nsw commission for children & young people

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NSW Child Sex Offender Counsellor Accreditation Scheme

ANZATSA Code of Conduct and Ethics

The Australian and New Zealand Association for the Treatment of Sexual Abusers (ANZATSA) is dedicated to community protection and safety, through the promotion of professional standards, practices and education in sex offender management, treatment, assessment and research in Australia and New Zealand.

ANZATSA members shall:

Community and safety:

1. Be committed to community protection and safety.

2. When considering case management or intervention, hold the interest and safety of victims and potential victims, as always the priority.

3. Ensure adherence to the priority of safety for actual or potential victims by convening a case meeting or other form of consultation where ever issues concerning known, potential or suspected victims are unclear.

4. Recognise the rights of indigenous peoples, taking into account the impacts of the coloniali-sation process on them and their ancestors.

a. Recognise the Treaty of Waitangi and its relevance to those working in Aotearoa, New Zealand, and to ensure their practice is conducted in accordance with the articles contained in the Treaty of Waitangi.

b. Carry out their work in ways appropriate to and respectful of the Maori peoples of Aotearoa, New Zealand, of Aboriginal peoples of Australia and of Torres Strait Islands.

This includes
(1) Consulting with,
(2) Working alongside and
(3) Sharing resources with indigenous peoples so they can work with their own peoples.

c. Recognise Aboriginal peoples and Maori peoples (Tangata Whenua of Aotearoa) as the indigenous people with whom an individual or agency must relate in defining bi-cultural relationships.

5. Be knowledgeable of statutes and scientific data relevant to this area of specialised practice.

Professional practice:

6. Not discriminate against clients with regard to race, religion, gender preference or disability.

7. Perform professional duties with the highest level of integrity, maintaining confidentiality within the scope of statutory responsibilities.

8. Refrain from using professional relationships to further theirpersonal, religious, political or economic interest other than accepting customary fees.

9. Not engage in sexual relationships with clients.

10. Fully inform clients in advance of fees for services.

11. Neither accept nor make payment for referrals.

12. Refrain from knowingly providing treatment services to a client who is in treatment with another professional without initial consultation with the current provider.

Training and knowledge:

17. Refrain from falsely representing their level of training, expertise or experience or the type of their interventions to any person or agency.

18. Refrain from using interventions that cannot be justified on the basis of empirical evidence or clearly accepted precedents unless this is under the auspice of a peer reviewed research project that utilises informed consent.

19. Make appropriate referrals when the therapist is not qualified or is otherwise unable to offer services to a client.

20. Ensure that colleagues are qualified by training and experience before making a referral to them.

Respect for clients:

21. Ensure that the client fully understands the scope and limits of confidentiality in the context of his/her particular situation

22. When withdrawing services minimise possible adverse effects on the client and the community by continuing treatment until the client has been admitted elsewhere.

23. Take into account the legal/civil rights of the clients, including the right to refuse therapy.

23. Treat clients with dignity and respect, regardless of the nature of their crimes or conduct.

ANZATSA members assert that:

1. Community safety takes precedence over any conflicting consideration, and ultimately, is in the best interests of the offender.

2. Inappropriate or unethical treatment damages the credibility of all treatment and presents an unnecessary risk to the community.

3. Sex offender therapists shall have no history of criminal or sexually deviant acts.

4. Criminal investigation, prosecution, and court orders for treatment can be components of effective intervention.

5. Where possible, therapists should actively involve correction officers, child protection workers, and victim therapists in case management.

6. A voluntary client accepted for treatment should be held to the same standards of compliance as are mandated offenders.

7. For some offenders, incarceration without treatment may increase the risk of recidivism. It is imprudent to make recommendations for release an untreated sex offender without providing offence-specific evaluation and treatment or specialised supervision.

8. Without external pressure many sexual offenders will not follow through in treatment. Internal motivation improves the prognosis, but is not a guarantee of success.

9. Many sexual offenders require comprehensive, long-term, offence specific treatment. Currently, Cognitive-Behavioural approaches that utilise sexual offender peer groups and drug intervention appear to be the most effective and best evaluated methods. Self-help or time limited treatment should be used only as an adjunct to comprehensive treatment.

10. Each offender will have an individual plan that identifies the issues, intervention strategies, and goals of treatment. This plan should outline expectations of the offender, his family (when possible), and support systems. Treatment contracts should include provisions

11. Progress, or lack thereof, should be clearly documented in treatment records. Specific achievements, failed assignments and rule violations should be recorded.

