



SEX OFFENSE TREATMENT AND ASSESSMENT PROGRAMS INFORMED CONSENT FOR COMMUNITY TREATMENT

Name: _____ DOC number: _____

By agreeing to participate in treatment with the Sex Offense Treatment and Assessment Programs (SOTAP), you will be held to certain expectations. This document will help you become familiar with what is expected of you and what you can expect from the community program.

The community SOTAP employee will help me apply the skills and knowledge I have learned during Prison-based treatment to assist me in living a more positive, pro-social lifestyle, and making the necessary adjustments when and if I experience set-backs/relapses.

As a participant in community SOTAP with the Washington State Department of Corrections, I agree to the following:

1. I will attend all treatment sessions, including group and individual sessions as assigned by the program.
2. I will attend all treatment sessions without being under the influence of mood altering substances, being ready and willing to learn, receive, and accept information shared by my treatment provider and fellow group members.
3. I will attend treatment sessions regularly and understand that excessive absences of 3 or more consecutive unexcused absences may result in my automatic unsuccessful discharge from treatment. Absences may be excused by the treatment provider after discussion for preventable situations.
4. I understand I am voluntarily participating in community SOTAP and may leave the program at any time. I understand I may be unsuccessfully discharged if:
 - a. I am making no progress, despite the best and repeated efforts of myself and community SOTAP employees.
 - b. I refuse to follow the rules, my treatment plan, and/or treatment agreement.
 - c. My behavior is consistently aggressive and/or disrupts treatment progress.
5. I understand that if I am unsuccessfully discharged from treatment, I have the right to appeal the decision to the SOTAP director/designee. I must notify my provider within 3 business days.
6. I will actively participate in all treatment sessions by demonstrating that I am:
 - a. Applying treatment concepts to myself and discussing with the group.
 - b. Being transparent and forthcoming with information regarding my risk factors and other treatment relevant topics.
 - c. Providing meaningful and relevant feedback to my fellow group members.
 - d. Open to feedback from my group members.
 - e. Completing all assignments, treatment activities, safety plans, and other requirements.
 - f. Making progress on my goals as outlined in my treatment plan.

7. I will treat all others and myself with dignity and respect, holding the treatment information of others confidential. Breach of confidentiality may result in unsuccessful discharge from the treatment program following SOTAP protocol.
8. I will complete relationship disclosures facilitated by my treatment provider in the presence of my Community Corrections Officer who will authorize relationships with the following:
 - a. Sexual partners (before engaging in sexual activity)
 - b. Supervisors of contact
 - c. Chaperones
9. I will discuss any and all use or exposure to sexually stimulating material and experiences in treatment groups and individual therapy sessions.
10. I will consult with my treatment provider before engaging in any other treatment related to sexual offending and follow my treatment provider's recommendations.
11. I will consult with my treatment provider before attending any support group meetings that address sexual issues and follow my treatment provider's recommendations.
12. I understand that my treatment provider will routinely consult with my Community Corrections Officer on a variety of issues that are relevant to my treatment and continued community placement and safety.
13. I will follow all conditions of my Judgment and Sentence.

INFORMATION SHARING AND CONFIDENTIALITY
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Information will be shared per DOC 02-025 Sex Offense Treatment and Assessment Programs Limits of Confidentiality, which has previously been explained to me and I fully understand. At the completion of community treatment, a discharge summary will be completed to evaluate progress during treatment, including information about my risk factors, protective factors, and interventions I will use to prevent new offenses.

By signing this form, I acknowledge that I have been made aware of the content of this treatment agreement. I understand that failure to abide by the treatment agreement may result in my unsuccessful discharge from community treatment.

Signature

Date

Treatment Provider

Signature

Date

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

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