

West's Illinois Administrative Code  
Title 20. Corrections, Criminal Justice, and Law Enforcement  
Chapter VII. Sex Offender Management Board  
Part 1905. Adult Sex Offender Evaluation and Treatment

20 Ill. Adm. Code Ch. VII, Pt. 1905, Refs & Annos  
Currentness

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West's Illinois Administrative Code  
Title 20. Corrections, Criminal Justice, and Law Enforcement  
Chapter VII. Sex Offender Management Board  
Part 1905. Adult Sex Offender Evaluation and Treatment (Refs & Annos)  
Subpart A. General

20 Ill. Adm. Code 1905.20

1905.20 Definitions

Currentness

In this Part, the terms "Board", "sex offender", "sex offense", "management", and "sexually motivated" have the meanings ascribed to them in Section 10 of the Act. In addition, the following definitions apply:

"Act": Sex Offender Management Board Act [20 ILCS 4026].

"Case management": The coordination and implementation of the cluster of activities directed toward supervising, treating and managing the behavior of individual sex offenders.

"Evaluation": The systematic collection and analysis of psychological, behavioral and social information; the process by which information is gathered, analyzed and documented.

"Informed assent": Compliance; a declaration of willingness to do something in compliance with a request; acquiescence; agreement. The use of the term "assent" rather than "consent" in this Part recognizes that sex offenders are not voluntary clients and that their choices are therefore more limited. "Informed" means that a person's assent is based on a full disclosure of the facts needed to make the decision intelligently; e.g., knowledge of risks involved, alternatives.

"Informed consent": "Consent" means voluntary agreement or approval to do something in compliance with a request. "Informed" means that a person's consent is based on a full disclosure of the facts needed to make the decision intelligently; e.g., knowledge of risks involved, alternatives.

"Parole": Parole or mandatory supervised release.

"Polygraph": The employment of instrumentation, as defined by the Illinois Detection of Deception Examiners Act [225 ILCS 430], used for the purpose of 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 examinations. Clinical polygraphs may also be referred to as post-conviction polygraphs.

"Professional license": A license issued by a State governmental body to practice a particular health or mental health profession.

"Sex offense specific": Relating to the problem of sexual offense behavior.

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1905.30 Provider Qualifications

Currentness

Only individuals licensed as Sex Offender Therapists, Sex Offender Evaluators or Associate Providers by the Illinois Department of Professional and Financial Regulation (DFPR) are approved to conduct the evaluation and treatment services described in the following Sections.

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20 Ill. Adm. Code 1905.50

1905.50 Assessment Guidelines

Currentness

a) Licensed evaluators shall conduct objective, impartial and reliable sexual abuser-specific assessments that support well-informed decision making and maintain the credibility and integrity of the profession.

1) Evaluators conduct sexual abuser-specific assessments in accordance with any additional ethical standards, codes, laws or other expectations for the respective profession or discipline of practice. This includes ethical standards pertaining to, but not limited to, the following:

A) Informed consent;

B) Specialized training, knowledge, expertise and scope of practice;

C) Documentation and retention of records;

D) Currency of research;

E) Confidentiality;

F) Professional relationships; and

G) Conduct.

2) Evaluators:

A) explore and disclose any conflicts of interest or other issues that may interfere with their ability to provide an objective, fair and impartial assessment; and

B) refer the potential client to another clinician or agency if the assessment process and findings will be compromised by those factors.

- 7) Evaluators recognize the potential for disclosures of previously undetected sexually abusive behaviors, work closely with other system stakeholders to establish protocols for the fair, ethical and responsible handling of the disclosures, and ensure the client understands the evaluator's duty to disclose as required by law.
  - 8) Evaluators take reasonable steps to ensure that assessments of sexual abusers are current when that information will be used to inform case management decisions, such as sentencing, civil commitment, release, treatment and supervision.
  - 9) Evaluators take reasonable steps to clearly articulate the specific rationale for all conclusions and recommendations provided in a given assessment, using language that is readily understandable to the consumers of the assessment, including the client.
  - 10) Evaluators consider community safety and the degree to which the client is capable of and willing to manage his or her sexual behavior when making recommendations in the assessments.
- b) Evaluators shall clarify with the requestor and subject the specific purposes for which an assessment is being conducted and shall document accordingly.
- 1) Evaluators conduct sexual abuser-specific assessments primarily for the following purposes:
    - A) Understanding the nature and extent of a client's sexually abusive behavior;
    - B) Exploring criminogenic and other needs that should be the focus of treatment and other interventions;
    - C) Estimating short-and long-term recidivism risk, both sexual and nonsexual;
    - D) Identifying specific responsivity factors; and/or
    - E) Obtaining baseline information about a client against which progress and other changes can be gauged.
  - 2) Evaluators recognize that sexual abuser-specific assessments are not designed or reliable for, and should not be conducted for, the following purposes:
    - A) Substantiating or refuting allegations that are the focus of a criminal, civil, child custody or other investigation;
    - B) Exploring the veracity or motivations of an alleged victim's statements;

