Assessment, Treatment, and Risk Management of Persons Who have Sexually Offended: A Report to the Connecticut Sentencing Commission

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EXECUTIVE SUMMARY

As part of its ongoing mandate to ensure public safety, the Connecticut Sentencing Commission sought a review of practices regarding the assessment, treatment, and risk management of persons who have sexually offended. The Sentencing Commission is currently engaged in a wide-scale review of policies and practices in the state, specifically focused on ensuring evidence-based assessment and treatment services and the promotion of best practices.

An evaluation and review was undertaken of sexual offender processes in Connecticut; specifically with respect to sentencing practices, assessment procedures, provision of treatment to sexual offenders in institutional and community settings, and methods employed to supervise and monitor offenders in community settings. This process also included a review of current practices regarding sexual offender registration.

To complete this evaluation, policy and practice documents were reviewed from the Connecticut Department of Corrections, the University of Connecticut Health Center, the Center for the Treatment of Problem Sexual Behavior (affiliated with The Connection, Inc.), the Connecticut Board of Pardons and Paroles, and the Connecticut Judicial Branch – Court Support Services Division, among others (see Appendix I). Additionally, various key personnel were consulted, some individually and many during site visits in March 2010 that included a visit to Osborn Correctional Institution. An extensive review of the literature regarding the assessment, treatment, and risk management of persons who have sexually offended is provided, with sections indicating the relevance of this literature review to policy and procedure in Connecticut.

Recommendations are made regarding areas of policy and practice that the Connecticut Sentencing Commission may wish to consider in furthering its goal of increased public safety and enhanced reintegration opportunities for released and supervised sexual offenders. Many of these recommendations focus on maintaining adherence to prescriptions of the Risk-Need-Responsivity model (Bonta & Andrews, 2016) that underpins the majority of correctional programming and supervision endeavors in the United States, Canada, and other similar nations. Specifically, treatment providers and risk managers are encouraged to ensure that intensity of interventions matches level of assessed risk to reoffend, that treatment and supervision attend to identified criminogenic needs, and that services for persons who have sexually offended are offered in a manner that reflects the individual case presentations of clients. With respect to the

latter point, institutional and community treatment providers are strongly encouraged to consider offering modified interventions to clients with special needs (intellectual and cognitive disabilities, serious mental illness, highly entrenched antisocial values and attitudes), as well as those clients demonstrating significant treatment interfering factors that pose barriers to success in treatment and on supervision.

Recommendations are also made regarding management of technical violations. Specifically, probation and parole staff are encouraged to consider other options to address non-offense-related misbehavior while on supervision. Given the strong collaborative model already existing in Connecticut, there are additional avenues of case management that could be employed. Of note, involvement of victim services in routine case management of sexual offenders is viewed as an example of best practice.

Finally, recommendations are made regarding potential revisions to Connecticut's sexual offender registration processes. Currently, most offenders are maintained on a publicly accessible registry for either 10 years or life; although a private law enforcement registry is also an existing option. Current registration standards are determined by an offense-based scheme. The Connecticut Sentencing Commission is encouraged to consider a risk-based scheme that would increase the use of the law enforcement registry for low to moderate risk offenders; saving the publicly accessible registry for higher risk offenders causing greater concern. Additionally, the Sentencing Commission is encouraged to consider options for relief and removal of sexual offenders from the registries, provided that they meet certain risk-based and treatment-based benchmarks.

INTRODUCTION

The assessment, treatment, and risk management of persons who have sexually offended is of considerable interest to a wide variety of stakeholder groups, including legislators and policymakers, court and law enforcement personnel, corrections and community supervision staff, mental health clinicians, victim advocates, and the community-at-large, among others. Many of these stakeholders have expressed concerns regarding the potential for sexual recidivism and other harms posed by offenders released to the community. As a consequence, most jurisdictions have enacted legislative frameworks to manage those risks.

The past 40 years have been witness to significant growth in our understanding of the dynamics of sexual offending, the people who engage in these behaviors and how best to assess their risk for reoffending, and what treatment and supervision interventions are most likely to result in success. In this context, success may be defined as: (1) greater community safety, and (2) safe and humane reintegration opportunities for offenders returning to the community.

Connecticut

Connecticut represents a relatively small footprint geographically in the United States, but there are many areas in which it has "outperformed" in spite of its size. Of particular importance to this report is the historical influence CT has had on sexual offender policy and practice. From an early point in contemporary sexual violence prevention, many noteworthy contributions have been made by either native Connecticutters or those who ultimately made the state their home. In the early 1980s, CT psychiatrist Suzanne Sgroi began publishing books about vulnerable populations; especially regarding treatment for survivors of sexual abuse. Although he began his career in his home state of Massachusetts, Nicholas Groth made many of his most important contributions to typological understandings and treatment methods for sexual offenders while he was in CT from 1976 onward. In the field of victim advocacy, there are few people with as big an influence as Gail Burns-Smith. A prestigious award established by the Association for the Treatment of Sexual Abusers is presented each year to the person who best embodies Gail's spirit and tenacity in ensuring rights for victims of sexual violence. In regard to juveniles who have sexually offended, Jonathan Ross and Peter Loss of Forensic Mental Health Services of Connecticut in New London were on the cutting edge before many practitioners around the country knew where that edge was. On the policy front, David D'Amora started as a

leader in sexual offender treatment in CT, but has continued to influence the public policy aspect of the field across the country as Director of Special Projects for the nonpartisan Council of State Governments Justice Center.

This report is intended to provide a comprehensive review of best practices in the assessment, treatment, and risk management of persons who have sexually offended. In each section, I have included a section entitled "Relevance for Connecticut." Finally, recommendations are made for policy and practice going forward.

In composing this report, I had available to me a large number of documents (policies, practice guidelines, etc.), a listing of which is provided in Appendix A. I was also fortunate to be able to speak with many correctional, probation, and administrative personnel from around the state during a site visit in March 2017, followed-up by teleconferences with others. These persons are listed in Appendix B. Additionally, I had the opportunity to speak with a client who was attending treatment while I was onsite.

BEST PRACTICES IN THE ASSESSMENT, TREATMENT, AND RISK MANAGEMENT OF PERSONS WHO HAVE SEXUALLY OFFENDED

Assessment

The methods and technologies used to assess persons who have sexually offended have changed greatly over the past 40 years. Subjective techniques have been replaced by objective approaches highlighting empiricism and evidence-based practices. Idiosyncratic and largely subjective methods have given way to structured models; at times dominated by the influence of actuarial risk assessment instruments (e.g., *Static-99R*; see Hanson et al., 2016a,b). As a field, we are also now keenly aware of the need to be comprehensive in our assessment processes. Indeed, whereas "sexual offender specific" was the key catchphrase of the 1990s moving into the new millennium, we now know that a failure to consider all psychologically meaningful risk factors (see Mann et al., 2010) is also a failure to holistically address both public safety concerns and the breadth of difficulties experienced by many persons who have sexually offended.

Interventions for Persons who have Sexually Offended

Interventions for persons who have sexually offended have changed greatly over the years. Marshall and Laws (Laws & Marshall, 2003; Marshall & Laws, 2003) provide a helpful

overview of the development of sexual offender treatment over the past century or more, highlighting that, often, treatment for persons who have sexually offended have mirrored the approaches popular during a certain time period. For instance, when psychodynamic approaches were in favor, clinicians treating sexual offenders were also likely to use psychodynamic methods. Similarly, the same was true for cognitive, behavioral and, ultimately, cognitive-behavioral methods – the latter of which are currently most popular (see McGrath et al., 1998, 2010) and evidence suggests that they may be most likely to achieve positive outcomes (see Bonta & Andrews, 2016).

Prior to the mid-1980s, sexual offender treatment practitioners employed an eclectic mix of methods and approaches, generally according to the individual preferences of the respective provider. This lack of consistency was likely contributory to pessimistic results obtained by Furby and associates (1989), when they found that the existing literature base regarding the efficacy of treatment for persons who sexually offend was mired in methodological problems and flimsy evidence. Their findings were somewhat different than other reviews of correctional programming (e.g., Martinson, 1974 – see below), generally, in that while Martinson reported that treatment was ineffective, Furby et al. stated that the quality of the science regarding sexual offender treatment was insufficient to make any definitive statements about effectiveness.

Relapse Prevention

In the mid-1980s, researchers on the US west coast working with persons with substance abuse difficulties noticed that many of the behavioral dynamics associated with alcohol and drug abuse were similar to impulse control problems commonly seen in clients who had engaged in sexually offensive conduct. The Relapse Prevention model (RP – see Laws, 1989) they were employing with alcohol and substance abusers proposed that persons with impulse control difficulties would be more susceptible when under conditions of stress or negative emotion, as well as when clients encountered high risk situations. It appeared that the RP model was good fit for clients with sexual behavior problems. Indeed, the RP model represented the first coherent approach to treatment programming for sexual offenders and quickly became a mainstay of programs throughout the United States, Canada, and other western nations. Clients engaged in group psychotherapy focusing on risk factors, developing avoidance strategies, building and learning offense cycles, and engaging in cognitive restructuring around thoughts and fantasies of sexual deviance.

Self-Regulation, Good Lives, and Strength-Based Approaches

Approximately 10 years after the general adoption of the RP model, practitioners began questioning whether the adaptation of a substance abuse treatment model to problematic sexual behavior was truly a good fit. In their seminal book *Remaking Relapse Prevention*, Laws and associates (2000) suggested that the RP model failed to adequately reflect the complexity of sexually offensive conduct. They contended that sexually offensive conduct is not always the result of negative stimuli, observing that some persons who engage in sexual offending actually do so as a result of positive feeling states. They also noted that there are multiple pathways to offending requiring different approaches to helping clients address their difficulties related to sexual and other interpersonal conduct. One particularly important aspect of this reframing of treatment was the resurgence of self-regulation theory, which holds that success as a human being requires lifestyle balance and effective self-determination.

By the mid-2000s, the majority of sexual offender treatment programs across the western world were subscribing to the Good Lives model or variants thereof (see Yates et al., 2010). This mirrored a resurgence of self-psychology in interventions for persons engaging in crime generally, and a focus on not just risk factors, but protective factors as well (see de Vogel, 2009, 2012; Marshall et al., 2011). According to evaluations completed by the Safer Society Foundation (McGrath et al., 2010) and the Sex Offender Civil Commitment Programs Network (SOCCPN, 2014), a majority of programs in the United States and Canada employ self-regulation and Good Lives curricula in their treatment interventions.

Community-Based Treatment and Risk Management

In their highly influential text *The Psychology of Criminal Conduct*, Andrews and Bonta (originally 1994, but now in its sixth edition [Bonta & Andrews, 2016]) state that, where feasible, treatment services for offenders are best accomplished in the community. Of course, many clients are of too high risk to contemplate immediate community placement; however, many of these clients may be managed safely in the community provided they have access to effective treatment options and evidence-based case management (via enhanced parole or probation supervision – see Wilson et al., 2009; Wilson & Prescott, 2014; Wilson et al., 2000). The literature is clear that the quality of community reintegration planning can have marked effects on recidivism and client reintegration potential (Willis & Grace, 2008, 2009).

Defining and Assessing Treatment Success

Determining treatment success can be a daunting task. Practically and theoretically, treatment for sexual offenders cannot be regarded as 100% effective unless all offenders who attend treatment return to the community and live the remainder of their lives without engaging in additional sexual violence. This would be particularly difficult to monitor; especially given our understanding of the high numbers of victims who do not report their victimization experiences. Consequently, we are forced to rely on research findings and other indications that the methods we use to measure treatment success are assisting us in adjusting treatment and risk management endeavors along the way.

Earlier, it was reported that Furby et al. (1989) found a lack of research of sufficiently high quality establishing the efficacy of treatment interventions for sexual offenders. The forensic psychological literature has demonstrated an effect of treatment over sanction-alone in several key meta-analyses[1] (e.g., Smith et al., 2002); however, the true effectiveness of sexual offender treatment has yet to be established. Notwithstanding this difficulty, of those meta-analytic studies available regarding outcomes of treatment, the majority show a reduction in reoffending of approximately 40% for those who attend treatment and make reasonable efforts to incorporate new learnings into their lives (see Hanson et al., 2009; Hanson et al., 2002). Even the one study typically referred to as showing "no treatment effect" includes fine print demonstrating how treatment could be more effective (e.g., paying attention to Risk-Need-Responsivity [Bonta & Andrews, 2016 – see below] concerns and ensuring that clients actually learn the curricula – see Marques et al., 2005). However, these outcome data pertain only to rates of reoffending post-intervention; it is also important to measure attendance to important targets while clients are in treatment. At present, there are few structured means by which to accomplish this goal; however, instruments like the *SOTIPS* (McGrath et al., 2013 – currently used in CT) and the *VRS:SO* (Olver et al., 2007) appear to show promise as effective measures of in-treatment change.

[1] Meta-analysis is a type of research that is essentially a study of studies. Individual studies tend to have relatively small sample sizes that ultimately limit the degree of generalizability to the greater population. By combining studies with similar objectives and methodologies, we can substantially increase sample sizes and the power of the research to make inferences about the bigger picture. This sort of research is particularly popular in regard to issues such as risk assessment methods and the efficacy of treatment interventions.

Principles of Effective Correctional Interventions

Do interventions offered to persons who have engaged in inappropriate sexual conduct actually reduce reoffending? This is a veritable million dollar question, and debate continues to rage on a number of fronts – especially in regard to programming designed to reduce sexual recidivism. In the early 1970s, a large-scale research project was undertaken to assess the relative benefits of various treatment options available to prison inmates, generally (see Martinson, 1974). The conclusion reached was that there was no evidence that programs were reducing rates of reoffending. Although reportedly not his intent, Martinson's study spurred the so-called "Nothing Works" movement that espoused a belief that if there was no evidence that programs reduced reoffending then they should not be funded.

> *"With few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism."* (Martinson, 1974)

Interestingly, Martinson (1979) subsequently changed his position and "withdrew" his earlier conclusion stating, "treatment programs: some help, some harm." Indeed, in his reframing of the earlier research, Martinson clarified that it was not his intention to suggest that all treatment did not work; rather, his assessment – perhaps, somewhat poorly elaborated – was that the relative contributions of good and bad programming amounted to a relative bust. The two aspects negated each other, leaving a final conclusion that there was no evidence to show that programming overall was having an effect on the desired outcome – less recidivism. Ultimately, Martinson (1979) called on correctional researchers and practitioners to consider the relative helpfulness and harmfulness of programs being offered, allowing for classification according to three categories (NB: "reprocessing" is equivalent to reoffending):

1. beneficial (the program *reduces* reprocessing rates)
2. neutral *(no impact,* positive or negative, can be determined)
3. detrimental (the program *increases* reprocessing rates)

Martinson's revised position also foreshadows findings I will discuss below, in suggesting that while no program used in his time was found to be inherently helpful or harmful, there was something to be said for the conditions under which programs were delivered. It was

this sort of nuanced view of the findings that ultimately led Martinson to conclude that some programs do actually achieve the desired goal of lowering recidivism rates. This perspective was later confirmed in several large-scale meta-analyses (see Aos et al., 2006; Lipsey & Cullen, 2007; Smith et al., 2002) that have essentially rendered the question of sanctions vs. interventions an "answered question." Resoundingly, we now know that punishment alone will not reduce bad behavior; it is the application of human service interventions that is most likely to achieve the desired effect (Smith et al., 2002).

