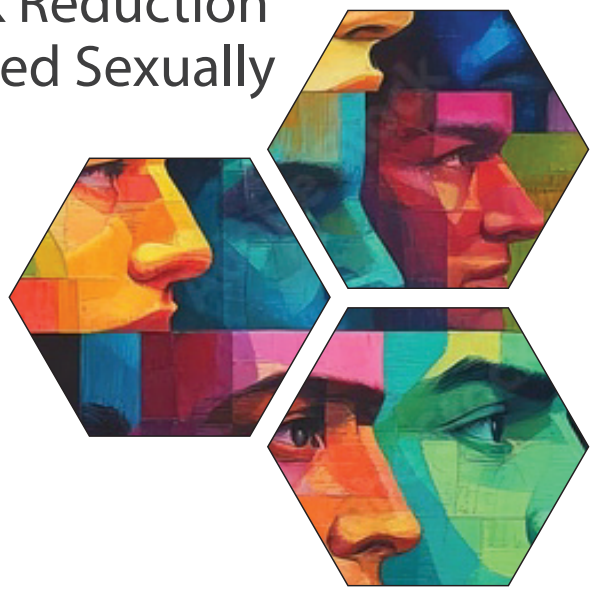
ATSA

6th Edition

# BEST PRACTICE GUIDELINES FOR MEN

Best Practice Guidelines for the Assessment, Treatment, Risk Management, and Risk Reduction of Men Who Have Committed Sexually Abusive Behaviors



ATSA

Welcome to the *Best Practice Guidelines for the Assessment, Treatment, Risk Management and Risk Reduction of Men Who Have Committed Sexually Abusive Behaviors* (short title: *Best Practice Guidelines for Men*).

The first ATSA practice guideline document was published in 1993. The objective was to provide ATSA members and other stakeholders working in the areas of assessment, treatment, risk management, risk reduction and prevention a document outlining the best practices of the day to inform and guide their practice. Over time, the guidelines have also served to stimulate research, guide case management and supervision practices and inform public policy, legislation and prevention initiatives. The guideline documents have been valued by the membership and beyond, with ATSA members identifying the practice guidelines as one of the most important services provided by ATSA.

The practice guidelines have gone through several iterations with revisions in 1997, 2001, 2003, 2005 and 2014. Each revision seeks to update the guidelines to reflect current best practices. Our ATSA Guideline Review Committee was established by the ATSA Board of Directors to conduct a thorough review of the *Practice Guidelines for the Assessment, Treatment, and Management of Male Adult Sexual Abusers* (2014). In this review, we saw an opportunity to evolve the document in both content and form. This version has been updated with the specific goals of being attentive to language, enhancing the organization and flow of the content, evolving and enhancing the clinical commentary and streamlining the document. As with prior revisions, the guidelines have been updated based on the current state of best practice in our field as supported by the empirical, theoretical, and clinical literature on the assessment, treatment, risk management and risk reduction of and for men who have committed sexually abusive behaviors.

We hope the 2025 *Best Practice Guidelines for Men* will contribute to the understanding and implementation of best practices for ATSA members and non-members committed to providing clinical, risk management, and risk reduction services for men who have committed sexually abusive behaviors, and who through their work strive to prevent sexual abuse and create safer communities.

The committee would like to express our thanks and appreciation to those who assisted, supported, and helped guide this review process. Great appreciation and thanks to Aniss Benelmouffok, ATSA Public Affairs Director, for his remarkable assistance throughout this process. We are grateful to Bob McGrath for his thoughtful review, wisdom, and guidance. Thanks also to Chris Lobanov-Rostovsky for his valuable input and balanced perspectives. We also extend our sincere appreciation to the ATSA Board of Directors, who offered sage commentary that advanced the content of the guidelines and for their support of the committee during this process.

We would particularly like to acknowledge the insightful contributions of Ainslie Heasman, Sharon Kelley, Janet DiGiorgio-Miller, Heather Moulden, and Amanda Pryor.

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Association for the Treatment and Prevention of Sexual Abuse. (2025). Best Practice Guidelines for the Assessment, Treatment, and Risk Management and Risk Reduction of Men Who Have Committed Sexually Abusive Behaviors. https://www.atsa.com

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# INTRODUCTION

The Association for the Treatment and Prevention of Sexual Abuse (ATSA) is an international, multidisciplinary organization committed to the prevention of sexual abuse. ATSA's mission is to prevent sexual abuse through the assessment, treatment, risk management, and risk reduction of individuals who are at risk of engaging in or who have committed sexually abusive behaviors.[1] This is achieved through collaborating with other professionals to develop and highlight comprehensive prevention strategies, promote sound research and education, and advocate for informed public policy. ATSA subscribes to empirically based, responsible, and ethical approaches to addressing sexually abusive behaviors through evidence-based assessment, treatment, risk management, risk reduction, and policy strategies. ATSA believes this will result in reduced sexual recidivism, a corresponding decrease in victimization, and the prevention of the additional serious personal and societal impacts of repeated sexually abusive behaviors. ATSA advocates for assessment, treatment, risk management, risk reduction, and policies that prioritize community safety and are attentive to and respectful of individuals who have experienced the effects of sexually abusive behaviors.[2] ATSA believes evidence-based assessment, treatment, risk management, risk reduction, and policy strategies can facilitate the efforts of those who are at risk of engaging in sexually abusive behaviors to address and manage their vulnerability and risk factors and enhance their functioning to support desistance. This mission aims to transform the lives of people who have experienced, perpetrated, and been impacted by sexual exploitation and sexual abuse.

The current guidelines reflect accepted and promising practices. These practices are supported, to the extent possible, by current research regarding men who have committed sexually abusive behaviors and the broader literature related to other criminal justice-involved populations and populations in general clinical settings. These are practice "guidelines" versus "standards." ATSA is not a registration or licensing body that can direct member practice. Additionally, we recognize that what constitutes best practice in this field is dynamic and evolving, informed by ongoing empirical investigation and the development of practices

1 Terms such as "individuals who are at risk of engaging in or who have committed sexually abusive behaviors," "men who have committed sexually abusive behaviors," and "clients" are used interchangeably throughout this document. These guidelines may also help guide the provision of services to men who have not committed sexually abusive behaviors but are identified as at risk to do so.

2 The term "individuals who have experienced the effects of sexually abusive behaviors" has been used in this document. It is important those affected by sexual abuse self-identify their preferred terminology (e.g., victim, survivor, thriver).

that meet unique client needs and practitioner circumstances. The guidelines are offered as recommended "best practices" and consider both the current state of the empirical literature and innovative approaches that show promise.

ATSA members have consistently identified the offering of *Best Practice Guidelines* as one of the most significant benefits of ATSA membership. As well, since ATSA's *Best Practice Guidelines* are now free and openly available, these guidelines can provide information and direction for non-members with roles and responsibilities related to the assessment, treatment, risk management and risk reduction of men who have committed sexually abusive behaviors as well as support the development of meaningful and effective policies and prevention strategies globally.[3] As such, when implemented appropriately, these guidelines can offer a measure of protection for clients, practitioners, and the public against ineffective, inappropriate, unethical, or unprofessional practices.

The *Best Practice Guidelines for Men* can also support policymakers and other stakeholders across organizations, agencies, and disciplines to reduce and prevent sexual exploitation and abuse through educating and engaging the public and others regarding generally accepted principles and practices specific to reducing and managing risk among men who have committed sexually abusive behaviors. Finally, these guidelines may serve as a catalyst for additional empirical research to further inform practices and policies regarding this client population.

The primary objectives of the *Best Practice Guidelines for Men* are to:

- Highlight, disseminate, and promote empirically derived information pertaining to current best practices and promising innovative approaches in the assessment, treatment, risk management, and risk reduction of men who have committed sexually abusive behaviors;
- Support risk management, risk reduction, harm reduction, and sexual abuse prevention;
- Guide professionals working with men who have committed sexually abusive behaviors to optimize and enhance their capacity to facilitate and support risk reduction and desistance and to improve the client's quality of life with the ultimate goal of prevention and making communities safer;
- Promote a collaborative, multidisciplinary approach to assessment, treatment, risk management, risk reduction, and prevention;
- Maintain a high standard of professionalism and integrity within the membership.

3 While recognizing the value these guidelines offer for informing practices of ATSA members as well as non-members, the term "member" is used in this document for the economy of presentation and to emphasize the importance of ATSA members' understanding of, and agreement to implement, these guidelines whenever possible.

## APPLICABILITY AND USE

The *Best Practice Guidelines for Men* are designed as a companion resource to the ATSA *Professional Code of Ethics* (2024),[4] a compilation of principles and procedures to which members are required to adhere. ATSA conducts a professional review of the guidelines every five years to determine whether revisions are required to ensure the document aligns with current evidence and advances in the field.

The *Best Practice Guidelines for Men* are designed to complement rather than supplant or replace any statutes, provisions, or mandates (e.g., local, state, provincial, or federal); ethical codes; or practice requirements and parameters established for regulated professions. Where conflicts exist, statutory and other promulgated regulations take precedence. It should be noted that ATSA does not certify, credential, or license individuals to practice in any given discipline or specialization. At the time of publication ATSA membership is not a designation of formal certification, credentialing, or licensure specific to professionals providing assessment, treatment, or other services to individuals who have committed sexually abusive behaviors.

## SCOPE

The information and guidelines detailed in this document are based on contemporary theories, current empirical research, and promising practices specific to adult males, ages 18 years and older, who have committed sexually abusive behaviors. As a result, these guidelines should inform practices with this client population and not be considered generalizable to other client populations. Individuals who engage in sexually abusive behaviors are not a homogeneous group. A one-size-fits-all approach is not appropriate for addressing issues related to these behaviors. ATSA recognizes that children with sexual behavior problems, adolescents who have engaged in sexually abusive behavior, and women who have committed sexually abusive behaviors are distinct subpopulations with etiological influences, risk and protective factors, and intervention needs that do not necessarily parallel those of men who have engaged in such behaviors.

4 The ATSA *Professional Code of Ethics* (2024) details the principles and procedures that guide ATSA members in resolving ethical and professional dilemmas. It also outlines the procedures for filing ethical complaints regarding ATSA members. The *Best Practice Guidelines for Men* should be considered along with the most current version of the ATSA *Professional Code of Ethics*.

Within the adult male client population, it is important to recognize and be responsive to unique client characteristics that should inform and shape clinical practice. This involves understanding the nuanced considerations that are required when working with distinct subgroups within the adult male population.

This includes, for example:

- A client's age (young adult, adult, older adult) at the time of the sexually abusive behavior or at the time of assessment or treatment, and the need to consider the distinct neurological changes that occur during young adulthood and the unique social and psychological stressors experienced by older adults;
- Ethnocultural background and the cultural contexts and consideration of relevant cultural treatment/healing approaches;
- Sexual orientation and gender identity, and the diversity in the LGBTQIA+ community;
- Mental health (e.g., trauma history, major mental illness, personality disorders);
- Cognitive functioning;
- Assessed level of risk and identified risk factors, and areas of vulnerability and strength.

Members must be aware of the diversity among clients and how this can influence practice, such as developing case conceptualizations, understanding psychologically meaningful vulnerability areas and risk factors, recognizing strengths and protective factors, and determining intervention and risk management and risk reduction needs.

Members are encouraged to remain aware of developments in research and practice with various populations of individuals who have committed sexually abusive behaviors and to use relevant resources to guide such practices.

## CORE TENETS AND GUIDING PRINCIPLES

ATSA has evolved key tenets and guiding principles for clinical service provision with men who have committed sexually abusive behaviors. Members are expected to adhere to the following core tenets and guiding principles in their practice:

I. Reducing, managing, and preventing sexually abusive behaviors is a complex public health issue that requires a multifaceted, multidisciplinary, and collaborative approach.

A. Risk management, risk reduction, and prevention efforts can be enhanced by working collaboratively. Building working relationships with relevant stakeholders can enhance clinical practice, provide benefit to the client, and enhance community safety.

B. It is important to consider relevant stakeholders who can support clinical practice, risk management, risk reduction and prevention and, as appropriate, collaborate with these stakeholders. These collaborations may include representatives from criminal justice (e.g., correctional staff, probation and parole officers, halfway homes, law enforcement, prosecutors); mental health (e.g., psychologists, psychiatrists, therapists, clinical counselors, hospitals, mental health programs, and support groups); child protection professionals; mental health professionals, case managers or advocates providing services to individuals who have experienced the effects of sexually abusive behaviors; as well as with the client's support network (e.g., family members, faith-based supports, volunteer programs, employer), and any other relevant stakeholder.

II. The presenting issue bringing members in contact with clients is their sexually abusive behaviors. These behaviors and their precursors must be a central component of any assessment, treatment, risk management or risk reduction process. Notwithstanding, sexually abusive behaviors are complex and must be understood and addressed within the larger context of considering and conceptualizing the client in a holistic and multidimensional manner. Assessment, treatment planning and interventions, risk management and risk reduction plans, and research projects and protocols need to consider the client as more than their sexually abusive behaviors and orient to the client in a holistic manner.

III. Community safety and the rights and interests of individuals who have experienced the effects of sexually abusive behaviors and their families are paramount considerations when developing and implementing assessment, treatment, risk management, risk reduction and other strategies designed to reduce the risk posed by men who have committed sexually abusive behaviors.

IV. Resource utilization and outcomes for communities, individuals who have experienced the effects of sexually abusive behaviors and their families, and at-risk clients and their families are enhanced when policies and practices are grounded in empirical research.

- Research-informed practice guidelines are an important mechanism for promoting quality and consistency in delivering best practice services.
- Expanding the knowledge base of the field through empirical investigation, theoretical development, and clinical initiatives strengthens professionals' ability to effectively practice from an evidence-based foundation.
- Providing empirically informed assessment, treatment, risk management and risk reduction services to men who have committed sexually abusive behaviors increases their ability to live adaptive, non-abusive/offending lives, with the goal of making communities safer.
- Effectiveness of interventions is contingent on the fidelity of implementation. This is supported through knowledge and skills-based training, ongoing clinical supervision, and quality assurance protocols (e.g., program evaluation, fidelity, and adherence checks).

V. Providing meaningful treatment to optimally support risk management and risk reduction and desistance is not typically achieved by offering clients a strictly or primarily psycho-educational intervention, such as having them independently complete self-guided workbooks or complete a series of program tasks based on readings, or purely psychoeducational groups. Meaningful intervention requires discussing, processing, and working toward the development and integration of insight into one's sexually abusive behaviors and learning and practicing the skills required for healthy coping and risk management and reduction. Therefore, treatment providers must strive to develop and maintain strong therapeutic relationships with clients and build cohesion among clients in group therapy to facilitate these processes.

VI. Although external motivators often provide necessary catalysts to promote participation in and compliance with interventions designed to address sexually abusive behaviors with many non-voluntary clients, working toward developing internal motivation and personal commitment to and engagement in treatment is optimal for facilitating risk reduction and long-term change.

VII. Clinical practitioners and other professionals play an important role in collaborating with researchers to support empirical examinations of current assessment, treatment, risk management, and risk reduction practices with individuals who have committed sexually abusive behaviors and to identify areas that warrant additional research to inform future practices.

   A. Clinical practitioners can play an important role in conducting research and are encouraged to integrate this into their practice (e.g., research projects related to their client population, topics of interest, program/practice evaluations).
   B. Clinical practitioners can play an important role by collaborating with researchers to assist and support knowledge development in the field.

VIII. Applying expertise beyond providing direct client services and contributing to primary prevention initiatives. This could include becoming involved in the development of public health policies, community engagement and public education, and early intervention and sexual health initiatives, all of which attempt to prevent the development of sexually abusive behaviors.

## EMPIRICAL FRAMEWORK

The general clinical literature on best practices in assessment and treatment, and the more specific literature on conducting evaluations and providing treatment for justice-involved individuals are important to consider and are applicable in clinical work with men who have committed sexually abusive behaviors. There are however some unique aspects to clinical practice with this population. The *Best Practice Guidelines for Men* identifies these issues and provides guidance and direction regarding specific considerations when working with this client group.

Empirical findings in the research literature have identified that treatment for criminal justice-involved populations is most effective when it is delivered in accordance with the Risk-Need-Responsivity model (RNR). Given the efficacy of this model and its applicability for men who have committed sexually abusive behaviors, the principles of RNR are prevalent in the *Best Practice Guidelines for Men*. Key features of the model are:

**Risk Principle** — Guides *who* to target for intervention based on the likelihood of recidivism.

Higher intensity and dosage of treatment services should be delivered to individuals presenting with multiple criminogenic needs (some of which are severe, chronic, or entrenched) and who are at higher risk of engaging in sexually abusive behaviors. Individuals with no or few criminogenic needs (that are mild or transitory) and are at lower risk of engaging in future sexually abusive behaviors should receive a lower-level intervention or an alternative to treatment specifically focused on sexually abusive behaviors. Providing an inappropriate intensity of services can negatively influence the effective allocation of resources, may result in interventions that are not optimal for treatment effectiveness and outcome and may be harmful.

