Sex Offender Treatment Standards of Care Manual

Alaska Department of Corrections

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Section 1

Introduction and Overview

The Sex Offender Standards of Care Manual (hereafter referred to as the "Standards") sets minimum requirements for all contractors, approved providers, and agencies for providing services to sex offenders who are under the jurisdiction of the Alaska Department of Corrections (hereafter referred to as the "Department").

The Standards are intended to serve the following purposes:

1. Enhance public safety;
2. Align service delivery with evidence-based practices;
3. Apply the risk, need, and responsivity model for using state resources wisely;
4. Support provider professionalism;
5. Provide consistency of service delivery across programs;
6. Facilitate ease of transfer of offenders within and between programs;
7. Define the scope of work to be provided under sex offender program contracts;
8. Facilitate uniform data collection;
9. Support program evaluations and other research; and
10. Provide guiding principles for service delivery in institutional and community settings.

1.100 Terminology

Appendix A contains a glossary of terms used in this document and corrections, mental health, and sexual offender programming.

1.200 Guiding Principles

The following guiding principles provide the foundation for the Standards and guidance on issues without specific standards. The Standards' guiding principles are based on the premise that victims' rights and safety are paramount, sex offenders can change, and community safety can be enhanced. The Standards strive to be evidence-based by integrating the best available research with provider expertise.

1. **Prioritize Community Safety.** The highest priority of these Standards is to fulfill Department's mission of "working together to protect the public from sexual violence." Sex offender assessment, treatment, and supervision services promote the safety, well-being, and protection of the citizens of Alaska by preventing future crimes and potential victims of crime.
2. **Support Victims.** Sexual offenses are traumatic and can have long-lasting adverse effects on the victim, the victim's family, and the community. Protecting victims, their families, and potential victims should be paramount when developing and implementing sex offender assessment, treatment, and supervision services. All professionals managing the offender should treat Victims and their families with dignity and respect. Victims have the right to be informed of an offender's status in the criminal justice system to the extent that they are interested. The Department has processes for supporting information sharing with victims and providing input into an offender's supervision and

treatment services.

3. **Treat Individuals with Dignity and Respect.** Sex offender assessment, treatment, and supervision services should be non-discriminatory, humane, and bound by the rules of ethics and law. Individuals and agencies providing services to sex offenders should not discriminate based on race, religion, gender, sexual orientation, disability, or socioeconomic status. Sex offenders are treated with dignity and respect by all professionals who manage the offender regardless of the nature of the offender's crimes or conduct.
4. **Hold Offenders Accountable.** Sex offenders are responsible for their crimes and should be held accountable for their behavior. Offender accountability includes following court orders and Department rules in institutions and conditions of community release. Accountability also includes being responsible for changing one's behavior.
5. **Engage and Motivate Offenders.** Although responsibility for change ultimately rests with the offender, approved providers, probation and parole officers, and other service providers strive to develop a therapeutic working alliance with offenders. A therapeutic working alliance is associated with greater offender motivation to engage in and benefit from treatment and supervision services designed to promote an offense-free life and community safety.
6. **Match the Intensity of Services to Offender Risk Level.** Following the risk principle of effective correctional practice, each offender's risk to reoffend is assessed using research-supported risk tools. Reoffending reductions are achieved by matching the level of treatment and supervision services to each offender's risk level. Lower-risk individuals would receive a lower intensity and duration of services, and higher-risk individuals would receive a higher intensity and duration of services.
7. **Target Offender Factors Relevant to Reoffending.** Following the need principle of effective correctional practice, each offender's potentially changeable risk factors linked to reoffending – also called dynamic risk factors or criminogenic needs – are assessed using research-supported risk tools. Reoffending reductions are achieved when treatment and supervision services target these factors for change.
8. **Match Services to Offender Abilities and Learning Style.** Following the responsivity principle of effective correctional practice, factors that impact how each offender may respond to treatment and supervision services are assessed and considered. Regarding general responsivity factors, cognitive-behavioral programs have the most significant research support for reducing reoffending. Regarding specific responsivity factors, programs address individual offender characteristics that may impact service delivery, including motivation, intellectual abilities, gender, culture, and personality characteristics.
9. **Provide Offender Continuity of Care and Supervision.** The progress offenders make in institutional settings should be reinforced and strengthened by follow-up treatment and supervision services in the community. Progress made in community settings should be reinforced and maintained by periodic booster sessions, maintenance of support systems, and correctional supervision. Continuity of care is essential because programs must make efforts to ensure that offenders are successful not just in the short term but over the long term.

10. **Select and Support Qualified Staff.** Staff with relevant education, experience, skills, and values are critical to the success of services for reducing offending. Ongoing staff training, supervision, and support enhance service effectiveness. Programs that select and support qualified staff evidence lower reoffending rates than those that do not focus on essential staff issues.
11. **Use a Multidisciplinary Team Approach.** Effective management of sex offenders requires a coordinated multidisciplinary team approach. Prison staff, approved providers, probation and parole officers, polygraphers, and other service providers and agencies keep open channels of communication and coordinate services. Successful management of sex offenders is enhanced by enlisting natural supports such as family, friends, clergy, spiritual advisors, employers, and other community members to provide positive support to the offender.

Section 2

Provider Qualifications

Staff with relevant education, experience, skills, and values are critical to the success of offender services for reducing offending. Ongoing staff training, supervision, and support enhance service effectiveness.

The Department has established an approved provider Level System that sets minimum training, education, experience, and supervision standards for approved providers, polygraph examiners, and Abel Assessment examiners who provide services to sex offenders under its jurisdiction.

2.100 Ethics and Professional Conduct

Approved providers shall be committed to the welfare of offenders, their family members, victims, victims' family members, and the community. Approved Providers shall follow the professional code of ethics of their mental health profession, the Association for the Treatment and Prevention of Sexual Abuse (ATSA) Professional Code of Ethics, and State and Federal laws governing mental health professionals' conduct.

2.200 Department Approval of Providers

This section of the Standards and the Alaska Administrative Code for Regulating Sex Offender Approved Providers (see Appendix B) detail how an individual can obtain and maintain an Approved Provider status.

An individual who wishes to apply to become an Approved Provider must apply to the Department. The application is available at the Department's Health and Rehabilitation Services website https://doc.alaska.gov/health-rehab-services. Applications are reviewed by the Sex Offender Treatment Committee, which the Commissioner of the Department establishes.

For a sex offender to be considered in compliance with a sex offender treatment requirement imposed by the court, the parole board, or the Department, the offender's treatment must be provided by an Approved Provider. This requirement for an offender to receive treatment from an Approved Provider applies regardless of whether the offender pays for their treatment or whether the treatment occurs in an institution or the community.

The Department only approves individuals as Approved Providers. It does not authorize agencies as Approved Providers. There is no "agency umbrella" for approval as a Department provider. All agency staff persons who provide assessment or treatment services to sex offenders who are under the jurisdiction of the Department must be Approved Providers.

The Department is not a governing agency regarding the licensure or competence of professionals in their respective fields of training and expertise. However, the Department reserves the right to maintain a list of Approved Providers that sex offenders under the Department's jurisdiction must select from when participating in institutional or community-based treatment programs for sex offending. Approved Providers delivering sex offender

treatment services may be added and deleted from the list of Approved Providers based on compliance or lack of compliance with these Standards and the Alaska Administrative Code for Regulating Sex Offender Approved Providers 22 AAC 30.

2.210 Levels of Approval for Providers

Providers may be approved to provide assessment and treatment services to sex offenders at one of five levels. The five levels and the approval requirements, approved practice areas, and responsibilities for each are as follows:

1. **Sex Offender Treatment Supervisor**

Requirements

a. Have a master's or doctorate in the behavioral sciences and be licensed to practice by the State of Alaska;
b. Have three years of full-time experience or 6,000 documented hours of direct experience providing assessment and treatment services to sex offenders in a Department program or a program using a similar philosophy and approach; and
c. Have one year of supervised experience under the supervision of a Sex Offender Treatment Supervisor in supervising other professionals treating sexual offenders or have equivalent experience approved by the Department.

Approved Practice Areas and Responsibilities

d. May provide a full range of clinical services;
e. May supervise other approved providers;
f. Must develop written supervision plans for all supervisees;
g. Must read and co-sign all reports and assessments completed by Sex Offender Approved Provider Intern supervisees;
h. Must conduct ongoing assessments of Intern level approved providers' progress in supervision; and
i. Must reapply to remain a Sex Offender Treatment Supervisor every three years and have obtained, within the preceding three years, 20 hours of approved continuing education in treating sexual offenders.

2. Sex Offender Approved Provider Level I – Full Service Provider

Requirements

a. Have a master's or doctorate in the behavioral sciences and be licensed to practice by the State of Alaska; and
b. Have one year of full-time experience or 2,000 documented hours of direct experience providing assessment and treatment services to sex offenders.

Approved Practice Areas and Responsibilities

c. May provide a full range of clinical services;
d. Must receive a minimum of one hour of clinical supervision by a Sex Offender Treatment Supervisor every two weeks for a caseload of 10 or more offenders and one hour per month for a caseload of fewer than ten offenders for at least the first year of providing services as a Sex Offender Approved Provider Level I– Full Service Provider to offenders who are under the jurisdiction of the Department;
e. Must receive, if required by Department, an additional period of clinical supervision by a Sex Offender Treatment Supervisor; and
f. Must reapply to remain a provider every three years and have obtained 20 hours of approved continuing education in treating sexual offenders within the preceding three years.

3. Sex Offender Approved Provider Level II – Partial Service Provider

Requirements

a. Have a master's or doctorate in the behavioral sciences and be licensed to practice by the State of Alaska.

Approved Practice Areas and Responsibilities

b. Must work under the clinical supervision of a Sex Offender Treatment Supervisor and receive a minimum of one-hour supervision every two weeks for a caseload of 10 or more offenders and one hour per month for a caseload of fewer than ten offenders;
c. Must have Department and a Sex Offender Treatment Supervisor approval to provide specific types of clinical services (e.g., individual, group, and family counseling sessions and assessment procedures); and
d. Must reapply to remain an approved provider every three years and have obtained, within the preceding three years, 20 hours of approved continuing education in treating sexual offenders.

4. Sex Offender Approved Provider Intern – Post-Graduate Level

Requirements

a. Have a master's or doctorate in the behavioral sciences;
b. Have completed a pre-graduate internship or the equivalent; and
c. Have filed an application for a license to practice in a behavioral science discipline by the State of Alaska.

Approved Practice Areas and Responsibilities

d. Must work under the clinical supervision of a Sex Offender Treatment

Supervisor and receive a minimum of one hour of supervision per week;

e. Must have a written supervision plan developed by the Sex Offender Treatment Supervisor;
f. May provide specific clinical services (e.g., individual, group, and family counseling sessions and assessment procedures) only with the approval of the Department and the Sex Offender Treatment Supervisor; and
g. Must have all reports and assessments reviewed and co-signed by the Sex Offender Treatment Supervisor.

5. Sex Offender Approved Provider Intern – Pre-Graduate Level

Requirements

a. Must have a bachelor's level degree in the behavioral sciences;
b. Must have completed the necessary work for a master's or doctoral degree at a regionally approved college or university;
c. Must be approved by their educational institution for the internship; and
d. Must commit to the internship for a minimum of one academic year or the equivalent of two semesters.

Approved Practice Areas and Responsibilities

e. Must work under the direct on-site supervision of a Sex Offender Treatment Supervisor and receive a minimum of one hour of supervision per week;
f. Must have a written supervision plan developed by the Sex Offender Treatment Supervisor in collaboration with the college or university clinical supervisor;
g. May observe but may not independently conduct individual, group, or family counseling sessions; assessment procedures; or other clinical activities; and
h. Must have all reports and assessments reviewed and co-signed by the Sex Offender Treatment Supervisor.

2.220 Movement Between Levels

A provider may make a request to their supervisor to move between levels. Movement between levels of approved provider status must be recommended by a Sex Offender Treatment Supervisor and reviewed and approved by the Department's Offender Programs Division. Level I providers may request to be trained as a Sex Offender Treatment Supervisor and must be trained and supervised for at least one year by a Sex Offender Treatment Supervisor.

2.230 Reciprocity

The Department may grant reciprocity to a provider from a jurisdiction outside Alaska to practice in Alaska as a Sex Offender Approved Provider Level I– Full Service Provider if the provider meets the following minimum qualifications:

1. Has a master's or doctorate in the behavioral sciences and is licensed or certified to provide sex offender assessment and treatment services in a jurisdiction outside Alaska;
2. Meets the reciprocity requirements of the State of Alaska to practice as a Licensed

Psychiatrist, Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, or Licensed Professional Counselor;

3. Has had five years of direct experience in providing sex offender assessment and treatment services to offenders needing a variety of levels of care;
4. Must reapply to maintain reciprocity status as a provider every three years and have obtained 20 hours of approved continuing education in the treatment of sexual offenders within the preceding three years; and
5. Agrees to follow the Standards.

Providers seeking reciprocity shall send an application to the Sex Offender Treatment Committee (Committee) on a form provided by the Department. The Committee shall follow the Alaska Administrative Code Regulating Sex Offender Approved Providers 22 AAC 30 as a guide for reviewing applications for reciprocity, making recommendations to the Department regarding applications, reviewing and investigating complaints against providers who have received reciprocity, and making recommendations to the Department regarding the disposition of complaints.

2.240 Supervision Plans and Evaluations

All approved providers who require supervision shall have a Supervision Plan, and their supervisor shall evaluate them regularly.

2.241 Guidelines for Supervisors

Sex Offender Treatment Supervisors shall evaluate approved providers under their supervision on a schedule established when the individual is approved.

2.242 Guidelines for Supervisees

All approved providers who require supervision shall file a Supervision Plan with the Department's Criminal Justice Planner for Offender Programs before providing assessment or treatment services to an offender under the jurisdiction of the Department. The Supervision Plan shall address the frequency, method, and supervision mode. The plan shall specify any special conditions required (e.g., additional training) and practice restrictions.

2.250 Notification, Suspension, and Termination

Approved providers and contractor are obligated to notify the Department the next working day if:

1. They are being investigated for malpractice and/or ethical violations by a licensing board or professional organization, such as the American Psychological Association and Academy of Certified Social Workers; or
2. They are named a party in any civil or criminal litigation relating to their professional activities.

Contractors and approved providers may be suspended from delivery of sex offender treatment services if either item 1 or 2 applies.

Contractors are subject to termination, and approved providers may be removed from the approved provider list, if they are found civilly or criminally responsible in circumstances related to items 1 or 2.

2.300 Department Approval of Polygraph Examiners

2.310 Levels of Approval

Polygraph examiners may be approved to conduct sex offender polygraph assessments at one of two levels:

1. Polygraph Examiner - Full Operating Level
2. Polygraph Examiner - Associate Level.

Approval requirements, approved practice areas, and responsibilities for each of the two levels are detailed as follows:

1. Polygraph Examiner - Full Operating Level

Requirements

a. Have a bachelor's degree from a four-year college or university;
b. Have graduated from an accredited American Polygraph Association (APA) school;
c. Have conducted at least two hundred (200) criminal specific-issue examinations, of which at least one hundred (100) must be a post-conviction adult or juvenile sexual offender polygraph examinations, at least fifty (50) must be post-conviction adult sexual offender examinations, and at least twenty (20) must be adult sex offender maintenance/monitoring examinations.
d. Have completed forty (40) hours of APA-approved training specific to sex offender post-conviction polygraph examinations and twenty-four (24) hours of specialized sex offense-specific training in any of the following areas:
    1. Behavior and motivation of sex offenders;
    2. Victim trauma associated with sexual victimization;
    3. Sex offender assessment and treatment approaches; and
    4. Sex offender denial;
e. Agree to adhere to the current version of the Association for the Treatment of Sexual Abusers (ATSA) Professional Code of Ethics.
f. Agree to conduct all examinations in a manner that is consistent with the reasonably accepted standards of practice in the clinical polygraph examiner community;
g. Provide satisfactory references as requested by the Department, which may include, but not be limited to, members of Case Management Teams;
h. Shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior or a felony that would bring into question the competence or integrity of the individual to provide sex offense-specific polygraph services; and
i. Submit to a current background check and be fingerprinted.

Approved Practice Areas and Responsibilities

j. May conduct polygraph assessments of sex offenders without supervision;
k. May supervise Associate Level polygraph examiners;
l. Must apply for continued placement on the Provider List every three years by

the date provided by the Committee. Requirements are as follows:

1. Must demonstrate continued compliance with the Standards;
2. Must complete a minimum of forty (40) hours of continuing education every three years, thirty (30) hours of which must be directly related to sex offender assessment, treatment, and supervision;
3. Must conduct a minimum of 100 post-conviction sex offense polygraph examinations in the 3-year listing period;
4. Must provide satisfactory references as requested by the Department, which may include, but not be limited to, members of Case Management Teams;
5. Must submit documentation that the examiner has engaged in, at a minimum, biannual peer review of at least two examinations by other clinical polygraph examiners listed at the Full Operating Level operating separately from the examiner's agency;
6. Must not have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior or a felony that would bring into question the competence or integrity of the individual to provide sex offense-specific polygraph services;
7. Must submit to a current background check and be fingerprinted;
8. Must report any practice that is in significant conflict with the Standards; and
9. Must comply with all other requirements outlined in American Polygraph Association guidelines and Department policy.

2. Polygraph Examiner - Associate Level

Requirements

a. Has graduated from an accredited American Polygraph Association (APA) school;
b. Shall receive supervision from a Polygraph Examiner - Full Operating Level for all polygraphs conducted on sex offenders under the jurisdiction of the Department until being approved by the Department as a Polygraph Examiner - Full Operating Level;
c. Shall have the supervisor review and sign off on polygraph examination reports completed under their supervision;
d. Agree to adhere to the current versions of the Association for the Treatment of Sexual Abusers (ATSA) Professional Code of Ethics;
e. Shall provide satisfactory references as requested by the Department, which may include, but not be limited to, members of Case Management Teams;
f. Shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior or a felony that would bring into question the competence or integrity of the individual to conduct polygraph services; and
g. Submit to a current background check and be fingerprinted.

Approved Practice Areas and Responsibilities

h. May conduct polygraph assessments of sex offenders under the supervision of a Polygraph Examiner - Full Operating Level;
i. Must apply for continued placement on the Provider List every three years by the date provided by the Committee. Requirements are as follows:
    1. Must demonstrate continued compliance with the Standards;
    2. Must complete a minimum of forty (40) hours of continuing education every three years, thirty (30) hours of which must be directly related to sex offender assessment, treatment, and supervision;
    3. Must conduct a minimum of 75 post-conviction sex offense polygraph examinations in the 3-year listing period;
    4. Must provide satisfactory references as requested by the Department, which may include, but not be limited to, members of Case Management Teams;
    5. Must submit documentation that the examiner has engaged in at a minimum biannual peer review by other clinical polygraph examiners listed at the Full Operating Level operating separately from the examiner's agency;
    6. Must not have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior or a felony that would bring into question the competence or integrity of the individual to conduct polygraph assessments;
    7. Must submit to a current background check and be fingerprinted;
    8. Must report any practice that is in significant conflict with the Standards; and
    9. Must comply with all other requirements outlined in American Polygraph Association guidelines and Department policy.

