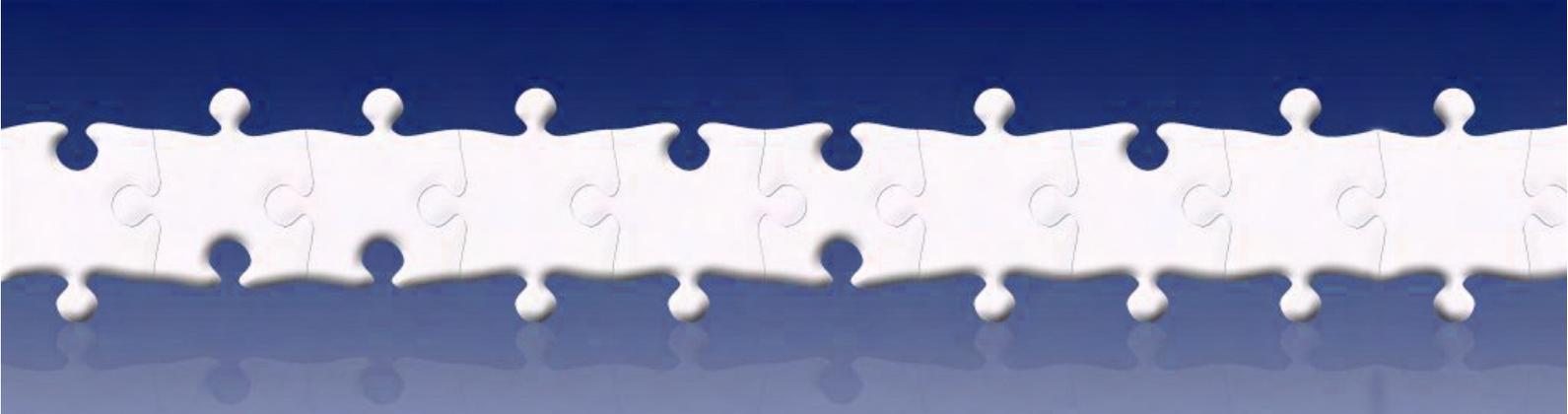


**A Report to the Montana Department of
Corrections on the Establishment of a
Minimum Security Sex Offender
Treatment Facility**



CONFIDENTIAL

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EXECUTIVE SUMMARY

In February 2007, the Montana Legislature passed Senate Bill 547. In addition to modifying criminal penalties for those convicted of sex offenses, expanding registration laws, defining conditions and requirements for sex offender assessments and treatment, and other measures designed to strengthen Montana's management of sex offenders, this Bill allows "the Department of Corrections to contract for a residential sexual offender treatment program."

Senate Bill 547 provides the opportunity to expand the capacity and continuum of treatment services for sex offenders and augment ancillary services for this population. Perhaps most importantly, it creates an opportunity for a systemwide strengthening of sex offender management policies and practices. Indeed, for this facility to be successful – *with success defined as delivering to sex offenders the level and type of interventions that are most likely to result in recidivism reduction* – the broader system of sex offender management must be observed.

Recognizing the unique opportunity Senate Bill 547 offers, the Montana Department of Corrections (DOC) contracted with the Center for Sex Offender Management (CSOM) to provide recommendations for the establishment of this new facility and enhancement of the broader system of sex offender management that are necessary for supporting the success of the facility. The resulting report is comprised of three sections that are designed to provide the DOC with a comprehensive analysis that can assist them in these efforts.

Section I outlines the rationale and scope of work for the consultants, which was not limited by an exclusive focus on the establishment of a minimum security sex offender treatment facility; rather, the consultants also explored critical areas of policy and practice in Montana that will ultimately influence the establishment and successful operation of this facility. Section II addresses four fundamental areas of sex offender management (assessment, treatment, supervision, and reentry). Within each of these areas, a summary of relevant contemporary research and practice, the consultants' understanding and observations regarding policy and practice in Montana, and issues for consideration are included. Section III of the report includes the consultants' suggestions regarding the parameters for defining the minimum security sex offender treatment facility's offender population and programmatic structure, as well as key facility-specific and broader system supports.

The extent to which Montana has embraced promising practices in many areas of sex offender management is particularly noteworthy. Indeed, the overall sex offender management structure currently in place has the potential to contribute significantly to public safety. At the same time, the need to develop a policy-driven approach to sex offender management within the state is evident. The existing structure can be strengthened by the establishment of a multidisciplinary policy-level group whose mission is to oversee and advance sex offender management policy and practice throughout the criminal justice system.

SECTION I: BACKGROUND

REQUEST FOR ASSISTANCE

In February 2007, the Montana Legislature passed Senate Bill 547. In addition to modifying criminal penalties for those convicted of sexual offenses, expanding registration laws, defining conditions and requirements for sex offender assessments and treatment, and other measures designed to strengthen Montana's management of sex offenders, this Bill allows "the Department of Corrections to contract for a residential sexual offender treatment program." Presently, Montana is among a number of states that provides for prison-based sex offender treatment¹. Community-based treatment, common in other localities across the country, is also routinely provided. The establishment of a minimum security sex offender treatment facility under Senate Bill 547 will expand considerably the array of treatment options available for this population. The importance of this cannot be underestimated for two reasons: (1) Research indicates that specialized treatment reduces recidivism among sex offenders, and (2) Montana's incarceration rate of sex offenders is among the highest in the country, thus supporting the need for sufficient capacity for specialized treatment services.²

Recognizing the unique opportunity Senate Bill 547 creates, staff from the Department of Corrections (DOC) contracted with the Center for Sex Offender Management (CSOM)³ to provide recommendations for the establishment of this facility and enhancement of the broader system of sex offender management that are essential for supporting its success. Two CSOM staff members served as the technical advisors under this contract:

- o Dr. Kurt Bumby has worked extensively on the CSOM project for several years. He received his doctoral degree from the Law/Psychology and Clinical Psychology Training Program specialty track at the University of Nebraska, Lincoln. Specializing in the assessment and treatment of sex offenders, Dr. Bumby has worked with adult and juvenile offenders in both state and federal correctional, mental health, and juvenile justice

¹ A study conducted in 2000 by the Colorado Department of Corrections reported that a total of 28 states offered prison-based sex offender treatment program of one year or longer.

² Montana Department of Corrections informal study (2008), Colorado Department of Corrections (2000).

³ Established in June 1997, the Center for Sex Offender Management's (CSOM) goal is to enhance public safety by preventing further victimization through improving the management of adult and juvenile sex offenders who are in the community.

settings. He has published extensively on sex offenders and other forensic topics such as youth violence, child maltreatment, alternative sentencing, judicial education, and prison rape in a variety of professional journals and books. In 1994, he received the Association for the Treatment of Sexual Abusers (ATSA) Graduate Research Award for Research Excellence in the Field of Sex Offender Treatment, and was co-recipient of the Hugo G. Beigel Research Award from the Society for Scientific Study of Sexuality in 1996. Dr. Bumby currently serves on the Executive Board of Directors for ATSA and is a member of the National Advisory Committee for the Safer Society Foundation, Inc.

- o Madeline (Mimi) Carter, M.S. has served as the Director of the Center for Sex Offender Management since its inception in 1997. She is also a Principal of CSOM's parent organization, the Center for Effective Public Policy. Ms. Carter holds a Bachelor of Science and a Master of Science degree in Criminal Justice Administration from the American University in Washington, D.C., and conducted post-graduate work in Organizational Development at Johns Hopkins University. She spent a decade in government working for a local corrections agency in a variety of capacities. She has published widely on critical issues in criminal justice, including sex offender management, collaboration, offender reentry, probation and parole violations, and intermediate sanctions. Ms. Carter is also a member of the National Advisory Committee for the Safer Society Foundation, Inc.

The Montana DOC is to be commended for recognizing both the unique opportunity before them in establishing a minimum security sex offender treatment facility and the challenges associated with such an endeavor. Senate Bill 547 provides an invaluable prospect to expand the capacity and the continuum of treatment services for sex offenders and augment ancillary services for this population. Perhaps most importantly, it creates an important opportunity for a systemwide strengthening of sex offender management policies and practices currently in place within the state. Indeed, for this program to be successful – *with success defined as delivering the level and type of interventions to sex offenders that is most likely to result in a reduction in recidivism following release* – the broader system of management must be examined.

As such, the consultants developed a scope of work such that, in addition to considering key parameters for a minimum security sex offender treatment facility, also provided for reviewing critical areas of policy and practice that will ultimately influence the operation of such a facility. For example, because some broad policy decisions regarding the target population for this facility have already been made (e.g., restricted to Tier I sex offenders and

the potential for some Tier II sex offenders), it was important to understand the specific methods used to assign these tier designations. Likewise, the DOC's stated intent for the facility is to provide intensive sex offender treatment and other necessary services in a minimum security setting. To provide well-informed recommendations in this regard, however, it was essential to understand the range of services currently available within the broader sex offender management system (e.g., capacity and delivery of intensive treatment services at MSP, capacity and delivery of community-based programs) and current contextual dynamics (e.g., negative public sentiment, exclusionary criteria for some pre-release facilities) operating within the system.

SCOPE OF WORK CONDUCTED

Through the contract between CSOM and DOC, the following scope of work was defined and conducted. Over the course of a 90 day period (April to June, 2008) – which included two site visits (April 28 – May 2 and May 26 – May 30, 2008) – the CSOM staff:

- Reviewed existing statistical reports and requested data runs provided by DOC staff, which included, but were not limited to, the following:
 - Offender population/census data for the DOC
 - Documented tier designations for sex offenders at Montana State Prison (MSP) and under supervision in the community
 - Breakdowns of assigned supervision levels for sex offenders
 - Data from the sex offender treatment program at MSP
 - Board of Pardons and Parole (BOPP) appearances and parole approval release trends
 - Release, revocation, and recidivism data;
- Conducted a series of individual and group interviews with representatives from the following agencies and organizations:
 - Montana Department of Corrections
 - Montana Board of Pardons and Parole
 - Montana Sex Offender Treatment Association (MSOTA)
 - Montana Public Defender's Office
 - Cascade County Sheriff's Office;
- Participated in tours and briefings at the following facilities:
 - Montana State Prison
 - Great Falls Pre-Release Center
 - Elkhorn Treatment Center;
- Observed the conduct of sex offender treatment groups at the MSP;
- Conducted focus groups with:
 - The mid-management team from the DOC's Adult Community Corrections Division

- Probation and parole officers (sex offender specialists)
- Representatives from community-based programs and services, including sex offender treatment programs and pre-release centers
- Offenders participating in the sex offender treatment program at MSP;
- Conducted documentation reviews of:
 - Pertinent state statutes and administrative rules
 - MSOTA standards and guidelines established for individuals who provide evaluations and treatment for sex offenders
 - Treatment manuals and other program information for the sex offender services offered at MSP
 - Treatment records for sex offenders participating in the MSP sex offender treatment program
 - Guidelines established for officers responsible for supervising sex offenders
 - Supervision files for sex offenders on the caseloads of sex offender specialists
 - Case files for sex offenders under consideration by BOPP;
- Developed a “system map” of the flow and management of sex offense cases as driven by current policies and practices in Montana (see Appendix I); and
- Conducted a literature review on evidence-based correctional strategies and the research and practice literature specific to adult sex offender management.

INTRODUCTION TO THIS REPORT

In addition to the sources of information detailed, this report is based on direct observations (and the observations of other stakeholders when the views expressed were widely held by those stakeholders). As is true for any work of this nature, it must be recognized that these observations – and the associated recommendations – are offered within the constraints of the limited time, available data, and scope of the contract. Nonetheless, the consultants made all reasonable efforts to ensure a comprehensive, objective, and representative “snapshot” of the current system in order to provide well-informed recommendations.

As an important foundation, Section II of this report highlights four fundamental areas of sex offender management (assessment, treatment, supervision, and reentry) that the DOC administration must take into account as it moves forward. For each of these four areas, the following are provided:

- A synopsis of pertinent contemporary research and practice literature in the sex offender management field, against which current strategies in Montana could be gauged;
- The consultants' understanding and observations of relevant policies and practices within the state (outlined in terms of noteworthy strengths and issues warranting further consideration); and
- Key recommendations as applicable to the minimum security facility and/or the broader systemic supports.

Section III of this report addresses a series of elements that should be considered by the DOC as they strive to define the specific parameters of the minimum security sex offender treatment facility. These include recommendations regarding the target population, programmatic structure, performance measures, and additional systemic supports.

