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Collaboration Among Sex Offender Treatment Providers and Probation and Parole Officers: The Beliefs and Behaviors of Treatment Providers

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New and emerging collaborative responses to sex offender management are challenging traditional notions about how treatment providers and probation and parole officers (POs) deliver services to this difficult population. Typically, sex offender treatment professionals provide community-based services to offenders who are supervised by POs. Yet, no comprehensive survey has investigated how treatment providers and POs collaborate and view their relationships with each other. This national random survey examined the beliefs and behaviors of community-based adult sex-offender treatment providers concerning various types of provider and PO interactions and collaborative models. Overall, treatment providers reported that they value frequent and substantive communication with POs concerning mutual clients. There was, however, considerable diversity in practice and opinion among providers with regard to POs leading, coleading, and observing sex offender treatment groups. Treatment providers' opinions about various clinical, ethical, and legal issues evident in these collaborative approaches are examined.

KEY WORDS: ethical standards; interagency collaboration; probation officer; multiple relationships; sexual offending.

INTRODUCTION

Recent estimates indicate that nearly 60% of sex offenders currently under the control of correctional agencies in the United States are being supervised in the community (Greenfeld, 1997). This percentage represents approximately 140,000 sex offenders on probation, parole, or other forms of community supervision. The

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results of another recent survey suggest that a significant proportion of these offenders receive some form of sex offender treatment. Jones et al. (1996) found that over 85% of probation and parole supervisors contacted in a national telephone survey reported that sex offender treatment was "always" or "often" a condition of supervision in their jurisdictions. Certainly, a large number of treatment resources exist to meet such a demand in the United States. The Safer Society Foundation's biannual national survey has identified community-based adult sex offender treatment programs in 48 states with the number of programs totaling 455 (Burton & Smith-Darden, 2000).

Several studies have examined the effectiveness of combining treatment services with community supervision among the general criminal population. Petersilia and Turner (1993) evaluated generic intensive supervision programs in nine states and found that probationers who were also involved in treatment recidivated at a significantly lower rate than those who were not. Gendreau, Goggin, and Fulton's recent extensive meta-analysis also found that a combination of treatment and supervision was associated with reduced recidivism rates (Gendreau, Goggin, & Fulton, 2000), whereas intensive supervision alone showed little or no benefit in reducing criminal reoffense rates. In the area of sex offender management, Cumming and McGrath (2000) found that the combination of supervision and treatment is much less studied but argue that it is also the preferred service delivery method for managing this population. English, Pullen, and Jones (1996) support this view and maintain that a more collaborative response among treatment provider, PO, and polygraph examiner is a necessary component of comprehensive sex offender management.

Because community corrections professionals typically mandate sex offenders to attend sex offender treatment programs (Jones et al., 1996), how sex offender treatment providers and supervising POs collaborate in delivering services is an important area of investigation. Several models exist. These models range from programs in which there is considerable overlap in the roles of POs and treatment staff to those in which roles are more separate.

Descriptions of highly regarded programs in the United States and other countries suggest that the use of POs to actually lead sex offender treatment groups is uncommon (Knopp, 1984; Laws, 1989; Marshall, Fernandez, Hudson, & Ward, 1998). Some programs however do utilize POs in varying capacities with respect to treatment groups. In Connecticut, D'Amora and Burns-Smith (1999) describe a community-based program for high-risk sex offenders in which POs participate in weekly treatment groups and treatment providers share supervision responsibilities with POs. For example, treatment providers and victim advocates make field and home visits with POs. Although evaluation efforts with this program have not been completed, D'Amora and Burns-Smith (1999) indicate that such a collaborative response is critical to effectively managing this population.

