CALIFORNIA DEPARTMENT OF
Mental Health

LTCS BEST PRACTICE CATALOG SUBMISSION COVER SHEET

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[ ] **CHANGE IN CONTACT INFORMATION**

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Date Submitted To Hospital/Division: ______________________

Approved for submission to LTCS Best Practice Committee [ ]

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LTCS BEST PRACTICE CATALOG SUBMISSION

Project Title: Cognitive Behavioral Relapse Prevention Treatment for the Sexual Offender Comittment Program at Atascadero State Hospital

Function Category:

☒ **PATIENT-FOCUSED** ☐ **ORGANIZATION** ☐ **STRUCTURES**

Sub-category(s): Care of the Patient

Heading: Programming

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The following items are available regarding this Best Practice:

☒ **Staff Training Materials**
☒ **Staff Treatment Modules**
☒ **Patient Workbooks**

1. SELECTION OF PROJECT/PROCESS AREA (Describe how and why your team selected this project/process area for improvement.):

On January 1, 1996, a new law (Section 6600 *et seq*. California Welfare and Institutions Code) was implemented that provided for the civil commitment of people deemed likely to commit sexually violent acts in the future following completion of their prison sentences. In passing this law, the California Legislature declared that there is a small group of extremely dangerous sexual predators who have diagnosable mental disorders and can be readily identified while incarcerated. It further declared that these individuals are not safe to be at large in the community and represent a danger to the health and safety of others if they are released. It was the intent of the Legislature that such Sexually Violent Predators (SVP's) be confined and treated until they no longer present a threat to society. The aim of this law is to treat and confine these individuals only as long as their disorders continue to present a danger to the health and safety of others and not for any punitive purposes. The Legislature determined that these "persons shall be treated, not as criminals, but as sick persons." (AB 888).

I. C. 5. 038

Currently, the scientific literature points to two particularly useful treatment approaches with sex offenders: 1)medications and 2)cognitive-behavioral therapies. In contrast, treatment programs that rely exclusively on behavioral conditioning techniques have not been proven to be useful in reducing re-offenses in this population. All three approaches are used in the comprehensive treatment orientation supplied by the Sex Offender Commitment Program.

Cognitive-Behavior Therapy is oriented towards changing the variety of risk factors that are related to sexual offending. The treatment program at ASH is based on a cognitive-behavioral treatment model with an emphasis on Relapse Prevention (RP). The model is aimed not at "cure", but at helping the individual learn strategies to effectively control his deviant sexual impulses and behavior. The concept of control involves the active participation of the offender in the behavior change process and reinforces the fact that continued abstinence from offending requires constant vigilance and effort. According to this orientation, sex offenses are not simple or isolated events. Rather, rape and child molestation, are complex behaviors with multiple determinants ranging from broad lifestyle factors and cognitive distortions to deviant sexual arousal patterns and more circumscribed skill deficits. **The major task for treatment is to identify specific risks for re-offense and to plan and practice coping strategies to reduce these risks.**

Risk management strategies may include:

- correcting distorted thinking
- enhancing victim empathy
- effective use of medications
- eliminating substance abuse
- learning control of deviant sexual urges
- improving interpersonal relationships skills
- handling negative emotional states such as boredom or anger
- identifying and avoiding high-risk situations

2. UNDERSTANDING EXISTING CONDITION WHICH NEEDS IMPROVEMENT

(Describe the relationship of your project to your goals for improvement, and describe current process performance.):

3. ANALYSIS **(Describe how the problem was analyzed.):**

The SVP statute required that DMH establish a treatment protocol that specified how assessment data would be used to determine the course of treatment for each individual offender and the measures that would be used to assess treatment progress and changes in risk for reoffense (WIC 6606 (c)). In addition to a standard admission assessment, as the offender progresses in treatment, he is administered a specialized battery of psychological assessment instruments developed for sex offenders. The results of these tests, behavioral observations, and clinical interview results are combined in a comprehensive psychological evaluation that leads to identifying, cognitive deficits, skill deficits, high risk areas and treatment recommendations. Deficits in the various areas lead to greater concentration in treatment on that area.