Overall, the consultants were impressed by the extent to which Montana has embraced promising practices in many areas of sex offender management. Indeed, the citizens of Montana are likely well-served by the comprehensive sex offender management structure currently in place, which has the potential to contribute significantly to public safety. At the same time, the need to develop a policy-driven approach to sex offender management is evident. The existing structure can be strengthened considerably by the establishment of a multidisciplinary policy-level group whose mission is to oversee and advance sex offender-related policy and practice throughout the criminal justice system. Advancement in this area offers the greatest promise for state-of-the-art sex offender management, and the greatest likelihood of community safety.

SECTION II: OVERVIEW OF CURRENT SEX OFFENDER MANAGEMENT PRACTICES IN MONTANA

SEX OFFENDER ASSESSMENT

Throughout the nation, correctional agencies are charged with identifying and implementing effective sex offender management strategies. Oftentimes, sex offender management poses greater challenges than managing other justice-involved populations because of a number of factors, such as under-reporting and under-detection of sex crimes, widely held myths about sex offenders, heightened scrutiny by stakeholders, negative public sentiment, exacerbated housing and employment challenges, and growing trends involving largely untested sex offender-specific policies.

Although the label of “sex offender” suggests that the individuals who commit sex offenses are a homogeneous population, research clearly indicates that they are a heterogeneous group. Differences exist across a variety of domains including, but not limited to, the factors that are associated with the initiation of sex offending behaviors (e.g., motivational, situational, contextual, individual variables), the nature and dynamics of the offenses, levels of functioning and intervention needs, amenability and response to intervention, and risk to reoffend. Individually and collectively, these variations highlight the importance of developing policies that recognize the diversity of this special population, rather than attempting to design “one size fits all” sex offender management strategies.

At the practice level, the differences that exist within the sex offender population require the application of individualized, case-specific management approaches. This is best accomplished when assessment data is used to inform decisions, beginning at the point of sentencing. Indeed, when taking into account the goal of increasing public safety through reducing recidivism – beyond an exclusive focus on goals of deterrence and punishment – specialized assessments can assist judges and others with making informed, consistent, and objective decisions at the point of sentencing that can enhance sex offender management efforts throughout the rest of the system.

- ***Pre-sentence Investigations.*** The pre-sentence report is often the first opportunity to obtain a comprehensive assessment of sex offenders who have come to the attention of the courts. It is designed to provide judges and other interested parties with a wide range of information about an individual offender (e.g., social, family, financial,

medical, mental health, and prior criminal history), strengths and assets, the circumstances surrounding the case (e.g., victim statements, police reports), and disposition recommendations that balance offender accountability, offender needs, victim needs and desires, and community safety needs (e.g., incarceration vs. probation, treatment recommendations, special conditions of supervision). The pre-sentence investigation is generally conducted by a community supervision officer who ideally has specialized training and experience in sex offender management.

- ***Psychosexual Evaluations.*** Similarly, specialized assessments (i.e., psychosexual evaluations) conducted by specially qualified evaluators are commonly requested to assist judges and others with sentencing and disposition considerations. The scope of psychosexual evaluations extends beyond that of routine psychological evaluations that are often based on general assessments of broad psychosocial functioning. Psychosexual evaluations additionally include a thorough exploration of sexual attitudes, interests, behaviors, and adjustment through the use of sex offender-specific assessment instruments. Broadly speaking, the goals of psychosexual evaluations include, but are not limited to, providing information about the level of risk for sexual and non-sexual recidivism, intervention needs and amenability to intervention, the types and intensity of programs and strategies that are likely to be most beneficial, and recommended level of placement or care.

Psychosexual evaluations are not appropriate as a means of assisting with determinations of guilt or innocence, which is exclusively the purview of the trier-of-fact. Along a similar vein, because sex offenders represent a diverse population that varies across multiple domains, assessment findings cannot be used to conclude that a person has the "typical" characteristics or matches a "profile" of a sex offender. Conducting psychosexual evaluations to assist with charging decisions falls outside of the proper scope of these evaluations as well; such decisions are determined by the evidence of the case and applicable statutory definitions, not a presumptive level of risk and/or intervention needs of a given defendant. Nor are psychosexual evaluations designed as a proxy for investigating additional or undisclosed sex crimes during the adjudication or sentencing process, for providing evidence that a crime has been committed, or for exploring the veracity of an alleged victims' statements or motivations. Responsibility and expertise for those types of issues are reserved for trained sex crimes investigators, forensic medical experts, law enforcement officials and, in some circumstances, prosecutors and triers-of-fact.

- **Risk Assessments.** Within the context of a pre-sentence report and/or psychosexual evaluation, the results of a validated sex offender-specific risk assessment tool can be used to inform sentencing recommendations and decisions. Risk assessment tools are based on static, or unchangeable, risk factors that have been identified through research. As such, they offer fairly robust predictors of long-term recidivism. These tools are used to provide a baseline measure of relative risk (e.g., low, moderate, high) for a given sex offender, which can assist the courts with making important decisions such as the type of sentence (probation or incarceration) and the tier designation relative to sex offender registration and community notification.

The evidence-based correctional literature with general offenders – as well as sex offenders – indicates that risk assessments are most reliable and valuable when empirically-validated instruments are used (Hanson & Morton-Bourgon, 2007). Because these tools are developed through extensive research and include specific scoring and weighting criteria of known risk factors, the resulting risk estimates are more objective, reliable, consistent, and accurate than those obtained from other means of assessing risk with sex offenders, such as the unstructured and subjective judgments of clinicians (Hanson & Morton-Bourgon, 2007).

It is important to note that empirically validated risk and need assessments designed for “general” offenders (e.g., the Level of Service Inventory/Case Management Inventory, Andrews, Bonta, & Wormith, 2004) are useful with sex offenders for determining “general” risk and needs. However, several risk factors are unique to sex offenders and cannot be assessed through these instruments. Empirically-validated tools designed specifically for sex offenders are therefore an essential part of an overall risk assessment strategy with this population.

To promote responsible assessment practices in the sex offender management field, some states have created certification processes, statewide standards, and policy-driven guidelines within agencies that establish minimum qualifications for evaluators and the specific approaches to be used when conducting these types of evaluations. In addition, some professional membership and affiliate organizations – such as the Association for the Treatment of Sexual Abusers (ATSA) have also established practice standards and guidelines for their members (ATSA, 2005). These types of standards and guidelines are generally based on

contemporary research and accepted practices. In order to ensure that they are maximally useful, oversight and quality assurance processes and accountability measures must be implemented.

Observations in Montana

The current philosophies, policies, and practices relative to assessments within the state of Montana offer invaluable opportunities to facilitate informed decisionmaking with respect to sex offender management. This potential holds true not only for decisions at the point of sentencing, but also at other key decision points throughout the system, including determinations relevant to placement and release decisions for the minimum security sex offender treatment facility currently under consideration.

Identified Strengths

- ***Observation 1: Stakeholders recognize the value of using specialized assessments to assist judges and others with making well-informed decisions about sex offender management.*** The range of practitioners across multiple disciplines who were interviewed during the course of the site visits seemed to appreciate the diversity of the sex offender population. Many noted the importance of having sound assessment data to respond effectively to sex offenders on a case-by-case basis, including at the sentencing phase. There also appeared to be an overall appreciation of the need for specialized knowledge and training to conduct psychosexual evaluations and the use of sex offender-specific assessment tools to assess the risk factors that are unique to sex offenders.
- ***Observation 2: Pre-sentence investigations are statutorily mandated to be conducted and considered in sex offense cases.*** Relative to their counterparts in many other states, stakeholders in Montana are in a unique and enviable position in that pre-sentence investigations are required by statute (46-18-111, Montana Annotated Code (MAC)) for all convicted sex offenders. In addition to a thorough review of current and historical information about the offender, case-specific variables, and pertinent records, the pre-sentence investigations in Montana are expected to include findings from psychosexual evaluations and recommendations regarding treatment in the least restrictive environment – considering risk to the community and the intervention needs of offenders.

In practice, pre-sentence investigations appear to be conducted routinely and thoroughly, and include the specific areas of inquiry and

recommendations required by statute. As such, these pre-sentence reports can offer a rich source of information for judges and other consumers of this assessment data.

Although not specifically noted during random file reviews, this strength could be compromised by the variability in sex offender-specific expertise among the officers conducting these pre-sentence investigations. In addition, officers acknowledge a lack of formal policy and indicate that they are afforded considerable autonomy and professional latitude when conducting pre-sentence investigations. As such, the reports and recommendations that are produced have the potential to vary considerably as a function of officers' respective philosophies, values, training, and experiences.

- ***Observation 3: Psychosexual evaluations are statutorily mandated for all individuals convicted of sex offenses.*** Montana statutes also require psychosexual evaluations to be conducted and included as part of the pre-sentence investigation (46-18-111 and 46-23-509, MAC) for convicted sex offenders. More specifically, these evaluations are required to include an assessment of risk for sexual recidivism – and an accompanying recommendation for a tier designation to be imposed by the judge at the time of sentencing (i.e., Tier I when the risk for sexual recidivism is assessed to be low, Tier II for moderate risk of sexual recidivism, and Tier III for offenders assessed as posing a high risk to recidivate sexually).

Psychosexual evaluations appear to be conducted as a matter of course, and are reportedly available to prosecutors, defense attorneys, probation/parole officers, and judges at the time of sentencing. The fees for conducting psychosexual evaluations are the responsibility of the offenders, with the exception of indigent offenders, for whom the costs are assumed by the state and/or county. According to the clinicians who conduct these evaluations, costs average \$1,500 for self-pay clients and \$1,250 when public defenders request and are responsible for the evaluations.

Random reviews of case files (e.g., from MSP, P&P, and BOPP) revealed that psychosexual evaluations are generally present in offenders' files and often include estimates of sexual recidivism risk with an accompanying recommendation for tier designation. As is the case with the supervision officers responsible for conducting pre-sentence investigations, the evaluators conducting specialized sex offender-specific evaluations can provide important guidance to judges and other decisionmakers about sex offender management strategies – including identifying potentially

suitable candidates for the minimum security sex offender treatment facility currently under consideration.

- ***Observation 4: A set of standards is in place to guide the conduct of psychosexual evaluations, including minimum qualifications for the evaluators.*** In Montana, the DOC has the statutory authority and obligation to adopt rules governing psychosexual evaluations, including the conduct of the evaluations and the qualifications of the evaluators (46-23-509, MAC). To that end, Administrative Rule 20.7.3 (Sex Offender Evaluation and Treatment Provider Guidelines and Qualifications) outlines the minimum qualifications for evaluators. In addition, state statute (46-18-111, MAC) mandates that the psychosexual evaluations ordered within the context of pre-sentence investigations must be conducted by members of the Montana Sex Offender Treatment Association (MSOTA), or by evaluators who have comparable credentials acceptable to the Department of Labor and Industry.

MSOTA has a published set of standards and guidelines (Revised and Adopted in January 2002) that outline the minimum qualifications for evaluators. Included among the requisite criteria are advanced degrees in the behavioral/social sciences, specified hours of clinical supervision, continuing education, and membership in relevant organizations at the state or national level. Several of the qualifications listed in the administrative rule are similar, but not identical, to those included in the MSOTA standards. It is assumed that where the standards vary, the specific rule or statute that provides the higher standard prevails.

The Administrative Rules are silent on the issues of standards and guidelines for conducting such evaluations. However, it appears that current statute provides an independent source of governance for the conduct of these evaluations (46-18-111, MAC). In this instance, because psychosexual evaluations must be conducted by MSOTA members (or their equivalent), the MSOTA standards and guidelines – which address the conduct of these evaluations – seem to be applicable. Examples of areas addressed by the MSOTA standards and guidelines are the intended and appropriate scope of evaluations, the range of collateral information that should be reviewed, and the types of assessment instruments that could be utilized.

The existence of these standards and guidelines indicates a high level of commitment in the state of Montana to promoting quality evaluations by qualified providers. As is the case in all other jurisdictions, the ultimate utility and value of these standards is dependent upon the extent to which they are based on evidence-based principles and practices in the

broader corrections field, contemporary research and commonly accepted standards of practice specific to the sex offender management field, and sufficient oversight to ensure adherence to such standards. It is from this perspective that the standards and guidelines warrant further discussion below.

Issues for Consideration

- ***Issue 1: The methods used by evaluators to determine recidivism risk raise questions about reliability and validity.*** Montana statute (46-23-509, MAC) clearly articulates that tier designations are intended to reflect the broad estimate of a risk to reoffend sexually (i.e., low, moderate, or high). Although the DOC has the advantage of being fully authorized to provide governance over the conduct of psychosexual evaluations, including risk assessments, no specific evaluation and assessment methods have yet been delineated through administrative rules.