**Need Principle** — Guides *what* areas should be identified and targeted for intervention and supervision.

Assessment, treatment, and supervision should identify, target, and manage empirically supported dynamic or psychologically meaningful vulnerability and risk factors that are linked to recidivism (i.e., criminogenic needs such as pro-criminal attitudes, offense-related sexual interests, sexual preoccupations, negative social influences, lifestyle impulsivity, problems with intimacy, resistance to supervision) over factors not empirically linked to recidivism.

**Responsivity Principle** — Guides *how* interventions should be delivered.

Clinically delivered assessment and treatment processes as well as risk management and risk reduction strategies implemented through supervision should be delivered in a manner that optimizes the client's ability to engage, respond, learn, and benefit from their participation. The *general responsivity principles* dictate that intervention models with empirical support for promoting behavioral change and demonstrating efficacy in reducing sexual recidivism should be utilized and prioritized. Cognitive-behavioral, social learning, and skills-oriented methods to facilitate behavior change have been found to be most effective across client characteristics. Attending to general responsivity factors also includes attending to developing and maintaining a strong therapeutic alliance with attention to implementing research-supported therapist characteristics such as respectfulness, directiveness, warmth, openness, and empathy. The use of models that are unstructured and primarily insight oriented

without a skill-based approach have not been found to be effective in reducing sexual recidivism. The *specific responsivity principle* advises that assessment, treatment, and supervision should also be delivered in a manner that appropriately considers individual factors that can increase the potential for the client to benefit from the provided services. This can include client characteristics such as level of intellectual functioning, learning style, personality characteristics, culture, mental and physical abilities or disabilities, and motivation level. Services also build upon client strengths, which may include motivation, lifestyle stability, and prosocial support systems.

## STRUCTURE OF THE DOCUMENT

The *Best Practice Guidelines for Men* is divided into four main sections:

**A. General Guidelines**
**B. Assessment**
**C. Treatment**
**D. Risk Management and Risk Reduction in the Community**

Each section begins with a framing of the topic area followed by subsections identifying specific guidelines for various practice areas related to that topic. The guidelines are numbered consecutively throughout the document for ease of reference.

# A

## GENERAL GUIDELINES

**1 Members provide and support ethically sound and empirically informed assessment, treatment, and supervision to their clients in a manner that facilitates appropriate client care, successful outcomes, sensitivity to the needs and interests of individuals who have experienced the effects of sexually abusive behaviors and the community, and that maintains the integrity of the field. Members should:**

1.01 Commit to reviewing and understanding the ATSA *Best Practice Guidelines for Men*.

1.02 Commit to adhering to the ATSA *Best Practice Guidelines for Men* in all circumstances where it is feasible to do so.

1.03 Adhere to the ethical standards detailed in the ATSA *Professional Code of Ethics* and other applicable ethical standards and guidelines for their respective professions.

1.04 Demonstrate transparent decision making and practices that align with the ATSA *Best Practice Guidelines for Men* and the *Professional Code of Ethics* when providing assessment, treatment, risk management and risk reduction services.

1.05 Have appropriate education, training, and, as required, clinical supervision for providing clinical services.

1.06 Engage with clients in a professional and respectful manner. Members should:

- Interact with clients and their families in a professional and respectful manner, provide support, encourage accountability, offer supportive challenges, and set appropriate boundaries in a therapeutic manner;

- Attend to building a therapeutic alliance to facilitate client engagement and optimize the treatment, risk management, and risk reduction process. This is achieved by adhering to empirically supported styles of therapeutic engagement (e.g., empathy, warmth, the provision of rewards for progress, flexibility, and some degree of guidance); and

1.07 Engage with collateral contacts and other stakeholders in a professional and respectful manner. Members should:

- Strive to understand the role and responsibilities of the various professionals involved in the client's life and case management. Members recognize differing requirements and obligations of the various professionals involved in a case and work to problem-solve any challenges or conflicting positions in a positive manner to benefit client and community safety.

1.08 Remain informed about current research and practice literature and the associated implications for assessment, treatment, risk management and risk reduction strategies.

1.09 Work collaboratively with academics and researchers and contribute data if approached by researchers and if feasible, conduct their own research.

1.10 Strive to raise awareness among other stakeholders about the *Best Practice Guidelines for Men* as a means of advancing the vision and mission of ATSA.

1.11 Attend to appropriate self-care to facilitate resiliency and to avoid or manage conditions that could interfere with the ability to provide appropriate, effective and ethical care. Members who are responsible for the program management or supervision of staff should also attend to supporting self-care initiatives for staff. Members should:

- Evaluate how factors such as personal experiences, needs and circumstance as well as external pressures might influence decision making. These identified factors should be

appropriately addressed to enhance the effectiveness of one's clinical, case management, or supervision work and to ensure services benefit and do not harm others.

- Engage in behaviors that serve to maintain and promote physical and emotional wellbeing.
- Understand that self-care and wellness activities should be a proactive and continuous processes, rather than reactive interventions occurring only in response to a critical incident having occurred or after professional integrity and competence have been compromised.

# B

# ASSESSMENT

Members conduct a range of assessments to assist clients and other involved stakeholders in understanding the pertinent issues related to a client's behaviors of concern and offer clinical impressions and recommendations based on the nature and context of the assessment. Assessments promote informed decision making related to treatment, case management, risk management, risk reduction, and legal decision making. Assessments may be requested and conducted for a range of purposes. Examples include:

- Legal decision making (e.g., sentencing, identification of conditions);
- Identifying mental health issues (e.g., diagnostic formulations);
- Treatment planning and recommendations;
- Treatment progress;
- Release decision making (e.g., from a correctional institution, mental health center, or hospital); and
- Case management, risk management and risk reduction planning (e.g., institutional placement, release planning, supervision intensity and focus, and community risk management and risk reduction interventions such as notification, registration, child protection, protection actions).

Assessments are most reliable and beneficial for guiding decision making, maximizing public safety, and promoting successful client interventions and outcomes when evaluators:

- Adhere to ethical practices;
- Use current empirically informed and research-supported methodologies; and
- Strive to engage clients in the assessment process.

Assessments should be based on the most current information and data available. Historical assessments can offer important background information; however, findings and recommendations can be time limited. Key issues related to client circumstances, need areas, and risk factors change over time. Assessments must be considered snapshots and client re-evaluation should occur as needed to provide current information to assist with the decision-making needs at that time.

# Overarching Assessment Guidelines

Assessments come in various forms including intake reports, screenings, comprehensive psychosocial and psychosexual evaluations, diagnostic assessments, risk assessments, and treatment progress and closure reports. Each of these reports has specific and, at times, different objectives. Notwithstanding, the following overarching assessment guidelines apply to all forms of assessment:

## 2 **Members conduct objective, impartial, and reliable assessments that support well-informed decision making and maintain the credibility and integrity of the profession. In this regard members should:**

2.01 Conduct assessments in accordance with relevant standards of practice. This includes:

- ATSA *Professional Code of Ethics*[5]
- Ethical standards, codes, laws, or other expectations for each member's respective profession and/or discipline of practice
- Jurisdictional standards, codes, laws, or other expectations of practice and
- Specialty practice standards and guidelines for assessment (e.g., forensic practice, sexual abuse, and trauma)

Particular attention should be given to ethical standards pertaining to:

- Informed consent;
- Specialized training, knowledge, expertise, and scope of practice
- Documentation and retention of records;
- Current research;
- Confidentiality;

5 The ATSA *Professional Code of Ethics* is provided to members, and all members agree to adhere to such standards. The ATSA *Professional Code of Ethics* is publicly accessible at www.atsa.com.

- Mandatory reporting requirements;
- Professional relationships; and
- Professional and respectful conduct

2.02 Interact with clients and stakeholders who are part of the assessment referral (e.g., lawyers, probation or parole officers, correctional staff, mental health, or child protection workers) and assessment process (e.g., collateral interviews) in a respectful and professional manner.

2.03 Ensure the client is clearly aware of who the referring agency is (e.g., corrections, the court, or child protection) if they are not self-referred, as well as the implications of being referred for assessment by a third party.

2.04 Consider, identify, and disclose any conflict of interest or potential conflict of interest.

- Seek consultation or supervision to determine whether a conflict of interest or potential conflict of interest negates or compromises providing services to the client.
- If it is determined that a conflict or potential conflict would not negate or compromise providing services for a client, the conflict should be disclosed to the client, the referring agency, and any relevant stakeholders, and should be noted in the assessment report.
- If an identified conflict has the potential to interfere with the ability to provide an objective, fair, and impartial assessment, the client should be referred to another clinician or agency.
- If an identified conflict has the potential to undermine or compromise the assessment process and findings, or the perception of the process and findings, the client should be referred to another clinician or agency.

2.05 Identify and attend to dual and conflicting roles when present. Members should:

- Seek consultation or supervision to determine whether having dual or conflicting roles could negate or compromise providing services to the client.
- If it is determined that dual or conflicting roles would not negate or compromise providing services for a client, the dual or conflicting roles should be disclosed and discussed with the client, the referring agency, any other relevant stakeholders, and should be noted in the report.
- If an identified dual or conflicting role has the potential to interfere with the ability to provide an objective, fair, and impartial assessment, the client should be referred to another clinician or agency.
- If an identified dual or conflicting role has the potential to undermine or compromise the assessment process and findings, or the perception of the process and findings, the client should be referred to another clinician or agency.

2.06 Recognize and identify their areas of competency. If a referred client presents with characteristics or issues beyond one's experience and expertise, or the assessment question or requirements of the evaluation are outside a member's training and experience, the member should seek consultation or supervision to determine whether they can provide the service. If so, it should be determined whether they are expected to seek consultation, supervision, and training or professional development opportunities. If not, the client should be referred to another clinician or agency.

2.07 Consider and acknowledge any personal biases or assumptions they may have based on age, ethnocultural diversity, sexual orientation, gender identity, socioeconomic difference, education, language, intellectual functioning, and mental or physical disability. As required, members should seek consultation or supervision to address any such issues to prevent these from influencing the assessment process and outcome. If the member recognizes their beliefs might influence the assessment process or outcome, they should refer the client to another clinician or agency.

2.08 Recognize the heterogeneity of the population of men who have committed sexually abusive behaviors. In conducting assessments, members should give specific attention to identifying and considering diversity and responsivity factors. Diversity and responsivity factors should be considered in strategizing how to conduct the assessment (e.g., interviewer style of engagement, appropriate use of testing and risk assessment tools) and should be identified and discussed in the report (e.g., what they are and how they may have influenced the assessment process). Diversity and responsivity factors should also be considered in the report's conclusions and recommendations. Members should seek consultation or supervision as required to ensure that diversity and responsivity factors are properly considered in assessments.

2.09 Consider the client's current legal status (e.g., no legal status, pre-adjudication, pre-trial psychiatric hold, pre-sentencing, civil commitment referral, parole hearing, revocation) and the ways in which that status may influence the nature or scope of the assessment.

2.10 Be aware of and clearly inform clients about mandatory reporting and the limits of confidentiality prior to the commencement of an assessment or the onset of a treatment process that may result in the preparation of a report. Members should:

- Ensure the client is aware of the mandatory reporting requirements of their jurisdiction and professional discipline and identify disclosures that would be subject to mandatory reporting (e.g., disclosure of a child who has been abused or children at risk, concern about client self-harm, threats indicative of imminent risk to harm a specified person).
- Ensure the client is aware of the limits of confidentiality and understands that the information gathered (e.g., from clinical interviews, individual or group therapy sessions, psychological testing, risk assessment, collateral interviews) during the assessment or during treatment can be used and included in a report.

2.11 Recognize the potential for clients to disclose previously unreported sexually abusive behaviors and other antisocial or criminal conduct (despite being cautioned about mandatory reporting and limits of confidentiality) and understand and be prepared to manage this appropriately if it occurs. Members should:

- Be aware of the types of disclosures that are reportable and those that are not. This includes but extends beyond disclosures that are legally reportable and may include behaviors deemed reportable in various settings (e.g., in a correctional or mental health center, on campuses, at a place of employment).
- Clarify with clients the types of disclosures that require mandatory reporting in their jurisdiction and profession and the limits of confidentiality in relation to information shared.
- Guide clients on how to share information that can facilitate gathering data to enhance the accuracy and usefulness of the assessment in a manner that does not place clients at risk of self-incrimination.
- Consider if it is necessary and beneficial to report previously undisclosed information shared by the client that does not meet mandatory reporting requirements. If sharing such information is determined to be important in addressing the assessment questions, consider how to report this information in a manner that balances providing meaningful assessment data with client privacy and being mindful of self-incrimination concerns. This consideration should occur even when there are identified limits in confidentiality.
- Be aware of the need to seek consultation or supervision if unclear about mandatory reporting requirements, what disclosures require and do not require reporting, the boundaries that should set with clients related to the limits of confidentiality, and what or how to share certain information in a report.

2.12 Determine whether an updated report is required. Historical reports can offer useful background information; however, it is critical that members provide current and relevant information detailing change over time and up to date information specific to a client's present-day functioning, current clinical issues, and updated estimations of risk and identification of risk factors when a report is used to inform legal and case management decisions.

2.13 Gather information from multiple sources (e.g., existing case background information, clinical interviews, testing, risk assessment tools, and collateral interviews).

2.14 Use assessment tools that are appropriate and relevant to the focus of the evaluation and are empirically validated. Any tools used and reported should be administered in a manner consistent with the protocols, requirements, and best practice information specific to the use of that tool. Members should have the requisite training for any tool or protocol used as part of conducting an assessment. Limitations of the data arising from the use of tools in an assessment should be identified in the report. If assessment tools applied and reported on are not standardized measures or have not been standardized for the population to which the individual being assessed belongs, this should be identified, the rationale for using the tool should be described, and appropriate descriptions of the limitations and cautions related to the data from such measures highlighted. *For further guidelines on the use of risk assessment tools, see subsection 6.03 on Testing.*

2.15 Use research-informed risk assessment tools that include static and dynamic risk factors specific to men who have committed sexually abusive behaviors. The use of risk estimation tools enables members to obtain a more accurate understanding of the relevant risk factors, level or categorization of risk, probability of recidivism, and intervention needs. Tools should be used in a manner consistent with the protocols, requirements, and best practice information specific to that tool. Members should have the requisite training for any tool or protocol used as part of conducting a risk assessment. For further guidelines on the use of risk assessment tools see subsection 6.04 on Estimation of Risk Tools.

2.16 Use language in reports that is understandable to the consumers of the assessment (e.g., clients, legal representatives, judges, correctional staff, probation and parole officers, child protection representatives).

2.17 Avoid the use of terminology/jargon that would not be readily understood by the client and non-mental health professionals who are receiving and/or will be using the report in case planning and decision making.

2.18 Use language in reports that is professional and that does not include unnecessary pejorative labels.

2.19 Consider client needs along with community safety when making recommendations in assessments. This includes considering client responsivity factors, risk factors and vulnerability areas, strengths and capacities, and recommendations that are realistic, achievable, and relevant to the client.

2.20 Take reasonable steps to clearly articulate the specific rationale for all conclusions and recommendations provided in a report.

## 3 Members ensure they have a clear understanding of the purpose of a requested assessment, the key questions of interest and determine when an assessment request is appropriate or inappropriate. Members should:

3.01 Conduct assessments of men who have committed sexually abusive behaviors primarily for the following purposes:

- Understanding the nature, context, and extent of a client's sexually abusive behavior;
- Identifying specific responsivity factors;
- Identifying offense precursors, risk factors, and vulnerability areas;
- Identifying client strengths and risk moderating factors;

- Assessing the level or category of risk and probability of recidivism;
- Exploring needs that should be the focus of treatment and other interventions;
- Obtaining baseline information to gauge risk reduction progress and changes;
- Contributing to criminal justice, mental health, and child protection decision making and planning.

3.02 Recognize that assessments of men who have committed sexually abusive behaviors are not designed for and should not be conducted for the following purposes:

- Addressing or alluding to a client's guilt or innocence.
- Substantiating or refuting allegations that are the focus of a criminal, civil, child custody, or other investigation;
- Exploring the veracity or motivations of an allegation or complainants' statements;
- Directing law enforcement, prosecutorial, or charging determinations;
- Suggesting the existence of a predetermined profile of an individual who might commit a sexual crime against which an individual can be compared.