12. Progress in treatment must be based on specific, measurable objectives, observable changes, and demonstrated ability to apply changes in relevant situations. For most offenders, progress requires changes in the offender's behaviour, attitudes, social and sexual functioning, cognitive processes, and arousal patterns. These changes should demonstrate increased understanding of deviant behaviour, victim sensitization, and ability to seek and apply help.

13. When an offender has made the changes required in treatment, there should be a gradual and commensurate decline of intervention, support, and supervision following an offence-specific treatment program. Ongoing support, aftercare and monitoring are desirable.

14. There will be instances when the clinician should refuse to treat an offender because essential ancillary resources do not exist to provide the necessary levels of intervention or safeguards.

15. When a treatment provider determines that an offender is not making the changes necessary to reduce his/her risk to the community, the provider has an ethical obligation to refer the client to a more comprehensive treatment program and/or the judicial system.

16. Where a client presents with a problem or need outside the member's ability to provide treatment, s/he has a duty to refer the individual for assessment/treatment by a suitably qualified person.

17. Members will ensure that colleagues have appropriate experience and training before making a referral to them.

18. Failure on the part of clients to abide by the treatment contact should result in referral back to the justice system.

19. A therapist may decide to decline further involvement with a client who refuses to address any critical aspect of treatment.

20. Treatment providers need to immediately notify the appropriate authority when a client drops out of Court-ordered treatment.

21. Most sex offenders enter the system with varying degrees of denial regarding their behaviour. Overcoming denial is a gradual process achieved in treatment. The existence of some degree of denial should not preclude any offender entering treatment, although the degree of denial should be a factor in identifying the most appropriate form and location of treatment.

22. Sex offender treatment is unlikely to be effective unless the offender admits his behaviour. Community based treatment is not appropriate for offenders who continue to demonstrate complete denial after a trial period of treatment.

23. Therapists should not rely exclusively on self report by the offender to assess progress or compliance with treatment requirements and/or probation orders. Therapists should rely on multiple sources of information regarding the offender's behaviour and when possible utilize methods such as polygraphy and plethysmography.

24. Polygraphs and plethysmography should not replace other forms of monitoring but may improve accuracy when combined with active surveillance, collateral verification, and self-report.

25. Plethysmography cannot be used to prove an individual did or did not, or will or will not commit a sexual offense. However, it can be useful in identifying sexual preferences and changes in preferences over time.

26. Polygraphy can be effective in encouraging disclosure of prior events and adherence to rules. The method should not be solely relied upon to determine factual information.

27. Informed, voluntary consent should always be obtained prior to engaging clients in aversive conditioning. For juveniles 15 years or younger, consent should be gained from the juvenile offender and the offender's parents.

28. When plethysmography or aversive therapies are used with persons under age 15, procedures should be reviewed by a community or institutional advisory group. This will insure that individuals not intimately involved in the treatment of the patient/client, have input regarding the appropriateness of such methods.

29. Individuals under age 13 should not undergo plethysmography or aversive therapies except in rare cases.

30. In cases of intellectually handicapped offenders who are unable to give consent interdisciplinary review and parental consent is advised.

31. Removal of an intra familial offender from a residence in which children reside is the preferred option.

32. Treatment referrals should be offered to the non-offending spouse and children in cases where a parent has been removed.

33. If the offender has a history of sexual arousal, or reported fantasies of sexual contact with children, s/he should be restricted from having access to children. If (a) it is determined that sufficient safeguards exist, (b) the offender has demonstrated control over his/her deviant arousal, and (c) it does not impede the offender's progress in treatment, supervised contact may be considered.

34. There is evidence to support family participation in the treatment of sexual offenders. Where reasonable, spouses and other family members should be included. Victims or vulnerable children should be excluded until such time as joint therapy is determined to be appropriate for the children by their therapist(s). It is advisable that the therapists for the children to be present.

35. The sex offender treatment provider should make every effort to collaborate with the victim's therapist in making decisions regarding communication, visits and reunification. Sex offender therapists should be supportive of the victim's wishes regarding contact. Contact should be arranged in a manner that places the child/victim safety first. When assessing child/victim safety, both psychological and physical well-being should be considered. The sex offender treatment provider shall insure that custodial parents or guardians of the children have been consulted prior to authorizing contact and that contact is in accordance with Court directives.

36. If reunification is deemed appropriate, the process should be closely supervised. There must be provisions for monitoring behaviour and reporting rule violations. Victim comfort and safety should also be assessed on a continuing basis. The offender therapist should recognise that supervision during visits with children is critical for those whose crimes are against children, or who have the potential to abuse children. Caution should be taken when selecting and preparing visitation supervisors.

37. It is advisable to limit child molesters decision-making or disciplinary authority over minors.