

**COLLABORATION BETWEEN SUPERVISION OFFICERS
AND TREATMENT PROVIDERS INVOLVED IN SEX
OFFENDER MANAGEMENT**

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ABSTRACT

Collaboration between treatment providers and supervision officers is frequently cited as essential to effective sex offender management; however, there is a marked lack of information pertaining to the nature and quality of such collaboration. Furthermore, there are many disparities in practices and opinions concerning the extent to which supervision officers should be involved in the treatment process. Some treatment providers and supervision officers maintain that the participation of supervision officers in the treatment groups enhances sex offender management, whereas others argue that such participation may be detrimental to the therapeutic process. This pilot project, conducted in partnership with Correctional Services Canada (CSC), explores the practices and opinions of supervision officers involved in the adult outpatient sex offender treatment programs offered by Vancouver Area Community Corrections. In particular, issues related to the collaborative interactions between supervision officers and treatment providers and the participation of supervision officers in treatment groups are investigated.

Keywords: Sex offenders; Sex offender treatment; Collaboration; Ethical standards; Supervision officers

Subject Terms: Sex offenders; Sex offenders -- Rehabilitation; Psychotherapists -- Professional ethics

*In loving memory of my grandmother, Sarah Watts, whose kindness and
compassion for others continues to inspire me*

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INTRODUCTION

The effective community supervision and management of sex offenders confronts correctional agencies with unique challenges, as this population of offenders is one of the most difficult to supervise and treat in the community. A recent statistical review revealed that as of December 31st, 2004, there were approximately 3,457 sex offenders under federal jurisdiction in Canada; of those offenders, an estimated 1, 154 were under community supervision (Motiuk and Vuong, 2005). Indeed, the majority of convicted sex offenders are eventually released from custody and managed in the community. As such, the effectiveness of community supervision and management strategies employed by correctional agencies in dealing with sex offenders and the implications of current policies and practices surrounding the management of this offender population are key areas of investigation.

A substantial number of sex offenders under community supervision are mandated to participate in sex offender specific treatment as a condition of their release. Community-based sex offender treatment, a relatively recent contribution in the area of sex offender treatment, is typically comprised of relapse prevention strategies. The emphasis of relapse prevention being risk management, this form of treatment is increasingly being employed by parole/probation services as a strategy for sex offender management (Cumming & Buell, 1996; Polaschek, 2003; Wilson, Stewart, Stirpe, Barrett, & Cripps, 2000).

Indeed, the integration of relapse prevention treatment with other techniques of parole supervision, such as surveillance and monitoring, has been found to be an effective means of controlling sexual recidivism in the community (Wilson et al, 2000) and is a preferred approach to the management of this difficult offender population (Cumming & McGrath, 2000). The combination of treatment and supervision engenders a more comprehensive approach to the management of sex offenders, necessitating close collaborative relationships between supervision officers and treatment providers (ATSA, 2005; Cumming & McGrath, 2000, 2005; Cumming, McGrath, & Holt, 2002).

INTEGRATING COMMUNITY SUPERVISION AND TREATMENT

The efficacy of integrating community supervision with treatment interventions among the general offender population has been evaluated in a number of studies. Research indicates that intensive supervision programs (ISPs) are relatively ineffective in terms of reducing recidivism (Gendreau, Goggin, Cullen, & Andrews, 2000). ISPs are models of community supervision involving intensive monitoring and surveillance techniques, with little to no emphasis on treatment or rehabilitation. While it has been found that ISPs alone do not reduce recidivism, it appears that ISPs are successful in decreasing rates of re-offending when coupled with intensive treatment (Gendreau, 1998 in Cumming & McGrath, 2000; Papanozzi, 1999 in Serin, Vuong, & Briggs, 2003).

Unfortunately, it appears there is a lack of research looking exclusively at the effectiveness of combining community supervision and treatment with sex offenders. However, the studies that have been conducted in this area are promising. Gordon and Packard (1998, as cited in Cumming & McGrath, 2000), in an evaluation of the treatment and supervision approach, investigated the sexual recidivism rates of 306 offenders who had completed a sex offender treatment program while incarcerated. Following release, 209 of these offenders were mandated to as many as three years of community-based sex offender treatment and supervision, while the remaining 97 offenders were supervised in

the community without treatment. A five-year follow-up yielded statistically significant differences in sexual recidivism between the two groups; the group that had received treatment and supervision had a 2% rate of recidivism versus 8% for the group that had received supervision alone.

McGrath, Hoke, and Vojtisek (1998) examined a community sex offender treatment program that primarily delivered services to probationers. Of 122 sex offenders at risk in the community for an average of over 5 years, 71 participants enrolled in a cognitive-behavioural and relapse prevention-based supervision and treatment program, 32 participants were referred to the program but entered less specialized treatment services due to scheduling conflicts or geographic reasons, and 19 participants received community supervision because they denied their sexual offending behaviour or refused to undergo treatment. The participants in the no-treatment group had more extensive histories of general criminal offending; however, researchers were unable to identify any other differences related to risk of recidivism among the three groups. At follow-up, statistically significant differences in rates of sexual recidivism were found between the three groups; while 1.4% of the cognitive-behavioural treatment and supervision participants re-offended, 15.6% of the non-specialized participants and 10.5% of the no-treatment participants recidivated. It should be noted that the no-treatment group had the highest rate of nonsexual recidivism.

Wilson et al. (2000) investigated a community-based sex offender management practice that combined cognitive-behavioural relapse prevention treatment and parole supervision. Of the 107 offenders included in this study, 75

had participated in a sex offender maintenance program administrated and provided by Correctional Services of Canada staff. The sex offender maintenance program, cognitive-behavioural in nature, offers a low intensity relapse prevention intervention for sex offenders who have completed treatment in the institution and acknowledge their offending behaviour. The remaining 32 offenders participated in the high risk offender program, which was contracted with the forensic branch of a local psychiatric facility. This program, also cognitive-behavioural in nature, was designed for higher risk offenders, and involved professionals from various disciplines, including psychiatry, psychology, social work, nursing, etc. The rates of re-offending for the two groups combined were found to be 21% for general recidivism, 10.3% for violent recidivism, and 3.7% for sexual recidivism, over a mean follow-up period of 3 years, 7 months. Because the Wilson et al. (2000) study lacks an appropriate control group, we are unable to ascribe the low recidivism rates primarily to community management practices or collaboration between treatment staff and parole officers. Nonetheless, this study appears to suggest that an approach involving effective management and collaborative efforts can reduce recidivism among sex offenders.

The aforementioned studies offer promising results. Indeed, the lower rates of recidivism demonstrated in these studies indicate that the integration of sex offender treatment with community supervision is an effective means of controlling sexual recidivism. Furthermore, because the combination of treatment and supervision requires close collaboration between treatment providers and

supervision officers, it can be speculated that the collaborative efforts of treatment and supervision staff may have contributed to the lower recidivism rates found in these studies.

COLLABORATION: A MULTIFACETED APPROACH TO SEX OFFENDER MANAGEMENT

Collaboration, which can be defined as “joint, interest-based problem solving,” is centered on building trust and relationships (Shilling, 2007). Indeed, the underpinnings of collaborative relationships are mutual respect and an appreciation of the abilities and limitations of each vested partner/agency. Notably, collaboration involves mutually beneficial and clearly defined relationships, shared objectives as agreed upon by all parties involved, collective responsibility, communication and planning, and the sharing of resources (Center for Sex Offender Management, 2005).

As noted previously, collaboration between treatment providers and supervision officers is a necessary component of responsible and effective sex offender management. Indeed, such an approach should provide an infrastructure that facilitates the successful reintegration of this difficult offender population (Shilling, 2005). Collaborative efforts are most efficient when both parties have clearly defined functions, possess compatible ideals, and routinely engage in open dialogue that is relevant to the status, risk factors, and treatment progress of the offenders under supervision (Cumming & McGrath, 2005; Jenuwine, Simmons, & Swies, 2003).