3.03 Members take steps to educate, promote, and collaborate with other stakeholders (e.g., lawyers, correctional staff, probation and parole officers, mental health professionals, child protection workers, the public) to inform them about the appropriate purposes and effective use of assessment data, the benefits of assessment data to inform case, risk management and risk reduction decisions, and the limitations and potential misuses of assessments.



## 4 Members ensure a client is providing informed consent to participate in an assessment, understands the voluntary nature of their participation and the implications of refusing to participate. Members should:

4.01 Ensure the client, and if required, also the client's legal guardian or legal decision maker, are provided with information to allow the opportunity to make an informed decision about participating in the assessment process and to decline participation if they so choose. This should occur even in instances when a report is ordered by the court and will be produced regardless of the provision of informed consent. Information provided should include identifying, discussing, and responding to questions about the:

- Nature and purposes of the assessment;
- Assessment components and process;
- Potential benefits, risks, and limitations of the assessment procedures;
- Potential benefits and impact of participating in or declining to participate;
- Specific limits on confidentiality. This includes identifying what information will be included in the report, who will and who might (with their consent) receive the report and have access to the information contained in it, and the circumstances under which information may otherwise be released;
- Mandatory reporting requirements; and
- Responses to questions posed by the client regarding the assessment process.

The process for establishing informed consent and any related issues should be documented in the report.

4.02 Ensure clients understand an assessment may still proceed without their consent when applicable, based on the nature of the assessment. In cases where a client is considering refusing to participate or refuses to participate, members should attempt to inform them of the potential implications of their refusal. This should be recorded in the report.

4.03 Determine a client's capacity to effectively participate in an

assessment. If a client referred for assessment is presenting with acute mental health concerns or problematic acting out behaviors that will interfere with their ability to meaningfully participate in an assessment process, the client should be referred to a mental health professional to provide appropriate intervention to stabilize the client prior to initiating an assessment. If there is a need to proceed with an assessment under these conditions, the presence and impact of the presenting concerns on the assessment process and the report's conclusions and recommendations should be identified in the assessment.

**5. Comprehensive assessments of sexually abusive behaviors are empirically informed and have a specific focus on assessing a client's sexual development and history, paraphilic interests, inappropriate and criminal sexual behaviors, and risk of sexual recidivism. These assessments are used in various stages of criminal justice system processes, by child protection and family court, and in mental health systems. They inform about a client's problematic sexual interests or arousal, sexually abusive behaviors, treatment amenability, treatment needs, treatment progress, risk management, and risk reduction needs, and healthy living plans to support future case management, child protection, treatment, risk management, and risk reduction needs. Comprehensive assessments may play a significant role in decision making that can have profound implications for a client's future, and as such, members must conduct these evaluations with a high level of integrity and in an empirically informed manner. Members recognize that conducting comprehensive assessments provides a critical opportunity to assess and provide information to decision makers and the client on key issues such as:**

- A clinical and contextual conceptualization to assist in understanding the client's inappropriate or sexually abusive behavior;
- Relevant issues related to the client's sexual history and sexual interests, arousal, and preferences;
- Risk factors, vulnerability areas, strengths, and risk moderating factors;

- Level or categorization of risk for future sexual acting out/ recidivism;
- Compliance and engagement (e.g., with court-ordered conditions, institutional rules, participation in programs and treatment);
- Treatment amenability, responsivity factors, and intervention needs; and
- Recommendations related to treatment and case and risk management and risk reduction.

Assessments also offer the opportunity to:

- Engage the client in the assessment process and commence the process of insight development and motivation for treatment engagement;
- Provide a baseline to consider at the time of future evaluations; and
- Offer reliable data to inform decision making.

5.01 Members rely on multiple sources of information when conducting a comprehensive assessment. These information sources should ideally include:

- Thorough review of available background information (e.g., police reports, complainant statements, pre-sentence reports, correctional and criminal justice reports, social services investigations, previous mental health assessments, treatment reports);
- Client interviews;
- Empirically grounded general psychometric testing (e.g., designed to assess intellectual functioning, personality characteristics, psychopathology) and self-report test instruments (e.g., designed to measure issues such as cognitions and attitudes, sexual behaviors and interests, coping styles);

- Administration of empirically grounded, objective psychophysiological measures to evaluate patterns of sexual interests, arousal, and preferences as deemed clinically appropriate, and necessary;
- Empirically grounded strategies to estimate the risk of a client continuing to engage in problematic sexual or non-sexual behaviors; and
- As applicable, collateral interviews (e.g., with family members, intimate partners and spouses, key community supports, mental health staff, correctional professionals, all with knowledge of the client).

5.02 Comprehensive assessments should identify, document, and explain the implications of specific responsivity factors, including:

- Age;
- Ethnocultural heritage;
- Language or communication barriers;
- Sexual orientations or gender identity;
- Physical disability;
- Literacy;
- Mental health diagnosis or symptoms;
- Neuropsychological, cognitive, and learning impairments;
- Adverse childhood experiences;
- Level of adaptive functioning;
- Denial;
- Level of motivation (e.g., in assessment participation and orientation towards treatment participation and change); and
- Strengths.

5.03 A comprehensive assessment of a client who has committed sexually abusive behaviors should be grounded in the evaluation of the client's sexual history, interests, and behaviors in the larger context of their life experiences and personality. A comprehensive assessment should include a range of client background information relevant to the nature of the referral and referral question. This may include:

- Developmental history (e.g., family of origin, family dynamics, trauma history that includes exposure to or experience with all forms of maltreatment and abuse);
- Medical history (e.g., history of physical injury trauma, current health, medication history);
- Mental health history regarding client and family (e.g., past contacts with mental health professionals, existing diagnoses, medication history, symptoms of past or pre-existing major mental health, personality, or personal functioning impairments);
- Current mental status;
- Intelligence and cognitive functioning;
- Past treatment and program history;
- Education and employment history;
- Relationship history (i.e., nature and quality of past and current relationships with family, peers, intimate partners);
- Substance use and abuse history;
- Criminal conduct and history (e.g., juvenile, youth, and adult acting out, antisocial, and criminal behaviors - reported and unreported; history of criminal charges, convictions, and sentences; for all criminal offenses, and specific attention to sexual and non-sexual violence).
- Prior history of response to supervision and outcome of prior supervision orders.

5.04 A comprehensive assessment of sexually abusive behaviors focuses specifically on gathering and reporting information about a client's sexual history; sexual interests and arousal; and their evolution into and engagement in sexually abusive behaviors. This should include:

- Psychosexual development:

  -Premature awareness of sex;

  -Early exposure to the sexual activity of others;

  -Early exposure to sexually explicit images and pornography;

  -Early experiences of physical experimentation, recognizing when this behavior is childhood sexual experimentation that is motivated by curiosity without knowledge of sexual connotations or intent;

  -Experiences of childhood, adolescent, and adult sexual abuse, including being exposed or subjected to inappropriate sexual boundaries or sexually abusive behaviors;

  -Commencement of sexual fantasies, use of sexual imagery, and masturbation;

  -Early instances of acting out inappropriate boundaries, problematic physical exploration, and problematic sexual behaviors and;

  -Factors contributing to and the needs attempting to be met by early instances of acting out inappropriate boundaries, problematic physical exploration, and problematic sexual behaviors.

- History of age-appropriate, consensual sexual relationships;
- Nature and frequency of sexual practices (e.g., masturbation, appropriate and consenting sexual behaviors, unconventional or risky sexual activities);
- Nature and frequency of non-criminal paraphilic interests, fantasies, and behaviors (e.g., fetishes, voyeurism, exhibitionism, masochism);

- History of using stimuli for sexual stimulation, the type of content accessed and the means of accessing content (e.g., magazines, television, movies, Internet, gaming systems, other technology);
- History of using sexually oriented services or outlets (e.g., online sexual chat groups, forums, webcam use; massage parlors; exotic dance clubs; sex trade workers);
- Factors contributing to and the needs attempting to be met by specific problematic sexual stimuli sought out and behaviors engaged in.
- Sexual fantasies, interests, arousal, and preferences:

    -Preferred or prominent sexual interests;

    -Preferred or prominent fantasy content;

    -Paraphilic sexual interests and fantasy content;

    -Abusive or offense-related sexual interests and fantasy content;

    -Themes evident in and needs being met by sexual fantasy content; and

    -Use of sexual fantasy and masturbation to sexual fantasy as a style of coping.
- History of inappropriate sexual boundaries, problematic sexual behaviors, and sexually abusive behaviors. This includes both officially documented and unreported information (if identified through credible records or sources including self-report);
- Information about current and previous victims (e.g., age, gender, relationship to client);
- The nature and dynamics of the sexually abusive behaviors (e.g., motivators, triggers, offense precursors, patterns);
- The client's account of their sexually abusive behaviors:

    -Ability and willingness to disclose and discuss these behaviors (e.g., level of self-disclosure, presence of denial, or minimizations);

-Perceptions of these behaviors and the presence of cognitive distortions related to their behavior or their victim's behavior (e.g., rationalizations, justifications, projections of responsibility, distorted perceptions);

- Attitudes and cognitions supportive of sexually abusive behaviors;
- Level of insight into their sexually abusive behaviors (e.g., the degree to which they understand the needs they were attempting to meet by their behaviors, motivations or intent, factors that allowed them to engage in and maintain their behaviors);
- Recognition and appreciation of the impact and harm caused by their sexually abusive behaviors; and
- Awareness of the changes and coping strategies they would need to work on and use to manage their vulnerability areas and risk factors to support healthy coping and risk management and reduction.

In reporting on a client's sexual history, sexual interests and arousal; and evolution into and engagement in sexually abusive behaviors, it is important to consider what details are appropriate and necessary to include in a report and to not include extraneous information and explicit or graphic details that are not necessary to respond to the referral questions of interest.

5.05 Comprehensive assessment should explore and identify a client's strengths, competencies, and capacities, and identify protective factors. These may include:

- Motivation to change, engagement in the change process, and demonstration of change;
- Insight development into their sexually abusive behaviors;
- The presence of generalized empathy such as demonstrating appropriate emotional responses related to the impact their behavior has on others;

- Implementing strategies to address and manage offense precursors, vulnerability, and risk factors;
- Stability factors (e.g., housing, financial, employment, relationships);
- Compliance (e.g., adherence to institutional rules, supervision and conditions, treatment, and medication if relevant);
- Healthy and age-appropriate relationships (e.g., family, friends, intimate partner);
- Consenting and age-appropriate sexual relationships;
- Prosocial community supports and influences (e.g., family, friends, professional supports, treatment peer supports, volunteer supports, faith-based supports);
- Appropriate emotional regulation skills;
- Healthy approach oriented coping skills; and
- Avoiding unhealthy and potentially risky circumstances and behaviors (e.g., access to potential victims, distance from substance abuse, problematic relationships).

## Assessment Components

6 **Comprehensive assessments should involve multiple assessment modalities for gathering data to support developing a clinical conceptualization of a case and enable members to provide information that will be reliable and helpful in case management and decision making. The following guidelines outline central assessment modalities:**

### BACKGROUND INFORMATION FILE REVIEW

6.01 Members ensure they gather appropriate background information to assist and support the assessment process. At the time of referral, comprehensive background information may or may not

be provided. If it is not provided or key documents are identified as missing, efforts should be made to access this information from the client or agency of referral. Required background documentation may also be secured by directly contacting the source. This requires the client to provide signed consent authorizing the release of the documents to the assessor. Documentation reviewed and considered as part of conducting an assessment should be identified in the report. If identified and requested background information cannot be accessed, this should also be identified in the report.

Information from historical documents reviewed, referred to, or integrated into the writing of a report should be contextualized. The historical nature of this information should be identified, and information referred to should be discussed in terms of how it remains or no longer remains relevant based on current information gathered for the assessment.

Client Interview Process

6.02 Clinical interviews tend to be a cornerstone of the assessment process and should be conducted in a manner that optimizes client engagement. In conducting clinical interviews, members should:

- Gather information in a manner that can facilitate the development of a clinical conceptualization that will assist the client and support decision makers.
- Interact with clients in ways designed to promote engagement, decrease resistance, and foster internal motivation throughout the assessment process.
- Recognize that a client's presentation in the interview may be associated with having to participate in an assessment. Their style of presentation can be affected by the demand characteristics of the task (e.g., wanting to present themselves well to obtain a good assessment and to mitigate negative consequences) and the emotions evoked by participating in an assessment process (e.g., anxiety, fear, distress, anger, shame). Efforts should be made to understand the factors contributing to a client's presentation during clinical interviews and to focus

on engaging the client. This could mean helping them feel comfortable and safe in the interviews and supporting them to work through a defensive, resistant, or agitated and hostile presentation.

- Explore and incorporate the client's own perspectives, interests, and goals.
- Use communication methods that consider specific responsivity factors.
- Consider how responsivity factors may influence a client's presentation during an interview and be cautious not to misinterpret observations (e.g., not identifying an individual avoiding eye contact due to their ethnocultural background as being unengaged, avoidant, or resistant; not attributing the presentation of a client with PTSD and a history of defensive avoidance as being resistant if they are guarded and defended).
- Take steps to ensure appropriate communication can occur when there is an issue with language fluency. If members are unable to communicate fluently with a client, they may refer the client to another qualified professional who is able to communicate fluently with that client. A professional interpreter may be used with the client's permission, provided that confidentiality agreements are in place and steps are taken to brief the interpreter on the interview content and objectives, clarify the importance of direct translation, and offer to debrief the interpreter following the clinical interviews based on the nature of the subject matter. Members should note within their assessment report if an interpreter is used and what steps were taken to maintain the integrity of the clinical interview.

Testing

6.03 Members may utilize psychometric measures, self-report instruments, and—as appropriate based on training and profession—psychological tests, to gather further data to assess the client's personal functioning and needs. Testing selected should be relevant for addressing the specific assessment questions and goals, used in a manner consistent with their design, and be appropriate for the client being assessed. In administering testing members should:

- Use only those tests for which they are qualified and trained to administer.
- Be familiar with the psychometric properties of the measures to be used, including reliability, validity, and normative data. Empirically supported and well-accepted instruments should be favored.
- Select the most appropriate tests based on the client's age, gender, ethnocultural background, language, developmental and intellectual functioning, and other unique characteristics. When testing specific client populations, members should have the requisite training and expertise to administer and interpret testing with the client being assessed. Members should note in the report any limitations or biases related to using tests that were not developed to consider a particular client type (e.g., age, ethnocultural background, socioeconomic status, education, language, level of intellectual functioning).
- Follow the identified administration protocols for the test measures used.
- Identify any limitations or cautions that may be applicable related to any test measures used or findings discussed.
- Use recent test data. If historical test data are being considered, members should determine whether it is still valid and reliable information, identify the historical nature of any past test data reported, and discuss any limitations.

Estimation of Risk Tools

6.04 Comprehensive assessments should involve the inclusion of tools that estimate a client's level or category of risk for sexual recidivism and may offer probabilities for sexual recidivism over time. Risk may also be assessed for violent non-sexual recidivism and general recidivism. Risk assessments may be conducted and reported as part of a stand-alone risk assessment report that incorporates some, but not necessarily all, components of a comprehensive assessment.

The reported results of a risk assessment for sexual recidivism can have significant implications for the client. They are considered with weight and seriousness by associated stakeholders and decision makers (e.g., lawyers, judges, correctional case managers, parole and review board members, probation and parole officers, child protection workers). The results of risk assessments may have significant implications for a client's civil liberties and for community safety. Accordingly, members should recognize the critical need to ensure reliable and valid findings. In using and reporting risk estimation tools for sexual recidivism in reports (e.g., a comprehensive assessment or a risk assessment), members should:

- Clarify the specific purpose of conducting a risk assessment for a given client and how such information will be used and articulate this in communications regarding the findings.
- Be well-versed in current research regarding static and dynamic factors linked to sexual recidivism. These factors fall into the following categories:

  -Criminal history (e.g., prior arrests, convictions);

  -Variables related to the victim (e.g., stranger, non-related, young male);

  -Non-consensual sexual interests (e.g., offense-related sexual interests, arousal, and preferences, sexual preoccupation);

  -Antisocial orientation (e.g., criminal attitudes, values, and behaviors; lifestyle instability);

  -Intimacy and relationship difficulties (e.g., problems with intimacy, unstable relationships, conflictual intimate relationships, deficits in social support, restricted social interaction, involvement);

  -Pro-offense attitudes and cognitions (e.g., supportive of sexual contact with children, sexual entitlement, rape myths);

  -Self-regulation difficulties (e.g., hostility, substance abuse, impulsivity, access to victims).