Waiver to Reduce Supervision Requirement

j. If an Associate Level polygraph examiner has met all the requirements for Full Operating Level status except for obtaining a bachelor's degree, the supervision requirement that supervisors sign off on each exam may be waived by the Department if the following conditions are met:
    1. Provide documentation that all other criteria for Full Operating Level status have been met;
    2. Provide evidence of continuing work toward obtaining a bachelor's degree with a proposed completion date;
    3. Provide evidence that the examiner is continuing to conduct clinical polygraph exams; and
    4. Provide a letter from the examiner's supervisor indicating their proficiency and the supervisor's willingness to lower the intensity of supervision to one hour per month.

2.320 Supervision

The polygraph examiner and their supervisor shall sign a supervision agreement. The supervision

agreement shall specify the supervision type, frequency, and length. Supervision shall be a minimum of thirty (30) minutes for each of 100 sex offense polygraphs for a total minimum of fifty (50) face-to-face supervision hours. The supervisor shall document the supervision in writing.

The components of supervision shall include, but are not limited to:

1. Preparation for a polygraph examination;
2. Live observation of an examination;
3. Review of video and/or audio tapes of an examination; and
4. Review of other data collected during an examination.

2.330 Movement to Full Operating Level

Associate Level clinical polygraph examiners who want to move to Full Operating Level status must complete and submit the following documentation:

1. Evidence that they have met all the requirements to become a Full Operating Polygraph Examiner; and
2. A letter from their supervisor indicates the applicant's readiness to move to Full Operating Level status, including documentation of completing the professional supervision components.

2.400 Department Approval of Abel Assessment Examiners

2.410 Levels of Approval

Abel Assessment examiners may be approved to conduct Abel assessments at one of two levels:

1. Full Operating Abel Examiner
2. Associate Level Abel Examiner

Approval requirements, approved practice areas, and responsibilities for each of the two levels are detailed as follows:

1. Full Operating Abel Examiner

Requirements

a. Have a bachelor's degree from a four-year college or university;
b. Have been trained and licensed as an Abel site to utilize the instrument;
c. Have had one year of supervised experience using the Abel;
d. Adhere to the current version of the Association for the Treatment of Sexual Abusers (ATSA) Professional Code of Ethics.
e. Agree to conduct all assessments in a manner that is consistent with reasonably accepted standards of practice;
f. Provide satisfactory references as requested by the Department, which may include, but not be limited to, members of Case Management Teams;
g. Shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior or a felony that would bring into question the competence or integrity of the individual to provide sex offense-specific assessments; and
h. Submit to a current background check and be fingerprinted.

Approved Practice Areas and Responsibilities

i. May conduct Abel assessments of offenders without supervision;
j. May supervise Associate Level Abel Examiners; and
k. Must apply for continued placement on the Provider List every three years by the date provided by the Committee. Requirements are as follows:
    1. Must demonstrate continued compliance with the Standards;
    2. Must document continued administration of the Abel Assessment;
    3. Must submit to the Department, if requested, reports or program materials specific to Abel Assessment administration;
    4. Must provide satisfactory references as requested by the Department, which may include, but not be limited to, members of Case Management Teams;
    5. Must not have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior or a felony that would bring into question the competence or integrity of the individual to conduct Abel assessments;
    6. Must submit to a current background check and be fingerprinted; and
    7. Must report any practice that is in significant conflict with the Standards.

2. Associate Level Abel Examiner

Requirements

a. Have a bachelor's degree from a four-year college or university;
b. Have been trained and licensed as an Abel site to utilize the instrument;
c. Adhere to the current version of the Association for the Treatment of Sexual Abusers (ATSA) Professional Code of Ethics.
d. Agree to conduct all assessments in a manner that is consistent with the reasonably accepted standards of practice;
e. Provide satisfactory references as requested by the Department, which may include, but not be limited to, members of Case Management Teams;
f. Shall never have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior or a felony that would bring into question the competence or integrity of the individual to conduct sex offense-specific assessments; and
g. Submit to a current background check and be fingerprinted.

Approved Practice Areas and Responsibilities

l. May conduct Abel assessments of sex offenders with supervision by a Full Operating Abel Examiner; and
m. Must apply for continued placement on the Provider List every 3 years by the date provided by the Committee. Requirements are as follows:
    1. Must demonstrate continued compliance with the Standards;
    2. Must document continued administration of the Abel Assessment;
    3. Must submit to the Department, if requested, reports or program materials specific to Abel Assessment administration;
    4. Must provide satisfactory references as requested by the Department, which may include, but not be limited to, members of Case Management Teams;
    5. Must not have been convicted of or received a deferred judgment for any offense involving criminal sexual or violent behavior or a felony that would bring into question the competence or integrity of the individual to provide sex offense-specific assessments;
    6. Must submit to a current background check and be fingerprinted; and
    7. Must report any practice that is in significant conflict with the Standards.

2.500 Exclusions

The Department reserves the right to deny placement on the Provider List to any applicant to be an approved provider, evaluator, clinical polygraph examiner, or Abel Assessment examiner under these Standards. Reasons for denial include but are not limited to:

1. The Department determines that the applicant does not demonstrate the qualifications required by these Standards;
2. The Department determines that the applicant is not in compliance with the Standards of practice outlined in these Standards;
3. The applicant fails to provide the necessary materials for application as outlined in the application materials and the administrative policies and procedures;
4. The applicant has been convicted or received a deferred judgment for any criminal

offense;

5. The applicant has been found to engage in unethical behavior by any licensing or certifying body or has had a license or certification revoked, canceled, suspended, or been placed on probationary status by any professional oversight body;
6. The applicant is addicted to or dependent on alcohol or any habit-forming drug as defined or is a habitual user of any controlled substance or any alcoholic beverage;
7. The applicant has a physical or mental disability that renders the applicant unable to treat clients with reasonable skill and safety or which may endanger the health or safety of persons under the individual's care; and
8. The Department Board determines that the background investigation results, the references given, or any other aspect of the application process are unsatisfactory.

Section 3

Framework for Assessment, Treatment, and Supervision

The risk, need, and responsivity (RNR) principles of effective correctional practice provide the foundation of these Standards and a framework for delivering assessment, treatment, and supervision services to sex offenders. Greater reductions in reoffending are achieved in programs that adhere to these principles compared to programs that do not adhere to these principles.

RNR principles are a who, what, and how model for planning and delivering effective services to sex offenders.

3.11 Risk Principle

The risk principle concerns "who" should receive the most intensive treatment and supervision services. Implementing the risk principle involves two steps.

First, assessors should use empirically supported risk assessment instruments to evaluate offenders' risk to reoffend. Risk assessments should account for factors concerning an offender's history that predict risk but are unchangeable (i.e., static risk factors) and aspects of an offender's current circumstances and functioning that predict risk and are potentially changeable (i.e., dynamic risk factors).

Second, treatment and supervision service providers should match the level of services provided with the offender's level of risk. Higher-risk individuals have multiple problems, some of which are severe, chronic, and entrenched, and should receive a higher dosage (i.e., amount, frequency, and duration) of services to reduce reoffending. Lower-risk individuals whose problems, if any, are mild and/or transitory may need no or few services to reduce reoffending.

By following the risk principle, providers and programs can allocate resources wisely and improve interventions' effectiveness.

3.200 Need Principle

The need principle concerns identifying "what" problems an offender has that are directly linked to reoffending behavior and, therefore, should be a focus of services. These problems are called criminogenic needs or dynamic risk factors, which are terms used interchangeably in this document. Implementing the need principle involves two steps.

First, assessors should use empirically supported need assessment instruments to evaluate offenders' criminogenic needs. Examples include offense-related sexual interests, sexual preoccupation, attitudes that support offending, lifestyle impulsivity, poor problem-solving, problems with intimacy, and resistance to supervision.

Second, treatment and supervision service providers should focus interventions on criminogenic needs over factors not linked to reoffending.

3.300 Responsivity Principle

The responsivity principle focuses on "how" providers can maximize offenders' ability to benefit from assessment, treatment, and supervision services. The responsivity principle has general and specific responsivity components.

General responsivity concerns that the most effective intervention models for reducing reoffending are based on cognitive-behavioral and social learning approaches.

Specific responsivity concerns individual characteristics of the offender that impact response to services. Implementing the specific responsivity principle involves two steps.

First, assessors should use evidence-supported methods to evaluate offenders' individual characteristics that may impact their response to services. These include factors such as gender, intellectual ability, culture, personality characteristics, level of denial, and motivation. Second, treatment, and supervision service providers should account for these individual factors when delivering services.

Section 4.000

Sexual Offender Assessment

4.100 Psychological and Risk Assessment

4.110 General Considerations

Sex offender assessments form the foundation for designing and delivering appropriate services to this population. Assessments provide an opportunity to gather and synthesize information about offenders to inform a variety of important clinical, management, and legal decisions, which can include:

1. Sentencing and other legal decisions;
2. Institutional placement;
3. Treatment planning, progress, and completion;
4. Release decisions;
5. Transition and reentry planning;
6. Community supervision and case management; and
7. Family integration and reunification.

For addressing most of these issues, referral questions and the assessment will focus on an offender's:

1. Risk to reoffend;
2. Treatment and supervision needs,
3. Responsivity issues; and
4. Disposition recommendations.

Assessment is an ongoing process. As offenders move through the criminal justice and mental health systems, later evaluations should build on information contained in earlier ones.

The evaluator shall be sensitive to cultural, ethnic, developmental, sexual orientation, gender, medical, and educational issues that may impact an assessment.

4.120 Timing of Assessments

Typically, evaluators conduct sex offender assessments on individuals who have already pled or been found guilty of committing a sexual offense and are under the jurisdiction of the Department. Evaluators are cautioned about conducting sex offender assessments on individuals who have not pled or been found guilty of committing a sexual offense. Evaluators shall not conduct evaluations where the explicit or implicit request involves determining an individual's guilt or innocence. No known assessment can prove or disprove whether an individual has committed a specific act. It is the role of a legal entity, such as a court, to determine guilt or innocence.

Nevertheless, evaluators may accept referrals to assess alleged sex offenders in circumstances that do not involve attempting to determine guilt or innocence. Examples include assessing an alleged sex offender's need for mental health services and assisting an attorney construct a plea

agreement.

4.130 Informed Consent

The evaluator shall obtain the informed consent of the offender before conducting an assessment. The informed consent shall be obtained verbally and in writing.

Providing informed consent is an ethical obligation. It is also a way to engage the offender by taking the time to explain the evaluation process. An offender has the right to decide whether to participate or decline participation in an assessment.

Elements of informed consent include the following:

1. Explaining the nature, methods, and purpose of the assessment;
2. Presenting alternatives to the types of assessment services proposed;
3. Explaining the evaluator's role regarding the offender and the referral source;
4. Highlighting the implications of participating or declining to participate in the assessment;
5. Outlining the potential benefits and limitations of the assessment;
6. Specifying the limits of privilege and confidentiality, such as the release of assessment findings and the evaluator's obligations as a mandatory reporter; and
7. Answering the offender's questions about the assessment process.

When providing assessment services to offenders who cannot give informed consent, the evaluator shall obtain consent from the offender's legal guardian.

4.140 Preparation for the Assessment

The evaluator shall clarify with the referral source the purpose of the assessment. Referral sources may be a court, attorney, probation or parole officer, mental health professional, or child protective services professional. The evaluator shall request that the referral source provide relevant documents about the case, or the evaluator shall otherwise obtain them. The evaluator shall review relevant documents in preparation for a meeting with the offender.

Records that may be reviewed before meeting with the offender include the following:

1. Indictments;
2. Criminal history records;
3. Presentence Investigation Reports;
4. Sentencing Documents;
5. Probation/Parole Conditions;
6. Reports of Parole/Probation Violations;
7. Police Reports;
8. Victim Statements;
9. Prior Psychological/Psychiatric Reports;
10. Prior Treatment Records/Risk Assessments;
11. Institutional Records; and

12. Juvenile Records.

4.150 Collateral Interviews

In addition to reviewing relevant offender records, other sources of information may inform the assessment. This may include interviewing significant persons in the offender's life who may have information pertinent to the assessment. These persons include:

1. Spouses and partners;
2. Relatives and other significant social influences;
3. Probation and parole officers;
4. Child protection professionals;
5. Law enforcement professionals; and
6. Victim advocates.

Decisions to interview a collateral and the timing of the interviews must be made on a case-by-case basis. Considerations include resources allocated to the assessment, the likelihood that a collateral possesses relevant information, and potential harm to a collateral. In most cases, information that might be gained by interviewing a victim is outweighed by the potential harm to a victim who has likely undergone multiple prior interviews concerning the case. Relevant victim information about a case typically can be obtained from sources such as victim statements, indictment documents victim advocates.

4.160 Offender Interviews

The evaluator shall interview the offender whenever possible. If the offender is not available to be interviewed, the evaluator shall determine whether it is prudent to proceed with the assessment without interviewing the offender. Depending on the referral request, some referral questions may be addressed without interviewing the offender. For example, some risk instruments can be scored without interviewing the offender.

4.200 Assessment of Risk for Sexual Reoffending

The primary purpose of risk assessment is to assess the likelihood that an offender will commit a new sexual offense and use this information to allocate treatment and supervision resources wisely.

4.210 Methods of Describing Risk to Reoffend

Risk to reoffend can be described in various ways, including relative risk, absolute recidivism rates, percentile ranks, and risk ratios.

1. **Relative Risk Categories**. Relative risk categories – such as whether an offender is at low, average, and above average risk to reoffend – are generally sufficient for making most treatment and supervision allocation decisions. Offenders categorized as low risk have relatively lower rates of reoffending than those classified as average risk, who in turn have lower rates of reoffending than those categorized as above average risk. Using relative risk categorizations, lower-risk offenders would receive few treatment and supervision services, offenders in the average risk range would receive a moderate level

of services, and above average risk individuals would receive a high dosage of services. Empirically validated risk instruments for assessing sexual reoffense are generally robust in determining relative risk.

2. **Absolute Recidivism Rates**. An absolute recidivism rate is the percent likelihood of reoffending among offenders with the same risk score. For example, a risk assessment might conclude that the reoffense rate of individuals with the same score as a particular offender is 8% over five years. Whereas risk instruments are generally robust in assessing relative risk, more caution is needed when determining how well absolute recidivism rates associated with various risk instruments apply to sex offenders in a particular jurisdiction, such as in Alaska.
3. **Percentile Ranks**. Percentile ranks show the percentage of offenders scoring higher or lower than a particular offender. For example, a risk assessment might conclude that an offender's risk score places him in the top 10% in terms of risk to reoffend, meaning that 90% of offenders have a lower score than the offender being assessed.
4. **Risk ratios**. Risk ratios show how a particular offender's reoffense risk compares with offenders with an average score. For example, an offender's risk to reoffend might be like that of the average offender (i.e., in the middle of the risk distribution) or two times higher than the average offender.

Evaluators must decide the most appropriate method of reporting risk based on the purpose of the assessment and the nature of the normative data available for a given risk tool.

4.220 Sexual Offense Risk Factors

Empirically validated risk assessment tools are composed of risk factors that have been linked to the risk of reoffending. Risk factors for reoffending are commonly categorized as static, stable dynamic, or acute dynamic. Each of these types of risk factors is described, and examples are provided in Table 4.220

1. **Static Risk Factors**. Static risk factors are historical in nature and thus cannot change. Although static risk factors help predict reoffending over the long term, since they cannot change, they are not a focus of treatment and supervision services.
2. **Stable Dynamic Risk Factors**. Stable dynamic factors, also called criminogenic needs, are relatively ingrained behavioral and personality characteristics that are rather constant over time but are potentially amenable to intervention. Stable dynamic risk factors are critical targets of treatment and supervision interventions.
3. **Acute Dynamic Risk Factors**. Acute dynamic risk factors can change rapidly and are potentially more responsive to supervision and treatment interventions than stable dynamic ones. Regular assessment of acute dynamic risk factors, such as during each supervision meeting, can help predict when an individual is at increased risk of reoffending and what interventions should be done promptly.

Table 4.220 Types of Sexual Reoffense Risk Factors

Type of Risk Factor		
Static	**Dynamic**	**Acute Dynamic**
Prior sex offenses	Deviant sexual interest	Rejects supervision
Prior non-sexual violence	Sexualized coping	Increased victim access
Prior sentencing dates	Attitudes support offending	Marked hostility
Prior violations of release	Lifestyle impulsivity	Social supports collapse
Young age	Social rejection/loneliness	Emotional collapse
Never lived as married	Resistance to supervision	Sexual preoccupation
Any male victims	Poor problem-solving	Substance abuse
Any unrelated victims	Intimacy deficits	
Any stranger victims	Grievance/hostility	
	Poor self-regulation	

4.230 Sexual Offense Risk Instruments

Evaluators shall use empirically validated risk instruments for assessing sexual reoffense risk when they are available for the offender population being evaluated.

Research favors actuarial risk tools over other risk assessment tools and methods, such as structured professional judgment tools and unaided clinical judgment methods. Actuarial risk tools are based on statistical models that determine a particular offender's similarity to groups of sex offenders for whom the reoffense risk is known. Actuarial risk tools comprise several predetermined risk factors, each with a certain weight. These weights are added in a prescribed manner to yield a risk score, which is then translated into a risk level (or a percent reoffense rate, percentile rank, or risk ratio) that measures the likelihood of reoffense.

Table 4.230 lists several commonly used actuarial risk instruments for assessing the risk to sexually reoffend among adult males and the types of risk factors that comprise each instrument. Each listed instrument has been empirically validated. Across at least three studies, each tool has shown that it can be scored reliably and has predicted sexual reoffending with at least moderate accuracy. Most of these risk tools have adopted Council of State Governments Justice Center's five-level risk and needs common language system for communicating assessment results, which is described in Table 5.720 Sex Offender Five-Level Risk and Needs System.

Table 4.230 Empirically Validated Sex Offense Risk Instruments

Instrument	Type of Risk Factors		
	Static	Stable Dynamic	Acute Dynamic
Acute-2007			x
Assessment of Risk and Manageability of Individuals with Developmental and Intellectual Limitations Who Offend - Sexually (ARMIDILO-S)		x	x
Child Pornography Offender Risk Tool (CPORT)	x		
Risk Matrix 2000 (RM2000)	x		
Sex Offender Treatment Intervention and Progress Scale (SOTIPS)		x	
Stable-2007		x	
Static-99R	x		
Static-2002R	x		
Violence Risk Scale-Sex Offense Version (VRS-SO)	x	x	

Research favors using multiple tools to ensure a more comprehensive and balanced assessment. Combinations of some static and dynamic risk tools have been found to predict sexual reoffending better than using a single tool. Examples are the following:

1. Static-99R and Stable-2007;
2. Static-99R and SOTIPS;
3. Static-2002R and Stable-2007;
4. RM2000 and Stable-2007; and
5. VRS-SO (which includes static and dynamic factors).