Treatment providers and supervision officers have the mutual goal of protecting the community; however, it is significant that their respective occupational roles are distinguished as being separate of one another (Cumming and McGrath, 2005; Jenuwine, Simmons, & Swies, 2003). Treatment providers are responsible for the delivery of a program designed to address cognitive distortions, enhance victim empathy, facilitate the development of appropriate social behaviour, identify risk factors, and construct individually tailored relapse prevention plans. On the other hand, supervision officers are charged with monitoring offenders' behaviours in the community and gathering relevant information in order to continuously evaluate their risk and progress. It is important that professional boundaries are recognized and maintained so as to avoid the ethical dilemma of "multiple relationships". Indeed, practice standards strongly discourage supervision officers from co-facilitating treatment groups attended by offenders on their caseloads (ATSA, 2005a) and the majority of treatment providers consider such practice inappropriate (McGrath, Cumming, & Holt, 2002). Furthermore, research suggests that co-therapy teams of treatment providers and supervision officers are relatively uncommon; in a nationwide survey, McGrath, Cumming, and Burchard (2003) found that 10.7% of adult outpatient programs engaged in this practice, similar to the 8.9% found by McGrath et al. (2002). The occasional group attendance by supervision officers, however, is a generally accepted practice and it is argued that such practice provides supervision officers with the opportunity to become more knowledgeable about sex offenders and the treatment process, thereby

enhancing the quality of supervision (ATSA, 2005a; Cumming & McGrath, 2005). It is further maintained that this practice demonstrates to offenders the collaborative nature of relationships between supervision officers and treatment providers (Cumming & McGrath, 2005).

It is generally accepted that treatment is beneficial for most sex offenders and that community safety and prevention of recidivism is the chief aim of treatment for this population. Additionally, treatment effectiveness is considered to be enhanced when the professionals involved hold mutual treatment philosophies (Cumming & McGrath, 2005). Indeed, discrepancies in ideological perspectives may obstruct collaborative efforts. For those community correctional organizations contracting treatment providers from other agencies, it is essential that treatment philosophies are clearly delineated and that offenders are referred to treatment programs and providers with compatible ideals. Some community corrections agencies hire staff directly to carry out their rehabilitative needs; in such circumstances, the professionals involved in sex offender management ideally share the ideological perspectives outlined by the correctional organization for which they work. Nonetheless, it is significant that the treatment philosophies of the correctional agency are outlined and reinforced among staff members.

Sexual offences are characterized by secrecy, manipulation, and deceit; consequently, a multifaceted approach to supervision and management provides a more comprehensive knowledge base of the sex offender's risk of recidivism and progress in the community. The frequent exchange of relevant information is

essential in order to continually monitor and evaluate offenders' risk and progress, and allows supervision officers to tailor supervision and treatment plans accordingly. Indeed, consistent information sharing between supervision officers and treatment providers, a practice which should be made standard, is indicative of positive collaborative relationships (Cumming & McGrath, 2005). According to the findings of a national random survey of outpatient treatment programs for adult sex offenders, clients were required to provide written consent permitting treatment providers to share information with supervision officers in a vast majority of programs (94%) (McGrath, Cumming, & Holt, 2002). Additionally, a significant proportion of treatment providers surveyed (87%) reported that close interactions with supervision officers were "essential" to the effective case management of sex offenders.

Collaboration between supervision officers and treatment providers presents a number of advantages to sex offender management. A mutually reliant relationship allows treatment providers and supervision officers to enhance the quality of services and supervision. Supervision officers are able to provide treatment providers with additional information surrounding the offender's life to both complement and substantiate the offender's discussions in therapy. Under circumstances in which offenders lack motivation for treatment and/or fail to adhere to their treatment plan, treatment providers depend on supervision officers to reiterate to offenders that treatment is a condition of release and to enhance motivation through encouragement. Treatment providers report treatment attendance and progress to supervision officers on a regular basis;

such reports typically include information on the offender's participation, disclosure about risk-related thoughts and behaviours, and compliance with treatment plan requirements. The work of each respective professional complements one another, forging a more united approach to case management that provides the supervision team with a better understanding of the offender's risk and progress in the community.

The community management of sex offenders can be greatly enhanced through the inclusion of other vested criminal justice and community organizations. While the main focus of this paper is collaboration between supervision officers and treatment providers, it is nonetheless important to briefly address collaborative efforts among various agencies concerned with sex offender management. Traditionally, criminal justice and community agencies have worked separately in their efforts to address sexual offending (English, Pullen, & Jones, 1997). Although collaboration between those directly involved in the supervision and treatment of sex offenders is an essential component of sex offender management, the inclusion of a variety of criminal justice and community agencies denotes a more concerted effort to effectively manage this offender population. The development of interagency and interdisciplinary teams that include parole/probation services, sex offender treatment staff, law enforcement/child protection services, victim advocates, and other partners in risk management represents a shared responsibility for sex offender management and protection of the community.

In the Vancouver area, representatives from several criminal justice agencies attend a monthly sex offender supervision meeting. Federal parole officers responsible for the supervision of sex offenders, local police officers from the High-Risk Offender Unit, treatment providers offering sex offender specific treatment, surveillance team members and intelligence team members meet to discuss the cases of all sex offenders currently under federal supervision in the community. This approach to sex offender management presents a number of advantages. Interagency and interdisciplinary networking and collaboration enhances communication between stakeholders, allows for the exchange of case-specific information, encourages the sharing of knowledge and ideas, maximizes resources, and minimizes professional burnout (English, Pullen, & Jones, 1997).

Despite the notable advantages of interagency collaboration, there are also several barriers to this approach. For instance, conflicting organizational structures, ideological discrepancies, lack of resources, time demands, power struggles, and turf concerns may negatively impact efforts to effectively collaborate with other agencies (Center for Sex Offender Management, 2000; D'Amora & Burns-Smith, 1999).

Treatment Service Delivery and Collaboration between Treatment Providers and Supervision Officers: Factors Influencing the Practices and Opinions of Professionals

Interestingly, although collaboration between supervision officers and treatment providers is frequently cited as crucial to the effective management of sex offenders, there is a marked lack of information pertaining to the nature and quality of such collaboration. Given that sex offenders are often required to participate in treatment as a condition of release into the community, and that collaboration is considered integral to the effective management of this offender population, it is critical to explore the nature and quality of collaborative relationships between supervision officers and treatment providers in the delivery of sex offender services.

There are various models of treatment service delivery; for instance, some treatment programs do not include supervision officers in the treatment process, whereas other programs allow supervision officers to facilitate, co-facilitate, or observe sex offender treatment groups. However, the extent to which supervision officers should be involved in the delivery of treatment services is the subject of much controversy within the field. While it is maintained by some treatment providers and supervision officers that the participation of supervision officers in the treatment groups enhances the treatment and supervision process, others argue that such participation may work to debilitate the therapeutic process.

There are numerous factors that may impinge on the practices and opinions of supervision officers and treatment providers. McGrath, Cumming, and Holt (2002) argue that professional role conflict may be one of these influencing factors. The work of supervision officers typically entails two main functions: 1) the protection of the community through mechanisms of control (i.e. law enforcement) and 2) the reintegration and rehabilitation of offenders through the provision of supportive services (i.e. social work). Both functions have traditionally been a part of community corrections, and there has always been a great deal of controversy in the field as to which should take greater priority (Petersilia, 1998). Clear and Latessa (1993) argue that role conflict in community corrections occurs as a result of the gap between these two main functions of supervision officers; indeed, there appears to be an inherent conflict between treatment and control. Role conflict in community corrections is frequently described in terms of “the competing concerns for the community and the offender, the incompatibility of control tasks and assistance tasks, and the differing role conceptions of ‘law enforcer’ and ‘social worker’” (Fulton, Stichman, Travis, & Latessa, 1997, p. 296). Although tasked with these inherently conflicting functions, it is common practice for supervision officers to perform their law enforcement duties themselves and fulfill their social work responsibilities by referring offenders to community agencies or by contracting for services (Abadinsky, 2000; Petersilia, 1998).

