



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

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By Robin J. Wilson, Ph.D., ABPP
McMaster University, Hamilton, ON, Canada
Wilson Psychological Services LLC, Sarasota, FL, USA

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.

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.

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 Subjective techniques have been replaced by objective approaches highlighting empiricism and evidence-based practices.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., 2016 a, 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-analyses¹ (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

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

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) and the *VRS:SO* (Olver et al., 2007) appear to show promise as effective measures of in-treatment change.

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 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 metaanalyses 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 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,

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.

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 underprediction).

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 AUC³ = .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 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

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.

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), 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.

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 re-offense 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 reinvolved 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.

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 & MortonBourgon, 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.

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., re-offense), 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.

Sexual Offender Registration

Across the United States, many jurisdictions maintain 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, most jurisdictions use 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.

SUMMARY & RECOMMENDATIONS

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 re-offense 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.

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, 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 re-offense 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, sexual offenders are subject to registration for determined period of time. Determining placement on the law enforcement or publicly accessible registries may be 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.

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

Tyrone Abrahamian, Chief Probation Officer II

Monica Alvarenga, FCBT

Bill Anselmo, Chief Probation Officer II

Craig Burns, Chief of Psychiatric Services, CT-DOC

Paul Chaplin, CMHC Director of Psychological Services

Laura Condes, CT Alliance to End Sexual Violence

Stephanie Donovan, CTPSB Evaluation Manager

Eric Ellison, Deputy Director

Roberta Filip, Probation Officer for split sentence offenders

Maurice Flowers, Probation Officer II

Kevin Lawrence, CPOI (HTFD)

David Maiga, Director CT-DOC Offender Classification and Population Management

Tracy Miller, Director of Victim Advocacy CT Alliance to End Sexual Violence

Frank Mirto, Department of Correction Parole

Justin Quick, Adult Probation Officer

Gary Roberge, Director

David Rentler, Board of Parole

Dorian Santoemma, Regional Manager Probation

Robert Santoemma, Chief Probation Office II

Steven Tenenbaum, CSW at Osborn CI

Alex Tsarkov, Sentencing Commission

Elizabeth Tugie, Offender Clarification and Population Management

Shane Vincelette, Probation Officer II

David Zemke, CTPSB Program Director

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Shaina Vanek

Acting Director

Robert Brown, Jr.

Deputy Director

Holly Busby

*Division Chief, Community
Services*

Kathryn Green

Project Manager

www.nicic.gov

National Institute of Corrections • 500 First Street, NW • Washington, DC 20534 • 800-995-6423