The choice of risk instruments will depend on factors such as the offender's characteristics, evaluator training, referral questions, and available resources. The Department may require approved providers to use specific risk tools to provide consistency in service delivery across programs, enhance communication about offenders' risk and needs across the continuum of institutional and community-based services, facilitate uniform data collection, and support program outcome evaluations and other research.

4.240 Assessment of Criminogenic Needs

Evaluators shall use empirically validated instruments to assess offenders' criminogenic needs, also called dynamic risk factors, when available for the assessed offender population.

The risk instruments listed in Table 4.230 include several empirically validated dynamic risk tools. These dynamic risk tools, in addition to assessing the risk of reoffending sexually, are useful for identifying each offender's treatment and supervision needs. Examples are the following:

- Acute-2007

- SOTIPS;
- Stable-2007; and
- VRS-SO.

Evaluators may use methods other than or in addition to these tools to assess offenders' dynamic risk factors for treatment and case planning purposes. Other methods include offender and collateral interviews, records reviews, polygraph testing, sexual interest testing, and various psychological tests and inventories.

4.250 Assessment of Responsivity Factors

Evaluators shall assess offenders' major responsivity factors. Identifying responsivity factors helps guide institutional, community supervision, and treatment staff in delivering services most effectively to each offender.

Individual offender responsivity factors that can impact responsiveness to treatment, institutional adjustment, and community supervision include the following:

1. Gender;
2. Motivation for treatment;
3. Denial and minimization;
4. Developmental disability;
5. Learning disability;
6. Personality characteristics;
7. Mental health needs;
8. Culture;
9. Adverse childhood experiences; and
10. Active substance abuse.

Evaluators may use several methods to assess offenders' responsivity factors. These methods include offender and collateral interviews, records reviews, and selected psychological tests and inventories.

4.260 Assessment of Risk for General and Violent Reoffending

Evaluators shall use empirically validated risk instruments when assessing risk for violent and general reoffending when available for the offender population being evaluated.

Although the primary purpose of risk assessment of sex offenders is to determine the likelihood of a new sexual crime, sex offenders are more likely to reoffend by committing a non-sexual offense. Depending on the nature of the referral questions, risk assessments of sex offenders should also include the assessment of risk for general and violent reoffending.

General Reoffending

Most tools for general Reoffending assess reoffending risk collectively for any crime, typically including sex offenses, non-sexual violent offenses, and non-sexual and non-violent offenses.

Examples of empirically validated risk instruments for assessing general reoffense risk include the following:

1. Level of Service Inventory-Revised (LSI-R);
2. Level of Service Inventory - Screening Version (LSI-SV); and
3. Brief Assessment for Recidivism Risk (BARR-2002R).

Violent Reoffending

Some risk tools are specifically designed to assess the likelihood that a sexual offender or other type of offender will commit some violent crime in the future. Most tools for violent reoffending define violent crimes as including sexual offenses and other violent crimes such as assault, robbery, kidnapping, murder, and wounding. Examples of empirically validated risk instruments for assessing violence reoffense risk include the following:

1. Historical, Clinical, Risk-20 (HCR-20);
2. Violence Risk Appraisal Guide-Revised (VRAG-R); and
3. Brief Assessment for Recidivism Risk (BARR-2002R).

4.270 Other Sexual Reoffending Risk Considerations

The preceding sub-sections focus on the first of five critical issues concerning the risk of sexual reoffending. These five critical issues are listed below in the form of questions and are then detailed further.

1. What is the likelihood of a reoffense?
2. What degree of harm might likely result from a reoffense?
3. What are the conditions under which a reoffense would most likely occur?
4. Who would be the most likely victims of a reoffense?
5. When would a reoffense be most likely to occur?

1. What is the Likelihood of a Reoffense?

The preceding sub-sections reviewed several risk instruments that assessors can use to assess the likelihood that a sex offender will reoffend.

2. What Degree of Harm Might Likely Result from a Reoffense?

The harm inflicted on victims of a sexual offense can be psychological and physical. Predicting the psychological trauma to victims of offenses is more complex than assessing physical harm. Victims generally experience more significant psychological harm when crimes involve abuse by a trusted person, force, penetration, overt violence, bodily injury, and abuse over a long time.

In assessing the likelihood that if an offender reoffends that it will be in a violent manner, an assessor can be guided by the evidence that the severity of past sexual offenses is moderately predictive of the severity of future sexual reoffenses. Other data sources may help assess this issue, such as the results of risk tools designed to evaluate the likelihood of committing some violent crime in the future, inventories that include items that assess interest in sexual and non-sexual violent behavior, and collateral and offender reports of prior violence or intention to commit violence.

3. What Are the Conditions Under Which a Reoffense Would Most Likely Occur?
Assessments should determine if specific risk factors have been antecedent to an offender's past sexual offending. Of course, access to potential victims will always be an antecedent. Without an available victim, an offender cannot commit a sexual offense. Other common early warning signs of increased risk are acute dynamic risk factors such as the collapse of the offender's social support systems, rejection of supervision, marked hostility, emotional collapse, substance abuse, and sexual preoccupation.

4. Who Would Be the Most Likely Victims of a Reoffense?
Sex offenders who sexually reoffend typically do so against victims of the same gender and similar age as their past victims. A caution, though, is that a significant minority of offenders engage in crossover offending. They offend victims of multiple age, gender, and relationship categories. The likelihood of offender crossover offending varies by offender type. Other data sources that may help assess this issue include sexual interest measures, collateral reports, and offender self-reports.

5. When Would a Reoffense Be Most Likely to Occur?
Sex offenders are at the greatest risk for sexually reoffending during the first few years of placement in the community. For this reason, the amount and intensity of treatment and supervision services should generally be greatest during this time.

The longer that sex offenders live sex offense free in the community, the lower the risk of sexual reoffending. Sexual recidivism rates decline by approximately half every five years a person lives sex offense-free in the community. For example, if the 5-year sexual recidivism rate of a group of individuals was 20% at placement in the community, of those who lived sex offense free in the community for five years, the group sexual recidivism rate over the next five years would be about 10%, after ten years it would be 5%, and after 15 years 2.5%. Virtually all individuals who have lived sex offense-free in the community for 20 years can be considered to have desisted from sexual offending.

4.300 Assessment Reports
Evaluators shall document their assessment procedures, findings, and recommendations in writing. A report's structure and detail should match the context and purpose of the assessment. Content areas typically include the following:

1. Identifying offender information;
2. Purpose of the assessment;
3. Current sexual offenses;
4. Prior sexual offending and other criminal history;
5. Mental status;
6. Sexual history;
7. Personal and social history;
8. Risk, needs, and responsivity factors;
9. Need for and amenability to treatment; and

10. Recommendations that address the referral questions.

4.400 Standards of Practice for Polygraph Assessment

4.410 Equipment

Polygraph examiners shall use a computerized polygraph system or a late model state-of-the-art, four or five-channel polygraph instrument that will simultaneously record the physiological phenomena of abdominal and thoracic respiration, galvanic skin response, and the cardiovascular system.

Polygraph examiners shall use recognized scoring software must (e.g., Johns Hopkins Applied Physics Laboratory scoring algorithm). Computerized charts must also be independently hand scored by the examiner.

4.420 Examination Length

The duration of each examination (including the pre-test, in-test, and post-test phases) shall be scheduled for a minimum of 90 minutes. The time begins when the examinee enters the examination room with the examiner and ends when the examinee departs after the conclusion of the polygraph examination.

4.430 Design of Test Questions

The design of polygraph test questions shall adhere to standardized and recognized procedures. The number of relevant test questions per exam should be limited to no more than four (4) and shall:

1. Be simple, clear, direct, and as short as possible;
2. Not include legal terminology that allows for examinee rationalization or misinterpretation;
3. Not include mental state or motivation terminology;
4. Not allow for multiple interpretations;
5. Contain a reference to only one issue under investigation;
6. Not presuppose knowledge on the part of the examinee;
7. Use language easily understood by the examinee, and all terms used by the examiner should be fully explained to the examinee;
8. Be easily answered yes or no;
9. Avoid the use of any emotionally laden terminology (e.g., rape, molest, murder); and
10. Use behaviorally descriptive language.

4.440 Examination Procedures

Examiners shall use a recognized Comparison Question Technique. Examiners shall adhere to the established ethics, standards, and practices of the American Polygraph Association. In addition, clinical polygraph examiners shall demonstrate competency according to professional standards and conduct all polygraph examinations in a manner that is consistent with the reasonably accepted standard of practice in the clinical polygraph examination community.

Examiners shall use the following specific procedures during the administration of each examination:

1. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination;
2. The examinee shall agree in writing or videotape to a standard waiver/release statement. The language of the statement should be agreed upon before the polygraph examination with the probation/parole officer;
3. The examiner shall elicit relevant biographical and medical history information from the examinee prior to administering the actual polygraph examination;
4. The testing process shall be explained to the examinee, including an explanation of the instrumentation used and causes of general nervous tension;
5. Examiners shall review and explain all test questions to the examinee;
6. Examinees must demonstrate that they comprehend the meaning of each question;
7. All test questions must be formulated to allow only Yes or No answers;
8. An optional acquaintance/practice test may be run;
9. A minimum of three primary test charts shall be administered on the primary issue(s); and
10. Test results shall be reviewed with the examinee.

The polygraph examiner shall videotape polygraph examinations and maintain the entire examination tapes for at least three years from the examination date.

4.450 Peer Review

Examiners shall use a Department approved quality control assurance process that allows for a periodic independent review of all documentation, polygraph charts, and reports.

4.460 Reporting Results

Examiners shall issue a written report. The report must include factual, impartial, and objective accounts of the pertinent information developed during the examination, including statements made by the offender. The information in the report must not be biased or falsified in any way. The examiner's professional conclusion shall be based on the analysis of the polygraph chart readings and the information obtained during the examination process.

All polygraph examination written reports must include the following:

1. Date of examination;
2. Name of person requesting exam;
3. Name of examinee;
4. Location and supervision status of the examinee in the criminal justice system (an incarcerated offender, an offender on probation/parole, etc.);
5. Reason for examination;
6. Date of last clinical examination;
7. Examination questions and answers;
8. Any additional information deemed relevant by the polygraph examiner (e.g., examinees' demeanor);

9. Reasons for inability to complete exam, information from examinee outside the exam, etc.; and
10. Results of pre-test and post-test examination, including answers or other relevant information provided by the examinee.

4.500 Standards of Practice for Abel Assessment

An Abel assessment is intended for use in providing treatment and supervision services. It is not intended for use in a court of law to determine the guilt or innocence of an individual. As in other assessment procedures, it cannot determine if an individual committed a specific act.

4.510 Examination Procedures

An Abel assessment examiner shall adhere to the guidelines for administration and interpretation recommended by the licensed trainers of the instrument. The examiner shall demonstrate competency in administering the instrument and interpreting data stemming from the examination.

Abel assessment examiners shall adhere to the following specific procedures during the administration of each examination:

1. The examiner must have received all pertinent and available case facts within a time frame sufficient to prepare for the examination;
2. The examiner shall obtain the informed assent of the offender for the Abel assessment examination, and shall inform an offender of the examination methods, how the information will be used, and to whom it will be given. The examiner shall also inform the offender about the evaluator's relationship with the offender and the court. The examiner shall respect an offender's right to be fully informed about the examination procedures, and results of the examination should be shared with the offender and any questions clarified;
3. The examinee shall sign a standard waiver and release of information statement;
4. The examiner shall elicit relevant historical information from the examinee before administering the examination; and
5. The examiner shall review the test results with the examinee.

Abel assessment examinations should not be used in isolation. The results must be utilized in conjunction with other evaluative measures or as a part of a treatment program to assess risk and needs effectively.

4.520 Reporting

The Abel assessment examiner shall prepare a written report of findings summarizing the results of testing. Reports must include the following:

1. Date of test or evaluation;
2. Name of person requesting exam;
3. Name of examinee;
4. Location and supervision status of the examinee in the criminal justice system (an incarcerated offender, an offender on probation/parole, etc.);

5. Type of examination (e.g., initial assessment, follow-up assessment).
6. Date of last Abel examination;
7. A description of the type of stimuli presented;
8. Any additional information deemed relevant by the examiner (e.g., examinees' demeanor);
9. Reasons for inability to complete exam if relevant; and
10. Results of the examination, including deviant and non-deviant interest patterns.

Section 5.000

Sexual Offense-Specific Treatment

5.100 Sex Offender Program Referral Process

The Department's continuum of care of services for sex offenders includes specialized institutional and community-based sex offender treatment.

Department staff refer sex offenders to available programs and providers that best meet sex offenders' treatment needs. Department staff members use motivational interviewing and other strategies to motivate sex offenders to enroll in treatment and other services to decrease their risk to reoffend. Approved providers shall give referring Department staff input on the appropriateness of referrals to their programs.

Institutional Program Referrals

Sex offenders with the closest projected release date or parole eligibility date shall be given preference for admission into institutional programs. Institutional probation officers monitor available openings in institutional programs for sexual offending and are responsible for referring incarcerated sex offenders on their caseloads to an appropriate institutional program.

Community Program Referrals

Sex offenders with the least time left on probation or parole shall be prioritized for admission into community programs. Institutional furlough officers are responsible for referring incarcerated sex offenders who are being furloughed to an appropriate community sex offender treatment program in coordination with the receiving probation and parole officer. Probation officers are responsible for referring sex offenders on probation to an appropriate community sex offender treatment program.

Offender Ability to Pay Considerations

Sex offenders who cannot pay for treatment services shall be referred to a Department contracted approved provider. Sex offenders who can pay for treatment services may be referred to either a Department contracted or a non-contracted approved provider.

Inappropriate Referrals

A provider may believe it is inappropriate to provide services to a sex offender referred by the Department. Reasons include the provider having a conflict of interest in the case or lacking specialized competence to treat a particular offender. The field probation and parole officer and the Criminal Justice Planner for Offender Programs may review the appropriateness of a provider's request not to accept a referral and document their findings in a Management Team Report.

5.200 Program Eligibility Criteria

The Department's minimum mandatory criteria for sex offenders to be accepted into an approved institutional or community-based program for sexual offending are as follows:

The offender has been convicted of and sentenced for committing a sexual offense or criminal behavior with sexual intent, or a sentenced offender has admitted to committing a sexual offense;

1. The offender's conviction for the sexual offending behavior is not under appeal;
2. The offender has sufficient time remaining on their sentence or supervision to participate meaningfully in the program;
3. The offender has requested to participate in a program, has completed a program application form, and the Case Management Team has reviewed and accepted the application;
4. The offender is judged to need sex offender treatment;
5. The offender understands that admission to and discussion of the sexual offending behavior for which they have been convicted is a requirement for successful completion of the program; and
6. The offender has no mental illness or other medical condition with current symptoms so severe as to preclude them from program benefit.

5.300 Program Descriptions

Department-contracted sex offender approved providers shall develop and maintain an up-to-date written program description. The program description shall describe who the program is for, its admission criteria, philosophy, services, and evidence base or credible rationale for reducing reoffending, and it shall be consistent with the Standards. The Criminal Justice Planner for Programs or designee shall approve the program description before making it available to offenders and other interested parties. The program shall operate by its program description.

5.400 Informed Consent

The provider shall obtain the informed consent of the offender (hereafter called "client" in this Standards section) before providing treatment services. The informed consent shall be obtained verbally and in writing.

Providing informed consent is an ethical obligation. It is also a way to engage and motivate the offender by explaining the treatment process. An offender has the right to decide whether to participate or decline to participate in treatment.

Elements of informed consent include the following:

1. Explaining the nature, methods, frequency, and purpose of treatment;
2. Describing how the duration of treatment will be determined;
3. Explaining the potential benefits and limitations of treatment;
4. Explaining the implications of participating or declining to participate in treatment;
5. Explaining how failure to actively participate in treatment or follow conditions of probation, parole, or furlough may result in termination from the program;
6. Explaining that active participation includes attending treatment sessions and attending on time, completing and discussing treatment assignments, reporting risk behavior, and encouraging relevant family and support persons to participate in recommended treatment sessions;

7. Explaining that the admission to and discussion of the sexual offending behavior for which they have been convicted is a requirement for successful completion of treatment;
8. Describing the limits of privilege and confidentiality and waivers of confidentiality that the client will be required to sign as a condition of program admission;
9. Explaining the costs of treatment services and obligations for payment; and
10. Answering the offender's questions about the treatment process.

When providing treatment services to offenders who cannot give informed consent, the evaluator shall obtain consent from the offender's legal guardian.

5.500 Confidentiality

An approved provider shall make acceptance into a sex offender treatment program contingent on the offender agreeing to and signing a waiver of confidentiality that allows unrestricted communication between the approved provider, the Department, the Alaska Parole Board, the Court, and members of the Case Management Team. The Case Management Team will consist of the approved provider, supervising officers, polygraph examiner, and criminal justice planner. The Case Management Team may include other individuals or agencies responsible for the offender's treatment and supervision, such ancillary approved providers and the Office of Children's Services.

The waiver of confidentiality shall explain mental health providers' obligations under Alaska law to report acts of abuse towards children, people with disabilities, and the elderly, as well as providers' general duty to inform the authorities or others if, in the professional opinion of a provider, the offenders' behavior presents a clear and imminent danger to either themself or to other persons.

Depending on the circumstances, the provider shall ask the offender to agree to and sign waivers of confidentiality to allow the provider to communicate with the victim/s, victims' custodial parents or Guardians ad Litem, and victim therapist/s, particularly for making decisions about and monitoring victim contact and facilitating family reunification.

5.600 Payment for Services

The supervising officer shall determine the extent of each offender's ability to pay for community-based sex offender program services.

Department Payment Contracts for Services

Suppose the supervising officer determines that an offender cannot afford to pay for some or all services. In that case, the Department may enter a contract with an approved provider to pay for some or all of the offender's sex offender program services specified in the contract.

Offender Payment for Services
Suppose the supervising officer determines that an offender can afford to pay for all or some of their sex offender program services. In that case, the offender will be required to pay for services to the extent of their ability.

Approval for Changes to Payment Agreement
An approved provider, probation or parole officer, or other member of the Case Management Team may recommend that services be provided to an offender in addition to those specified in the original case management plan.

