The Texas Resource

The Newsletter on Sex Offender Treatment Issues from the
Council on Sex Offender Treatment

Volume 2, Issue 3 **Spring 1995**

THE COUNCIL ON SEX OFFENDER TREATMENT

Chapter 512.0. STANDARDS OF PRACTICE

Inside this Issue:

IN THIS ISSUE: STANDARDS OF PRACTICE

512.1 Introduction.

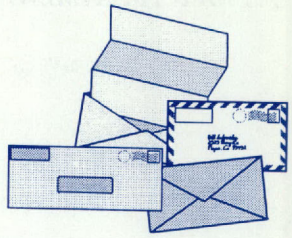
The Council on Sex Offender Treatment (CSOT) is a state organization dedicated to the prevention of sexual assault through effective treatment and management of sex offenders. It attempts to carry out its legislative mandate by identifying and certifying mental health treatment providers who have the appropriate training and experience in the treatment of sex offenders, by sponsoring training seminars and conferences, and by disseminating information about sex offender treatment to the Texas Legislature, Texas state and local governmental agencies, professional organizations, and the public. The Council publishes a Registry of Sex Offender Treatment Providers which lists the names, addresses and credentials of mental health treatment providers who strive to incorporate findings from empirical research into effective evaluation of and treatment strategies for sex offenders.

Sexual deviance is a learned or acquired behavioral disorder but may also be influenced by biological factors. Treatment is focused on recognizing, changing and managing deviant behavior and the attitudes that promote it. Sexual deviance is not considered to be a disease that can be cured. The focus of contemporary treatment is on techniques designed to assist sex offenders in maintaining control throughout their lifetime. Therefore, treatment should include simple, practical techniques that can be used during and after formal therapy.

Sex offender evaluation and treatment requires an approach unfamiliar to most mental health professionals. For example, therapists of sex offenders exercise substantial control over the lives of their clients because of the concern for community protection. For this and other reasons, standards of practice specific to the treatment of sex offenders are necessary.

This document was developed by CSOT to delineate appropriate evaluation and treatment procedures and policies. The standards promulgated herein were largely adapted from the *Practitioner's Handbook* of the Association for the Treatment of Sexual Abusers (ATSA) They are not intended to supplant the standards of the clinician's licensing/certifying board, but are intended to supplement them. These standards delineate professional expectations for the treatment of sexual offenders.

LETTER FROM THE CHAIR



Dear Colleague:

We as a Council, extend our thanks to those of you who provided input on the Standards of Practice and the Code of professional Ethics. As always, we remain open and appreciative of all feedback and opinions. After all, we are striving to maintain high professional standards when it comes to effective treatment for this serious social problem. We can only do this with your assistance.

All information sent in was reviewed and evaluated by the Council, and adapted where seen appropriate. The following pages are the results of our combined efforts. The Council with your assistance, pledges to maintain high standards of professionalism with respect to the treatment of sex offenders.

The Legislature has been very active in the last few months. We request that you stay abreast on the actions of the Senate and the House of Representatives. To do so, please remain in contact with your local State Representative and Senator. Also, contact Eliza May, Executive Director of the Council on Sex Offender Treatment, for updates on the status of key legislative issues.

On another note, the Council has been working with the Texas Polygraph Examiners Board on the RECOMMENDED GUIDELINES FOR CLINICAL POLYGRAPH EXAMINATION OF SEX OFFENDERS. CSOT has approved the Guidelines contingent on the approval from the Texas Polygraph Examiners Board. They will meet in April to consider the adoption of these guidelines. The Council believes that all polygraph examiners conducting examinations on sex offenders should have knowledgeable guidelines to follow, thus allowing for greater accuracy and reliability.

Once again, we thank you for assisting us in enhancing our profession. Hope to see you in July at the Juvenile Offender Conference.

Sincerely,

Collier M. Cole

Collier M. Cole, Ph.D., Chairperson
Council on Sex Offender Treatment

512.2 CSOT Assertions.

(a) SEX OFFENDER TREATMENT PROVIDERS SHALL:

(1) Be committed to community protection and safety;

(2) Not discriminate against clients with regard to race, religion, gender preference or disability;

(3) Treat clients with dignity and respect, regardless of the nature of their crimes or conduct;

(4) Be knowledgeable of legal statutes and scientific data relevant to this area of specialized practice;

(5) Perform professional duties with the highest level of integrity, maintaining confidentiality within the scope of statutory responsibilities;

(6) Insure that the client fully understands the scope and limits of confidentiality in the context of his or her particular situation;

(7) Refrain from using professional relationships to further their personal, religious, political, or economic interest other than accepting customary professional fees;