The MSOTA standards offer some guidance for evaluators, but a careful review of those standards indicates that they do not provide sufficient structure and are not adequately grounded in relevant research. As outlined previously, evidence-based principles indicate that the accuracy of risk assessment is maximized when empirically-validated instruments are the basis of the risk determination. Yet the MSOTA standards suggest that clinical judgment can reasonably prevail over empirically-validated assessments: “Ultimately it is the clinician’s experience and clinical judgment that are used to assess the level of risk in each individual case.”⁴

In addition, although a list identified as “recognized risk assessment tools” is included within the MSOTA standards, the standards do not require that evaluators use the named tools, leaving the methods to determine sexual recidivism risk to the discretion of the individual evaluator. Complicating this further, the listed tools are not comparable in terms of the type of risk they assess, the populations for which they are designed, or the level of empirical support for their reliability and validity. For example, while some of the tools listed in the MSOTA standards are indeed validated risk assessment tools designed specifically for sex offenders (i.e., MnSOST-R, RRASOR, SORAG, Static-99)⁵, others were designed for the “general” offender population and do not take into

⁴ MSOTA, 2002.

⁵ MnSOST-R, Epperson, Kaul, & Hesselton, (2000); RRASOR, Hanson (1999); SORAG, Quinsey, Harris, Rice, & Cormier (2006); Static-99, Hanson & Thornton (1998).

account risk factors that are unique to sex offenders (e.g., Level of Service Inventory-Revised [LS-R])⁶. One of the instruments (i.e., Sex Offender Registration Act Risk Assessment Instrument) appears to be designed as a sex offender-specific instrument, but it is not a commonly accepted tool in the field and has not been the subject of widespread reliability and validity research. Another listed instrument (the SONAR, now commonly referred to as the STABLE- and ACUTE-2000⁷) is commonly accepted in the field and has a growing body of research-support, but it is not designed to provide estimates of risk over the long term. Rather, it is used as a supervision tool and as a measure of treatment progress by monitoring dynamic risk factors over time.

Based upon the analysis of the MSOTA standards, interviews with evaluators, and random file reviews, it appears that the methods by which risk determinations are made (i.e., risk to reoffend sexually, as defined by statute) lack consistency, clarity, reliability, and, in some cases, validity. To illustrate, when reviewing the psychosexual evaluations included in 35 case files, the following practice patterns were identified with respect to estimates of risk for sexual recidivism:

- In 29% of the cases, the assessment tools cited as the basis for making the determination about sexual recidivism risk are not instruments recognized as reliable or valid for the purposes of estimating sexual recidivism risk.
- In 43% of the cases, a combination of appropriate tools (i.e., validated, sex offender-specific risk instruments) and inappropriate tools (i.e., non validated, non sex offender-specific instruments) were included in the evaluation protocol, but it was not possible to identify how the combination of these tools were used to form the risk determinations. Evaluators in some instances discussed factors external to the validated risk assessment tools (and included among these were factors that are not supported by research on sexual recidivism risk) to make adjustments to the presumptive level of risk.
- In 17% of the cases, no specific assessment measures were listed in the psychosexual evaluation, eliminating the ability of an independent reviewer to identify the process for determining risk for sexual recidivism.

⁶ LS-R, Andrews & Bonta (2003).

⁷ SONAR, Hanson & Harris (2000); STABLE/ACUTE-2000, Hanson & Harris (2001).

- In 11% of the cases, the use of empirically-validated sex offender-specific tools clearly formed the basis of the evaluators' determinations of risk for sexual recidivism.

Taken together, these indicators suggest that the reliability and validity of risk assessments – and the accompanying tier designations recommended by evaluators – are likely to vary widely. Different providers could evaluate the same sex offender and arrive at disparate conclusions about that offender's risk to recidivate sexually. This limits significantly the ability of stakeholders (e.g., judges, paroling authorities, screening committees) to make well-informed and reliable decisions about placement in the minimum security sex offender treatment facility with a high level of confidence, as well as other key decisions that are important to effective sex offender management.

- ***Issue 2: The process by which tier designations are imposed at the point of sentencing is unclear.*** Stakeholders from multiple disciplines expressed concern about the consistency and reliability of the tier designations imposed by the court at the point of sentencing. These concerns were attributed to two specific variables: (a) incongruence between the risk estimate and recommended tier designation from the psychosexual evaluator and the actual designation imposed by the judge; and (b) inconsistent practices relative to the actual assignment of tier designations by sentencing judges.

The review of 35 case files provided evidence of stakeholders' concerns, in that only 37% of the cases clearly demonstrated a court imposed tier designation that paralleled the recommendation of the psychosexual evaluator. Upward departures were readily identifiable in 6% of the cases (i.e., the court imposed a higher tier than the evaluator recommended). In half of the cases (57%), it was not possible to determine congruence because the evaluator provided a recommendation but the court did not impose a designation. Similar statistics provided by the DOC revealed that 60% percent of a recent cohort of sex offenders entered prison with no tier designation assigned by the courts.

These tier designations carry significant weight in decisionmaking, particularly with respect to the sentencing practices, treatment mandates, parole considerations, placement decisions, and registration requirements. This highlights the need to have a tier designation process that is reliable and valid, and one that is consistently followed by all parties involved. For example, when designations are not imposed at sentencing and offenders are placed at MSP, the sex offender program staff members are responsible for assigning a tier designation prior to the

offenders' release. Given the previously discussed variability with evaluators' approaches to risk assessments and the lack of an adequate framework provided by the MSOTA standards for evaluations, the same potentially negative implications for decisionmaking (e.g., parole, screening committees) apply.

- ***Issue 3: Offense-based tier determinations may supersede assessment-driven tier designations in some instances.*** By statute, tier designations are intended to reflect sexual recidivism risk. As established elsewhere in this report, the use of empirically-validated tools provides the most reliable estimates of recidivism risk. During the course of this review, multiple practitioners noted that individual offense-related factors (e.g., statutory rape cases, failure to register convictions, victim age less than 12 years) automatically result in Tier III/Sexually Violent Predator designations, regardless of the level of risk assessed by the psychosexual evaluator. If this is accurate, such policy decisions will have significant implications for eligibility for the minimum security sex offender treatment facility. For example, an offender who is assessed to pose a low risk for sexual recidivism and who may be better suited for a community-based or minimum security treatment facility than incarceration at MSP may be ineligible for program consideration as a result of Tier III designation on the basis of these offense variables (rather than risk to reoffend).
- ***Issue 4: The fidelity, integrity, and overall quality of psychosexual evaluations and evaluators' practices are highly variable.*** Interviews with evaluators and officers, coupled with reviews of treatment files at MSP, case files of supervision officers from multiple regions, and BOPP case files, all revealed quality control issues with respect to psychosexual evaluations. A potential contributing factor, as discussed previously, is the nature of the MSOTA standards and guidelines. In addition to the quality control issues, a common issue arose across stakeholder groups (e.g., Parole Board, supervision officers, and other evaluators/providers) regarding the appearance of conflict of interest for some clinicians conducting psychosexual evaluations. This specifically surrounded the vested interest that some evaluators may have in sentencing decisions, parole release decisions, and screening committee decisions – in that those decisions (which appear to be heavily influenced by the clinician's recommendations) could have a direct impact on increased referrals and revenue. Unfortunately, the very limited pool of MSOTA providers increases the likelihood for such a circumstance. Whether real or perceived, measures should be explored to reduce the potential for appearance of conflict of interest.

Key Recommendations

- ***Recommendation 1: Strengthen the standards for conducting psychosexual assessments through the Department's statutorily afforded rulemaking authority (46-23-509, MAC).*** The current administrative rule is limited only to the minimum qualifications of providers and does not capitalize upon the ability of the DOC to enhance the consistency, quality, and ultimate value of these psychosexual evaluations. Moreover, it does not appear that the DOC is precluded from establishing more stringent standards than currently exist within the MSOTA standards and guidelines. The DOC is strongly encouraged to collaborate with MSOTA to develop more structured and research-supported standards to be included in administrative rule and to facilitate the concurrent development of complementary/parallel MSOTA standards.
- ***Recommendation 2: Adopt an empirically-validated sex offender-specific risk assessment tool (e.g., Static-99) that is to be used throughout the system by those who evaluate sex offenders.*** Requiring the use of a common tool is an important means of strengthening the evaluation standards – and in particular the reliable and valid determination of risk for sexual recidivism – and enhancing the consistency of practices. The reliability and validity of the risk assessments can also be improved by limiting downward/upward adjustments by evaluators to exceptional circumstances as identified in the accompanying manual for a given instrument.

The DOC is further encouraged to adopt research-supported tools for assessing dynamic risk factors and monitoring changes over time (e.g., Sex Offender Treatment Needs and Progress Scale, STABLE/ACUTE-2000), also to be used by practitioners throughout the system. For this to be effectively implemented, evaluators must be required to attend credible skills-based trainings (ideally underwritten by the DOC) that include the demonstration of proficiency in the scoring, interpretation, and practical application of the tools adopted by the DOC.

- ***Recommendation 3: Utilize the leverage of contracts with evaluators/providers to ensure quality assurance relative to risk assessments.*** The DOC has a longstanding history of promoting quality and effective service delivery through quality assurance and performance measurements. The same process can be applied to monitoring assessments conducted by vendors, specifically with respect to the selection and application of risk assessment tools. Indeed, given the importance of having reliable risk assessments, inter-rater reliability verifications may be worth considering as a quality assurance and/or

performance indicator for vendors, thus providing an additional measure of checks and balances. In addition, the DOC may wish to establish the same expectations for community-based sex offender treatment providers who are interested in receiving referrals.

- ***Recommendation 4: Require evaluators involved in the screening committee processes to be independent.*** To the extent possible, referrals made to community-based residential facilities and other community-based programs/services should not include evaluations or recommendations from the providers who deliver those services within those facilities/programs. The use of independent evaluators reduces the potential for dual roles or questions about conflict of interest.

SEX OFFENDER TREATMENT

The treatment of sex offenders has been long recognized as a specialty within the field of correctional interventions. Throughout the nation, the standard model for sex offender treatment is grounded in the cognitive-behavioral framework, which has been demonstrated to reduce recidivism with this special population (Aos, Miller, & Drake, 2006). The overarching goal of sex offender treatment is to ensure that sex offenders develop the skills and competencies that will reduce their likelihood of reoffending and increase their potential to lead productive and prosocial lives.

To be most effective in reducing recidivism, the targets of treatment should be factors that are directly linked to recidivism (i.e., criminogenic needs, or dynamic risk factors) (Andrews & Bonta, 2006). Although some of the dynamic risk factors associated with recidivism among sex offenders parallel those for “general” offenders, researchers have also identified a number of dynamic risk factors that are unique to sex offenders and that should be addressed in treatment (Hanson & Morton-Bourgon, 2005). In addition, research reveals that process-related variables such as therapist features (e.g., empathic, genuineness) and a change-promoting climate play an important role in maximizing treatment outcomes. This, too, is consistent with the evidence-based principles and practices identified in the broader correctional interventions research.

Because sex offenders are a diverse population with varying levels of risk and needs, treatment programs must be individualized and should not be designed under a “one size fits all” model. This also necessitates a continuum of treatment services – both in terms of level of care (i.e., from community-based to prison-based programming) and intensity/dosage (i.e., from low intensity, short-term interventions to high intensity, longer-term programs). Evidence-based principles in corrections indicate that

determinations about programming should be driven by validated assessments of risk and need. More specifically, recidivism reductions and treatment outcomes are maximized when higher risk offenders receive higher intensity/higher dosage services; lower intensity/lower dosage interventions are more effective for offenders assessed to pose a lower risk to reoffend and who have fewer intervention needs (Andrews & Bonta, 2006). Put simply, treatment should be assessment-driven.

Finally, because sex offender-specific treatment is a specialized area of practice that continues to evolve as new research emerges, treatment providers must have advanced skills and expertise in order to provide ethically sound, high quality, and effective services. In several states (e.g., Colorado, Illinois, Texas, Utah), clinicians must meet minimum qualifications in order to be considered as qualified sex offender treatment providers, and treatment programs are expected to adhere to a prescribed set of standards and guidelines that address the theoretical model, targets, and approaches to intervention. Many of the criteria used for these purposes are based on published practice standards and guidelines from the Association for the Treatment of Sexual Abusers (ATSA, 2005), a leading authority on the types of educational and practical experiences that are considered essential before engaging in this work. But as mentioned previously, the mere existence of standards and guidelines is unlikely to result in sound programming or quality providers in the absence of ongoing quality assurance strategies.