Suppose the cost of the additional services is greater than what Department subsidizes or the offender may be able to pay. In that case, the Case Management Team must approve the additional services and the payment methods, be it a contract adjustment, offender self-pay, or some other payment method. Approved providers requesting payment for additional services must submit a written request and rationale to the Criminal Justice Planner for Offender Programs for approval.

New services must be written into the treatment plan, and the plan must be approved and signed by all members of the Case Management Team, including the offender.

Providers must obtain Department approval before requiring an offender to participate in extra services for which he will be responsible for payment. An offender may not be discharged from a program by a contractor for non-compliance with a plan for additional services that the Department has not approved.

5.700 Treatment Models and Methods
Approved providers shall use evidence-based treatment models and approaches with a credible rationale for reducing reoffending. More effective correctional programs are manualized and provide clear direction to staff about delivering treatment services.

Cognitive-Behavioral Model
Cognitive-behavioral treatment models delivered following the risk, needs, and responsivity principles have the most empirical support for reducing sexual reoffending. The cognitive-behavioral model blends two approaches. Cognitive therapy is based on the premise that how individuals think largely determines how they act and that changes in individuals' behavior can be accomplished by helping them change their thinking patterns. Behavior therapy is founded on the premise that behavior is learned and can be changed through various methods such as modeling, skill training, coaching, role-play, and effective rewards and punishments. Rewards should exceed punishers by a ratio of about 4 to 1.

Pharmacological Treatment
Pharmacological Treatment can be a beneficial adjunctive treatment for some individuals who are sexually preoccupied and have marked deviant sexual interests.

Skill Training and Practice
A foundation of cognitive-behavioral treatment is skill training and practice. Approved providers emphasize helping offenders learn and practice skills to live offense-free lives. Skill teaching and practice typically involves:

1. Defining the skill
2. Identifying the usefulness of the skill
3. Detailing the skill steps
4. Modeling the skill
5. Practicing the skill
6. Giving feedback
7. Assigning practice homework

Therapeutic Working Alliance
Approved providers shall strive to develop a therapeutic working alliance with the offenders they evaluate and treat. A therapeutic working alliance is a respectful and cooperative working relationship between an offender and a therapist marked by positive emotional connections and mutually agreed-upon treatment tasks and goals. The quality of the working alliance between treatment staff and the offender is an essential aspect of successful treatment services. A firm, fair, respectful, warm, empathetic, rewarding, and directive therapist treatment style contributes to developing a therapeutic working alliance. An overly confrontational, judgmental, and harsh treatment style undermines a therapeutic working alliance and is associated with poor treatment outcomes.

Motivational Interviewing
Approved providers support and strengthen offenders' motivation to change. In the spirit of motivational interviewing, they communicate clearly and concisely and generally talk less than offenders. They use reflective listening much more than questioning. They primarily use open, thought-provoking, and non-hostile questions to help offenders think things out themselves. They avoid getting ahead of offenders' level of readiness to change. They generally avoid arguments and warnings, giving unwelcomed advice, and taking the "good" side an argument.

Trauma Informed Care (TIC)
Approved providers recognize and are responsive to the impact of trauma on sexual abuse victims and others who have suffered trauma. Following the principles of a Trauma-Informed Care approach, providers emphasize trauma survivors' physical, psychological, and emotional safety. Providers help survivors create opportunities to rebuild a sense of control and empowerment.

5.710 Treatment Targets
Approved providers shall focus treatment primarily on empirically supported criminogenic needs, also called dynamic risk factors, over factors not linked to reoffending. Approved providers shall also target offender responsivity factors that, if not addressed, may significantly interfere with an offender's ability to engage in and benefit from treatment. Additionally, providers shall target protective factors linked to reoffending reductions.

1. **Engagement and motivation**. Providers assist offenders in identifying and addressing fears and concerns about engaging in treatment, recognizing the benefits of treatment, and reinforcing offenders' motivation to engage in treatment.
2. **Offense admission**. Providers assist offenders in providing an accurate account of their sexual offending behavior in sufficient detail for treatment staff to identify offenders' risks and needs and develop a treatment plan that could reasonably be expected to reduce the risk to reoffend. The strength of the relationship between reoffense risk and denial and minimization varies among subgroups of sex offenders in ways that are not clearly understood. Although denial and minimization are not established criminogenic needs, they are responsivity factors that may impact client engagement, treatment motivation, and identifying relevant treatment and supervision targets.
3. **Prosocial identity**. Providers assist offenders in developing an identity that finds meaning and value in society's rules and values, which uphold the safety, dignity, and worth of self and others.
4. **General self-regulation**. Providers assist offenders in identifying and learning to manage emotional states linked to their sexual offending.
5. **Sexual interests**. Providers assist offenders in identifying, reducing, and managing deviant sexual arousal and interests; and identifying, developing, maintaining, and strengthening appropriate sexual arousal and interests.
6. **Sexual preoccupation**. Providers assist offenders in identifying maladaptive sexual coping strategies and learning and using adaptive coping strategies.
7. **Offense-supportive attitudes**. Providers assist offenders in learning how to identify, counter, and manage thoughts and attitudes that support sexual and other offending behavior.
8. **Lifestyle impulsivity**. Providers assist offenders in learning how to act less impulsively and behave in a more planned, thoughtful, and deliberate manner.
9. **Problem solving**. Providers assist offenders in learning how to set realistic goals, recognize life problems, generate reasonable solutions, weigh the pros and cons of possible solutions, carry out action plans, and recognize and ask for help when needed.
10. **Concern for others**. Providers assist offenders in learning how to see situations from another's perspective and how to understand and value others.
11. **Adult intimate relationships**. Providers assist offenders in developing skills to support having consensual, satisfying, age-appropriate, intimate relationships with adults.
12. **Social connections and influences**. Providers help offenders identify the characteristics of family, friends, and associates that are positive and negative influences and decrease negative and increase positive social influences.
13. **Supervision and treatment cooperation**. Providers assist offenders in learning how to understand, accept, and follow their conditions of supervision and treatment.
14. **Sexual Risk Management**. Providers help offenders learn how to identify the feelings, thoughts, attitudes, behaviors, and situations linked to their sexual offending behavior, develop plans to manage them in their life and implement those plans successfully.
15. **Impediments to Treatment Engagement.** Providers assist offenders in identifying and successfully addressing responsivity factors that interfere with engaging in treatment

services designed to reduce sexual reoffending. This may include providing services within a sex offender program or referrals to other programs to address issues such as current substance abuse, major mental illness, and trauma symptoms.

5.720 Treatment Dosage

Providers shall match the amount, frequency, and duration of treatment services – called treatment dosage – to the risk and needs of offenders. Those with fewer risks and needs should receive fewer services than those with higher risks and needs. Determining a particular offender's optimal treatment and supervision dosage is not a well-researched area and requires professional judgment. Table 5.000 provides broad guidance for making treatment and supervision dosage decisions. It is based on the Council of State Governments Justice Center's five-level risk and needs common language system for communicating assessment results.

Table 5.720 Sex Offender Five-Level Risk and Needs System

(Note. SOST = sexual offense-specific treatment)

Risk and Needs Level	Criminogenic Needs	Treatment Dose	Supervision Dose
Very Low	None or few – if any, mild and/or transitory	None or minimal SOST– if other treatment needs, refer to community services	Minimal need for monitoring
Below Average	A few – some mild and transitory, or possibly acute	Minimal, in any SOST– if other treatment needs, refer to community services	Some monitoring for compliance; provide some change focused interventions
Average middle of risk and needs distribution	Multiple – some severe	Significant SOST – 100 to 200 hours	Considerable need to monitor for safety and compliance, provide change focused interventions
Above Average	Multiple – some chronic and severe	Very significant SOST – 200 to 300 hours	Intensive need to monitor for safety and compliance, provide change focused interventions
Well Above Average	Multiple – chronic, severe, and entrenched across multiple life domains	Very significant SOST – 200 to 300+ hours	Intensive need to monitor for safety and compliance, provide long-term change focused interventions

Several reasons exist for providing no or minimal services to offenders with very low or below-average risk and needs. First, they have few treatment needs. Second, since they have very low reoffending rates, reducing reoffending much further is difficult. Third, requiring lower-risk offenders to engage in time-consuming services runs the risk of disrupting their housing, employment, financial, and social supports, all of which are protective factors against reoffending. Lastly, suppose services place lower-risk sex offenders in contact with higher-risk offenders. In that case, they may develop anti-social attitudes and beliefs from these associations, adopt deviant self-labels, and see themselves as more criminal than they are.

Although offenders assessed as very low or below average risk generally may require no or minimal treatment services to reduce reoffending, lower-risk sex offenders that are integrating or hope to integrate into a living situation where children reside may need significant treatment services to help them do so safely.

Treatment and case planning should also consider the need for services that may not be sexual offense specific. For example, some offenders may need a referral for substance abuse and mental health services instead of or in addition to sexual offense-specific treatment.

5.730 Treatment Plan

Approved providers shall write an individualized treatment plan for each offender under their care and update it every six months or earlier if needed. Treatment plans shall, at a minimum, include the following:

1. Problem statement
2. Treatment goals
3. Treatment objectives
4. Interventions and services

The type and nature of interventions and services approved providers provide each offender will be determined by the offender's risk, needs, and responsivity issues and available resources.

5.740 Intake Assessment

Approved providers shall base an offender’s initial treatment plan on the results of an intake assessment conducted at the beginning of services. If the offender has had one or more prior assessments, the intake assessment should build on the earlier assessments.

5.750 Polygraph Testing

The Alaska Legislature passed legislation enacted on July 1, 2007, requiring all sex offenders under the jurisdiction of the Department to submit to periodic post-conviction polygraph testing. Approved providers shall collaborate with supervising officers and other members of the Case Management Team when utilizing polygraph testing with offenders under their care.

The Department uses three types of polygraph exams at a frequency detailed in Table 8.600, Polygraphy Type and Frequency Guidelines, for the following purposes:

1. Maintenance and Monitoring Polygraphs are used regularly to detect compliance and non-compliance with conditions of supervision or treatment-related issues.
2. Sex History Polygraphs are used under special circumstances to investigate the sex offender's lifetime sexual history, particularly the history of sexually victimizing others.
3. Specific Issue Polygraph tests are used under special circumstances to examine potential involvement in an expressly prohibited behavior, such as unauthorized contact with a victim.

Polygraph testing can support information gathering to inform treatment and supervision services, but results shall be used in conjunction with other data sources. Polygraph results shall not be used as the sole criteria for making treatment and supervision decisions, such as those related to treatment planning, progression, termination, and completion, and those related to community placement conditions, compliance, and violations. Polygraph tests focusing on specific, narrow, and concrete issues are more accurate than those focusing on broad, poorly defined issues.

5.760 Treatment Modalities

5.761 Group Treatment

Group treatment is the most common treatment modality for providing services to sex offenders. It has several advantages. Group treatment is more economical than individual, couples, or family therapy. Offenders often feel more comfortable admitting and discussing problems in a treatment group where others are modeling openness. Offenders often accept feedback about their behavior more willingly from other group members than approved providers. Finally, a group treatment setting allows offenders to role-play and practice social and other skills with each other.

Group Composition

Group treatment does have some risks. Just as group members can be prosocial influences on each other, they also can influence each other in antisocial ways. Similarly, the treatment needs of some sub-groups of sex offenders are better met in groups composed of individuals with broadly similar risk, needs, and responsivity factors. Examples include specialty groups for sub-populations of sex offenders with the following characteristics:

1. Females
2. Intellectual and developmental disabilities
3. Child sexual abuse material only offenses
4. Low risk and needs
5. Statutory rape only offenses

Approved providers shall not place female sex offenders in treatment groups with male offenders. Approved providers shall use their clinical judgment in making other decisions about whether an offender would likely benefit from group treatment and the composition of groups. Approved providers are cautioned against placing low-risk sex offenders in groups with high-risk offenders,

offenders whose only know sexual offenses are possessing child sexual abuse material in groups with offenders who have committed contact sex offenses, and individuals with intellectual and developmental disabilities in groups with offenders with normal intellectual abilities.

Group Size

Effective group treatment requires an appropriate group size. Approved providers shall limit the number of individuals in a treatment group to 12 offenders, ideally about eight members per group. Approved providers shall limit the number of individuals in a treatment group for persons with developmental and intellectual disabilities or major mental health problems to a maximum of eight offenders and ideally slightly less.

Co-therapy

Approved providers recognize that there are some benefits to co-facilitating treatment groups. Co-facilitation allows two or more approved providers to manage behavioral problems, contribute to group discussions, and facilitate skill teaching and practice activities. Additionally, when one co-facilitator is absent from a group, the other facilitator can hold the group, which results in fewer group cancellations.

5.762 Individual Treatment

Individual treatment is generally an adjunct to group treatment but may also be the primary treatment modality for some sex offenders.

Individual Treatment as An Adjunct to Group

As an adjunct modality to group treatment, approved providers shall, as resources allow, provide at least one hour of individual treatment per month to offenders during the initial phases of treatment to enhance the therapeutic alliance and support treatment engagement. The approved provider shall consult with the Case Management Team about the need for ongoing adjunctive individual treatment. Individual treatment may also focus on subjects more appropriately dealt with outside the treatment group setting. These may include providing individualized assistance with group treatment assignments, behavior therapy for arousal management, and therapy concerning personal victimization.

Individual Treatment and the Primary Modality

As a primary treatment modality, individual treatment may be appropriate for individuals for whom group treatment, or an available treatment group, is not a good fit. For example, individuals with severe social anxiety may not initially be appropriate group treatment candidates. Similarly, young, pro-social, low-risk offenders may be better served in individual treatment than in a group composed of high-risk offenders with high treatment needs in criminality and sexual deviancy.

5.763 Couples and Family Treatment

Couples and family therapy should be conducted with the support of the Case Management Team. Family and significant other involvement in treatment can help develop and enhance offenders' prosocial support networks. If the Case Management Team considers allowing an offender to have

contact with a child or victim, couples or family treatment is often indicated (see Section 9.000, Victim Issues).

5.764 Psycho-Education Classes

Educational sessions may occur within therapy groups or as special classes. Educational classes may be co-taught by the approved provider and a probation or parole officer. Education classes may include orientation groups and groups focused on specific criminogenic needs such as anger management, substance abuse, and preparation for community release.

5.765 Behavioral Therapy for Arousal Control

Approved providers shall give offenders verbal and written informed consent before providing behavioral therapy for arousal control. Approved providers shall have documented training and experience in the behavioral therapy treatments they offer and conduct them in adherence to ethical and professional standards.

5.766 Medication Therapy for Reduction of Sexual Drive

Medication prescribed to reduce sexual drive shall be supervised by a licensed medical doctor. Prescribing physicians shall provide informed consent verbally and in writing before administering the medication. This therapy shall not be used for experimental purposes or as punishment. The use of this therapy method is determined on a case-by-case basis.

5.767 Non-Standard Practices

Approved providers shall follow their respective professions' standard practices and procedures when providing rehabilitation services to sex offenders. Sometimes, providers may employ a method that is not standard in their field. An example is a therapist who wishes to provide therapy via telephone to an offender in a remote area of the State.

Providers who wish to employ a non-standard practice shall obtain approval from a sex offender treatment supervisor, if the provider has one, and the Department before employing a non-standard approach. The provider shall submit a written request with an explanation and rationale for using the practice to the Criminal Justice Planner for Offender Programs. A copy of the offender's Treatment Plan signed by the approved supervisor and other members of the Case Management Team should accompany the written request. Approval from the Department must precede the implementation of the procedure.

5.768 Telehealth

In-person meetings are the preferred method of assessing and treating sex offenders. However, in some circumstances, telehealth can be an appropriate alternative to in-person meetings. Telehealth delivers assessment and treatment services using telecommunications technologies, including telephone, mobile devices, interactive video conferencing, email, chat, and text.

Approved providers shall obtain approval from the Case Management Team before providing assessment and treatment services to sex offenders under the jurisdiction of the Department. Circumstances in which telehealth may be an appropriate method of delivering services to an

offender include the following:

1. An approved provider is not available within a reasonable distance of the offender, for example, offenders who live in remote rural areas;
2. Commuting to in-person services creates an undue hardship for the offender;
3. The offender is homebound or has medical problems that preclude them from attending sex offender treatment; and
4. Department or local public health policies prohibit delivering in-person services during extraordinary circumstances, such as quarantines to protect against the spread of contagious diseases.

Before using telehealth as a modality, approved providers shall complete formal or informal training through supervision specific to this modality. Approved providers shall follow all applicable laws for delivering telehealth services and follow commonly accepted professional guidelines for using telehealth. For example, providers shall ensure that the platform utilized complies with all HIPAA and confidentiality requirements.

When providers are considering using telehealth, they are strongly encouraged to conduct the initial meeting with the offender in person. Within a series of telehealth treatment sessions, approved providers are strongly encouraged to conduct in-person meetings with the offender periodically.

When telehealth is used, telehealth with video is generally preferred to audio-only or other telehealth modalities. This allows the approved provider to see the offender and read non-verbal cues.

5.800 Specific Responsivity Issues

The Department and providers recognize the heterogeneity of sex offenders and shall consider individual differences such as gender, culture, cognitive functioning, communication barriers, and psychiatric disabilities. The Department will make reasonable accommodations within existing resources to address offenders' specific responsivity issues, including the following.

Gender

Approved providers shall provide gender-specific treatment to female sex offenders. Approved providers shall not place female sex offenders in treatment groups with male offenders.

Communication Barriers

The Department will make reasonable accommodations to assist offenders that need support to communicate effectively. For example, offenders who are non-English speaking or for whom English is a second language will receive assistance when necessary. Reasonable accommodations will be made for offenders with hearing and visual impairments. Services will be modified for offenders that have deficit reading and writing skills.

Culture and Religion

The Department will make every effort within existing resources to ensure that offenders' religion and culture are recognized and respected by Department staff and contract personnel. For

example, offenders will be free to practice the religion of their choice while residing in Department institutions. Approved clergy from the community may provide religious services in Department institutions. For example, Alaskan Native Elders and other Alaska Natives, in coordination with program staff, may help incorporate traditional values and healing methods in programs.

Intellectual and Developmental Disabilities

Approved providers shall provide specialized services for individuals with intellectual and developmental disabilities. Treatment groups for this population should not exceed eight individuals per group.

Child Sexual Abuse Material (CSAM) Only Offenders

The treatment needs of offenders whose only known sexual offenses are for possession of child sexual abuse material typically have treatment needs that are somewhat different from those of other sex offenders. CSAM only offenders, especially those at low risk to sexually reoffend, normally should be placed in sex offender treatment groups composed only of other CSAM offenders or be provided individual treatment.