(8) Not engage in sexual relationships with clients (sex between a therapist and a client is a third degree felony in Texas);

(9) Fully inform clients in advance of fees for services;

(10) Refrain from knowingly providing treatment services to a client who is in treatment with another professional without initial consultation with the current provider;

(11) Make appropriate referrals when the therapist is not qualified or is otherwise unable to offer services to a client;

(12) Insure that colleagues are qualified by training and experience before making a referral to them;

(13) When withdrawing services, minimize possible adverse effects on the client and the community by continuing treatment until the client has been admitted elsewhere;

(14) Take into account the legal/civil rights of the clients, including the right to refuse therapy;

(15) Make no claims regarding the efficacy of treatment that exceed what can be reasonably expected and supported by empirical literature;

(16) Avoid drawing conclusions or rendering opinions that exceed the present level of knowledge in the field or the expertise of the evaluator; and

(17) Attempt to resolve with the clinician and/or report to the appropriate licensing or regulatory authority unethical, incompetent, and dishonorable treatment or evaluation practices.

(b) SEX OFFENDER TREATMENT PROVIDERS ASSERT THAT:

(1) Community safety takes precedence over any conflicting consideration, and ultimately, is in the best interests of the offenders and society.

(2) Inappropriate or unethical treatment damages the credibility of all treatment and presents an unnecessary risk to the community.

(3) Sex offender treatment providers shall have no history of criminal or sexually deviant acts.

(4) Criminal investigation, prosecution, and court orders for treatment may be components of effective intervention.

(5) Where practical, therapists should actively involve community supervision officers, child protective services workers, and victim therapists in case management.

(6) A voluntary client accepted for treatment should be held to the same standards of compliance as are mandated offenders.

(7) It is imprudent to release an untreated sex offender without providing offense-specific evaluation and treatment or specialized supervision.

(8) Without external pressure many sex offenders will not follow through in treatment. Internal motivation improves the prognosis, but is not a guarantee of success.

(9) Sex offenders require comprehensive, long term, offense-specific treatment. Currently, cognitive-behavioral approaches that utilize sex offender peer groups may be the most effective and best evaluated methods of treatment. Self-help groups, drug intervention, or time limited treatment should be used only as adjuncts to more comprehensive treatment. For some offenders, incarceration without treatment may increase the risk of recidivism.

(10) The therapist shall have a written individualized treatment plan that identifies the issues, intervention strategies, and goals of treatment for each offender. Treatment plans should be reassessed periodically.

(11) The treatment plan may include behavioral contracts which outline specific expectations of the offender, his/her family, and the offender's support systems. These contracts should include provisions to avert high risk situations. These contracts should be reassessed periodically.

(12) Progress, or lack thereof, should be clearly documented in treatment records. Specific achievements, failed assignments and rule violations should be recorded. This information should be provided to the appropriate supervising officer in the justice system.

(13) Progress in treatment must be based on specific, measurable objectives, observable changes, and demonstrated ability to apply changes in relevant situations. For most offenders, progress requires changes in the offender's behavior, attitudes, social and sexual functioning, cognitive processes, and arousal patterns. These changes should demonstrate increased understanding by the offender of his own deviant behavior, sensitization to the effects on a victim, and ability to seek and apply help.

(14) When an offender has made the changes required in treatment, there should be a gradual and commensurate decline of intervention, support, and supervision following an offense-specific treatment program. Ongoing support to maintain changes made in treatment is necessary and aftercare and monitoring are desirable.

(15) There will be instances when the clinician should refuse to treat an offender because essential ancillary resources do not exist to provide the necessary levels of intervention or safeguards.

(16) The provider has an ethical obligation to refer the client to a more comprehensive treatment program and/or to the judicial system, when the treatment provider determines that an offender is not making the changes necessary to reduce his/her risk to the community.

(17) Failure on the part of clients to abide by their treatment plans and/or contracts should result in referral back to the supervising officer in the justice system.

(18) A therapist may decide to decline further involvement with a client who refuses to address any critical aspect of treatment.

(19) Treatment providers need to immediately notify the appropriate authority when a client drops out of Court-ordered treatment.

(20) Most sex offenders enter the criminal justice system with varying degrees of denial regarding their behavior. Overcoming denial is a gradual process achieved in treatment. The existence of some degree of denial should not preclude an offender entering treatment, although the degree of denial should be a factor in identifying the most appropriate form and location of treatment.

(21) Sex offender treatment is unlikely to be effective unless the offender admits his/her behavior. Community based treatment may not be appropriate for offenders who continue to demonstrate complete denial after a trial period of treatment.

