

INTENSIVE OUTPATIENT TREATMENT FOR CHILDREN/ADOLESCENTS WITH SEXUAL OFFENSE ISSUES

This Guideline specifically refers to Intensive Outpatient Treatment Programs for children/adolescents who present with inappropriate or criminal sexualized behaviors. Traditional psychotherapy is not sufficient for sex offense specific treatment. Such programs are staffed by persons listed as qualified providers by the Colorado Sex Offender Management Board. Treatment is consistent with the most recent revision of the Sexual Offender Management Board's Juvenile Treatment Standards.

Such programs are not paid for by Medicaid except in very limited circumstances. Medicaid may cover such treatment when the child/adolescent has a primary covered diagnosis and also a secondary diagnosis of paraphilia, especially if it is a factor in exacerbation of the primary diagnosis (For example, a child with PTSD because of abuse who may be dealing with it by offending against others.).

Treatment with a qualified provider in a community mental health center must be reviewed and approved by the MHC Clinical Director and/or Medical Director. Treatment with a qualified provider, who is part of the external network must be reviewed and approved by the BHO Medical Director and/or Clinical Director.

If the sexually inappropriate behavior requires residential placement, the CHN Clinical Director or Medical Director must first review the case prior to authorizations. Factors that may lead to this recommendation include: the child or adolescent is unable or unwilling to contract for safety of self and/or others; the child or adolescent presents with a level of violence in sexual or other offenses considered unmanageable in outpatient care.

I. Definition of Service:

This level of care includes comprehensive offense-specific services for children/adolescents who are or may become a threat to others through their inappropriate sexualized behaviors. The program of treatment includes planned and coordinated services provided by a multidisciplinary treatment team (MDT). At a minimum, the treatment team generally consists of the supervising probation/parole officer, the offender's treatment providers, the polygraph examiner and representatives of other agencies involved, such as the Department of Social Services, Developmental Disabilities, the school, and/or the primary care physician.

Evaluation and assessment is to occur at specified phases and clinicians are required to comply with the standards at each phase. Services provided by mental health clinicians in this level of care may include: diagnostic evaluation, psycho-social education, group therapy, family therapy, case management, clinical

polygraph, Abel Screen, and other services as identified by offense-specific treatment providers listed with the SOMB.

Because victim and community safety is paramount, sex offenders (parents/legal guardians) must sign a waiver of confidentiality for the entire treatment team.

II. Admission Criteria:

- A. A child or adolescent who is acting out sexually and/or manifesting sexualized behaviors in the community, and who is potentially dangerous to others, who presents with psychological symptoms consistent with a covered ICD-9-CM and DSM-IV-TR (Axis I-V) diagnosis, and which require and are likely to respond to, planned sex offense-specific therapeutic interventions.
- B. A child or adolescent who exhibits significant impairment of functioning in at least one life area as a result of maladaptive sexual behavior.
- C. A child or adolescent is transitioning back to the community from residential treatment services for his/her sexual behavior. This level of care is required when treatment in a less intensive setting may increase risk to victims.
- D. A child or adolescent who verbalizes a willingness to address his/her treatment goals.
- E. The parent, guardian, family member, or custodian accepts responsibility to participate in the treatment program.
- F. Special consideration will be made on a case-by-case basis for individuals exhibiting impaired intellectual functioning.

III. Exclusion Criteria:

- A. The child or adolescent has a primary diagnosis of active Substance Abuse, Delirium, Dementia, or any other non-covered diagnosis.
- B. The child or adolescent needs a 24-hour supervised treatment setting because of his/her risk to others.
- C. The child or adolescent has significant psychopathology or cognitive disorders that impair his/her ability to effectively participate in the program.
- D. The child or adolescent has a condition requiring acute inpatient medical or surgical care.

IV. Continued Stay Criteria:

- A. The child or adolescent continues to meet admission criteria.
- B. The child or adolescent exhibits an ability to respond positively to the treatment program and is motivated for continued treatment as evidenced by compliance with program rules and procedures.
- C. The child or adolescent exhibits progress in attaining or working towards treatment goals; progress is measured by achievement of change not passage of time.