Similarly, McGrath, Hoke, and Vojtisek (1998) describe an outpatient program in Vermont in which treatment staff and POs freely discuss offender progress

and case planning issues on a regular basis, typically weekly. POs, however, do not participate in therapy sessions. Instead, they visit treatment groups about four times per year to observe group members' progress, learn about the treatment process, and model their collaborative relationship. McGrath et al. (1998) have speculated that the close communication between treatment staff and POs contributed to lower rates of sexual reoffense in their program versus a comparison treatment group that did not evidence collaborative relationships with supervising POs. Unfortunately, the design of their study did not allow for such a hypothesis to be tested. Scott (1997) has likewise stressed the importance of open communication between treatment staff and POs in Arizona where POs are also encouraged to periodically visit treatment groups.

Another interesting collaborative model was developed in Texas to address the shortage of trained sex offender treatment providers (Coxe, 1996). Under the supervision of a consulting psychologist, POs led weekly psychoeducation groups for sex offenders. Psychoeducational modules that comprised the program included offender denial, victim sensitivity, relapse prevention, and social skill development. A consulting psychologist facilitated a module that focused on controlling sexual impulses, a treatment which was deemed to require therapeutic expertise.

A shortage of available sex offender treatment providers in England in the early 1990s, also led to the emergence of POs as the lead providers of rehabilitation services to sex offenders. POs led treatment groups themselves, sometimes with advice and consultation from forensic psychologists (Beckett, 1998). More recently, mental health providers have begun serving as coleaders in these probation initiated programs. Because of continuing staff shortages, Beckett (1998) predicts that POs in England will continue to play a central role in delivering treatment services to sex offenders. Lack of available sex offender treatment providers is not new to rural America either despite the growing number of sex offender treatment programs nationally. Sex offenders in rural states like Alaska, Montana, and Idaho can be required to travel many hours to participate in treatment groups. POs in rural parts of the country, not unlike England, are beginning to explore alternative ways to provide adequate supervision and treatment for sex offenders in their communities, particularly those where qualified treatment providers do not exist.

The beliefs and behaviors of treatment providers and POs about various collaborative models are likely influenced by a variety of factors. Traditionally, POs have been charged with protecting the community and rehabilitating offenders. Role conflict is considered inherent in these two functions and has been the subject of much debate (Clear & Latessa, 1993). In practice, POs typically carry out their community protection or "law enforcement function" themselves, and broker the rehabilitation or "social work" function by referring offenders to existing community services or by contracting directly for services (Abadinsky, 2000; Petersilia, 1998). POs who actually lead or colead sex offender treatment groups would appear to be providing services outside the roles for which they are traditionally trained (Abadinsky, 2000).

Mental health professionals are not as accustomed to such role conflicts. Nonforensically trained mental health professionals are typically taught to provide treatment that is voluntary, client centered, nonjudgmental, and confidential in nature. Clinicians who treat sex offenders generally deliver services in a manner that is quite different. Sex offenders are mandated to treatment, have committed illegal behaviors, pose risk to harm others, and are often required to have their treatment progress reported to the court or a correctional agency. Providers in this situation are faced with similar role conflicts as POs. Is their primary allegiance to protect the community, rehabilitate the offender, or some combination of both? How providers and POs answer this question influences how they supervise and treat sex offenders on their caseloads.

The policies and mandates of correctional agencies, professional organizations, and legislation also have an effect on the behaviors of POs and treatment providers. Several studies, for example, have found that if correctional agencies emphasize a treatment philosophy, then POs are more likely to increase the degree to which they engage in rehabilitative versus law enforcement oriented interventions with offenders (e.g., Clear & Latessa, 1993; Foulton, Stichman, Travis, & Latessa, 1997).

In the case of professional organizations, the Association for the Treatment of Sexual Abusers (ATSA) and the National Adolescent Perpetrator Network (NAPN) direct treatment providers to take on a community protection role. In fact, both of these organizations use identical language in stating one of their core principles, "Community safety takes precedence over any conflicting consideration, and ultimately, is in the best interest of the abuser and his or her family (ATSA, 1997, p. 11; NAPN, 1993, p. 12)." The focus on community safety is perhaps the most notable difference between traditional psychotherapy and sex offender specific treatment.