(22) Therapists should not rely exclusively on self report by the offender to assess progress or compliance with treatment requirements and/or probation or parole orders. Therapists should rely on multiple sources of information regarding the offender's behavior and when possible utilize physiological methods such as polygraphy, phallometric, or other research based physiological measurements.

(23) Physiological measures should not replace other forms of monitoring but may improve accuracy when combined with active surveillance, collateral verifications, and self-report. Phallometric assessment in Texas must be conducted by an order and under the supervision of a physician. Polygraph examinations should only be conducted by licensed examiners.

(24) Polygraphy can be effective in encouraging disclosure of prior events and adherence to rules. This procedure should never be the only method used to determine factual information.

(25) Phallometric methods cannot be used to prove an individual did or did not, or will or will not commit a sexual offense. However, they can be useful in identifying sexual preferences and changes in preferences over time.

(26) Informed, voluntary consent should always be obtained prior to engaging clients in aversive conditioning.

(27) If phallometric assessment or aversive therapies are used with persons 15 years of age or younger, consent for such assessment and therapy should be obtained from the juvenile offender and the offender's parents, and the procedures should be reviewed by a multidisciplinary professional or institutional advisory group. This is intended to insure that individuals not intimately involved in the treatment of the patient have input regarding the appropriateness of such methods consistent with the developmental level of the child.

(28) Individuals under age 13 should not undergo phallometric assessment or aversive therapies except in rare cases which must be approved by a multidisciplinary advisory group.

(29) In cases of intellectually handicapped offenders who are unable to give consent, an interdisciplinary review and parental consent are the ways to obtain permission to proceed with treatment.

(30) Removal of an intrafamilial sex offender against children from a residence in which children reside (instead of the children) is the preferred option.

(31) Treatment referrals should be offered to the non-offending spouse and children in cases where a parent has been removed and to the family where a juvenile offender has been removed.

(32) If the offender has a history of sexual arousal to or reported fantasies of sexual contact with children, he or she should be restricted from having access to children. Supervised visits may be considered if (a) it is determined that sufficient safeguards exist, (b) the offender has demonstrated control over his or her deviant arousal, (c) it does not impede the offender's progress in treatment, and (d) court mandated conditions do not prohibit such contact.

(33) There is evidence to support family participation in the treatment of sexual offenders. Where feasible and appropriate, spouses and other family members should be included. Victims or vulnerable children should be excluded until such time as joint therapy is determined to be appropriate.

(34) The sex offender treatment provider should make every effort to collaborate with the victim's therapist in making decisions regarding communication, visits and reunification. Sex offender treatment providers should be supportive of the victim's wishes regarding contact with the offender. Contact should be arranged in a manner that places child/victim safety first. When assessing child safety, both psychological and physical well-being should be considered. The sex offender treatment provider shall insure that custodial parents or guardians of the children have been consulted prior to authorizing contact and that contact is in accordance with Court directives.

(35) If reunification is deemed appropriate, the process should be closely supervised. There must be provisions for monitoring behavior and reporting rule violations. Victim comfort and safety should be assessed on a continuing basis. The offender's therapist should recognize that supervision during visits with children is critical for those whose crimes are against children,

or who have demonstrated the potential to abuse children. Caution should be taken when selecting and preparing visitation supervisors.

512.3 ISSUES TO BE ADDRESSED IN TREATMENT:

During the past decade, the field of sex offender evaluation and treatment has undergone many changes. Research and clinical reports are beginning to demonstrate that a number of treatment methods may be effective in reducing some forms of sexual deviance.

Although existing data are inadequate to determine which type of treatment is the most effective for which type of offender, the following treatment methods generally are accepted as those most important to the effective treatment of sexual deviancy.

(1) Arousal Control. Control of deviant arousal, fantasies, and urges is a priority with most sex offenders. Fantasy and sexual arousal to fantasy are precursors to deviant sexual behavior. It should be assumed that most offenders have gained sexual pleasure from their specific form of deviance. Arousal control methods do not eliminate but only help control arousal. It is therefore necessary that clients learn to apply these techniques in everyday situations, without reliance on a special apparatus. Arousal control may require periodic "booster" sessions for the remainder of the client's life. Effective arousal control must also include methods to control spontaneous deviant fantasies and to minimize contact with stimulating objects or persons. Arousal control should proceed from the most effective methods for reducing arousal to less effective methods. To document changes in arousal control, physiological measurement is essential. Multiple measures over time are required to determine change reliably.

(2) Cognitive Therapy. Cognitive distortions are thoughts and attitudes that allow offenders to justify, rationalize, and minimize the impact of their deviant behavior. Cognitive distortions allow the offender to overcome prohibitions and progress from fantasy to behavior. These distorted thoughts provide the offender with an excuse to engage in deviant sexual behavior, and serve to reduce guilt and responsibility. Cognitive therapy strives to identify, assess, and modify cognitions that promote sexual deviance. Cognitive therapy is considered a vital component of treatment.