Section 6.000

Treatment Progress and Completion

6.100 Court-Ordered Treatment Completion Criteria

Successful treatment completion shall be determined in collaboration with the offender's Case Management Team. Criteria for successful treatment completion are based on the Association for the Treatment and Prevention of Sexual Abuse (ATSA) Practice Guidelines for the Assessment, Treatment, and Management of Male Adult Sexual Abusers (2014). An offender who has successfully completed treatment generally has met the following:

1. Acknowledged the sexual offending behavior and treatment needs for which they were referred in sufficient detail for treatment staff to have been able to develop a treatment plan that, if implemented correctly, could be reasonably expected to reduce their risk to reoffend;
2. Demonstrated an understanding of the thoughts, attitudes, emotions, behaviors, and sexual interests linked to their past sexual offending behaviors and can identify these when they occur in their present functioning; and
3. Demonstrated sufficiently sustained changes in managing these thoughts, attitudes, emotions, behaviors, and sexual interests and developed or enhanced prosocial attitudes such that it is reasonable to conclude that they have reduced their risk to reoffend.

Successful treatment completion does not mean the elimination of reoffense risk. Sex offenders who have completed sex offender treatment and remain under the jurisdiction of the Department shall receive ongoing community supervision at a level commensurate with their risk level. If an offender's risk increases after treatment completion, the Department may refer the offender for further treatment.

Approved providers and other members of the Case Management Team shall make treatment completion decisions based on assessments that include multiple data sources. No one data source should be used as the sole basis for making treatment completion decisions.

Evidence of successful treatment completion shall include the following data sources:

1. Interviews with the offender;
2. Collateral reports;
3. Alignment of the offender's and official descriptions of the index sexual offense;
4. Level of attendance, participation, and engagement in treatment;
5. Progress made on treatment goals;
6. Stability and nature of social supports;
7. Dynamic risk tool re-assessments (e.g., Stable-2007, SOTIPS, and VRS-SO);
8. Compliance with community release conditions; and
9. Maintenance and monitoring polygraph examination results, especially the two or more most recent consecutive examination results, yield no concerns.

6.200 Case Staffing

The Case Management Team shall meet face-to-face regularly to review and consult about offenders' progress in treatment and supervision. Department-contracted community providers, if authorized, should bill for case staffing meetings under Program Consultation.

Case Management Team meetings shall be held at least once per month for a minimum of one hour and a maximum of two hours for every ten sex offenders in community programs reviewed.

The Case Management Team shall prioritize cases for discussion from most to least urgent in roughly the following order:

1. Cases presenting immediate reoffense risk concerns, which are typically related to the presence of acute dynamic risk factors such as:
    a. Rejection of supervision;
    b. Increased access to potential victims;
    c. Marked hostility;
    d. Collapse of social support system;
    e. Emotional collapse;
    f. Sexual preoccupation; and
    g. Substance abuse.
2. Cases going back to court for a Petition to Revoke Probation or before the Parole Board for a parole violation;
3. Cases being terminated from treatment;
4. Cases that have been approved for victim contact or reunification;
5. Cases in which the offender is scheduled for a polygraph exam;
6. New and other cases who have not been staffed within the last six months; and
7. Cases assessed as above average or well above average risk to reoffend but do not present with acute risk issues.

The goals of case staffings are to:

1. Review and determine progress in treatment and supervision;
2. Establish, review, and finalize treatment and case management plans;
3. Review the results of polygraph examinations and determine rewards and sanctions, as appropriate;
4. Review the results of psychological testing, substance abuse evaluations, and other pertinent assessments and modify treatment and case management plans as necessary;
5. Make program completion, suspension, removal, and reentry decisions;
6. Review discharge plans and approve as appropriate; and
7. Update the results of risk and needs assessments as necessary.

6.300 Program Removal

The offender's Case Management Team shall convene a case staffing meeting to make program removal decisions and include as many team members as necessary and possible. The team shall

make reasonable efforts to obtain the input of members who cannot attend program removal case staffings. The field or institutional probation officer shall process all program removals.

A sex offender may be removed from an institutional or community-based sex offender treatment program in one of the three ways.

6.310 Offender Requests Removal

An offender may request to be removed from a program. If an offender's request to be removed from a program is against the advice of their Case Management Team, the team shall meet with the offender to discuss the reasons for the request. The team shall detail the consequences to the offender of removing oneself from the program against the team's advice, which can include revocation of community release status and failure to complete sex offender treatment. The Case Management Team shall encourage the offender to reflect upon their request, weigh the consequences of self-removal, and encourage the offender to remain in treatment.

6.320 Administrative Removal

The Case Management Team may remove an offender from a program for administrative reasons without being judged non-compliant with their individualized management plan. These are called "no-fault" removals. Examples include medical problems that interfere with an offender's current ability to focus on treatment and legal issues that must be resolved before treatment can proceed.

6.330 Case Management Team Removal

The Case Management Team may remove an offender from a program for being noncompliant with their individualized case management plan, such as not cooperating with treatment, supervision, or facility rules or for being judged unlikely to benefit from further treatment.

Before removing an offender from a treatment program, the Case Management Team shall meet with the offender to discuss the reasons for the potential removal. At this meeting, the team shall develop a plan of action that the offender may take to avoid program removal, set a timeline to carry out the plan, and set a date for the team to review progress on the plan. The Case Management Team shall give an offender reasonable opportunity to address issues of concern.

The Case Management Team shall record final program removal decisions and supporting rationale and place them in an offender's record. If a decision is to remove an offender from a program, the offender shall be given the last Case Management Team vote sheet and guidelines for seeking program reentry if reentry is an option.

6.400 Program Reentry

An offender who has been removed from a program may seek re-entry by completing an application for reentry available from the offender's field or institutional probation officer. The Case Management Team shall review an offender's application and decide whether to grant reentry into a program. The team may ask an offender to supplement an application with further information or complete additional tasks (e.g., homework assignments) before rendering a reentry decision.

For an offender to gain re-entry into a program, an offender must demonstrate an understanding of the issues that resulted in the program removal and present a plan for addressing those issues if accepted back into the program. The offender's recent behavioral record since the time of removal should demonstrate compliance with the program's behavioral expectations if readmitted. An offender seeking re-entry must continue meeting the general program admission requirements.

Community approved providers shall not accept into a sex offender treatment program an offender who has been removed from another sex offender treatment program until an expected or active Petition to Revoke Probation or Parole Violation Report is resolved.

Community approved providers shall accept into sex offender treatment an offender who was removed, dropped out, or intends to switch from another sex offender program only after they have received and reviewed the offender's prior treatment records, reviewed the case with the offender's probation or parole officer, and believe that they can develop an appropriate treatment plan.

No Reentry Options for Some Program Removals

The Case Management Team may determine that some offenders should not regain entry into a program. Typically, this is because an offender has had multiple program removals, further treatment would likely not be beneficial, and program resources would be better utilized elsewhere.

Section 7.000

Program Records, Reviews, and Research

7.100 Program Records

Institutional and community-based approved providers and programs shall maintain a treatment program file for each offender in accordance with the professional standards of their mental health discipline, Alaska state law on health care records, and these Standards.

The program file will include the following documents:

1. Intake Psychosexual Assessment;
2. Treatment contract and other informed consent documents;
3. Releases of information;
4. Presentence investigation (PSI) reports;
5. Record checks (may be in the PSI);
6. Police reports (may be in the PSI);
7. Victim statements (may be in the PSI);
8. Treatment plans;
9. Treatment notes;
10. Polygraph test reports;
11. Discharge and treatment summaries; and
12. Other documents pertinent to treatment.

Treatment plans shall be updated every six months or earlier if indicated. Treatment plans shall, at a minimum, include the following:

1. Problem statement;
2. Treatment goals;
3. Treatment objectives; and
4. Interventions and services.

Approved providers shall submit monthly attendance records and quarterly progress reports or submit these documents more frequently at the request of the supervising officer. Approved providers shall submit discharge summaries when offenders are released from a program, or their program involvement is terminated.

The Department may require providers and programs to comply with other data collection requirements for evaluation and management functions. Approved providers shall respond to Department data requests in a timely fashion.

The Department may establish a list of specific measures for offender assessments, and providers may be required to use these measures.

Contract approved providers are the custodian of program files, but the files are the property of the Department. Contract providers may elect to keep a separate clinical file on program

participants. The nature, organization, and content of separate contractor files are the business of the contractor's establishing them.

7.200 Program Evaluation

The Department conducts annual audits and evaluations of sex offender treatment programs to ensure they comply with the Standards. Such audits and evaluations are components of the Department's quality assurance, quality improvement, and utilization review activities. Audits and evaluations may be conducted by Department personnel and by contracted consultants with demonstrated relevant expertise. Programs will be given advance notice of the intent to conduct a program audit or evaluation whenever possible. The Department reserves the right to conduct an audit whenever deemed necessary.

The Department has established program evaluation criteria available to programs for review. Program evaluation criteria are subject to change at the discretion of the Department. Approved providers may request changes in these criteria by submitting them in writing to the Department before an audit or evaluation. The Department will notify providers and programs when program audit and evaluation criteria are changed.

7.300 Case Review Team Reviews

The Department shall maintain a Case Review Team responsible for periodically reviewing offender cases. The case review team shall comprise the Criminal Justice Planner for Offender Programs and clinical and correctional staff as appropriate for the type of review.

The types of case reviews include the following:

1. **Record Keeping**. These are periodic reviews of randomly selected case files to assess provider compliance with record-keeping standards outlined in the Standards. Record-keeping reviews are typically a component of each program's annual evaluation.
2. **Special Requests**. These are reviews of an individual case at an offender's or third party's request. For example, the request for the review may concern an offender's complaint about their treatment programming. A request could also be from a third party, such as an offender's family member or attorney, legislators, or others interested in a particular case. The Case Review Team shall ensure they have the appropriate signed information releases before communicating with third parties about an offender.
3. **Post-event Reviews**. These reviews are designed to examine untoward events and identify ways to improve services and prevent future adverse outcomes. Cases that could be subject to post-event reviews include sexual reoffenses, suicides, and assaults on staff or others.

7.400 Research

The Department supports efforts to increase scientific knowledge regarding assessing, treating, managing, and preventing sexual offending. The Department recognizes that research in these areas can contribute to improved services, conservation of resources, and public safety. All research projects must comply with Department Policy and Procedure 501.02, which includes requirements for obtaining approval for conducting research.

Section 8.000

External Management and Case Management Teams

8.100 Standards of Practice for Supervising Sexual Offenders

The Division of Probation and Parole has developed Standard Operating Procedures for probation and parole officers supervising sex offenders. A copy of these procedures is available from the Division.

8.200 Establishment of a Case Management Team

As soon as possible after the conviction and referral of a sex offender to the Division of Probation and Parole, the supervising officer shall form a Case Management Team. The team's purpose is to share information and make informed decisions about the assessment, treatment, and supervision of each offender during their term of supervision. The team should use the offender's initial psychosexual assessment and presentence investigation report as a starting point to inform case management activities.

Teams shall strive to make case management and treatment planning decisions collaboratively. The supervising officer, however, is ultimately responsible for making decisions about an offender's supervision conditions, and the approved provider is ultimately responsible for making clinical decisions about an offender's treatment.

Each team, at a minimum, should consist of the following core members:

1. Supervising officer;
2. Approved provider;
3. Polygraph examiner; and
4. Criminal Justice Planner.

Additional individuals may be added to the team on an as-needed basis, depending on the case circumstances at various stages of supervision. Other team members may include:

5. Adjunct approved providers;
6. Child protection professionals;
7. Victim advocates; and
8. Victim therapists.

To use resources efficiently, when appropriate, officers shall structure teams so that team members share as many of the same offenders as possible. Such arrangements can reduce the number of team meetings members must attend and make scheduling meetings and communication about cases easier.

The supervising officer shall coordinate and facilitate team meetings. The supervising officer shall develop collaborative relationships with other team members but is ultimately responsible for determining the following:

1. Team membership and who should attend a meeting;
2. Frequency of team meetings; and

3. Meeting agenda.

8.210 Case Management Team Norms and Approach

The team should demonstrate a commitment to the following norms:

1. Team approach;
2. Community safety;
3. Respect for each team member, the offender, and the victims;
4. Regular attendance;
5. Active participation;
6. Unified decisions and responses;
7. Open communication and flow of information; and
8. Conflict resolution and seeking assistance when needed.

Team members recognize that intensive supervision focused on surveillance only is unlikely to reduce reoffending. The effective treatment models and methods detailed in Section 5.700 are applicable and should also set the norms for how Case Management Teams operate.

Supervision that utilizes the risk, need, and responsivity approach and sexual offense-specific treatment is the most research-supported approach to reducing reoffending. Team members should help support and strengthen offenders' motivation to change. They should strive to develop and maintain a therapeutic working alliance with offenders. They should be firm, fair, warm, direct, rewarding, and empathic while holding offenders accountable for meeting supervision and treatment expectations. They should utilize cognitive-behavioral strategies to help offenders learn and practice skills to live offense-free lives.

8.300 Supervising Officer Training

Within the first year of supervising sex offenders, probation and parole officers shall complete an initial 16-hour training specific to sex offenders and be supervised by or have access to consultation from a supervisor with specialized training and experience in supervising sex offenders. The initial training shall include the following topics:

1. Sex offender characteristics;
2. Assessment of sex offenders;
3. Community management of sex offenders;
4. Interviewing skills;
5. Victim issues;
6. Sex offender treatment;
7. Choosing evaluators and approved providers;
8. Determining progress;
9. Offender denial;
10. Special populations of sex offenders; and
11. Cultural competency.

Probation and parole officers that supervise sex offenders shall obtain 16 hours of bi-annual continuing education training specific to sex offenders and other training as required by the

Department.

8.400 Roles and Responsibilities of Case Management Team Members

8.410 Supervising Officer's Roles and Responsibilities

The supervising officer's responsibilities include the following:

1. Coordinate and facilitate Case Management Team meetings;
2. Refer sex offenders for assessment and treatment services to approved providers who can meet an offender's needs for services;
3. Develop a supervision plan and contact standards based on an assessment of an offender's risk, needs, and responsivity factors;
4. Ensure each sex offender signs information releases to enhance treatment and case planning activities. Releases of information shall include the following if relevant to an offender's case:
    a. Approved providers and programs, current and past;
    b. Polygraph examiners;
    c. Child protection caseworkers and agencies;
    d. Victim's therapists;
    e. Victim's parents and Guardian ad Litems; and
    f. Victim advocates.
5. Refer offenders to approved polygraph examiners for polygraph examinations consistent with the Polygraph Examination Type and Frequency Guidelines detailed in Table 8.600.
6. Utilize the results of polygraph examinations in collaboration with team members and for program planning and other case management activities as detailed in 8.500;
7. Require sex offenders to provide a copy of their written success plan, signed by the offender and the therapist as soon as it is available. The supervising officer should utilize the success plan for monitoring offenders' behavior;
8. Require sex offenders to obtain the officer's written permission to change sex offender programs;
9. Obtain the provider's written monthly offender attendance reports and quarterly progress reports and use the reports to inform case plans;
10. Review with the approved provider and other relevant individuals (e.g., victim, victim's therapist, custodial parent, foster parent, and Guardian ad Litem) requests and proposed plans for any contacts between an offender and a child victim and plans for family reunification, and reject, modify, or approve the requests and plans as appropriate;
11. Develop and monitor safety plans for offenders who are allowed contact with potential victims, such as children, during a family reunification process (see Section 9.000 Victim Issues);
12. Not request early termination of a sex offender from supervision unless approved by the officer's supervisor;
13. Review and regularly assess an offender's compliance with conditions of probation, parole, or furlough;

14. Recruit, train, and monitor a minimum of three Safety Net chaperones for each offender in collaboration with the Case Management Team;
15. Request an extension of supervision to allow an offender to complete sex offender treatment, if necessary and possible;
16. Notify sex offenders, if required, that they must register with local law enforcement to comply with state sex offender registration laws;
17. Discuss treatment participation and progress with offenders during office visits and other contacts;
18. Impose or request criminal justice sanctions for offenders who are unsatisfactorily terminated from sex offender treatment;
19. Require sex offenders who are transferred from other states through an Interstate Compact Agreement to agree in advance to participate in approved sex offense-specific treatment and follow specialized conditions of supervision; and
20. Attend group treatment only if there is a clear therapeutic and necessary purpose. Officers and approved providers recognize the presence of probation and parole officers in treatment sessions can disrupt the continuity of the treatment process. If an officer is to attend a group treatment session, appropriate informed and voluntary consent from offenders shall be obtained, and the officer shall be bound by the same confidentiality rules as the approved provider and should sign a confidentiality agreement.

8.420 Approved Provider's Roles and Responsibilities

The approved provider's responsibilities include the following:

1. Establish and maintain collaborative professional relationships with the supervising officer and other team members;
2. Report to the supervising officer all concerns related to increases in an offender's reoffense risk as soon as feasible and within 24 hours. Report promptly violations of an offender's treatment agreement and violations of the conditions of probation, parole, or furlough;
3. Report to the supervising officer significant changes in an offender's treatment plan or compliance following the plan;
4. Provide written monthly attendance reports to the supervising officer and quarterly progress reports on each program participant**.** Progress reports shall document an offender's participation and progress in treatment and any changes to the treatment plan. Reports shall be submitted in a timely fashion;
5. In special circumstances, provide additional attendance and progress reports at the request of the supervising officer, such as those related to the filing of a probation or parole revocation;
6. Be willing to testify in court or before the Parole Board if requested. Payment for testimony shall be the responsibility of the individual or agency requesting the testimony;
7. Assist each offender in developing a written success plan, which should be signed by the offender and the therapist and provided to the supervising officer;
8. Discuss recommendations for modifying supervision conditions with the supervising

officer, such as recommendations for initiating a family reunification process;

9. Provide services to facilitate family reunification if approved by the supervising officer. Collaborate with others as appropriate, such as victim therapists, victims, and victims' parents, foster parents, and Guardian ad Litems.
10. Make recommendations to and assist the supervising officer in selecting and training individuals to be Safety Net chaperones; and
11. Allow officers to attend group treatment only if there is a clear therapeutic and necessary purpose. Officers and approved providers recognize the presence of probation and parole officers in treatment sessions can disrupt the continuity of the treatment process. If an officer is to attend a group treatment session, appropriate informed and voluntary consent from offenders is obtained, and the officer shall be bound by the same confidentiality rules as the approved provider and should sign a confidentiality agreement.

8.430 Polygraph Examiner's Roles and Responsibilities

The polygraph examiner's responsibilities include the following:

1. Establish and maintain collaborative professional relationships with the supervising officer and other team members;
2. Submit written polygraph examination reports to each member of the supervision team within two (2) weeks post-testing or sooner; and
3. Attend Case Management Team meetings as needed as determined by the supervising officer.