Observations in Montana

The current conditions in Montana provide an excellent opportunity to provide a comprehensive continuum of sex offender services, from outpatient community-based programming to prison-based treatment – and including the incorporation of a minimum security sex offender treatment facility as an intermediate option along this continuum. In addition, the existing range of programs and services that address other intervention needs of sex offenders creates further potential to increase public safety in Montana through risk-reducing strategies.

Identified Strengths

- ***Observation 5: Stakeholders appreciate the importance of sex offender-specific treatment and other rehabilitative programs and services as a means of reducing recidivism and increasing public safety in Montana.*** Throughout the system, representatives across disciplines and agencies (e.g., supervision officers, Parole Board members, agency administrators, victim services representatives, treatment providers, law enforcement officials) agree that specialized

treatment is a vital part of sex offender management efforts in the state. This creates a climate that is conducive for expanding sex offender treatment capacity beyond that which is currently available at MSP and in the community, and increases the potential for receptivity to establishing a minimum security sex offender treatment facility, expanding considerably the current range of treatment options (in terms of both bed capacity and type of service available).

- ***Observation 6: The legislature demonstrates support for a balanced approach to sex offender management, including a significant investment in sex offender treatment.*** The state of Montana is in the desirable position of having the legislature's ongoing commitment to ensuring the provision of – and sex offenders' mandatory participation in – specialized treatment within the prison. Further evidence of their support is the recent legislative initiative resulting in an increase in sex offender treatment capacity through the establishment of a minimum security sex offender treatment facility. This level of support and investment is particularly noteworthy given the national trends toward punishment- and surveillance-driven approaches to sex offender management. Montana has followed suit in many ways, through recent statutory provisions that have: modified sentencing structures and increased penalties for sex offenses (particularly those involving young children); expanded registration requirements and penalties for failure to register; mandated lifetime supervision strategies; required the use of global positioning monitoring technology (GPS) for some offenders; and established limits on parole eligibility.

What remains somewhat unique in Montana is the demonstrated commitment – at the highest policy level – to balancing retributive and deterrence goals with rehabilitative goals, thus supporting a more balanced approach to sex offender management. The evidence-based correctional literature clearly indicates that balanced approaches are more effective in reducing recidivism and increasing public safety (Aos et al., 2006).

- ***Observation 7: Standards and guidelines for sex offender treatment exist within the state.*** As referenced previously in this report, MSOTA standards and guidelines outline the minimum qualifications for clinicians who provide evaluation and treatment to sex offenders. These minimum qualifications include specialized training and clinical supervision, advanced degrees in the behavioral/social sciences, specified hours of clinical supervision, continuing education, and membership in relevant professional associations at the state or national level. The MSOTA standards provide an opportunity to facilitate high

quality, consistent, and effective sex offender treatment throughout the state.

- ***Observation 8: Case managers and treatment providers at MSP have the benefit of baseline assessment information about each sex offender entering the prison.*** Because pre-sentence investigations and psychosexual evaluations are statutorily mandated for sex offenders, baseline assessment data is readily available to institutional case managers and program staff at the point of intake at MSP. These assessments and the accompanying intervention recommendations can enhance the efficiency of operations by potentially reducing the need for institutional practitioners to conduct certain types of assessments (e.g., risk assessments, sex offender-specific measures that identify targets of intervention), thereby facilitating treatment planning and case management efforts at the outset.
- ***Observation 9: The current conceptual structure of sex offender programming at MSP is designed to provide services that maximize impact, outcomes, and resources.*** Sex offender treatment has been a longstanding service at MSP and has the official mission of enhancing community safety by providing extensive educational and cognitive-based treatment to sex offenders. The program's mission extends further, with an explicit purpose of preparing sex offenders for return to the community and working with the community to reintegrate released offenders in a safe and responsible manner.

In its current structure, there are three formal phases of sex offender treatment at MSP. Phase I is a relatively short-term and minimally intensive educational component (two hours per week over the course of 4 months) that is delivered either by unit managers or MSOTA providers. It is required for all convicted sex offenders sentenced to prison. Successful completion of Phase I is a prerequisite for Phase II, the longer term treatment component. Presently, approximately 40 sex offenders are involved in Phase I.

Phase II programming is statutorily mandated for all Tier III sex offenders sentenced to prison, and is typically a pre-requisite for parole consideration for sex offenders. According to documentation provided by the DOC, Phase II services are delivered by two full-time DOC employees who are masters' level MSOTA therapists and through contractual agreement with four part-time (10 hours per week) MSOTA providers. Programming is provided either through the Intensive Treatment Unit (ITU) or on an Outpatient (OP) basis. The ITU is a special housing unit specifically for sex offenders in which treatment groups meet twice per

week for two hours each. Sex offenders participating in the OP format reside within general population housing units and attend a two-hour treatment group once per week.

Program documentation and interviews with treatment staff indicate that Phase II is comprised of 45 written assignments that the program participants present during treatment groups; length of stay in programming until the point of completion ranges from 18-30 months. Special Phase II "tracks" are reportedly available for statutory offenders (select cases involving young offenders whose victims are close in age but statutorily unable to consent to sexual activity) and individuals with interfering symptoms such as significant mental health difficulties, cognitive impairments, and functional skills (i.e., specific responsivity factors). Approximately 60 sex offenders are currently participating in the Phase II-ITU program, and 73 sex offenders are receiving Phase II-OP services.

Phase III is a low intensity service required for all sex offenders who have completed Phase II. The group, which meets once per month, is designed to provide ongoing maintenance interventions and other assistance (e.g., relapse prevention techniques, discharge planning, Parole Board readiness) to sex offenders until the time of their discharge from MSP. Presently, approximately 85 sex offenders are involved in Phase III programming at MSP.

The apparently intended structure for programming at MSP (i.e., to provide different levels of intensity and duration of treatment, with individualized targets of intervention, and in ways that take into account specific responsivity needs) is grounded in evidence-based correctional principles. If well-designed and well-implemented, sex offender treatment within this structure can enhance treatment outcomes and reduce recidivism post-release, while maximizing the available resources and program capacity within MSP specifically and the DOC overall. Furthermore, it affords the DOC the flexibility to consider a range of options for the types of referrals that could be served in the desired minimum security sex offender treatment facility.

- ***Observation 10: Treatment programs and services that address core criminogenic needs are in place at MSP (and exist in community based residential/treatment facilities).*** In addition to specialized sex offender treatment, other key services are available for sex offenders sentenced to MSP. These programs are designed to target important need areas that are associated with recidivism (e.g., core

criminogenic needs such as substance abuse, antisocial values, attitudes, and beliefs). Included among the specific programs are the following:

- Cognitive Principles and Restructuring (CP&R);
- Anger Management (AM); and
- Chemical Dependency (CD).

The intensity and duration of some of these risk-reducing programs and services are designed to vary as well, presumably to accommodate the diverse risk and needs of offenders. Programming that specifically targets the criminogenic needs of offenders – as opposed to services that tend to address non-criminogenic needs – is critical to reducing recidivism. In combination with educational, vocational, and other skills-based programs and services within MSP, the availability of these types of risk-reducing interventions demonstrate an appreciation that individuals who are convicted of sex offenses have other need areas that must be taken into account in order to be successful in the community. Such a philosophy and practice is equally important for promoting successful outcomes with respect to community-based programming. Indeed, research demonstrates that appropriate services delivered in the community are often associated with even greater recidivism reductions (Andrews & Bonta, 2006; Aos et al., 2006). And with respect to designing services for the minimum security sex offender treatment facility, similar types of interventions – beyond sex offender programming – will be important to consider as part of the overall milieu.

Issues for Consideration

- ***Issue 5: Key decisions about sex offender treatment at MSP are not informed by objective or consistent assessment data.*** Although the treatment services at MSP vary in terms of intensity and duration, the program staff indicate that decisions about placement in the various phases are not informed by validated assessment information that takes into account risk or need. Rather, these decisions are driven by a combination of factors: statutory mandates, parole eligibility requirements, available capacity, and providers' subjective assessments of offenders' appropriateness for programs.

Additionally, program staff acknowledge that resource limitations result in treatment plans that are not individualized or based on formal assessment findings. Further, they acknowledge that all sex offenders, regardless of risk level or assessed need, follow the same treatment path, if deemed appropriate for participation. They further indicate that treatment progress is determined by clinical impressions, not from any

research-based, sex offender-specific assessment tools designed to measure treatment progress across key domains. The same applies to the ways in which completion is defined and determined. As a result, the extent to which sex offenders have adequately addressed risk-related factors throughout the course of treatment is difficult to ascertain. This is particularly problematic in that treatment progress and treatment completion are very influential with respect to release decisionmaking, post-release placements, post-release supervision strategies, and assessments of risk over time.

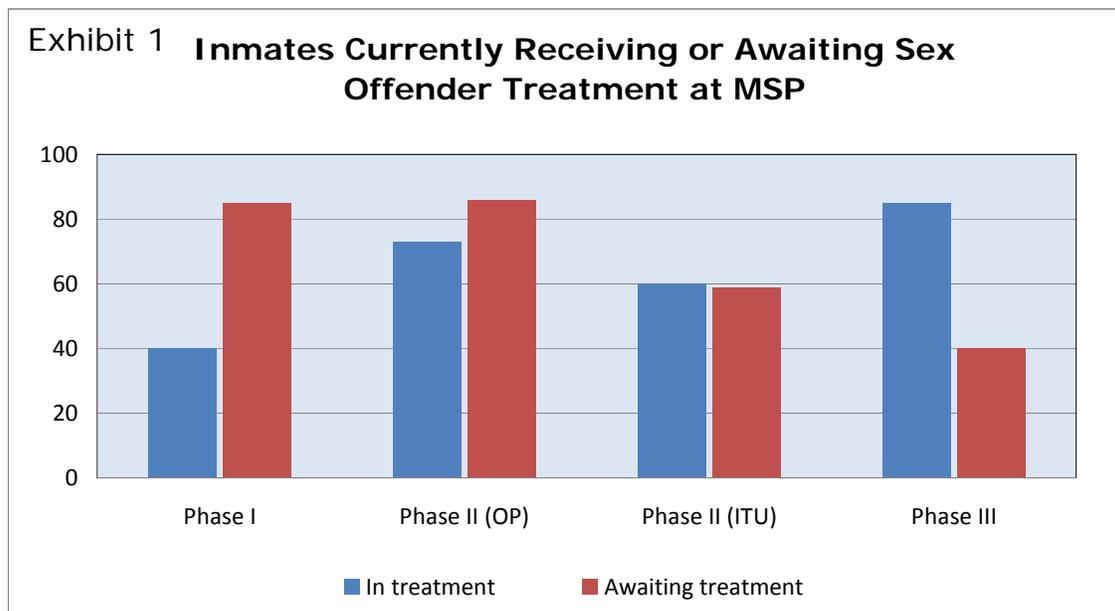
- ***Issue 6: Sex offenders do not appear to have timely access to treatment at MSP.*** Multiple stakeholders interviewed during the course of this review expressed concerns about the ability of sex offenders to access needed treatment in a timely manner. Indeed, recent statistics indicate that 51% of the sex offenders at MSP are currently on the waiting list for sex offender treatment (this does not take into account the small percentage of inmates who are refusing treatment). Exhibit 1 illustrates the numbers of sex offenders currently in treatment and those who are on the waiting list at MSP by specific phases of programming.

Information provided by the DOC indicates that sex offenders may remain on the waiting list for up to 2 years; priority for treatment access for those on the waiting list is given to sex offenders who have earlier release dates. Although it is not possible to ascertain the reasons for this delayed access to treatment, contributing factors could include, but are not limited to, the following:

- Increasing numbers of sex offenders being sentenced to MSP because of limited treatment capacity in the community;
- Insufficient treatment capacity at MSP;
- Statutory and parole requirements for sex offenders sentenced to MSP to complete Phases I and/or II regardless of level of risk and need;
- The absence of a “triage” approach for sex offender treatment at MSP, whereby prioritization for program placement and course of treatment are based upon assessed level of risk and need;
- Insufficient intensity provided in Phase II to allow offenders to more quickly progress through the program (i.e., groups meet only twice per week within the ITU);
- Excessive lengths of stay in Phase II that result from a lack of structured (or unrealistic) goals for advancement and completion; and/or

- Excessive lengths of stay in Phase II that result from a lack of formal, consistent, and objective measurements of treatment progress and completion.