Approximately 15 years after Martinson's conclusion that interventions for offenders generally were not reducing reoffending, Furby et al. (1989) came to a similar conclusion regarding programming specifically aimed at reducing sexual recidivism. In their still influential review, Furby and her colleagues reviewed all of the sexual offender treatment programming outcome studies available at the time and came to the conclusion that: (1) the studies completed to date were methodologically weak or poorly conducted, and (2) there was no clear evidence that treatment for sexual offenders was reducing sexual recidivism. Concerns remain as to the true value-added of sexual offender treatment interventions (see Hanson et al., 2009; Långström et al., 2013; Levenson & Prescott, 2013), but there is cause to be optimistic (see Schmucker & Lösel, 2015).

Risk, Need, and Responsivity

While the effect of Martinson's initial conclusion on many correctional administrators was to curtail both research and practice regarding rehabilitative interventions, a different effect was noted in the research community. Indeed, many researchers regarded Martinson's pronouncement that "nothing works" to be a call to arms. Among the more prominent of these researchers were Donald Andrews and James Bonta of Canada.

Andrews and Bonta (see 1994) undertook a large-scale meta-analysis that sought to investigate the relative benefits of correctional programming vs. sanction (punishment). The resulting findings were the basis for a number of particularly important steps forward in the work we do with offenders. First, Andrews and Bonta published their seminal text *The Psychology of Criminal Conduct* (originally 1994, but now in its sixth edition [Bonta & Andrews, 2016]). In many important ways, this text outlines the rationale for why most western correctional services manage their clients in the manner they do. Next, reviewing offender characteristics and their

responses to interventions helped to identify robust predictors of future difficulties; in particular, the "Big Four" predictors of reoffending (see Bonta & Andrews, 2016):

- Antisocial cognitions
- Antisocial personality pattern
- History of antisocial behavior
- Antisocial associates

Added to the Big Four were four additional factors, somewhat less predictive of outcome. Ultimately, these factors and the four above comprised the "Central Eight" predictors of future involvement in criminal conduct:

- Family/marital circumstances
- School/work
- Leisure/recreation
- Substance abuse

These eight risk factors were subsequently used to comprise the major domains of the *Level of Service Inventory* (*LSI*, see Andrews, 1982; now revised as *LSI-R* [see Andrews & Bonta, 1995]), a popular actuarial risk assessment instrument helpful in gauging risk for future involvement in general criminality. The LSI-R forms an integral part of the case management framework in Connecticut for establishing risk for general recidivism; however, it has often been noted that this instrument is not sensitive to risk specific to sexual recidivism.

Perhaps, the most important contribution of the Andrews and Bonta research stream has been that of the Risk, Need, Responsivity (RNR) model. Often misunderstood as a model of treatment, RNR is actually an evidence-based framework in which effective treatment is more likely to occur. In response to Martinson's damning proclamation that nothing works, RNR provides us a roadmap to "What Works?" – a popular slogan used in answer to the "Nothing Works" precursor. The Andrews and Bonta meta-analyses pulled together all studies reporting outcomes of correctional interventions and then looked for common features present in studies identifying lower rates of reoffending and absent in those studies reporting higher rates of reoffending. The resultant framework has been nothing short of revolutionary in assisting

program managers in offering interventions more likely to achieve positive outcomes. Andrews and Bonta were able to show that interventions were incrementally more effective the more they adhered to the RNR principles (e.g., adherence to one principle was better than no adherence, adherence to two principles was better than adherence to one, and so forth – see Andrews & Bonta, 1994). Interestingly, Hanson and associates (2009) were later able to show that the RNR principles functioned in essentially the same fashion when applied specifically to persons who had sexually offended.

Risk Principle. The Risk Principle decrees that the level of intervention offered to a client must be in line with the level of risk s/he poses to reoffend. Following this logic, high-risk offenders require high intensity interventions while lower risk offenders require lower intensity interventions. This is a simple dosage principle, and the research is clear that when we mismatch risk and treatment intensity, the chance that problems will ensue is heightened (see Bonta & Andrews, 2016). Interestingly, this is not only true when we under-intervene with high-risk offenders, it is also true when we over-intervene with lower risk offenders (i.e., if it ain't broke, don't fix it). Indeed, many researchers (e.g., Quinsey et al., 2015) would suggest that a sizeable proportion of low risk offenders may not need any formal intervention beyond simple monitoring and routine case management.

However, the assertion that lower risk offenders do not require intensive interventions has been something of a sticking point for many correctional administrators who have had a hard time believing that some criminal offenders may not need highly structured interventions, and nowhere has this been the case more than in regard to sexual offender programming. In this example, the behavior engaged in by sexual offenders is so upsetting that most people strongly disbelieve that anyone who engages in such behavior could possibly be at low risk to do it again. Yet, the research is exceedingly clear: low risk sexual offenders really do reoffend at considerably lower rates that would be expected by most legislators or members of the community-at-large (see Hanson et al., 2014; 2016a,b).[2] Further, plotting sexual offenders by risk level reveals what is known as a positively skewed distribution, in which there are many

[2] It is important to note that underreporting of sexual offenses affects our appraisal of true rates of sexual offending and reoffending. Early reports (see Finkelhor, 1984) suggested that as many as 90% of victims did not report their experiences of being offended; however, this percentage has dropped over the years, but still greatly exceeds 50% (see London et al., 2005). It is important to note that the effects of underreporting are likely to be greater in regard to sexual offending vs. reoffending – the logic being that once identified, known offenders will have a harder time engaging in new sexual offending with the same impunity.

more offenders clustered at the lower end of the risk continuum (70% are low to low-moderate) while those at the high end are far fewer in numbers (less than 10%). Data provided by staff at The Connection, Inc. demonstrate that, among referrals to their programming, almost 60% are low to moderate, while only 12% are in the high or high-moderate range (NB: 20% were noted as "unknown" in regard to risk level).

Methods of determining risk to reoffend have varied over time. Early approaches were based largely in expert ratings offered by seasoned practitioners relying on education and experience in the field. In this vein, it would be common for a front line worker to question the potential that an offender on his/her case load would reoffend, requiring consultation with the local expert. On accepting the referral, the local expert would then engage in a process of file review, clinical interviewing, collateral contacts, and consideration of academic knowledge and practical experience in offering a rating of high, moderate, or low risk to reoffend. On the surface, this appears to be a pretty reasonable process; at least until we explore the reliability and predictive validity of those ratings. Ratings of this sort have come to be known as "unstructured clinical judgment" due to their over-reliance on subjective processes.

In the 1980s, researchers began to question the reliability and validity of subjective processes of assigning risk ratings. In a highly influential study, Monahan (1981; see also Monahan, 2008) asked a group of expert risk assessors to rate the potential for reoffending in a group of offenders for whom the outcome (reoffense or not) was already known. Surprisingly, those experts did not turn out to be quite as adept at rating risk as was hoped. Indeed, in some cases, the proverbial flipping of a coin may have led to more accurate outcomes. Further, employing the same methodology with a group of non-expert, but otherwise intelligent raters led to largely similar outcomes. As Meehl (1954/1996) had demonstrated earlier, Monahan found that subjective processes led to poor risk assessment outcomes, with many raters tending to rate risk higher than was actually the case (i.e., over-prediction was more common than under-prediction).

Just as Martinson's "nothing works" conclusion was a call to arms for treatment professionals, so too was Monahan's finding that unstructured clinical judgment was no more helpful than flipping a coin. This led to the development of actuarial risk assessment instruments – like the *LSI-R* referred to above. However, scales aimed specifically at risk for sexual and violent reoffending had yet to be developed, the *LSI-R* being noted as less likely to accurately

predict these outcomes. Researchers in Canada have done a lot to inform the field regarding actuarial methods and risk for violent and sexual reoffending. In the mid-1990s, Quinsey and his colleagues (2015) began developing a scale known as the *Violence Prediction Scheme* (*VPS*) – an early precursor to the *Violence Risk Appraisal Guide* (*VRAG*) and the *Sexual Offender Risk Appraisal Guide* (*SORAG*). At or about the same time, Karl Hanson used data from his meta-analysis with Monique Bussière to devise a short, four-item scale known as the *Rapid Risk Assessment of Sexual Offense Recidivism* (*RRASOR*, Hanson, 1997). Those items were:

1. Prior sexual offenses (not including index offenses)
2. Age at release (current age)
3. Victim gender
4. Relationship to victim

Interestingly, the *RRASOR* demonstrated moderate predictive accuracy (average AUC[3] = .71), meaning that while not perfect, with only four items the scale achieved outcomes substantially better than those found by Monahan regarding unstructured clinical judgment.

Hanson later collaborated with British scientist-practitioner David Thornton and collapsed their two scales (*RRASOR* and *SACJ-MIN* [Grubin, 1998]) into a single scale named the *Static-99* (Hanson & Thornton, 2000). The *Static-99* quickly became the industry standard in many international jurisdictions, including the United States. A revision of the scale in 2009 accounted for new conceptions of the effects of aging on risk (see Helmus et al., 2012) and a further revision in 2016 saw an update of the coding rules used by practitioners to score the items, as well as a reframing of how scores should be interpreted (see Hanson et al., 2016a,b; Phenix et al., 2016). Although analogs are available (e.g., *VASOR*, *VRS:SO*), the *Static-99R* remains by far the most widely used scale of its type in the world. However, in spite of the breadth of its usage, it is important to note that the *Static-99R* (and other similar scales, for that matter) does not constitute a comprehensive assessment of risk to sexually reoffend in and of

[3] AUC is the area under the curve in an evaluation of the validity of a measure. It essentially represents the likelihood that a randomly selected recidivist will have a higher score on the measure than a randomly selected non-recidivist. An AUC of .50 means that the measure is not distinguishing, while figures less than .50 demonstrate negative predictive validity and those over .50 represent positive predictive validity. Most scales used to predict criminal, violent, or sexually offensive conduct have AUCs in the .65 to .75 range, indicating moderate predictive accuracy.

itself. Rather, scales of this sort provide an empirically sound anchor and other sources of information assist in rounding out the "comprehensive" element. The items of the *Static-99R* are:

1. Age at release
2. Ever lived with a lover for at least two years
3. Index nonsexual violence convictions
4. Prior nonsexual violence convictions
5. Prior sexual offenses
6. Prior sentencing dates
7. Convictions for noncontact sexual offenses
8. Any unrelated victims
9. Any stranger victims
10. Any male victims

Scores on the Static-99R range from -3 to 12, with scores of -3 to -2 being interpreted as indicating "very low risk" to reoffend, while scores of -1 to 0 signifying "below average risk," 1 to 3 being "average risk," 4 to 5 being "above average risk," and 6 or higher signifying "well above average risk" (see Hanson et al., 2016a; Phenix et al., 2016) These interpretations of scores are norm-referenced, meaning that they are tied to percentile rankings across a large sample of persons for whom both scores and outcomes (i.e., reoffense rates over a certain period of follow-up) are known. The median score on Static-99R is 2, which is the 50th percentile. As noted above, the Static-99R provides risk ratings that have moderate predictive validity, meaning that they are far better than the 50-50 outcomes we would expect from either a coin-toss or unstructured clinical judgment, but also far less than 100% accurate. Again, this underscores the need for comprehensive approaches to risk assessment that consider all psychologically meaningful risk factors (see Hanson & Yates, 2013; Mann et al., 2010). It is also important to note that the Static-99R focuses only on static risk variables – those that are either historical in nature (prior sentencing dates, any stranger victims) or unlikely to respond to interventions. This means that Static-99R scores are highly unlikely to change over time. As such, we must also consider other empirically supported variables that can increase the predictive validity of the risk assessment process.

In a parallel research stream, Hanson and associates (2007; see also McGrath et al., 2013) sought to identify dynamic predictors of sexual offense recidivism. In contrast to static variables, which are largely historical in nature and are not subject to change through intervention, dynamic predictors are representations of personality orientation, lifestyle management, and patterns of behavior. These variables are subject to change over time – through processes of aging (including maturity) or participation in correctional programming. Indeed, in many respects, the variables we now focus on in dynamic risk assessment are also the major areas of focus in treatment interventions for persons who have sexually offended. Those major areas of focus are typically "significant social influences," "intimacy deficits," "general self-regulation," "sexual self-regulation," and "cooperation with supervision" with additional sub-variables often included in each domain (see Hanson et al., 2007). Research has indicated that consideration of dynamic risk factors provides incremental predictive validity over and above static factors alone (van den Berg et al., 2016).

There are two overarching risk factors pertinent in assessing persons who have sexually offended: sexually deviant interests and core antisociality. A review of all of the major scales used to evaluate risk to reoffend in sexual offender populations reveals variables that tap into each of these two overarching risk factors (see also Hanson & Yates, 2013). For example, referring to the *Sex Offender Treatment Intervention and Progress Scale* (*SOTIPS*, McGrath et al., 2013) commonly used in CT, items such as "sexual behaviors," "sexual interests," and "sexual attitudes" are specifically related to sexual deviance, whereas items like "criminal and rule-breaking behavior," "impulsivity," and "social influences" are more aligned with antisociality. In keeping with contemporary thinking in sexual violence prevention regarding holistic approaches, it is important to assess the relative influence of both sexual deviance and antisociality in all evaluations of risk to reoffend in persons who have sexually offended.

RELEVANCE FOR CONNECTICUT

Ratings of risk to sexually reoffend in Connecticut are compiled using a comprehensive process that includes consideration of the offender's criminal history, reference to actuarial risk assessment instruments (e.g., *LSI-R* for general criminality, *Static-99R* or *Static-2002R* for static factors related to sexual recidivism, and *SOTIPS* or *Stable-2007* for dynamic factors related to

sexual recidivism [reliance on *Stable-2007* appears to have waned in favor of *SOTIPS*]), clinical interviewing, *DSM-5* diagnoses (where applicable), and other important lifestyle management variables. This process is in keeping with general best practice guidelines for assessing risk to sexually reoffend.