Similarly, legislation in many some states now prescribes that sex offender treatment providers embrace community safety as a treatment goal. For example, the Colorado legislature has created the Sex Offender Management Board that requires POs to refer sex offenders to providers approved by the Board. In order to be approved, providers must agree to attend their local Interagency Community Supervision Team meetings that are chaired by a PO and at which the provider must provide detailed information about the progress of each offender the PO supervises (Colorado Sex Offender Management Board, 1999). The Board also encourages POs to periodically visit treatment groups.

Despite the fact that several provider and PO collaboration models exist, there continues to be an absence of comprehensive, systematically gathered data in this area. This deficiency creates challenges for treatment providers, POs, administrators, and others who are charged with developing and managing sex offender treatment programs. Thus, this study was designed to survey the beliefs and behaviors of sex offender treatment providers regarding various collaborative practices with POs. (A companion survey focused on this topic that reflects the opinions of

POs is forthcoming by the American Probation and Parole Association. B. Ney, personal communication, July 20, 2000.) No implication is intended that norms identified in this study will or should be equivalent to ethical standards or appropriate practice. Rather, the goal is to describe the current state of practice patterns and provider beliefs in this area. Further, it is hoped that this article will stimulate examination of the clinical, ethical, and legal issues that surround several of these practices.

METHOD

Sample

A national data-base maintained by the Safer Society Foundation (SSF) was utilized to randomly select one half ($N = 379$) of treatment programs identified as providing clinical services to adult sex offenders on probation, parole, and other forms of community release in the United States. The SSF is a national nonprofit research, advocacy, and referral center for the prevention and treatment of sexual abuse. Each selected program was sent a cover letter, questionnaire, and stamped return envelope.

Questionnaire

The survey questionnaire was divided into four main parts. In the first part, data concerning each program's size and treatment approaches were elicited. The second part of the questionnaire asked respondents to provide information about their age, gender, education, and professional affiliations. In the third part of the questionnaire, participants were asked to rate the type, frequency, and value of different methods of communication that their programs have had with POs. The fourth part of the questionnaire consisted of seven scenarios depicting various levels of collaboration among treatment providers and POs in the provision of group rehabilitation services. These scenarios were constructed to be representative, but not inclusive, of several of the different types of practices that have been utilized in the United States. Participants were asked if they engaged in the practices outlined in each scenario and to rate each scenario in terms of how appropriate it would be for a licensed mental health treatment provider to collaborate with POs in the manner described. Five options were available for rating each scenario: *appropriate, somewhat appropriate, not sure, somewhat inappropriate, and inappropriate.* Participants were also asked if any individual or organization had made any complaints about them or their program for engaging in one or more of the practices listed in the scenarios. Lastly, participants were provided space and encouraged to make comments about their responses.

Return Rate

Of the 379 questionnaires sent in this study, 201 surveys were returned and 20 were undeliverable. Of the 201 returned surveys, 11 respondents reported that they no longer provided community-based treatment services to adult sex offenders. Thus, the adjusted response rate of 53% reflects the beliefs and behaviors of 190 practitioners who completed the survey.

RESULTS

Program Characteristics

Programs from 45 states and Washington, DC responded. Sixty percent of programs had been serving sex offender clients for more than 10 years. A similar number of programs (57.9%) served 26 or more adult sex offender clients in a typical month. Almost all programs provided individual (92.1%) as well as group treatment services (85.5%) to their clients. Most (57.4%) respondents reported that, on average, their programs took over 2 years to complete.

Participant Demographics

Of program representatives who completed the questionnaire, 69% were male and 31% were female. Over four fifths (87.9%) of respondents were aged 41 or older and 41.6% were aged 51 or older. Sixty-nine percent had been treating adult sex offender clients for 11 years or longer. Most had advanced degrees with 38.9% holding a doctorate degree and 57.9% a masters degree. The most common professional disciplines of respondents were psychology (33.2%), social work (27.4%), and counseling (21%). Almost all respondents (93.2%) were state licensed or certified in their respective discipline and over half (58.9%) were members of the Association for the Treatment of Sexual Abusers.