7) Evaluators assess/screen clients for acute mental or behavioral health needs that may require intervention prior to initiating assessments or interventions specific to sexually abusive behavior and, if necessary, refer clients to other professionals who are qualified to provide these services. The impact of those mental health or behavioral needs on the assessment procedures or findings should be noted in the evaluator's report.

8) Evaluators strive to meet the special needs of clients with developmental, learning or physical impairments during assessments (e.g., using taped versions of questionnaires, modifying terminology/language on self-report instruments). Reasons and the rationale for using alternative testing methods should be documented in the report, and it should be noted that these special accommodations may have an impact on the reliability and validity of instruments that are typically self-administered.

9) Evaluators should note in the report any limitations or biases related to using instruments or procedures that were not developed to take into account a client's age, race, gender identity, sexual orientation, faith practice, cultural background, socioeconomic status, education, language or level of intellectual functioning.

d) Evaluators shall recognize that conducting psychosexual evaluations provides a critical opportunity to gain comprehensive understanding of the client's circumstances, risk, intervention needs and responsivity factors; engage the client in the assessment and overall intervention process; and offer reliable data to inform decision making.

1) Evaluators rely on multiple sources of information when conducting a psychosexual evaluation, preferably to include the following:

A) Client interviews;

B) Interviews with collateral informants, as applicable (e.g., family, intimate partner/spouse);

C) Thorough review of official documents (e.g., police reports, victim impact statements, criminal justice records, previous assessment and treatment records, presentence or social services investigations);

D) Empirically grounded general psychometric testing (e.g., intellectual, diagnostic);

E) Empirically grounded strategies to estimate risk of sexual and/or nonsexual recidivism; and

F) When professional judgement dictates:

i) Empirically grounded instruments designed to measure broad sexual, as well as offense-related, attitudes and interests;

ii) Empirically grounded, objective psychophysiological measures of sexual arousal, interests and/or preferences.

- B) Nature and quality of past and current relationships (e.g., family, peers, intimate partners);
  - C) Medical and mental health history (i.e., client and family);
  - D) Intelligence, cognitive functioning and level of maturity;
  - E) Education and employment history;
  - F) Antisocial orientation (e.g., antisocial attitudes and values, psychopathy, antecedents of juvenile delinquency, adult criminal history, violence or aggression); and
  - G) History of substance use and abuse.
- 8) Evaluators collect information regarding sexual history information that includes, but is not limited to, the following:
- A) Psychosexual development, early sexual experience, and history of age-appropriate, consensual sexual relationships;
  - B) Nature and frequency of sexual practices (e.g., masturbation, nonabusive and nondeviant sexual behaviors, unconventional or risky sexual activities);
  - C) Paraphilic interests, fantasies and behaviors that may not be sexually abusive (e.g., fetishes, masochism);
  - D) Use of sexually oriented services or outlets (e.g., magazines, internet access, telephone sex lines, adult establishments);
  - E) Abusive or offense-related sexual arousal, interests and preferences;
  - F) History of sexually abusive behaviors, both officially documented and unreported (if identified through credible records or sources);
  - G) Information about current and/or previous victims (e.g., age, gender, relationship to client);
  - H) Contextual elements of sexually abusive behaviors (e.g., dynamics, motivators, patterns, circumstances); and

E) The evaluator shall interview victims only when possessing the requisite knowledge, experience, skills and training to work with sexual abuse victims.

F) The victim may opt to provide a statement at any time.

f) The Written Report

1) In the psychosexual evaluation report, evaluators outline the full range of information sources used to conduct the psychosexual evaluation, note any relevant information sources that were unavailable at the time of the evaluation, and highlight the potential implications of any data limitations on the conclusions and recommendations contained in the report.