With respect to sentencing, Connecticut uses a degree-based system (e.g., first, second, third, or fourth degree Sexual Assault – "first" being the most serious; see CGS Chapter 952, Sec. 53a). First and second degree sexual assaults include those in which a person compels another to have sex with him or her either through force or threat of force against the victim or another person. First degree also includes those instances where sexual intercourse occurs with a person who is unable to consent, either because of age or mental incapacity. Second degree sexual assault occurs in a variety of situations in which the offender has sexual intercourse with the victim while taking advantage of a position of trust or power over the victim (e.g., teachers, healthcare providers, etc.), or if the offender has sexual intercourse with a person who is between 13 and 16 and the offender is more than three years older. Third and fourth degree sexual assaults are similar to first and second, except that the sexual contact is something other than sexual intercourse.

Penalties for Sexual Assault in CT can vary greatly, but are based largely on the degree of the offense. Within degrees, there are also different classes of felony or misdemeanor, which may affect the ultimate sentence – incarceration, fine, or some combination thereof. Any sexual assault that involves a person under the age of 16 results in an automatic additional charge of Risk of Injury to a Minor, which often carries a mandatory minimum period of incarceration. While there is likely to be a correlation between degree of sexual assault and level of risk to reoffend, the strength of that correlation will be affected by individualized aspects of the offenders charged. That is, risk to reoffend is likely to vary within each degree of sexual assault, with some higher risk offenders being charged with third or fourth degree offenses while some lower risk offenders may be charged with first or second degree offenses. The sentencing guidelines used in CT are similar to those used in many jurisdictions both nationally and internationally; however, a failure to consider empirically validated risk assessment information may put such schemes at a disadvantage. It is also noteworthy that some offenses in CT come with mandatory minimum penalties for convicted offenders. This practice has become more popular in recent times as legislators secure election or re-election based on "get tough on crime"

platforms.[4]

Similarly, in assigning sexual offenders to its registry, Connecticut uses a system that relies on the nature of the offense committed, not the level of risk the offender poses to reoffend. This ultimately increases the potential for lower risk offenders to be maintained on the registry for longer than may be required and at an intensity or frequency-of-contact that could potentially lead to a negative, not positive, impact. This potential negative outcome is sometimes observed as lifestyle destabilization caused by having to meet sometimes onerous requirements that serve to interfere with the offenders' already stable existence (see Levenson et al., 2016; regarding juveniles, see Letourneau & Caldwell, 2013). For those offenders on continued supervision, this is also sometimes seen in release violations that represent a breach of acceptable conduct, but are not necessarily related to increased likelihood of sexual recidivism. McGrath et al. (2007) report that over a 5-year period just shy of 50% of sexual offenders in Vermont experienced violations of probation/parole not ultimately leading to a new conviction for sexual offending. This represented a 40% increase in the same population (sexual offenders on community supervision in Vermont) as reported by McGrath et al. in 1998. Data from Florida (Levenson & Shields, 2012) show that 32% of new arrests in that state were for technical violations. Interestingly, a similar report from Connecticut (Kuzyk, 2012) reported a rate of 65% for violations of probation in that state. While sexual recidivism rates reported for CT (see Kuzyk, 2017) are not appreciably different from those reported in other US jurisdictions, it would appear that VOP rates may be somewhat higher. Data reported by The Connection, Inc. would seem to contradict the CT data reported above, however, in that they reported a VOP rate of those referred to their program as 29%. It may be, however, that data reported by the treatment provider do not take into consideration all sexual offenders under supervision.

Currently, certain offenders must register with the Department of Emergency Services and Public Protection for a specified period following their release into the community. This requirement applies to persons convicted of sexual offenses, or acquitted by reason of mental disease or defect, of three categories of offenses:

[4] Interestingly, although get tough on crime agendas have become front and center in the management of criminal behavior, they have risen in spite of solid evidence showing that rates of all types of crimes, including violent and sexual offenses, have been on a steady decline for the last 20 or more years (https://ucr.fbi.gov/crime-in-the-u.s/2015/crime-in-the-u.s.-2015).

1. Criminal offenses against a victim who is a minor: generally 10 years for a first conviction or lifetime for a subsequent conviction
2. Nonviolent sexual offenses: generally 10 years for a first conviction or lifetime for a subsequent conviction
3. Sexually violent offenses: lifetime

Crimes for a sexual purpose (a felony conviction in which the purpose of the conduct was to engage in sexual contact or intercourse without the person's consent) are also subject to 10 years on the registry.

Treatment Placement

With respect to treatment placement considerations, it is imperative that offenders be offered interventions that are in line with the level of risk they pose (Bonta & Andrews, 2016). Putting high-risk offenders in lower intensity interventions risks a failure to attend to the extent and complexity of their treatment needs. Conversely, putting lower risk offenders in higher intensity programming detracts from their ability to maintain and enhance processes that are likely already going well. Additionally, including a small number of lower risk offenders in a group populated largely by higher risk offenders potentially leads to a certain degree of regression towards the mean in which lower risk participants may acquire attributes of their higher risk compatriots. Doing the converse risks disruption of the group by persons with highly entrenched antisocial values and attitudes.

Truth be told, the potential for higher risk sexual offenders to receive too little attention has rarely been as likely as the potential for lower risk sexual offenders to receive too much. This is apparent in most jurisdictions where programs and supervision are mandated for sexual offenders. Although there is a stated intent on the part of treatment providers in CT to adhere to the Risk Principle, the potential remains for lower risk offenders to be over-treated and over-supervised (via parole, probation, or sexual offender registration) as a consequence of the aforementioned offense-based scheme of assessing reoffense risk, rather than use of a system anchored in risk-based judgments.

In speaking with Probation staff, a perspective was put forward that CT has become increasing more stringent in its approach to supervision and treatment, with lower risk offenders

being maintained in treatment for longer than seems necessary. This phenomenon appears to be linked to the occurrence of violations of probation (VOP). Probation staff noted that once someone is violated, even for a scenario unrelated to risk for future sexual offending, the potential for extended treatment participation is increased. In documents provided by The Connection, Inc. regarding its Center for the Treatment of Problem Sexual Behavior (CTPSB), it is noted that "certain low risk clients will complete this phase [i.e., Phase 1] of the program as the sole form of clinical intervention due to the recommendations resulting from the assessment." Phase 1 can reportedly be completed in nine months to a year. Such a process would be generally in keeping with the Risk Principle; however, feedback from Probation staff is that this largely does not occur and that even lower risk clients may be maintained in treatment for three years or longer.

During my time onsite in CT, I had the opportunity to speak with an offender in community-based treatment. It should be noted that his comments constitute uncorroborated self-report, but he appeared to give frank and honest answers to my questions. This gentleman reported that he was convicted of statutory sexual misconduct with a young woman (post-pubescent, older teenager) over whom he had had a prior position of trust, garnering him a 20-month sentence. While in prison, he completed the 12-week introductory module; although he expressed frustration that he had to restart it after being almost finished in one location because of a transfer to another institution. He subsequently completed the 12-month program. Generally, regarding treatment in prison he opined, "If you don't take the class, you can't get out." Once released, he entered community-based programming offered by The Connection, Inc. CTPSB intervention, and he has been attending group weekly for 75 minutes. He stated that he has been in this group for 14 months, and he expects to be in it for a few more. This gentleman questioned whether he required treatment of the length and intensity that he has received and, given his circumstances as reported, I am inclined to ask similar questions. Regarding the quality of treatment offered in the community, he opined that staff from The Connection, Inc. have made efforts to maintain responsivity levels in the group, but noted that topics of discussion are not always relevant to him and he suggested that most of what he needed to learn was likely accomplished during his institutional treatment experience.

One last consideration is worthy of mention. Where possible and feasible with respect to risk to the community, treatment services are best offered in community settings (Bonta & Andrews,

2016). This has implications for sentencing frameworks, in which there are sometimes legal constraints on what sorts of sentences (i.e., incarcerative vs. community-based) are possible. In a system where type of offense is more likely to determine the type of sentence received by an offender, there is a possibility for some lower risk offenders to be given incarcerative sentences that limit opportunities for participation in community-based sexual offender treatment. Further, the tendency towards stringent community supervision noted by Probation staff also increases the likelihood that some lower risk sexual offenders will spend more time in prison because of non-sex-related VOPs (e.g., general antisociality or failure to attend to all conditions of release). Generally, there is a tendency for even seasoned practitioners to question whether there are some sexual offenders who truly require very little in the way of post-conviction management other than monitoring and evidence-based case management. Treatment may not be necessary at all for many lower risk sexual offenders but, if mandated by law or policy, attempts should be made to keep those interventions relevant to the population at hand, in keeping with the prescriptions of the RNR principles.

Need Principle. Equally simple to the Risk Principle, the Need Principle states that interventions should be focused on those variables actually linked to risk for reoffending; these variables are also commonly known as *criminogenic needs*. There is a simple truth in crafting effective interventions for offenders: Not all offenders have the same criminogenic needs profile. To be effective, programming must include a healthy component of individualization (see Bonta & Andrews, 2016). However, individualization can sometimes be a tricky objective to achieve in a field in which group psychotherapy is the primary mode of service delivery. It is well-known that there are certain risk-increasing factors that apply to a majority of potential sexual offender treatment participants (e.g., lack of or instability in intimate relationships, deviant sexual interests, poor cognitive problem solving, and impulsivity) while other factors may be less commonly found amongst the majority of offenders (emotional identification with children, sex as coping, negative emotionality/ hostility, and problems in following supervision rules – see Brankley et al., 2017; Hanson et al., 2007; McGrath et al., 2013).

A potential problem with Martinson's original research (1974) was that programs offered between 1945 and 1967 (the period captured in Martinson's original study) were likely focused on factors and attributes that were not necessarily linked to reoffense potential – at least there

was little empirical evidence to assist practitioners in focusing on the most important elements. Andrews and Bonta started publishing findings regarding general predictors of reinvolvement in crime in the 1980s (e.g., Andrews, 1982) and the first, large-scale meta-analytic investigation of the predictors of sexual reoffending was not published in peer-reviewed form until 1998 (see Hanson & Bussière, 1998; an update was published as Hanson & Morton-Bourgon, 2005). Like Andrews and Bonta's work in identifying the Central Eight risk factors for general criminality, Hanson and Bussière's findings provided much-needed focus in highlighting those areas most in need of attention regarding sexual reoffending.

Surprisingly, some factors traditionally regarded as paramount in addressing risk to sexually reoffend (e.g., victim empathy, denial and minimization) were found by Hanson and Bussière to be largely unrelated to risk to sexually reoffend in the grand scheme of things. This is not to say that these are not important aspects of the human condition in need of some degree of attention. Indeed, it would be hard to believe that social acceptance would be available to anyone who continually fails to take responsibility for their actions or who has an inability to appreciate the potential negative impact of their actions on others. As such, these require some degree of attention in programming; however, the Need Principle would suggest that primary focus should be on those factors central to the client's offending behavior (e.g., deviant sexual interests, poor problem solving, impulsivity, intimacy deficits). Logic holds that if you address the factors that increase social isolation, the client has more opportunity to hone his/her skills in the social arena with greater acceptance. Simply put, while many criminology theorists (reviewed in Bonta & Andrews, 2016; see also Prendergast, 2004) have suggested that offenders engage in bad behavior because they have low self-esteem, that low self-esteem is unlikely to abate unless the personal attributes leading to continued involvement in crime are addressed.

To ensure that offenders truly focus on areas of criminogenic need, assessments must attend to empirically derived frameworks, such as those identified in scales such as the *Stable-2007* (Hanson et al., 2007) and *SOTIPS* (McGrath et al., 2013). Following rigorous reviews of the available literature regarding lifestyle management issues, personality structure, and patterns of behavior prevalent in persons who have sexually offended, these authors provided us with a relatively comprehensive listing of the domains that require attention in sexual offender treatment programming. Consequently, it is reasonable to conclude that those programs that (1) adhere to the risk principle and (2) focus on areas of lifestyle management and criminogenic

need demonstrated by scientific inquiry are more likely to garner significant returns in both community safety and offender reintegration potential.

RELEVANCE FOR CONNECTICUT

Prison-Based Treatment

It is an unfortunate reality that prison-based treatment for sexual offenders is not always available across the United States. Fortunately, this is not the case in Connecticut. At present, there are two general treatment streams available, the first of which is a Short-Term Group that is aimed at addressing the treatment needs of low-risk offenders. This program is offered over 12 weeks or sessions and meets for 1.5 to 2.0 hours per week/session. Topics of discussion include:

1. Healthy sexual attitudes and continuum of consent.
2. Empathy & Cognitive Distortions
3. Pathways to offending
4. Life Goals & Motivation
5. Offense Chain & Problem-Solving
6. Assertiveness & Anger Management

The second stream is aimed at clients with higher levels of risk and need and includes two components:

1. A 12-session introductory sexual offender group that is noted as addressing two specific concerns: (1) offering treatment to those high-risk offenders who will be discharging too soon to allow for participation in more extensive intervention, and (2) offering treatment to lower risk offenders who will not likely require more extensive intervention. The 12 areas of focus in this stream are:
    a. Healthy Sexual Attitudes
    b. Victim Empathy
    c. Thought Process and Cognitive Distortions
    d. Motivation and Goals in Life
    e. Schemas

f. Offense Chain
g. Pathways to Offending
h. Goals and Problems Meeting Goals
i. Problem Solving and Working Toward Life Goals
j. Anger Management
k. Assertiveness
l. Post-Test and Group Termination

2. (a) **Track One** (one year program) is described as a cognitive-behavioral, interpersonal, insight-oriented psychoeducational program where inmates meet weekly in a group for about 1.5 to 2.0 hours a week. The topics of discussion are:
    i. Understanding Sexual Assault (12 weeks)
    ii. Relapse Prevention (12 weeks)
    iii. Victim Empathy (8 weeks)
    iv. Interpersonal Relationships (8 weeks)
    v. Anger Management (Assertiveness Training – 8 weeks)

    (b) **Track Two** (one year) is described as a process-oriented group that meets weekly for about 1.5 to 2.0 hours over a year. The intent of the group is to reinforce materials presented in Track One. It is noted that all inmates in Track Two have completed Track One.

The University of Connecticut Health Center, which provides all institutional sexual offender treatment in Connecticut, notes the following six treatment goals as its criteria for success in treatment:

1. Take full responsibility for your sexual offense behaviors.
2. Describe how you created the situation before the offense(s) occurred.
3. How did you benefit from the offenses?
4. How did your offenses affect the victim? Describe the emotional, psychological, physical, spiritual and sexual ways your sexual abuse affected the victim.
5. Describe, in detail, how you have or will establish positive relationships with appropriate peers in your life.