Communication Patterns

Treatment provider and PO communications appeared to be valued, common, and frequent. Almost all programs (93.7%) required their sex offender clients to sign confidentiality waivers to allow treatment staff to communicate freely with POs. A similarly larger percentage (87.4%) described such communications as "essential" for effectively managing this population in the community. Almost 90% ($N = 169$) of respondents described their relationship with the POs that supervise their clients as positive, either "excellent" (44.2%) or "good" (44.7%). How often treatment providers report that they communicate with POs about a variety of topics is detailed in Table I.

Table I. Percentage of Sex Offender Treatment Programs ($N = 190$) Providing Information to Probation and Parole Officers

Information category	Frequency ratings			
	Always	*Usually*	*Sometimes*	*Never*
Client attendance in treatment	80.0 (152)	13.2 (25)	3.2 (6)	0.5 (1)
Periodic client progress reports	68.4 (130)	18.9 (36)	8.9 (17)	0.5 (1)
Client violation of supervision conditions	76.3 (145)	11.1 (21)	8.4 (16)	1.6 (3)
Client violation of treatment conditions	75.3 (143)	15.8 (30)	4.7 (9)	1.6 (3)
Client assessed as an increased risk	82.1 (156)	10.5 (20)	4.2 (8)	0.0 (0)

Note. Values enclosed in parentheses indicate number in each group. Responses in each row sum to less than 100% due to missing data.

Responses to Collaboration Scenarios

Table II presents the responses of participants to seven scenarios depicting various levels of provider and PO collaboration in providing group rehabilitation services. These responses reveal that there is a considerable diversity of opinion among treatment providers on these issues. In general, treatment providers do not appear to support the practice of POs leading or coleading sex offender treatment groups. In fact, the data suggest that that such practices are very uncommon in the United States. Conversely, treatment providers, as a group, are more favorable than not to POs attending, but not coleading, sex offender treatment groups either regularly or on a periodic basis. Almost one quarter (24.2%) of programs report that POs in their jurisdiction attend weekly sex offender treatment groups and 23.4% report that POs in their jurisdiction attend group sessions four times per year. Only nine respondents reported that they had received complaints about engaging in any of the practices outlined in the scenarios and none of the complaints involved professional licensing or certifications boards.

Several respondents explained their answers to various scenarios in space provided on the questionnaire. Although the number of these comments was not sufficient to conduct a formal qualitative analysis, a variety of clinical, legal, and ethical themes emerged concerning several of the practices outlined in the scenarios. These themes serve to organize the following discussion about the results of this study.

DISCUSSION

This study was an initial inquiry into the behavior and beliefs of treatment providers who treat adult sex offenders in the community concerning various types of provider and PO interactions. As such, it furnishes normative data about different provider and PO communication and collaborative models.

Caution is required in interpreting these data. First, as an initial study, it awaits replication. Second, questionnaires were sent to a random sample of programs

Table II. Responses of Sex Offender Treatment Programs ($N = 190$) to Collaboration Scenarios