- D. The child or adolescent's family demonstrates on-going active participation in the treatment process.
- E. The child or adolescent continues to have the ability to contract for safety of self and others.

V. Discharge Criteria:

- A. The child or adolescent has made substantial progress and/or completed his treatment goals and is being referred to a less intensive level of care.
- B. The child or adolescent has been non-compliant with treatment goals and/or program guidelines and his/her behavior is interfering with his/her treatment and/or the treatment of others, which may indicate a need for a higher level of care, as evidenced by: client consistently fails to attain treatment goals; and/or client remains in denial after four to six months; and/or client and/or family member(s) have poor attendance.
- C. The child or adolescent has become gravely disabled or a danger to self or others and requires a more intensive level of care in an inpatient setting to stabilize symptomology.
- D. Individual meets criteria for an alternative level of care.

Appendix I

The Guiding Principles as set forth by The Colorado Sex Offender Management Board (SOMB) for juvenile offenders are as follows. They are included in this document for reference only.

1. Sexual offending is a behavioral disorder which cannot be “cured.”
2. Sex offenders are dangerous.
3. Community safety is paramount.
4. Assessment and evaluation of sex offenders is an on-going process. Progress in treatment and level of risk are not constant over time.
5. Assignment to community supervision is a privilege, and sex offenders must be completely accountable for their behaviors.
6. Sex offenders must waive confidentiality for evaluation, treatment, supervision and case management purposes.
7. Victims have a right to safety and self-determination.
8. When a child is sexually abused within the family, the child’s individual need for safety, protection, developmental growth and psychological well-being outweighs any parental or family interests.
9. A continuum of sex offender management and treatment options should be available in each community in the state.
10. Standards and guidelines for assessment, evaluation, treatment and behavioral monitoring of sex offenders will be most effective if the entirety of the criminal justice and social services systems, not just sex offender treatment providers, apply the same principles and work together.
11. The management of sex offenders requires a coordinated team response.
12. Sex offender assessment, evaluation, treatment and behavioral monitoring should be non-discriminatory and humane, and bound by the rules of ethics and law.
13. Successful treatment and management of sex offenders is enhanced by the positive cooperation of family, friends, employers and members of the community who have influence in sex offender’s lives.

Appendix II: Sexual Offender Terminology

Abuse or Misuse
of Power:

Using one’s power over another person to get one’s needs met without regard for the other person’s needs. A person can exercise power by being older, bigger or stronger than another, by being in a position of trust (such as a family member, friend, babysitter, teacher, minister, etc.), by being in a supervisory role with another (such as a teacher, an employer or boss), or by being popular in school or a role model for other (such as the class president, the star football player, etc.).

- Assessment:** The collection of facts gathered to draw conclusions that may suggest the proper course of action. Although the term “assessment” may be used interchangeably with the term “evaluation,” assessment generally has the broader usage, implying the collection of facts by a variety of agencies or individuals. Evaluation generally refers to the mental health sex offense specific evaluation conducted by a therapist.
- Behavior Monitoring:** A variety of methods for checking, regulating, and supervising the behavior of sex offenders.
- Child Sexual Abuse:** Any sexual contact with a child. Children are unable to consent to sexual contact because they lack the maturity and ability to make decisions concerning sexual contact. Children cannot give consent.
- Clinical Polygraph:** The employment of instrumentation used for detecting deception or verifying truth of statements of a person under criminal justice supervision and/or treatment for the commission of sex offenses. A clinical polygraph examination is specifically intended to assist in the treatment and supervision of convicted sex offenders. Clinical polygraphs include specific-issue, disclosure and periodic or maintenance examination.
- Coercion:** Using threats, force, tricks, bribes, or intimidation to get a child or an adult to go along with sexual contact.
- Compliance:** Occurs when a child or an adult goes along with sexual contact and does not actively resist the contact, but doesn’t want to participate, feels that what is being done is wrong, and doesn’t like what is happening to him/her. The victim may not actively resist due to confusion, fear, shame, or embarrassment.
- Consent:** Occurs when a person agrees to sexual contact. The person must be mentally competent, and have a full understanding of the kind of sexual contact that is being agreed to. The person must understand the consequences of agreeing to sexual contact and must feel assured that if he/she decides to say “no” to sexual contact, this decision will be respected. Children cannot give consent.
- Enticement:** Communication with anyone under the age of 18 for the purpose of being sexual with them through words and/or actions and behavior. For example, asking a child to have sexual contact, showing child pornography, talking to a child about inappropriate sexual matters are all considered crimes.
- Frottage:** Purposefully rubbing against another person’s body or sexual