2) Evaluators provide an addendum to the psychosexual evaluation report when additional key information is received about the client that significantly impacts the initial findings, conclusions and recommendations.

3) Evaluators document areas of convergence and/or divergence among the client's self-report, collateral information, and other sources of assessment data, including objective behavioral or psychophysiological assessment measures.

4) Evaluators clearly articulate conclusions and recommendations based on supporting evidence documented in the body of the report, and that generally address the following (as relevant to the purpose of the assessment):

A) Recidivism risk (sexual and nonsexual);

B) General and offense-related criminogenic needs;

C) Responsivity factors;

D) Other intervention needs;

E) Current stressors;

F) Client-identified goals and interests;

G) Implications of the client's strengths and assets;

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1905.60 Risk Assessment

Currentness

Evaluators shall appreciate the potential weight of general and sexual abuser-specific risk assessments across various criminal justice-related and civil contests and the associated implications (not only for community safety, but also for the potential impact on the client's civil liberties) and the critical need to ensure reliable and valid findings.

a) Evaluators clarify the specific purpose for conducting a risk assessment on a given client and the way in which that information will be used, and articulate this in communications regarding the findings.

b) Evaluators conducting risk assessments on sexual abusers are well versed in the contemporary research regarding static and dynamic factors linked to recidivism among sexual abusers. These variables fall into the following categories:

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

2) Victim-related variables (e.g., age, gender, relationship);

3) Sexual deviancy (e.g., offense-related sexual arousal, interests and/or preferences; sexual preoccupation);

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

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

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

c) Evaluators conducting risk assessments of sexual abusers use empirically supported instruments and methods (i.e., validated actuarial risk assessment tools and structured, empirically guided risk assessment protocols) over unstructured clinical judgment.

d) Evaluators conducting risk assessments of sexual abusers are appropriately trained in scoring, interpreting effectively and accurately reporting, and applying the findings of the risk assessment instruments/protocols employed.

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20 Ill. Adm. Code 1905.70

1905.70 Psychophysiological Assessments

Currentness

Evaluators shall recognize that psychophysiological assessment methods such as phallometry, viewing time and polygraphy may have particular utility to obtain objective behavioral data about the client that may not be readily established through other assessment means; explore the reliability of client self-reporting; and explore potential changes, progress and/or compliance relative to treatment and other case management goals and objectives, not determine guilt or innocence. Each assessment method is further explained in Section 1905.140.

- a) Evaluators obtain specific informed consent from clients prior to using psychophysiological measures.
- b) Evaluators are familiar with the strengths and limitations of psychophysiological instruments and note these issues when interpreting and communicating the findings from these instruments.
- c) Evaluators take reasonable steps to obtain assurances that examiners utilizing psychophysiological assessment instruments are appropriately trained in the use of those instruments, use accepted methods, and adhere to applicable professional/discipline-specific standards or guidelines.
- d) Evaluators recognize that the findings from psychophysiological measures are to be used in conjunction with other sources of assessment information, not as the single source of data for any assessment.
- e) Evaluators recognize that the results of psychophysiological measures are not to be used as the sole criterion for any clinical decision regarding offending, including, but not limited to, the following:
  - 1) Estimating level of risk for recidivism;
  - 2) Making recommendations for release to the community from a correctional, institutional or other noncommunity placement;
  - 3) Determining treatment completion; or
  - 4) Drawing conclusions regarding compliance with or violations of conditions of release or community placement.

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community resources and supports. Treatment providers should remain abreast of current research and align practices accordingly. Recommended methods include structured, cognitive-behavioral, and skills-oriented treatment approaches that target dynamic risk factors. These methods have the greatest potential for reducing rates of sexual and other types of criminal reoffending in the male adult sexual abuser.

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4) Treatment providers encourage, support and, whenever possible, participate in ongoing empirical research efforts designed to identify and refine effective interventions for sexual abusers and those at risk to sexually abuse others.

5) Treatment providers working with sexual abusers collaborate with other professionals who are involved in the management of clients, including judges, probation/parole officers, correctional and other facility staff, child welfare workers, and victim therapists in order to facilitate information sharing and further the goals of treatment. This collaboration/cooperation is consistent with and limited to activities and behavior appropriate to treatment providers' professional roles.