Scenario	Responses[a] *A*	*SA*	*NS*	*SI*	*I*	mean[b]	freq[c]
1. A licensed treatment provider coleads sex offender treatment groups with a PO (probation or parole officer). *Some* of the probationers or parolees that the PO supervises are members of the groups.	16.8 (32)	6.8 (13)	2.6 (5)	12.1 (23)	56.3 (107)	3.9 *SD* = 1.6	8.9 (17)
2. A licensed treatment provider coleads sex offender treatment groups with a PO. *None* of the probationers or parolees that the PO supervises are members of the groups.	17.9 (34)	16.3 (31)	6.8 (13)	16.8 (32)	35.8 (68)	3.4 *SD* = 1.6	5.3 (10)
3. A licensed treatment provider leads sex offender treatment groups. The PO may attend *weekly* groups sessions. The PO does not colead the group, but participates in group discussions pertaining to supervision conditions and status. Some of the probationers or parolees that the PO supervises are members of the group.	31.6 (60)	17.9 (34)	5.3 (10)	10.5 (20)	28.9 (55)	2.9 *SD* = 1.7	24.2 (46)
4. A licensed treatment provider leads sex offender treatment groups. The PO may attend group sessions only *four times per year*. The PO does not colead the group, but participates in group discussions pertaining to supervision conditions and status. Some of the probationers or parolees that the PO supervises are members of the group.	49.5 (94)	15.8 (30)	3.2 (6)	7.4 (14)	17.9 (34)	2.2 *SD* = 1.6	23.2 (44)
5. A licensed treatment provider conducts *ongoing clinical supervision* of a PO who is leading weekly sex offender treatment groups for the probationers or parolees the PO supervises.	15.8 (30)	7.4 (14)	10.0 (19)	6.3 (12)	56.8 (108)	3.8 *SD* = 1.6	3.7 (7)
6. A licensed treatment provider conducts *limited clinical supervision* of a PO who is leading weekly sex offender treatment groups for the probationers or parolees the PO supervises.	9.5 (18)	7.4 (14)	7.9 (15)	6.3 (12)	64.2 (122)	4.1 *SD* = 1.4	2.1 (4)
7. A licensed treatment provider conducts *limited consultation* of a PO who is leading weekly sex offender *supervision groups* for the probationers or parolees the PO supervises.	25.3 (48)	10.5 (20)	12.6 (24)	3.2 (6)	43.7 (83)	3.3 *SD* = 1.7	5.3 (10)

Note. Responses are reported in percentages and values enclosed in parentheses indicate number in each group.

[a]Responses *A* through *I* sum to less than 100% due to missing data (*A*: *appropriate*, *SA*: *somewhat appropriate*, *NS*: *not sure*, *SI*: *somewhat inappropriate*, *I*: *inappropriate*).

[b]Mean: mean of responses *A* through *I*; *A* (1), *SA* (2), *NS* (3), *SI* (4), and *I* (5).

[c]Freq: Programs that report engaging in the practice described in the scenario.

listed in the data base of the SSF. Respondents typically were well-educated, very experienced, treated large numbers of offenders, and represented programs that have been in existence for several years. It is not known, though, whether respondents were representative of the sample pool or of programs in the United States. Third, some of the survey questions, especially those related to the collaboration scenarios, involved complex legal, ethical, and clinical issues. No claim is made that survey questions contained all of the information that a clinician should consider in responding to these complex issues. For example, information was not contained in scenario #4 as to whether visits by POs to a group would occur with or without the permission of group members. Thus, assumptions respondents may have incorporated into the scenarios and how these affected their responses is unknown.

These cautions notwithstanding, the data suggest several interesting practice patterns. The following discussion highlights some of the major themes, patterns, and dilemmas emerging from these initial data.

Community Safety

It appears that the degree to which treatment providers and POs have common goals, is the degree to which they can benefit from collaborating. The goal of community safety appears to have widespread support in the field and among survey participants. As has been noted, leading professional organizations in the area of sex offender treatment unabashedly embrace the notion that the "community" is the treatment providers' primary client (ATSA, 1997; NAPN, 1993). Although this survey did not explicitly ask respondents the degree to which they embrace a community safety philosophy, the data suggest that it is high. Almost 95% of programs said that they "always" or "usually" inform POs if they assess a client as an increased risk.

Despite the fact that the majority of sex offender treatment providers appear to view the community as their primary client, it is clear that the sex offenders they treat are also their clients. Given that 93.2% of survey respondents were state licensed or certified in a mental health discipline, almost all of these providers are obligated to treat those under their care according to the ethical guidelines of their state boards and professional associations. It is these ethical guidelines that comprised many of the respondents' concerns about various collaborative practices outlined in the survey.

Provider Liability

Some respondents expressed concern about their liability for coleading groups with POs. A common legal and ethical standard in the mental health field is

that clinicians are responsible for their supervisees (e.g., American Counseling Association, 1995; American Psychological Association, 1992; National Association of Social Workers, 1996). The Association for the Treatment of Sexual Abusers (1997) states this standard as, "A service provider is expected to hold all of those he or she directly supervises to ATSA standards and principles (p. 10)." When a licensed mental health provider coleads a group with a PO, a practice engaged in by at least 8.9% of respondents, the clinician customarily serves as the lead facilitator and supervises the PO.