6. Develop a personal relapse prevention plan.

In and of themselves, these goals are fine; although the language used suggests a greater adherence to outdated models of treatment (e.g., relapse prevention model). The topic areas included in both the short and longer term programs are generally in line with what one would expect to see in an institutionally based sexual offender treatment program. However, it appears that there may be difficulties in practical application of the treatment curricula. In speaking to institutional treatment staff, issues of classification and wait-listing were raised as potentially affecting practical concerns. Additionally, there are likely issues in regard to responsivity, which will be addressed in the next section. Briefly, issues of treatment readiness, allocation to 12-week or 12-month programming, denial and minimization, and appreciation of special needs status (e.g., intellectual or mental health difficulties) appear to present challenges to institutional treatment staff.

Another area raised in discussions with institutional treatment staff centered on staffing. Many correctional and other institutional treatment facilities are found in rural or somewhat remote locations, and this is certainly not only true of CT. As a natural consequence, recruitment and retention of professional staff can prove daunting. In speaking with correctional treatment personnel, this would also appear to be the case in Connecticut. First and foremost, although there is a specially designated institution for chronically mentally ill inmates (i.e., Garner CI), other institutions (e.g., Osborn CI) suffer from a dearth of psychiatric services. One staff member opined, "Osborn desperately needs a psychiatrist." This is of key consideration given the overlap between clinical and behavioral difficulties demonstrated by many persons who have sexually offended; especially in regard to potential use of sex drive reducing medications that are indicated in clients with intrusive deviant fantasies and urges.

Further in regard to staffing, it would appear that the treatment staff complement is insufficient to meet the level of need. Institutional treatment staff reported that as many as 50% of inmates referred for sexual offender treatment will not get seen before reaching their end of sentence date. As a result, the unofficial policy is to triage potential participants by risk/need levels, which reflects a combination of sex treatment need (STN) scores, Static-99R scores, clinical judgment, and sometimes more importantly, parole status (i.e., special parole vs. discretionary parole). CT-DOC treatment staff reported that, generally, inmates eligible for

special parole take precedence over other inmates, given that they cannot be held beyond their special parole date. Inmates subject to discretionary parole are admitted to treatment as resources permit, but many may not receive treatment until they arrive in the community. STN scores (1 to 5) are calculated based on the nature of the inmate's sexual offending, considering aspects such as persistence, degree of violence, and other offense-specific elements. According to the CT-DOC Classification Manual, all inmates with an STN score greater than or equal to 2 and who indicate an interest in participating in treatment are referred for programming. If programming is not available at the inmate's home institution and he is at least STN = 2 and is showing an interest in treatment, the inmate can be considered for transfer.

Regardless of how inmates are chosen for participation, it would appear that the number of clinicians available to offer treatment is insufficient to meet the need. Presently, there are four facilities with sexual offender treatment services. Amongst them, there are three full-time (two at Brooklyn CI, one at Osborn CI) and five part-time treatment providers. Of the approximately 2100 inmates at Osborn CI, classification and treatment staff reported that there are 386 identified sexual offenders, with only 56 in service as of March 2017. At present, there appears to be no concerted effort to encourage offenders who are disinterested in treatment to consider enrolling, which is likely fortuitous given the general lack of staff who would be available to meet any increased numbers wanting treatment.

During this evaluation, I was able to visit Osborn CI and speak with the main treatment provider onsite. This gentleman spoke frankly about his experience at Osborn and described the treatment services he provides. He opined that the program "on paper" is "eclectic" and noted further that there is no formal consideration of dynamic risk variables; although there is apparently some thought being given to instituting the *SOTIPS* as is used in the community. The treatment provider impressed as a thoughtful clinician dedicated to assisting his clients, and I have little doubt that he has done so. However, it did not appear that he was adhering closely to the curricula as provided by the University of Connecticut Health Center (UCHC), the CT-DOC's contracted institutional sexual offender treatment provider. He stated that he sometimes likes to let the group "drive the curriculum," which raises issues of fidelity to the established model. To be fair, I have little doubt that inmates who complete treatment with this individual are likely better for the experience; however, his idiosyncratic approach to treatment provision raises concerns regarding the degree to which similar processes may be in use in other CT-DOC

facilities. Further, given that the Osborn CI provider is the only one onsite, if he should leave the facility for any reason, I would have great concerns regarding continuity of care.

Another issue of some concern raised by the institutional treatment provider was a lack of case coordination as inmates move from institutional treatment to community follow-up. At present, all community-based sexual offender treatment is provided by The Connection, Inc. regardless of whether the offender is on parole or probation. Treatment provided in prison is provided by staff affiliated with the UCHC. The reasons for this lack of communication were not specified, but it would appear that a combination of factors may be at play, including "turf" issues, proprietary concerns, and hostile relationships. Mr. Zemke of the CTPSB noted that there have traditionally been difficulties between the institutional and community-based treatment programs.

Regardless of the reason for any acrimony between institutional and community-based treatment programming, the research literature is particularly clear that coordination between institutional and community-based treatment staff is of great importance in ensuring continuity of care and continued client buy-in to the treatment process (see Barrett et al., 2003; Stirpe et al., 2001; Willis & Grace, 2008, 2009). Simply put, success in the community relies on thoughtful preparation for that often-difficult transition. This cannot occur when staff in those two locations fail to communicate with one another or, worse still, may be undermining each other.

Overall, it was not entirely clear that sexual offender programming in the CT-DOC is offered fully in keeping with the prescriptions of the RNR model and current perspectives in ensuring strength-based treatment opportunities. On paper, the program appears to be reasonable; however, implementation may be an issue; especially considering concerns conveyed by staff regarding a lack of staffing sufficient to meet demand. It may very well be that individual staff are knowledgeable and helpful in providing clients with an opportunity to make prosocial changes; however, it appears that greater administrative attention regarding budgeting, staffing, and model fidelity is required.

Community-Based Treatment

Whether on parole or probation, all sexual offenders referred for treatment in the community receive that treatment from The Connection, Inc. through its Center for the Treatment of Problem Sexual Behavior (CTPSB). This is a private agency under contract to the Government of

Connecticut and this arrangement has been in place for many years at this point. In preparing this report, I had the opportunity to speak with David Zemke, Program Director of the CTPSB, who provided documentation and helpful perspective on the role and functions of his service.

Although homelessness was identified as a principal concern by community supervision officers, there has apparently been a dramatic decrease in the use of homeless shelters over the past five years. It was suggested that this change was the result of collaborative problem-solving amongst stakeholders, including victim advocates. According to community supervision staff, there are a number of housing opportunities available to offenders released to the community, depending on risk and need. Two locations noted by community supervision staff were the January Center (located on the grounds of the prison; locked) and beds available through Re-entry Assisted Community Housing (REACH) and Chrysalis. Halfway house opportunities are also apparently available through the Eddie Center and a work release halfway house.

The CTPSB rates the risk to reoffend of clients referred to its service using the *Static-2002R* and the *SOTIPS*. About 60% of persons referred to CTPSB are in the low to moderate risk range, while approximately 10% would be considered high or high-moderate. This is pretty much in line with what would be expected given actuarial risk ratings using either *Static-99R* or *Static-2002R*. Based on risk ratings and other clinical considerations outlined in the CTPSB Community Intake Packet, clients are triaged into different treatment streams. Treatment goals, overall, are generally in keeping with contemporary methods and consist of the following:

1. Treatment Goal One: Accept Responsibility.
    a. Be able to accurately describe your offense behavior.
    b. If you are denying, be able to accurately describe your behavior that lead to your arrest and/or conviction without making it less than it was, making excuses, or blaming others.
2. Treatment Goal Two: Identify and be aware of relevant risk factors.
    a. Identify your risk factors at the time of your offense/arrest/conviction.
    b. Identify and be aware of your current and possible risk factors that could lead to a future offense.
    c. Identify your sexual thinking that connects to your offense behavior.
    d. Identify any high-risk sexual interests.

3. Treatment Goal Three: Understand the behavior that led to your offense/arrest/ conviction.
    a. Identify the influence of significant past life events on the behavior that lead to your offense/arrest/conviction.
    b. Identify and understand the impact of thinking patterns, emotional management, interpersonal styles, and sexual fantasies, values and beliefs on the behavior that lead to your offense/arrest/conviction.
    c. Identify signs that you and others can observe that indicate increased risk.
4. Treatment Goal Four: Demonstrate that you are managing risk factors.
    a. Identify internal controls and changes in your thinking that help you manage risk factors and decrease your risk of sexual offending now and in the future.
    b. Identify external supports and protective factors that will help you manage risk and achieve positive goals.
    c. Demonstrate that you have developed skills and activities that help you to be productive, help others, meet your needs and goals in a positive manner and lead to positive feelings and living.
5. Treatment Goal Five: Identify positive future goals and develop a plan to achieve them.
    a. Complete a Good Lives Plan.
    b. Demonstrate progress in meeting your goals.
6. Treatment Goal Six: Present a discharge plan that shows that you can:
    a. Manage personal risk factors.
    b. Control deviant sexual arousal and/or change risky sexual thinking.
    c. Use prosocial skills and activities in your everyday life.
    d. Maintain a support system.
    e. Successfully complete maintenance polygraph examinations.

Phase I of the CTPSB runs typically for nine months to a year, depending on the client. Mr. Zemke reported that some clients are successfully discharged from treatment after completing only Phase I and that this would normally apply to those offenders judged to be at low risk and of low need. All offenders are subject to polygraph evaluation during Phase I, including an Index Offense polygraph and a Sexual History polygraph – both of which are often offered early in

Phase I. Mr. Zemke reported that offenders are not required to admit to "all" offenses, but noted that deceptive results may result in a Specific Issue polygraph examination. He noted further that successful completion of polygraph examinations could shorten the amount of time the offender might spend in treatment. During treatment in Phase I, it is also possible that Maintenance polygraph examinations may be conducted as requested by Probation or Parole staff.

CTPSB is currently working on updating its Phase I Workbook; however, Mr. Zemke provided me with a draft of the work in progress. Overall, the materials contained in this workbook are in line with most sexual offender treatment programs across the country. Focus is on dynamic risk factors and development of a balanced, self-determined lifestyle that includes reference to goal-setting, self-regulation, and consideration of protective factors. Regarding the latter, this is an area of new exploration in sexual offender treatment programming and it highlights recent trends towards strength-based approaches (see Marshall et al, 2011). In this vein, Mr. Zemke reported that CTPSB has contracted with David Prescott, a noted sexual offender treatment theorist and practitioner, who is assisting them in bolstering the self-regulation and strength-based elements of their program, including implementation of modules consistent with the currently popular Good Lives model (see Yates et al., 2010).

Following completion of Phase I, most offenders will advance to Phase II, which can reportedly last anywhere from 12 to 48 months, depending on the participant. Mr. Zemke attributed the large variation in potential time in treatment to several factors, including individual differences, problems for clients high in both antisociality and sexual deviance, denial and minimization, and what he characterized as a high frequency of parole/probation violations. Average length in Phase II is apparently two years; although Mr. Zemke noted that he and his staff are attempting to shorten time in treatment for those offenders who can progress more quickly.

Mr. Zemke answered a series of questions regarding applying the responsivity principle in CTPSB programming. Although CTPSB has a protocol for the treatment of persons who are in denial or who strongly minimize their behavior (shared by Mr. Zemke), there is presently no "deniers" group available. The intention of policy and procedure regarding denial is to assess the function of the denial and then to intervene to ensure that the client has opportunities to engage in skill-building and examination of risk and need. Denial is apparently not necessarily an impediment to treatment completion and discharge.

Individual treatment sessions are available for offenders with highly entrenched antisocial values and attitudes who become disruptive in normal groups. Similarly, accommodations are made for offenders with special needs (e.g., intellectual disabilities, autism spectrum, serious mental illness). These groups are offered at a slower pace and with limited written materials. CTPSB offers "responsivity groups" that are specifically oriented to assist clients with these sorts of difficulties, and Mr. Zemke reported that some special needs clients only attend responsivity groups. Of potential concern regarding programming for special needs clients is a lack of specific written curricula. Mr. Zemke reported that although accommodations are made, there is no formal guide for staff working with such clients; although there are plans to develop curricula in the near future.

The CTPSB treatment program is modeled largely after the National Sex Offender Treatment Program from Canada, which was developed in the late 1990s moving into the 2000s as a means to standardize programming for sexual offenders in that country. Mr. Zemke reported that the core assignments in the Canadian program form an important part of the CTPSB curricula. At present, the CTPSB uses the *SOTIPS* as its "treatment plan"; however, Mr. Zemke noted that this is something he is revisiting. Although the dynamic risk variables included in the *SOTIPS* will be important to consider in treatment planning for offenders on community supervision, it cannot stand on its own as a *bona fide* treatment plan. As such, it may be necessary for CTPSB staff to secure training in case conceptualization and treatment planning, which would also be available from David Prescott, someone already familiar to CTPSB.

Overall, it would appear that the CTPSB is in something of a state of flux. Documents provided to me detailing what The Connection, Inc. intended to do in its programming (via documents submitted in 2015 as a response to the request for proposals issued by the CT Judicial Branch) were noted by Mr. Zemke as being outdated and not fully representative of the changes either already made or in process in the CTPSB. Mr. Zemke reported that he has a number of new staff members who are in need of training. As noted, CTPSB has contracted with David Prescott to train staff in self-regulation and Good Lives approaches to treatment, trauma-informed care, and motivational interviewing. Mr. Zemke also indicated that the CTPSB would be endeavoring to include protective factors in its treatment focus going forward and that he intended to secure training for staff in the SAPROF, an assessment tool focusing on protective factors (see de Vogel et al., 2009, 2012).

Programming for Women who Sexually Offend

Briefly, CT-DOC provides programming to female inmates convicted of sexually motivated offenses. The curriculum currently consists of 12 sessions, based largely on Charlene Steen's *Choices* (2006) workbook. This is likely to be more than adequate for the majority of female sexual offenders who are largely unlikely to reoffend sexually (see Cortoni et al., 2017). There are reportedly approximately 21 female sexual offenders in the CT-DOC.

In the Executive Summary submitted as part of its 2015 response to the CT Judicial Branch RFP, CTPSB noted that it offers treatment for female clients who have committed sexual offenses. Specifically, the Executive Summary notes that there are three groups available, in addition to individual treatment for those women who are not able to travel to those groups.

Responsivity Principle. It has previously been stated that interventions for offenders require individualization. The Responsivity Principle decrees that to be effective, program options must take into consideration the idiosyncratic aspects of individual offenders, including such constructs as motivation, learning styles, and potential barriers to treatment success. A complaint that has been leveled at many sexual offender treatment programs is that they tend to use a one-size-fits-all approach that fails to consider these important responsivity domains. Such approaches are unlikely to achieve optimal outcomes for persons who do not fit the mold, such as offenders with special needs considerations (e.g., intellectual and other cognitive processing disabilities, serious mental illness, and other issues that might affect comprehension of treatment curricula, such as issues covered under the Americans with Disabilities Act [ADA; e.g., hearing, sight, etc.]). The literature is clear (see Blasingame et al., 2014; see also Wilson & Burns, 2011; Wilson et al., 2014) that modifications must be made to programming to ensure that persons with special needs can respond appropriately and achieve maximum benefit of treatment – in both institutional and community settings.