6) Treatment providers recognize that correctional staff and community supervision practitioners who are well-trained and skilled in using evidence-based behavioral techniques and interventions (e.g., prosocial modeling, skill practice, rehearsal of strategies, redirection, positive reinforcement) can complement treatment activities in correctional and other facilities and post-release.

#### b) Assessment-Driven Treatment

Treatment providers shall recognize the importance of individualized, assessment-driven treatment services and deliver treatment accordingly.

1) Treatment providers ensure that, prior to initiating treatment services for individuals who have sexually abused or are at risk of sexually abusing others, a psychosexual evaluation of a client's recidivism risk and intervention needs has been conducted, is current and is comprehensive.

2) Treatment providers rely on research-supported assessment methods that are designed to identify dynamic risk factors present for a given client.

3) Treatment providers develop and implement an individualized, written treatment plan for each client, outlining clear and specific treatment goals and objectives that are consistent with the results of a current psychosexual evaluation.

4) Treatment providers routinely review and update treatment plans based on multiple methods of assessment.

5) Treatment providers offer treatment that is appropriate for a client's assessed level of risk and intervention needs.

6) Treatment providers offer treatment only when they have the resources necessary to provide an adequate and appropriate level of intervention for a client's risk and needs.

7) Treatment providers refer a potential client to other treatment providers or agencies when they cannot provide an adequate and appropriate level of intervention. This may involve a full transfer or sharing of clinical responsibility.

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1905.100 Treatment Methods

Currentness

a) Treatment providers working with sexual abusers shall utilize empirically supported methods of intervention. Recommended methods include structured, cognitive-behavioral, and skills-oriented treatment approaches that target dynamic risk factors.

1) Treatment providers deliver services to clients using a variety of modalities, including individual, family and group therapy, that are matched to each client's individual intervention needs and responsivity factors.

2) Treatment providers assist clients with identifying and analyzing the individual's factors (e.g., environmental, cognitive, affective and relational) that increase the individual's vulnerability to engage in sexually abusive behaviors.

3) Treatment providers use cognitive-behavioral techniques, at the earliest opportunity, to help clients develop and rehearse strategies (i.e., avoid or escape high risk situations, use adequate coping skills) to effectively manage situations that may increase their risk of sexually abusing or otherwise reoffending.

4) Treatment providers use behavioral methods, such as education, prosocial modeling, skill practice, rehearsal of strategies, redirection and positive reinforcement, to teach or enhance skills that will help clients achieve prosocial goals.

5) Treatment providers encourage clients to practice the skills they learned in treatment and ensure that these skills generalize to clients' environments.

6) Treatment providers assist clients in developing individualized strategies and plans for effectively managing their risk of sexual abuse or other harmful or illegal behaviors. These plans include specific strategies for avoiding or limiting access to potential victims, recognizing and coping with risk factors, and building social support systems.

7) Treatment providers assist clients with identifying and enhancing prosocial interests, skills and behaviors that the clients themselves seek to enhance or attain (i.e., approach goals that are oriented toward a nonoffending lifestyle), as opposed to strictly focusing on managing inappropriate thoughts, interests, behaviors and risky situations (i.e., avoidance goals).

A) Treatment providers recognize that client attitudes and beliefs that are tolerant of sexual abuse (e.g., women enjoy being raped, children should be able to make up their own mind about having sex with adults) are important treatment targets.

B) Treatment providers:

i) use established cognitive therapy techniques to strengthen attitudes, beliefs and values that support prosocial sexual behaviors; and

ii) help clients manage or decrease those that support sexually abusive behavior.

C) Treatment providers are aware that, although clients may hold attitudes, beliefs and values that are unconventional but unrelated to their risk for sexually abusive or criminal behaviors, these attitudes, beliefs and values are not deemed appropriate primary treatment targets.

#### 4) Intimate Relationships

A) Treatment providers assist the client in the development of skills that can enable the experience of prosocial intimate relationships with adults. Treatment providers orient their interventions so that they build on strengths in the client's existing relationships, when appropriate.

B) Treatment providers aim, when possible and appropriate, to include adult romantic partners in treatment in order to maximize treatment gains and enhance prosocial lifestyles.

#### 5) Social and Community Supports

A) Treatment providers encourage and assist clients in identifying appropriate, prosocial individuals who can act as positive support persons.

B) Treatment providers encourage family members and other support persons to actively participate in the treatment process and to help clients achieve and maintain prosocial lifestyles.

