**Section 1905.130 Risk Reduction and Risk Management in the Community**

a) Many adult sexual abusers residing in the community are supervised under the jurisdiction of the courts, correctional departments, probation or parole divisions or mental health agencies. Approaches to reducing and managing risk in the community may involve imposing various supervision conditions, expectations and requirements; monitoring and tracking; linking clients to appropriate programs and services; facilitating successful reentry to and stability in the community following release from correctional or other facility custody; promoting continuity of care within and across facility-based programs and services and community-based services; educating and engaging the public and communities; using and encouraging other system partners to use empirically informed assessment information to guide interventions and strategies; and engaging positive community support networks, which may include trained volunteers. Some strategies are explicitly designed to reduce the recidivism risk of sexual abusers by assisting them with developing and enhancing prosocial attitudes, skills and behaviors; increasing healthy and appropriate interests; effectively managing risk factors; developing positive and prosocial community supports; and enhancing other protective factors. Other strategies are primarily designed to promote accountability, deterrence and risk management.

b) Research indicates that focusing supervision activities primarily or exclusively on risk management is not effective in reducing recidivism, whereas using risk-reducing interventions, such as treatment and other skill-building interventions, to complement risk management-based supervision strategies leads to better outcomes. To support a balance of risk reduction and risk management efforts, contemporary trends involving sexual abusers in the community often emphasize multidisciplinary and multi-agency collaborations. These collaborative efforts are part of contemporary practices in the treatment and supervision of sexual abusers, as supported by the extant literature. It may include communication and partnerships among professionals, such as sexual abuser-specific treatment providers and other treatment providers (e.g., substance abuse, mental health, marital and family therapists), probation or parole officers, case managers, child welfare professionals, victim advocates, law enforcement officials, polygraph examiners and others.

c) In many jurisdictions, collaboration occurs through multidisciplinary case management teams, the composition of which may vary depending on the risk, needs and circumstances of a given client. Key elements of effective collaboration include a clear delineation of roles and responsibilities, complementary policies and procedures, ethically sound communication and information-sharing mechanisms, and a shared community safety goal. Through effective partnerships, early intervention can be exercised to reduce the risk posed by sexual abusers prior to behaviors that are not yet criminal in nature and to facilitate the exchange of information to develop appropriate treatment plans, inform risk management decisions, make recommendations regarding victim contact, and increase the overall stability and success of clients in the community.

d) In cases in which 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 collaboration exists among professionals with case management responsibilities in the facility and in the community. Transition and reentry planning should be initiated well in advance of the client's release in order to identify any current and ongoing intervention needs, promote continuity of care, explore and begin to address potential barriers to reentry in the community (e.g., housing or employment challenges), clarify any post release conditions and expectations, and facilitate access to community resources and services, which may include community-based sexual abuser-specific treatment.

e) Research on correctional populations, including sexual abusers, demonstrates that interventions are most effective when guided by evidence-based principles of correctional intervention (i.e., risk, need and responsivity). Therefore, community-based risk reduction and risk management strategies involving sexual abusers are ideally matched accordingly and may change over time, based on current and empirically informed assessment information. Although higher risk/higher need clients may require supervision, monitoring and treatment of greater intensity and dosage, less intensive supervision and other risk management and risk reduction strategies may be more effective and sufficiently adequate for sexual abusers with lower recidivism risk, fewer intervention needs and greater protective factors.

f) Overarching Risk Reduction and Risk Management Considerations

1) Treatment providers recognize that the community management of sexual abusers generally involves a variety of interventions, strategies and mechanisms.

2) Treatment providers appreciate that sex offender-specific public policies and practices have varied goals (e.g., deterrence, retribution, risk management, risk reduction, prevention) and may reflect different interests and priorities for stakeholders. Some may complement sexual abuser-specific treatment, other risk-reducing interventions and prevention strategies; others may not.

3) Treatment providers recognize that some interventions and strategies used to promote risk management and risk reduction with clients have more empirical support than others.

4) Treatment providers remain apprised of the current research pertaining to the impact and effectiveness of various risk management and risk reduction policies and strategies utilized with clients in the community.

5) Treatment providers are encouraged to work with researchers to assess the impact and effectiveness of community-based risk management and risk reduction strategies utilized with clients.