- Use empirically supported instruments and methods (i.e., validated actuarial risk assessment tools and structured, empirically guided risk assessment protocols) rather than unstructured clinical judgment.
- Use the most current and updated form of the risk assessment tools being used.
- Be appropriately trained in scoring, interpreting, effectively and accurately reporting, and applying the findings of the risk assessment instruments and protocols used.
- Be aware of the relative strengths and limitations of the risk assessment measures or methods used and reference these issues when communicating risk assessment findings.
- Receive appropriate training on how bias can result in scoring differences on risk assessments and be informed of empirically-based bias mitigation strategies.
- Ensure statements about the findings remain within the scope and capability of the risk assessment measures or methods used (e.g., refrain from making absolutes about whether a client will or will not recidivate).
- Ensure any communications about a client's risk factors, risk level or categorization, and probability data related to recidivism risk are based on current and reliable assessment data.
- Contextualize the information being provided when reporting risk. It is not sufficient or appropriate to simply provide a risk categorization (e.g., low to high). Members should provide information identifying what these ratings mean (e.g., the test score, how this was achieved, and the relevant risk factors present; the nature of the risk, descriptors of the attributes of individuals with this risk categorization; the normative probability data on recidivism associated with the reported score).
- Understand and clarify that the risk identified by risk assessment tools is based on group normative data and may not be predictive of an individual's risk.

- If reporting normative data related to probabilities of offending, it is important to ensure:

  -The most current normative data are being used and cited.

  -There is clarification that the identified normative data and probabilities of sexual recidivism are derived from group-based data and that the report is focused on the specific individual being assessed. Any important individual factors related to that client and the implication of these for considering group-based normative data should be identified and discussed (e.g., ethnocultural factors, sexual orientations or gender identities, physical disability).

  -There is an indication that the normative data and probabilities are based on data from individuals who have been charged or convicted of a sexual offense, and as such, these data do not reflect the entirety of men who have committed sexually abusive behaviors.

- Recognize the potential for both sexual and non-sexual recidivism when assessing a client and clarify the type of recidivism risk assessed in the report. When assessing risk for general recidivism or violent non-sexual recidivism, members should follow similar protocols regarding appropriate knowledge, training, administration, application, and reporting of risk.

- Appreciate that recidivism risk is not static and may change as a result of the lapse of time since the last risk assessment, participation and progress in treatment, or following significant changes in case dynamics. Therefore, members should identify the need for and conduct updated estimations of risk as required.

Psychophysiological Protocols

6.05 There has long been ongoing discussion about the reliability, validity, clinical utility, and ethics of using psychophysiological procedures, such as phallometry (also known as penile plethysmography or penile tumescence testing), viewing time measures, and polygraph in the assessment and treatment of men who have committed sexually abusive behaviors.

The presence of age-inappropriate and non-consensual sexual arousal has consistently been found to be a significant risk factor for sexual recidivism.

As a result, this is an important assessment consideration. Phallometry may be useful to evaluate a client's sexual arousal response, particularly if a client's sexual offending history or offense dynamics are indicative of a high level of risk and there is concern about sexual arousal as a risk factor and about the reliability of client self-report. In determining if it is necessary and appropriate to use phallometry to evaluate arousal responses it is important to consider when this procedure may have clinical, risk management and risk reduction benefits and when such procedure may cause harm given the ethical considerations related to the intrusiveness of this procedure.

Viewing time procedures remedy the ethical concerns related to the intrusiveness of phallometry and the use of nude child imagery or depictions in some phallometric testing protocols. However, the empirical foundation for these protocols is still limited in the peer-reviewed scientific literature and caution needs to be taken regarding the reliability and validity of viewing time data. It is also important to attend to the distinction that viewing time evaluates sexual interests, in contrast to phallometry which assesses sexual arousal. The empirical literature to date identifies problematic sexual arousal responses versus problematic sexual interests as being a primary risk factor.

Members who choose to use phallometry or viewing time measures as part of their assessment processes are expected to be knowledgeable about these procedures, the empirical literature related to their use for such purposes, and their potential benefits and limitations. Members using these protocols must ensure data from these procedures are used and reported in an ethical, empirically accurate, and responsible manner. Members should:

- Be familiar with the strengths and limitations of phallometry and viewing time measures and note these issues when interpreting and communicating the findings from these instruments.

- Take reasonable steps to obtain assurances that examiners using phallometry and viewing time measures are appropriately trained in the use of such instruments, use accepted methods, and adhere to applicable professional and discipline-specific standards or guidelines.
- Consider and assess the client's willingness and level of motivation to participate in the procedure.
- Consider what might constitute optimal timing of conducting this type of evaluation during the assessment process.
- Obtain specific informed consent from clients prior to using phallometry or viewing time measures.
- In obtaining informed consent, and to proceed in a clinically sensitive and ethical manner, it is important to ensure clients understand the purpose, process, potential impacts and implications associated with the procedure they are being asked to participate in. It is also important they have the opportunity to ask questions and process any concerns they may have. Attending to this can support the maintenance of a therapeutic alliance in the assessment context, enhance client engagement and cooperation with the procedure, and address potential responsivity issues that may impact the testing or the client's experience of the testing (e.g., a trauma history).
- Recognize that the findings from phallometry or viewing time measures should be used in conjunction with other sources of assessment information, not as the single source of data for any assessment.
- Understand that the results of phallometry or viewing time measures are not to be used as the sole criterion for the following:

    -Diagnosis;

    -Estimating the level of risk for recidivism;

    -Admission into treatment;

    -Determining treatment progress;

-Making recommendations for placement in a lower level of security in a correctional institutional or other non-community placement, release to the community from a correctional institutional or other non-community placement, changes in supervision, focus of community supervision and monitoring;

-Determining treatment completion; or

-Drawing conclusions regarding compliance with or violations of conditions of release or community placement.

- Members appropriately limit phallometry to the following purposes:

  -Assessing a client's sexual arousal regarding age and gender;

  -Evaluating a client's arousal responses to various stimuli scenarios and /or sexual stimuli which may include neutral scenarios, consensual sexual stimuli and sexually intrusive, coercive and/or aggressive behaviors;

  -Exploring the potential role of sexual arousal as a contributing factor to the sexually abusive behavior, as a risk factor and as a treatment target; and

  -Monitoring the effectiveness of interventions involving the management and potential modification of offense-related sexual arousal, as well as assessing the experience of age-appropriate and consenting sexual arousal.

- Members appropriately limit the use of viewing time measures to the following purposes:

  -Assessing a client's sexual interests regarding age and gender;

  -Providing information about a client's sexual interests in consensual, sexually intrusive, or aggressive and coercive behaviors.

- The administration of polygraph and reporting of polygraph test results to evaluate and/or verify candor in a clients account of their sexual interests, arousal and offending history is the subject of much debate. Members know that there is a range of research regarding the reliability of the polygraph with this population. There are particular concerns about the use of polygraph as part of a comprehensive risk assessment. Polygraph should not be used in assessments to attempt to determine guilt or innocence or to evaluate risk.

Collateral Interviews

6.06 Members recognize that gathering information from informants with knowledge of the client being assessed can provide additional and helpful information. Collateral information may assist in the development of clinical formulations and case conceptualization, identification of risk factors, estimation of risk, and formulating recommendations for treatment and case planning. An array of individuals may be considered in conducting collateral interviews. Members should determine the appropriateness of potential collateral interview candidates by considering the potential strengths, limitations, and challenges that may be associated with information obtained from a particular collateral source. Potential collateral interview candidates may be identified from the background file review, clinical interviews, or by the client. Collateral interview candidates may include:

- Professionals (e.g., prior or current mental health or treatment providers; legal counsel; prior or current case managers (e.g., corrections case managers, probation, and parole officer).
- Formal support people (e.g., faith-based, and spiritual leaders; volunteer or work supervisors; circles of support and accountability); and
- Family members.

In conducting and reporting collateral interviews, members should:

- Secure specific and appropriate consent from the client to conduct collateral interviews with each identified source.
- Explain the nature, purpose, and goals of the collateral interview to the interviewees;
- Ensure that interviewees are aware of the limits of confidentiality and restrict their comments during the interview to information relevant to the report, and ensure they are prepared to have their comments used in the assessment report. If the interviewee shares information and retracts their consent to share the information, their decision must be respected. The interviewee should be reminded and cautioned about what information they share and the limits of confidentiality.
- Ensure the client's confidentiality when gathering information from collateral sources by not divulging information about the client during these interviews unless the client has provided written consent for the sharing of information.
- Consider and report any identified limitations related to the interviewee (e.g., a collateral interview subject who has not had recent contact with a client, or a family member who may have biased or distorted perceptions).
- Not include the individual(s) who the client has committed sexually abusive behaviors against as collateral interview subjects. It is not appropriate to risk harming that person(s) by asking them to share information as part of an assessment process. Any relevant information of interest should be accessed through other sources (e.g., background information such as police reports and court transcripts). There may be occasions based on the nature of the assessment and the assessment question when it would be appropriate for a parent or a therapist of the individual the client sexually abused to be considered for a collateral interview (e.g., assessments where the individual being assessed has offended against a family member and there are issues to address specific to family dynamics and safety planning).

# Report Writing

7 **How members compile, interpret, and report the data and information gathered during an assessment process in the written report is critical. This document can have significant implications for the client and play an important role in decision making and case planning. In completing written reports, members should:**

- Outline the full range of information sources used to conduct the assessment, note any relevant information sources that were unavailable at the time of the evaluation, and highlight the potential implications of any data limitations in the conclusions and recommendations.
- Use language and provide information in a manner that will be clear and understood by the consumers of the report, be person-first, and not contain unnecessary or pejorative labeling.
- Ensure that factual information and assessment data are addressed separately from the section of the report that addresses inferences and opinions or there is a clear identification and delineation in reporting what is factual information, data and clinical impressions.
- Identify relevant observations, impressions, and interpretations about the client's engagement, presentation, and participation in the assessment process and ensure these are considered in the context of relevant responsivity factors.
- Do not provide clinical opinions on any single source of data. In particular, client self-report should always be considered along with other sources of information (e.g., case background information, testing, professional risk assessment tools, collateral interviews).

- Document areas of convergence or divergence between self-report, file information, collateral information, and other sources of assessment data - including testing, objective behavioral, or psychophysiological measures - and offer clinical conceptualizations and hypotheses for any noted discrepancies.
- Clearly articulate conclusions and recommendations based on supporting evidence documented in the body of the report.
- Identify recommended interventions or services relevant to addressing the client's specific areas of need, risk and vulnerability factors, responsivity factors, and strengths.
- Recommendations should be accessible to the client. If an identified recommendation is or may become unavailable due to limitations of existing resources, it is important to state this, identify why this recommendation is being provided, and offer any information, guidance, or advocacy to support access to services to accommodate the identified recommendation.
- Members recognize that communicating the results of an assessment report with the client may be beneficial and should be considered when warranted, practical, and appropriate.

# C

# TREATMENT

Treatment designed to target the needs of men who have committed sexually abusive behaviors is a specialized form of therapeutic intervention. Treatment attends to the criminogenic or psychologically meaningful factors identified as contributing to the sexually abusive behaviors to support the therapeutic goal of risk management and risk reduction. While this form of treatment orients to harm reduction and desistance, interventions should also target broader therapeutic goals relevant to responsivity factors and other clinically relevant mental health and wellness treatment targets. This more holistic approach can facilitate treatment engagement, strengthen therapeutic alliance, enhance broader coping skill development and mental health wellness, and foster positive and prosocial identity development, all of which can further facilitate desistance from inappropriate or sexually abusive behaviors.

Participation in programs following established best practices are associated with statistically significant reductions in sexual offense recidivism. Current best practice adheres to the RNR model as outlined in the Empirical Framework section of this document's Introduction. Treatment interventions that are implemented based on the client's presenting level of risk, identified criminogenic needs, and relevant responsivity factors have demonstrated the greatest potential for reducing rates of sexual and other types of criminal recidivism. It is important for treatment providers to remain current with the empirical literature on treatment for men who have committed sexually abusive behaviors as research continues to explore and evaluate the efficacy of various models and methods of intervention. Familiarity with the literature will enable continued adherence to best practice approaches.

# Overarching Treatment Guidelines

Treatment of men who have committed sexually abusive behaviors occurs in many different contexts (e.g., without any criminal justice or child protection processes in place, post-criminal charge, prior to a conviction and sentencing, post-conviction while under sentence, post-sentence) and in various settings (e.g., correctional and mental health centers, the community). Treatment can occur in large urban centers with many resources or in smaller or remote communities with fewer resources. Men who have committed sexually abusive behaviors are a heterogeneous population and will present with a myriad of issues and treatment needs despite the common denominator of having sexual behavior problems. Treatment may be provided by clinicians with extensive academic, clinical, and practice related experience or by individuals who have less formal training and are newer to providing clinical interventions for this population. As a result, it is important that members consider their treatment practice based on the specific context and circumstances of their practice, the unique needs of their individual clients, and the context of their cases. It is also important to consider and attend to common therapeutic factors related to best practices in the provision of general therapeutic services, in addition to best practices specifically indicated for the treatment of individuals who have committed sexually abusive behaviors.

8 **Members provide treatment that is guided by ethical principles and current empirical research to promote public safety, maximize treatment effectiveness, facilitate prosocial goals for clients, and maintain the integrity of the profession. In this regard, members should:**

8.01 Provide treatment in accordance with relevant standards of practice. This includes:

- Ethical standards, codes, laws, or other expectations for each member's respective profession and/or discipline of practice;
- Relevant professional standards or guidelines applicable to the member's area of practice (e.g., for psychologists, social workers, psychiatrists);

- Specialty practice standards and guidelines (e.g., guidelines specific to the provision of group therapy, forensic practice, or the treatment of sexual abuse, trauma);
- Specialty practice standards and guidelines for specific populations;
- Practice standards applicable to the members geographical location (e.g., country, state, province).

Particular attention should be given to practice and ethical standards pertaining to:

- Informed consent;
- Specialized training, knowledge, expertise, and scope of practice;
- Documentation and retention of records;
- Currency of research;
- Confidentiality;
- Mandatory reporting requirements;
- Professional relationships; and
- Professional and respectful conduct.

8.02 Recognize the importance of remaining current with research on the treatment of men who have committed sexually abusive behaviors.

- Understand that the treatment for men who have committed sexually abusive behaviors is an evolving science. Participating in ongoing professional development activities and remaining current with the empirical literature on the treatment for this population is required to stay informed and guided by research-supported and evidence-based interventions.

- Appreciate that although some treatment providers may lack the resources or expertise to conduct research, treatment providers are in a unique position to encourage, support, and participate in empirical research and are encouraged to do so as they are able.

8.03 Approach interacting with clients in treatment in a respectful and professional manner.

8.04 Consider, identify, disclose, and address any existing or potential conflict of interests or dual relationships. A conflict of interest occurs when a treatment provider is in a position where their personal interests may influence their decision making in a manner that could compromise the integrity of their professional roles or adversely affect their client. A dual relationship exists when a treatment provider has more than one role with a client or has a relationship with someone close to their client.

- Seek consultation or supervision to review if a conflict of interest or dual relationship may influence providing services to the client.
- If it is determined that a conflict of interest or dual relationship would not negate or compromise services for a client, the conflict of interest, or dual relationship should be disclosed to the client, the agency of referral, and any relevant stakeholders, and should be documented in treatment notes.
- If an identified conflict of interest or dual relationship has the potential to interfere with the ability to provide objective, fair, and impartial treatment, the client should be referred to another clinician or agency.
- If an identified conflict of interest or dual relationship has the potential to undermine and/or compromise the treatment process or the perception of the process, the client should be referred to another clinician or agency.

8.05 Recognize and identify areas of competency. If a referred client presents with characteristics or presenting issues outside a member's training and experience, members should seek consultation, supervision, or training and professional development opportunities to support them in providing treatment or refer the client to another clinician or agency.

8.06 Ensure personal biases and countertransference reactions do not interfere with client care. Any personal biases, countertransference reactions, or assumptions a treatment provider may have based on age, ethnocultural diversity, sexual orientations, gender identities, sexuality, socioeconomic differences, education, language, intellectual functioning, and mental or physical disability should be considered, acknowledged, and attended to. If biases and countertransference reactions that would influence the treatment process are identified, treatment providers are expected to seek consultation, supervision, or training and professional development opportunities to help them better understand and address these biases and countertransference reactions so they can work effectively with the client. If a treatment provider's beliefs could negatively influence the treatment process, they should refer the client to another clinician or agency.

8.07 Recognize the heterogeneity of the population of men who have committed sexually abusive behaviors. In developing treatment plans and providing treatment services, members should give specific attention to identifying and considering diversity and responsivity factors. Diversity and responsivity factors should be considered in the development of treatment plans, approaches to therapeutic engagement, style of treatment delivery, and identification of potential sources of support for the client. Treatment providers should seek consultation or supervision as required to ensure diversity and responsivity factors are properly considered in treatment planning and delivery.