On the other hand, a PO, unless providing counseling or psychotherapy under a mental health license, is not bound by any specialized professional ethical or state licensing board guidelines. The American Probation and Parole Association has not codified written standards for its members and the American Correctional Association standards encourage its members to develop community resources but is mute on the topic of POs providing counseling services (American Correctional Association, 1998). The lack of practice guidelines for POs may not, however, in and of itself, be a reason for clinicians to refrain from coleading groups with POs. But it should be a consideration.

As has been noted, despite liability concerns by therapists about coleading groups with POs, no survey respondent reported any licensing or certification board complaints concerning this issue or any other behavior described in the seven practice scenarios. This lack of formal complaints notwithstanding, many respondents expressed other ethical concerns about some of the practices outlined in the scenarios and these are highlighted in the next few sections.

PO Training

A common concern about POs coleading groups is that they typically do not have the necessary training (Abadinsky, 2000; Dietrich, 1979). Most states require those who practice psychotherapy or counseling to be state registered, certified, or licensed or to be under the supervision of such a person. ATSA (1997) standards require that service providers possess an appropriate advanced degree and have specialized training and competence in evaluating and treating sexual deviance or hold a bachelor's degree in the social sciences, demonstrate competence, and work under the supervision of a licensed mental health professional.

Another training issue concerns the nature of the cotherapy relationship. Yalom (1995) in his standard text on group therapy asserts that cotherapists should ideally be of equal status, competence, and philosophy because imbalances in these areas can lead to a variety of problems in the effectiveness of the group. Even when a treatment provider and a PO have similar experience, training, and philosophy, the PO is the only one in the cotherapy relationship—by law—who can bring a client back to court or a parole board on a violation. The degree to which this power imbalance causes problems in PO coled groups is an open question.

Confidentiality

There seems to be considerable agreement in the field (ATSA, 1997; NAPN, 1993) and among survey respondents that providers should communicate with POs about the sex offenders they treat. Almost all (93.7%) programs required sex offender clients to sign a confidentiality waiver that allows such communications. There are differing opinions, though, about the type of information that should be shared.

Probably because community safety seems to be a primary goal of provider and PO communication, offender risk was the topic providers reported that they most consistently discussed with POs. But what client behavior or which thinking patterns constitute risk was not examined in the survey. Professionals who advocate for PO attendance in all treatment groups, either as an observer or cotherapist, often argue that everything that a sex offender says and does in treatment can be related to his reoffense risk. Consequently, the best way for a PO to understand and manage an offender's risk is to be present in each group.

Conversely, those who argue against POs attending groups emphasize that confidentiality is a hallmark of the therapeutic relationship and must be protected as much as possible. Of course, every mental health professional, even those who do not work with forensic clients, work under conditions of limited confidentiality with their clients (e.g., *Tarasoff v. Regents of the University of California*, 1976). The central issue, though, for most sex offender treatment providers and POs is determining what a PO needs to know about a sex offender's treatment to manage the offender's risk and vice versa.

Multiple Relationships

Multiple relationships was the topic most commonly mentioned in the comment section on the survey, particularly with respect to clinicians coleading treatment groups with POs. A multiple relationship occurs whenever a clinician interacts with a client in more than one capacity, such as a clinician and a business partner or as a clinician and a teacher (Bennett, Bryant, Vandenbos, & Greenwood, 1990). Virtually all ethical guides and state regulations that govern mental health professionals caution practitioners from engaging in such relationships with clients (e.g., American Counseling Association, 1995; American Psychological Association, 1992; Association for the Treatment of Sexual Abusers, 1997; National Association of Social Workers, 1996).

The American Polygraph Association (2000) has gone beyond simply issuing cautions about multiple relationships. They have recently adopted practice standards that prohibit polygraphers from engaging in dual roles with examinees. This policy states, "The distinct roles of polygraph examiner, treatment provider and parole officer cannot be combined without compromising the efficacy of the process.