C) Treatment providers assist clients who are transitioning to the community or are already in the community to develop and maintain stable prosocial lifestyles, which are characterized by stable and appropriate housing, employment and leisure activities.

D) Treatment providers recognize that developing a support network may be contraindicated with clients who have a history of violence toward support persons and have not been violence-free for a significant amount of time. Hence, treatment providers encourage clients to make small and gradual changes and closely monitor

9) Treatment providers are aware that attempting to provide treatment for problems that a client persistently denies having results in limitations in making reliable clinical recommendations about the individual's treatment progress and re-offense risk, and that this has ethical implications.

10) Treatment providers routinely seek and explore the client's perspectives and offer feedback on the client's engagement, motivation and progress in treatment, or lack thereof.

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3) Client self-report; and

4) Collateral reports.

c) Treatment providers routinely review the client's individual treatment plan and clearly document in treatment records the specific and observable changes in factors associated with the client's risk to recidivate, or the lack of changes.

d) Treatment providers recognize that a client who has successfully completed treatment has generally:

1) Acknowledged the problems for which the client was referred in sufficient enough detail for treatment staff to have developed a treatment plan that, if implemented properly, could be reasonably expected to reduce the risk to reoffend;

2) Demonstrated an understanding of the thoughts, attitudes, emotions, behaviors and sexual interests linked to sexually abusive behavior and can identify these when they occur in the client's present functioning; and

3) Demonstrated changes in managing these thoughts, attitudes, emotions, behaviors and sexual interests that are sufficiently sustained to create a reasonable assumption that the client reduced the risk to reoffend.

**AGENCY NOTE:** Offenders under conditional release, parole or probation may have additional specific indicators to enable the treatment provider to assess treatment completion to include completion of levels of supervision (this may include various components such as compliance with conditions of supervision, lack of sanctions, employment, progress in treatment, etc.), polygraph examinations and/or plethysmographs, etc. The decision to successfully terminate a supervised offender from treatment should be made by the multidisciplinary team.

e) Treatment providers evaluate a client's treatment progress within the context of a thorough understanding of the client's individual capacities, abilities, vulnerabilities and limitations. Associated recommendations should reference these factors and aim to stay within the bounds of what is likely or possible for the individual client.

f) Treatment providers providing community-based treatment recommend:

1) more intensive treatment and/or supervision if a client experiences significant difficulties managing the risk for sexual abuse in a way that jeopardizes community safety; and

2) gradual adjustments to the intensity of services as the client consistently demonstrates stability and positive gains.

g) Treatment providers prepare their clients for treatment completion, which may include a gradual reduction in frequency of contacts over time as treatment gains are made, booster sessions to reinforce and assess maintenance of treatment gains, and consultation to any future service providers.

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20 Ill. Adm. Code 1905.120

1905.120 Responsivity Factors and Special Populations

Currentness

Treatment providers shall acknowledge the diversity among individuals who sexually abuse others and that responsiveness to sexual abuser-specific treatment can vary as a function of client characteristics such as demographics, language, development, capabilities, functioning and motivation to change.

a) Treatment providers recognize that not all treatments have been developed or evaluated with various subpopulations of sexual abusers (e.g., individuals with intellectual and developmental disabilities, clients with serious mental illness, those with varied cultures and other demographics). The limitations of treatments with these populations should be identified prior to initiating treatment services.

b) Treatment providers appreciate that treatment for sexual abusers is more effective when responsivity factors are addressed and recognize the potential for unintended collateral consequences when services fail to take into account responsivity factors.

c) Treatment providers assess and identify responsivity factors, such as comprehension, cognitive capabilities, adaptive functional level, psychiatric stability, and other factors that may impact a client's ability to maximally benefit from sexual abuser-specific treatment.

d) Treatment providers strive to adjust approaches to interventions and match clients to appropriate services based on identified responsivity factors in order to facilitate clients' maximum benefit from services. This includes, for example, the provision of language interpreters, services for deniers, services for clients with cognitive or developmental limitations, and culturally competent programming.

e) Treatment providers strive to equip themselves with the knowledge and skills necessary to adequately address clients' responsivity factors and/or special needs by participating in professional development activities.

f) Treatment providers recognize their own strengths and limitations with respect to their ability to provide adequately responsive services to clients and refer clients to qualified providers skilled in addressing specific responsivity factors, when necessary.

g) Treatment providers understand that, for some subpopulations of sexual abusers, sexual abuser-specific treatment services are best provided subsequent to or in concert with other psychiatric, behavioral or responsivity-oriented

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20 Ill. Adm. Code 1905.130

1905.130 Risk Reduction and Risk Management in the Community

Currentness

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

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.