6) Treatment providers 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 reduction and risk management with clients in the community.

7) Treatment providers 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 sexual abusers in the community and support the use of those assessments system-wide.

8) Treatment providers 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 sexual abusers in the community.

g) Multidisciplinary Collaboration

1) Treatment providers recognize that effectively reducing and managing risk among sexual abusers in the community often involves collaboration across multiple agencies, entities and disciplines.

2) Treatment providers appreciate that their respective roles and responsibilities with clients are part of a broader system of community management.

3) Treatment providers strive to engage stakeholders, such as the judiciary, treatment providers, probation and parole officers, correctional staff, victim advocates, law enforcement agents, employers, landlords and housing officials, civic organizations, mentors, the faith community, and other community supports, in contributing to risk reduction, risk management and prevention activities.

4) Treatment providers recognize that collaborative partnerships are more effective at increasing community safety when the various stakeholders are appropriately trained and knowledgeable about working with sexual abusers. Therefore, treatment providers promote education and training of the involved professionals and nonprofessionals (e.g., family members, community supports).

5) Treatment providers ensure that information-sharing and collaboration occur within the parameters of confidentiality provisions, informed consent and other ethical standards.

h) Collaborating with Probation/Parole or Other Community Supervision Professionals

1) Treatment providers working with sexual abusers shall collaborate with probation and parole officers, correctional and other facility staff, case managers, and post release aftercare professions to support successful public safety and client outcomes.

2) For clients who are under court-mandated or other formal supervision in the community (e.g., probation, parole, aftercare/step-down from an inpatient treatment facility), treatment providers strive to obtain supervision- and treatment-related information from the appropriate authorities. This minimally includes copies of:

A) presentence investigations, prerelease evaluations, previous sexual abuser-specific evaluations, treatment summaries, and conditions of probation/parole or post release placement in the community; and

B) when possible, documents regarding the investigation of the offenses.

3) Treatment providers working with sexual abusers review with the probation officers/parole agents and other case managers the specific conditions that are designed for risk reduction and management purposes and discuss the rationale with the clients. These conditions often include, but are not limited to, the following:

A) Abstaining from alcohol and/or illegal drugs, when substance use is a risk factor;

B) Adhering to treatment expectations (e.g., participation, compliance with program rules and individual treatment plans);

C) Practicing healthy sexual attitudes and behaviors;

D) When appropriate, disclosing offense history, risk factors and effective coping strategies to professionals who are involved with the client and the client's significant others;

E) Making plans for work, social and leisure activities to enhance quality of life and reduce possible exposure to cues or situations associated with the client's risk of reoffending;

F) Complying with other conditions of supervision, such as restricted internet access, employment, volunteering, polygraph examinations and electronic/GPS monitoring; and

G) Complying with restrictions on contact with children or other vulnerable parties (e.g., adults with developmental limitations), as deemed necessary for a given individual.

4) Treatment providers working with sexual abusers establish and clarify the appropriate parameters (e.g., timing, type of content) and mechanisms (e.g., written, verbal, face-to-face) for reciprocal information-sharing with the probation/parole officer or other relevant case management professionals in order to promote well-informed decision making. This minimally includes the following:

A) Attendance in treatment;

B) Overall participation in treatment;

C) Specific changes in dynamic and protective risk factors;

D) Progress toward specific goals in treatment;

E) Engagement and compliance with supervision;

F) Referrals to and/or participation in additional programs and services; and

G) Adjustments to level of supervision or supervision strategies.

5) Treatment providers report, to the appropriate professionals with the authority and responsibility for supervision, in a timely manner, any violations of their clients' conditions of supervision and significant adverse changes in dynamic risk factors.

i) Treatment providers shall recognize the distinct but potentially complementary roles and responsibilities of treatment providers and supervision officers, clarify these roles and responsibilities to clients and other professionals, and actively strive to maintain these professional boundaries.

1) Treatment providers are 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.

2) While supporting complementary risk reduction and risk management efforts with clients, treatment providers strive to ensure that:

A) Sexual abuser-specific treatment providers limit their role to that of a clinician and do not attempt to assume the roles of supervision officers or law enforcement agents, or represent themselves as such.