Therefore, it shall be considered unethical for any member of the treatment team to serve as both polygraph examiner and parole officer or treatment provider of the same sex offender (American Polygraph Association, 2000, p. 8)."

For mental health practitioners, determining whether a multiple relationship rises to the level of being unethical is not always an easy matter (Sonne, 1994). Not all multiple relationships are inherently unethical or problematic. They should be avoided, however, if they case harm to the client. According to Peterson (1996), harm can be caused to the client if the multiple relationship (a) impairs the client's ability to develop an open, trusting relationship with the treatment provider, (b) impairs the treatment provider's professional judgement, or (c) exploits the client.

From a POs perspective, the role of coleader in a sex offender treatment group may not, on the face of it, be outside the bounds of his or her typical role. POs in most jurisdictions serve as both a law enforcer and social worker (Petersilia, 1998). From the perspective of a licensed mental health professional, however, this arrangement posses potential problems. The treatment provider, who is expected to ensure that his or her supervisee refrain from engaging in unethical multiple relationships (e.g., ATSA, 1997, p. 10), is supervising a PO who is serving in the role of both PO and treatment provider. Additionally, the PO may serve as a referral source to the provider, manage the provider's contract for services, and evaluate the provider's program. These relationships can be quite complicated. Whether these roles are conflicting ones and whether they cause harm to clients and are therefore unethical is a matter that demands close scrutiny.

The survey results indicated that most respondents had concerns about POs coleading groups whose members were their probationers or parolees. Sixty-eight percent identified such a practice as "inappropriate" or "somewhat inappropriate." Written comments on the questionnaire noted several concerns related to this multiple relationship. For example, some noted that clients fear being open and trusting in a group with a cotherapist who can violate their probation or parole. Others stated that a POs professional judgement can be impaired when he or she develops a treatment relationship with a client. Others expressed concern about whether a PO should act as a treatment provider or PO when he or she hears information in a treatment group about a client's supervision violations.

Some respondents countered concerns about these issues. They cited that most sex offender treatment providers have some of the same role conflicts as POs. Namely, most sex offender treatment providers provide treatment and act as social control agents. Indeed, almost every respondent in this survey (97%) reported that they talk with POs at least "frequently" about client behaviors that can lead to restriction of their clients' liberty, such as increased supervision or incarceration.

There were also concerns raised about allowing POs to attend all groups but not serve as a coleader. In this model, the PO attends groups to discusses supervision

issues and learn more about each offenders' risk factors. About one quarter (24.2%) of respondents said they allow POs to attend weekly group sessions for these purposes and almost one half (49.5%) said that this practice was "appropriate" or "somewhat appropriate." In reality, it is probably very difficult for a PO to attend a group on a weekly basis over a long period of time and to not take on a coleader role. The authors have had contact with programs in which administrators state that POs regularly attend group sessions but do not colead them, yet the POs who attend these groups describe their role as coleaders.

Informed Consent

Informed consent is central to several of the practices outlined in the survey. For example, however a program defines its policy on confidentiality, clients should be informed about these practices and provided written consent. Clients should be made aware of the types of information that are not confidential and to whom and how it may be disclosed. As another example, some practitioners support the practice of POs visiting groups periodically only if grounds rules for the visit are determined in advance and clients agree to them.

Some respondents noted that clients in their programs give informed consent concerning the POs serving as coleaders. It is suggested that if POs serving as coleaders is an ethical practice, then providing informed consent about this arrangement with clients is important and appropriate. If POs serving as coleaders is deemed to be an unethical practice, the process of informed consent cannot be used to sanction an unethical arrangement.

Other Issues

There are several other issues that may influence the beliefs and behaviors of treatment providers and POs in this area. Financial matters may be important. POs typically have lower salaries than do licensed mental health clinicians and therefore may be able to provide treatment services less expensively.