Motivation is another important responsivity construct requiring consideration in developing and offering effective interventions to persons who have sexually offended. A complicating issue here is that motivation has been poorly defined operationally and, as a consequence, its importance is difficult to quantify. It stands to reason that levels of motivation for change will vary across the population in need of service and their place in the clinical

continuum (see Barrett et al., 2003; Stirpe et al., 2001; Wilson, 2009). Many programs use some version of the Transtheoretical Stages of Change model (see DiClemente & Prochaska, 1998) to rate their clients in regard to where they are on a continuum of preparation for change via treatment (i.e., precontemplation, contemplation, preparation, action, maintenance). Movement through this continuum of readiness for change is thought to be closely aligned with general success in treatment (Thornton, 2002).

One consideration in this line of inquiry regarding responsivity and motivation is related to denial and minimization. Prior to the Hanson meta-analyses, conventional wisdom was that persons in denial or minimization were unmotivated to change and disinterested in addressing issues of risk; thus, they were typically excluded from treatment as unlikely to succeed or because they were perceived as obstinate or otherwise antisocially unwilling to address their personal issues. Further, denial and minimization were seen as potent risk factors, such that persons who demonstrated these constructs were unlikely to receive community-based sentences or to be considered for early release. However, we now know that denial and minimization are either unrelated to risk to reoffend, or their influence on recidivism is much more complicated than simple cause and effect (see Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005). In some instances we may regard both denial and minimization as ego defenses, used by offenders to manage the cognitive dissonance that arises from recognition that they have engaged in harmful behaviors with others. In this line of thinking, denial or minimization may be less an indication of deception and lack of insight than they are psychological means used by offenders to protect against emotional collapse. Regardless, the literature is clear that denial and minimization are not necessarily related to either risk to reoffend or failure in treatment (Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005).

Following from the previous paragraph, program curricula have been developed for so-called "deniers," with outcomes quite similar to those achieved with "admitters" (see L.E. Marshall et al., 2008). It would appear also that preceding formal treatment with a "treatment readiness" preparatory module (see Cullen & Wilson, 2003; Prescott & Wilson, 20113; Wilson, 2009) increases the likelihood that persons in denial will succeed in treatment. L.E. Marshall and associates (2008) noted that, amongst their clients in a deniers program, several were ultimately able to take responsibility for their actions once the strong push to admit and accept responsibility was taken off the table. A typical scenario might be:

Clinician: Tell me what happened in your sexual offenses.

Client: I didn't commit any sexual offenses.

Clinician: Are you sure that you did nothing that could have been viewed as offensive?

Client: No, the "victim" misinterpreted my behavior.

Clinician: OK, let's say for a moment that you didn't do anything wrong; look at where you are. You're in prison having been convicted of Sexual Assault. Are there things that you may need to do or be aware of going forward, in order to make sure that you don't find yourself in the same situation again?

Client: I suppose. What would I have to do?

Clinician: Let's just try it and see how you make out.

With this admittedly passive recognition of a need to review conduct and circumstances, the client allows for the possibility of personal growth without having to admit any wrongdoing. L.E. Marshall and associates (2008) suggested that clients in denial or minimization who subsequently engage in treatment programming ultimately do better than those offenders in denial who do not entertain prosocial change.

Management of offenders in denial or exhibiting minimization has implications for program management; particularly with respect to use of polygraph examinations. There is a degree of controversy as to the relative value-added of polygraphy in both treatment and supervision of persons who have sexually offended. Proponents assert that knowing the client's full offense history, sexual thoughts and fantasies profile, and their adherence to treatment and supervision prescriptions is of paramount importance in effective risk management (see Ahlmeyer et al., 2000). Critics of polygraphy (e.g., Meijer et al., 2008) have pointed to difficulties with respect to the reliability and validity of the examination process. Also, the linkage between providing nondeceptive results on polygraph examinations and success or failure on community release has not been empirically demonstrated. This point is illustrated in the reality that the United States is the principal user of polygraphy in sexual offender risk management, yet rates of reoffending in jurisdictions that do not use polygraphy are not appreciably different from those in the United States. Violations of conditional release – often via failed polygraph evaluations – are, however, more prevalent in the United States.

Of other potential concern is the manner in which case managers interpret polygraph outcomes; specifically, deceptive results are generally received poorly, but inconclusive or nondeceptive results are not always received favorably. A strong reliance on polygraph evaluations also potentially increases the incidence of community supervision violations (VOP), even when the issue leading to deceptive results may not be specifically related to risk to reoffend. For those offenders likely to be reincarcerated following a VOP, this revolving-door experience can have drastic negative effects on attempts to establish stability in the community. In speaking with Probation staff for this evaluation, it was clearly reported that polygraph results do not form the basis of decisions to utter violations of community supervision. Rather, polygraph results are seen as a helpful tool to assist clients on supervision in maintaining treatment gains and remaining compliant with the terms of their release.

Another group of offenders causing great concern regarding responsivity are those who demonstrate highly entrenched antisocial values and attitudes (i.e., clients likely to be high in the Big Four predictors of general criminality). Clients with an antisocial personality orientation present a myriad of difficulties to both clinical and supervisory personnel, in that they continually test boundaries in a variety of domains and often resist treatment recommendations and risk management restrictions. Indeed, for some offenders with antisocial orientations, denial and minimization are more sport than ego defense and it has been said that for some highly antisocial clients, treatment may actually make them worse (Salekin, 2002; Seto & Barbaree, 1999). However, additional research (Mailloux et al., 2003) suggests that it is not programming that potentially makes antisocial clients worse; it is actually a failure to attend to issues of risk, need, and responsivity that is most contributory to failure. That is, highly antisocial clients require intensive treatment interventions that focus on reciprocal prosocial engagement and reducing antisocial values and attitudes (Looman et al., 2005; Mailloux et al., 2003).

In summary, developing an effective sexual offender treatment curriculum is not all that needs to be done to ensure positive outcomes for program participants. It is also critically important to ensure that all persons included in programming are actually able to interface with the materials and be successful. Sometimes, this requires modification of the curriculum to meet the responsivity concerns of those who might not necessarily fit the mold. As noted, common group of clients in need of responsivity consideration are persons with intellectual and other cognitive processing disabilities, persons with persistent mental illness, persons with ADA

concerns, and those with highly entrenched antisociality that presents significant barriers to both participation and success.

RELEVANCE FOR CONNECTICUT

The population of persons in CT who have sexually offended is likely no different from any other jurisdiction in the United States or other similar nations. Although the majority of offenders will be without obvious responsivity concerns beyond a need for programming that attends to their individual risk and need profiles, there are no doubt clients who will require special attention to ensure that they are also able to achieve positive treatment outcomes. In many unfortunate circumstances, persons with special needs and other responsivity concerns fall through the cracks, being perceived as unmotivated or antisocial when they may actually be demonstrating an inability to appropriately respond to the curricula they are offered (or are sometimes mandated to attend).

Policy #G 4.07e of the University of Connecticut Health Center – "Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Special Populations" outlines the policy and procedures relevant to ensuring specialized treatment services for persons with mental health and ADA concerns in prison settings. Clients with mental health concerns are to receive case management services while incarcerated, including treatment and discharge planning that takes into consideration both risk for sexual offending and mental health issues. The policy refers to specialized sexual offender groups with modified curriculum materials; however, the nature of those modifications is not specified. Bonta and Andrews (2016) assert that interventions are more likely to be successful if there is a written program guide that directs program staff coordinating the intervention.

The Connecticut Department of Corrections makes allowances for those clients with serious mental illness who are also in need of sexual offender treatment services through a dedicated program at Garner CI. Corrections treatment staff also reported that some offenders might be referred to a state psychiatric hospital if there mental health treatment needs cannot be met in a correctional institution.

Correctional treatment staff at Osborn CI noted a dearth of psychiatric services available to sexual offenders outside of the specific mental health facility stating, "[Osborn] desperately

needs a psychiatrist." This is a common complaint amongst many institutional treatment providers across the country and highlights a general lack of appropriately trained and available psychiatric professionals to meet the needs of sexual offender treatment programs. That said, the lack of psychiatric coverage presents difficulties for those programs dealing with higher risk, higher need offenders who may require assistance with mood stabilization and therapeutic sex drive reduction.

CTPSB documentation makes reference to specialized programming for clients with responsivity concerns, including provision of "responsivity" groups. However, Mr. Zemke identified current problems in providing specific interventions for clients with treatment readiness concerns (e.g., denial and minimization), entrenched antisocial values and attitudes, serious mental health conditions, and cognitive limitations (e.g., intellectual disability). While some accommodations are made, it would appear that most clients with responsivity concerns are mainstreamed with a degree of special attention. Given that many special needs clients have learned to be adept at presenting a cloak of competence and tend to approach difficult situations with an acquiescence bias (i.e., the tendency to go along with whatever people in positions of power suggest, even if they do not understand the implications), there is a need to be proactive in monitoring treatment progress (see Wilson & Burns, 2011)

Overall, it is apparent that of the three RNR principles important to consider in developing effective interventions for persons who have engaged in sexual offending, the one that requires the greatest attention in CT going forward is responsivity. In both institutional and community-based programming documentation, there is clear reference to a need to provide programming that attends to individual needs of clients; however, practical implementation appears to have fallen short of hopes and expectations. Treatment staff from Osborn CI and CTPSB identified that there are attempts made to place clients with responsivity concerns into specialized programming or "responsivity" groups, but neither provider could point to written guidelines specifying how that should be accomplished. As a consequence, it is likely that clients with special needs (particularly, those with cognitive limitations) are being subjected to treatment interventions that they do not fully understand. To be fair, this is a common difficulty amongst sexual offender treatment programs around the country and internationally. That does not, however, absolve CT sexual offender treatment providers from making better efforts to address the unique treatment and supervision needs that many of these clients present.

COMMUNITY SUPERVISION

The community is where the rubber meets the road in risk management of persons who have sexually offended. Until an offender is released, all activities with him/her have been undertaken in environments that are akin to a laboratory. Although opportunities to engage in sexually inappropriate conduct exist in jail, prison, or secure treatment settings, access to vulnerable target persons (e.g., children) are usually quite limited. Of course, the community presents a multitude of possible avenues to reoffending – all of which must be identified and competently managed.

The primary conduit for community risk management of persons who have sexually offended is a supervision officer – most often a probation or parole officer. Early models of supervision saw officers managing their caseloads with little to no consultation with others. We now know this to be insufficient to truly guard against recidivism and additional instances of victimization by known offenders, and each jurisdiction can likely point to at least one unfortunate incident that occurred with a sexual offender who was released in their state, province, etc. If there is any positive aspect to take away from these terrible events, it is that they have taught us how to be better in appreciating the need for a coordinated and collaborative approach to managing offenders in the community. Just as advances have taken place in the assessment and treatment of persons who have sexually offended, the same has been true of methods in supervision.

Collaborative Models

Beginning in the 1990s (see English et al., 1996), approaches such as the Containment Model started to enter the community supervision nomenclature. These approaches represented an early understanding that probation or parole supervision alone was unlikely to account for the holistic risk profile presented by many offenders in the community. In the Containment Model, a collaborative approach included case management coordination by a probation/parole officer who worked cooperatively with a treatment provider and a polygraph examiner. Together, these three personnel formed the so-called containment triad. While the PO managed the day-to-day supervisory framework, the treatment provider focused on managing criminogenic needs and the polygrapher was tasked with ensuring that the offender was adhering to his/her conditions of

release and treatment recommendations. This model quickly became the most popular approach to the community risk management of persons who have sexually offended, and appeared to work quite well within a relapse prevention framework.

As focus in assessment and treatment grew more holistic and comprehensive moving into the new millennium, there was also a need to reconsider how community risk management might also require some revision. Incorporation of RNR principles suggested that the list of potential stakeholders in need of consideration was larger than typical of the containment approach (see Wilson et al., 2000; 2009). It was also clear that training and professional support for front line risk managers (i.e., probation and parole officers) was also in need of bolstering. In today's community risk management endeavor, POs are highly trained experts who have considerably more understanding and technology available to more effectively manage their caseloads. POs are now routinely trained in motivational interviewing techniques, as well as being trained in actuarial risk assessment (e.g., *Static-99R*, *SOTIPS*) and other similar tools. In my opinion, it is quite reasonable to suggest that at least some of the significant reductions we have witnessed in regard to sexual recidivism rates (see Finkelhor & Jones, 2006) is attributable to the professionalization of community supervision officers.

Building on the containment foundation, other jurisdictions have attempted to be more inclusive regarding stakeholder representation. For instance, the Multi-Agency Public Protection Arrangement framework in the United Kingdom (see Wood & Kemshall, 2007) takes the containment approach and expands it by including at the risk management table local law enforcement, social service agencies (who may be providing housing and job search services), faith-based groups (e.g., Salvation Army, Circles of Support and Accountability – see Wilson & McWhinnie, 2013), and victims' advocacy groups or agencies (e.g., Stop It Now!, rape crisis centers), among others. The result is that the risk management process becomes much more comprehensive and representative of the community's true stake in preventing future victimization. A helpful side benefit is that agencies previously unaware or, perhaps, suspicious of each other's goals and agendas have become more closely allied towards that common goal. As above, it would be my position that this increase in cooperation, too, has contributed to lowered rates of sexual recidivism (and, alternatively, growth in more broadly defined community collaboration).

As much as collaboration may be the ultimate goal, there are potential drawbacks that sometimes arise. In the end, someone has to be the responsible party in any collaborative approach to risk management; and, in most cases that is likely to be the probation or parole officer. However, this is not to suggest that the perspectives of others are any less important to consider. Rather, it means that the buck must stop somewhere. Although there may be broad representation of non-statutory bodies, criticisms of the containment and MAPPA approaches have been that whenever something goes wrong (e.g., reoffense), those statutory agencies "circle the wagons" and leave the non-statutory parties out of the decision making process. While it is clear that there are situations in which law enforcement and probation/parole staff must make difficult decisions, if the non-statutory parties were valuable enough to be at the table when things were going well, they should also be valuable in problem-solving situations when things are not going well. This can certainly present challenges, but the resultant teambuilding can help inoculate communities against future difficulties by ensuring that all stakeholders understand and feel valued in their place at the risk management table. As such, best practice in community risk management is clearly a collaborative enterprise that appreciates and incorporates the viewpoints and concerns of a wide variety of stakeholders – professionals and laypersons.