Data from a variety of assessments is entered into databases by the Hospital's Outcome Evaluation Services staff and can be viewed in the aggregate.

4. IMPLEMENTATION **(Describe your implementation of the solution.):**

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ASH has an interdisciplinary SOCP Design team that researches available literature, develops treatment protocols and staff training materials, monitors the effectiveness of treatment, and improves treatment interventions based on findings.

5. RESULTS (Demonstrate that an improvement has occurred as a result of the project/process area implementation.):

The Sex Offender Commitment Program (SOCP) at ASH is designed for SVP patients and is organized into five phases. The first four phases are inpatient. The fifth phase of the treatment program is intended to be outpatient and will be conducted under the auspices of the Conditional Release Programs (CONREPs).

Phase I – Treatment Readiness. Treatment Readiness prepares the patient to begin the work of learning cognitive-behavioral methods for preventing re-offense. The treatment is conducted in relatively large (>25 patients) group settings using didactic methods. Patients are not required to acknowledge or discuss their crimes in any specific way. The patient receives an overview of the SOCP and each of its five phases. Topics include basic information about: The law (WIC 6600 *et seq*.), prison vs. hospital attitudes, interpersonal skills, anger management, mental disorders, victim awareness, cognitive distortions, and relapse prevention.
An offender must meet the following criteria for advancement from this phase to Phase II:

- Acknowledge committing past sexual offenses and express a desire to reduce his risk of re-offending in the future;
- Demonstrate a willingness to discuss his past offenses;
- Agree to participate in the required assessment procedures; and
- Show an ability to conduct himself appropriately in a group setting.

Patients who wish to progress to more advanced phases of treatment are required to sign an informed consent statement acknowledging their past problems with sexual offending, their desire to reduce their risks for re-offending, and a willingness to complete specific assessment procedures such as a plethysmograph evaluation.

In addition to the regular Phase I groups, a Phase I Alternate Group has been provided since October 1998. It is designed to assist patients in a small group format to resolve concerns that inhibit them from entering Phase II.

Phase II – Skills Acquisition. This phase marks the shift from education and preparation to personal therapy. In this phase of treatment, patients acquire new fundamental skills for preventing re-offense. Due to the intensive nature of this phase, group size is reduced to between six and ten patients. They learn how to use basic relapse prevention tools (such as behavior chains and decision matrices). They also learn to identify their personal cognitive distortions, how to alter their distorted thinking patterns, and how to cope in high-risk situations. They begin the process of developing an awareness of the trauma that victims typically experience after being sexually abused. They write an autobiography that gives them the opportunity to examine their personal history and to discover how present attitudes, feelings, and behavior are based on

past experiences and observations. In addition to the Phase group, patients may also be assigned to special skill building groups on human sexuality and interpersonal relationships during this phase of treatment.

In order to progress into Phase III of treatment, the interdisciplinary treatment team must determine that the patient has met the following criteria:

- Successfully completed Phase II assessments and demonstrated a willingness to cooperate with further required assessments;
- Fully acknowledged his past sexual offenses and accepts them as his responsibility;
- Articulated a commitment to abstinence which is reflected in his current behavior;
- Understands that the goal of treatment is management and control, not “cure”;
- Satisfactorily Completed behavior chain and decision matrix assignments;
- Indicated an awareness of his cognitive distortions and an ability to correct them;
- Understands and has described all identified high-risk factors;
- Successfully completed prescribed specialty groups; and
- Identified typical responses to sexual abuse

Phase III – Skills Application. In this phase offenders integrate the skills they learned during Phase II in a rigorous and consistent way to their daily lives. Their skills in relapse prevention, coping with cognitive distortions, and developing victim awareness are deepened and broadened. Their daily experiences in unit life are examined and subjected to cognitive-behavioral interventions through the intensive use of journals and logs. During this phase, based on individual patient need, they may be assigned to specialty groups and treatments that include sexual arousal modification, family relationships, and family or couples counseling sessions with their significant community support systems.