8.500 Polygraph Examination Type, Frequency, and Use Guidelines

In collaboration with the Case Management Team, the supervising officer shall refer offenders to approved polygraph examiners for polygraph examinations as appropriate. Table 8.600 details guidelines for making these referrals. Supervising officers and the Case Management Team shall use Department approved risk assessment instruments administered or reviewed for accuracy within the last 12 months to make determinations concerning polygraph type and frequency. An offender should not be referred for a polygraph exam during the first approximately three months of community supervision unless specific treatment or supervision concerns exist.

Table 8.600 Polygraph Examination Type and Frequency Guidelines

Offender Characteristic	Polygraph Exam Type and Frequency
Risk assessment - Level I - Very low risk - Level II - Below average risk - Level III - Average risk	Monitoring/Maintenance Exam: - Every 12 months - May discontinue if strong evidence of compliance, including if two successive polygraph tests yield no concerns
Risk assessment - Level IVa - Above average risk - Level IVb - Well above average risk	Monitoring/Maintenance Exam: - Every 6 months - May discontinue or reduce frequency if strong evidence of compliance, including if three successive polygraph tests yield no concerns
History of Violence - Kidnapping - Use of a weapon during crime - Serious victim physical injury - Other serious concerns	Monitoring/Maintenance Exam: - Every 6 months - May discontinue or reduce frequency if strong evidence of compliance, including if three successive polygraph tests yield no concerns
Special Issues, such as: - Parole Board request - Potential unauthorized contact with a victim - Potential involvement in other serious risk behavior - Decisions to allow child contact	Special Issue Exam: - As approved by supervisor Sex History Polygraphs - As approved by supervisor

The supervising officer shall use the results of polygraph examinations in collaboration with Case Management Team members for program planning and other case management activities in the following manner:

1. Deceptive findings on a polygraph test shall not be used as the basis for a violation of probation or parole;
2. Deceptive findings on a polygraph test may be considered in determining the intensity and conditions of supervision;
3. Pre-test and post-test admissions may be used in a revocation hearing;
4. Failure to take a polygraph test as directed shall be considered a violation of probation or parole;
5. Offenders shall not be required to answer questions during a polygraph exam about any

unreported crime(s) that would give information such as victim names, dates of offenses, locations of offenses, and any other information that would incriminate them and could lead to prosecution for a new crime; and

6 . Offenders may assert their Fifth Amendment rights if asked to give specific details of prior unreported offenses.

8.700. Safety Net Team Standards

A Safety Net is a group of natural helpers that form to support an offender in leading an offense-free life and alert professionals working with the offender when they need to intervene rapidly. An offender's chances of successfully developing and maintaining a pro-social lifestyle in the community can significantly increase with the support and monitoring of prosocial family, friends, and associates.

The field probation or parole officer shall recruit, train, approve, and monitor Safety Net members and oversee the Safety Net team. Approved providers and other members of the Case Management Team shall assist in these activities as requested by the officer.

The Case Management Team shall follow the following standards for creating Safety Nets:

1. All sex offenders on community supervision shall have a Safety Net;
2. A Safety Net should be composed of a minimum of three persons. There is no maximum size, but a Safety Net typically has three to five persons;
3. The Safety Net should include people interacting with an offender across significant aspects of their life, including home, work, school, religious environments, cultural groups, and self-help groups (e.g., AA and NA);
4. Safety Net team members may include family, employers, clergy, elders, friends, and others with frequent contact with the offender. At least two members of the Safety Net must be persons outside the offender's immediate family;
5. Safety Net members should have regular opportunities to observe and be prosocial influences on the offender. Frequent or prolonged absences may disqualify an individual from being part of a Safety Net;
6. Safety Net members shall be non-paid volunteers. Safety Net members may not accept payment from offenders or others for their involvement in a Safety Net;
7. All Safety Net members must undergo training conducted by the supervising officer and approved approved provider;
8. Objectivity and a willingness to report pre-relapse warning signs are essential characteristics of a good Safety Net member. Safety Net members must be selected with these traits in mind. Safety Net members who are reluctant to report or are non-objective observers are subject to removal from the Safety Net; and
9. The removal of a Safety Net member may be recommended by any member of the Case Management Team, but the field officer makes the final decision to remove a member. All removals are subject to review by the Criminal Justice Planner for Offender Programs.

8.800 Behavioral Monitoring

Case Management Team members shall communicate regularly about each offender's progress, including reporting positive and negative behaviors. Team members use this information to reinforce positive behaviors and sanction negative ones.

Approved providers, contractors, and Safety Net members shall report condition violations to the field probation or parole officer as soon as possible after becoming aware of violations so that officers can respond accordingly to ensure community safety.

Over the long term, supervision focused solely on surveillance and sanctions is unlikely to achieve reductions in reoffending. Team members emphasize using incentives and rewards over punishments to help offenders make long-term positive behavior changes. The effectiveness of reinforcements for positive behaviors and sanctions for negative behaviors is enhanced when team members have a good working alliance with the offender.

8.810 Positive Behaviors and Incentives

Team members shall strive to reinforce positive offender behavior by a ratio of rewards to punishments of about 4 to 1. Examples of positive behaviors include being honest, reporting on time, having an open channel of communication with staff, participating in treatment, completing treatment assignments, completing treatment, maintaining employment, associating with prosocial individuals, meeting case plan goals, passing polygraphs, staying employed, demonstrating prosocial thinking, and demonstrating effective time management.

Examples of reinforcers for positive behaviors include verbal praise, written praise (e.g., letter or certificate), travel permit approval, reduced reporting frequency, waiving fees, vouchers or gift certificates, altering or reducing a sanction, reducing reporting requirements, reducing U/A testing, and community service credit.

8.820 Negative Behaviors, Technical Violations, and Sanctions

Field officers shall respond to violations and other negative behavior swiftly and in proportion to their seriousness. The seriousness of the conduct will be determined in part by the offender's risk and needs profile and offending modus operandi. Officers should strive to respond consistently to similar negative behaviors among offenders with similar risk, needs, and offending profiles. Community safety should be the overriding consideration when responding to violations and other negative behavior.

Examples of technical violations and other negative behavior include missing or coming late to appointments, being untruthful, using alcohol or other drugs, failing to pay supervision or other fees, not living where approved, having unauthorized contact with a victim or child, failing to submit to a polygraph, accessing the Internet without permission, failing to participate in or attend treatment.

Hierarchy of Sanctions

Field officers have a wide range of options for sanctioning offenders. The following types of sanctions are listed from least to most severe.

1. **Verbal Warning.** In some cases, all that is necessary is to remind the offender of his probation or parole conditions or clarify the meaning or extent to which those conditions apply.
2. **Written Warning.** It is frequently important to clarify conditions in writing and give written notice of warning and potential consequences for noncompliance.
3. **Outpatient Therapeutic Sanctions.** The supervising officer, in consultation with the Case Management Team, may determine that additional outpatient therapeutic measures such as homework (e.g., behavior chain, thinking report, decisional balance, or problem-solving assignments) and increased frequency of therapy sessions, AA meetings, or other treatments can reduce the risk of reoffense to safe levels.
4. **Change of Probation or Parole Conditions.** Field officers typically can apply special sanctions and conditions to improve case management when special needs apply. When the supervising officer becomes aware of factors that affect community safety that were not evident when conditions were set, special instructions can be given to the offender. These should be in writing and sent to the offender as well as all members of the Case Management Team.
5. **Alternative Therapeutic Placements.** In consultation with the Case Management Team, the supervising officer may determine that a residential therapeutic setting, such as a substance abuse treatment facility, psychiatric hospital, or other therapeutic settings, may be the most appropriate intervention to reduce risk to the community and stabilize the offender. Placement in a residential facility can only occur through a court or parole board order unless the offender is willing to enter the facility voluntarily.
6. **Alternative Correctional Placement.** Placement in a Community Residential Center or other closely monitored residential setting may be deemed a safe and appropriate alternative to reincarceration in prison. Placement at a Community Residential Center can only occur when an appropriate order exists. Under certain conditions and if the sentencing order allows, the supervising officer may place the offender under house arrest employing electronic monitoring to manage the offender's movements in the community.
7. **Reincarceration.** If less intrusive measures are considered inadequate to protect the community and stabilize the offender, the supervising officer should file a petition to revoke probation or parole and seek reincarceration.

8.900 Policy on Pornography

Approved providers may not encourage or permit sex offenders to use pornography per the Alaska Administrative Code 22 AAC 30 regulating sex offender approved providers. Similarly, the possession or use of pornographic materials by sex offenders in Department treatment programs is prohibited.

Broadly, pornography is sexually arousing material in literature, art, pictures, videos, or other means of communication or expression. For this document, pornography includes any material that can reasonably be expected to trigger or encourage sexual fantasies or behaviors that are part of the offender's pattern of sexual offending or that could promote new forms of sexually deviant thoughts, feelings, and behaviors. The offender's Case Management Team will

determine on an individual basis which materials are prohibited. For example, seemingly innocuous photos of children may be erotic to some sex offenders but may cause no risk concerns to other types of sexual offenders.

Members of the offender's Case Management Team shall respond to violations of the pornography policy in proportion to the type and frequency of pornography use and the risk level of the offender. Among convicted sex offenders, the use of pornography that includes deviant themes such as coercive sexual behavior and children has been associated with an increased risk for sexual reoffending. Frequent pornography use that interferes with prosocial functioning (i.e., work, school, relationships) is a risk factor for sexual reoffending, particularly among higher-risk sex offenders.

Section 9.000

Victim Issues

9.100 Role of Victims/Survivors in Sex Offender Treatment

Protecting victims, their families, and potential victims is paramount when developing and implementing sex offender assessment, treatment, and supervision services. Victims and their families should be treated with dignity and respect by all team members managing the offender.

In Alaska, victims have the right to provide input into an offender's presentence investigation and to the court during sentencing. Victims also have the right to be informed of an offender's status in the criminal justice system to the extent that they are interested. The Department has processes for supporting this information sharing with victims and providing input into an offender's supervision and treatment services.

Department staff and other members of an offender's Case Management Team shall be sensitive and respectful when seeking input from a victim. To reduce the risk of retraumatizing a victim, initial communication typically should go through a third party, such as a victim's designated victim advocate, therapist, or family member. Some victims may ultimately want to communicate directly with team members.

A victim's perspective about an offender and the offense can be beneficial in helping the Case Management Team complete a comprehensive and informed offender assessment and implement an appropriate treatment and supervision plan.

9.200 Offender Contact with Victims and Children

Sex offenders are commonly prohibited from having contact with victims and children. Prohibitions against victim and child contact may be a court order, probation or parole condition, or a statutory requirement (e.g., Child Protective Statute AS 11.51.100).

No member of the Case Management Team shall allow an offender to have contact with any victim, child, or other potential victims until the team meets to review the case and makes an agreed-upon plan. Contact is defined as any of the following:

1. Physical, face-to-face, and verbal contact;
2. Being in residence with a child or victim;
3. Being in a vehicle with a child or victim;
4. Visitation of any kind;
5. Correspondence (both written and electronic), telephone contact (including messages left on a voice mail or answering machines), gifts, or communication through third parties;
6. Entering the premises, traveling past or loitering near the child or victim's residence, school, daycare, or place of employment; and
7. Frequenting places used primarily by children, as determined by the Case Management Team.

The Case Management Team shall prioritize the rights, well-being, and safety of victims and children when making decisions about offender contact with victims and minors. Recommendations to allow an offender to have contact with a victim or minor should have the approval of all team members and other appropriate parties, such as the victim, the victim's therapist, the victim's parent or guardian, and the victim's advocate or Guardian ad Litem.

Suppose a court order prohibits contact between the offender and victim, child, or potential victims. In that case, this order must be followed unless altered by the court or, if allowed and indicated, by the supervising officer.

The nature, amount, and frequency of all contact between a sex offender and victims, children, or potential victims must be approved by the supervising probation or parole officer. Case Management Team members shall report all non-authorized contact with victims, children, and potential victims immediately to the supervising probation or parole officer.

The Case Management Team's recommendations regarding contact with victims and minors shall be based on a thorough assessment of the case that includes consideration of the following:

1. Assessment of the offender's risk and needs;
2. The offender's history of atypical sexual interests, fantasies, and behaviors involving children;
3. The nature, extent, and duration of the offender's offending behaviors;
4. The offender's engagement and progress in treatment;
5. The offender's level of engagement and compliance with supervision expectations;
6. The presence of positive prosocial supports who can serve as chaperones for the offender;
7. The ability, skills, and willingness of non-offending parents or guardians to provide an environment that is appropriately conducive to maintaining the child's emotional and physical safety; and
8. The adequacy of and resources to monitor child safety plans.

The Case Management Team shall review victim and child contact plans regularly and make changes to the plans as needed.

9.300 Victim and Family Clarification

Clarification is a process for helping victims and family members talk about and process the harm caused by and the impact of sexual offenses on everyone in the family. Clarification sessions may be helpful for victims and family members even if there is no intention to reunite with the offender. In cases where the victim and family members hope to reunify with the offender, clarification sessions are necessary.

The Case Management Team shall review the case to determine whether a clarification process would be in the victim's and family's best interests and, if recommended, what permissions would be obtained (e.g., from the court or parole board) to allow such contact. The victim or an advocate for the victim may contact a team member to request a clarification meeting with an offender. Conversely, a designated team member may contact the victim or an advocate for the victim (e.g., a designated victim advocate or family member) to determine the victim's and family

members' interest in clarification meetings.

In collaboration with the Case Management Team, the supervising officer shall decide whether to allow the offender to participate in clarification sessions. If sessions are approved, the approved provider shall facilitate clarification meetings and ideally do so with the victim's therapist and suitable support person.

Approved providers shall ask the victim and family members whom they would like to attend clarification meetings and strive to accommodate these requests.

The components of clarification sessions should be based on what the victim and the victim's advocate request. Commonly requested features of a clarification process include the offender completing the following:

1. Acknowledging the abusive behaviors;
2. Taking responsibility for their behavior;
3. Expressing awareness of the impact of the abuse on the child victim and family;
4. Describing and committing to a plan to ensure future safety; and
5. Answering questions the victim and family members may have about the abuse.

Although clarification meetings are generally held in person, team members should make reasonable accommodations for the victim if the victim prefers the clarification process to occur through written correspondence, video-conferencing, or other methods.

In cases where an offender is requesting approval to live with a new partner who has children, clarification sessions may be appropriate to educate members of the new household about the offender's history, treatment and supervision conditions, and contacts for reporting concerns.

9.400 Family Reunification

Some families who are victims of intra-familial child sexual abuse do not reunite, which can be an appropriate resolution. Sometimes the decision to not reunite will be based on the victim's or a family member's wishes and sometimes due to the Case Management Team's concerns that the risk and potential for harm to a victim may be unmanageable. For other families, family reunification may be an appropriate way to resolve issues generated by the abuse.

Before deciding whether to move forward with a family reunification process, the Case Management Team shall consider the wishes of the victim and family members. In cases where family reunification is being considered, members of the Case Management Team must include key professionals involved in the case, such as child protective services professionals, victim therapists, and victim advocates. Additionally, before initiating a family reunification process, conditions of probation and parole may need to be modified by the Court or Parole Board.

Reunification is a gradual process that the Case Management Team shall closely supervise. The Case Management Team shall consider several reunification factors concerning the victim, offender, and non-offending family caregivers (e.g., non-offending parent of the victim) that

include:

9.410 Victim Considerations

1. Victim wants reintegration, knows what it entails, and it is in their best interest;
2. Victim is living at home, is in treatment, and feels supported by their caregiver and siblings;
3. Victim's siblings believe that the abuse occurred, do not blame them, and want reintegration;
4. The siblings are either in treatment or willing to be involved in recommended treatment;
5. Victim, as is developmentally appropriate, has been trained to recognize and report pre-relapse behaviors; and
6. A clarification is completed.

9.420 Offender Considerations

1. Offender is in treatment;
2. Offender takes responsibility for the abuse;
3. Offender is adhering to probation or parole conditions;
4. Offender has developed risk management skills;
5. Offender completed a clarification
6. Offender has an established Safety Net; and
7. The Case Management Team believes present risk can be managed with a safety plan.

9.430 Caregiver Considerations

1. The caregiver believes that the abuse occurred;
2. Caregiver is actively involved in treatment;
3. Caregiver has a good relationship with the child and her/his other children;
4. Caregiver has insight into the behavior of the person who has abused and is assertive with them;
5. Caregiver is willing to begin the reunification process and knows what it entails; and
6. Caregiver is a trained Safety Net member and is a good supervisor and protector.

The team shall have a written reunification safety plan, which requires that all contact between the offender and the victim or potential victims be supervised until the team believes this is no longer necessary. The plan shall also include a graduated schedule of offender and victim contact that provides adequate opportunity to evaluate the safety of the reunification process. The dimensions of the graduated schedule include the following elements:

1. Brief visits before more extended visits;
2. Visit locations from very public to possibly not public places; and
3. Supervision from eyes-on to within-hearing to maybe none.

The Case Management Team shall modify the reunification safety plan as necessary.

Appendix A

Glossary of Terms

Abel Assessment for Sexual Interest. An assessment test designed to provide an objective measurement of sexual interests. The examinee completes a paper and pencil questionnaire and views and rates sexual interest in slides of clothed male and female adults, teens, and children.

Access to the Community. A sex offender's ability to leave the physical confines of a secure residential setting, with or without permission, and enter the community for any purpose and under any level of supervision or no supervision.

Access to Potential Victims. Any time a sex offender is alone with or has the opportunity to be with a potential victim.

Accountability. Being responsible for one's behavior, including motives, actions, and outcomes.

Actuarial Risk Assessment. A risk assessment based upon a statistically calculated prediction of the likelihood an individual will engage in a particular behavior, such as a sexual reoffense, within a given time period.

Acute-2007. A 7-item instrument designed to assess acute dynamic (i.e., rapidly changing) risk factors for sexual recidivism.

Adjudication. The judicial process that ends a criminal proceeding by a judgment of acquittal, conviction, or dismissal of a case.

Affidavit. A written, sworn statement made under oath, in which the writer swears the information stated therein is true.

Aftercare Plan. A plan the offender and others (e.g., caseworkers, supervising officers, treatment staff, family, and friends) develop to assist the offender in transitioning successfully from more to less structured and restrictive environments (e.g., from prison to community). The plan should address the offender's needs in housing, employment, treatment, transportation, and prosocial positive supports.

Aftercare Treatment. Treatment that occurs in the community after an individual has completed a residential sex offender treatment program. Aftercare treatment can also refer to sessions provided periodically after sex offense-specific treatment has been completed. These are often referred to as booster sessions.

Anti-Androgen. A substance that is used with sex offenders to lower sex drive by reducing serum testosterone (male sex hormone) in the bloodstream. The anti-androgens used most frequently

in the United States with sex offenders are medroxyprogesterone acetate (Depo-Provera) and depo-leuprolide acetate (Depo-Lupron).

Appeal. A request by either the defendant or prosecutor in a case to have a higher court review and possibly reverse the decision or sentence of a lower court.