B) Probation/parole officers do not represent themselves as specialized sexual abuser-specific treatment providers unless they possess the requisite education, training, supervision, licensure and continuing education;

C) Probation/parole officers who deliver "general" cognitive and/or behavioral interventions to promote skill-building and behavior change among clients are well-trained and appropriately supervised to deliver those interventions with fidelity; and

D) Probation/parole officers do not assume specialized clinical responsibilities within treatment programs for sexual abusers with clients for whom they have supervision responsibility.

3) In order to promote a collaborative treatment approach, treatment providers are encouraged, when clinically appropriate, to allow probation/parole officers to observe clinical treatment sessions in programs for sexual abusers. However, the following guidelines should be taken into consideration:

A) Treatment providers recognize that these observations can:

i) help educate officers about individuals who sexually abuse and the nature and approach to treatment for sexual abusers; and

ii) help officers obtain information that may enhance their supervision of a given client.

B) Treatment providers recognize that these observations can impact client confidentiality, inhibiting client participation and disclosure; disrupt continuity of the treatment process; and blur clients' perceptions of officers' roles.

C) If allowing these observations, treatment providers:

i) Ensure that officers identify themselves by position and work responsibilities and clarify to session participants their roles and responsibilities as supervision officers;

ii) Review and clarify the purpose and possible impact of having officers present;

iii) Obtain appropriate informed and voluntary consent from clients; and

iv) Ensure that officers are aware of and adhere to professional ethics, including, but not limited to, confidentiality limits and boundaries.

j) Engaging Community Supports

1) Treatment providers shall recognize that an appropriate support person can assist professionals and clients with risk reduction, risk management and other successful outcomes for clients, victims and communities.

2) Treatment providers collaborate with clients and other professionals to identify and engage community support persons in the supervision and treatment processes, when appropriate and feasible.

3) Treatment providers acknowledge that appropriate support persons are able and willing to:

A) Appreciate that clients are responsible for having engaged in sexually abusive behavior;

B) Recognize that recidivism risk can increase and decrease over time;

C) Maintain routine contact with the individual who has engaged in sexually abusive behavior;

D) Understand, recognize, intervene and report when risk factors are present;

E) Maintain, model and assist clients with practicing prosocial attitudes and behaviors;

F) Support adherence to supervision, treatment and other expectations pertaining to risk reduction and risk management;

G) Participate in the development and implementation of safety plans for victims and other vulnerable persons as applicable; and

H) Communicate routinely and effectively with the professionals responsible for assessing, supervising and providing treatment to sexual abusers.

4) Treatment providers establish and clarify appropriate parameters (e.g., timing, nature, limits, methods) of reciprocal information-sharing with support persons.

5) Treatment providers take appropriate steps to ensure that support persons are equipped with knowledge and skills regarding risk factors for reoffending, strategies for effectively reducing and managing clients' risk for recidivism, and the strengths and limitations of strategies in place.

6) Treatment providers:

A) educate clients and identified support persons regarding the roles, responsibilities, expectations and risks and benefits associated with serving as part of a collaborative support network; and

B) elicit informed consent accordingly.

k) Collaborating with Child Protective/Child Welfare Professionals

This Section pertains to clients whose sexually abusive behaviors, interests, preferences, or arousal involve children and the potential for these clients to have planned or unplanned contact with children (e.g., children in their own families, the children of new romantic partners, friends, coworkers, or neighbors). It is important to note that contact is not limited to the client's close physical proximity with a child or adolescent, but also includes one-to-one interactions such as telephone calls, emails, written notes and communications through third parties.

1) Treatment providers shall prioritize the rights, well-being and safety of children when making decisions about client contact with minors.

2) Treatment providers take reasonable steps to support a client's adherence to any no contact orders or other restrictions that have been imposed by the courts or other entities statutorily authorized to impose restrictions for that client.

3) When contact with children is at issue under the terms of any legal disposition (e.g., court order, probation/parole order), treatment providers may provide written assessment-driven recommendations regarding an individual client's acceptable level of contact with children that range from no contact to supervised or unsupervised contact.