(3) Relapse Prevention. Current knowledge of deviant sexual behavior suggests that there is a series of behaviors, emotions, and cognitions that is identifiable and which precede deviant sexual behavior in a predictable manner. The ability to accurately identify these maladaptive behaviors is a primary goal for every offender in treatment. Autobiographies, offense reports, interviews and cognitive-behavioral chains are used to identify antecedents to offending. The ability to intervene can be enhanced by training primary partners and other support persons to recognize maladaptive behaviors and to encourage application of proper coping behaviors.

(4) Victim Empathy. Although there is no clear evidence to suggest that all sex offenders can gain true empathy for victims of abuse, a universal goal of treatment is to learn to understand and value others. Highlighting the consequences of victimization helps sensitize the offender to the harm he or she has done. The use of analogous experiences has been shown to be effective, especially with adolescents.

(5) Biomedical Approaches. Intervention with psychopharmacological agents is useful in select cases. Antiandrogens such as depo-provera act by reducing testosterone and may be helpful in controlling arousal and libido when these factors are undermining progress in therapy or increasing the risk of reoffending before significant progress can be made in the cognitive aspects of therapy. Antidepressants and medications targeting obsessive compulsive symptoms are also useful in some individuals where those symptoms play a role in the overall psychodynamic picture. Likely candidates are those who are predatory, violent, have had prior treatment failures, and report an inability to control deviant sexual arousal. Use of these agents should never be the only method of treatment.

(6) Increasing Social Competence. Sex offenders often have deficits in basic social and interpersonal skills. They may lack the ability to develop and sustain reciprocal friendships. Many offenders are poor problem-solvers, lack assertiveness, and do not adequately manage anger or stress. One goal of treatment is to improve the offender's ability to deal effectively with social situations and develop meaningful relationships with others.

(7) Improving Primary Relationships. Failure to develop and maintain a reciprocal, loving sexual relationship with an adult partner may lead one to seek out alternative sexual outlets. Identifying specific sexual dysfunctions, sex therapy, and training in dating skills and erotic techniques may be necessary to develop a functional lifestyle. Failure to involve the current partner*(s)* in therapy often leads to the same stresses and failure in the relationship that precipitated the sexual deviancy.

(8) Couples/Family Therapy. To facilitate transition of the offender's partner into therapy a variety of treatment modalities are recommended. Individual therapy, non-offending spouses groups, and/or parents of victims groups prepare the partner for the issues and methods involved in sex offender treatment. Marital therapy or couples group therapy focused on sexual offending is essential in cases where an offender is to return home. If an offender is to eventually live in a home where victims or children reside, a predetermined integration sequence should be followed which addresses role and boundary issues. This should include close supervision and a variety of safeguards for the protection of children.

(9) Support Systems. Involvement of close friends and family in therapy provides the offender with a milieu in which support is available. Part of the transition to follow-up treatment is a reduction in group and individual therapy. To compensate for this loss of support and surveillance, the support system should assist the offender in avoiding and coping with antecedents to sexual deviance. The support system should include individuals from the offender's daily life (i.e., family, friends, co-workers, church members and extended family).

(10) Comorbid Diagnosis. In some sex offenders there are sufficient signs and symptoms to merit an additional diagnosis by DSM IV criteria. These diagnoses can be anywhere in the entire spectrum of psychiatric disease. The most common are alcohol abuse, substance abuse and affective disorders. Treating an alcohol or substance abuse problem should not be assumed to make sex offender treatment unnecessary. Occasionally, the delusions and hallucinations of schizophrenia will be associated with the individual committing sexual offenses. The comorbid diagnoses should be treated with the appropriate therapies concomitantly with the treatment for sex offending behavior except in the case of schizophrenia where the antipsychotic therapy would obviously take precedence.

(11) Follow-up Treatment. A therapeutic regime that includes follow-up significantly increases the likelihood that gains made during treatment will be maintained. In order for new habits and skills to be reinforced and to monitor compliance with treatment contracts, follow-up treatment should involve periodic "booster" sessions to reinforce and assess maintenance of positive gains made during treatment. This can be facilitated by involving the support group, and using polygraphy and phallometric assessment. Input from support group members, polygraph examinations, and phallometric assessments may serve to deter future offenses or alert therapists to problems.