Treatment providers also face issues of role conflict; however, such issues may create more dilemmas for these professionals as sex offender treatment contravenes traditional ethical standards of mental health practice. As a rule, mental health ethical codes emphasize the provision of services that are client centered, voluntary in nature, and confidential. Treatment providers delivering services to sex offenders, however, are often obligated to breach these ethical codes. As stated by Glaser (2003: p. 144),

“Some offender treatment programs, especially many serving sex offenders...*require* therapeutic staff to explicitly and uncompromisingly adopt particular values and practices...which cannot be reconciled with traditional mental health ethics in any way.”

It is rationalized that such infringements on ethical guidelines are the only means by which therapy can be effective for forensic populations, particularly sex offenders (Glaser, 2003).

One of the most salient differences between traditional mental health practice and correctional therapy, particularly sex offender treatment, is that the emphasis of treatment is not the individual wellbeing of the offender, but rather, the protection of the public and community safety (Glaser, 2003; McGrath et al., 2002). Furthermore, in contrast to traditional psychotherapy, sex offender treatment is often a mandatory component of the offender's release plan. As such, it has been argued by some that sex offender treatment is a form of punishment (directly or indirectly). The mandatory (i.e. involuntary) nature of sex offender treatment clearly contravenes ethical standards of mental health practice; in fact, according to all ethical standards of mental health, involuntary

treatment should only be considered when there are no alternative options and the individual in question is likely to cause significant harm to his or her self or others without treatment (Glaser, 2003).

Treatment providers delivering services in correctional settings, particularly those involving sex offenders, must also adopt values and practices surrounding issues of confidentiality in breach of the traditional ethical standards they were trained to adhere to. While confidentiality is traditionally central to the therapeutic alliance, it is very much limited in correctional practice (Haag, 2006). It is obligatory for offenders to consent to having information about their cases shared with a number of professionals and organizations. Individuals who become privy to this personal information include members of the judiciary, corrections and parole/probation officers (POs), family members, victims (both past and potential) and their associates, and other offenders (for instance, in group therapy settings).

According to McGrath, Cumming, and Holt (2002), the practices of supervision officers and treatment staff are also influenced by the policies and mandates of correctional organizations and professional agencies. In a study conducted by Clear and Latessa (1993), it was found that the organizational philosophies of correctional agencies are central to the attitudes and task preferences of supervision officers. In particular, it was found that organizational statements emphasizing rehabilitative objectives are likely to enhance the extent to which supervision officers perform assistance tasks, as opposed to law enforcement oriented tasks, when working with offenders. Significantly, the

mission statement of the Correctional Service of Canada (i.e. the organization employing the participants in this pilot study) incorporates rehabilitative values as well as law enforcement objectives. Their mission states:

The Correctional Service of Canada (CSC), as part of the criminal justice system and respecting the rule of law, contributes to public safety by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control (CSC, 2007b).

Because CSC embraces a rehabilitative philosophy, the professionals participating in this pilot project may be more likely to engage in assistance-oriented tasks, including the delivery of treatment services.

The Association for the Treatment of Sexual Abusers (ATSA), a leading professional organization of clinicians and researchers delivering sex offender treatment services, aims to promote best practices in the field of sex offender treatment through the dissemination of current knowledge, provide optimal treatment to individuals who sexually offend, prevent sexual assault through effective management of sex offenders, and maintain high standards of professionalism and integrity. ATSA encourages treatment providers and other staff involved in sex offender management to adopt a community protection role, as exemplified by one of the foremost goals of the organization:

The protection of our communities through responsible and ethical treatment of individuals who sexually offend, effective risk management strategies, public education and awareness, and the use of evaluation, treatment and management strategies that reflect the best available clinical and research knowledge (2005a, p.vi).

This emphasis on community safety contrasts with traditional ethical standards of mental health practice, which promote the delivery of client centered services. The sanctioning of this value by ATSA, which is known for its commitment to professional ethics and integrity, is likely to be influential on the practices and opinions of professionals concerned with sex offender management.

THE SEX OFFENDER PROGRAM OFFERED AT VANCOUVER AREA COMMUNITY CORRECTIONS (CSC)

The Sex Offender Programs offered by the Correctional Service of Canada are primarily geared towards male offenders who have been identified by their offence histories. Federal offenders who meet the referral criteria for Sex Offender Programs include those who have been convicted of a sexual offence, have been convicted of a sexually motivated crime, or have admitted to a sexual offence for which they have not been convicted. Sex Offender Program delivery is guided by Correctional Program Standards and the National Sex Offender Program Guidelines, which outline the details of program implementation (e.g. selection criteria, program facilitator role, etc).

The National Sex Offender Program is “a cognitive-behavioural intervention that is designed to be a therapeutic, rather than solely a didactic or psychoeducational program” (CSC, 2007a). Cognitive-behavioural group therapy is the most widely practiced intervention used to address sex offending (Grubin, 2007). While the cognitive component addresses offenders’ distorted thinking patterns (i.e. cognitive distortions), the behavioural component is geared towards teaching offenders to manage or modify deviant sexual arousal and fantasies (Beech & Scott Fordham, 1997).

The National Sex Offender Program, based on empirical evidence and best practice in the delivery of sex offender services, applies the principles of therapeutic relationships and alliance, motivational enhancement, social learning, adult learning, group processes, and skills development (CSC, 2007a). The program addresses criminogenic needs and identified risk factors for sexual offending. Treatment plans are tailored to individual offenders in order to target the criminogenic needs and known risk factors related to their particular patterns of sex offending behaviour. Offenders in the program are considered to be “experts” about their own behaviour, and the program facilitator’s role is to help offenders develop an understanding of the dynamics and motivations involved in their sex offending. In addition, program facilitators assist offenders in creating individualized self-management plans to prevent recidivism. The program’s treatment format comprises both individual and group work.

The Correctional Service of Canada offers two sex offender programs nationally: the Moderate Intensity Sex Offender Program (NMISOP) and the Low Intensity Sex Offender Program (NLISOP). A specialized sex offender assessment is used to determine the risk and needs of offenders, and they are referred to the programs accordingly. Maintenance programming is offered as a component of both Sex Offender Programs, and is delivered in the institution as well as the community to highlight the significance of follow-up and continuity of care within the institution and between the institution and the community (CSC, 2007a). In maintenance programming, offenders review their self-management

plans with the goal of embedding the plans and strategies they have learned, modifying these when circumstances change.

The purpose of institutional maintenance programming is to help offenders maintain any gains made in treatment and modify their relapse prevention plans. In addition to these functions, maintenance in the community consistently reevaluates risk levels and dynamic risk factors. Sex offenders in the community should ideally have a self-management/release plan identifying their high-risk situations, triggers to sex offending, and behaviours that would indicate to their case management team an elevation in risk. Self-management/release plans should be continuously reevaluated and modified accordingly.

Vancouver Area Community Corrections offers group maintenance programming to federal sex offenders on conditional release in the Vancouver area. Within the first month of release into the community, offenders referred to the Sex Offender Maintenance Program are scheduled for an intake assessment with a program facilitator or staff psychologist trained in sex offender assessment. Assessments conducted in the institution are necessary in order to appraise treatment gains and determine post-release risk and needs; however, the controlled and artificial environment in which these assessments take place makes it difficult to accurately assess potential risk as the likelihood of encountering high-risk situations is significantly minimized (Marshall & Eccles, 1991). Triggers for relapse and opportunities to re-offend are much more prevalent in the post-release environment; as such, it is imperative that offenders are reevaluated upon release. During the intake assessment for community

maintenance programming, offenders' sexual preferences, attitudes, emotional functioning, current lifestyle and living conditions are reevaluated, and modifications may be made to relapse prevention plans as needed.