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

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.

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.

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.

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.

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20 ILAC § 1905.130, 20 IL ADC 1905.130

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2) As is the case with hormonal agents, the prescriptive use of nonhormonal pharmacological agents to treat sexual offenders will not address all etiologies and risk factors and should therefore be combined with psychotherapy specific to sexual offenders.

d) Pharmacological Treatment of Comorbid Psychiatric Conditions

1) Studies of sexual offenders, men with paraphilias, and those with nonparaphilic expressions of "hypersexuality" suggest that mood disorders (dysthymic disorder, major depression and bipolar spectrum disorders), certain anxiety disorders (especially social anxiety disorder and childhood-onset posttraumatic stress disorder), psychoactive substance abuse disorders (especially alcohol abuse), Attention-Deficit/Hyperactivity Disorder (ADHD), and neuropsychological conditions (e.g., schizophrenia, Asperger's syndrome, head injury) may occur more frequently than expected in sexually impulsive men, including sexual offenders.

2) Empirically established effective pharmacological treatments for mood disorders, ADHD and impulsivity are well documented. These conditions affect prefrontal/orbital frontal executive functioning and are associated with impulsivity; therefore, amelioration of those conditions could certainly affect, if not markedly ameliorate, the propensity to be sexually impulsive.

e) Practice Guidelines

1) Nonphysician treatment providers do not make specific recommendations about what medications should be prescribed. It is appropriate for treatment providers to refer clients to physicians who have experience working with individuals who sexually offend as possible candidates for pharmacological therapy. They can provide information about the role of pharmacological therapy in sexual deviancy treatment to the consulting doctor. Nonphysician treatment providers could consider referring clients to a physician for possible pharmacological therapy if these clients have relatively high levels of deviant sexual arousal, are considered to be at moderate to high risk for reoffending, or have not been able to achieve control over their deviant sexual arousal using sexual arousal conditioning procedures. Clients who repeatedly engage in impulsive or compulsive behavior, or who report a persistent inability to control deviant sexual fantasies, arousal or behavior may also be reasonable candidates for pharmacological therapy. Motivated and informed clients are often the best candidates for pharmacological therapy.

2) A physician prescribes medications only after a comprehensive sexual abuser evaluation has been completed. It is important to individualize medical treatment for the patient based on the patient's particular need, response, medical history and personal agreement with the treatment offered. Pharmacological therapy is linked to appropriate treatment and supervision and is medically monitored. As with any treatment, appropriate informed consent is obtained when pharmacological therapy is implemented. Informed consent includes a discussion of medication options, targeted symptoms, potential side effects, and the expected course of pharmacological therapy.

3) The use of medication may help clients manage their risk for sexually abusive behavior, but medications do not "cure" deviant sexual interests or fully eliminate the risk of reoffending.

f) Ethical Considerations

West's Illinois Administrative Code  
Title 20. Corrections, Criminal Justice, and Law Enforcement  
Chapter VII. Sex Offender Management Board  
Part 1905. Adult Sex Offender Evaluation and Treatment (Refs & Annos)  
Subpart B. Standards of Practice

20 Ill. Adm. Code 1905.150

1905.150 Psychophysiological Tools

Currentness

Treatment providers and evaluators shall recognize that the usage of psychophysiological tools may be utilized in the assessment of offenders in relation to treatment progress, compliance with supervision, and support effective risk management and risk reduction. The following will detail each type of psychophysiological tool.

a) Phallometry

1) Phallometry is a specialized form of assessment used in treatment with individuals who have committed sexual offenses. Responsible use of phallometry results requires at least a rudimentary understanding of how phallometry works and its advantages and limitations. As with any instrument or procedure, treatment providers are familiar with current literature and obtain appropriate training before using or interpreting phallometric testing results. Examiners receive training in phallometric testing in order to become knowledgeable about the technical aspects of the equipment and the appropriate protocols for conducting phallometric testing specific to the equipment being used. Examiners are also familiar with the research evidence on the reliability and validity of phallometric testing.

