniques that can be applied for the remainder of their lives.

Some specific ATSA Standards on treatment are as follows:

4.01 Involvement in and successful completion of a treatment regimen does not cure sexual deviance.

4.03 Many sexual abusers require long-term, comprehensive, offense-specific treatment.

4.05 Currently, cognitive-behavioral approaches appear to be the most effective method of treatment intervention.

4.06 Anti-androgen and other pharmacological therapies, substance abuse treatment, educational programming, including social competency building, and peer-facilitated self-help programs can be used as adjuncts to the cognitive behavioral model of treatment for sexual deviance.

4.09 The therapist must provide a client with an explanation of the rationale for the need of treatment, the goals and objectives of the treatment program, the order of treatment, as well as the techniques and methods to be used in therapy.

4.13 The treatment provider should not rely exclusively on the client's self-report to assess progress or compliance with treatment requirements and/or court orders.

4.14 Progress in treatment must be based on the measurement of specific objectives, including observable changes in cognitive process, arousal patterns, and social and sexual functioning and behavioral patterns, as well as a consistent willingness and ability to apply newly learned behaviors.

4.15 Progress in treatment, or the lack thereof, should be clearly identified and documented in treatment records and progress reports.

4.16 As a client continues to meet treatment expectations and accomplish the identified treatment goals, a gradual reduction of structured intervention should occur.

4.17 If a client does not address the identified treatment objectives and the cognitions or behavioral patterns remain at a level determined to present a risk to the community, the treatment provider has an obligation to refer that client to a more intensive treatment program and/or to the judicial system.

4.18 A treatment provider should immediately notify the appropriate authorities if a client is unsuccessfully terminated from or discontinues involvement in the treatment program.

5.03 Many sexual abusers have experienced sexual arousal/pleasure from their specific form of deviance. Control of deviant arousal, fantasies and urges is a treatment priority with those clients.

6.03 Effective cognitive therapy not only challenges dysfunctional cognitive messages, but replaces faulty beliefs with accurate responsible messages.

6.05 When the cognitions that support denial and minimization are modified, the client is better able to understand the damage done to sexual abuse victims.

7.01 The goal of treatment, from a Relapse Prevention perspective, is not to cure sexual offending, but rather to teach the client how to successfully manage his or her behavior. Self management is seen as a lifelong endeavor for a sexual abuser.

7.05 The construction of cognitive-behavioral offense chains is an important part of relapse prevention. Clients should learn to analyze the chain of events, including situations, behaviors, cognitions and emotions that lead to the sexual abuse, as well as to develop and practice a range of coping responses to interrupt the chain.

8.01 An increase in awareness, knowledge and insight is necessary for the abuser to counter the cognitive distortions that supported the decision to abuse.

8.02 Emphasizing the consequences of sexual victimization sensitizes the abuser to the physical, psychological and emotional harm caused.

9.03 Treatment groups offer a milieu for improving communication proficiencies, assertiveness skills, anger management, stress management, and relationship skills.

9.05 Clients should be required to demonstrate increased social competencies in developing and maintaining relationships within and outside the family unit.

10.01 Effective training in relationship and dating skills can result in an enhanced sense of confidence, increased personal and social skills and a more fully functional client.

10.02 **S**exual dysfunction should be evaluated, accurately identified and appropriate treatment provided. If the service provider does not have the resources to offer therapy for sexual dysfunction, an appropriate referral should be made.

10.03 Emphasis should be placed on achieving and maintaining healthy, respectful and compatible relationships based on mutual interests and affection.

10.04 A client who is unwilling to participate in skills training or develop functional relationships should not be considered as meeting treatment expectations.

11.01 Gaining the cooperation and alliance of either the partner or parents of the sexual abuser is an extremely important factor in reducing risk.

11.02 Individual and/or group therapy for the partner or parents should be incorporated into the sexual abuser's individual treatment plan.

13.01 If a client is determined to present a high risk to re-offend [pharmacological agents] such agents should be considered.