4) Treatment providers' recommendations regarding contact with minors should be minimally informed by the following:

A) Empirically informed assessments of recidivism risk and protective factors;

B) The client's history of deviant sexual interests, fantasies and behaviors involving children;

C) The nature, extent and duration of the offending behaviors of the client;

D) The client's engagement and progress in sexual abuser treatment, particularly with respect to general and sexual self-regulation, sexual preoccupations and extent of sexual deviance variables; the abuser-victim relationship; and offense-related motivations, grooming patterns, attitudes and offense-specific variables;

E) The presence of positive prosocial supports for the client who can serve as chaperones;

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

G) The ability, skills and willingness of nonoffending parents or guardians to provide an environment that is appropriately conducive to maintaining the child's emotional and physical safety;

H) The availability and professional opinions of a qualified child advocate, mental health or child welfare professional to whom the child and family are therapeutically engaged, and the confidence that the child will be able to articulate interests and concerns regarding the potential for contact with the client;

I) The child's reported interests for contact or no contact, or if contact would not be in the best interests of the child; and

J) The extent to which community strategies are currently in place to provide adequate mechanisms and resources to ensure adequate child safety plans for victims and other minors.

5) Treatment providers collaborate with the proper authorities or professionals to support restrictions that prohibit clients from having contact with a child if the child does not want contact or if contact would not be in the best interests of the child or other vulnerable persons.

6) Treatment providers consider the impact that the client's contact with siblings may have on the victim and approve contact that minimizes distress to the victim.

7) Treatment providers work collaboratively with child welfare/child protection agencies, victim advocates and others (e.g., treatment providers, probation/parole officers) to develop safety plans for victims and other vulnerable children.

8) Treatment providers obtain informed consent from a child's nonoffending parent or legal guardian before approving a client's contact with that child, while adhering to the parameters of any legal or other restrictions.

9) Treatment providers may support structured and/or supervised contact with children when the following occur:

A) the client is making acceptable progress in treatment and/or supervision;

B) he/she is effectively managing dynamic risk;

C) appropriate safety precautions are in place; and

D) contact is assessed to be in the best interest of the child by the appropriate/designated professionals working with those responsible for child welfare decisions, taking into account the expressed interests of the child.

10) Within the bounds of confidentiality, treatment providers regularly exchange information in a timely manner with child welfare workers involved in a client's case and with child welfare workers involved in monitoring the safety of children with whom the client is having or considering having contact, unless otherwise specified by law. Information may include, but is not limited to, the following:

A) Client's treatment progress;

B) Significant changes in dynamic risk factors; and

C) Significant barriers and social services agreements in place with goals and objectives that have to be met by all in order to promote contact or reunification.

11) Treatment providers familiarize themselves with restrictions related to client-victim contact and abide by those restrictions in a therapeutic manner.

12) Treatment providers ensure that, as warranted for a given client, contact with children is addressed as part of a comprehensive community risk management plan and should be linked to the client's re-offense risk, progress in treatment, and/or compliance with supervision, as applicable.

13) Treatment providers document all decisions about a client's contact with children, including whether contact is recommended, the type of contact that is recommended, the preparations made with children and chaperones, and information obtained during the ongoing monitoring process.

l) Addressing Family Reunification and Visitation

1) Treatment providers shall collaborate with child welfare workers to address family reunification efforts when clients have abused children in their own families and wish to have contact with them, or they seek to begin relationships with individuals who have children.

2) Treatment providers recognize that family reunification, in many cases, is not an advisable goal because of the risk and potential for harm that may be unmanageable (e.g., high risk, lack of appropriate caregiver supervision, nature of the victimization, impact on family and victim). However, family reunification may be one of the many ways that victims and families attempt to resolve issues generated by the offender's abuse and may be beneficial for other reasons in some circumstances.

3) Treatment providers are aware that reunification is a gradual and well-supervised procedure in which a sexual abuser is allowed to reintegrate into the familial network where the victims or potential victims are present.

4) Before providing recommendations regarding family reunification, treatment providers collaborate with professionals from a range of disciplines who have different agency missions and mandates, which may include child welfare professionals, family therapists, victim services providers or advocates, treatment providers, supervision officers, and other community supports.

5) Treatment providers ensure that any child contact decisions within the context of family reunification efforts should be informed by a thorough assessment of the client's risk, the child's safety plan, and consultation with other members of the community risk management team, such as collaborative partners and stakeholders.

6) Treatment providers ensure that, as appropriate and indicated, contact with the client's children, his/her current partner's children, or children of family members are also discussed as part of the reunification process.