2) Phallometric testing using penile plethysmography involves measuring changes in penile circumference or volume in response to sexual and nonsexual stimuli. Circumferential measures (measuring changes in penile circumference) are much more common than volumetric measures (measuring changes in penile volume), which are used in only a few laboratories worldwide. However, there is good agreement between circumferential and volumetric measures once a minimal circumference response threshold is reached. Therefore, circumferential measures are the focus of this subsection (a).

3) Phallometric testing provides objective information about male sexual arousal and is therefore useful for identifying deviant sexual interests during an evaluation, increasing client disclosure, and measuring changes in sexual arousal patterns over the course of treatment.

4) Phallometric test results are not used as the sole criterion for determining deviant sexual interests, estimating risk for engaging in sexually abusive behavior, recommending that clients be released to the community, or deciding that clients have completed treatment programs. Phallometric test results are interpreted in conjunction with other relevant information (for example, the individual's offending behavior, use of fantasy and pattern of masturbation) to determine risk and treatment needs. Phallometric test results are not to be used to draw conclusions about whether an individual has committed a specific sexual crime. As well, there are limited data available regarding the use of plethysmography with clients who have developmental disabilities and clients with an acute major mental

12) Deviance indices can be calculated by subtracting the mean peak response to nondeviant stimuli from the mean peak response to deviant stimuli. For example, a pedophilic index could be calculated by subtracting the mean peak response to stimuli depicting adults from the mean peak response to stimuli depicting prepubescent children. Thus, greater scores indicate greater sexual arousal to child stimuli.

13) Because the sensitivity of phallometric testing is lower than its specificity, the presence of deviant sexual arousal is more informative than its absence. Results indicating no deviant sexual arousal may be a correct assessment or may indicate that a client's deviant sexual interests were not detected during testing.

14) Research indicates that initial phallometric assessment results are linked with recidivism. Repeated assessments can be helpful to monitor treatment progress and to provide information for risk management purposes.

#### b) Viewing Time

1) Viewing time is a specialized form of assessment used in the treatment of individuals who have committed sexual offenses. Responsibly using the results of viewing-time measures requires treatment providers to have at least a rudimentary understanding of how viewing time measures work, as well as their advantages and limitations. As with any instrument or procedure, treatment providers should be familiar with current literature and obtain appropriate training before using or interpreting viewing time testing results.

2) Unobtrusively measured viewing time is used as a measure of sexual interest. The relative amount of time clients spend looking at pictures of children (who can be clothed, semiclothed or nude) is compared to the time that the same adult spends looking at pictures of adults. Research suggests that, as a group, individuals who have offended against children look relatively longer at stimuli depicting children than adults. Unobtrusively measured viewing time correlates significantly with self-reported sexual interests and congruent patterns of phallometric responding among nonoffending subjects. Little is known, however, about the value of retesting using viewing time as a measure of treatment progress.

3) As with any test, specific informed consent for the test procedure and release forms for reporting results are obtained prior to beginning testing. Examiners have a standardized protocol for presenting the stimuli, recording and scoring. Examiners are familiar with the reliability and validity of the test. In particular, it is important that examiners know the degree to which the viewing time measure being used has been validated for the client population being assessed. This technology has primarily been used to identify sexual interest in gender and age. As well, there is limited information specific to the use of viewing time with clients with developmental disabilities.

4) For testing sexual interest in children, examiners have a set of pictures depicting males and females at different stages of development, ranging from very young children to physically mature adults. It is important that stimuli are of good quality and avoid any distracting elements. Treatment providers who use sexually explicit stimuli are aware of applicable legislation in their jurisdiction about possession of these materials.

5) The test report includes a description of the method used for collecting data, the types of stimuli used, an account of the client's cooperation and behavior during testing, and a summary and description of the client's responses.

5) The American Polygraph Association, the National Association of Polygraph Examiners, and other polygraph associations have developed standards for certifying polygraph examiners who work in sex offender management and treatment, as well as standards for administering sex offender tests. Some states also regulate post conviction sex offender testing standards and procedures. Treatment providers are familiar with laws, state regulations, and association guidelines governing post conviction sex offender testing where they practice. Treatment providers work with examiners who meet certificate requirements and adhere to procedures recommended by a relevant polygraphists' organization.

6) Four types of post conviction polygraph exams are commonly performed with sex offenders:

A) Instant/Index Offense Tests are designed to explore and clarify discrepancies between the offender's and the victim's descriptions of the conviction offenses.