For a patient to advance from this phase to Phase IV, his treatment team must determine:

- He can fully describe the negative impact of abuse on his victims;
- He continues to acknowledge his past sexual offenses and accepts them as his own responsibility;
- He continues to articulate a commitment to abstinence which is reflected in his current, daily behavior;
- He recognizes and corrects all cognitive distortions that lead to offenses using behavioral and cognitive restructuring techniques;
- He shows an on-going ability to control his deviant sexual urges and interests;
- He can describe a complete range of prospective high-risk factors and internal warning signs that signal increased risk of re-offending and demonstrates effective coping with risk factors in the hospital setting; and
- His local CONREP program is willing to accept him into outpatient treatment and supervision.

Phase IV – Skills Transition. During this phase, a detailed discharge plan is developed in conjunction with the offender’s assigned Conditional Release Program (CONREP). It provides the patient with the opportunity to prepare for his discharge to a supervised setting in the community via CONREP. He continues to develop his skills in relapse prevention, managing

cognitive distortions, developing victim empathy, and using journals and logs. Particular attention is paid to how these skills will generalize into the community. The patient has an opportunity to involve family members and significant others directly into his relapse prevention plan. The patient learns about specific resources available in his placement. CONREP becomes directly involved at this point in treatment planning, and specific work is done to develop the terms and conditions under which the patient will be released. Also in-depth release planning is done that includes conditions of community treatment, supervision, housing, employment, and safe community activities. Community notification and registration laws are thoroughly reviewed so the offender is clear about his responsibilities and potential community reactions upon his release. In addition to the core group, the offender may continue in couples or family therapy, addressing issues of adjustment to the community and family settings. The offender may be required to continue in the sexual arousal management group emphasizing booster and maintenance sessions, and a CONREP treatment planning group.

Phase V – Community Outpatient Treatment. The outpatient phase of treatment is intended to provide patients with ongoing relapse prevention treatment as well as supervision and monitoring. This phase is administered by CONREP.

THE ASH TREATMENT PLANNING PROCESS FOR SOCP

All patients in the SOCP are rated at least quarterly on the Atascadero Skills Profile (ASP) for treatment progress. This assessment tool is composed of behaviorally anchored items that are rated on 5-point scales. There are 10 different skill domains in this instrument. Domain 8 ("Control of Deviant Sexual Impulses and Behaviors") of this instrument is particularly relevant for the SVP population. There are five items in this domain, which are rated on a scale of 0-4.

- Patient accepts responsibility for his past devient sexual behavior.
- Patient understands the trauma that resulted from his sexual crimes.
- Patient can correct deviant thoughts that promote sexual offending.
- Patient demonstrates ability to manage deviant sexual urges and impulses.
- Patient demonstrates ability to cope with high risk factors for sexual reoffending.

Patients in Phases II and III of the treatment program have shown greater improvement as measured by the ASP than those patients in Phase I of the program. This result suggests that patient who are actively involved in the treatment process do improve their skills relative to the "Control of Deviant Sexual Impulses and Behaviors".

Skill building specialty groups and adjunctive treatment activities are also included as part of the cognitive behavioral relapse prevention treatment program for sex offenders.

In the course of treatment individual patients identify areas of high risk that are specific to them. Specialty groups and adjunctive treatment activities are resources available to patients in their development of adequate coping responses for their specific high risks. These activities focus on learning improved management of deviant sexual interests, they aid offenders in developing healthy and more productive lifestyles that could ultimately reduce risks for re-offending. A healthy lifestyle promotes a balance between work, rest, and play.

Offenders often report that they have greater difficulty controlling deviant urges when their self-esteem is low and their lifestyle is out of balance. The following list includes the type of adjunctive treatments included in the Sex Offender Commitment Program.

Specialty groups include; Sex Education, Human Sexuality, Covert Sensitization/Sexual Arousal Modification, Interpersonal Skills, Anger Management, Gay Interpersonal Skills, Medication Management, and Family Support Group. Adjunctive treatment activities include; Sponsor Group, Therapeutic Community Meetings, Individual Therapy, Couples and Marital Therapy, Substance Abuse Treatment, Education, Vocational Training, Leisure and Recreational Activities.

6. LEARNING **(Describe what the team learned and how they used those lessons to continuously improve the success of this Best Practice.):**

An adaptive approach to Relapse Prevention and Cognitive Restructuring has also been developed for patients with major mental illness.