Approved Provider. A provider who has been approved to provide treatment services to sex offenders including sex offender treatment, polygraph services, and assessments.

Assessment. Evaluating an offender's risk, treatment needs, responsivity factors, and other areas of interest using interviews, records reviews, standardized assessment tools, observations, and other methods.

Assessment of Risk Manageability for Intellectually Disabled Individuals Who Offend (ARMIDILO). The ARMIDILO is a 30-item scale composed of stable and acute dynamic factors to assist in managing individuals with borderline or mild intellectual impairment, with or without learning disabilities who have sexually offended or displayed sexually offensive behavior.

Aversive Conditioning. A behavioral technique designed to reduce deviant sexual arousal by pairing unpleasant stimuli, such as aversive imagery or an unpleasant odor, with deviant sexual arousal.

Brief Assessment of Recidivism Risk (BARR). A scale comprising of six items from the Static-2002R designed to predict general and violent recidivism among adult male sexual offenders.

Behavior Chain. The typical pattern of thoughts, feelings, behaviors, and situations that precede an individual's sex offense or other problem behavior.

Booster Sessions. Aftercare treatment sessions are provided periodically after sex offense-specific treatment has been completed.

Case Management Team. The team of professionals that works together collaboratively to share information and make informed decisions related to the assessment, treatment, supervision, and management of offenders during their term of supervision. Each offender's team includes the supervising officer, approved provider, polygraph examiner, and the SOMP Criminal Justice Planner. Depending on the circumstances of a case, additional team members may include adjunct approved providers, child protection professionals, and victim advocates.

Chaperone. A person whom a supervising officer has approved, in collaboration with the Case Management Team, to supervise contact between a person at risk (generally a minor or developmentally disabled person) and an offender.

Child Pornography. Any audio, visual, or written material that depicts children engaging in sexual activities or behaviors, or images that emphasize genitalia and suggest sexual interest or availability.

Child Pornography Offender Risk Tool (CPORT). A 7-item actuarial risk tool designed to assess the risk of sexual recidivism among adult males with a history of possessing child sexual abuse images.

Clarification. A method for helping victims and family members process the harm caused by and the impact of the sexual offenses on everyone in the family. Clarification commonly involves the offender acknowledging and taking responsibility for their offending behavior.

Clinical Services. The application of assessment and psychotherapeutic techniques by an individual licensed to practice in psychiatry, psychology, social work, marital and family therapy, or professional counseling.

Cognitive-Behavioral Treatment. A treatment model that blends two approaches. Cognitive therapy is based on the premise that how individuals think largely determines how they act and changes in individuals' behavior can be accomplished by helping change thinking patterns. Behavior therapy is founded on the premise that behavior is learned and can be changed through various methods such as modeling, skill training, coaching, role-play, and the effective use of rewards and punishments.

Cognitive Restructuring. A treatment technique wherein sex offenders are taught to become aware of and change distorted thinking and attitudes that support offending behavior.

Collaboration. The practice of individuals and organizations working together for a common purpose, such as supervising officers, approved providers, polygraph examiners, and victim advocates working together to reduce reoffending and help victims heal.

Collateral Contacts. The sharing and use of information regarding a sex offender amongst law enforcement, probation and parole officers, approved providers, employers, family members, and friends of the offender to enhance the effectiveness and quality of community supervision.

Committee. The Sex Offender Treatment Committee established under 22 AAC 30.010.

Commissioner. The Commissioner of the Alaska Department of Corrections.

Community Notification Laws. Laws that allow or mandate law enforcement, criminal justice, or corrections agencies give citizens access to relevant information about certain convicted sex offenders living in the community.

Community Supervision. Day to day casework by a supervising probation or parole officer that centers around monitoring an offender's compliance to conditions of supervision and assisting

the offender in learning skills to lead an offense-free life.

Conditions of Community Supervision. Conditions prescribed by the court as part of the sentence to assist the offender to lead a law-abiding life. Failure to observe these conditions may lead to a revocation of community supervision or sanctions by the court. Examples of special conditions of community supervision for sex offenders may include requirements to complete a sex offender treatment program and avoid contact with the victim or children.

Contact. Refers to interactions a sex offender may be prohibited from having with a victim or potential victims, such as being in the presence of the person or communicating in any form, such as verbal, written, and electronic communication, including contact through a third party.

Conviction. The judgment of a court, based on the verdict of guilty, the verdict of a judicial officer, or the defendant's guilty plea.

Covert Sensitization. An aversive behavioral technique designed to reduce deviant sexual arousal by pairing deviant sexual thoughts with unpleasant ones.

Criminogenic Needs. Risk factors that are potentially changeable and closely linked to an individual's sex-offending behavior; also called dynamic risk factors**.** Examples include offense-related sexual interests, attitudes supportive of offending, impulsivity, and negative social influences.

Crossover Sexual Offending. Offending in which victims are from multiple age, gender, and relationship categories.

Denial. Failure to accept responsibility for committing a sexual offense.

Department. The Alaska Department of Corrections.

Deviant Sexual Interest. Sexual attraction to illegal sexual acts, such as rape or sex with children, and to those that are highly unusual or very atypical.

Dynamic Risk Factors. Risk factors that are potentially changeable and are closely linked to an individual's sex-offending behavior; also called criminogenic needs.

Electronic Monitoring. An electronic system used to monitor a person's compliance with geographical conditions of release.

Evidence-based. The integration of the best available research with provider expertise.

Family Reunification. The gradual process of reuniting a family unit after it has been separated because a family member was convicted of a sex offense.

Guardian Ad Litem. A person appointed by the court to represent a minor child's best interests in a court case.

High-Risk Factors. A set of internal motivations or external situations/events that threaten a sex offender's sense of self-control and increase the risk of reoffending.

Historical, Clinical, and Risk Management - 20 ***(HCR-20).*** A 20-item structured professional judgment measure that provides guidelines for the assessment of risk for inpatient and community violence in people with mental disturbances.

Index Sex Offense. Generally, the most recent offense known to authorities, which could be an arrest, charge, or conviction.

Instant Offense Disclosure Polygraph Test. Refers to testing the accuracy of the offender's report of their behavior in a particular sex offense; usually the most recent crime resulting in a criminal charge.

Lapse. An emotion, fantasy, thought, or behavior that is part of a sex offender's behavior chain and relapse pattern. Lapses are not sex offenses. Instead, they are precursors or risk factors for sex offenses. Lapses are not necessarily failures but are often valuable learning experiences.

Level of Risk. The likelihood of reoffending and degree of dangerousness a sex offender is believed to pose to potential victims or the community at large.

Level of Service Inventory-Revised (LSI-R). A 54-item actuarial risk assessment tool designed to assess reoffense risk and treatment needs among the general criminal population.

Maintenance/Monitoring Polygraph Test. Refers to testing the verification of the offender's report of compliance with supervision and treatment rules and restrictions.

Multi-Disciplinary Team. A team of professionals that work together collaboratively to share information and make informed decisions related to the assessment, treatment, supervision, and management of offenders during their term of supervision. The team is typically comprised of the supervising officer, approved provider, polygraph examiner, and SOMP Criminal Justice Planner and, depending on the case circumstances, may also include adjunct approved providers, child protection professionals, and victim advocates.

Needs. Shorthand for criminogenic needs, which are risk factors that are potentially changeable and closely linked to an individual's sex-offending behavior; also called dynamic risk factors.

Parole. The release of a person from jail, prison, or other confinement after serving a portion of their sentence. People released on parole are supervised and must follow certain conditions. Violating these conditions could result in a revocation of parole and a return to jail, prison, or other confinement to complete the original sentence.

Polygraph. A diagnostic instrument and procedure designed to detect and record changes in physiological characteristics, such as a person's pulse and breathing rates, is used especially in treating and supervising sex offenders for detecting deception or verifying the truth of statements by persons under correctional supervision.

Pornography. The presentation of sexually arousing material in literature, art, motion pictures, or other means of communication or expression.

Positive Support Person. A person who provides an offender positive support for behavior change, such as an approved member of an offender's Safety-net team.

Presentence Investigation Report. A court-ordered report prepared by a supervision officer. The report includes information about an offender's index offense, criminal record, family and personal history, employment and financial history, substance abuse history, and prior community supervision or incarceration periods. At the conclusion of the report, the officer assesses the information and often makes a dispositional recommendation to the court.

Probation. A court-ordered disposition through which an adjudicated offender is placed under the control, supervision, and care of a probation field staff member instead of imprisonment, so long as the probationer offender meets specific conditions.

Psychosexual Evaluation. A comprehensive evaluation of an alleged or convicted sex offender to determine such issues as the person's risk of recidivism, treatment and supervision needs, and responsivity factors.

Recidivism. Commission of a crime after an individual has been criminally adjudicated for a previous crime; also called reoffense.

Reintegration. Gradual re-acclimation or adjustment to a non-supervised, less structured environment featuring opportunities to demonstrate new social skills and responsible decision-making in support of community and personal safety.

Relapse. A re-occurring sexually abusive behavior or sex offense.

Release of Information. A signed document for purposes of sharing information between and among individuals involved in managing sex offenders (e.g., two-way information release between approved providers and legal professionals includes the sharing of sex offender legal and treatment records and other information necessary for effective treatment, monitoring, and supervision).

Reoffense. Commission of a crime after an individual has been criminally adjudicated for a previous offense; also called recidivism.

Responsivity Factors. Individual offender characteristics that may impact response to services, such as gender, intellectual ability, culture, personality characteristics, level of denial, and motivation. Programs should take these into account when delivering services.

Reunification. A gradual supervised procedure in which a sex offender can re-integrate into the home where children are present.

Risk. The likelihood a sex offender will commit a new offense and the likely degree of harm that would result.

Risk Assessment. An assessment of an offender's risk of reoffending or noncompliance with treatment conditions or correctional requirements.

Risk Factors. Personal characteristics or environmental conditions that place an individual at increased risk for committing a sex offense.

Risk Level. The determination by evaluation of a sex offender's likelihood of reoffense. Risk level is commonly expressed as very low, below average, average, above average, and well above average.

Risk Management. A term used to describe services provided by corrections personnel, approved providers, community members, and others to manage the risk presented by sex offenders. Risk management approaches include supervision and surveillance of sex offenders in a community setting (risk control) and require sex offenders to participate in rehabilitative activities (risk reduction).

Risk Matrix 2000 (RM2000). A static actuarial risk assessment tool for predicting the likelihood of future sexual and nonsexual violence in adult male sex offenders.

Risk Reduction. Activities designed to address the risk factors contributing to the sex offender's sexually deviant behaviors. These rehabilitative activities provide the sex offender with the necessary knowledge, skills, and attitudes to reduce their likelihood of reoffense.

Safety-Net. A group of natural helpers that form to support an offender in leading an offense-free life and alert professionals who are working with the offender of potential pre-relapse indicators so that they can intervene rapidly.

Safety Plan. A plan developed by an offender, in conjunction with a approved provider and supervising officer, designed to help the offender manage risky situations and remain offense-free in the community.

Sex Offender. The term most commonly used to define an individual who has been charged and convicted of illegal sexual behavior.

Sex Offender Registration. Sex offender registration laws require offenders to provide their addresses and other identifying information to a state or law enforcement agency for tracking purposes to increase community protection.

Sex Offender Treatment Committee. A committee established by the commissioner to assist in developing the Sex Offender Treatment Standards of Care Manual and review and make recommendations regarding sex offender approved provider applications and complaints against providers.

Sex Offender Treatment Intervention and Progress Scale (SOTIPS). A provider-administered 16-item dynamic actuarial risk and needs tool designed to assess treatment and supervision needs and measure progress among adult male sex offenders.

Sexual History Disclosure Polygraph Test. Refers to verification of completeness of the offender's disclosure of their entire sexual history, generally through completing a comprehensive sexual history questionnaire.

Sexual Offense Specific. Treatment, assessment, and supervision that targets sexually abusive behaviors rather than generic problems. Sexual offense-specific treatment often includes limited confidentiality, involuntary client participation, and a dual responsibility for the therapist to meet the offender's needs while protecting society.

Stable-2007. An actuarial measure of 13 dynamic risk factors relevant for treating and supervising adult males convicted of a sexually motivated offense.

Static Risk Factors. Risk factors based on an individual's past and cannot change. These include the number of prior sex offenses, history of committing other crimes, and childhood problems.

Static-99R. An actuarial risk tool comprised of 10 static risk factors designed to assess the risk of sexual recidivism among adult males with a history of sexual offending.

Static-2002R. An actuarial risk tool comprised of 14 static risk factors designed to assess the risk of sexual recidivism among adult males with a history of sexual offending.

Success Plan. An offender's comprehensive strategy to solidify strengths and manage risk to successfully establish a pro-social lifestyle that is incompatible with offending behavior.

Technical Violation. A violation of a sex offender's pretrial release, probation, or parole conditions. Technical conditions are requirements that, if violated, constitute rule-breaking rather than illegal behavior. Commission of a new crime is also considered a violation of one's conditions, but it is not referred to as a "technical" violation.

Telehealth. The delivery of psychological services using telecommunications technologies, which include telephone, mobile devices, interactive video conferencing, email, chat, and text.

Therapeutic Alliance. A cooperative working relationship between an offender and a therapist, supervising officer, or other helping professional considered an essential aspect of successful treatment and supervision services. It is marked by positive emotional connections, mutually agreed upon treatment and supervision tasks, and mutually agreed upon goals, also called working alliance.

Treatment Contract. A document explained to and signed by a sex offender that outlines the purpose and nature of the treatment.

Treatment Plan. A document articulating a plan for addressing a sex offender's treatment needs. It typically includes problems to be addressed, treatment methods, staff that will provide the treatment, and relevant time frames.

Treatment Progress. Gauges the offender's success in achieving the specific goals in the individual treatment plan.

Triggers. An external event that has or could begin a behavior leading to an offense.

Victim Impact Statement. A statement that describes the impact of a sexual offense on the victim, which is typically taken while interviewing the victim during the presentence investigation report and is considered by the court at a sex offender's sentencing.

Violence Risk Appraisal Guide (VRAG). A 12-item actuarial risk assessment tool to assess sexual and nonsexual violence reoffense risk among adult male offenders.

Violence Risk Scale – Sexual Offense Version (VRS-SO). A clinician-rated scale designed to assess pre- and post-treatment risk for sexual recidivism comprises 7 static and 17 dynamic factors combined to form a total score.

Working Alliance. A cooperative working relationship between an offender and a therapist, supervising officer, or other helping professional considered an essential aspect of successful treatment and supervision services. It is marked by positive emotional connections, mutually agreed upon treatment and supervision tasks, and mutually agreed upon goals, also called the therapeutic alliance.

Appendix B

ALASKA ADMINISTRATIVE CODE REGULATING SEX OFFENDER TREATMENT PROVIDERS

Section

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(History: Eff. 11/2/2002, Register 164 Authority: AS 33.30.011 AS 33.30.021 AS 44.28.030)

22 AAC 30.010. Sex offender treatment committee.

(a) The commissioner will establish a Sex Offender Treatment Committee for the purposes of

(1) assisting in developing a Sex Offender Treatment Standards of Care Manual for use by providers approved under this chapter;

(2) reviewing applications from individuals applying for approval, or renewal of approval, to provide sex offender treatment to offenders under the department's jurisdiction and making recommendations to the department regarding the applications; and

(3) reviewing and investigating complaints against approved providers and making recommendations to the department regarding disposition of the complaints.

(b) The committee will include

(1) the department employee with responsibility for oversight of the sex offender treatment

program;

(2) one department employee representing the department's correctional facilities;

(3) two department employees representing the department's community corrections programs; and

(4) three public members, from different judicial districts in the state, who are licensed under AS 08 in a professional field listed in 22 AAC 30.030(b)(1) and who have experience in providing clinical services to sex offenders.

(c) The committee's members serve on the committee at the pleasure of the commissioner. The commissioner will designate one of the committee members to be the committee chairperson.

22 AAC 30.020. Provider approval.

(a) An individual who wishes to provide sex offender treatment to a sex offender who is under the department's jurisdiction first must obtain, and then maintain, approval from the department under this chapter in order for the treated sex offender to be considered in compliance with a sex offender treatment requirement imposed by the court, the parole board, or the department. Department approval of such a provider is required regardless of who pays for the sex offender's treatment and regardless of whether the treatment takes place in a correctional facility or is community-based.

(b) An individual does not need approval under this chapter in order to provide a service that is not sex offender treatment, as defined in 22 AAC 30.900, to a sex offender who is under the department's jurisdiction.

22 AAC 30.030. Application process; qualifications.

(a) An individual who wishes to become an approved sex offender treatment provider must apply to the department on a form provided by the department. Only an individual may be approved as a sex offender treatment provider.

(b) To become an approved provider under this chapter, an individual must

(1) have a current professional license, in good standing, issued under AS 08, as a psychiatrist, psychologist, psychological associate, social worker, marital and family therapist, or professional counselor;

(2) be of good moral character; and

(3) agree to abide by the standards set out in 22 AAC 30.200 in providing sex offender treatment to a sex offender who is under the department's jurisdiction.

(c) An application for provider approval must include

(1) the applicant's name, business mailing address, and telephone number;

(2) a statement of the applicant's educational degrees, the year they were obtained, and the institutions from which they were obtained;

(3) verification from the relevant Alaska licensing board that the applicant has a current professional license, as described in (b) of this section, in good standing;

(4) a history of the applicant's specialized training in the treatment of sex offenders;

(5) a history of the applicant's professional work experience;

(6) the applicant's complete criminal history, if any;

(7) information about any investigations of the applicant by any licensing authority in this or any other jurisdiction for possible professional license violations; and

(8) references from at least two individuals familiar with the applicant's professional training

and experience.

(d) Except as provided in 22 AAC 30.100, initial department approval of a provider lapses three years from the date of the approval.

22 AAC 30.040. Provider levels; supervision condition.

(a) The department will establish different provider levels, including a full-service level, and will approve a provider at a particular level based on the provider's education, training, experience, and professional license.

(b) Department approval of a provider at a provider level less than the full-service level will be conditioned on the requirement that, in providing sex offender treatment to a sex offender who is under the department's jurisdiction, that approved provider must be supervised by an approved full-service-level provider.

22 AAC 30.050. Application review; approval or denial; request for review of denial.

(a) The Sex Offender Treatment Committee shall review an application for approval as a sex offender treatment provider and shall place in the applicant's file the committee's recommendation to the department regarding approval or denial of the application. The committee may recommend denial only if the committee determines that the applicant does not meet the requirements for approval in 22 AAC 30.030. If the committee recommends denial of an application, the committee's recommendation to the department must include a written statement of the committee's reasons for recommending denial. The committee shall forward the applicant's file to the department.