8.08 Consider the client's current legal status (e.g., no legal status, pre-adjudication, pre-trial psychiatric hold, pre-sentencing, civil commitment referral, parole hearing, revocation) and how that status may influence the client's treatment presentation, motivation, and participation, and the member's style of engagement and strategies for treatment delivery.

8.09 Be aware of and clearly inform clients about mandatory reporting and the limits of confidentiality prior to the commencement of treatment.

- Ensure clients are aware of the mandatory reporting requirements and what type of disclosures would be subject to mandatory reporting (e.g., disclosure of an identified minor who has been abused or a child who is at risk, concern about client self-harm, threats indicative of imminent risk to harm a specified person).
- Ensure clients are aware of the limits of confidentiality and understand what information outside the confines of mandatory reporting may be shared with others over the course of their participation in treatment.

8.10 Recognize the potential of, and be prepared for, clients disclosing previously unreported inappropriate or sexually abusive behaviors and other antisocial or criminal conduct.

- Be aware of what types of disclosures do and do not require reporting. This includes but extends beyond disclosures that are legally reportable and may include behaviors deemed reportable in various settings (e.g., in a correctional or mental health center, on campuses, at a place of employment).
- Be prepared to guide clients on how to share information that can facilitate information gathering to support treatment in a manner that does not place them at risk for self-incrimination.
- Be attentive to and consider how to manage previously undisclosed information shared by the client over the course of treatment that does not meet mandatory reporting requirements.

  -Consider if such information is required by other stakeholders involved in the case (e.g., probation and parole, child protection, mental health staff) and if so, how to provide such information in a manner that balances client privacy and self-incrimination concerns, even when there are identified limits in confidentiality.

-Consider how sharing such information may influence the therapeutic alliance.

-Consider if sharing such information is related to risk management for the safety of others or the client.

- Seek consultation or supervision if there is a lack of clarity about which disclosures require and do not require reporting, the boundaries that should be set related to the limits of confidentiality, and what and how to share certain information shared in treatment with other stakeholders

## Treatment Modalities and Intensity

**9 Members deliver treatment modalities and provide an intensity of treatment as clinically indicated. Members should recognize:**

9.01 The type of therapeutic modalities (e.g., individual, group, couple, family therapy) and intensity of service delivery (e.g., type and number of modalities, frequency of therapeutic contact, duration of participation in the treatment) should be matched to each client's individual risk, needs, and responsivity factors.

- The highest level of intensity of treatment should be provided to clients at the highest level of risk and criminogenic needs.
- Individuals assessed as very low or low risk may not require offense-specific treatment. These individuals have no or few treatment needs. Reducing their already low expected rate of reoffending is unlikely. Protective factors against reoffending may be undermined if services disrupt housing, employment, financial stability, and social supports. If services place lower-risk individuals in contact with higher-risk individuals, their risk may be elevated by developing anti-social attitudes and beliefs from these associations and unnecessarily adopting deviant self-labels.

- Risk assessment and treatment planning should also consider the changing context of the individual's life. For example, if an individual assessed as very low or low risk with few criminogenic needs plans to reside in a living situation that may elevate their vulnerabilities and risk, they may require a higher level of intervention than what would otherwise be considered.
- Some individuals assessed as not needing offense-specific treatment may be motivated to complete treatment for reasons such as to achieve a reduction in security, gain privileges in an institution, be considered eligible for a community release, or to comply with community supervision requirements. In these instances, members should educate referral sources about the reasons treatment was not recommended. If members provide treatment services in these situations, they should reduce potential negative effects of treatment as much as possible (e.g., by limiting the treatment dosage, considering the most appropriate treatment modality, minimizing disruption in housing, employment, financial stability, and social support, and limiting unnecessary associations with negative social influences).
- Clients with non-criminogenic needs (e.g., personal distress, emotional crisis, loss), who do not require offense-specific treatment, may still require general psychotherapy to alleviate distress and restore wellbeing.

9.02 Not all clients benefit from all treatment modalities. The type of treatment modalities prescribed should be consistent with the client's level of risk, need, and responsivity issues versus a "one-size-fits-all" approach that may not meet their needs or be best suited to a positive treatment outcome.

9.03 The provision of treatment modalities, such as group therapy, couple's counseling, and family therapy, are specialized forms of intervention. Group therapy is a primary intervention for treating men who have committed sexually abusive behaviors. Members should have appropriate training in group facilitation and group therapy and be aware of and adhere to the academic literature on

best practices as well as specialty guidelines specific to the provision of group therapy. Similarly, members providing couple counselling, family therapy, or other specialized treatment modalities should have the requisite training and be aware of and adhere to the academic literature on best practices as well as specialty guidelines specific to the provision of those modalities.

9.04 If a client requires a treatment modality outside a member's training and experience, members should seek to determine whether they can provide the service. If so, they should seek training and supervision to support their clinical work in that modality. If not, members should refer the client to another clinician or agency who is able to provide the intervention when possible. If a client works with another provider in a different treatment modality, members should collaborate with that provider to develop an integrated and complementary intervention plan.

## Treatment Planning

10 **Members recognize the importance of individualized treatment plans to optimize delivering effective and efficient treatment interventions. Members should:**

10.01 Ensure that, prior to initiating treatment, a treatment plan is identified and developed based on assessing and identifying individual risk, need, strengths, and responsivity issues. A treatment plan may be established based on information from an existing assessment report or through a treatment intake process in which a client's intervention needs are assessed to determine treatment goals.

10.02 Develop and implement an individualized, written treatment plan for each client, outlining:

- Recommended treatment modalities and intensity of treatment;
- Treatment goals, time-limited objectives, and targets for therapeutic intervention;

- Therapeutic styles that can optimize motivation, engagement, and therapeutic alliance;
- Research-supported assessment methods and instruments that can assist in identifying criminogenic risk factors present for a given client.

10.03 Routinely review and update treatment plans based on the client's level of participation and progress in treatment and ongoing identification of relevant treatment and risk management and risk reduction goals for therapeutic interventions. This will support the monitoring of treatment adherence and assessment of treatment progress.

## Treatment Models and Methods

**11 Members providing treatment for men who have committed sexually abusive behaviors should use empirically supported models and methods of intervention to optimize successful outcomes. To this end, members should recognize:**

11.01 The greatest predictor of successful therapy outcomes is the quality of the therapeutic alliance. This extends to the treatment of men who have committed sexually abusive behaviors. As a result, client engagement is central to this specialized form of treatment. Concerted efforts need to be made to establish and maintain a therapeutic alliance and adhere to therapeutic styles that have been demonstrated to be effective in client engagement (e.g., warm, empathic, rewarding and directive) to support positive treatment outcomes. It is important to assess the therapeutic relationship on an ongoing basis, work to maintain it, and repair any ruptures that may take place during the course of treatment.

11.02 Structured interventions focused on criminogenic risk factors that involve cognitive-behavioral and skill-oriented treatment approaches have been demonstrated to have the most effective treatment outcomes for treating men who have committed sexually abusive behaviors. Members should have a comprehensive understanding of various treatment methods and a broad repertoire of skills to meet the needs of the heterogeneous and clinically diverse population of men who have committed sexually abusive behaviors.

11.03 Interventions should be delivered in a manner attentive to and consistent with trauma-informed care. Members should be aware of the prevalence of adverse childhood experiences among individuals who are in conflict with the law. These experiences can negatively influence coping skill development and contribute to emotional vulnerabilities and problematic cognitions, which may be contributing factors to sexually abusive behaviors.

## Treatment Engagement

12 **Members strive to foster clients' engagement and internal motivation at the outset, and throughout the course of treatment, recognizing these variables are crucial to enhancing treatment responsiveness and outcomes. To support this, members should:**

12.01 Recognize that although many clients present for treatment as a direct result of legal or other mandates, external motivators alone are generally insufficient for producing long-term change.

12.02 Be aware that clients present with differing levels of internal motivation to change, and that it is the goal of the treatment provider to work toward engaging the client and building motivation to participate in treatment and work toward sustained change.

12.03 Understand that clients who are mandated and/or expected to attend treatment may enter treatment with a resistant attitude or a focus on secondary gains (e.g., achieve a reduction in level of security in custodial settings, support release to the community from a correctional or mental health center, comply with conditions of probation and parole, reunite with family). A key treatment goal is to help mandated clients see the benefits of treatment beyond secondary gains and to engage them in the treatment process.

12.04 Support clients to recognize, understand, and work through defensive and self-protective strategies that can be obstacles to treatment engagement or progress in treatment. In addition to the potential challenges working with mandated clients, individuals referred for treatment often present with some level of denial, minimization, rationalization, justification, cognitive distortion, or projection of responsibility in relation to their sexually abusive behaviors. This style of presentation can be a product of diverse factors that may include an investment in avoiding culpability for their behavior, the experience of a marked level of shame and embarrassment in relation to their behavior, fear of the consequences of candid self-disclosure, a presentation style associated with mental health challenges (e.g., anxiety, defensive avoidance associated with trauma, unsophisticated efforts at self-protection associated with intellectual disability), or an antisocial orientation. Members should:

- Recognize that denial and minimization of sexually abusive behaviors, interests, or arousal, and evident distortions in perceptions, attitudes, and beliefs are not uncommon and should not preclude access to treatment.
- Recognize that denial and minimization may influence the client's engagement in treatment, but that the influence of denial and minimization in sexual recidivism risk has not yet been clearly established and may vary among client groups.

12.05 Support the client to be forthright in discussing their personal history, offending behaviors, and offense-specific contributing factors, but recognize it is not the role of treatment providers to attempt to determine or verify a client's legal guilt or innocence or to secure confessions of unreported or undetected sexually abusive behaviors. Enhancing self-disclosure can facilitate assisting clients to enhance their level of openness and accountability for their sexually abusive behaviors, enhance identification of offense precursors and risk factors, and support treatment and risk management and reduction interventions and planning. Attempting to have clients provide an account of their sexually abusive behavior that is completely consistent with the allegations or legal findings reported or identified in case background information is however not typically a required or recommended treatment goal.

12.06 Be aware that while treatment may be provided for clients who are highly invested in persistent denial and minimization, these conditions may result in limitations in making reliable clinical recommendations about the individual's treatment progress, identifying relevant risk factors, and assessing risk of recidivism.

12.07 Recognize that client engagement may increase, and resistance may decrease, when the treatment provider and client are in relative agreement about treatment goals and objectives. As such, to the extent possible, members should involve clients in the development of their treatment plans and in the identification of realistic goals and objectives.

12.08 Explore and clarify, at the onset of treatment, the client's understanding of why they have been referred to treatment and their perception of their presenting problems. Clients should be clearly informed that the primary treatment targets to address sexually abusive behaviors include attending to offense-specific issues, such as offense precursors and risk factors; sexual interests, arousal, and behaviors; attitudes; intimacy deficits; coping skills; and risk management and risk reduction strategies.

12.09 Routinely seek and explore the client's perspectives and offer feedback on engagement, motivation, and progress in treatment, or lack thereof.

## Specific Responsivity Factors

13 **Members acknowledge the heterogeneity among men who have committed sexually abusive behaviors and that responsiveness to treatment can vary as a function of client characteristics and responsivity factors, such as:**

- Age;
- Ethnocultural heritage;
- Language or communication barriers;
- Academic ability;
- Sexual orientation;
- Gender identity;
- Physical disability;
- Literacy;
- Mental health diagnosis or symptoms;
- Neuropsychological, cognitive, and learning impairments;
- Adverse childhood experiences;
- Level of adaptive functioning;
- Denial;
- Level of motivation for change (e.g., in assessment and treatment participation);
- Institutional history and potential institutionalization; and
- Strengths and skill sets.

In this regard, members should:

13.01 Assess and identify responsivity factors that may influence a client's ability to maximally benefit from treatment.

13.02 Recognize that clients may have experienced adverse childhood experiences or other forms of trauma. The impact of these may be associated with the development or manifestation of certain dynamic risk factors and may be evident in the clients style of treatment engagement and participation. As such, addressing adverse childhood experiences and trauma can be relevant and important therapeutic goals to support treatment engagement, treatment progress, risk reduction, and client wellness.

13.03 Recognize that not all treatments have been developed or evaluated for various subpopulations of men who have committed sexually abusive behaviors (e.g., individuals with intellectual and developmental disabilities, clients with serious mental illness, those with varied ethnocultural heritages). The limitations of treatments for these populations should be considered and identified prior to initiating treatment, and as appropriate during and at the end of treatment.

13.04 Appreciate that treatment is more effective when responsivity factors are addressed and recognize the potential for reduced treatment benefit when services fail to consider and attend to responsivity factors.

13.05 Strive to adjust treatment approaches to optimize interventions by attending to identified responsivity factors. For example, matching a client with a clinician who can provide interventions in their preferred language or providing opportunities for language interpreters; modifying treatment tasks and processes based on level of cognitive ability, academic proficiency, mental health, or developmental functioning; providing access to culturally sensitive, attuned, and relevant programming.

13.06 Strive to equip themselves with the knowledge and skills necessary to adequately address clients' responsivity factors or functional needs by remaining up to date with current research literature, consulting with subject matter experts, accessing specialized training, and participating in professional development activities.

13.07 Recognize their own limitations with respect to their ability to provide adequate clinical services based on a client's specific responsivity factors. Members seek consultation, supervision, or training and professional development opportunities to support them provide treatment in a manner appropriate to the identified responsivity factor(s) or, as required and appropriate, refer the client to another clinician or agency skilled in addressing specific responsivity factors.

13.08 Understand that for some subpopulations of men who have committed sexually abusive behaviors, treatment services are best provided after, or in combination with, psychiatric, or other behavioral, responsivity-oriented interventions. Members offering treatment should collaborate with the providers of such services to ensure their treatment services are complementary and not contraindicated.

13.09 Work with a client's partner, family members, and other community support persons who can facilitate successful treatment outcomes because of their abilities to attend to a given client's specific responsivity factors.

## Treatment Targets

14 **Members primarily focus treatment interventions related to identified criminogenic needs and dynamic risk factors that are empirically associated with engagement in problematic and criminal sexual and non-sexual behaviors. Members should ensure treatment attends to the following targets, if identified as a need for their client:**

Self-Regulation

14.01 Assist clients in learning to identify, understand, recognize, monitor for, and self-manage emotional states that have contributed to their sexually abusive behaviors and have the potential to make them vulnerable and at risk for future problematic or sexual abusive behavior.

14.02 Assist clients in learning and practicing a range of emotional regulation skills (e.g., grounding techniques, cognitive restructuring, problem solving, impulse control skills, appropriately using supports).

14.03 Assist clients in developing safety plans for times when they are emotionally dysregulated.

14.04 Assist clients in obtaining appropriate services for evident problems that make them more vulnerable to challenges with managing self-regulation. This may include referrals for psychiatric assessment, consultation, and treatment; other mental health services (e.g., specific interventions for trauma or personality disorders), or supporting referrals and attendance to substance use/abuse services).

<u>Sexual Preoccupation, Paraphilic Sexual interests/Behaviors, and Self-Regulation</u>

14.05 Treatment should assist clients in understanding the factors contributing to age-inappropriate, non-consensual, and sexually violent sexual interests, arousal, fantasies, and behaviors.

14.06 For clients with a non-exclusive sexual interests in children and/or interest in sexual violence (with children and/or adults) therapeutic techniques can be used to:

- Assist clients to develop insight into the non-sexual needs they are attempting to meet through these sexual interests and any commission of sexually abusive behaviors, emphasizing the acquisition of healthy skills to meet these needs.
- Support the modification of and ability to control problematic and potentially harmful sexual interests, arousal, and behaviors. This could include but is not limited to:

  -Implementing arousal management and reconditioning techniques (e.g., covert sensitization, satiation therapy, aversive behavioral rehearsal, and orgasmic reconditioning).

-Assisting clients to enhance their sexual self-regulation by targeting cognitions that support age-inappropriate and non-consensual sexual arousal, and behavior as well as emotions that triggers problematic and distorted cognitions.

-Considering the potential benefits of psychopharmacological interventions.

-Support and reinforce age-appropriate and consensual sexual interests and arousal.

-Promote age appropriate and consenting sexual interests, arousal, fantasies, and sexual behaviors with age-appropriate and consensual partners.

-Promote the development of knowledge acquisition and skill development in the areas of healthy sexuality, emotional and sexual intimacy, and healthy relationships and interpersonal relationship skills.

14.07 For clients with exclusive sexual interest, arousal, and preference for children, treatment targeting their sexual interests, arousal, and preference should focus on teaching self-control and compensatory strategies, as opposed to attempting to develop an age-appropriate sexual interests, arousal, and preference which will most likely be unsustainable.