Following the intake assessment, offenders are assigned to a group. Vancouver Area Community Corrections offers the Sex Offender Maintenance Program on a weekly, bi-weekly, and monthly basis. Typically, offenders are initially assigned to one of two weekly groups. The decision to transfer offenders from one group to another is made by the program facilitators in consultation with the supervising parole officers.

The program follows an open or "rolling" treatment format. In open groups, offenders do not begin treatment simultaneously, but rather, new members join the group as other members complete treatment and space is made available. As such, at any point in time, different group members may be disclosing their offences, producing an offence cycle, working on cognitive distortions, addressing issues related to victim empathy and relationships, or discussing relapse prevention plans (Fernandez & Marshall, 2000).

The open group format offers a number of advantages. In contrast to closed groups, in which offenders are often in treatment for a set period of time, open groups allow program facilitators to adjust the amount of time spent in treatment in accordance with the individual needs of offenders. The promotion of support and assistance among group participants is a significant feature of group therapy; open-ended groups allow those offenders approaching the end of their treatment program to offer encouragement and assistance to newer group

members. Another advantage of open groups is that those offenders nearing the end of their treatment program are generally comfortable with the treatment process and participate actively in group; this is significant as active participation is deemed an important component of most treatment programs. In addition to modeling active group participation for newer members, senior group members can use their own experiences to appropriately challenge denial or cognitive distortions displayed by newer members. Challenges presented by peers are often regarded as more credible than those provided by program facilitators (Fernandez & Marshall, 2000).

It was mentioned previously that there are various models of treatment service delivery, and while some programs do not involve supervision officers in the treatment process, others have supervision officers facilitate, co-facilitate, or observe sex offender treatment groups. The programs offered at Vancouver Area Community Corrections are facilitated by health care professionals (e.g. psychologists, psychiatric nurses, etc.) trained to deliver the Sex Offender Maintenance Program; parole officers are included in the treatment process as co-facilitators.

METHOD

Sample

Archived clinical notes were used to compile a list of parole officers (PO's) involved in the delivery of community-based sex offender treatment at Vancouver Area Community Corrections. Records prior to the year 2000 were unavailable; consequently, the list of parole officers used to form the sample reflects those PO's involved in sex offender treatment groups from January, 2000, to April, 2007 (when the survey was administered). Due to time constraints, each parole officer was sent a cover letter and questionnaire via email. Participants were given the option to return the questionnaire by email or, for complete confidentiality, to mail it to the Vancouver Area Community Corrections office. Of the 15 questionnaires that were sent for the purposes of this pilot project, 7 were returned.

Questionnaire

The survey questionnaire (see Appendix) was constructed based on the McGrath, Cummings, and Holt (2002) questionnaire administered to treatment providers, and modified for applicability to supervision officers. The questionnaire was divided into four main parts. The first part asked participants to provide information about their age, gender, and education. Participants were also asked about the length of time they have been supervising sex offenders and the nature

and quality of sex offender specific training they have received. The second part of the questionnaire elicited data pertaining to the nature and quality of the participants' relationships with the treatment providers supervising their sex offender clients. Participants were asked to rate the value, frequency, and type of interactions they have with treatment providers treating their sex offender clients. The third part of the questionnaire asked questions related to the issue of including parole officers in the treatment groups. Participants were questioned about their involvement in treatment groups, training for participation in group, benefits and drawbacks of participation in sex offender treatment groups, and were encouraged to describe "other" benefits and drawbacks they may have experienced. Participants were also asked about their beliefs related to the issue of participating in treatment groups attended by their clients, and they were prompted to comment on these responses in space that was provided.

RESULTS

Participant demographics

Of the parole officers who completed the questionnaire, 71% were female and 29% were male. All participants were aged between 31 and 40. The highest level of education obtained for all participants was a Bachelor of Arts; psychology and sociology were the most common professional fields of study (57% and 29%, respectively). The mean average length of sex offender supervision reported by respondents was 5.3 years.

Training

The majority of parole officers reported the quality of their sex offender specific training as either “excellent (43%) or “good” (43%). Training included workshops on risk assessment, workshops on the practice and principles of effective treatment, and on-the-job training.

Collaborative Relationships between Parole Officers and Treatment Providers

It appears that supervision officers and treatment providers communicate routinely, and that these interactions are valued. All respondents (N=7) reported positive relationships with the treatment providers delivering services to their clients; 57% described their relationship as “excellent”, while 43% considered their relationship to be “good”. The majority (86%) described collaboration

between PO's and treatment providers as "essential" to effective sex offender management. On average, respondents reported that contact was equally initiated. Most PO's reported the frequency of contact as 2-3 times per month (43%) or more than once a week (43%). The variance in frequency of contact may be explained by the fact that there are three parole offices in the Greater Vancouver Area; the treatment providers facilitating the sex offender programs work out of the Vancouver Area Community Corrections office. As such, it is likely that PO's working out of the Vancouver Area Community Corrections office communicate with the treatment staff on a more frequent basis.

Respondents were asked to report how often they communicate with treatment providers regarding several issues: client violation of supervision conditions, problematic behaviour in the community, and assessment as an increased risk. It appears that communications surrounding these areas of concern are relatively consistent. Most participants (86%) reported that they "always" or "usually" communicate with treatment providers about these issues.

Parole officers appeared to be relatively satisfied with the frequency of communication between themselves and the treatment providers delivering services to their sex offender clients, with 72% (N=5) reporting that they are "very satisfied" and 29% (N=2) noting that they are "somewhat satisfied" with the regularity of these communications. It appears that respondents are also satisfied with the quality of information communicated by treatment staff. 57% (N=4) described being "very satisfied" and 43% (N=3) reported being "somewhat satisfied" with the quality of information related to them by treatment providers.

Unfortunately, the survey questionnaire was flawed in that “satisfied” was not included as a potential option for participants to select; therefore, participants were required to select either “very satisfied” or “somewhat satisfied” in lieu of the “satisfied” option, potentially skewing the results.

Participants largely shared the belief that treatment staff tends to utilize the information provided by PO’s when treating their sex offender clients. 57% (N=4) reported that in their opinion, treatment providers “usually” employ the information given to them; 43% (N=3) opined that treatment staff “always” makes use of the information they provide. On average, parole officers in this study believed that treatment providers are usually respectful of their opinions and roles; 86% (N=6) of participants reported their belief that treatment providers are “always” or “almost always” respectful.

Parole Officer Involvement in Sex Offender Treatment

All parole officers in this study have been involved in the running of a community-based sex offender treatment group. 71% of respondents reported being “somewhat active” and 29% described themselves as “very active” in terms of their participation in the treatment groups they co-facilitated.

Training

On average, respondents rated the quality of training to prepare parole officers for participation in group as “good”. More specifically, training for group participation was rated as “excellent” by 14%, “good” by 43%, “fair” by 29%, and “poor” by 14%.

Risk Management

The majority of parole officers (71%; N=5) reported their belief that if an offender under their supervision attends the same treatment group they are involved in co-facilitating, they are better able to manage his risk. Because practice standards strongly discourage supervision officers from co-facilitating treatment groups attended by their clients, and the majority of treatment providers consider such practice inappropriate, it is important to further explore the opinions of supervision officers respecting this issue. As such, respondents were prompted to expand on their responses by providing qualitative explanations. Although there is insufficient data to conduct a formal qualitative analysis, it is nonetheless important to include qualitative responses in this study.

One parole officer explained that

...having a client in group better enables you to challenge the individual on their behaviour and its relationship to their risk factors. At the same time it may be counterproductive for the client as they may not be as truthful as they otherwise would without their supervising parole officer in the same treatment group. With that said, it all comes down to rapport building and a level of trust and encouragement.