7) Treatment providers do not recommend the involvement of the victims or potential victims in family reunification efforts unless that involvement is likely to benefit the victims or potential victims and unlikely to cause them inordinate levels of distress.

8) Treatment providers, if necessary, recommend that the client be removed from the residence of the victims or potential victims rather than removing the victims or potential victims.

9) Treatment providers consider the wishes of the victims or potential victims with regard to family reunification, taking into account their ability to understand the ramifications of their decisions.

10) Treatment providers ensure that a child has access to a responsible adult chaperone trusted by that child before recommending the client be allowed to have contact with that child.

11) Treatment providers may make recommendations for a client to have contact with interfamilial victims and other family members under 18 (or otherwise vulnerable persons) only when the following are present:

A) A nonoffending parent or another responsible adult who is adequately prepared to supervise the contact;

B) The victim or minor is judged to be ready for the contact by a professional who can monitor the victim's or minor's safety; and

C) The client has made acceptable progress in treatment.

12) Treatment providers ensure that appropriate safety plans are developed and monitored during the family reunification process. Safety plans should include explicit and nonnegotiable rules and boundaries, as well as the method to address infractions.

m) Engaging Chaperones and Community Supports

1) Treatment providers shall exercise prudence and caution when involved with the selection and education of responsible adult chaperones for contacts between clients and children and other vulnerable parties who may be unable to give consent.

2) Treatment providers recommend as potential chaperones only adults who:

A) Accept and understand the client's history of sexually abusive behavior;

B) Appreciate that the client is solely responsible for decisions to act in a sexually abusive manner (i.e., chaperones do not place responsibility on victims or external circumstances);

C) Recognize the potential for risk and intervention needs to change over time, either increasing or diminishing;

D) Appreciate the need for the client to have prosocial supports; and

E) Accept the role and responsibilities of being an effective chaperone.

3) Treatment providers ensure that clients educate potential chaperones candidly about the clients' sexually abusive behaviors, antecedent and ongoing risk factors, and treatment and/or supervision conditions.

4) Treatment providers ensure that chaperones fully understand the safety plan for the children and appropriate reporting procedures for violations of the safety plan.

5) Treatment providers monitor authorized contacts between the client and children through interviews with the client, the chaperone and/or the child's therapist/support person, and through other supervision options.

n) Continuity of Care

1) Treatment providers shall recognize that continuity of care is necessary to support effective risk management and risk reduction of sexual abusers in the community.

2) Treatment providers facilitate, in a timely manner, the seamless access to and provision of follow-up services for clients who transition from one program to another. This may include transition from:

A) Institutional to community-based treatment;

B) Community-based treatment to treatment in a correctional, inpatient or other institutional setting;

C) Programming within a facility/institution or within the community, at a lateral level of transfer; or

D) The current jurisdiction/place of residence to a new jurisdiction of residence, due to relocation or transfer of supervision.

3) Treatment providers seek information, through appropriate release of information when necessary, regarding treatment progress and take this into consideration when initiating treatment services for a client who has been receiving services elsewhere or in another setting in order to prevent duplication of efforts and promote timely, assessment-driven, well-informed treatment planning.

4) Treatment providers, to the greatest degree possible, include the client, institutional caseworker, institutional treatment staff, community supervision staff, community treatment staff, family members, and support persons in release planning meetings. When this is not possible, electronic alternatives, such as teleconferencing or videoconferencing, may be used.

5) Treatment providers providing services to clients prepare written treatment/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/security). These summaries usually include the following elements:

A) Assessment of risk to sexually harm others, including individualized risk factors and indicators of imminent risk;

B) Assessment of dynamic risk factors and protective factors/client strengths (e.g., prosocial support systems);

C) Description of offending pattern;

D) Description of sexual and nonsexual criminal history;

E) Identification of relevant problems and continuing interventions needs (including medication);

F) Level of participation in programming; and

G) Recommendations for community supervision, treatment and support services to guide post-release case management decisions.

6) When appropriate and within ethical parameters, bounds of confidentiality, and other information-sharing statutes or professional regulations, treatment providers working in correctional facilities or inpatient/other institutional settings provide community-based providers, supervision officers/case managers, aftercare workers, and other appropriate support persons with information that can be used to inform appropriate post release or transitional treatment, supervision and management in the community.