14.08 For clients with exclusive sexual interests, arousal, and preference for children, therapeutic techniques can be used to:

- Support clients by developing insights into pedophilia. This can include:

-Helping clients understand having pedophilic interests is not a choice, is likely a lifelong condition, and despite the nature of an exclusive sexual interest in children, they can benefit from therapeutic intervention to support healthy mental health and psychosocial functioning and desistance from acting out in illegal and harmful ways.

-Assist clients with understanding the most current findings related to the antecedents related to a sexual attraction to children (e.g., genetics and epigenetics, differences in brain structure, hormones, developmental issues, head and brain injury, childhood abuse experiences).

- Provide therapeutic support to address the psychological impacts that living with pedophilia may have (e.g., rejection, social isolation, depression, anxiety, shame, confusion, negative self-identity).
- Develop self-regulation skills and arousal management strategies to contain and not act out their sexual interests and arousal in ways that are illegal and could cause harm to a child.
- Strategize ways of meeting sexual needs in non-illegal and non-harmful ways.
- Identify ways of meeting companionship, friendship, community development and interpersonal emotional intimacy needs.

14.09 As appropriate, use or support referrals for pharmacological interventions that can reduce sexual preoccupation (paraphilic and non-paraphilic), potentially contain age-inappropriate and non-consensual sexual arousal, and enable improved management and control of sexual impulses.

14.10 Support clients to find effective ways to minimize contact with persons or situations that evoke or increase age-inappropriate and non-consensual interests and arousal.

<u>Attitudes Supportive of Sexually Abusive Behaviors</u>

14.11 Assist clients to recognize, understand, challenge, and replace perceptions, attitudes, and beliefs that minimize the seriousness or impact of their age-inappropriate and non-consensual sexual thoughts, fantasies, and behaviors.

14.12 Assist clients to recognize, understand, challenge, manage, and replace perceptions, attitudes, and beliefs that rationalize or justify engaging in age-inappropriate and non-consensual sexual behaviors.

14.13 Assist clients to recognize, understand, challenge, manage, and replace perceptions, attitudes, and beliefs that project responsibility for their age-inappropriate and non-consensual sexual thoughts, fantasies, and behaviors onto other people or life circumstances.

14.14 Assist clients to recognize, understand, challenge, manage and replace thinking patterns related to their age-inappropriate and non-consensual sexual thoughts, fantasies, and behaviors and potential or past victims.

14.15 Use established therapy techniques to strengthen perceptions, attitudes, beliefs, and values that support a prosocial and healthy orientation to sexuality, sexual behaviors, intimacy (sexual and non-sexual), and relationships.

14.16 Use established therapy techniques to support the development of a healthy, empirically based, and prosocial understanding of:

- Child physical and sexual development;
- Impact of sexual abuse on children;
- Healthy attitudes toward women and men;
- Impact of sexual abuse on adults;
- Gender roles in non-sexual and sexual relationships.

14.17 Employ established therapy techniques to support the development of generalized empathy including demonstrating appropriate understanding and, ideally, emotional response related to the impact their behavior has had or could have on others. This will assist in challenging and replacing distorted perceptions about victims.

14.18 Recognize that clients may hold attitudes, beliefs, and values that are unconventional but unrelated to their risk for problematic or criminal sexual behaviors. These unconventional attitudes, beliefs, and values are not deemed appropriate primary treatment targets.

Victim Impact and Empathy

14.19 Addressing the potential impacts and harm sexual offending behaviors have on the individual(s) that were offended against and the impact experienced by those close to and connected to the victim(s) as well as to the client has often been identified as a central treatment target. Notwithstanding, to date research has not identified a link between addressing victim impact and empathy on recidivism or desistance from offending. Providers may feel it is important to highlight the range of serious consequences associated with sexual offending behavior and believe this intervention target is warranted to enhance client awareness and as a recognition and demonstration of respect for individuals who have experienced the effects of sexually abusive behaviors. If victim impact and empathy issues are addressed in treatment, it is important clients are not shamed as part of this process. It is also important that key treatment and case management decisions impacting the client not be made solely or primarily based on their response to addressing this treatment target that has not been found to be empirically related to recidivism.

Healthy Relationships and Intimacy

14.20 Assist clients in developing an understanding of what constitutes healthy relationships (e.g., functional dynamics in family, friendship, work, and romantic relationships).

14.21 Support clients to build insight and skills that can enable them to develop and experience healthy relationships, build on strengths in existing relationships, and navigate relationship challenges in healthy ways.

14.22 Support clients to identify past and potentially current unhealthy relationship dynamics and to understand the risks associated with maintaining oneself in unhealthy relationships.

14.23 Assist clients in identifying, recognizing, monitoring, and addressing obstacles that interfere with and negatively influence their functioning in relationships.

14.24 Assist clients in developing an understanding of intimacy in sexual and non-sexual relationships (e.g., family, platonic friendships, romantic, and sexual), the range or continuum of intimacy in relationships, the diversity of intimate relationships, and to develop skills to facilitate participation in intimate relationships.

14.25 Frame the importance of prosocial and psychologically healthy support people as part of a positive relationship network.

14.26 Consider whether it would be appropriate and possible to include individuals in the client's relationship network in their treatment to further support the development of relationship skills, support relationship health and stability, maximize treatment gains and enhance prosocial lifestyles, and support risk management and reduction.

Development of Prosocial Community Supports

14.27 Encourage and assist clients in identifying appropriate, prosocial individuals who can act as positive support people.

14.28 As appropriate and possible, encourage the client to consider inviting family members and significant others to actively participate in the treatment process to facilitate having informed support people who can assist them in desistance from sexually abusive behaviors and support them to achieve and maintain a prosocial lifestyle.

14.29 As appropriate and possible, encourage the client to consider inviting other support people (e.g., other social service and health care professionals they are involved with, faith-based support people, landlords, employers, friends) to actively participate in the treatment process, facilitate their desistance from sexually abusive behaviors, and support them to achieve and maintain a prosocial lifestyle.

14.30 Recognize that in addition to having prosocial community support people, it is critical to assist and support clients to develop and maintain prosocial community supports such as stable and

appropriate housing, health care, financial security, education, employment, and recreational and leisure activities, all of which support desistance from sexually abusive behaviors and are vital to achieve and maintain a prosocial lifestyle.

14.31 Recognize that developing a support network may be challenging and gradual for clients based on their past sexually abusive behaviors, criminal histories, periods of institutionalization as well as their own level of defensiveness and mistrust. As a result, members should support clients to make small and gradual changes, monitor progress, acknowledge the challenges of establishing a new social support network and integrating into a prosocial lifestyle, and encourage and support clients to establish and preserve a healthy lifestyle.

15 **Members recognize that, in addition to treatment targets specifically focused on criminogenic risk factors, interventions should consider and include treatment targets that are not clearly established by research to be criminogenic. In such cases, non-criminogenic targets should enhance therapeutic alliance, treatment engagement, and treatment responsiveness. Such factors may include:**

- Adverse childhood events;
- Adult trauma history;
- Institutionalization;
- Defense mechanisms and unhelpful self-protection strategies;
- Negative sense of identity and low self-esteem;
- Shame;
- Mental health diagnosis or symptoms (e.g., depression, anxiety);
- Self-centered or entitled orientation;
- Empathy deficits; and
- Management of an identified personality disorder.

16 **Members recognize that men who have committed sexually abusive behaviors often present with a multitude of deficit areas and challenges in their skill sets and abilities that contribute to difficulties in managing their lives in healthy and prosocial ways. These issues require interventions to support both offense-specific treatment as well as overall stability and capacity to function in the community.**

**Some of these needs have been identified as criminogenic needs and others have not. Members identify these areas of challenge and either incorporate interventions and supports to assist clients make gains in these areas or support referrals to appropriate resources that attend to these needs. Such factors may include:**

- Financial security
- Housing
- Health care;
- Substance abuse programming;
- Education;
- Employment;
- Spiritual supports;
- Cultural supports; and
- Prosocial recreational and leisure supports.

16.01 If additional treatment programs, interventions, and support services are relevant for a client, members should assist with and support making appropriate referrals (e.g., substance abuse treatment, psychiatric services, housing assistance, financial support, spiritual based services).

17 **Members recognize that men who have committed sexually abusive behaviors often present with various strengths and pre-existing skill sets and protective factors. Client strengths, skills, and capacities should be identified, reinforced, and supported. These should also be highlighted as protective factors when appropriate.**

## Treatment Continuum

18 **Members ensure there is continuity of care for their clients. Treatment effectiveness is bolstered when there is the capacity to offer a coordinated continuum of care and ideally continuity of care. In this regard, clients who are institutionalized benefit from receiving treatment in a correctional or mental health center, followed by continued treatment if they are cascaded to a lower-security facility or upon release or discharge to a residential facility or the community. Individuals participating in community treatment may benefit from, and have treatment gains bolstered by, participation in maintenance follow-up treatment available at a lower intensity. Follow-up treatment should be consistent with and build on previous treatment provided, rather than repeat previous treatment, unless there is a specific rationale for doing so. Follow-up treatment should be delivered at an intensity consistent with the client's level of risk and need at the time.**

## Treatment Progress, Completion or Discharge

19 **Members recognize the importance of communicating client progress both during and at the end of treatment. Members should provide timely treatment progress, completion, or discharge reports to the client, and, as applicable, the agency of referral and other potential stakeholders if consent has been provided to share this information.**

19.01 In communicating information about treatment progress, completion, or discharge with a client, agency of referral, or other relevant stakeholders, members identify:

- The nature of the treatment provided or completed in terms of:

  -Treatment modalities provided;

  -Frequency and duration of treatment, and

  -Goals and objectives of treatment.

- Attendance;
- Level of engagement and participation;
- Progress made on specific treatment goals; and
- Recommendations for future treatment, case and risk management and risk reduction planning.

19.02 In evaluating treatment progress or completions members should routinely utilize multiple methods to gauge treatment progress objectively and reliably, particularly with respect to criminogenic needs and dynamic risk factors. These methods include:

- Structured, research-supported tools, inventories, and assessment measures;
- Specialized behavioral and psychophysiological tools;
- Clinical impressions of the client's level of participation, engagement, and progress;
- Observable changes in factors associated with the client's risk to recidivate, or the lack of such changes that have been noted and identified in clinical notes, treatment progress reports, or assessments; and
- Collateral reports from individuals with knowledge of the client such as family members, intimate partners or spouses, correctional professionals, mental health professionals, and key community supports.

19.03 Evaluate and identify a client's treatment progress within the context of a thorough understanding of their individual capacities, abilities, vulnerabilities, limitations, and strengths. Positive treatment progress and challenges in progress should be identified. Associated recommendations should reference these contextual issues and aim to stay within the parameters of what is likely or possible for the individual client.

19.04 Identify recommendations for further treatment based on the client's presenting risk factors, criminogenic need areas, responsivity factors, protective factors, and progress in treatment. If a client still presents with a number of criminogenic need areas that require further intervention to support risk management, desistance, and community safety, continued treatment or an increase in the intensity of treatment should be considered. Recommendations may also include other interventions that could support improved risk management (e.g., participation in adjunct treatment programming, life skill programming, increased supervision). Conversely, if a client has made progress in addressing their criminogenic need areas to the extent that they are assessed as well equipped to support risk management, desistance, and community safety, a reduction of the intensity of treatment or treatment completion should be considered.

19.05 Members recognize that a client who has successfully completed treatment has generally:

- Acknowledged treatment needs for which they were referred in sufficient detail for treatment providers to have been able to develop a treatment plan that, if implemented properly, could be reasonably expected to reduce their risk of recidivism;
- Demonstrated an understanding of the risk factors and criminogenic need areas relevant to their past sexually abusive behaviors and can identify these when they occur in their present functioning;
- Demonstrated the development of coping skills and risk management and risk reduction strategies that have the capacity to manage risk and support desistance. They have sufficiently sustained changes in managing risk factors and criminogenic need areas relevant to their past sexually abusive behaviors, such that it is reasonable to conclude they have increased their capacity to manage their risk of recidivism and reduced their level of risk; and
- Demonstrated strengths and personal growth that have enhanced their overall functioning and that serve as protective factors and mitigate risk.

19.06 In preparing clients for treatment closure, members may:

- Gradually reduce the frequency of contacts over time as treatment gains are made; offer maintenance or booster sessions to reinforce and assess stability of treatment gains following the closure of regular treatment; or consider any required or potentially beneficial referrals to other none offence specific treatments or support services;
- Provide the client with feedback about their level of progress in treatment and any recommendations for follow up intervention and support, and
- As appropriate, and with the client's consent, provide their primary support persons and potentially other professionals (i.e., those who may be involved in ongoing case management or support or providing future treatment or programming) with verbal or written information that includes follow-up recommendations for maintaining treatment gains.

## 20 **Members recognize the importance of working in a collaborative, respectful, and coordinated manner with other professionals involved in their client's case. Collaboration with other stakeholders, such as institutional staff, probation and parole officers, staff at halfway house or supported residential placement facilities, mental health workers, and child protection workers can enhance treatment, risk management, risk reduction, and desistance goals. In this regard, members should:**

20.01 Collaborate with other professionals involved in treatment cases as warranted and as deemed appropriate with the client's consent or as allowed, specified, or required by local laws.

20.02 Such collaboration and cooperation should be consistent with and limited to activities and behavior appropriate to members' professional roles (see section D on Risk Management and Risk Reduction in the Community).

20.03 Recognize that correctional staff, probation and parole officers, and other social service professionals can complement and strengthen treatment, risk management and risk reduction activities in institutional, residential, and community settings.

## Psychophysiological Methods in Treatment

**21 Members who use psychophysiological methods such as phallometry or visual reaction time measures as part of treatment should adhere to best practices in the use, administration, interpretation, and application of test results as part of treatment. In this regard, members should:**

21.01 Consider the empirical support for using any psychophysiological test with clients and consider factors that would suggest such tests need to be used with caution or are contraindicated (e.g., individuals with developmental disabilities, acute major mental illness, medical conditions). The appropriateness of and potential negative implications of using such methods with specific clients must be considered.

21.02 Be familiar with the reliability and validity of the test.

21.03 Obtain specific informed consent for the testing procedure and release forms for reporting test results at the beginning of the initial appointment.

21.04 Consider factors that could impact the beneficial nature of these procedures or a client's participation. This could include factors such as when in the treatment process the psychophysiological procedure is being administered, the client's level of motivation and readiness to participate, the context and goal of administering a psychophysiological procedure, and the potential implications of administering a psychophysiological procedure, particularly ones that are countertherapeutic.

21.05 Have a standardized protocol for presenting the stimuli, recording, and scoring.

21.06 Use the appropriate stimulus set to assess sexual arousal or interests that are the subject of clinical concern. It is important to ensure that the stimuli are good quality and avoid any distracting elements.

21.07 Not use stimuli that consist of images/videos depicting child sexual abuse.

21.08 Be aware of the applicable legislation in their jurisdiction regarding the possession of sexually explicit materials.

21.09 Ensure that if psychophysiological tests are used as part of treatment, these are incorporated into a larger intervention process as outlined in these guidelines.

21.10 Ensure psychophysiological test results are not used as the sole criterion for determining diagnosis, age-inappropriate and non-consensual sexual interests, and arousal, estimating risk for engaging in sexually abusive behavior, identifying treatment progress, recommending that clients be released to the community, or deciding that clients have completed treatment programs.

21.11 Provide interpretations in a manner that identifies any limitations of the test data.

22 **The use of polygraph to evaluate and/or verify candor in a client's account of their sexual interests, behaviors, arousal, and offending history is the subject of much debate. Members know that the reliability of the polygraph is still a subject of ongoing concern. There are jurisdictions in which institutions, organizations, agencies, including probation and parole departments and individual practitioners, use polygraph as part of their protocols with men who have committed sexually abusive behaviors. Members are urged to use caution in using polygraph and in such instances members should:**

22.01 Be aware of the research literature on the use of polygraph in the treatment of men who have committed sexually abusive behaviors and the findings related to its reliability, validity, and any impacts on risk reduction, recidivism, and treatment outcome.

22.02 Inform institutions, organizations, agencies, and individual practitioners using polygraph about the ATSA guidelines caution in the use of the polygraph.

22.03 Adhere to the most current existing practice standards or guidelines specific to the use of polygraph in the treatment of men who have committed sexually abusive behaviors.

22.04 Take steps to minimize any potential negative impacts of the use of polygraph in treatment.

22.05 Ensure that clients are appropriately clinical prepared prior to participation in a polygraph exam to attend to critical therapeutic issues such as managing the therapeutic relationship, managing anxiety, ensuring the client understands the testing protocols and procedures and understands and is prepared for the type of questions asked and the purpose of these and has had the opportunity to process these issues in treatment first.