Chapter 513.0 CODE OF PROFESSIONAL ETHICS

513.1 PREAMBLE. Sex offender treatment providers are trained in dealing with the assessment and treatment of sex offenders. These providers constitute a professional discipline which has a membership committed to establishing and maintaining the highest level of professional standards related to the assessment and treatment of sexual abusers. As such, they are conscious of their special skills and aware of their professional boundaries. They perform their professional duties with the highest level of integrity and appropriate confidentiality, within the scope of their statutory responsibilities. They will not hesitate to seek assistance from other professional disciplines when circumstances dictate. They are committed to protect the public against and will not hesitate to expose unethical, incompetent, or dishonorable practices. In order to maintain the highest standard of service and consumer protection, they commit themselves to the following principles designed to earn the greatest level of public confidence.

513.2 CODE OF ETHICS

(a) Professional Conduct

(1) Each clinician will provide professional service to anyone, regardless of race, religion, sex, political affiliation, social or economic status, or choice of life style. A provider will not allow personal feelings related to a client's alleged or actual crimes or behavior to interfere with professional judgment and objectivity. When a therapist cannot offer service to a client for any reason, he or she will make a proper referral. Providers are encouraged to devote a portion of their time to work for which there is little or no financial return.

(2) Each provider will refrain from using his or her professional relationship, related to the assessment or treatment of a client, to further personal, religious, political or economic interests, other than customary professional fees.

(3) The proper conduct of each therapist is a personal matter to the same degree as it is with any other individual, except when such conduct compromises the fulfillment of professional responsibilities or reduces the public trust in this specialty area. Consequently, providers are sensitive to predominant community standards and the potential impact that either conformity

to, or deviation from, these standards can have on the perception of their own performance, as well as that of their colleagues.

(4) Each provider has an obligation to engage in continuing education and professional growth including active participation in meetings and affairs or relevant professional affiliations.

(5) Each provider will refrain from diagnosing, treating or advising on problems outside the recognized boundaries of his/her competence.

(b) Client Relationships

(1) Each provider, offers dignified and reasonable support to a client, and does not exaggerate the efficacy of his or her service.

(2) When engaged in private practice, each provider recognizes the importance pertaining to financial matters with clientele. Arrangements for payments are to be settled at the beginning of an assessment or a therapeutic relationship.

(3) Each provider will avoid dual relationships with clientele. These may impair professional judgment or pose a risk of exploiting the client. Examples of dual relationships include, but are not limited to, the following: treatment of family members, close friends, employees, supervisors, or supervisees.

(4) Sexual harassment or intimacy with clients is unethical. Sexual behavior between a therapist and a client constitutes a felony offense in Texas.

(5) A provider shall not withdraw services to clients in a precipitous manner. Each member shall give careful consideration to all factors in the situation and take care to minimize possible adverse effects on the client.

(6) Each provider who anticipates termination or disruption of service to clients shall notify the clients promptly and provide for transfer, referral, or continuation of service in keeping with the client's needs and preferences.

(7) Each provider who serves the clients of a colleague during a temporary absence or emergency will serve those clients with the same consideration of that afforded any client.

(8) In their professional role, providers will avoid any action which will violate or diminish the legal and civil rights of clients or others who may be affected by their actions.

(c) Confidentiality

(1) Providers will keep records on each client, storing them in such a way as to ensure their safety and confidentiality in accordance with the highest professional and legal standards.

(2) Each provider is responsible for informing clients of the limits of confidentiality. Clients should be informed of any circumstances which may trigger an exception to the agreed upon confidentiality. The client being evaluated or treated has the option to decide what information to reveal and what risks to confidentiality he or she may wish to bear. A written and signed document (contract) is recommended.

(3) Providers in criminal justice settings, or elsewhere, should inform all parties with whom they are working of the level of confidentiality which applies. They should clarify any circumstances which would constitute exceptions to confidentiality, in advance of the service being rendered. Each provider should make clear to the client any "conflicts of interests" or dual-client relationships which affect his/her current relationship with a client.

(4) Written permission and informed consent shall be granted by the client before any data may be divulged to other parties.

(5) When responding to an inquiry for information and when a written release by the client is obtained, written and oral reports should present data germane to the purpose of the inquiry. Every effort should be made to avoid undue invasion of privacy for the client or other related person.

(6) As noted above, information is not communicated to others without the consent of the client unless the following circumstances occur:

(A) There exists a clear and immediate danger to the person(s) from the client.

(B) There is an obligation to comply with specific statutes requiring reports of suspected abuse to authorities. Each provider is responsible for becoming fully aware of all statutes which pertain to the conduct of his or her professional practice.

(d) Assessments

(1) Providers make every effort possible to promote the client's nonoffending behavior while at the same time, acting in the best interest of the client, so long as others are not placed at identifiable risk. They guard against the misuse of assessment data. They respect their clients' rights to know the results, the interpretations made, and the basis for the conclusions and recommendations drawn from such assessments. They endeavor to ensure that the assessments and reports they provide are used appropriately by others as well. Reports are written in such a way to communicate clearly to the recipient of the report.