(b) After review of the application and the committee's recommendation, the department will approve or deny an application for provider approval and will notify the applicant of the decision. If the department denies the application, the department will furnish the applicant with a statement of its findings regarding the denial and with instructions for requesting a review of the denial under 22 AAC 30.060. Failure to timely request review as provided in 22 AAC 30.060(a) precludes further department consideration of the denial.

22 AAC 30.060. Review of denial.

(a) An applicant whose application for provider approval was denied under 22 AAC 30.050 may request review of the denial by filing a request with the commissioner within 30 days after the date of the department's notification of denial under 22 AAC 30.050(b). The request for review must contain a statement of why the department's decision should be changed and must indicate which department findings the applicant believes are in error.

(b) If the commissioner determines that the request for review demonstrates a genuine issue in contention, the commissioner will grant an administrative review. The commissioner's denial of a request for review is a final administrative decision for purposes of appeal to the superior court under the Alaska Rules of Appellate Procedure.

(c) If the request for review is granted, the commissioner will appoint a review officer to conduct the review. If the commissioner appoints a department employee as the review officer, the employee will not be a person who participated in the decision to deny the application.

(d) In conducting the review, the review officer may

(1) request additional information from the applicant if the review officer considers the information to be necessary to the review; and

(2) conduct an additional investigation if the review officer believes that the information to be obtained from the additional investigation is necessary to the review.

(e) All information resulting from the review officer's review will be retained in the applicant's file.

(f) Upon completion of the review, the review officer shall prepare a written report that summarizes the case and recommends a decision, and shall submit the report and the applicant's file to the commissioner. The commissioner will review the report and will issue a written decision that sets out the reasons for accepting or rejecting the review officer's recommendation. The review officer's report and a copy of the commissioner's decision will be retained in the applicant's file. The commissioner's decision is a final administrative decision for purposes of appeal to the superior court under the Alaska Rules of Appellate Procedure.

(g) In a review under this section, the burden of proof is on the applicant to establish by a preponderance of the evidence that the applicant meets the department's requirements for provider approval under this chapter.

22 AAC 30.070. Renewal process; qualifications.

(a) To renew provider approval under this chapter, an approved provider must apply for renewal of approval no later than 60 days before the end of the provider's current approval period by submitting an application for renewal to the Sex Offender Treatment Committee on a form provided by the department.

(b) For a provider's approval to be renewed, the provider must

(1) have a current professional license, in good standing, as described in 22 AAC 30.030(b);

(2) be of good moral character;

(3) have obtained, within the preceding three years, 20 hours of continuing education in the treatment of sex offenders that

(A) was sponsored or conducted by the Association for the Treatment of Sexual Abusers;

(B) fulfills a continuing education requirement imposed by the board that licenses the provider as a psychiatrist, psychologist, psychological associate, social worker, marital and family therapist, or professional counselor; or

(C) has been approved by the department as being substantially equivalent to the continuing education described in (A) or (B) of this paragraph;

(4) agree to abide by the standards set out in 22 AAC 30.200 in providing sex offender treatment to a sex offender who is under the department's jurisdiction; and

(5) provide a reference, on a form provided by the department, from the supervising full-service-level approved provider if the applying provider's current approval is conditioned under 22 AAC 30.040 on that supervision.

(c) A renewal application must include

(1) the provider's name, business mailing address, and telephone number;

(2) verification from the relevant Alaska licensing board that the provider has a current professional license, as described in (b)(1) of this section, in good standing;

(3) documentation verifying that the provider has obtained the continuing education required by (b)(3) of this section;

(4) the reference described in (b)(5) of this section, signed by the supervising full-service-level provider, if the reference is required under (b)(5) of this section;

(5) all information not previously provided to the department regarding the provider's criminal history; and

(6) information not previously provided to the department regarding any investigations of the provider within the past three years for possible professional license violations.

(d) A renewed provider approval lapses three years from the date of renewal.

22 AAC 30.080. Renewal application review; approval or denial; request for review of denial.

(a) Review of an application for renewal of provider approval by the Sex Offender Treatment Committee and the department, and approval or denial of the application, will be conducted in the manner provided in 22 AAC 30.050 for an application for initial provider approval.

(b) Review of denial of a renewal application may be requested as provided in 22 AAC 30.060(a). The review of a denial will be conducted as described in 22 AAC 30.060.

22 AAC 30.090. Transition: previously approved providers.

(a) Notwithstanding the provisions of 22 AAC 30.020 – 22 AAC 30.060, an individual who, on 11/1/2002, had approval from the department to provide sex offender treatment to sex offenders who are under the department's jurisdiction is considered on 11/2/2002 to be an approved provider under this chapter.

(b) The individual's provider approval under (a) of this section lapses on 11/2/2003. To maintain provider approval under this chapter, the individual must, no later than 60 days before the lapse date of the individual's provider approval under this section, apply for renewal of provider approval under 22 AAC 30.070. The individual must meet the requirements of 22 AAC 30.070 in order to obtain renewal of approval.

22 AAC 30.100. Lapsed approval.

(a) If an individual's provider approval under this chapter lapses, the individual may submit to the department, no later than 60 days after the approval lapsed, a request to submit a late renewal application. The request must state the reasons for late application. If the department determines that good cause exists to allow a late renewal application, the department will notify the individual that a late renewal application may be submitted and will be processed under 22 AAC 30.070 and 22 AAC 30.080. If the department determines that good cause does not exist to allow a late renewal application, the department will notify the individual of that determination and that the individual must instead follow the procedures in 22 AAC 30.030 for a new initial approval.

(b) An individual whose approval under this chapter has lapsed and who subsequently applies for a new initial approval under 22 AAC 30.030 must, in addition to meeting the requirements of 22 AAC 30.030, meet the continuing education requirement in 22 AAC 30.707(b) and must submit with the application under 22 AAC 30.030 documentation of having met that requirement.

22 AAC 30.110. Complaints; subsequent action against provider approval.

(a) A person, including an employee of the department, may bring a complaint against an approved provider, alleging a violation of a requirement for provider approval under this chapter, a violation of a supervision condition placed on the approval as described in 22 AAC 30.040, or a violation of a standard of care in 22 AAC 30.200 by submitting the complaint in writing to the Sex Offender Treatment Committee. The committee shall open a complaint file and review the complaint. Upon

completion of initial review of the complaint, the committee shall prepare for the complaint file a report regarding the complaint, including the committee's conclusion as to whether there is probable cause to believe that a violation has occurred. In the report, the committee may recommend that the department suspend the provider's approval under this chapter until the complaint is resolved, in order to prevent an undue risk of harm to the public. The committee shall forward the complaint file to the department.

(b) If, after review of the complaint file, the department determines that probable cause does not exist to believe that a violation has occurred, the department will furnish a written report of the complaint to the provider who is the subject of the complaint, setting out the reasons for the determination, and will place a copy of the report in the complaint file.

(c) If, after review of the complaint file, the department determines that there is probable cause to believe that a violation has occurred, the department will notify the provider who is the subject of the complaint of the allegations contained in the complaint, and will furnish the provider with a response form. The department will return the complaint file to the committee and direct the committee to investigate the allegations in the complaint.

(d) If the department directs the committee to conduct an investigation as described in (c) of this section and the department concludes that suspension of the provider's approval pending resolution of the complaint is necessary to prevent an undue risk of harm to the public, the department will notify the provider that the department intends to suspend the provider's approval under this chapter pending resolution of the complaint and that the provider may contest the suspension determination by providing to the department, within three days after the date of the notification under this subsection, a written statement as to why suspension is not necessary to prevent an undue risk of harm to the public. The department will consider the provider's statement, make a final determination as to whether the provider's approval under this chapter should be suspended pending resolution of the complaint, and will notify the provider of that final determination. If the department's final determination is that the provider's approval under this chapter should be suspended, the suspension takes effect upon the provider's receipt of notification of that final determination.

(e) Within 14 days after the date of the notification of allegations under (c) of this section, the provider shall submit to the committee, on the response form furnished by the department, a sworn statement in response to the allegations in the complaint. The provider shall cooperate with the investigation of the complaint by providing to the committee any documents or information requested by the committee. The provider's failure to respond to the allegations or to cooperate with the committee's investigation as required by this subsection may result in revocation of the provider's approval. The committee shall place in the complaint file the provider's response statement, any other documents or information provided to the committee under this subsection, and any other material considered by the committee in its investigation. (f) Upon completion of its investigation, the committee shall prepare for the complaint file a report of the results of the committee's investigation and a recommendation for department action regarding the complaint, and shall forward the complaint file to the department. The committee's recommendation may be that the department

(1) take no action;

(2) continue the provider's approval under this chapter with conditions designed to correct the violation, if the committee considers the violation to be a minor one that does not create an undue risk to the public and is amenable to correction within a specified period of time; or

(3) revoke the provider's approval under this chapter.

(g) If, after review of the complaint file, including the committee's report and recommendation under (f) of this section, the department decides to

(1) take no action on the complaint, the department will notify the provider of the decision, will furnish the provider with a written report of the decision and will retain a copy of the notification and report in the complaint file;

(2) continue the provider's approval under this chapter with specified conditions designed to correct the violation, the department will notify the provider of the continued approval and conditions, will furnish the provider with a written report of the decision, including a statement of the reasons for the conditions, and will retain a copy of the notification and report in the complaint file;

(3) revoke the provider's approval under this chapter, the department will notify the provider of the revocation decision, will furnish the provider with a written report of the decision, including a written statement of the reasons for revocation and instructions for requesting a review of the decision, and will retain a copy of the notification and report in the complaint file.

(h) A provider who receives notification of a decision under (g)(2) or (3) of this section has 30 days from the date of the notification to request review of the decision in the manner described in 22 AAC 30.060(a). If the provider timely requests review as provided in this subsection, the department's review of the decision will be conducted as described in 22 AAC 30.060. If a timely request for review is not received as provided in this subsection, the revocation or the placement of conditions takes effect on the 31st day after the date of the notification of the decision under (g) of this section.

(i) After resolution of a complaint under this section, the department will inform the complainant of the disposition of the complaint.

(j) In this section, "violation" means a violation of a requirement for provider approval under this chapter, a violation of a supervision condition placed on the approval as described in 22 AAC 30.040, or a violation of a standard of care in 22 AAC 30.200.

22 AAC 30.120. Summary suspension or revocation of provider approval.

(a) Notwithstanding the procedures set out in 22 AAC 30.110, the department will summarily suspend or revoke a provider's approval as provided in this section.

(b) The department will summarily suspend a provider's approval under this chapter if the department determines that the provider's professional license issued in this or another jurisdiction has been suspended or determines that the provider has violated a condition placed on the approval under 22 AAC 30.110(g). The department will notify the provider of the suspension of provider approval under this section. Suspension of provider approval under this subsection takes effect on the date the provider is notified of the suspension. The provider may not apply for renewal of the approval, or apply for a new initial approval, under this chapter while the provider's approval is suspended under this section. If, before the lapse date of the provider's approval, the provider

(1) submits verification to the department that the provider's suspended professional license has been restored to good standing, or that the provider is in compliance with the relevant condition, as applicable, the department will lift the suspension of the provider's approval under this chapter;

(2) has not submitted verification to the department that the provider's suspended professional license has been restored to good standing or that the provider is in compliance

with the relevant condition, as applicable, the provider's approval under this chapter lapses.

(c) A provider whose professional license was suspended and whose approval under this chapter lapsed under (b)(2) of this section because that professional license had not been restored to good standing must comply with the procedures and requirements of 22 AAC 30.100 to obtain a subsequent approval under this chapter and must submit verification acceptable to the department that the provider's suspended professional license has been restored to good standing.

(d) The department will summarily revoke a provider's approval under this chapter if the department determines that the provider's professional license issued in this or another jurisdiction has been revoked. The department will notify the provider of the revocation. Revocation under this subsection takes effect on the date the provider is notified of the revocation.

(e) In this section, "professional license" means a license described in 22 AAC 30.030(b)(1) or a license to practice in one of the fields listed in 22 AAC 30.030(b)(1) issued by another licensing jurisdiction.

22 AAC 30.130. Revoked approval.

If an individual's provider approval under this chapter is revoked under 22 AAC 30.110 or 22 AAC 30.120, the individual

(1) may not apply for a new initial approval under 22 AAC 30.030 sooner than two years after the effective date of the revocation;

(2) in applying for a new initial approval under 22 AAC 30.030 also must meet the continuing education requirement of 22 AAC 30.070(b) and must submit documentation of meeting the requirement.

22 AAC 30.200. Standards of care.

(a) An approved provider shall comply with the standards of care set out in this section in providing sex offender treatment to a sex offender who is under the department's jurisdiction.

(b) An approved provider may not

(1) allow personal feelings about a client or the client's crimes to interfere with the provider's professional judgment and objectivity, and shall make appropriate referrals to other professionals if the provider is unable to manage negative reactions to a client;

(2) discriminate based on age, gender, race, ethnicity, national origin, religion, sexual orientation, political affiliation, social or economic status, disability, or any basis proscribed by law;

(3) engage in behavior that is harassing, exploitative, or demeaning to a client;

(4) barter for services;

(5) advise or facilitate family reunification unless suitable measures have been taken to ensure the safety of, and appropriateness of reunification for, the client's victim;

(6) provide sex offender treatment to a sex offender who is under the department's jurisdiction if the provider has a pre-existing relationship with that person and that relationship could impair the provider's professional judgment;

(7) engage in a sexual relationship with a client or former client, regardless of whether payment was made for the sex offender treatment, and may not engage in a sexual relationship with a family member of a client or former client;

(8) engage in a business or social relationship with a client if that relationship could conflict with or compromise the primary professional relationship;

(9) disclose identifying information about a client during professional training or workshops; an audiotape or videotape to be used by the provider during training or a workshop must protect the identity of the client and may be used only after obtaining written informed consent from the client; or

(10) encourage or permit the use of pornography.

(c) An approved provider shall

(1) discuss fees to be charged for services before, or at the time of, the client's initial appointment, and shall inform the client before a change is made regarding fees that will be charged;

(2) at the time of the initial appointment, inform the client about the types of services to be provided, reasonable expectation of outcomes, alternatives to the type of services proposed, potential benefits and risks involved in the services, and the limits of privilege and confidentiality; if a client is incapable of consenting to services, the provider shall explain to the client the proposed assessments and treatments in a manner commensurate with the client's developmental and psychological capabilities and shall obtain a signed informed consent from the client's legal guardian;

(3) carry out professional duties regarding a client in a way that maximizes safety for the client's victims and potential victims;

(4) hold in confidence information provided by a client's victim, and not provide the information to others, including the client, without the written permission of the victim;

(5) comply with all state and federal reporting laws;

(6) advise each client as to the confidentiality of communications with the client, how confidentiality applies when multiple clients are members of the same family, and of statutory requirements for mandatory reporting;

(7) except when reporting is mandated by state statute, obtain a written waiver of confidentiality before releasing information about a client; the provider shall inform the client about the reasons for the release of information; and

(8) cease sex offender treatment for a client if

(A) the client also is receiving treatment from a provider who is not approved under this chapter;

(B) it is determined by another provider who is an approved full-service-level provider that that treatment is interfering with sex offender treatment with the approved provider; and

(C) the client does not cease treatment with the unapproved provider.

(d) Supervision arrangements between a supervising provider under 22 AAC 30.040 and a supervised provider must be agreed upon in writing before the supervised provider begins providing sex offender treatment to a client. The written document must specify the duties to be performed by the supervised provider, the scope and focus of the supervision, and the frequency and duration of supervision meetings.

(e) An approved provider who is supervising another approved provider under 22 AAC 30.404 may not delegate responsibilities to or advise professional activities for the supervised provider unless the supervising provider is confident that the responsibilities or activities are within the competencies of the supervised provider. In deciding whether to delegate or advise, the supervising provider shall consider the training, education, and experience of the supervised provider.

(f) A provider who is supervising another provider under 22 AAC 30.040 shall take the steps necessary to ensure that the supervised provider performs professional duties ethically, competently, and responsibly. A supervising provider shall review and co-sign all reports prepared by the supervised provider, to indicate either concurrence or nonconcurrence with the opinions, conclusions, and recommendations stated in the report.
(g) A provider who is supervising another provider under 22 AAC 30.040 may not engage in a sexual relationship with that provider.
(h) A provider whose approval is conditioned under 22 AAC 30.404 upon being supervised shall inform clients of the supervision, supply the name of the supervising provider, and explain the impact of the supervision on the confidentiality of communications with the client.
(i) In this section, "client" means a sex offender who is under the jurisdiction of the department and who is receiving, or will be receiving, sex offender treatment.

22 AAC 30.900. Definitions.

In this chapter,
(1) "approved provider" means an individual who has received approval from the department under this chapter to provide sex offender treatment to sex offenders who are under the department's jurisdiction;
(2) "clinical services" means the application of assessment and psychotherapeutic techniques by an individual licensed under AS 08 to practice in the field of psychiatry, psychology, social work, marital and family therapy, or professional counseling;
(3) "committee" means the Sex Offender Treatment Committee established under 22 AAC 30.101;
(4) "commissioner" means the commissioner of corrections;
(5) "department" means the Department of Corrections;
(6) "good moral character" means, based on consideration of all aspects of an individual's character, the absence of acts or conduct that would cause a reasonable person to have substantial doubts about the individual's honesty, fairness, and respect for the rights of others and for the laws of the state and the nation; the following are indicia of a lack of good moral character:

(A) illegal conduct;

(B) conduct involving moral turpitude, including dishonesty, fraud, deceit, or misrepresentation;

(C) intentional deception or fraud, or attempted deception or fraud, in an application, examination, or other document submitted to secure employment, eligibility for licensure, or certification;

(D) conduct that adversely reflects on a person's fitness to provide sex offender treatment, including intoxication while providing treatment and undue familiarity with a client, or with a sex offender, or correctional inmate, probationer, or parolee, with whom the provider has a professional relationship;

(7) "moral turpitude" means an act that

(A) is contrary to justice, honesty, principle, or good morals;

(B) violates the private and social duties that a person owes to another or to society in general; or

(C) is immoral in itself, regardless of illegality;

(8) "sex offender" means an individual who

(A) has been convicted of a sexual offense as defined in

(i) AS 11.41.410 - 11.41.470, AS 11.61.110(a)(7), 11.61.120(a)(4) or (5), or 11.61.125; or

(ii) former AS 11.15.120, 11.15.134, 11.15.160, AS 11.40.080, 11.40.110, 11.40.130, or 11.40.200 - 11.40.420;

(B) has been convicted under a statute of another jurisdiction that is substantially similar to a statute listed in (A) of this paragraph; or

(C) acknowledges behavior that, if charged, would have been a crime under a statute listed in (A) of this paragraph;

(9) "sex offender treatment" means the provision of clinical services to a sex offender and includes assessment of the sex offender;

(10) "undue familiarity" means developing, or attempting to develop, an intimate, personal, or financial relationship with an individual, or otherwise failing to maintain an appropriate professional relationship with the individual.