22.06 Polygraph scoring results should not be used in isolation for clinical decision making (e.g., program discharge, privileges in the community, allowing contact with children).

## Psychopharmacological Interventions in Treatment

**23. Members recognize pharmacological interventions can be an important part of comprehensive treatment for men who have committed sexually abusive behaviors. Medication may be beneficial to support risk management and risk reduction or to assist with a variety of mental health needs. Pharmacological interventions may be used to assist in the management of age-inappropriate and non-consensual sexual interests, arousal,**

**fantasies, behaviors; and sexual compulsivity (e.g., selective serotonin reuptake inhibitors, antiandrogen, and gonadorelin analogue medications). Pharmacological interventions may also be used to assist in the management of diagnosed mental disorders such as anxiety disorders, depression, bipolar disorder, post-traumatic stress disorder, schizophrenia, obsessive compulsive disorder. Members should:**

23.01 Monitor and assess mental health symptoms that may benefit from pharmacological management.

23.02 Support appropriate referrals to qualified mental health professionals for a medication consultation as required.

23.03 Make themselves available to provide information and consultation to the assessing or prescribing professionals.

23.04 Develop an understanding of the benefits and risks of recommended and prescribed medications.

23.05 Consult with prescribing mental health professionals as required to support an integrated treatment approach when possible.

23.06 Consider the ongoing benefits, limitations, side effects, and physiological impacts of their clients' prescribed medications and communicate any concerns to the prescribing mental health professional.

23.07 Recognize the voluntary nature of client participation in psychopharmacological interventions.

23.08 Understand that psychopharmaceutical interventions are a component of an overall comprehensive treatment plan.

# D

## RISK MANAGEMENT AND RISK REDUCTION IN THE COMMUNITY

Many men who have committed sexually abusive behaviors are supervised in the community. Supervision may be provided by multiple agencies, organizations, and departments. This may include probation and parole officers, law enforcement, and child protection workers. Individuals in these professions are an important part of the ATSA membership and have roles that are both distinct from and sometimes overlap with the roles of clinical members who provide assessment and treatment services. Attending to risk management and risk reduction in the community requires that members whose primary responsibility is the supervision of men who have committed sexually abusive behaviors are aware of the empirical evidence on the efficacy of risk management protocols and their effectiveness in reducing recidivism and enhancing community safety.

A range of risk management strategies are utilized in the supervision and case management of men who have committed sexually abusive behaviors. These typically involve imposing and monitoring various supervision conditions, expectations, and requirements that are usually directed by the court, a parole board, a mental health review board, or a child protection agency and are monitored and supervised by probation or parole officers, law enforcement, and mental health or child protection workers.

It is important to be aware of and differentiate between risk management strategies, typically used in supervision, and risk reduction intervention strategies, which can be used in supervision and are used in treatment. Optimal efforts to support desistance from sexual recidivism requires a combination of risk management and risk reduction strategies. Focusing primarily or exclusively on risk management protocols, conditions, expectations, and supervision has not been found to be as effective in reducing sexual recidivism as blending risk management with risk reduction strategies. Members whose primary role is related to case management or supervision should incorporate risk reduction strategies in their case and risk management approach.

To support a balance of risk management and risk reduction efforts, multidisciplinary case management teams and multi-agency collaborative efforts are key. The

composition of these collaborations may vary depending on the risk, needs, and circumstances of a given client and may include professionals such as probation or parole officers, mental health or child protection workers, treatment providers who address sexually abusive behaviors, other treatment providers (e.g., for substance abuse, mental health, marital and family problems), faith-based supports, advocates for individuals who have experienced the effects of sexually abusive behaviors, and others.

In cases where a client will be released from a correctional, inpatient, or other institutional setting, the transition to the community is likely to be more successful when communication and case planning collaboration exists between the professionals with case management responsibilities in the facility and those who will be receiving the case in the community. Transition and reentry planning should be initiated well in advance of the client's release to identify any ongoing intervention needs; potential challenges and barriers to reentry in the community (e.g., institutionalization issues; financial support, housing, or employment challenges; potential implications of community notification if applicable; challenging family dynamics); and to facilitate making referrals to appropriate community resources in advance of release/discharge.

As previously identified, interventions are most effective when guided by evidence-based principles. Community-based risk management and risk reduction strategies should be based on a client's assessed risk, need, and responsivity factors. In this regard, clients assessed as higher risk or higher need should be considered for greater intensity and dosage of supervision, monitoring, and treatment, whereas clients assessed as lower risk or lower need and who have greater protective factors are likely to require less intensive supervision, monitoring, and treatment. Members recognize that individuals assessed as high risk do not necessarily remain high risk over time. An individual's assessed high risk may be mitigated over time based on their increased ability to manage their risk factors (e.g., enhanced insight, healthy coping skill development, successful management of their identified risk factors, stability in their community functioning) or case dynamics associated with increased desistance (e.g., aging, length of time an individual has been offense free). As risk is identified as changing, based on empirically informed assessment information, the level of intensity of risk management and risk reduction strategies should also be modified.

It is also important to note that not all men who have committed sexually abusive

behaviors require community-based treatment for the entirety of their sentence or entire duration of their case management by a supervising agency (e.g., probation, parole, child protection, mental health services).

## Overarching Risk Management and Risk Reduction Considerations

**24. Members recognize that the community management of men who have committed sexually abusive behaviors generally involves a variety of risk management protocols, conditions, expectations, and interventions, some of which have more empirical support than others. In this regard, members should:**

24

24.01 Appreciate that public policies and practices specific to sex crimes have varied goals (e.g., political positioning for public approval, punishment, deterrence, risk management, risk reduction, prevention) and may reflect different interests and priorities for stakeholders. While some policies and practices complement treatment and support risk reduction and prevention strategies, others have not received empirical support for being relevant to risk management, risk reduction, or crime prevention.

24.02 Remain apprised of the current research pertaining to the impact and effectiveness of various risk management and risk reduction policies and strategies used with clients in the community.

24.03 Work with researchers to assess the impact and effectiveness of community-based risk management and risk reduction strategies used with clients.

24.04 Play a role in educating stakeholders regarding the current empirical support for various strategies and encourage the use of research-supported principles and practices to promote effective risk management and risk reduction protocols with clients in the community.

24.05 Appreciate that the application of empirically-informed assessments of risk and need can enhance the potential effectiveness of risk

management and risk reduction strategies for clients in the community and support the use of such assessments.

24.06 Strive to ensure that collaborative partners and other stakeholders have access to current, empirically-informed assessments to guide decision-making regarding risk management and risk reduction of men who have committed sexually abusive behaviors in the community.

**25. Members should be aware of the empirical literature related to risk management protocols, conditions, and expectations. Members should be aware of which risk management approaches have been found to support a reduction in sexual recidivism and which risk management protocols lack empirical support demonstrating they are relevant to reducing recidivism. Members should also be aware of the value of integrating risk management strategies with risk reduction strategies to enhance the effectiveness of supervision, case management and treatment and to optimize desistance and reduced sexual recidivism.**

25

25.01 When possible, members should provide education and information on what constitutes a relevant and meaningful risk management protocol, condition, and expectation. Members should also be aware that appropriate risk management strategies will vary depending on the client and case dynamics and should be able to determine which risk management approaches are relevant for different clients. Risk management protocols and conditions often include both empirically grounded and empirically unsupported strategies.

Risk management protocols may include:

- The requirement for supervised contact with children under a certain age;
- No contact with individuals they subjected to sexually abusive behaviors;
- Residency conditions;
- Geographic restrictions;
- Curfew;

- Abstain conditions;
- Technology and internet restrictions;
- Attend and participate in treatment;
- Monitoring and tracking (e.g., electronic surveillance, curfew checks, surveillance);
- Registration; and
- Community notification.

Risk reduction strategies may include:

- Facilitating successful reentry to and stability in the community following release from correctional or other facility custody;
- Attending to issues specific to institutionalization for those who have been institutionalized for extended periods of time;
- Promoting continuity of care within and across facility-based programs and services and community-based services;
- Linking clients to appropriate programs and treatment and support services;
- Targeting case management or supervision to focus on key areas that have been identified as central to reducing the recidivism risk of men who have committed sexually abusive behaviors such as:

    -Assisting with the development of and enhancing prosocial attitudes, skills, and behaviors;

    -Increasing healthy and appropriate interests;

    -Focusing on effective management of a client's specific identified risk factors;

    -Encouraging and supporting academic or employment goals and stability; and

    -Encouraging and supporting the development of positive and prosocial community support.

- Attending to responsivity issues specific to the individual client being supervised;
- Engaging and working collaboratively with positive community support networks;
- Participating in information sharing that will support risk management and risk reduction;

- Encouraging other system partners to use empirically informed assessment and treatment strategies to guide evaluations and intervention strategies; and
- Educating and engaging the public and communities.

## Multidisciplinary Collaboration

**26. Members recognize that effectively reducing and managing risk among men who have committed sexually abusive behaviors in the community usually involves collaboration across multiple agencies, entities, and disciplines. Members should:**

26.01 Appreciate that their respective roles and responsibilities with clients are part of a broader system of community management.

26.02 Value and respect the roles, responsibilities, and perspectives of the full range of stakeholders invested in the management of clients in the community.

26.03 Strive to engage stakeholders in contributing to risk management, risk reduction, and prevention activities. This may include law enforcement, prosecutors, criminal defense counsel, the judiciary, correctional staff, probation and parole officers, treatment providers, advocates for individuals subjected to sexually abusive behaviors, employers, landlords, and housing officials, civic organizations, mentors, the faith community, and other community supports.

26.04 Recognize that collaborative partnerships are more effective at increasing community safety when the various stakeholders are appropriately trained and knowledgeable about working with individuals who are at risk of engaging in or have engaged in sexually abusive behaviors and, as such, promote education and training of the involved professionals and non-professionals (e.g., family members, community supports).

26.05 Ensure that information sharing, and collaboration occur within the parameters of confidentiality provisions, informed consent, and

other ethical standards.

26.06 Recognize statutory laws in their jurisdiction that attempt to reduce risk or manage risk (e.g., registration, housing restrictions).

**27. Members recognize key elements that characterize effective collaborations and partnerships and the benefits of effective collaborations and partnerships.**

27

27.01 Key elements of effective collaboration include:

- A clear delineation of roles and responsibilities;
- An understanding of and respect for each professional's role and responsibility;
- Complementary policies and procedures;
- Ethically sound communication and information-sharing mechanisms; and
- A recognized common goal of supporting the shared client to desist from further harmful and illegal behaviors and supporting community safety.

27.02 Effective partnerships can:

- Enhance access to critical information to support risk management and risk reduction and optimize case planning;
- Allow for collaborative case problem solving, planning, and risk management and reduction decisions;
- Enable a collaborative review of the required risk management and risk reduction protocols and interventions and recommend modifications as appropriate;
- Allow for earlier detection of deterioration or enhanced risk factors and support early interventions to contain and manage risk factors prior to a client escalating to serious acting out or recidivism; and
- Increase the overall stability and success of clients in the

community.

## Collaboration in Correctional Cases

**28. Members providing treatment to clients in custodial settings or to clients on probation or parole should collaborate with correctional, probation, and parole professionals to support successful public safety and client outcomes. Members should:**

28.01 Strive to obtain background information related to their client's previous criminal justice, corrections, supervision, mental health, and treatment involvement from correctional professionals and others as appropriate. This could include information such as pre-sentence reports, institutional progress reports, board decision reports, mental health reports, comprehensive assessments of sexually abusive behaviors, correctional program and treatment reports, court or board-ordered conditions, and information about prior releases and performance under supervision. Members who are correctional professionals should strive to obtain background information related to their client's previous mental health and treatment involvement from mental health professionals and others as appropriate. This could include information such as assessment reports completed in the community and treatment progress/completion reports related to prior community-based treatment.

28.02 Familiarize themselves with their clients' court- or board-ordered conditions or probation and parole conditions to ensure that interventions support compliance and do not inadvertently put the client at risk of being in breach of their conditions or restrictions.

28.03 Establish the parameters of information sharing between correctional, probation or parole officers, and mental health professionals at the onset of assessment and/or treatment and clearly inform clients about the established protocols around information sharing. This should include discussing the timing of sharing information, the type of information shared, and how information will be shared (e.g., written, verbal, face-to-face).

Treatment provider members should at minimum share the following information with correctional professionals or probation and parole officers:

- Attendance in treatment;
- Overall participation in treatment;
- Progress toward specific goals in treatment;
- Specific changes in dynamic and/or protective risk factors; and
- Clinically appropriate and relevant information to support risk management and risk reduction.

Correctional professionals or probation and parole officer members should at minimum share the following information with treatment providers:

- Supervision strategies to be implemented or in place to support risk management and risk reduction;
- Engagement and compliance with supervision;
- Concerns related to a client's change in risk, attention to risk management, and any observed increased vulnerabilities in coping and stability;
- Referrals to additional programs and services and associated progress reports; and
- Adjustments to level of supervision or supervision strategies.

28.04 Establish the parameters of information sharing specific to disclosures of noncompliance with court or board-ordered conditions with correctional professionals or probation and parole officers and with clients at the onset of treatment. Treatment providers should determine and identify what disclosures require reporting to a correctional professional or probation or parole officer and how best to manage these disclosures to balance risk management, support the therapeutic relationship, and

attend to public safety. Treatment providers should establish and communicate whether there are noncompliant client behaviors they may work with therapeutically versus reporting and should ensure in advance that this approach is acceptable to correctional professionals or probation and parole officers responsible for case management and supervision. If violations of a clients' conditions could potentially result in significant adverse changes in dynamic risk factors and influence a client's risk for causing harm to others or themselves, such behaviors should be shared in a timely manner.

28.05 Recognize the important balance between respecting and maintaining client privacy and requirements for sharing information to facilitate the maintenance of a therapeutic alliance and working rapport. While it is appropriate and necessary to share some information to support risk management and risk reduction and to assist correctional professionals or probation and parole officers to make informed decisions related to case management, it is also imperative to maintain a level of privacy related to a range of information disclosed and discussed in treatment that is not necessary to share or relate for these purposes.

**29. Members recognize the distinct but potentially complementary roles and responsibilities of treatment providers and correctional professionals or probation and parole officers; clarify these roles and responsibilities to clients and other professionals; and actively strive to maintain these professional boundaries. Members should:**

29.01 Be aware of the ethical concerns related to dual relationships and adhere to any licensing, discipline-specific, ethical, or other credentialing standards and guidelines regarding dual relationships and conflict of interest.

29.02 Be aware that institutional policies, procedures, and practices may create competing demands for treatment providers in adhering to licensing, discipline-specific, ethical, or other credentialing standards and guidelines. In these cases:

- Treatment providers take reasonable steps to resolve the conflict

and provide ethical care.

- Treatment providers exercise caution if institutions require that probation and parole officers be present in clinical treatment sessions or programs for clients. In this regard, members recognize:

  -The presence of probation and parole officers in treatment events can influence client confidentiality, inhibit client participation and disclosure, influence the therapeutic alliance, disrupt continuity of the treatment process, and blur clients' perceptions of officers' and therapist roles.

  -The presence of nonclinical professionals in therapy groups is inconsistent with best practices and can compromise group therapy design and dynamics as well as the experience of group members.

- If institutions require that probation and parole supervisors be present in treatment events, members should:

  -Obtain appropriate informed and voluntary consent from clients when applicable;

  -Ensure that probation and parole officers clarify their roles and responsibilities as supervision officers to the clients;

  -Review and clarify with affected clients the purpose and possible impact of having probation and parole officers present; and

  -Take the necessary steps and provide the requested information to ensure probation and parole officers attending a treatment event understand and are prepared to participate in that treatment event in a manner consistent with adherence to the *Best Practice Guidelines for Men* and other treatment guidelines identifying best practices.

- Treatment providers limit their role to that of clinicians and do not attempt to assume the roles of supervision officers or law enforcement agents or represent themselves as such.

- Probation and parole officers do not represent themselves as

specialized treatment providers to clients unless they possess the requisite education, training, supervision, licensure, and continuing education to treat individuals who are at risk of engaging in or have engaged in sexually abusive behaviors.

- Probation and parole officers who deliver general cognitive or behavioral interventions to promote skill-building and behavior change among clients should be trained in these approaches and appropriately supervised to deliver such interventions with fidelity.
- Probation and parole officers should not assume specialized clinical responsibilities within treatment programs for men who have committed sexually abusive behaviors (e.g., individual or group therapy) with clients for whom they have supervision responsibility. If this is unavoidable, probation and parole officers should seek support to manage their dual roles and engage in peer consultation or supervision to help them do this.