parts, to get sexual pleasure, without his or her consent.

Grooming: The methods that sexual offenders use to gain a position of trust with others in order to abuse them. For example, a sexual offender might give a younger child candy or other gifts to make that child feel that he can trust the sexual offender. Or a sexual offender might grant special favors to a potential victim, like letting the child stay up past her bedtime or watch whatever television shows the child desires, in order to fool the child into trusting him. Sexual offenders might also show a child pornographic material or talk to them about sexual matters as a grooming strategy.

Incest: Sexual contact with someone who is closely related. This includes grandchildren, nieces, nephews, brothers, sisters, children, stepchildren, mothers, and fathers.

Indecent Exposure (Exhibitionism): Exposing one's penis, breast, vagina, or anus in public. People may expose themselves to adults or children. In either case, it is a crime.

Masturbation: Sexual self-stimulation (i.e., touching one's own genitals) to the point of orgasm.

- Objectification:** Seeing another person as an object to meet one's needs for pleasure and not as a person with his/her own needs, feelings, thoughts, and personality.
- Oral Sex:** Use of one's mouth or tongue on another person's genitalia or anus for sexual stimulation.
- Plethysmograph Examination:** Phallometric assessment of sexual arousal to provide objective data regarding sexual preferences. It may also promote self-disclosure and reduce minimization and denial of sexual offenses. Additionally, it can assist in monitoring changes in sexual arousal patterns that have been modified by treatment.
- Power Abuse Cycles:** Patterns of maladaptive, inappropriate, and eventually abusive behavior that are initiated by feelings of helplessness and a sense that one has lost control. While a person is involved in a power abuse cycle, he/she falsely believes that he/she is regaining his/her sense of control. For example, an offender may feel powerful over another person while he/she is abusing that person. In reality, this person is not powerful, but rather this person is fearful, confused, angry, sad, lonely and lacking positive self-esteem and confidence.
- Rape:** Sexual intercourse with someone against his/her will. A person can say "no" verbally or nonverbally through his/her body language. A rapist may physically injure the victim and may use force, weapons and/or threats to rape the victim. Even if there are no physical injuries, weapons, force or threats employed, rape occurs whenever consent to sexual contact is not given.
- Sexual Assault:** Forcing or attempting to force another person to engage in sexual contact against his/her will. An example of sexual assault might be touching another person's body parts against his/her will or forcing another person to touch the perpetrator.
- Sexual Acting Out/Offense:** Engaging in public sexualized behavior or committing a sexual offense, such as incest, molestation, rape, or sexual assault.
- Sexual Harassment:** Unwelcome sexual advances, requests for sexual contact, and other verbal or physical conduct of a sexual nature (i.e., sexual gestures, overtures, innuendoes, and language).
- Sexualized Children:** Children who are exposed to explicit sexual information such as nudity, sexualized violence, foul language regarding sexual acts or

innuendos, and sexually stimulating situations, via television, video, magazines, etc. Children often do not have the internal or external resources to cope with these types of stimuli. They can experience distress and confusion that contribute to sexual acting out.

Sexual Contact: Sexual intercourse, oral sex, rubbing or touching genital areas, anus, or breasts, or masturbating onto or in front of another person.