Significantly, although this respondent highlights the advantages of having a client attend the same group she is involved in co-facilitating, she also suggests that this approach may be unhelpful for the client. In doing so, she emphasizes the importance of a positive client-supervision officer relationship, linking it to enhanced risk management. Another respondent similarly referred to the nature

of the relationship between the client and supervising officer, stating that whether or not she can better manage a client's risk if she attends the same group "depends on the relationship with the client." This respondent further noted that "for the most part I believe there is a positive relationship. They are more comfortable talking about their offending."

A few of the respondents noted that having a client in the group they co-facilitate allows them to find out about things they might not otherwise learn about in their regular interactions with the client. One of the parole officers reported that the "client appears to be more 'real' in group. You tend to hear what is really going on." Another respondent related that it allows him to have an additional meeting with the offender and that "they [the offenders] talk about things that might not get covered in a regular supervision meeting."

Benefits of Group Experience

Respondents unanimously reported that their group experiences were beneficial. Overall, participants believed that group involvement enhanced the quality of their sex offender supervision as well as their understanding of dynamic risk factors and the nature and goals of treatment. Participants were encouraged to list "other" benefits of their group experience. One parole officer stated:

I learned so much more about self-monitoring/logging and how to monitor this task as a parole officer. The group restored my optimism—most participants really want to make behavioural changes. I learned strategies to work with those offenders who deny their sexual offending.

Another parole officer noted that the groups gave her a “better understand[ing] of daily issues facing sex offenders and [opportunity to] observe offenders’ interaction with peers/other offenders.”

Drawbacks of Group Experience

As mentioned previously, several key concerns regarding parole officer involvement in sex offender treatment groups have been raised by academics and practitioners alike. Some of these concerns include client non-disclosure due to parole officer involvement, impaired judgment of parole officers due to having formed a therapeutic relationship with clients, professional role conflict, and dual relationships.

The majority of participants (71%; n=5) reported that they have not experienced drawbacks as a result of their involvement in sex offender treatment groups. There were no reported drawbacks in terms of participant non-disclosure or impaired judgment; however, it appears that a small percentage of respondents in this study have experienced drawbacks relating to issues of professional conflict and dual relationships. Fourteen percent of respondents in this study reported having experienced difficulty separating their role as a parole officer and treatment co-facilitator, and 29% related that their clients have had trouble differentiating these professional roles.

Although there were no reported drawbacks respecting client non-disclosure and only a small percentage of parole officers reported that their clients have had difficulties separating their role as a parole officer and a

treatment co-facilitator, it is likely that there are differences between the perceptions of professionals and the participants of sex offender groups. Several studies evaluating sex offender treatment programs have found significant differences between the perceptions of group leaders and participants (see Beckett, Beech, Fisher, & Scott Fordham, 1994; Beech & Scott Fordham, 1997), emphasizing the value of including the views of participants so as to more comprehensively inform future treatment practices (Garrett, Oliver, Wilcox, & Middleton, 2003).

DISCUSSION

As a preliminary investigation into the practices and opinions of federal parole officers currently and previously involved in the delivery of adult outpatient sex offender treatment services in the Vancouver area, this study has several limitations, including a small sample size, potential selection biases, participants from one outpatient treatment program, and the exclusion of the views of treatment providers. The main limitation of this study is the small sample size. A small sample size increases the potential for sampling error, which in turn reduces the likelihood that the sample is representative (Palys, 1997). Indeed, the participation of a mere 7 parole officers limits variation and generalizability, thereby rendering the findings of this study inconclusive. However, it is possible that the results of this study are conservative estimates of the practices and opinions of parole officers involved in the delivery of sex offender treatment services in this area.

Potential selection biases present another potential limitation of this study; the results only reflect the views of those respondents who were prepared to complete and return their questionnaires. Because participants responded to the questionnaires voluntarily, it is important to speculate as to why these particular individuals participated in the study compared to those who did not. In order to have participated in the questionnaire, parole officers would have had to have access to their CSC email accounts (which can only be accessed at the

workplace); read the email soliciting participation in the pilot project; have had enough interest in or concern about the issue to want his or her opinions heard; and have had the time to complete the survey questionnaire. Parole officers are often subject to excessive caseloads and charged with a number of tasks, including report writing, visiting and interviewing clients and their support networks, and collaborating with people in and out of the criminal justice system (Abadinsky, 2000). It is possible that time constraints contributed to the low response rate. Furthermore, a significant proportion of the work of a parole officer involves paperwork; supervision officers often spend more time writing reports than they do interacting with their clients. As such, the questionnaire may have been viewed by some as additional paperwork, particularly if there were any other reasons why they would be less compelled to participate in the study. Parole officers not presently or recently involved in the delivery of sex offender treatment services may have been less motivated to participate in the study as they may have felt that these issues are no longer applicable or relevant to them, or that too much time had passed since their involvement in the treatment process. Those parole officers more recently or currently involved in sex offender treatment may have had a more vested interest in expressing their views, or they may have felt more strongly about the topic given their recent participation in the delivery of treatment services. In addition, although the option to return the questionnaire via mail was offered, the questionnaire was administered via email; therefore, concerns related to confidentiality may also explain why some parole officers did not participate in the study. Another potential reason why some

parole officers may have opted to participate is that the researcher was also a practicum placement student. It is possible that those parole officers working directly with the practicum student were more likely to complete the questionnaire.

A further limitation of this study is that it did not explore the practices and opinions of treatment providers delivering sex offender treatment programs at Vancouver Area Community Corrections. The input of treatment providers would have allowed for a more comprehensive examination of the nature and quality of collaboration between parole officers and treatment staff, as well as the issue of including parole officers in the treatment process. However, it is important to note that this study was originally designed to include the views of treatment providers. Using the same methodology that was used to select the sample of parole officers, a companion survey was administered to 11 treatment providers. Because only 3 questionnaires were returned, the data was excluded from this pilot project.

Despite these limitations, this study offers initial data on the practices and opinions of supervision officers, an area which has received little to no attention in the academic literature. However, it is necessary that the results outlined herein are construed in light of the study's limitations and nature as a preliminary inquiry. The ensuing discussion examines several key issues surrounding parole officer involvement in sex offender treatment.

Confidentiality

Confidentiality is fundamental to the therapeutic relationship (Canadian Psychological Association, 2000). In correctional practice, however, confidentiality can be very much limited (Haag, 2006), and in the case of sex offender treatment, complete confidentiality can never be assured (Glaser, 2003). There is a general consensus within the field that treatment providers and supervision officers should routinely exchange information about their sex offender clients under community supervision (ATSA, 2005a). As such, most sex offender treatment programs require clients to sign a confidentiality waiver authorizing treatment providers to communicate with supervision officers and other professionals about their cases.

In the current study, parole officers reported relatively consistent communications with the treatment providers treating their sex offender clients, particularly regarding issues related to offender risk and community safety (i.e. client violation of supervision conditions, problematic behaviour in the community, and assessment as an increased risk). Discussing these issues with treatment providers can certainly result in the restriction of their clients' freedom, as more intensive techniques of surveillance and monitoring or incarceration may be employed to manage their risk. Consequently, some may argue that confidentiality, which is already substantially limited in this context, is not compromised by PO involvement in the delivery of treatment services. Moreover, it is often contended by those in support of PO participation in treatment groups that everything offenders say and do in group is relevant to their risk of

recidivism, and that routine parole officer involvement is the best means by which an offender's risk can be assessed and managed (McGrath et al., 2002). On the other hand, those in opposition of PO involvement in treatment groups generally maintain that confidentiality must be safeguarded to the extent that is possible given the context.