(2) Unless the client agrees to an exception in advance, each provider respects the right of the client to have a complete explanation, in language which the client is able to understand, of the nature and purpose of the methodologies, and any foreseeable *(side)* effects of the assessment.

(3) Each provider will obtain voluntary informed consent, in written form, from a client prior to conducting a physiological assessment or engaging in treatment. In cases where a question exists regarding the appropriateness of administering a test to a particular client, the provider shall seek expert guidance from a competent medical and/or psychological authority prior to testing.

(4) In court-ordered evaluations, the client should be informed of his rights as a client, including his rights of confidentiality.

(5) The responsible use of assessment measures is of paramount concern and a serious responsibility of each provider. Assessments regarding a person's degree of sexual dangerousness, suitability for treatment, or other forensic referral questions shall not be determined solely on the basis of a phallometric assessment. Rather, such data must be properly integrated within a comprehensive assessment, the components of which are determined by a person who has specific training and expertise in making such assessments.

(6) An assessment should not be used to confirm or deny whether an event or crime has taken place.

(7) In reporting assessment results, providers indicate any reservations that might exist regarding validity or reliability because of the circumstances of the assessment or the absence of comparative norms for the person being tested. Each provider endeavors to ensure that assessment results and interpretations are not misunderstood or misused by others. Proper qualifications will be made with regard to prediction and "generalizability of data" issues, in order to not mislead the consumer of the report.

(8) Since it is not within the professional competence of providers to offer conclusions on matters of law, unless they are trained to do so, they should resist pressure to offer such conclusions (e.g., while it would be appropriate to address an issue regarding the probability of a client committing certain criminal acts within a certain period of time, it would be inappropriate to state that "an individual is too dangerous to be released.").

(9) Each provider should be very cautious in offering predictions of criminal behavior for use in imprisoning or releasing individuals. If a provider decided that it is appropriate, on the basis of a thorough evaluation in a given case, to offer a prediction of criminal behavior, he or she should specify clearly:

(a) The acts being predicted;

(b) The estimated probability that these acts will occur during a given period of time; and

(c) The facts and data on which these predictive judgments are based.

(10) Each provider should be thoroughly familiar with the assessment or treatment procedures and data used by another provider before providing any public comment or testimony pertaining to the validity, reliability, or accuracy of such information.

(11) Each provider will safeguard sexual arousal assessment testing and treatment materials. Each provider will recognize the sensitivity of this material and use it only for the purpose for which it is intended in a controlled phallometric laboratory assessment. Providers will not make such materials available to persons who lack proper training and credentials, or who would misinterpret or improperly use such stimulus materials.

(e) Professional Relationships

(1) Each provider will refrain from knowingly offering services to a client who is in treatment with another professional without initially consulting with the professionals involved.

(2) Each provider will act with proper regard for the needs, special competencies, and perspectives of not only colleagues who treat sexual abusers but other professionals as well.

(3) Each provider is encouraged to affiliate with professional groups, clinics, or agencies operating in the assessment and treatment of sexual offenders. Similarly, interdisciplinary contact and cooperation is encouraged.

(f) Research and Publications

(1) Each provider is obligated to protect the welfare of his or her research subjects. Provisions of the "human subjects experimental policy" shall prevail as specified by the United States Department of Health, Education and Welfare guidelines.

(2) Each provider will carefully evaluate the ethical implications of possible research and has full responsibility to ensure that ethical practices are enforced in conducting such research.

(3) The practice of informed consent prevails. The research participant shall have full freedom to decline to participate in or withdraw from the research at any time without any prejudicial consequences.

(4) The research subject shall be protected from physical and mental discomfort, harm, and danger that may result from research procedures to the greatest degree possible.

(5) Publication credit is assigned to those who have contributed to a publication in proportion to their contribution, and in accordance with customary publication practices.

(g) Public Information and Advertising. All professional presentations to the public will be governed by the following standards on public information and advertising.