Probation and Parole

Connecticut has somewhat complicated processes for sentencing and releasing sexual offenders. Offenders receiving sentences of two years or less are eligible for community release (transitional supervision) through the Department of Correction, while offenders receiving two years plus a day or more will ultimately fall under the jurisdiction of the Board of Pardons and Parole. In certain sexual offense cases, offenders are sentenced by the Court to a split sentence, which will result in a mix of incarceration and probation supervision. Split sentence offenders are also eligible for parole, but this presently does not happen or rarely happens. However, a benefit of split sentencing is that probation staff are notified six months in advance of a pending release. This provides an opportunity for probation staff to make contact with inmates – either in person or by videoconference – in order to begin release planning, which is well-supported in the clinical literature (see Willis & Grace, 2008, 2009). Otherwise, some offenders are eligible for special parole, with community case management provided by CT-DOC parole officers.

Apparently, special parole is a common circumstance under which sexual offenders are supervised in the community.

The Judicial Branch provides an elaborate policy regarding Adult Services: Sex Offender Supervision that dictates how community supervision will be accomplished. For the most part, the policies included in this document are in line with similar policies in other US jurisdictions. The document is comprehensive and covers the majority of domains important in establishing effective case management for persons who have sexually offended. Based on results of a clinical assessment, offenders are placed into categories of supervision according to the following matrix:

Clinical Assessment	**Supervision Category**
High	Sex Offender High
High/Moderate	Sex Offender High
Low/Moderate	Sex Offender Medium
Low	Sex Offender / Medium / Maintenance

It is interesting to note that there is a tendency to supervise offenders at the higher end of their clinical assessment category (e.g., High/Moderate = Sex Offender High, Low/Moderate = Sex Offender Medium, and Low = Sex Offender Medium / Maintenance). There appears to be no true "Low" supervision category, in spite of good evidence suggesting that a sizeable proportion of sexual offenders will be at the lower end of the risk continuum (see Hanson et al., 2016a,b). This is a common practice amongst US community supervision agencies, and likely reflects a longstanding bias that sexual offenders pose greater risk to the community than is borne out in research findings.

Sexual offender Registration

As is true across the United States, Connecticut maintains a publicly accessible sexual offender registry (SOR). In many cases, offenders remain on a registry long after they have completed all aspects of their sentences (incarceration, parole, or probation), which allows for a measure of monitoring over an extended period. However, as noted elsewhere in this report, sexual offender registries are not without their critics. Of some concern is the way in which certain offenders are placed on the SOR and for how long. At present, CT uses an offense-based process to set registration terms; although proposals are being made to revise the SOR. Central to

these proposals is a recommendation that offenders be differentially placed on either a law enforcement registry (not available to the public) or a publicly accessible registry. If implemented, low and moderate offenders could potentially be placed on the law enforcement SOR (10 and 20 years, respectively) while high-risk offenders would be maintained for life on the public registry.

RELEVANCE FOR CONNECTICUT

Probation and Parole

Depending on original sentencing, sexual offenders in CT may be supervised in the community under probation or parole circumstances, the former being managed by Adult Probation Services while the latter falls under the CT-DOC. It would appear that the processes can, at times, be very similar, but some access to services may vary according to the particular supervision stream to which the offender is accountable.

In completing this review, I had the opportunity to speak with probation staff from the New London and New Haven offices. Staff reported that sexual offenders are typically managed in the community for 10 years post-release (the minimum for sexual offenders; although non-contact offenders may apparently be on probation for five years). Referral to treatment is in most cases mandated and one probation officer noted, "Almost everyone is found appropriate for treatment." This suggests a tendency to admit clients to treatment irrespective of RNR prescriptions. Indeed, probation staff also noted that even low risk offenders may be in treatment for three to five years, which is inconsistent with information provided by CTPSB.

Probation staff opined that a particular strength of the CT model of sexual offender risk management is the theory and "what's on paper"; although concerns were expressed about how often those guidelines are actually followed. A lack of statewide oversight of sexual offender management was noted, as was the potential for different offices to have slightly different practices. A tendency towards "over-supervision" was suggested and probation staff also questioned whether all standard probation conditions for sexual offenders were actually applicable to all sexual offenders. In this same line of thinking, probation staff questioned the value-added to community safety of mandatory minimum sentences, suggesting that some lower risk sexual offenders who might have done well on probation were sent to prison instead.

In regard to treatment services, probation staff were pleased that groups are mostly provided on-site at the local probation offices, which facilitates meetings with clients and case conferencing with treatment providers. Probation staff voiced some concerns about the size of some groups (up to 18 participants), as well as the relative experience of some younger treatment providers.

Collaboration

From early on, Connecticut demonstrated an understanding that collaboration is of key importance in building a best practice model of sexual offender risk management. Examples of this include:

- Offering treatment groups onsite at probation offices, so that "clinics" can be established where in clients may attend group and also meet with their PO on a regular basis.
- Weekly or biweekly "unit meetings" are held, which include the supervising officer, a Chief PO, the treatment provider, and a representative from victims services (formerly Connecticut Sexual Assault Crisis Services [CONNSACS]; now the Connecticut Alliance to End Sexual Violence).
- Opportunities for law enforcement personnel to accompany PO staff on compliance checks in the community.
- Opportunities for joint projects and contracts between CT-DOC and Adult Probation

Indeed, I know of no other jurisdiction that includes victim services as a key member of the case management team, and it is of no great surprise to find that this partnership was driven initially by the great victim advocate Gail Burns-Smith and policy analyst David D'Amora. Certainly, other services around the country include consultation with victim advocates, but rarely have I seen them included as an "equal party" to the process. However, while this comes with obvious benefits, there may also be potential drawbacks. Most professional frameworks in managing the risk posed by identified sexual offenders are "victim centered"; meaning that they consider the effects that case management decisions may have on victims – known, unknown, or future. However, while it is of great importance to consider those potential effects, there will be times when victim perspectives may not be fully in keeping with case management considerations. Ultimately, decisions will need to be made that balance victim concerns against

allowing opportunities for offenders to rebuild their lives in the community. While it is an absolute truism that the processes involved in managing persons who have sexually offended must be sensitive to the experiences and concerns of persons who have been victimized, it would be my contention that those aspects and case management concerns may not always converge. With fairness and sensitivity to those differences, the Probation or Parole service must be the final arbiter of what happens going forward.

Registration

Sexual offender registries have long been used in the United States to maintain lists of persons previously convicted of sexual offenses and to provide information to both law enforcement and local communities as to who lives where and may be in need of monitoring. Although commonly employed, sexual offender registration remains a particularly contentious issue – with legislators and community members being greatly in favor of full transparency and researchers and sexual offender treatment personnel suggesting that there may be times when registration actually impedes offender reintegration and might increase rather than decrease risk (see Letourneau et al., 2013; Levenson et al., 2016).

As is true across the United States, CT maintains a publicly accessible sexual offender registry (SOR). In many cases, offenders remain on a registry long after they have completed all aspects of their sentences (incarceration, parole, or probation), which allows for a measure of monitoring over an extended period. However, as noted elsewhere in this report, sexual offender registries are not without their critics. Of some concern is the way in which certain offenders are placed on the SOR and for how long.

Discussions with Probation staff raised concerns about how persons are placed on the registry and for how long. In one example, a PO noted that an offender who had sexually assaulted two of his children was allowed to plead down to a non-sexual offense (at least by statute), which allowed him to escape registration entirely. Conversely, a man (18) who had had sexual relations with a 14 year old "girlfriend" – apparently with the knowledge of her parents – will be maintained on the registry for 10 years. This caused the PO to question the logic involved in this process.

At present, CT uses an offense-based process to set registration terms – 10 years or lifetime; although proposals are being made to revise the SOR. Central to the draft proposal provided to

me is a recommendation that offenders be differentially placed on either a law enforcement registry (not available to the public – LESOR) or a publicly accessible registry (PSOR). If implemented, low and moderate offenders could potentially be placed on the LESOR (10 and 20 years, respectively) while high-risk offenders would be maintained for life on the public registry. These decisions would be reached by a Sexual Offender Registration Committee comprised of experts that would be independent but within the Board of Pardons and Parole. Although decisions to place an offender on the LESOR would not be subject to appeal, offenders on the PSOR could petition the court to be transferred to the LESOR after five years, while offenders on the LESOR could petition for removal after 5/10 years or 10/20 years. No direct removal from the PSOR would be possible without first being transferred to the LESOR. There are also proposed provisions for retroactive changes to offenders currently registered.

Overall, the proposed changes to the CT-SOR appear quite reasonable and in keeping with RNR prescriptions. They allow for monitoring and management of individuals who have engaged in sexual violence, but they also provide mechanisms for offenders who have rehabilitated themselves to regain some measure of self-determination in the community. However, as they stand, the proposed improvements do not appear to operationally define such key concepts as (1) criminal offenses against a victim who is a minor, (2) nonviolent sexual offenses, and (3) sexual violent offenses. Although there may be a degree of correlation between these three designations and risk to reoffend, it is likely that exceptions to the rules would be more common than anticipated.

In a recent paper, Levenson et al. (2016) made the following recommendations regarding sexual offender management policy:

- Juveniles should not be subject to sexual offender registration
- Registration durations should be guided by risk assessment research
- Procedures for relief and removal from registries should be available
- Discretion should be returned to judges
- Residence restrictions should be abolished

By and large, the recommendations made by Levenson et al. (2016) are in line with the proposals currently under consideration by the CT Sentencing Commission.

SUMMARY & RECOMMENDATIONS

For a state with a small geographic footprint, Connecticut has contributed greatly to the field of sexual violence prevention. There are best practice models evident in the work done in this state. However, as is the case with any jurisdiction, there is room for improvement. In the preceding, I have provided a review of the literature regarding assessment, treatment, and risk management and have highlighted those areas that have contributed most to our collective leaps forward in reducing harm in the community while ensuring opportunities for motivated offenders to reclaim their lives through self-reflection and treatment interventions.

There is now incontrovertible evidence that human service opportunities for offenders can and do reduce rates of reoffending more than punishment alone (see Aos et al., 2005; Lipsey & Cullen, 2007; Smith et al., 2002); however, those endeavors must adhere to certain well-described principles. Those principles are Risk, Need, and Responsivity – as defined by Bonta and Andrews (2016). Indeed, the literature is clear that the more treatment interventions adhere to these principles, the more likely they are to incrementally decrease recidivism and increase offender reintegration potential. Although Bonta and Andrews developed their model using general criminal offenders, Hanson and associates (2009) have shown clearly that these principles also apply to persons who have sexually offended.

The risk principle decrees that interventions should be at the same intensity level as the assessed level of risk: high to high, moderate to moderate, and low to low. Mismatching these two variables potentially leads to difficulties; not only when we under-intervene with high-risk offenders, but also when we over-intervene with lower risk offenders. This latter aspect is often overlooked in offender risk management. As a field, we seem content to apply stringent measures to sexual offenders, in spite of years of research showing that their reintegration potential is generally high and that their risk for reoffending is generally low. The tendency to over-supervise lower risk offenders is often reflected in a high violation to reoffense ratio. Some might argue that violations are actually prevention based on near-misses; however, this is not borne out when looks at differential rates of VOP usage across the country and internationally.

The need and responsivity principles govern the nuts and bolts of treatment provision. Following an assessment of risk to reoffend, it is important to specifically focus on those criminogenic need areas that led the offender into trouble in the first place. In this, we want to ensure that programming attends to the individualized presentation of the offender, even though

many sexual offenders will attend group therapy with others who may not share the totality of their need profile. The individual elements are often addressed through ancillary program participation (e.g., cognitive problem-solving programs, alcohol and substance abuse treatment, or sexual arousal management modules, among others). It is true to say that not all offenders share the same needs profile, and the onus is on treatment providers and clients to collaboratively craft a treatment plan that appropriately accounts for the issues experienced by the client. Which brings us to the responsivity principle. This is, by far, the most difficult of the RNR principles to manage appropriately. The responsivity principle requires that we consider the client as a person who brings both strengths and weaknesses to the table and we must develop interventions that account for issues such as learning style, motivation, and cultural concerns. While many programs seem to do well in addressing risk and need, they tend to fall down when it comes to specialized programming options for special clients. Issues of intellectual and cognitive disabilities, serious mental illness, entrenched antisocial values and attitudes, and other variables that would serve to diminish potential for treatment success must be considered if we truly want all clients to do well.

Overall, the principles and practices demonstrated in the Connecticut approach to assessment, treatment, and risk management of sexual offenders are in generally in line with what we would expect to see in a state with CT's pedigree. With the exception of a tendency to hold clients in treatment longer than likely required, the risk and need principles are more than adequately covered regarding treatment provision. However, as suggested above, CT falls prey to many of the same difficulties noted in other jurisdictions regarding ensuring responsivity. In both institutional and community-based programming, there is a clear understanding that responsivity is important – as indicated in program manuals and materials, but there are clear issues in implementation. Furthermore, there appears to be problems in regard to institutional to community continuity of care for offenders in treatment, fueled possibly by animosity between providers.

In regard to community supervision, there are two agencies involved – Department of Corrections and Probation, but only one treatment provider. There are also opportunities for representation of other important stakeholder groups, and CT's inclusion of victim services in the community supervision process likely represents something of a best practice. The guidelines for supervising sexual offenders are similar to those found in other jurisdictions. In CT, there is a

tendency to shift sexual offenders to higher levels of treatment supervision, seemingly just because they are sexual offenders. Community-based classification of sexual offenders on probation seems to have no true "low risk" classification, in spite of credible evidence to support a perspective that reoffense rates are low and that reintegration potential is high. Accordingly, this is apparently reflected in a relatively high rate of violations of community release. Bonta and Andrews (2016) are clear in recommending that, where feasible, treatment interventions for offenders are best accomplished in the community where there are opportunities for practice and feedback readily available in real-world circumstances. Research has shown that a combination of evidence-based supervision and treatment following RNR prescriptions can incrementally reduce reoffending in the community for sexual offenders (Wilson et al., 2000; 2009).

Beyond supervision and treatment in the community, all sexual offenders are subject to registration for either 10 years or life. At present, the CT system for determining placement on the law enforcement or publicly accessible registries is determined by offense parameters and not by level of risk to reoffend. Although this is not actually particularly uncommon, such a scheme fails to appreciate that many offenders who engage in offenses with relatively low levels of violence or overt victim harm may be at considerable risk to reoffend. Similarly, some offenders who engage in offenses that include levels of violence may not be at particularly high risk to reoffend. Levenson and associates (2016) have called for reforms to sex offender registration policies that include eliminating sexual offender registration for juveniles, risk-based procedures for determining level and duration of registration, opportunities for offenders to be removed from registries, a return of discretion to judges, and the abolition of residence restrictions.