These issues are problematic in that delayed access to treatment (or unnecessarily long stays in treatment) can result in release delays for parole-eligible sex offenders. In addition, sex offenders who would otherwise be appropriate for release will either discharge their sentence or be released prior to receiving necessary risk-reducing interventions and, depending upon the type of discharge/release, they may not be subjected to post-release treatment or supervision requirements.



- **Issue 7: Despite the existence of standards, the delivery of sex offender treatment lacks consistency both within MSP and in the community.** Standards and guidelines for sex offender treatment, which should be based on research-supported models and approaches, are designed to promote consistency and effectiveness. And although MSOTA has established treatment standards and guidelines for this purpose, providers readily acknowledge that the philosophies, models, approaches, targets, and quality of treatment delivery both at MSP and in the community vary considerably from provider to provider. With community providers, variations also exist with respect to the frequency of sex offender treatment groups. While some providers require weekly groups, others only require two groups per month. Furthermore, MSOTA providers acknowledge that individualized continuity of programming tends to be limited when sex offenders transition from the MSP sex

offender treatment program to community-based sex offender treatment, in that services may be duplicative and do not necessarily build upon progress made by offenders prior to release from MSP. Concerns about significant treatment inconsistencies were also noted by supervision officers and other stakeholders who, as a result, reported having varying degrees of confidence in the quality and effectiveness of the sex offender treatment that is provided throughout the state.

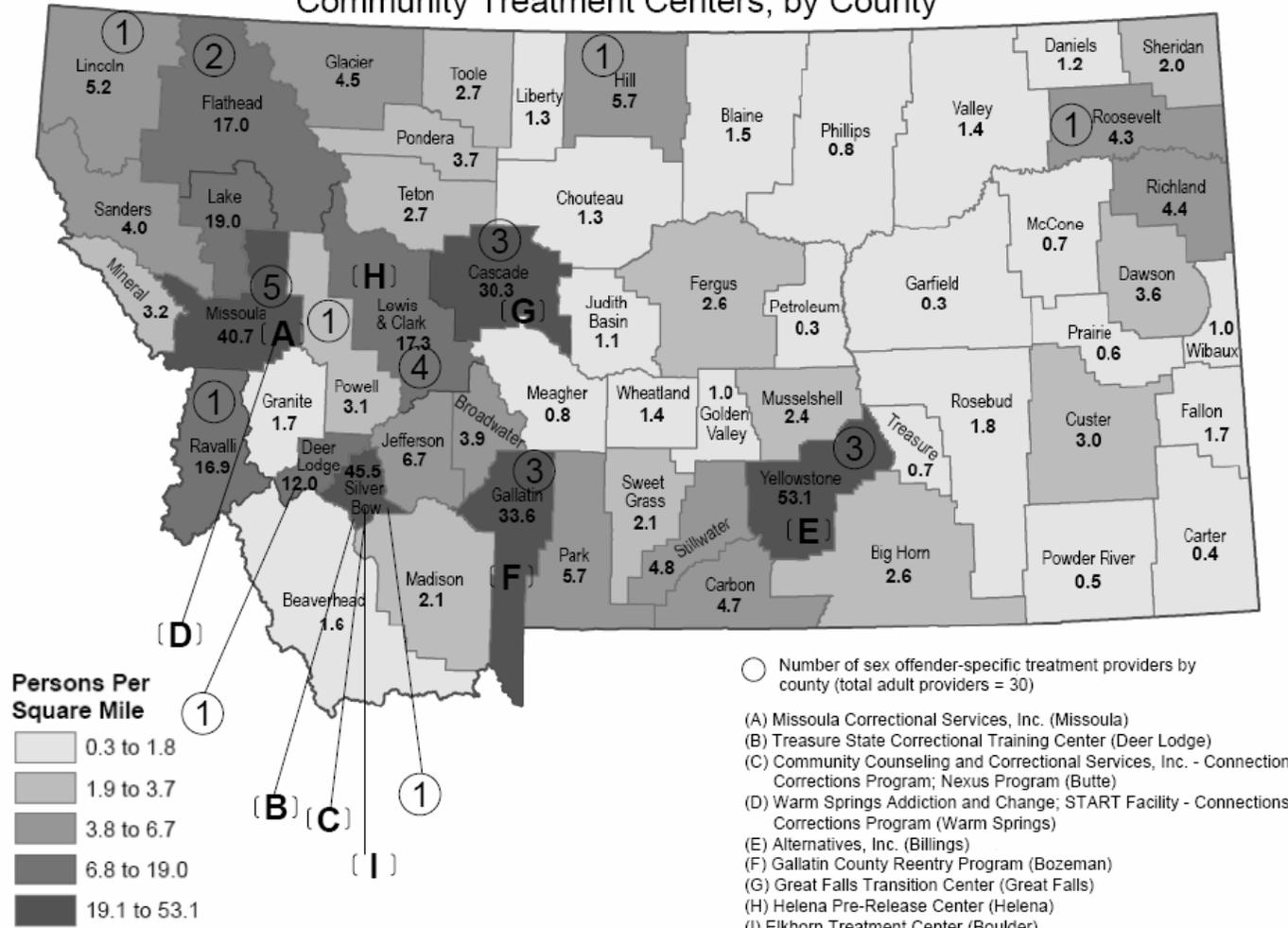
- ***Issue 8: Community-based sex offender treatment capacity is limited.*** Sex offenders under supervision are generally required to participate in community-based sex offender treatment. Providers indicate that the offenders are responsible for the cost of treatment, which ranges from \$180 – \$350 per month, and that sliding fees are generally not offered. The average length of time in community-based sex offender treatment is roughly 3.5 years.

Unfortunately, based on information provided by MSOTA representatives, there are only 30 clinical members throughout the state and, as such, treatment options for sex offenders are limited. Not surprisingly, providers are most likely to be located in the more populated areas of the state and, even then, the options are limited (see Exhibit 2). In many instances, only a single provider exists within a multi-county region. The eastern region of the state has almost no sex offender treatment providers.

The limited treatment capacity also limits the number of qualified and competitive candidates when contracting for services for the minimum security sex offender treatment facility.

EXHIBIT 2

Montana Treatment Providers, Pre-Release Centers, Community Treatment Centers, by County



Some MSOTA providers indicate that community-based sex offender treatment capacity is limited, to some extent, by an imbalance of the costs versus the benefits of providing this type of service. These include concerns about professional liability, difficulty collecting fees, and activities that are often “unbillable hours” (e.g., participating in multidisciplinary case management meetings, conducting ongoing assessments of dynamic risk, providing additional documentation to supervision officers).

Key Recommendations

- ***Recommendation 5: Establish a multiagency team of policymakers and other key decisionmakers to be charged with designing an assessment-driven continuum of sex offender treatment services in Montana.*** Because access to and placement in treatment programs is in part statutorily mandated – and because there are a variety of influences that impact placement decisions – representatives from the judiciary, Department of Justice, DOC, BOPP, MSOTA, and other relevant agencies/organizations are encouraged to engage in a strategic planning process (perhaps best facilitated by an external, neutral party) to develop a formal, assessment-driven system of sex offender services that is supported by all stakeholders. Ideally, through a careful balance of rehabilitative and retributive goals, such a team can establish complementary policies that guide the level of care and intensity of interventions in a manner that maximizes impact and effectiveness. The state of Vermont has worked to develop and maintain such a system and may serve as a useful example to Montana (see Appendix II).
- ***Recommendation 6: Adopt a research-supported, sex offender-specific assessment tool that will be used statewide to guide treatment planning and measure treatment progress.*** The use of a sex offender-specific assessment tool comprised of dynamic risk factors provides a standardized and more objective means of identifying appropriate targets of treatment and establishing clear and measurable treatment goals. In addition to promoting individualized treatment planning and establishing baseline assessments of sex offenders, it can increase the reliability of measuring treatment progress. Ideally, the use of such an instrument (e.g., Sex Offender Treatment Needs and Progress Scale⁸) would be incorporated into an administrative rule pertaining to treatment planning and delivery, MSOTA treatment standards and guidelines, and contractual requirements with treatment providers.

⁸ Sex Offender Treatment Needs and Progress Scale, McGrath & Cumming (2003).

- ***Recommendation 7: Create a system of incentives for sex offender treatment providers as a means of increasing treatment capacity and quality.*** The limited capacity for community-based sex offender treatment will continue to pose challenges to sex offender management efforts throughout the state. As a means of increasing such capacity, the DOC may wish to consider offering incentives to providers, such as the following:
 - Initial and ongoing specialized training opportunities at reduced or no cost;
 - Clinical supervision to support professional licensure and/or to become compliant with MSOTA standards guidelines;
 - Treatment space at local DOC offices (e.g., probation and parole offices) or facilities (e.g., pre-release centers);
 - Subsidies to cover treatment costs for indigent sex offenders who are referred for treatment;
 - Assistance with professional liability insurance or indemnification agreements for providers who meet and maintain specified program operation and quality assurance criteria; and
 - Placement on a "preferred providers" list when specified program operation and quality assurance criteria are met and maintained.

- ***Recommendation 8: Promote collaborative partnerships between community-based sex offender treatment providers and PRC administrators to explore the possibility of providing in-house sex offender treatment within PRCs.*** Continuity of treatment is an important component of an effective sex offender reentry strategy. To promote this continuity – and potentially alleviate some of the immediate treatment access concerns that can initially exist as sex offenders transition from prisons to the community – a facilitated dialogue between PRCs and MSOTA may be worthwhile for exploring treatment agreements. MSOTA providers may already be delivering limited services in the community, or are willing to offer sex offender treatment but do not have sufficient space to provide group treatment. Providing some of those services within the PRC setting can ensure that offenders have ready access to sex offender treatment (and that providers have access to treatment space), can create a mutually beneficial opportunity for the PRCs and providers, and may also alleviate some of the concerns of the PRCs and their screening committees.

SEX OFFENDER SUPERVISION

The evidence-based correctional literature indicates that balanced approaches to supervision with “general” offenders are more effective in reducing recidivism than a primary focus on enforcement and monitoring (Aos et al., 2006). Research also suggests that specialized supervision approaches – coupled with specialized treatment interventions – yield better outcomes with sex offenders than providing specialized supervision alone (McGrath, Hoke, & Vojtisek, 1998)). Moreover, to increase the effectiveness of sex offender management, many jurisdictions have implemented specialized caseloads. Such specialization facilitates expertise among select officers, increases collaboration with treatment providers and other stakeholders, and enhances the ability of the system to both hold offenders accountable and promote their stability and success in the community. And when sex offenders are stable and successful, public safety is realized.

Underlying effective supervision strategies is the importance of using specialized assessment information. Because risk levels and dynamic risk factors among sex offenders vary considerably, so should the intensity and targets of supervision. Again, sex offender-specific risk assessment instruments can assist officers with ensuring that management strategies (e.g., levels of supervision) are effectively matched to offenders based upon their assessed level of risk for sexual recidivism. In addition, specialized tools (i.e., STABLE/ACUTE-2000) now exist that can specifically assist supervision officers with focusing their ongoing management efforts on specific dynamic factors that are associated with sexual recidivism. When risk-increasing issues are identified through these routine assessments, or when supervision non-compliance is detected, officers must be poised to intervene accordingly. Through ongoing assessments and collaborative decisionmaking with treatment providers and other members of community management teams, officers’ responses will be more timely, proportionate, meaningful, and effective.

Observations in Montana

Sex offenders represent less than ten percent (6.6%) of individuals under community supervision. Nonetheless, with limited community-based resources available to sex offenders, negative public sentiment, and recent sex offender-specific statutory changes, supervising sex offenders has become increasingly challenging throughout the state. Important strategies to enhance supervision have been initiated in recent years and, with additional steps, the DOC can build upon and bolster the effectiveness of these efforts.