13.02 Candidates [for pharmacological agents] may be those who exhibit predatory, violent sexual behaviors or those who have experienced multiple treatment failures and/or those who report compulsive fantasizes with a proven inability to control their arousal.

13.03 Use of pharmacological agents, if not a component of a comprehensive sexual deviance treatment plan, is not recommended.

13.04 Anti-androgens are not appropriate for use with all sexual abusers. They pose considerable risk and should only be used with ongoing medical supervision.

14.04 If the client experiences problems maintaining non-abusive behaviors, a return to a more structured treatment regimen should be instituted.

5. **REUNIFICATION**: ATSA Standards on reunification are as follows:

12.01 The priority of treatment is to provide for the continued safety and protection of children, including those who have been previously victimized and those who are at risk of being victimized.

12.02 Removing a sexual abuser from a place where children reside is more appropriate than removing any of the children.

12.03 A client who has a history of sexual contact with children or who reports being aroused by children or who reports engaging in sexual fantasies about children should be restricted from having unsupervised contact with children.

12.04 Victims and/or other children should not be involved in family therapy with the sexual abuser until it is determined that involvement in the therapy is in the best interest of the children.

12.05 Contact with children may be considered if it has been determined that sufficient safeguards exist including:

a) The client has demonstrated the ability to control deviant sexual arousal.

b) The child, if an identified victim, has been involved in victim oriented therapy and/or abuse prevention skills training.

c) The child has access to a therapist who will evaluate continuing safety issues, as well as the child's comfort level with the contact.

d) A non-offending parent or other adult has received information and training to adequately supervise the contact between the client and the child(ren).

e) All parties agree to follow predetermined visitation rules and procedures.

f) Provisions for monitoring behavior and reporting rule violations are in place.

12.06 Prior to authorizing or arranging contact between the abuser and the child(ren), the service provider must ensure that the custodial parent or guardian of the child(ren) has been consulted. Proposed contact must always be in accordance with all court orders.

12.07 An individual who has sexually abused children should not have equal parenting rights with the non-offending parent. It is recommended that the service provider assist the family in limiting the client's decision making or disciplinary actions with children.

12.08 Successful family reunification should incorporate therapy sessions between the victim and the abuser, graduated contact and visitation schedules and a specific reunification plan. During the reunification process, safeguards addressing the emotional and physical protection of the child(ren) must be in place

12.09 The clinician should make every effort to communicate and collaborate with the victim's therapist to generate decisions regarding communication and contact between the abuser and the child(ren).

6. **THE USE OF PHYSIOLOGICAL MEASURES:** The use of phallometry (measure of the enlargement of the penis to specific stimuli) and polygraphy (lie detector) have become widespread in the identification, treatment and management of sexual abusers.

Some specific ATSA Standards on Physiological Measures are as follows:

15.02 Neither of the physiological assessments is appropriate for determination of guilt or innocence related to a specific crime.

15.04 Physiological measurements should always be used in conjunction with other data including police reports, victim statements and other psychometric testing and should not be used as the only means to assess sexual abusers.

15.05 Physiological assessments should only be conducted by specifically trained clinicians and examiners. These professionals should maintain membership in appropriate professional organizations and participate in regular relevant continuing educational opportunities. The examiners should adhere to the established practices, ethics and standards of their respective fields and professional organizations.

15.06 In order to promote the advancement and efficacy of physiological measures with sexual abusers, professionals engaged in either polygraphic or plethysmographic examinations with sexual abusers should have specific training in the dynamics and assessment of sexual abusers.

15.08 Physiological assessment data can be helpful in confronting a client who denies deviant sexual behavior, deviant sexual fantasies and/or deviant sexual arousal.

15.09 Physiological assessments are useful in monitoring treatment compliance and progress. Methods such as electronic surveillance, drug testing, support group reports, and probation/parole supervision can be used to corroborate information gained from the physiological test results.