Some participant comments concentrated on the important differences between treatment and education. Education interventions are typically part of both the treatment and supervision process. This issue is significant, for example, because some POs conduct psychoeducation or supervision groups where the intersection between treatment and education can be gray. Several respondents suggested that licensed or certified providers should deliver treatment services and that POs should focus on conducting supervision, be it individually or in groups. Clearly, these terms are often difficult to define. However, if a provider diagnoses an offender and bills for treatment services under that diagnosis, in the eyes of the law, a mental health provider–patient relationship has been formed and the services are considered treatment (Simon, 1987).

Professional identity issues are another consideration. Licensed mental health professionals tend to view their training and skills as special and typically resist supporting untrained and unlicensed or uncertified individuals from practicing counseling or psychotherapy. From a POs perspective, involvement in a treatment program may provide welcomed job diversity, enhanced status, and increased job satisfaction.

Time management practices are a further area that may influence provider and PO attitudes and behaviors. Most probation and parole departments require their staff to make a prescribed number of monthly contacts with the offenders they supervise. POs can efficiently make multiple contacts by attending treatment groups composed of offenders on their caseloads. Others argue that time spent in treatment groups is more productively used conducting visits with offenders in the community.

CONCLUSION

This study is one stage in the process of examining several complex issues about provider and PO collaborative models. At this point in time it is difficult to recommend to others how to address all of the issues identified in this study. Similar to other program administrators and practitioners, however, the authors need to make decisions about how to deliver supervision and treatment services to sex offenders. Our current analysis of these issues has led us to formulate the following beliefs that direct our practice.

Professionals should practice in their area of specialization. Treatment providers should focus on providing treatment and POs should focus on providing supervision. Community safety should be the primary goal of intervention with sex offenders. Community safety is enhanced when treatment providers and POs collaborate. This collaboration should include frequent and substantive two-way communication between treatment providers and POs about information that will assist in reducing an offender's risk to the community. Such communication requires the client's informed consent and it is a reasonable requirement for his or her entrance into a sex offender treatment program. For providers and POs who are committed to sharing relevant information, there is not any particular advantage to POs coleading or attending every treatment group. Further, ethical concerns about POs engaging in multiple relationships by coleading or attending every treatment group with their probationers or parolees are significant. When POs are familiar with the treatment process and treatment providers are familiar with supervision and monitoring requirements they can perform their jobs better. Moreover, when the PO and treatment provider mutually agree upon their goals, their individual roles, and the treatment and supervision intervention that will be pursued, the case can be managed much more effectively. This can be accomplish in many ways, including having the PO periodically visit groups. Clients should give permission for nongroup members to visit a treatment group. Obtaining such permission

is rarely a problem when clients have positive relationships with their therapists and POs.

Although the normative beliefs and behaviors of practitioners should not be construed as equivalent to ethical standards or appropriate practice, programs may find it helpful to consider the results of this survey. Programs should be cautious and thoughtful about engaging in practices that are uncommon, especially those that are viewed as inappropriate by a significant number of their colleagues. One suggestion is for programs to develop an approval process with a review board prior to initiating programs or employing techniques that are out of the bounds of common practice. Such reviews would be designed to protect clients as well as manage risk to the program or organization. Supervisors and administrators who oversee POs should be aware of the potential problems involved in various collaborative provider and PO approaches, and should be open to discussing these issues with all parties concerned.

It is hoped that professionals and organizations like ATSA will continue to examine the issues that have been raised in this study. For example, is the goal of community safety *first* in conflict with our professional ethics? Do multiple relationships constitute unethical behavior in the context of sex offender treatment? Do collaborative models of sex offender intervention require us to think about the delivery of treatment and supervision in new ways? If in the course of further study and research any of these practices are judged to be unethical, then treatment providers should adjust their practices accordingly. With respect to new collaborative models that are within the bounds of ethical practice, attention should focus on conducting outcome studies to identify those models that are most effective.

It is hoped that the data in this study will serve to stimulate discussion and inform the work of sex offender treatment professionals. Research on these new and emerging collaborative responses to sex offender management should be conducted to help further guide our practices.

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