Identified Strengths

- ***Observation 11: Specialized supervision of sex offenders is valued as a means of reducing recidivism and increasing public safety in Montana.*** Recognizing the unique risk and needs of sex offenders, the Probation and Parole Bureau (P&P) elected to adopt a specialized caseload strategy to enhance sex offender management efforts. These caseloads are currently managed by 12 officers (i.e., sex offender specialists) in 5 of the 6 regions. A primary expectation of these specialists is to collaborate with community-based sex offender treatment providers by routinely exchanging key information about changes in risk or intervention needs, observing treatment groups, keeping abreast of an offender's level of engagement and progress, and assisting offenders with the day-to-day application of skills that they are developing in treatment. Additionally, judges and Parole Board members demonstrate a commitment to supporting specialized supervision approaches by respectively imposing special conditions at the time of sentencing and upon approval of parole.
- ***Observation 12: Officers have the benefit of baseline assessment information for sex offenders placed under probation or parole supervision to inform case management decisions at the outset.*** The mandated pre-sentence investigations and psychosexual evaluations are generally available to P&P officers at the time these offenders are placed under supervision. And in many instances, the pre-sentence investigations are conducted by the very officers who ultimately receive the offenders on their caseloads, creating continuity in case management. These assessments, which ideally contain detailed information about offenders' general and sexual recidivism risk, specific risk factors, and recommended intervention needs, can facilitate the development of informed supervision case plans, and provide useful baseline data against which changes in risk and need can be assessed throughout the course of supervision. This assessment data can also be useful for immediately initiating collaborative case management discussions between officers and community-based sex offender treatment providers when sex offenders are received under P&P supervision.
- ***Observation 13: Supervision policies require officers to employ a combination of field and office contacts.*** P&P recognizes the importance of engaging in change-promoting interactions with offenders and their collaterals in their natural environments (e.g., employment, home, treatment setting). Indeed, through formal policies, the expectation that officers prioritize field visits over office-based contacts

has been clearly established. This promotes a balanced and more effective framework for supervision, as it takes into account rehabilitation-oriented case management activities as well as surveillance, monitoring, and enforcement functions.

- ***Observation 14: The Intensive Supervision Program (ISP) exists as an additional supervision option for select high risk offenders.*** Established as an alternative to incarceration, ISP provides for an intensive level of supervision with electronic monitoring for higher risk offenders. Reduced caseloads are an important feature of these two-officer supervision teams. Although Parole Board referrals to ISP must be accepted, all other potential candidates are screened by the intensive supervision team, and subsequently by a local screening committee comprised of local citizens and law enforcement representatives, to determine suitability. For higher risk sex offenders that require heightened supervision, ISP may be a viable strategy.
- ***Observation 15: The Sanction, Treatment, Assessment, Revocation, and Transition (START) Program provides a valuable option for officers to address supervision non-compliance.*** Nationwide, high re-incarceration rates are largely attributable to technical violations. The START Program in Montana offers an alternative to incarceration for offenders with technical violations. Through short-term revocation or sanctioning placement in this highly structured treatment facility, offenders participate in risk-reducing interventions that are designed to facilitate a successful return to community supervision.

Issues for Consideration

- ***Issue 9: Supervision strategies for sex offenders are not driven by the use of validated sex offender-specific assessment instruments.*** Although by policy, supervision levels are determined by the use of a “general” risk-need assessment tool, the tool does not take into account the unique risk factors associated with recidivism among sex offenders. P&P regional administrators and officers alike recognize the limitations of such a tool and express concerns that the risk estimates generated by these assessments may result in underestimates of risk for sex offenders. They appreciate the increased precision that a validated, sex offender-specific risk-need instrument can offer for determining levels of supervision and ongoing case management.

Furthermore, officers’ ongoing case management strategies are not informed by research-supported assessments designed to specifically assist supervision officers with monitoring and targeting the changeable

factors associated with recidivism. Rather, adjustments to supervision approaches tend to be determined by subjective impressions of relative risk over time. In the absence of policies to govern the use of sex offender-specific assessment to inform supervision practices, the potential to most effectively manage this population will be undermined.

- ***Issue 10: The informal guidelines for sex offender supervision reflect a “one size fits all” model.*** In the absence of formal Departmental policies, the sex offender specialists developed a set of guidelines that outline the suggested minimal standards for supervising sex offenders. The following are key examples of practices recommended in the guidelines:
 - Initial level of supervision for all sex offenders should remain at Level II for the first six months of supervision;
 - Supervision levels should not be less than Level III unless sex offender treatment has been completed;
 - Officers should have routine (monthly) contacts with the MSOTA providers serving sex offenders on their caseloads;
 - Officers should routinely attend/observe sex offender treatment groups in which offenders in their caseloads are participating; and
 - Polygraph examinations should occur annually as recommended by the supervision officer or MSOTA provider.

While taking the initiative to develop specialized supervision guidelines is laudable, these suggested minimal practice standards do not promote an individualized, assessment-driven case management philosophy. Rather, the guidelines reflect a “one size fits all” supervision framework that is offense-based as opposed to risk-need based. In light of evidence-based principles for effective correctional intervention, such an approach is unlikely to have the desired impact on recidivism – particularly in contrast to assessment-driven supervision strategies.

- ***Issue 11: Caseload sizes for sex offender specialists are not congruent with the intended philosophy and purpose for specialized caseloads.*** Fundamental to effectively implementing specialized caseloads for supervision officers is the commitment to reduced caseload sizes. Limited caseloads are designed to afford officers additional dedicated time and resources that are necessary to:
 - Establish and maintain meaningful collaborative relationships with sex offender treatment providers, law enforcement officials, victim advocates, polygraphers, and others;

- Build community partnerships that address the common housing and employment challenges faced by sex offenders;
- Participate in efforts to educate and engage the public;
- Routinely assess the unique risk factors of sex offenders; and
- Monitor the additional conditions of supervision that are common to specialized supervision.

However, P&P administrators and officers acknowledge that the caseloads for sex offender specialists exceed the desired and intended ratios. In addition to limiting the utility of caseload specialization, these high caseload sizes may increase the potential for sex offender specialists to experience burnout.

- ***Issue 12: Specialized training is reportedly lacking for P&P officers who supervise sex offenders.*** Perhaps the primary and most important feature of specialized caseloads is the enhanced level of expertise of the officers. By definition, sex offender specialists should have specialized training and experience in sex offender management, thus increasing their capacity to provide more effective supervision for this special population. Many of the officers primarily responsible for supervising sex offenders expressed considerable concerns regarding the extremely limited preparation and training they have received to carry out these duties. Indeed, some of the specialists report having received no more training or assistance to supervise sex offenders than their “generalist” counterparts.
- ***Issue 13: Responses to violations appear to be unstructured and inconsistent.*** Officers indicated that they are afforded considerable latitude when addressing supervision non-compliance. Some level of discretion and flexibility is important for ensuring that responses to violations can be individually tailored to the specific circumstances, risk level, and interventions needs for offenders. However, policy-level direction and supervisory oversight were reported to be largely lacking, leaving responses to violations to vary as a function of officer philosophies, values, and interests. At one end of the continuum, this can result in compromised public safety because sex offenders are not held accountable for non-compliance. Conversely, “extreme” and overly punitive responses that are neither proportional nor measured can result in time and resource inefficiencies and unnecessary revocations, with no accompanying increase in public safety.

Key Recommendations

- **Recommendation 9: Formally adopt research-supported, sex offender-specific assessment tools to inform initial and ongoing P&P supervision strategies for sex offenders.** As emphasized throughout this report, an important step toward maximizing the overall effectiveness of sex offender management throughout the state, including sex offender supervision, is to take advantage of the strides that have been made with respect to specialized assessments of risk and needs for sex offenders. These tools can be of tremendous benefit for supervision officers and their collaborative partners, particularly when partner agencies adopt and consistently use a common assessment tool.
- **Recommendation 10: Revise the guidelines for sex offender supervision and formalize them through DOC policy.** Official policies should be in place to guide the specialized supervision practices of officers who have sex offender caseloads (i.e., sex offender specialists) or who are responsible for supervising sex offenders on general caseloads. The DOC can build upon the strengths of the guidelines that were developed (e.g., specialized conditions, travel restrictions, collaboration with treatment providers) and, at the same time, modify the underlying philosophy of offense-based supervision and establish a model of supervision that is informed by specialized assessments of risk and need as outlined above and elsewhere in this report.
- **Recommendation 11: Develop a specialized training and mentoring strategy for sex offender specialists and other officers responsible for supervising sex offenders.** Establish a multidisciplinary committee to explore the specific information needs of officers, identify training and other resources that can be used to address these needs, engage experienced mentors who can provide peer consultation and supervision to other officers, and propose accompanying performance indicators for agency administrators.
- **Recommendation 12: Enhance agency capacity for supervising higher risk sex offenders in the community through greater utilization of the Intensive Supervision Program.** Caseloads for sex offender specialists remain excessively high, while those of ISP officers have been consistently low. Statistics provided by the DOC suggest that less than 1% (n = 2) of all sex offenders under community supervision are involved in the ISP. It may be prudent to analyze sex offender referral trends and decisionmaking regarding these cases and explore enhanced utilization potential for this specialized population. ISP is

especially worth considering for scenarios such as: (a) high risk sex offenders transitioning from MSP or from the minimum security sex offender treatment facility to community supervision, particularly those who failed to progress in treatment or are experiencing destabilizing influences, or (b) high risk sex offenders who require an intermediate community-based or “step-up” option in lieu of a placement at MSP or the treatment facility.

- ***Recommendation 13: Establish a policy-driven system of graduated violation responses that requires timely, proportional, efficient, and effective responses.*** Such a system should be designed to ensure that the following principles are included (Burke, 2004; Carter, 2001):
 - Supervision conditions and expectations - and the range of sanctions or responses that will be used to address any instances of non-compliance – are clearly understood by the offenders;
 - Officers understand and are expected to fulfill their own roles in preventing violations, through identifying and responding to risk and needs on a case-by-case basis, brokering services proactively, and assessing progress routinely;
 - Officers ensure that offender accountability is a priority by responding in a timely manner to each instance of non-compliance;
 - Responses to violations are determined on the basis of departmental policy that mandates a structured process considering level of risk and the severity of a particular violation in the determination of an appropriate response (see Carter, 2001);
 - A range of sanctions and other strategies (including referrals to programs or services) is in place for officers to use when responding to various levels of violations, such that responses are proportional;
 - The lowest level sanction or response is always used in order to manage correctional resources effectively and allow offenders the ongoing opportunity to modify their behaviors and work toward successfully completing supervision (provided that public safety will not be compromised);
 - Decisions about responses to violations are made collaboratively between officers and treatment providers who share responsibility for given cases;
 - The system processes violations efficiently for the benefit of both the offenders and the officers; and
 - Responses to violations assist officers and offenders alike with attaining successful supervision goals.

SEX OFFENDER REENTRY

National statistics indicate that the number of individuals sentenced to prison has begun to stabilize and, in many instances, is on the decline. The same does not hold true for sex offenders. And as the number of sex offenders entering prisons increases, so does the number of eventual releases from prisons.

Reentry is typically challenging for “general” offenders and, with sex offenders, it tends to be even more difficult. This is attributable to factors that include negative public sentiment, widespread myths about sex offenders and recidivism, exacerbated housing and employment challenges, and the proliferation of legislative changes that target sex offenders (e.g., residency restrictions, GPS monitoring, enhanced registration and notification, lifetime supervision). Release and reentry also pose challenges to those who have a stake and a role in the sex offender management process, such as paroling authorities and other release decisionmakers, institutional case managers, community supervision officers, victims and their families, and the general public.

To enhance sex offender reentry efforts, corrections and partner agencies have begun to build on the promising strategies developed for other offenders, tailoring those approaches to address the specific barriers that exist with the sex offender population. For example, some have initiated release planning for sex offenders earlier than for non sex offenders. This ensures that release preparation is a deliberate process that takes into account the unique risk factors, intervention needs, and reentry barriers that exist, above and beyond transition and release considerations (e.g., employment assistance, housing, continuity of health, and mental health care) that must be addressed for other offenders.

In several states, successful reentry is facilitated through discretionary release practices, whereby the incentive of conditional release is used to promote sex offenders’ participation in risk-reducing interventions within the prison, well-designed release plans must be in place when offenders appear for parole hearings, and special conditions are imposed for released offenders to ensure their ongoing participation in needed services and their ultimate success in the community. Other jurisdictions have developed specific services to assist reentering sex offenders who lack social or other ties in the community, through the use of volunteers who are specially trained to provide stabilizing assistance, support, and accountability. And finally, in some locales, researchers and policymakers have examined the impact of some sex offender-specific laws (e.g., residency restrictions) and identified a number of collateral consequences that actually serve to increase,

rather than decrease, recidivism potential among sex offenders. As a result, they have elected to modify (or decide against) these types of strategies and have opted to consider approaches that may better facilitate successful sex offender reentry as a means of promoting public safety.

For these and other efforts to be possible, stakeholders in the sex offender management field recognize that policymakers and practitioners benefit from a specialized understanding of sex offenders and effective management approaches. Also necessary is the need to better educate the public about sex offenders, make citizens aware of the steps that are being taken to manage sex offenders effectively and promote public safety, and elicit the support of key individuals in the community to help address barriers to reentry.