(1) General Principles: The practice of assessment and treatment of the sex offender exists for the public welfare. Therefore, it is appropriate for the well trained and qualified practitioner to inform the public of the availability of services. However, much needs to be done to educate the public as to the services available from qualified persons who engage in the assessment and treatment of sexual abusers. Therefore, providers have a responsibility to the public to engage in appropriate informational activities and avoid misrepresentation or misleading statements in keeping with the following general principles and specific regulations:

a. Selection of the therapist by a prospective client should be made on an informed basis. Advice and recommendations of third parties, such as community corrections officers, attorneys, physicians, other professionals, relatives or friends, as well as responses to restrained publicity, may be helpful. Advertisements and public communications, whether in directories, announcement cards, newspapers or on radio or television, should be formulated to convey accurate information which is necessary to make an appropriate selection. Self-praising and testimonials should be avoided. Information that may be helpful in some situations would include the following:

b. Office information such as name, including a group name and names of professional associates, address, telephone number, credit card acceptability, languages spoken and written, and office hours;

c. Earned degrees, state licensure and/or other certification, professional certification or affiliation;

d. Description of practice, including the statement that a practice is limited to the assessment or treatment of sexual offenders (if appropriate); and

e. Professional fee information.

(2) The proper motivation for community publicity by members who are engaged in the assessment and treatment of sexual abusers lies in the need to inform the public of the availability of competent professionals. The public benefit derived from advertising depends upon the usefulness and accuracy of the information provided to the community to which it is directed.

(3) The regulation of public statements by providers is rooted in the public interest. Public statements through which a provider seeks business by use of extravagant or brash statements or appeals to fears could mislead or harm the lay person. Furthermore, public communications that would produce unrealistic expectations in particular cases and would bring about a lack of confidence in the profession, would be harmful to the community. The therapist-client relationship is personal and unique and should not be established as the result of pressures, deception or exploitation of the vulnerability of clients.

(4) The name under which a provider conducts his or her practice may be a factor in the selection process. Use of a name or credentials which could mislead referral sources or lay persons is improper. Likewise, one should not hold oneself out as being a partner or associate of any agency or firm if he is, in fact, not acting in that capacity (e.g., a person engaged in private practice who is also employed at a state hospital should make it clear to a prospective client in private practice that he is not acting on behalf of a state hospital).

(5) In order to avoid the possibility of misleading persons with whom he or she deals, a provider should be scrupulous in the representation of his or her professional background, training and status. Each provider must indicate, if it is accurate, any limitations in his or her practice (e.g., a therapist who is a member should specify if, while working in a private practice setting, he/she needs to operate under the supervision of a licensed professional).

(6) Providers do not represent their affiliation with any organization or agency in a manner which falsely implies sponsorship or certification by that organization.

(7) ***Regulation of public information and advertising***

(a) A provider shall not knowingly make a representation about his or her ability, background, or experience, or about that of a partner or associate, or about a fee or any other aspect of a proposed professional engagement that is false, fraudulent, misleading, or deceptive.

(b) A false, fraudulent, misleading, or deceptive statement or claim is defined as a statement or claim which:
(i) Contains a material misrepresentation of fact;
(ii) Omits any material or statement of fact which is necessary to make the statement, in light of all circumstances, not misleading;
(iii) Is intended or likely to create an unjustified expectation concerning the clinician, or services.

This agency hereby certifies that the section as adopted has been reviewed by Legal Counsel and found to be a valid exercise of the agency's authority.

Issues in Austin, Texas on January 27, 1995

Training Announcement

The Council on Sex Offender Treatment, in collaboration with
the Texas Juvenile Probation Commission
and
the Texas Youth Commission
presents

The Third Annual Conference on
"Working With the Juvenile Sex Offender"

July 13-14, 1995
Wyndham Southpark Hotel, 4140 Governor's Row, Austin, Texas

Confirmed Speaker: **Jan Hindman,** Ontario, Oregon, National Expert on the Trauma of Sexual Abuse, Prevention and Treatment.

Breakout Sessions Include:

- ***Assessing Adolescent Sexual Offender's Modus Operandi: Enhancing Treatment Planning,*** K. Kaufman, Ph.D. Ohio State University
- ***Avoiding Iatrogenic Treatment of Juvenile Sex Offenders***
  W. Dubin, Ph.D., Austin, Texas
- ***Polygraph and Phallometric Testing of the Juvenile Sex Offender***
  W. Dutton, M.A., St. Joseph's Hospital, Arizona
- ***Clinical Distinctions of Sexual Offenses and Treatment for the Sexually Abusive Adolescent,*** C. Mitchell, Ph.D., Dallas, Texas
- ***Intervention Strategies and Treatment Methods for the Predatory Juvenile Sex Offender,*** David Navarre, LMSW-ACP, Austin, Texas

This conference is appropriate for victim advocates, treatment providers , law enforcement, juvenile probation detention officers, juvenile judges, juvenile prosecutors, educators, child care staff and other professionals in the field of juvenile sex offender treatment.