PO Training

One major source of concern with respect to parole officers co-facilitating treatment groups is that they generally lack the education and training to perform a sophisticated treatment function (Abadinsky, 2000; Dietrich, 1979). Typically, a bachelor's degree is the required level of education for parole officer positions, and it is argued that this is not sufficient in terms of providing the necessary background and skills required to appropriately deliver treatment services (Abadinsky, 2000; Dietrich, 1979). According to Dietrich (1979), the supervision officer "usually has not received extensive specialized training for the function of change agent; that is, the function of being competent to facilitate another person's changing his behaviour, attitude, affect, or personality style" (p. 15).

In most jurisdictions in the United States, those practicing psychotherapy or counselling must be licensed or they must work under the supervision of a licensed mental health professional. In Canada, those who practice psychology are required to be licensed or registered by the regulatory body in the province/territory they want to practice in (Canadian Psychological Association, 2008); however, with the exception of two provinces (Quebec and Nova Scotia), counselling in Canada is not regulated, nor is it subject to licensure (LaLande,

2004). It is clear that this lack of regulation may have an influence on the practices and opinions of treatment providers and supervision officers.

In terms of the general training and qualification standards of sex offender service providers, ATSA (2005a) requires its clinical members to possess an advanced degree in the behavioural, health, or social sciences or a health-related professional degree from a fully accredited university or college. Those members offering clinical services who do not possess graduate or professional degrees are required to have specialized training and experience in working with sexual offenders and must work under the direct supervision of a licensed mental health professional. Furthermore, according to ATSA's (2005ab) ethical principles, treatment providers are obligated to continually engage in activities to enhance their knowledge and professional growth and ensure that they are informed of ongoing advancements within the field. Significantly, ATSA's ethical standards also require that service providers "refrain from diagnosing, treating, or giving advice about problems outside the recognized boundaries of his or her discipline or training" (2005b, p.5).

In addition to these concerns, it appears that many parole officers do not consider their training for participation in group to be adequate. While the majority of participants in the current study reported that their training to prepare them for participation in group was "good" or "excellent", a significant proportion (43%) reported that their training was "fair" or "poor". Although programs are cautioned against using supervision officers as co-facilitators, for those programs that engage in this practice, it is essential that supervision officers receive the

best possible specialized training to prepare them for this role, and that they continue to supplement their education and experience in the field of sexual abuse with courses, seminars, conferences, workshops, and other training events.

POs Providing Co-therapy Treatment Services to Clients under Their Supervision

One of the foremost issues raised by the findings of this pilot study relates to the current practice in this area of supervision officers co-leading treatment groups their sex offender clients participate in. It was previously noted that practice standards strongly discourage supervision officers from co-facilitating treatment groups attended by offenders on their caseloads and that such practice is considered inappropriate by the majority of treatment providers. However, the majority of parole officers surveyed in this study (71%) reported that they have co-facilitated a community-based sex offender treatment group attended by offenders under their supervision.

Parole officers in many areas serve as both law enforcers and social workers; as such, they may not consider involvement as a co-facilitator in sex offender treatment groups as beyond the bounds of their usual duties (Petersilia, 1998). Given the detrimental effects of sex offences on the victims, it is imperative that professionals working with this offender population provide optimal treatment (Serran, Fernandez, Marshall, & Mann, 2003). There are several key issues warranting cautions against the practice of supervision officers co-leading treatment groups with offenders under their supervision,

including multiple relationships, professional role conflict, and client non-disclosure due to PO involvement. Because this practice may debilitate the therapeutic process, it is significant to consider these concerns and weigh them against any benefits of this approach.

Multiple Relationships/Professional Role Conflict

Previous research has highlighted the issue of multiple relationships as one of the most frequently cited concerns surrounding PO involvement in sex offender treatment groups (McGrath, Cumming, & Holt, 2002). A multiple relationship “occurs whenever a [treatment provider] and a Client have a relationship with one another in one context [e.g. professional, social, or business relationships] that conflicts with and/or compromises the primary Professional Relationship” (ATSA, 2005b: p. 9). Ethical guidelines and mental health professional regulations are unanimous in advising professionals against engaging in these types of relationships with their clients (American Psychological Association, 2002; ATSA, 2005b; Canadian Psychological Association, 2000; Canadian Association of Social Workers, 2005).

Treatment providers often struggle with complex concerns related to boundaries and dual relationships; recognizing whether a behaviour is an acceptable boundary crossing or a violation and whether a multiple relationship is ethical or not can pose significant dilemmas for these professionals (Barnett, 2007). While some argue that boundary crossings and multiple relationships are always unethical, others suggest that boundaries can be crossed and multiple relationships can exist without causing harm to the client (see Lazarus & Zur,

2002; Younggren & Gottlieb, 2004). The welfare of the client is paramount in determining whether or not engaging in such relationships is acceptable. According to the APA code of ethics, “multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical” (APA, 2002, p. 1065). Multiple relationships can result in harm if they damage the therapeutic relationship (i.e. the client’s capacity to develop an honest and trusting relationship with the treatment provider), exploit the client, or impair the professional judgment of the treatment provider (Haag, 2006; Lazarus & Zur, 2002; Peterson, 1996; Younggren & Gottlieb, 2004). Other potential problems presented by multiple relationships include confusion regarding the treatment provider’s role, blurred professional boundaries, and uncertainty as to who is benefiting from the professional relationship (Haag, 2006).

Although supervision officers may consider their participation as co-facilitators in treatment groups as within the scope of their routine duties, treatment providers are likely to view this practice in terms of the ethical issues that potentially arise from it. As mentioned previously, ATSA (2005) standards require that professionals delivering treatment services who do not possess graduate or professional degrees work under the direct supervision of a licensed mental health practitioner. Because parole officers generally do not have the qualifications to provide clinical services on their own, they must be supervised by a qualified treatment provider. As supervisors, treatment providers are charged with the task of ensuring that their supervisees perform services responsibly and ethically (ATSA, 2005b), which necessarily includes the

avoidance of multiple relationships. Furthermore, ATSA (2005a) recommends that treatment providers discourage supervision officers from treating clients under their supervision. Allowing POs to co-facilitate treatment groups creates a situation in which treatment providers are responsible for supervising professionals who are assuming the roles of both PO and treatment provider, and who may be providing treatment services to clients they supervise. Whether dual roles in this particular context are inherently conflictual and/or harmful to clients is ambiguous; as such, it remains unclear if they are unethical. This area is one that requires further analysis.

McGrath et al. (2002) found that the majority (68%) of treatment providers in their study considered it “inappropriate” or “somewhat inappropriate” for supervision officers to co-facilitate treatment groups attended by clients on their caseloads. Participants in their study reported several key concerns regarding these multiple relationships. One concern was that a supervision officer’s professional judgment can become impaired as a result of the therapeutic relationship developed with his or her client(s). Another concern was related to which professional role supervision officers should adopt when a client discloses information pertaining to supervision violations in treatment group. The inhibition of participation in treatment was also raised as a concern surrounding this practice.

Some of these concerns were echoed by parole officers in the current study; a few participants reported having experienced professional role conflict or that their clients have had difficulty separating their professional roles.

Unfortunately, the small sample size limits our ability to adequately explore the experiences of parole officers and how they view the concerns surrounding them.

Client Non-Disclosure

One concern related to having parole officers co-facilitate sex offender treatment groups is that clients will be less likely to disclose information due to the fact that parole officers, in contrast to treatment providers, have the authority to restrict their freedom through increased supervision or incarceration. It was mentioned previously that although respondents in this study did not report any drawbacks related to client non-disclosure as a result of their participation in sex offender treatment groups, previous research has highlighted significant differences between the perceptions of group leaders and their clients. Moreover, several of the treatment providers in the McGrath et al. (2002) study reported that their clients were apprehensive about being open and trusting in a group with a co-facilitator who has the power to violate their parole/probation. It is possible that the clients of the participants in the current study have been less disclosive in group due to the presence of their supervising parole officer. Indeed, without the clients' input, it is difficult to ascertain with any degree of certainty whether or not they fear being open and honest in a treatment group co-led by their supervision officer.