## Collaborating With Child Protection & Adult Protective Services

There are occasions when a client who has engaged in sexually abusive behaviors against children and who is assessed with sexual interest, arousal, or preferences for children may have planned or unplanned contact with children (e.g., children in their own families, children of new romantic partners, friends, co-workers, or neighbors). Similarly, there may be instances when a client who has engaged in sexually abusive behaviors against vulnerable adults (e.g., someone under their care and control, a person with a cognitive or physical disability, or an older adult) may have planned or unplanned contact with vulnerable adults. Contact may include in-person contact with a child or adolescent or vulnerable adult and interactions such as telephone calls, electronic communications, written notes, and communications through third parties.[6]

**30. Members prioritize the rights, wellbeing, and safety of children and**

6 For the purpose of these guidelines, "contact" generally does not include incidental contact such as walking by children on the street or in another public location. However, as part of a comprehensive evaluation of risk, members should determine if incidental contact is a concern based on legal restrictions, the client's level of risk, response to treatment or supervision, and other relevant considerations.

30 **vulnerable adults when making decisions about client contact with these populations. In this regard, members should:**

30.01 Take reasonable steps to support a client's adherence to any no-contact orders, conditions that prohibit volunteer or employment with children or vulnerable adults, or other restrictions that have been imposed by the courts or other entities statutorily authorized to impose such restrictions for that client.

30.02 Provide written assessment-driven recommendations regarding an individual client's acceptable level of contact with children or vulnerable adults that range from no contact to supervised or unsupervised contact when contact is at issue under the terms of any legal disposition (e.g., court order, probation or parole order, child protection directive).

- Recommendations regarding contact with minors or vulnerable adults should be informed by the following:

  -Empirically informed assessments of recidivism risk and protective factors;

  -The client's history of age-inappropriate and non-consensual sexual interests, arousal, fantasies, and behaviors;

  -The nature, extent, and duration of the client's offending behaviors;

  -The client's engagement and progress in treatment, particularly with respect to general and sexual self-regulation, sexual preoccupations, and the extent of age-inappropriate and non-consensual sexual interests, arousal, fantasies, and behaviors; the client's relationship to the child or vulnerable adult and if this child or vulnerable adult was ever victimized by the client; and offense-related motivations, grooming patterns, attitudes, and offense-specific variables;

  -The presence of positive prosocial support people who can serve as supervisors for the client;

  -The willingness and ability of potential supervisors to learn

about and understand the relevant risk factors and areas of concern and to learn about, understand and support an identified risk management plan;

-The client's engagement and compliance with supervision expectations and conditions;

-The ability, skills, and willingness of non-offending parents or guardians to provide an environment that is appropriately conducive to maintaining the child's or vulnerable adult's emotional and physical safety;

-The availability and professional opinions of a qualified advocate of children or vulnerable persons, a mental health professional, or a professional who is therapeutically engaged with the child or vulnerable adult and can offer an opinion about their capacity to articulate interests and concerns regarding the potential for contact with the client;

-The child's or vulnerable adult's reported interests for contact or no contact, or if contact would or would not be in their best interests; and

-The extent to which community strategies are in place to provide mechanisms and resources to ensure adequate safety plans are in place for any such contacts.

30.03 Collaborate with the proper authorities or professionals to support restrictions that prohibit clients from having contact with a child or vulnerable adult if they do not want contact, or if contact would not be in their best interests.

30.04 Consider the potential impacts of a client having contact with their victims' siblings or other family members and approve only contact that minimizes distress to the individual subjected to sexually abusive behaviors.

30.05 Work collaboratively with child and adult vulnerable persons

protection agencies and advocates for individuals subjected to sexually abusive behaviors and others (e.g., treatment providers, probation or parole officers, child protection workers) to develop safety plans for individuals subjected to sexually abusive behaviors and other vulnerable children or adults.[7]

30.06 Obtain informed consent from a child's non-offending parent or legal guardian or vulnerable person's family, caregiver, or legal guardian before approving a client's contact with that child or vulnerable person, while adhering to the parameters of any legal or other restrictions.

30.07 Support structured or supervised contact with a child or vulnerable adult if the client is making acceptable progress in treatment or supervision and effectively managing dynamic risk, if appropriate safety precautions are in place, if contact is assessed to be in the best interest of the child or vulnerable adult by the appropriate or designated professionals working with or responsible for protection decisions and if contact is desired by the child or vulnerable adult.

30.08 Exchange information, within the bounds of confidentiality, unless otherwise specified by law, in a timely manner with protection workers involved in monitoring the safety of children or vulnerable adults who will be overseeing or supervising contact with a client. Information may include the following:

- Client's treatment progress;
- Significant changes in dynamic risk factors; and
- Significant barriers and social services agreements with goals

7 A "safety plan" is defined as a detailed plan reviewed with the child's non-offending parent or legal guardian or a vulnerable person's support group or legal guardian that details parameters around contact to support risk management between the client and the child or vulnerable person. As relevant, the plan should include guidelines related to privacy and boundaries, discipline practices, sexual education, appropriate dress and hygiene, bedtime routines, considerations around physical contact and the conditions or limits that may apply, and how contact will be terminated if it is no longer appropriate.

and objectives that must be met by all involved (e.g, a child's non-offending parent or legal guardian or vulnerable person's family, caregiver, or legal guardian; case managers; mental health providers) in order to promote contact or reunification.

30.09 Familiarize themselves with restrictions related to a client's ability to have contact with the individual they subjected to sexually abusive behaviors and abide by and support and reinforce those restrictions in a therapeutic manner with the client.

30.10 Ensure that, as warranted for a given client, contact with a child or a vulnerable adult is addressed as part of a comprehensive community risk management plan and is linked to the client's risk of recidivism, progress in treatment, or compliance with supervision, as applicable.

30.11 Document all decisions about a client's contact with children and vulnerable adults, including whether contact is recommended, the type of contact recommended, the preparations made with children and supervisors, and information obtained during the ongoing monitoring process.

## Addressing Access to Children: Family Visitation and Reunification, New Relationship with a Partner with Children

**31. Members collaborate with child protection workers to address family reunification efforts when clients have committed sexually abusive behaviors in their own families and the families wish to have contact, or when a client seeks to begin a relationship with an individual who has children. Members should:**

31.01 Recognize that sexually abusive behavior within a family

can create complex family dynamics. In addition, if a client has committed sexually abusive behaviors involving children outside of the family, there can be significant implications related to the positions of the court, child protection, probation or parole officers, and treatment professionals on that individual having contact with their own children or other people's children.

While adhering to a blanket no-contact position may be easiest from a system and child protection perspective, this position is not always optimal or necessary. Individuals involved in the case management, supervision, or treatment of men who have committed sexually abusive behaviors within or outside of the family should consider child protection and risk management issues primarily, in addition to the wishes and best interests of the children and families. In some cases, a child who has been sexually abused by the client may want nothing to do with the client and visitation or reunification should not be considered. In other cases, the child may wish to have contact with the client, however, this individual's level of risk and the dynamics of risk in the family (e.g., child vulnerability, other adults' inability to appropriately supervise) are considered too high to support visitation, reunification, or integration into a new family with children. In some cases, there may be a combination of factors that support and suggest that visitation, reunification, or integration into a new family with children is manageable and appropriate. Such decisions should be made using empirically informed assessment protocols to assess risk and should consider risk management and child protection issues. If a decision is made to support contact with children, a comprehensive family safety and wellness plan should be established with the client and their intimate partner facilitated by professionals with expertise in risk, risk management, risk reduction, and child protection and considered by a multidisciplinary team.

31.02 Be aware that any reunification or family unification plan should be established as a gradual, well-supported, and supervised procedure.

31.03 Before providing recommendations regarding family reunification

or unification, collaborate with professionals from a range of disciplines who have different agency missions and mandates, which may include child protection workers, family therapists, victim/survivor services providers or advocates, treatment providers, supervision officers, and other community support people.

31.04 Ensure that any child contact decisions within the context of family reunification or unification efforts should be informed by a thorough assessment of the client's vulnerabilities and strengths, the child's safety plan, a family safety plan, the capacity of adult partners and other family members and support people to appropriately respond to any concerns about the client's behavior or functioning, and consultation with members of the community risk management team, such as collaborative partners and stakeholders.

31.05 Ensure that, as appropriate and indicated, contact with the client's children, their current partner's children, children of family members, and other children (friends of the children with whom contact may occur) are also discussed as part of the reunification or unification process.

31.06 Not recommend the involvement of a child who has been sexually abused or children viewed to be at potential risk in family reunification or unification efforts—unless such involvement is likely to benefit the children and unlikely to cause inordinate levels of distress.

31.07 Recommend that the client be removed from the residence of the child who has been sexually abused or children viewed to be at potential risk, rather than removing the children if risk and child protection issues are a concern.

31.08 Consider the wishes of the child who has been

sexually abused or children viewed to be at potential risk regarding family reunification or unification, taking into account their ability to understand the ramifications of their decisions, any identified vulnerabilities and strengths the child possesses that are relevant from a child protection perspective, and considering how restriction of contact may be beneficial or may create added harm and distress.

31.09 Ensure that a child has access to a responsible and informed adult supervisor trusted by that child before recommending the client be allowed to have contact with that child.

31.10 Do not support a client having contact with an intrafamilial child who they have sexually abused and other family members under 18 or a vulnerable person unless the following are present:

- The child or vulnerable persons wishes to have contact;
- The child or vulnerable persons is judged to be ready for such contact by a mental health professional who is familiar with the child or vulnerable person;
- A responsible and informed adult is available and appropriately prepared to supervise the contact and can monitor their safety; and
- The client demonstrates insight into the vulnerability and risk factors that contributed to their inappropriate or sexually abusive behaviors, has developed and demonstrated consistent implementation of an appropriate risk management and wellness plan, is prepared to commit to the identified safety plan and has demonstrated stability in their functioning in the community.

31.11 Ensure that appropriate safety plans are developed and monitored during a family reunification or unification process. Safety plans should include explicit and non-negotiable rules and boundaries as well as highlight areas the client needs to attend to in order to support healthy functioning, management of risk factors, and desistance.

## Engaging Community Support Persons

32 **Members recognize that appropriate support persons can assist professionals and clients with risk reduction, risk management, and other successful outcomes. Community supports can play key support roles though supporting the client in managing their vulnerability and risk factors; encouraging healthy coping and compliance with risk reduction and risk management strategies; monitoring for decompensation and behaviors of concern; and collaborating with the professional support team. In this regard, members:**

32.01 Collaborate with clients and other professionals to identify and engage community support persons in the supervision and treatment processes, when appropriate and feasible.

32.02 Acknowledge that appropriate support persons are able and willing to:

- Appreciate that clients are responsible for having committed sexually abusive behaviors and do not minimize or project responsibility for their culpability;
- Recognize that recidivism risk can increase and decrease over time;
- Maintain routine contact with the client who committed sexually abusive behaviors;
- Understand, recognize, and intervene when risk factors are present;
- Maintain, model, and assist clients with practicing prosocial attitudes and behaviors;
- Support adherence to supervision, treatment, and other expectations pertaining to risk management and risk reduction;

- Participate in the development and implementation of safety plans for individuals who have been sexually abused and other vulnerable persons, as applicable; and
- Communicate effectively with the professionals responsible for assessing, supervising, and providing treatment to clients.

32.03 Take appropriate steps to ensure that support persons are equipped with knowledge and skills regarding vulnerability and risk factors related to recidivism, risk management and risk reduction protocols and strategies for effectively reducing and managing clients' risk for recidivism and are able to identify the strengths and limitations of community supervision and treatment strategies in place.

32.04 Engage, encourage, and support clients to recognize the benefits of treatment and supervision compliance and foster a positive attitude about a collaborative support and risk management and risk reduction model involving the client, professionals, and the identified support people.

## Engaging Community Support Supervisors

33 **Community support people may also be involved in supervising contacts between a clients and a child/children or vulnerable adult. Members exercise prudence and caution when offering recommendations for, or are involved in the selection of appropriate supervisors. As applicable, members should contribute to supporting protection workers to appropriately educate and prepare responsible adult community support supervisors. Members should:**

33.01 Recommend potential adult community support supervisors based on their ability to:

- Acknowledge and understand the client's history of abusive behaviors, including but not restricted to sexually abusive behaviors;
- Understand and appreciate the client's assessed level of risk and relevant risk factors;

- Recognize that the client is solely responsible for their decisions to act in a sexually abusive manner (i.e., supervisors do not place responsibility on individuals subjected to inappropriate or sexually abusive behaviors or external circumstances);
- Recognize that the potential for risk factors and intervention needs change over time, either increasing or diminishing;
- Appreciate the need for the client to have prosocial support people; and
- Accept the role and responsibilities of being an effective supervisor.

33.02 Ensure that clients inform and educate protection workers and/or potential community support supervisors candidly about their sexually abusive behaviors. A community support supervisors does not need to be provided a highly detailed account of the sexually abusive behaviors but does need to know key information such as the age, gender, and relationship between the client they are supervising and the individual who they committed the sexually abusive behavior against, a synopsis of the type of sexually abusive behaviors engaged in, and any critical information related to the manipulations used to engage and maintain sexually abusive behaviors. The client should also be able to provide protection workers and community support supervisors with information about their vulnerability and risk factors that contributed to past sexually abusive behaviors and are ongoing risk factors; the insights and coping skills they have developed to address, avoid, or manage these; the nature and focus of their treatment and their court- or board-ordered conditions, and the status of their supervision by other agencies and professionals.

33.03 Ensure protection workers and/or community support supervisors fully understand the safety plan for children, family members, and other vulnerable parties, and appropriate reporting procedures for noncompliance with the safety plan.

33.04 Assess authorized contacts between clients and children or vulnerable adults through interviews with the client, protection worker, community support supervisors, children's or vulnerable adult's therapist or support persons, and others involved in case management, supervision, treatment, and support of the client, children, and family members.

## Continuity of Care

**34 Members recognize that continuity of care is necessary to support effective risk management and risk reduction of clients in the community. To this end, members should:**

34.01 Facilitate the seamless access to and provision of follow-up services for clients who transition from one program to another in a timely manner. This may include transition from:

- Institutional to community-based treatment;
- Community-based treatment to treatment in a correctional, inpatient, or other institutional setting;
- Programming within a facility/institution or within the community, at a lateral level of transfer; or
- The current jurisdiction or place of residence to a new jurisdiction or place of residence, due to relocation or transfer of supervision.

34.02 Seek information regarding treatment progress, as necessary and through appropriate releases of information, and take this into consideration when initiating treatment services for a client who has been receiving services elsewhere, in order to prevent duplication of efforts and promote timely, assessment-driven, and well-informed treatment planning.

34.03 Provide clinical services to clients in institutional settings and ensure that progress in such programs is documented and, ideally, reinforce and strengthen services with appropriate and relevant follow-up services in the community.

34.04 Include the client, institutional case worker, institutional treatment staff, community supervision staff, community treatment staff, family members, and support persons in release planning meetings to the greatest degree possible. When this is not possible, electronic alternatives, such as teleconferencing or video conferencing, may be used.

34.05 Prepare written treatment or discharge summaries for clients who change programs, transition from an institution to the community, or transition from the community to an institution (i.e., lesser level of care or increased level of care and security). These summaries usually include the following elements (not listed in order of priority):

- Assessment of risk to sexually harm others, including individualized risk factors and indicators of imminent risk;
- Assessment of dynamic risk factors and protective factors or client strengths (e.g., prosocial support systems);
- Description of offending pattern;
- Description of sexual and non-sexual criminal history;
- Identification of relevant problems and continuing intervention needs (including medication);
- Level of participation in programming; and
- Recommendations for community supervision, treatment, and support services to guide post-release case management decisions.

34.06 Be prepared to work collaboratively with other professionals involved in providing case management, supervision, and treatment with a client to facilitate a continuum and continuity of care, with the appropriate consent authorizing the sharing and exchange of information (written and verbal) within ethical parameters, bounds of confidentiality, and other information-sharing statutes or professional regulations. In this regard, with consent or information-sharing statues in place, members working in correctional facilities, mental health centers, or other inpatient/institutional settings provide community-based professionals with relevant and key information to inform and support discharge planning and community-based treatment, support, supervision, and case management. Similarly, with consent or information-sharing statues in place, members working in community settings make themselves available to provide information to case managers or treatment providers working in a correctional, mental health, or other inpatient/institutional setting to support their work with that client, if a client has been returned to custody or an institutional placement. This information can assist in identifying the factors contributing to the return to an institution or inpatient facility to ensure they are considered and addressed before the client's next release or discharge to the community.

Association for the Treatment and Prevention of Sexual Abuse. (2025). Best Practice Guidelines for the Assessment, Treatment, and Risk Management and Risk Reduction of Men Who Have Committed Sexually Abusive Behaviors.

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