B) Sexual History Disclosure Tests are designed to facilitate a client's disclosure to their treatment providers of sexual history information, which may include sexually abusive or offense-related behaviors.

C) Maintenance/Monitoring Tests are designed to explore potential charges, progress and/or compliance relative to treatment, supervision and other case management goals, objects and expectations.

D) Specific Issue Tests are generally designed to explore a client's potential involvement in a specific prohibited behavior, such as unauthorized contact with a victim at a particular time.

7) Polygraph test accuracy is believed to be greatest when examiners focus on highly specified (i.e., single issue, narrow and concrete) questions. Treatment providers cooperate with examiners in structuring tests that are responsive to program needs without unnecessarily compromising accuracy considerations.

8) Limits of confidentiality are fully disclosed to clients prior to polygraph testing. Clients are informed in writing about how the results of polygraph exams will be used and who will receive the results. Clients are informed about the possible consequences to them as a result of the polygraph exam.

9) There is very limited empirical research on the use of polygraph with clients who have developmental disabilities and clients with low/borderline IQs. Therefore, additional caution is advised if treatment providers use polygraph in the management and treatment of these clients.

10) Polygraph charts are not the only means of monitoring offenders' behavior and are not to be the sole basis for significant case decisions. Examiner and examinee characteristics, treatment milieu, instrumentation, procedures, examination type, base rates of attempted deception in the populations being tested, and other idiosyncratic factors can affect accuracy and usefulness. Likewise, when questions are not highly specific, there is reason for concern regarding the results of polygraph testing for monitoring purposes.

 KeyCite Red Flag - Severe Negative Treatment  
KeyCite Red Flag Negative Treatment 1905.200 to 1905.320 Repealed

West's Illinois Administrative Code  
Title 20. Corrections, Criminal Justice, and Law Enforcement  
Chapter VII. Sex Offender Management Board  
Part 1905. Adult Sex Offender Evaluation and Treatment (Refs & Annos)

20 Ill. Adm. Code 1905.200

1905.200 to 1905.320 Repealed

Currentness

**Credits**

(Source: Repealed at 40 Ill. Reg. 16236, effective January 1, 2017)

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20 ILAC § 1905.200, 20 IL ADC 1905.200

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 KeyCite Red Flag - Severe Negative Treatment  
KeyCite Red Flag Negative Treatment 1905.200 to 1905.320 Repealed

West's Illinois Administrative Code  
Title 20. Corrections, Criminal Justice, and Law Enforcement  
Chapter VII. Sex Offender Management Board  
Part 1905. Adult Sex Offender Evaluation and Treatment (Refs & Annos)

20 Ill. Adm. Code 1905.220

1905.200 to 1905.320 Repealed

Currentness

**Credits**

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 KeyCite Red Flag - Severe Negative Treatment  
KeyCite Red Flag Negative Treatment 1905.200 to 1905.320 Repealed

West's Illinois Administrative Code  
Title 20. Corrections, Criminal Justice, and Law Enforcement  
Chapter VII. Sex Offender Management Board  
Part 1905. Adult Sex Offender Evaluation and Treatment (Refs & Annos)

20 Ill. Adm. Code 1905.240

1905.200 to 1905.320 Repealed

Currentness

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20 ILAC § 1905.240, 20 IL ADC 1905.240

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 KeyCite Red Flag - Severe Negative Treatment  
KeyCite Red Flag Negative Treatment 1905.200 to 1905.320 Repealed

West's Illinois Administrative Code  
Title 20. Corrections, Criminal Justice, and Law Enforcement  
Chapter VII. Sex Offender Management Board  
Part 1905. Adult Sex Offender Evaluation and Treatment (Refs & Annos)

20 Ill. Adm. Code 1905.300

1905.200 to 1905.320 Repealed

Currentness

**Credits**

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20 ILAC § 1905.300, 20 IL ADC 1905.300

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 KeyCite Red Flag - Severe Negative Treatment  
KeyCite Red Flag Negative Treatment 1905.200 to 1905.320 Repealed

West's Illinois Administrative Code  
Title 20. Corrections, Criminal Justice, and Law Enforcement  
Chapter VII. Sex Offender Management Board  
Part 1905. Adult Sex Offender Evaluation and Treatment (Refs & Annos)

20 Ill. Adm. Code 1905.320

1905.200 to 1905.320 Repealed

Currentness

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20 ILAC § 1905.320, 20 IL ADC 1905.320

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