The following recommendations are made to assist Connecticut in maintaining best practices already in place and to ensure greater achievements in areas in need of attention:

1. Assessment procedures for sexual offenders in Connecticut are generally in line with expectations according to research findings. However, use of dynamic risk scales (e.g., *SOTIPS*) to enhance ratings based on static risk scales (e.g., *Static-99R, Static-2002R*) is not practiced in all locales. Specifically, although use of *SOTIPS* in institutional settings is being contemplated, use of this scale has not yet been implemented. Of particular benefit to treatment providers, the *SOTIPS* provides a measure of in-treatment change.

2. I have little doubt that treatment providers in Connecticut are dedicated professionals who care greatly about the welfare and success of their clients. However, not all providers appear fully knowledgeable about current treatment methods. This is also reflected in inconsistent documentation regarding what is supposed to happen in treatment.
    a. The Department of Corrections is encouraged to review current sexual offender treatment practices and consider developing a more extensive treatment manual that also includes documentation of program adjustments for special needs offenders and others with treatment interfering factors and other barriers to success.
    b. At present, CTPSB is undergoing significant changes to its treatment program, including updating modules to include aspects of Good Lives and self-regulation theories, motivational interviewing techniques, and increased focus on trauma in clients as a responsivity concern. CTPSB is encouraged to ensure that these updates are incorporated into a comprehensive program description and treatment goals document.
3. Psychiatric services are difficult to acquire in forensic mental health settings. That said, a concerted effort should be undertaken to ensure that all sites providing sexual offender treatment have adequate psychiatric coverage.
4. Sentencing practices in Connecticut seem biased against probation for sexual offenders on the lower end of the risk continuum, potentially through offense-based sentencing schemes and the imposition of mandatory minimum sentencing. Bonta and Andrews (2016) are clear that, where feasible, treatment interventions are best offered in community settings. It is likely that many sexual offenders who could be managed directly on community supervision are being sent to prison. While this may be beyond the purview of this review, there is merit in Levenson et al.'s recommendation that discretion be returned to judges and that decisions regarding both sentencing and registration be made based on risk and not on potentially arbitrary classification schemes. Otherwise, it appears that at least some incarcerated sexual offenders have limited opportunities for early release, which could also serve to maintain some lower risk offender in prison for longer than necessary in keeping with RNR prescriptions.

5. While Connecticut states on paper that it adheres to the prescriptions of the Risk-Need-Responsivity model, there are issues in need of attention:
    a. Use of a low, moderate, and high risk framework requires use of terminology that is not norm-referenced (see Hanson et al, 2016a; Hanson et al., 2017). Currently, there are efforts to reframe risk levels according to distributions observed in the offender population. Recommended specifiers on a 5-point scale would include I – very low risk, II – below average risk, III – average risk, IV – above average risk, and V – well above average risk.
    b. Interventions for offenders at the lower end of the risk continuum should reflect their risk and need status. The temptation to view all sexual offenders as being at elevated risk simply as a byproduct of abhorrence of the details of their offenses leads to both over-supervision and over-treatment, as evidenced in higher VOP rates in CT relative to other jurisdictions and a tendency to maintain offenders in treatment for longer periods than is likely necessary.
    c. Treatment offered in both institutional and community settings is not sufficiently responsive to the special characteristics that may inherent in some offenders (e.g., intellectual disabilities, mental health concerns, other treatment interfering factors and potential barriers to treatment success). Treatment personnel are strongly encouraged to monitor the progress of clients in treatment, being specifically mindful of those clients who appear to be falling through the cracks. Special needs clients require a higher degree of scrutiny in order to ensure that they receive services that are appropriately responsive to their individualized needs.
6. Further to 5b., VOP rates in CT appear to be relatively high in comparison to other jurisdictions and some probation staff have opined that, in some instances, a return to custody is not always because of an increased risk for reoffense; rather, many returns to custody occur as a matter of technical violation. Probation and parole officers are encouraged to consider other possibilities in managing VOPs, including consultation with members of the multidisciplinary team (e.g., treatment providers, probation/parole management, CT Alliance to End Sexual Violence).
7. Treatment in the Department of Corrections allows for short-term or introductory group interventions for lower risk offenders and more involved programming for those

demonstrating higher treatment needs. However, it would appear that the short-term or other introductory group options are not always the terminal option for lower risk offenders, with many such offenders entering institutionally based treatment that may exceed their actual needs.

8. Staffing for sexual offender treatment programming appears inadequate in institutional settings. Treatment staff reported that not all incarcerated offenders are able to start and finish treatment before their end of sentence date and that many offenders are admitted to treatment based more on how soon they are likely to be released than how much they actually need the program.
9. Just as treatment for offenders in institutional settings appears to exceed requirements according to risk and need, the same appears to be the case for community-based treatment services. Although frameworks exist for short-term interventions for lower risk offenders, it appears they are under-utilized. Discussions with both probation officers and a community-based treatment client suggest that many clients may be held in treatment beyond what is required according to risk and need prescriptions.
10. Evidence-based assessment, treatment, and risk management of women who sexually offend is in its relative infancy in comparison to male sexual offenders. Cortoni et al. (2017) assert that women who sexually offend are different from their male counterparts and that they require different processes in risk management. Both institutional and community-based personnel are encouraged to remain abreast of the developing knowledge base in this regard.
11. Polygraph evaluations are utilized in community-based treatment, which is common across the United States. However, it would appear that these evaluations are often required at an early stage in treatment when participants are arguably more likely to be in precontemplative or contemplative stages of change. As such, an adversarial dynamic may result simply because clients have not established sufficient treatment readiness to appreciate the value of disclosure. Also, given the increasing number of clients being released from prison without institutional treatment experience, this is likely to be exacerbated. It is recommended that consideration be given to conducting polygraph examinations towards the end of Phase I or, better still, early in Phase II.

12. Collaboration between the various government bodies and contracted agencies does not appear to be functioning optimally. At present, there appears to be a significant disconnect between institutional (UCHC) and community-based (CTPSB) treatment providers. I would not want to speculate as to the reasons for or the nature of the apparently acrimonious relationship between these two groups, but the current state of affairs does nothing to ensure continuity of treatment for offenders or to promote public safety for Connecticut. These fences must be mended.
13. As noted in 12, there are currently two providers – one institutional and one community-based. Questions have arisen as to whether it might be better to have one service provider across the board. Unless the two parties are able to resolve their differences, this may be an avenue to ensure continuity of care, both in terms of fidelity to a particular model of treatment and ensuring that offenders receiving institutional treatment services are adequately prepared for community aftercare.
14. Otherwise, collaboration between community-based groups appears to be functioning relatively well. Of particular interest is the inclusion of victim services in the multidisciplinary case management team. I have stated elsewhere in this report that I view this as a best practice element; however, some personnel interviewed expressed concerns that victim interests sometimes take precedence over community reintegration interests for offenders. While it is certainly not my intention to diminish the concerns felt by victims when offenders return to the community, it is not always possible to honor requests made by victims that are contraindicated by offender case management concerns. In the end, the probation or parole officer must be the final authority.
15. Probation staff noted during this evaluation that homelessness has dropped considerably with increased access to agency housing in CT; specifically accommodations through REACH and Chrysalis. Across the country, homelessness for released sexual offenders remains an area of considerable concern. Some of this is due to residence restrictions. In keeping with Levenson et al. (2016), I would advocate for either the abolition of residence restrictions or a risk-based framework governing where certain offenders are permitted to reside. Otherwise, continued partnership with community-based housing providers will decrease the amount of community destabilization felt by some returning offenders solely as a result of few options for housing.

16. Currently, placement on the sexual offender registry is determined by type and circumstances of offense. Offenders may be placed on a publicly accessible registry (PSOR) for 10 years or life, or on a law enforcement only registry (LESOR). It would appear that use of the LESOR is rare. A draft of proposed improvements to Connecticut's sexual offender registry was provided as part of this evaluation. The prospective changes included in that document make a lot of sense and are in line with recommendations by researchers (Levenson et al., 2016). Of particular benefit would be the migration from offense-based registration to risk-based registration.
17. Further concerning registration, greater use of the LESOR is recommended over use of the PSOR. Additionally, proposals to allow certain offenders to petition for relief or removal from the registry according to specified criteria is an important element to consider.

CLOSING REMARKS

In closing, it has been my great pleasure to provide this review and evaluation regarding the assessment, treatment, and risk management of persons who have sexually offended in Connecticut. I hope that the comments and recommendations included herein will be of value to the Sentencing Commission as deliberations continue towards greater emphasis of evidence-based policy and procedure and engagement in best practices. I remain available for further consultation regarding these matters and this report.

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06/22/2017

APPENDIX A – DOCUMENTS REVIEWED

CT DOC, Policy #3.2, Special Management Unit, dated 05/08/2008

CT Court Support Services Division, Policy # 4.18, Adult Services Sex Offender Supervision, dated 10/01/2014

CT Board of Pardons and Paroles, rev. 04/21/2016

CT DOC, Policy #8.13, Sex Offender Programs, dated 10/31/2007

The Connection, Response to CSSD Request for Proposal #3503, Adult Sex Offender Services Statewide, Organization and Experience, received 3/23/2015

The Connection, Response to CSSD Request for Proposal #3503 Adult Sex Offender Services Statewide, Budget/Financial, received 3/23/2015

The Connection, Response to CSSD Request for Proposal #3503 Adult Sex Offender Services Statewide, Program Narrative, received 3/23/2015

CT DOC, Notification of Hearing for Sexual Treatment Need Score Based on Non-Conviction Information, Rev. 01/13/2012

CT DOC, Hearing for Sexual Treatment Need Score Based on Non-Conviction Information, Rev. 01/13/2012

CT DOC, Health Services Sex Offender Program, Dated 12/29/2015

CT DOC, Classification Manual, dated 2012

CT Superior Court, Court Support Services Division, rev. 01/2007

CT Superior Court, Court Support Services Division – Adult Probation, rev. 10/2010

The Connection, Community-based Services, Advocacy and Research for Connecticut, Sexual Offender Risk Assessment and Intake Recommendations, rev. 4/12/2016

The Connection, Inc., Phases of Treatment, undated

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program, Policy #G 4.07, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program: Orientation, Policy #G 4.07a, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Track 1 – Intake Process, Policy #G 4.07b, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Track 1 – Group Programming, Policy #G 4.07c, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Track 2 , Policy #G 4.07d, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Special Populations, Policy #G 4.07e, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Deniers Group Programming, Policy #G 4.07f, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Use of Pharmacological Agents, Policy #G 4.07g, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Release to Community, Policy #G 4.07h, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Risk Instruments, Policy #G 4.07i, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Classification Risk Scores, Policy #G 4.07j, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Referrals, Policy #G 4.07k, Effective Date: 05/01/2002

CT DOC, University of Connecticut Health Center, Correctional Managed Health Care, Policy and Procedures, Multidisciplinary Treatment Program Description: Sex Offender Program (SOP): Staff Credentials and Training, Policy #G 4.07l, Effective Date: 05/01/2002

Statement of Understanding and Agreement Conditions of Interstate Parole, undated

Journal Client Information, Version 1.1, dated 04/15/2013

Due Process for Problem Sexual Behavior Not Supported by Conviction, dated 12/16/2011

CT Board of Pardons & Paroles, Notice of Hearing, undated

Parole and Community Services, Computer Access Agreement, PCS 3202, rev. 4/22/2009

Procedures for Inmates That Receive a Sexual Treatment Need Score Greater Than One (1) Based On Non-Conviction Information, rev. 03/25/2011

State of CT, Superior Court, Court Support Services Division, Sex Offender Conditions of Probation, rev. 3/2016

CT DOC, Parole and Community Services Division, Sex Offender Supervision Model, undated

The Connection, Treat Goals and Discharge Criteria, dated 6/2016

The Connection, CTPSB Community Intake Information and Roster Sheet, rev. 3/2017

The Connection, CTPSB Denial Policy and Procedure, dated 9/02/2010

CTPSB Phase One Workbook, Version 1.3: 8/2006

CTPSB Phase One Workbook – Table of Contents – New, revised 11/2016

UCHC, Sex Offender Program, Treatment Goals: Criteria for Success in Treatment, undated

Sex Offender Treatment Program Summary 2017, undated

6. Sex Treatment Need (S), undated

CT-DOC, Objective Classification Manual, Section III – Initial Classification Procedures, rev. 4/12

APPENDIX B – PERSONS CONSULTED

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REFERENCES

Alhmeyer, S., Heil, P., McKee, B., & English, K. (2000). The impact of polygraphy on admissions of victims and offenses in adult sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 12,* 123-138.

Andrews, D.A. (1982). The Level of Supervision Inventory (LSI): The first follow-up. Toronto: Ontario Ministry of Correctional Services.

Andrews, D.A. & Bonta, J. (1994). *The psychology of criminal conduct*. Cincinnati, OH: Anderson.

Andrews, D. A., & Bonta, J. (1995). The Level of Service Inventory–Revised. Toronto, Ontario, Canada: Multi-Health Systems.

Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based adult corrections programs: What works and what does not.* Olympia, WA: Washington State Institute for Public Policy.

Barrett, M., Wilson, R.J., & Long, C. (2003). Measuring motivation to change in sexual offenders from institutional intake to community treatment. *Sexual Abuse: A Journal of Research and Treatment*, *15*, 269-283.

Blasingame, G.D., Boer, D.P., Guidry, L., Haaven, J., & Wilson, R.J. (2014). A*ssessment, treatment, and supervision of individuals with intellectual disabilities and problematic sexual behaviors: Informational packet.* [Education & Training Committee Report] Beaverton, OR: Association for the Treatment of Sexual Abusers.

Brankley, A.E., Helmus, L.M., & Hanson, R.K. (2017). Stable-2007 Evaluator Workbook: Revised 2017. Ottawa, ON: Public Safety Canada.

Bonta, J. & Andrews, D. A. (2016). *The psychology of criminal conduct* (6th ed.). Cincinnati, OH: Anderson.

Cortoni, F., Babchishin, K.M., & Rat, C. (2017). The proportion of sexual offenders who are female is higher than thought: A meta-analysis. *Criminal Justice and Behavior, 44,* 145–162.

Cullen, M. & Wilson, R.J. (2003). *TRY – Treatment readiness for you: A workbook for sexual offenders*. Lanham, MD: American Corrections Association.

de Vogel, V., de Ruiter, C., Bouman, Y., & de Vries Robbe, M. (2009). *SAPROF. Guidelines for the assessment of protective factors for violence risk*. Utrecht, The Netherlands: Forum Educatief.

de Vogel, V., de Ruiter, C., Bouman, Y., & de Vries Robbe, M. (2012). *SAPROF. Guidelines for the assessment of protective factors for violence risk* (2nd ed.). Utrecht, The Netherlands: Forum Educatief.