Other Considerations

PO Attitudes towards Sex Offenders: Potential Implications for the Therapeutic Process

Although supervision officers' attitudes towards sex offenders were not explored in this survey, it is important to consider their perspectives when examining the appropriateness of having these professionals co-facilitate sex offender treatment groups. There is a marked paucity of research investigating the attitudes and perceptions of professionals working with sex offenders; however, it is likely that the attitudes professionals hold towards their sex offender clients affects their work. In particular, professionals' attitudes are likely to influence how offenders respond to the correctional environment and the efficacy of attempts to modify their behaviour (Hogue, 1993). Indeed, positive attitudes among professionals working with sex offenders are central to effective treatment and rehabilitative efforts.

In a survey administered to probation officers responsible for the supervision of sex offenders, Jenuwine et al. (2003) found that the majority of PO's surveyed hold negative attitudes towards this particular offender population (Jenuwine et al., 2003). While the PO's in the study maintained that negative responses to their clients' offenses do not affect their job performance, it is likely that these negative attitudes influence, directly or indirectly, interactions with their supervisees. Jenuwine et al. (2003) also found that most of the PO's surveyed do not consider their professional role as therapeutic to offenders. Further, the majority suggested that they are unable to empathize with sex offenders under their supervision and that empathy has no place in their profession. Significantly,

there is much evidence demonstrating that treatment provider empathy is critical to effective therapy (Marshall, Anderson, & Fernandez, 1999). As such, the findings that a majority of PO's tend not to view their role as therapeutic and are unable to feel empathy for their sex offender clients raise obvious concerns about the appropriateness of current practices sanctioning the participation of supervision officers in sex offender therapy.

The attitudes professionals hold towards sex offenders are likely to influence the approach they adopt when working with this particular offender population. According to Marshall (1996), those professionals who view sex offenders negatively (for example, as inherently evil or "monstrous"), are more likely to adopt a confrontational style to sex offender therapy. While confrontation is relatively common in correctional settings, it has been demonstrated that this approach is largely counter-therapeutic and ineffective (Beech & Scott Fordham, 1997; Marshall, Anderson, & Fernandez, 1999; Marshall et al., 2002). Kear-Colwell and Pollack (1997) argue that confrontational approaches to sex offender treatment are unlikely to yield positive results and may, to the contrary, produce negative consequences for the offenders subject to them. Confrontational approaches, they suggest, imply a sequence of negative assumptions regarding sex offenders; as such, proponents of this approach deem it necessary to respond to their clients in an authoritarian style devoid of empathy and warmth.

Marshall (1996) suggests that a constructive approach to sex offender therapy is one in which the program facilitator establishes a relationship with clients that is "respectful of their dignity, engenders trust, displays empathy for

them, and accepts them as persons while not accepting their offensive behaviors [sic]" (p.329). Indeed, the development of genuine positive relationships between clients and staff are significant to behavioural change (Anton Schweighofer, personal communication, January 25, 2007). In a qualitative study of sex offenders' perceptions of correctional treatment, Williams (2004) found that "human relationship dynamics between offenders and professional staff, not treatment content, are foundational to the treatment experience" (p.153).

While the majority of studies indicate that the attitudes of correctional staff towards sex offenders are overwhelmingly negative, these studies also suggest that a means by which more positive attitudes towards sex offenders may be fostered is through staff training and education. A research study conducted by Hogue (1993) explored professional attitudes towards sex offenders. The professionals involved in the study included police officers, prison officers involved in sex offender treatment, prison officers not involved in sex offender treatment, probation officers, and psychologists. In general, Hogue (1993) found that professionals working directly with sex offender clients maintain more positive attitudes toward them than those professionals with limited or indirect involvement with this offender population. Further, it was found that prison officers who participated in training for sex offender treatment held substantially more positive views towards sex offenders than those who did not participate in the training. In a later study, Hogue (1995) specifically investigated the effect of training programs on the attitudes of professionals (including prison officers, probation officers, and psychologists) towards sex offenders and sex offender

specific treatment. Hogue (1995) found that training improved professionals' attitudes towards sex offenders, increased confidence in their ability to work in the area of treatment, and enhanced their belief in the efficacy of treatment.

Another study emphasizing the significance of training to enhance attitudes of professionals working with sex offenders is that of Weekes, Pelletier, and Beaudette (1995). Weekes et al. (1995) explored correctional officers' attitudes towards sex offenders against women, sex offenders against children, and general population offenders. Overall, attitudes towards both groups of sex offenders were more negative than attitudes towards general population offenders. Sex offenders were viewed as more mentally ill and immoral than general population offenders, and only 20.7% of correctional officers believed that sex offenders are treatable. The majority of participants (over 68%) specified that they would like to receive more training on working with sex offenders, while only 12.3% believed that their training had sufficiently prepared them to work with sex offender clients. Weekes et al. (1995) suggest that in addition to providing correctional staff with strategies for efficient sex offender management, specialized training may improve the quality and effectiveness of their routine contact with sex offenders.

It is important to note that treatment providers may also hold negative views of sex offenders; however, in contrast to supervision officers, these professionals have typically received extensive specialized training in psychotherapy, which better prepares them to identify and appropriately address any issues that might arise as a result of their personal sentiments. Furthermore,

treatment providers are bound to a code of mental health ethical standards which outline that professionals are not to allow personal feelings to interfere with objectivity and professional judgment (ATSA, 2005b). Nonetheless, despite specialized training and ethical obligations, the work of some treatment providers may be affected by their personal feelings towards sex offenders.

Financial, Time Management, and Safety Issues

Issues related to finances, time management, and professional safety may provide rationale as to why some programs allow supervision officers to co-facilitate sex offender treatment groups despite the concerns outlined above. Financial constraints may be used to justify this practice; supervision officers generally make less income than licensed mental health professionals, and because they typically do not receive additional pay to provide treatment services, these professionals can deliver treatment services with little to no cost to the correctional organization for which they work.

Parole officer involvement in treatment groups attended by their clients may be rationalized as a time management strategy. Supervision officers are generally required to make a specified amount of face-to-face contacts with their clients per month. As one respondent in this study pointed out, co-facilitating groups attended by their clients can provide supervision officers with an additional supervision meeting. Involvement in groups attended by their clients also allows supervision officers to meet regularly with treatment providers, and can reduce the amount of additional time they would otherwise spend consulting with the treatment providers servicing their clients.

Safety concerns may also be used to justify parole officer involvement in treatment groups. To accommodate offenders' work schedules, treatment programs may be delivered in the evening after most staff members have left the office. For instance, at Vancouver Area Community Corrections, programs offered in the evening begin at 7pm. Some treatment providers may not be comfortable facilitating groups in the absence of other staff members, should a potentially dangerous situation arise. As such, PO involvement in sex offender treatment groups may be deemed a safety precaution.

Other Benefits of PO Involvement in Treatment Groups

There has been considerable emphasis on the potential problems presented by PO involvement in sex offender treatment groups; however, there are several advantages to such an approach. Allowing POs to attend treatment groups can help educate them about individuals who sexually offend and the treatment process, which in turn can enhance their ability to supervise their clients. Indeed, participation in group may allow POs to better understand and manage the risk presented by their sex offender clients.

PO attendance in treatment groups models for offenders the collaborative nature of relationships between supervision officers and treatment providers. Moreover, PO attendance in treatment reinforces three key issues to offenders: 1) treatment is part of their probation/parole, 2) probation/parole is part of their treatment, and 3) POs are there to assist them (Eric Sipe, personal communication, March 10, 2003). This practice can also enhance consistency

and continuity between treatment providers, supervision officers, and their clients (Scheela, 2001).