Observations in Montana

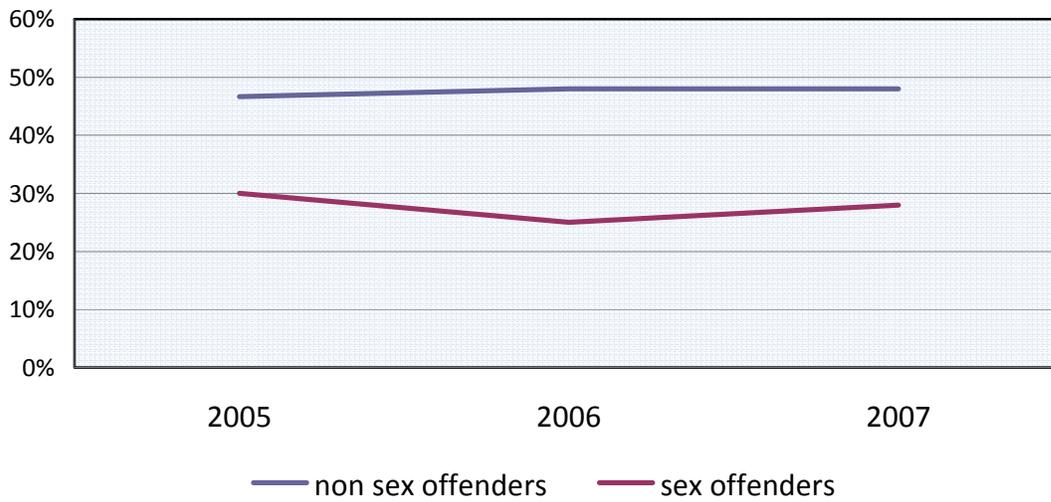
Much like other states, Montana faces significant challenges with the effective transition of sex offenders from prison to the community. Indeed, representatives across agencies and disciplines (e.g., Parole Board members, institutional and field officers, law enforcement, institutional and community-based treatment providers) concur that this special offender population often raises more concerns – and encounters more barriers – than most other groups of offenders.

Identified Strengths

- ***Observation 16: The leverage of discretionary parole is used to promote effective sex offender reentry through requirements for sex offender treatment pre- and post-release.*** Paroling authorities express considerable reservations about releasing sex offenders, and the parole approval rates confirm this. Statistics provided by BOPP indicate that over the past few years, the parole approval rate for sex offenders has remained significantly lower than the parole approval rate for non-sex offenders (see Exhibit 3). At the same time, the Parole Board recognizes that when sex offenders discharge their sentences, the system's ability to facilitate public safety through specialized sex offender management strategies is largely eliminated. And because the Parole Board has considerable confidence in the risk-reducing potential of the sex offender treatment program at MSP, they require most sex offenders to complete Phases I and II of the sex offender program before they will be considered for parole release. Further, the Parole Board requires sex offenders to continue in specialized treatment in the community and abide by other sex offender-specific expectations as conditions of release.

Exhibit 3

Parole Approval Rates for Non-Sex Offenders vs. Sex Offenders: 3 Year Trends



- **Observation 17: The Department's commitment to providing effective transitional programs and services is strong.** Over the past several years, significant investments have resulted in considerable capacity for community-based, residential pre-release centers (PRCs) – as well as a Transitional Living Program (TLP) – designed specifically to assist offenders in reentering the community successfully. The PRCs are strategically located in Billings, Bozeman, Butte, Great Falls, Helena, and Missoula, thus providing carefully screened offenders in several locations opportunities to benefit from these valuable programs (See Exhibit 2). Additionally, a number of promising prison-based strategies are in place to facilitate the transition and reentry process (e.g., Institutional Probation and Parole Officer (IPPO) positions, BOPP staff involvement at MSP intake screenings, and pre-parole classes offered by BOPP staff). These and other reentry-focused initiatives create an existing framework within which tailored sex offender release and reentry efforts can be strategically considered.
- **Observation 18: An array of community-based residential programs that target other "special needs" populations exists.** The DOC has developed, through contracts, increased capabilities to address the unique needs of other special needs offender groups in residential facilities – including gender-specific programs – that provide alternatives to incarceration. These include alcohol/drug treatment (e.g., throughout the Connections Corrections Programs at Butte and Warm Springs); methamphetamine-specific addictions treatment (e.g., Elkhorn

Treatment Center, Nexus); and specialized programming for technical violators (i.e., the START Program) (See Exhibit 2). The desire to establish a minimum security sex offender treatment facility is a logical addition to the existing cadre of programming along a continuum of care.

- ***Observation 19: Dedicated and ongoing efforts to inform and engage the public are a visible priority.*** Through its mission, values, philosophies, and stated goals, the DOC is committed to securing the trust and support of the public. This ongoing commitment is demonstrated in multiple ways, including the active engagement of the public when new programs or facilities are being considered in local communities, and the involvement of citizens on local screening committees. Furthermore, recognizing victims and their families as important stakeholders is a longstanding philosophy and practice within the Department, as evidenced by the following:
 - Striving to ensure victim-centered correctional policies and practices through the involvement of victims and their families on the Crime Victims Advisory Council;
 - Creating victim impact panels (VIP) to assist offenders with taking responsibility for their crimes and recognizing their impact on victims and others;
 - Incorporating restorative justice into programming efforts;
 - Developing thoughtful approaches to community notification through the conduct of public education meetings when sex offenders return to local communities; and
 - Providing ongoing education, information, and support to interested parties from the point of offenders' incarceration through the parole and post-release supervision process.

As a result, the DOC has been successful in establishing, maintaining, and expanding treatment facilities and other alternative-to-incarceration programs throughout the state.

Issues for Consideration

- ***Issue 14: Well-intentioned parole prerequisites regarding intensive prison-based sex offender treatment may not be well-informed.*** Although the Parole Board's interest in ensuring that all sex offenders complete Phase I and Phase II services prior to release is understandable, requiring higher intensity/high dosage treatment for all sex offenders – regardless of risk level – is unlikely to result in the desired recidivism reductions. Furthermore, such a practice can reduce timely access to treatment, which in turn can lead to greater numbers of

sex offenders being released to the community without having received needed services, or greater numbers of sex offenders remaining in secure confinement for longer periods of time than may be necessary. In some instances, therefore, a standard practice of requiring all sex offenders to complete both phases of sex offender treatment prior to release from prison can unintentionally result in a paradoxical effect that ultimately does not support the Board's desires to enhance public safety.

- ***Issue 15: The “general” risk assessment tool considered by the Parole Board for non-sex offense cases is not used to augment the sex offender-specific risk assessment findings.*** With non sex offenders, the Parole Board utilizes the findings from a validated risk assessment tool as one of the data points to consider when making release decisions with non-sex offense cases. BOPP does not use this risk assessment tool with the sex offender population however, and instead uses the Tier designation as a proxy. Because sex offenders are more likely to recidivate with non-sexual crimes than new sex crimes, the more general risk assessment tool should be considered in conjunction with the tier designation (i.e., estimate of risk for sexual recidivism).
- ***Issue 16: Transitional opportunities for sex offenders are extremely limited.*** Despite the significant capacity to promote successful reentry through PRCs, these and other community-based facilities tend to exclude sex offenders from placement. Only two of the PRCs routinely accept referrals of sex offenders (and then only under limited conditions and in limited numbers), leaving critically important intermediate options lacking for this special population. The already limited employment options, the shortage of sustainable, appropriate housing for sex offenders, and other barriers and needs that prevent sex offenders from being community-ready upon release from prison highlight the importance of increasing transitional placement options for sex offenders in the state.
- ***Issue 17: Negative public sentiment poses considerable challenges to sex offender reentry throughout the state.*** Stakeholders at all levels and across agencies/disciplines cited community resistance as the primary barrier to sex offender reentry, particularly with respect to housing and employment options for these offenders. In addition, pressure and negative sentiment from citizens can have a powerful influence on sentencing practices, release decisions, and program sitings, all of which may impact the effectiveness of community reintegration efforts with sex offenders.

Key Recommendations

- ***Recommendation 14: Engage the Parole Board in a collaborative dialogue about the effectiveness of risk-driven sex offender treatment intensity for parole-eligible sex offenders.*** The Parole Board plays a significant role in enhancing the effectiveness of sex offender treatment. Indeed, they can support an effective continuum of treatment services through differential, assessment-driven requirements and expectations they set for sex offenders. For this to occur, however, efforts must be made to assist the Parole Board with understanding the principles of effective correctional intervention (specifically the risk principle) and to provide a forum in which they can explore the application and implications of the risk principle for their day-to-day decisionmaking considerations with sex offenders. In addition, it requires that the Board receive reliable and valid risk assessments of sex offenders, such that they can have greater confidence in decisions to parole lower risk sex offenders following less intensive sex offender treatment. The establishment of a minimum security sex offender treatment facility offers an excellent opportunity for the DOC and Parole Board to begin exploring the issue of risk-based treatment and using existing and new resources accordingly.
- ***Recommendation 15: Provide a networking and problem-solving forum for PRC and other transitional facility administrators to examine policies regarding sex offender placements.*** With the growing demand for placements that can facilitate sex offender reentry, the programs that offer alternatives to incarceration in Montana are experiencing pressure to revisit policies that exclude sex offenders. Hesitation (and, in some instances, resistance to) accepting sex offenders is understandable, and may largely be a function of limited information – and a range of unanswered questions – about sex offenders, and about how best to ensure community safety and reduce liability if these offenders are accepted for placement. Because the Missoula and Billings PRCs have experience with this special population, they can serve as a valuable resource to those programs and facilities that are currently grappling with this issue. Indeed, they are in a unique position to provide their PRC counterparts with information about the screening process used for sex offender referrals, approaches to educating the public and garnering their trust and support, successes with sex offenders as residents of these centers, and strategies used to overcome the barriers to sex offender reentry efforts. This is also an opportunity to assist PRC administrators and screening committees with understanding the value of empirically-validated sex offender-specific risk assessment tools as a means of screening sex offenders for suitability.

- ***Recommendation 16: Ensure that the findings of a validated sex offender-specific risk assessment tool are among the formal criteria considered by the screening committees.*** For programs receiving referrals of sex offenders, decisionmaking by the local screening committees should be guided not only by a valid risk assessment tool designed for more “general” offenders (e.g., LS/CMI), but also a risk assessment instrument designed specifically for sex offenders (e.g., Static-99). Specialized training should be targeted to these screening committees about the strengths, limitations, and practical application of sex offender-specific risk assessment findings to their day-to-day decisionmaking efforts.

- ***Recommendation 17: Capitalize and build upon current community education efforts underway in Montana to develop a public education strategy specific to sex offender management.*** The DOC has a history of educating and engaging the public with respect to offender management, including some issues specific to sex offender management. The lessons learned from these and other public education and involvement efforts can be instructive as they embark upon the process of establishing the minimum security sex offender treatment facility. An ideal starting point is through the promising community notification strategies that have been implemented in some parts of the state, as well as the questions and concerns about sex offenders that are commonly addressed by the DOC’s Victim Services personnel.

As recommended by representatives across agencies and disciplines during the course of this review, the content of these public education strategies overall – and as specifically related to siting the minimum security sex offender treatment facility – should minimally include the following:

- Accurate information about sex offenders and effective sex offender management strategies;
- A clear description of the client population to be served (e.g., tier levels, types of offenses);
- The communities of origin for the offenders that will be targeted for the facility;
- The communities to which the sex offenders are expected to return post-release from the facility;
- Goals and descriptions of the interventions that will be provided;
- Expected outcomes from offenders’ participation/placement (e.g., impact on recidivism, other indicators of success);

- Specific measures that will be taken by the vendor to maintain the safety of the community;
- The role of other agencies (e.g., law enforcement, DOC) in safeguarding the community; and
- The ways in which the vendor's establishment and operation of the facility will support or enhance the local economy.

It should be noted that the development of a public education strategy must extend beyond the shorter-term goals of garnering support for the minimum security sex offender treatment facility. Rather, the strategy also should be geared toward longer-term public education initiatives that address management of all sex offenders as well as primary prevention measures.

SECTION III: RECOMMENDATIONS FOR THE ESTABLISHMENT OF A MINIMUM SECURITY SEX OFFENDER TREATMENT FACILITY

The DOC has considerable experience with establishing, monitoring, and supporting various correctional programs and services through partnerships and contractual arrangements. As such, the consultants understand and appreciate the DOC's desire for recommendations that focus primarily on the sex offender-specific nature of the proposed facility. A number of specialized considerations are therefore offered in this section as a means of guiding the DOC's deliberations. The foundation/rationale for many of these elements have been established throughout this report. It is important to reiterate that the majority of these items have significant implications for (or may be impacted by) current operations within the system. Each of these must be considered carefully within the context of a more comprehensive and effective approach to sex offender management in the state.