DiClemente, C.C. & Prochaska, J.O. (1998). Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviors. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Applied clinical psychology* (2nd ed., pp. 3-24). New York: Springer.

English, K., Pullen, S., & Jones, L. (1998). The containment approach: An aggressive strategy for community management of adult sex offenders. *Psychology, Public Policy, and Law, 4*(1/2).

Finkelhor, D. (1984). *Child sexual abuse: New theory & research.* New York: Free Press.

Finkelhor, D. & Jones, L. (2006). Why have child maltreatment and child victimization declined? *Journal of Social Issues, 62,* 685-716.

Furby, L., Weinrott, M. R., & Blackshaw, L. (1989). Sex offender recidivism: A review. *Psychological Bulletin, 105,* 3-30.

Grubin, D. (1998). *Sex offending against children: Understanding the risk.* Police Research Series Paper 99. London: Home office.

Hanson, R. K. (1997). *The development of a brief actuarial risk scale for sexual offense recidivism* (User Report 1997-04). Ottawa, ON: Department of the Solicitor General of Canada.

Hanson, R. K., Babchishin, K. M., Helmus, L. M., Thornton, D., & Phenix, A. (2016a). Communicating the results of criterion-referenced prediction measures: Risk categories for the Static-99R and Static-2002R sexual offender risk assessment tools. *Psychological Assessment*. Advance online publication.

Hanson, R. K., Bourgon, G., Helmus, L. and Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior,* 36(9), 865–891.

Hanson, R.K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). *A meta-analysis of the effectiveness of treatment for sexual offenders: Risk, need, and responsivity*. Research Report No. 2009-01. Ottawa: Corrections Research, Public Safety Canada.

Hanson, R.K., Bourgon, G., McGrath, R.J., Kroner, D., D'Amora, D.A., Thomas, S.S., & Tavarez, L.P. (2017). *A five-level risk and needs system: Maximizing assessment results in corrections through the development of a common language.* New York: Council of State Governments Justice Center.

Hanson, R. K., & Bussière, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66,* 348-362.

Hanson, R.K., Gordon, A., Harris, A.J.R., Marques, J.K., Murphy, W., Quinsey, V.L., & Seto, M.C. (2002). First report of the Collaborative Outcome Data Project on the effectiveness of psychological treatment for sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 14,* 169-194.

Hanson, R. K., Harris, A. J. R., Helmus, L. and Thornton, D. (2014). High-risk sex offenders may not be high risk forever. *Journal of Interpersonal Violence, 29,* 2792–2813.

Hanson, R. K., Harris, A. J. R., Scott, T. L. and Helmus, L. (2007). *Assessing the risk of sex offenders on community supervision: The Dynamic Supervision Project* (User Report 2007–05). Ottawa, ON: Public Safety Canada.

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. J*ournal of Consulting and Clinical Psychology, 73,* 1154–1163.

Hanson, R. K., & Thornton, D. (2000). Improving risk assessments for sex offenders: A comparison of three actuarial scales. *Law and Human Behavior, 24,* 119-136.

Hanson, R. K., Thornton, D., Helmus, L., & Babchishin, K. M. (2016b). What sexual recidivism rates are associated with Static-99R and Static-2002R scores? *Sexual Abuse: A Journal of Research and Treatment, 28,* 218-252.

Hanson, R.K. & Yates, P.M. (2013). Psychological treatment of sex offenders. *Current Psychiatry Reports, 15*: 348.

Helmus, L., Thornton, D., Hanson, R. K., & Babchishin, K. M. (2012). Improving the predictive accuracy of STATIC-99 and STATIC-2002 with older sex offenders: Revised age weights. *Sexual Abuse: A Journal of Research and Treatment, 24,* 64-101.

Kuzyk, I. (2012). *Recidivism among sex offenders in Connecticut.* Hartford, CT: Criminal Justice Policy and Planning Division, State Office of Policy and Management.

Kuzyk, I. (2017, May). *Notes on OPM's 2017 sex offenders recidivism study.* Presentation to the CT Sentencing Commission, May 25, 2017.

Långström, N., Enebrink, P., Laurén, E.-M., Lindblom, J., Werkö, S., & Hanson, R. K. (2013). Preventing sexual abusers of children from reoffending: Systematic review of medical and psychological interventions. *BMJ: British Medical Journal,* 347–358.

Laws, D.R. (1989). *Relapse Prevention Procedures with Sexual Offenders*. New York, NY: Guilford.

Laws, D.R., Hudson, S.M., & Ward, T. (2000). *Remaking relapse prevention with sex offenders.* Thousand Oaks: Sage Publishing.

Laws, D.R., & Marshall, W.L. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offenders: Part 1. Early developments. *Sexual Abuse: A Journal of Research and Treatment, 15,* 75-92.

Levenson, J.S., Grady, M.D., & Leibowitz, G. (2016). Grand challenges: Social justice and the need for evidence-based sex offender registry reform. *Journal of Sociology & Social Welfare, 43,* 3-38.

Levenson, J.S. & Prescott, D.S. (2013). Déjà vu: from Furby to Långström and the evaluation of sex offender treatment effectiveness. *Journal of Sexual Aggression,* 1-10.

Levenson, J.S. & Shields, R.T. (2012). *Sex offender risk and recidivism in Florida.* Washington, DC: National Institute of Justice.

Letourneau, E.J. & Caldwell, M.F. (2013). Expensive, harmful policies that don't work or how juvenile sexual offending is addressed in the U.S. *International Journal of Behavioral Consultation and Therapy, 8,* 23-29.

Lipsey, M. W., & Cullen, F. T. (2007). The effectiveness of correctional rehabilitation: A review of systematic reviews. *Annual Review of Law and Social Science, 3,* 297-320.

London, K., Bruck, M., Ceci, S.J., & Shuman, D.W. (2005). Disclosure of child sexual abuse: What does the research tell us about the ways that children tell? *Psychology, Public Policy, and Law, 11,* 194-226.

Looman, J., Abracen, J., Serin, R., & Marquis, P. (2005). Psychopathy, treatment change, and recidivism in high-risk, high-need sexual offenders. *Journal of Interpersonal Violence, 20,* 549-568.

Mailloux, D.L., Abracen, J., Serin, R., Cousineau, C., Malcolm, B., & Looman, J. (2003). Dosage of treatment to sexual offenders: Are we overprescribing? *International Journal of Offender Therapy and Comparative Criminology, 47,* 171-184.

Mann, R.E., Hanson, R.K., & Thornton, D. (2010).Assessing risk for sexual recidivism: Some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: A Journal of Research and Treatment, 22, 22,* 191-217.

Marques, J.K., Wiederanders, M., Day, D.M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California‘s Sex Offender Treatment and Evaluation Project (SOTEP). *Sexual Abuse: A Journal of Research and Treatment, 17,* 79-107.

Marshall, L.E., Marshall, W., Fernandez, Y., Malcolm, P., & Moulden, H. (2008). The Rockwood Preparatory Programme for Sexual Offenders: Description and preliminary appraisal. *Sexual Abuse, 20,* 25-42.

Marshall, W.L., & Laws, D.R. (2003). A brief history of behavioral and cognitive behavioral approaches to sexual offender treatment: Part 2. The modern era. *Sexual Abuse: A Journal of Research and Treatment, 15,* 93-120.

Marshall, W. L., Marshall, L. E., Serran, G. A. and O’Brien (2011). *Rehabilitating sexual offenders: A strength-based approach*. Washington, DC: American Psychological Association.

Martinson, R. (1974). Nothing works: Questions and answers about prison reform. *The Public Interest, 35,* 22-54.

Martinson, R. (1979). New findings, new views: A note of caution regarding sentencing reform. *Hofstra Law Review, 7,* 242-258.

McGrath, R.J., Cumming, G.F., Burchard, B.L., Zeoli, S., & Ellerby, L. (2010). *Current practices and emerging trends in sexual abuser management: The Safer Society 2009 North American survey*. Brandon, VT: Safer Society Press.

McGrath, R.J., Cumming, G.F., Hoke, S.E., & Bonn-Miller, M.O. (2007). Outcomes in a community sex offender treatment program: A comparison between polygraphed offenders and matched non-polygraphed offenders. *Sexual Abuse, 19,* 381-393.

McGrath, R.J., Cumming, G.F., & Lasher, M.P. (2013). *SOTIPS: Sex offender treatment intervention and progress scale manual*. Middlebury, VT: Author.

McGrath, R.J., Hoke, S.E., & Vojtisek, J.E. (1998). Cognitive-behavioral treatment of sex offenders: A treatment comparison and long-term follow-up study. *Criminal Justice and Behavior, 25*, 203-225.

Meehl, P. E. (1954/1996). *Clinical vs. statistical prediction: A theoretical analysis and a review of the evidence*. Minneapolis, MN: University of Minnesota Press.

Meijer, E.H., Verschuere, B., Merckelbach, H.L., & Crombez, G., (2008). Sex offender management using the polygraph: a critical review. *International Journal of Law and Psychiatry, 31,* 423-429.

Monahan, J. (1981). *The clinical prediction of violent behavior*. Originally published by National Institute of Mental Health. Reprinted as *Predicting violent behavior: An assessment of clinical techniques* by Sage Publications, also 1981.

Monahan, J. (2008). Structured risk assessment of violence. In R. Simon & K. Tardiff (Eds.), *Textbook of violence assessment and management* (pp. 17– 34). Washington, DC: American Psychiatric Publishing.

Olver, M. E., Wong, S. C., Nicholaichuk, T., & Gordon, A. (2007). The validity and reliability of the Violence Risk Scale-Sexual Offender version: Assessing sex offender risk and evaluating therapeutic change. *Psychological Assessment, 19,* 318 –329.

Phenix, A., Fernandez, Y., Harris, A.J.R., Helmus, M., Hanson, R.K., & Thornton, D. (2016). *Static-99R Coding Rules, Revised 2016.* Ottawa, ON: Public Safety Canada.

Prendergast, W. (2004). *Treating sex offenders: A guide to clinical practice with adults, clerics, children, and adolescents.* New York: Haworth.

Prescott, D.S. & Wilson, R.J. (2013). *Awakening motivation for difficult changes.* Holyoke, MA: NEARI Press.

Quinsey, V.L., Harris, G.T., Rice, M.E., & Cormier, C.A. (2015). *Violent offenders: Appraising and managing risk, 3rd Ed.*. Washington, DC: American Psychological Association.

Salekin, R. T. (2002). Psychopathy and therapeutic pessimism: Clinical lore or clinical reality? *Clinical Psychology Review, 22,* 79-112.

Schmucker, M. & Lösel, F. (2015). The effects of sexual offender treatment on recidivism: An international meta-analysis of sound quality evaluations. *Journal of Experimental Criminology, 11,* 597-630.

Seto, M.C., & Barbaree, H.E. (1999). Psychopathy, treatment behavior, and sex offender recidivism. *Journal of Interpersonal Violence*, *14*, 1235-1248.

Smith, P., Goggin, C., & Gendreau, P. (2002). *The effects of prison sentences and intermediate sanctions on recidivism: General effects and individual differences.* (User Report 2002-01). Ottawa, ON: Solicitor General Canada.

SOCCPN (2014). *2014 Annual Survey of Civil Commitment Programs.* Sexual Offender Civil Commitment Programs Network. Retrieved from http://www.soccpn.org/resources.html

Steen, C. (2006). *Choices: A relapse prevention workbook for female offenders.* Brandon, VT: Safer Society.

Stirpe, T., Wilson, R.J., & Long, C. (2001). Goal attainment scaling with sexual offenders: A measure of clinical impact at post treatment and at community follow-up. *Sexual Abuse: A Journal of Research and Treatment*, *13*, 65-77.

Thornton, D. (2002). Constructing and testing a framework for dynamic risk assessment. *Sexual Abuse: A Journal of Research and Treatment, 14,* 139–153.

van den Berg, J.W., Smid, W., Schepers, K., Wever, E., Van Beek, D., Janssen, E., & Gijs, L. (2017). The predictive properties of dynamic sex offender risk assessment instruments: A meta-analysis. *Psychological Assessment.* Manuscript available online first.

Willis, G. M. & Grace, R. C. (2008). The quality of community reintegration planning for child molesters: Effects on sexual recidivism. *Sexual Abuse: A Journal of Research and Treatment*, *20*, 218–240.

Willis, G.M. & Grace, R.C. (2009). Assessment of community reintegration planning for sex offenders: Poor planning predicts recidivism. *Criminal Justice and Behavior*, *36*, 494–512.

Wilson, R.J. (2009). Treatment readiness and comprehensive treatment programming: How do we ensure preparation for and commitment to change in persons who have sexually offended? In D.S. Prescott (Ed.), *Building motivation to change in sexual offenders.* Brandon, VT: Safer Society Press.

Wilson, R.J. & Burns, M. (2011). *Intellectual disability and problems in sexual behaviour: Assessment, treatment, and promotion of healthy sexuality.* Holyoke, MA: NEARI press.

Wilson, R.J., Cortoni, F., Picheca, J.E., Stirpe, T.S., & Nunes, K. (2009). *Community-based sexual offender maintenance treatment programming: An evaluation.* [Research Report R-188] Ottawa, ON: Correctional Service of Canada.

Wilson, R.J. & McWhinnie, A.J. (2013). Putting the "community" back in community risk management of persons who have sexually abused. *International Journal of Behavioral Consultation and Therapy, 8*, 79-87.

Wilson, R.J. & Prescott, D.S. (2014). Community-based risk management of sexual offender risk: Options and opportunities. In K. McCartan (Ed.), *Sexual offending: Perceptions, risks and responses.* Basingstoke, UK: Palgrave-MacMillan.

Wilson, R.J., Prescott, D.S., & Burns, M. (2014). People with special needs and sexual behaviour problems: Balancing community and client interests while ensuring effective risk management. In K. McCartan & H. Kemshall (Eds., Special Issue), Sex offender (re)integration into the community: Realities and challenges, *Journal of Sexual Aggression, 21,* 86-99.

Wilson, R.J., Stewart, L., Stirpe, T., Barrett, M., & Cripps, J.E. (2000). Community-based sex offender management: Combining parole supervision and treatment to reduce recidivism. *Canadian Journal of Criminology, 42*, 177-188.

Wood, J., & Kemshall, H. (2007). *The operation and experience of Multi-Agency Public Protection Arrangements (MAPPA).* London, UK: Home Office.

Yates, P. M., Prescott, D. S., & Ward, T. (2010). *Applying the good lives and self-regulation models to sex offender treatment: A practical guide for clinicians*. Brandon, VT: Safer Society.