CEUs: Approved for the SOTP REGISTRY and TJPC (12.15 hours); CJAD and Board of Social Work Examiners. LMFT, LPC credits pending.
CONFERENCE COST: $45.00/day; **LATE REGISTRATION:** $55.00/day
REGISTRATION DEADLINE: June 21, 1995. Space is limited to 250 participants on a first-come, first-served basis.
TO REGISTER: Return the registration form on the following page, along with payment, to: CSOT, P.O. Box 12546, Austin, Texas 78711. For further information, call (512) 463-2323.
HOTEL ACCOMMODATIONS: A block of rooms has been reserved at the Wyndham at a rate of $55.00/night, single occupancy. **Reservations must be made by June 21, 1995** to guarantee these rates. Call (800) 433-2241 for reservations and hotel information.

PLEASE POST THIS ANNOUNCEMENT

*******REGISTRATION FORM*******

Third Annual Conference on

"Working with the Juvenile Sex Offender"

Name _____ Agency _____

Street Address _____ City _____ State _____ Zip Code _____

Telephone _____ Fax _____ Social Security Number _____

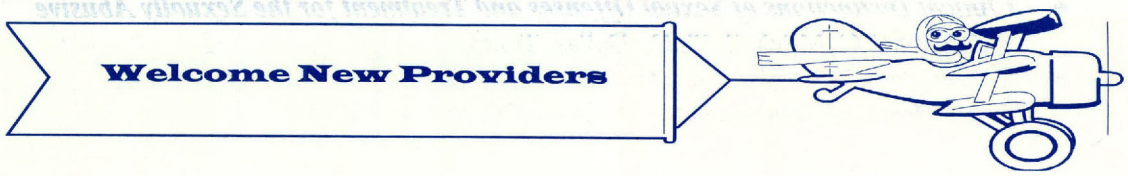
I would like to attend training on:

_____ Thursday, July 13, ($45.00) **_____ Friday, July 14 ($45.00)** **_____ July 13 & 14 ($90.00)**

_____ A check is enclosed **_____ Please invoice my Agency. Purchase order/ITV#:_____**

LATE REGISTRATION FEE OF $110.00 APPLIES AFTER JUNE 21, 1995.

Please make checks payable to the Council on Sex Offender Treatment. Refunds will be provided with notification of cancellation in writing by June 27, 1995. Early Registration Deadline: June 21, 1995



Giddings
Ronald Ross LPC
Texas Youth Commission
P.O. Box 600
Giddings, TX 78942
(409) 542-3686

Houston
James Lazarus, LPC
ADAPT
3355 West Alabama, Ste. 585
Houston, Tx 77098
(713) 271-9459

Hurst
Donna Sumlin, Ph.D.
Rehabilitation Counseling Associates
305 N.E. Loop 820, Ste. 416
Hurst, Tx 76053
(817) 595-1770

Lubbock
Beth A. Shapiro, Ph.D.
Gateways Counseling, L.L.P.
3410 22nd Place
Lubbock, Tx 74910
(806) 799-1033

Plainview
Ron Trusler, LMFT
Plainview Regional
Sex Offender Program
P.O. Box 996
Plainview, Tx 7073-0996
(806) 296-2368

Round Rock
John M. Holbert, LMSW-ACP
Family Guidance Center
1100 Round Rock, Tx 78681
(512) 255-2415

Rowlett
Paul Tathiah, Ph.D.
4106 Tracey Trail
Rowlett, Tx 75088
(214) 475-5292

San Antonio
Michael. Arambula, M.D.,Ph.D.
14800 US 281 N., Ste. 100
San Antonio, Tx 78232
(210) 490-9850

Training Calendar

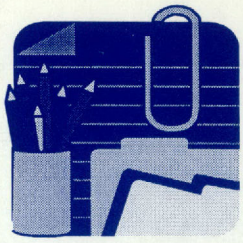
May 8-9, 1995
Child Victimization 95, Gene Abel, Stan Abrams
Fort Worth, Texas. For information call
(817) 232-7703.

May 16-17, 1995
Sexual Offenders. William Marshall, Ph.D.,
Austin, Texas. For information call (713) 688-6555

July 13-14, 1995
3rd Annual Conference on "Working with the Juvenile Sex Offender.", Jan Hindman
Austin, Texas For information call (512) 463-2323.

October 15-17, 1995
4th Annual Conference on the Treatment and Supervision of Sex Offenders, Roy Hazelwood
Huntsville, Texas. For information, call (409) 294-1677

The Texas Resource
Council on Sex Offender Treatment
P.O. Box 12546
Austin, Texas 78711-2546



Council on Sex Offender Treatment Staff

Eliza May, M.S.S.W., LMSW
Executive Director

Al Montes
Editor, Fiscal Officer

Leslie M. Ford
Staff Support

Ashley Westmoreland
Intern University of Texas