Sexual Intercourse: Penetrating one's vagina, anus or mouth with a penis, finger or other object.

Sex Offense: Includes: sexual assault in the first, second and third degree; sexual assault on a child; sexual assault on a child by one in a position of trust; sexual assault on a client by a psychotherapist; enticement of a child; incest; aggravated incest; trafficking in children; sexual exploitation of children; procurement of a child for sexual exploitation; indecent exposure; soliciting for child prostitution; pandering of a child; procurement of a child; keeping a place of child prostitution; pimping of a child; inducement of child prostitution; patronizing a prostituted child, or; criminal attempt, conspiracy, or solicitation to commit any of the above offenses.

Sex Offense Specific Treatment:

A long term comprehensive set of planned therapeutic interventions to change sexually abusive thoughts and behaviors. Such treatment specifically addresses the occurrence and dynamics of sexually deviant behavior and utilizes specific strategies to promote change. Sex offense specific programming focuses on the concrete details of the actual sexual behavior, the fantasies, the arousal, the planning, the denial and the rationalizations. Due to the difficulties inherent in treating sex offenders and the potential threat to community safety, sex offense specific treatment may continue for several years, followed by a lengthy period of aftercare and monitoring. Much more importance is given to the meeting of all treatment goals than the passage of a specific amount of time, since offenders make progress in treatment at different rates. The primary treatment modality for sex offense specific treatment is group therapy for the offenders. Adjunct modalities may include: partner or couples therapy, psycho-education, and/or individual therapy. However, such adjunct therapies by themselves do not constitute sex offense specific treatment.

Sexual Paraphilia/
Sexual Deviance

A subclass of sexual disorders in which the essential features are “recurrent intense sexually arousing fantasies, sexual urges, or behaviors generally involving (1) nonhuman objects, (2) the suffering or humiliation of oneself or one’s partner, or (3) children or other non-consenting persons that occur over a period of at least six months. The impairment in social, occupational, or other important areas of function. Paraphiliac imagery may be acted out with a non-consenting partner in a way that may be injurious to the partner. The individual may be subject to arrest and incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal sex acts” (DSM-IV, pages 533-523). This class of disorders is also referred to as “sexual deviations.” Examples include: pedophilia, exhibitionism, frotteurism, fetishism, voyeurism, sexual sadism, sexual masochism, and transvestic fetishism. This classification system includes a category labeled “Paraphilia Not otherwise Specified” for other paraphilias which are less commonly encountered.

Statutory Rape:

Sexual contact with someone not legally able to give consent. In Colorado, a person must be 15 years old before he/she can give consent to participate in any sexual act. Having sexual contact with someone under the legal age of consent, whether they agree to participate or not, is considered a crime – rape. It is generally not considered statutory rape when two teenagers who are close in age (within two years of each other) have sexual contact with each other as long as no force, threats, tricks, intimidation or bribes are used to get the younger teen to engage in sexual contact. However, if one of the teenagers is more than two years older than the other, and the younger teen is under the legal age of consent, the older teenager could be committing statutory rape and legal charges could be pressed.

Victim Awareness
and Empathy:

Because empathy is a mechanism that helps control negative impulses, one factor that is likely to enable sexually abusive behavior to continue is lack of empathy for the victim. Although there is no clear evidence to suggest a sexual abuser can develop true empathy for victims of abuse, it is possible to increase the abuser’s awareness of both the short and long-term impact of sexual victimization.

Victim Clarification
Process:

A process designed for the primary benefit of the victim, by which the offender clarifies that the responsibility for the assault/abuse resides with the offender. The process clarifies that the victim has

no responsibility for the offender's behavior and addresses the damage done to the victim and the family. This is a lengthy process requiring both verbal and written exercises on the part of the offender. Although victim participation is never required, and is sometimes contraindicated, should the process proceed to an actual clarification meeting with the victim, all contact is victim centered and based on victim need.

Voyeurism (Peeping): Looking into another person's windows, or otherwise violating their private living space, for sexual gratification. This is a crime.

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