Some argue that supervision officers should not adopt a therapeutic role when co-facilitating treatment groups, but rather, act as the “experts” in matters pertaining to the law and the criminal justice system (Jeannine Curtis, personal communication, March 10, 2003). Supervision officers can help clarify any questions or concerns related to legal and system matters that treatment providers may not be familiar with. Indeed, the presence of POs in group can educate offenders about the role of supervision officers and help them view POs as resources (Jeannine Curtis, personal communication, March 10, 2003).

CONCLUSION

This project paper presented initial data on the practices and opinions of parole officers involved in the sex offender treatment program offered at Vancouver Area Community Corrections. The findings of this study must be viewed within the context of its limitations and nature as a pilot project. Nonetheless, some significant issues were raised. In addition to the key issues gleaned from the results of this preliminary inquiry, several concerns related to PO involvement in the treatment process that were identified in the literature were explored. Many of these issues are complex and rather ambiguous in nature, and have yet to be adequately addressed in the literature; as such, it is not possible at this point to offer specific directions for future practices in the area of sex offender treatment and supervision. However, after careful consideration of these issues, this writer has formulated several opinions surrounding PO involvement in the treatment of sexual offenders.

Collaboration between supervision officers and treatment providers is critical to effective sex offender management and community safety. While there may be some overlap in the occupational roles of these professionals, it is important that they are distinguished as separate of one another. Professionals should work in their area of specialization, and avoid performing services for which they have not received adequate training.

Although there are several notable advantages to having POs attend or co-facilitate treatment groups, it is the opinion of this writer that the significant ethical concerns related to this practice should take precedence. Considering the detrimental effects of sex offences on victims, it is essential that sex offenders are offered the best possible treatment services. The legal context in which sex offender treatment takes place naturally lends itself to breaches of traditional mental health ethics; however, it is significant that ethical standards are preserved to the extent that is possible in order to maintain a level of professionalism and integrity that reflects the best interests of offenders, their victims, and the community as a whole. Indeed, most benefits of PO involvement in the treatment process can be achieved by less ethically invasive means, such as having POs occasionally attend treatment sessions.

Programs should carefully consider potential ethical and therapeutic implications prior to engaging in practices that are rare, particularly those that are advised against by practice standards and deemed inappropriate by the majority of practitioners. For those programs that allow POs to regularly attend or co-facilitate treatment groups, it is imperative that treatment providers focus on developing and delivering sex offender specific education in order to better prepare them for their role in group. Training should focus on empirical data on sex offenders and appropriate treatment for this offender population, risk management strategies, the significance of substantive collaboration between vested partners and agencies, as well as ethical principles and standards for professional conduct when working with sex offender clients. Training should

also concentrate on attitudes towards sex offenders in order to ensure that a positive approach is adopted; this, in turn, should enhance treatment effectiveness. Training should be offered regularly, and supervision officers should continue to supplement their education and experience with courses, seminars, conferences, workshops, etc. to ensure that they are informed of advances in the field.

The paucity of research examining the nature and quality of collaboration between supervision officers and treatment providers is an area that should be addressed. Considering that sex offenders are typically required to participate in treatment as a condition of their release into the community, and that collaboration is considered essential to effective sex offender management, further research is needed to examine the practices and opinions of these professionals. Research exploring the practices and opinions of supervision officers would benefit from a larger sample size, and should include probation/parole officers from various programs offering clinical services to sex offenders. It would also be valuable to direct attention towards the clients of sex offender programs and consider their views related to the involvement of supervision officers in the treatment process.

A substantial proportion of convicted sex offenders are eventually released into the community; as such, it is imperative that the most effective techniques of community supervision and treatment are employed when dealing with this population of offenders. We are aware of the potential ethical consequences of having POs regularly attend or co-facilitate sex offender

treatment groups; however, whether or not this practice is unethical has yet to be elucidated. It is hoped that future research will continue to investigate this issue, so as to better inform and direct treatment practices.

APPENDIX

Collaboration between Sex Offender Treatment Providers and POs - PO Questionnaire

Part 1 - Demographics

1. You are: Male / Female
2. Your age: 20-30 31-40 41-50 51-60 60+
3. Your most advanced degree: B.A., M.A., Ph.D. Other: _____
4. Your major area of study was:
Psychology___ Criminology___ Sociology___ Other (specify)_____
5. Are you a member of the Association for the Treatment of Sexual Abusers?
Y / N
6. How long have you been supervising sex offenders? _____
1. How would you describe the sex offender specific treatment training you have received?
Excellent ___ Good ___ Fair ___ Poor ___
2. The training you have received has included which of the following?
Workshops on risk assessment ___
Workshops on the principles and practices of effective treatment ___
On the job training ___
Graduate level courses dealing with the assessment and treatment of sex offenders ___
Other (specify) _____

Part 2

The following questions deal with the nature and quality of your relationship with the treatment providers who treat the sex offenders you supervise.

1. Overall, how would you describe the relationship that you have with the treatment providers who treat the sex offenders you supervise?

Excellent ___ Good ___ Fair ___ Poor ___

2. In your opinion, how important is collaboration between PO's and treatment providers in the effective management of sex offenders in the community?

Essential ___ Very important ___ Important ___ Not Important ___

Contraindicated ___

3. When you communicate with treatment provider(s) about sex offender clients who typically initiates the contact?

I do ___ Treatment provider does ___ Both equally ___ Other ___

4. On average how often do you communicate with the treatment provider(s) who treat your sex offender clients?

> Once a week ___ Once a week ___ 2-3 times a month ___

Once a month ___ < Once a month ___ Never ___

5. How often do you communicate with the treatment provider(s) who treat your sex offender clients about the following information?

	Always	Usually	Sometimes	Never
Client violation of supervision conditions	___	___	___	___
Problematic community behaviour	___	___	___	___
Client assessed as increased risk	___	___	___	___
Other (specify) _____	___	___	___	___

6. How satisfied are you with the frequency of communication between yourself and the treatment provider?

Very Satisfied ___ Somewhat Satisfied ___ Not Satisfied ___ Very Unsatisfied ___

7. How satisfied are you with the quality of the information that the treatment provider communicates to you?

Very Satisfied ___ Somewhat Satisfied ___ Not Satisfied ___ Very Unsatisfied ___

8. In your opinion do you believe that the treatment provider(s) use the information you provide them when treating the offender?

Always ___ Usually ___ Sometimes ___ Never ___

10. Do you believe that the treatment provider(s) who treat your sex offender clients are respectful of your opinions and role?

Always ___ Almost always ___ Sometimes ___ Never ___

Part 3

The following questions deal with the issue of including parole officers in treatment groups.

1. Do you currently or have you in the past participated in the running of a community based sex offender treatment group? Y / N

If the answer to the above question is "yes" please proceed to the following questions. If your answer is "no" then the following questions do not apply to you. Thank you for your participation.

2. If a sex offender who you supervise is in the same treatment group as the one you participate in do you believe you are better able to manage his risk?

Y / N

Please explain:

3. How actively do you participate in the group?

Very active ___ Somewhat active ___ Not at all active ___

4. How would you describe the training you have received to prepare you participating in the group?

Excellent ___ Good ___ Fair ___ Poor ___

5. In general, has your group experience been beneficial?

Y / N

6. If you have found the experience beneficial in which of the following ways has it been beneficial?

- a. Enhanced understanding of dynamic risk factors ___
- b. Enhanced overall quality of my supervision of sex offenders ___
- c. Enhanced understanding of the nature and goals of treatment ___
- d. Other (specify) _____

7. What drawbacks have you experienced as a result of participating in a sex offender treatment group?
- a. Too little benefit for the time required ____
 - b. Treatment participants become non-disclosive because parole officer is in group ____
 - c. My judgement was impaired as a result of having developed a treatment relationship with a parolee ____
 - d. I have had difficulty separating my role as a parole officer and a group participant ____
 - e. My parolees have had trouble separating my role as a parole officer and a treatment co-facilitator ____
 - f. Other (specify) _____
 - g. There have been no drawbacks ____

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