RECOMMENDATIONS REGARDING THE TARGET POPULATION

In determining the most appropriate population for the minimum security sex offender treatment facility, a variety of factors should be taken into account. A primary consideration is the set of parameters regarding the type of offenders who might be eligible for the program. It is the consultants' understanding that a determination has been made to consider offenders designated as Tier I for the program, and that some Tier II offenders may be considered eligible as well. The fact that Tier I offenders represent the lowest risk among all sex offenders in Montana, and Tier II the moderate risk offenders, dictates several practical considerations that are informed by research:

- Research clearly indicates that recidivism reduction is best attained by matching higher risk offenders to the most intensive (dosage and duration) services (Andrews & Bonta, 2006). It therefore stands to reason that the services at MSP (SOTP Phase I and Phase II) are best directed to Tier III and perhaps some Tier II offenders. As such, the expanded resources and services available through the minimum security sex offender treatment facility can therefore be directed primarily to Tier I and some Tier II sex offenders.
- Research also reveals that the rate of sexual recidivism among sex offenders is relatively low – less than 15% on the average, with an average 5-6 year follow-up period (Hanson & Morton-Bourgon, 2005). Moreover, when sex offenders recidivate, they most commonly do so

through the commission of a non-sexual offense. For these reasons, it is recommended (as noted elsewhere in this report) that potential candidates for the sex offender treatment program be screened for both sexual and general recidivism risk. It is further recommended that offenders who score low to moderate on empirically-validated sex offense-specific risk assessment tools – but who score high on general risk assessment tools - be excluded from the program, at least in its initial years.

- Finally, research demonstrates that there are no optimal “fixed” periods of treatment. Rather, the intensity and length of service should be determined based upon offenders’ level of risk, criminogenic needs/dynamic risk factors, and other considerations such as the pace of progress in treatment. For this reason, as is addressed elsewhere in this report, it is recommended that the sex offender treatment facility program length be flexible, allowing for offenders who are low risk/needs and demonstrate amenability to treatment to progress more quickly than others who may have higher levels of risk/need or be slower to progress. In other words, this suggests that there is not an “ideal” sentence length for participation in the program.

Based on the current sentencing structures within Montana, the following assumptions are also made about the parameters that further define the offender population:

- Many offenders admitted into the prison system have credit for time served prior to sentencing;
- Offenders sentenced to prison in Montana are eligible for parole review after completing 25% of their sentence;
- An average estimated time in treatment of 12-24 months could reasonably be estimated; and
- Most if not all offenders could benefit from six months or more in a pre-release setting prior to release.
- ***Recommendation 18: In light of the aforementioned considerations, it is recommended that offenders with sentences of approximately 7 years or less be considered for placement in the sex offender treatment facility.*** Specific agreement between DOC and the Parole Board should be reached in advance on this matter.

Specialized Subpopulations

- ***Recommendation 19: It is recommended that this facility be designated exclusively for male offenders.*** It is generally accepted practice not to co-mingle male and female sex offenders.
- ***Recommendation 20: Given that there is research support to indicate that population “mixing” can have iatrogenic effects, it is recommended that the DOC determine whether sufficient demand among the low to moderate risk offenders exist to justify the designation of a specialized unit within the sex offender treatment facility for this population.*** Insufficient data was available to assess the need for specialized services for sub-populations among sex offenders, most particularly low functioning/MRDD offenders.

Process Recommendations

Designing and operating the minimum security sex offender treatment facility requires attention to a number of essential process-related factors, many of which should be considered as prerequisites to the start-up of the facility. In the absence of dedicated efforts to address these factors, the vendor, the Department, and the system overall will be less likely to create an environment that is conducive to success. As such, the following recommendations are offered:

- ***Recommendation 21: Provide training to key decisionmakers (within DOC, the Parole Board, and others) on sex offender recidivism risk and the principles of correctional intervention⁹ to assure a common knowledge base regarding evidence-based practice with this population of offenders.***
- ***Recommendation 22: Prior to or during the RFP bidding process, convene a meeting between DOC leadership and key staff, and Parole Board Executive staff and Parole Board members (as appropriate), to discuss the facility design, structure, target population, screening process, methods to provide treatment, and assess treatment progress and release readiness, and potential parole release timing.***

⁹ These principles speak to fundamental policy and practice issues that are based upon extensive recidivism literature, such as risk, need, and responsivity and, for instance, directing the delivery of high intensity service to high risk offenders and the converse to low risk offenders (Andrews & Bonta, 2007).

- ***Recommendation 23: Convene an ad hoc committee of representatives from the Parole Board and the DOC to agree upon the inclusion criteria for Tier II offenders.***
- ***Recommendation 24: Establish an early screening process for potentially eligible offenders. Secure the agreement of the Parole Board to participate in the early screening process for eligible offenders.***
- ***Recommendation 25: Take steps to accurately assess and verify the tier designations of offenders, as noted elsewhere in this report, to avoid inappropriate inclusions/exclusions of offenders in this facility.***
- ***Recommendation 26: Identify an early point of identification based upon offenders' tier designation and non-sexual recidivism risk. Once identified, refer potentially eligible offenders to the Parole Board for review for suitability for placement in the facility.***
- ***Recommendation 27: Design a strategy to educate/build awareness among key stakeholders (judges, prosecutors, defenders, key community representatives) regarding the eligibility requirements and programmatic goals of the facility. Take steps to avoid potential actions that would result in "net widening" (the sentencing of offenders to periods of confinement that might make them eligible for this program that would otherwise [absent the program] not be sentenced to a term of confinement, or sentenced to lesser terms of confinement).***
- ***Recommendation 28: Develop a written policy to define and formalize the scope of the facility, specifically addressing the:***
 - ***Target population;***
 - ***Goals of the program;***
 - ***Eligibility criteria;***
 - ***Screening process;***
 - ***Formal admission process; and***
 - ***Intent to administer the program as an alternative to more secure confinement for sex offenders who would otherwise be sentenced and required to participate in the MSP program.***
- ***Recommendation 29: Because the vendor should be expected to maintain positive community relations long after the facility is sited and established – and as they will ultimately need to include a community member on the screening committee – the DOC is***

encouraged to require bidders to include in their proposals a strategic plan that addresses community engagement. It may be especially valuable to include the requirement that bidders demonstrate, through their proposal, the steps that have already been undertaken in this respect, and include evidence that the community in which they plan to establish the facility has been provided specific information about this potential facility and that they are poised to support such a facility. As such, the DOC and vendor will have an increased level of confidence that community reaction will not pose a significant barrier to the establishment of the facility and risk being left without an appropriate location after the contract award has been made.

RECOMMENDATIONS REGARDING ASSESSMENT

- ***Recommendation 30: As part of the program intake process, and as a means of guiding initial treatment/case management planning efforts, the following measures should be considered by the DOC as potential requirements:***
 - *Empirically-validated, sex offender-specific risk assessments (e.g., Static-99) adopted by the Department, thus ensuring consistency throughout the system;*
 - *Empirically-validated, general offender risk assessment (e.g., LS/CMI) adopted by the Department, thus ensuring consistency throughout the system;*
 - *Research-supported psychophysiological assessments of deviant sexual arousal, interests, and/or preferences (e.g., Abel Assessment for Sexual Interest); and*
 - *Sexual history polygraph examinations.*

- ***Recommendation 31: To objectively inform treatment plan reviews and modifications to treatment/case management plans, the following tools are worthy of consideration:***
 - *Polygraph maintenance exams (e.g., every six months and/or prior to release from the facility);*
 - *Research-supported, sex offender-specific clinician ratings of dynamic risk factors and treatment progress (e.g., Sex Offender Treatment Needs and Progress Scale) as adopted by the DOC for consistency throughout the system; and*
 - *Other assessments adopted by and/or through mutual agreement with the Department.*

While there are a number of unique risk factors and intervention needs specific to this special population, sex offenders also share risk factors and intervention needs that contribute to both sexual and non-sexual recidivism (Hanson & Morton-Bourgon, 2005). As such, the assessments listed above are not designed to replace traditional empirically-validated risk-need assessment instruments used with more general offenders (e.g., LS/CMI). Rather, sex-offender assessment tools are designed to complement, and provide additional focus, for treatment interventions and case management decisions within the sex offender treatment facility.

- ***Recommendation 32: The successful vendor must provide documentation of the qualifications and expertise of program staff and/or any subcontractors' credentials, expertise, and certifications pertaining to the administration, interpretation, and application of these and other assessments.***

RECOMMENDATIONS REGARDING TREATMENT MODEL AND GOALS

Because research demonstrates the effectiveness of a cognitive-behavioral approach to sex offender treatment (Aos et al., 2006; Hanson et al., 2002; Losel & Schmucker, 2005), this should be the expected model for the program/facility. Consistent with the other residential treatment programs contracted by the state, the DOC may wish to additionally require the sex offender treatment program to be delivered within the context of a therapeutic community/modified therapeutic community, with a progressive level system to be established by the vendor. Advancement through the vendor's proposed level system must include, but should not be limited to, factors such as motivation to change, participation and engagement in the program, conduct within the facility, leadership within the therapeutic community, and progress in treatment (as assessed by research-supported tools).

- ***Recommendation 33: The required modalities should include a combination of the following:***
 - ***Group therapy (8-10 clients per group), with groups co-facilitated by two therapists;***
 - ***Individual therapy; and***
 - ***Marital/partner/family therapy (as circumstances allow).***
- ***Recommendation 34: Treatment goals should be risk-need assessment-driven and individually-tailored for program participants. Generally speaking, the specific goals for offenders***

participating in sex offender treatment should include, but not be limited to, the following:

- *Modifying thinking errors, cognitive distortions, or dysfunctional schemas that support sex offending behaviors;*
- *Managing emotions and impulses in constructive ways;*
- *Developing healthy interpersonal and relationship skills, including communication, perspective-taking, and intimacy;*
- *Managing deviant sexual arousal or interest and increasing appropriate sexual interests;*
- *Practicing healthy coping skills that address identified risk factors;*
- *Establishing or expanding positive support systems;*
- *Addressing one's needs in positive ways and not at the expense of others; and*
- *Leading a productive, satisfying, and fulfilling life that is incompatible with sex offending.*

RECOMMENDATIONS REGARDING TREATMENT TARGETS

- *Recommendation 35: Consistent with the principles and practices of effective correctional intervention, the focus of the treatment program must primarily emphasize the criminogenic needs that pertain to general reoffending as well as sexual reoffending. For sex offenders, these include, but are not limited to, the following (Hanson & Morton-Bourgon, 2005):*
 - *Sexual deviance variables (e.g., deviant sexual interests, arousal, or preferences; sexual preoccupations);*
 - *Antisocial orientation (e.g., antisocial personality and traits, psychopathy, negative social supports, pervasive hostility, impulsivity, employment instability);*
 - *Intimacy deficits (e.g., absence of intimate relationships, conflicts in intimate relationships, emotional identification with children, attachment difficulties, distorted schemas and perceptions about individuals and relationships); and*
 - *Pro-offending attitudes and schemas (e.g., beliefs and attitudes that support sexually abusive and other problem behaviors; cognitive distortions such as minimizations, justifications, and rationalizations).*

In addition, the following treatment targets are commonly included in sex offender programs for individuals who have

assessed needs in these areas, and should be included in the program's content:

- *Relapse prevention;*
- *Communication and social skills;*
- *Substance abuse;*
- *Problem-solving and stress management;*
- *Sex education;*
- *Trauma resolution; and*
- *Victim impact and awareness.*

RECOMMENDATIONS REGARDING INTENSITY AND DURATION OF PROGRAMMING

- *Recommendation 36: Consistent with the expectations of other contracted treatment facilities who provide residential programs for the Department, 8-10 hours of programming per day (with programming taking multiple forms as defined by the Department and described above) would appear to be a reasonable expectation for the sex offender treatment facility, of which a minimum of 2 hours per day should ideally be dedicated to sex offender-specific programming. Sex offender-specific treatment groups of 90-120 minutes per group should be provided for offenders a minimum of 2-3 times per week, which is the average for institutional/residential sex offender treatment programs (McGrath, Cumming, & Burchard, 2003). It is expected that the length of stay would be in the average range of 12-24 months, varying as a function of the risk and needs of offenders and specific responsivity factors (e.g., motivation, cognitive functioning). Recent data for institutional/residential sex offender-specific treatment programs reveals an average of approximately 2 years for completion (McGrath et al., 2003).*

RECOMMENDATIONS REGARDING TREATMENT PLANS

- *Recommendation 37: For each offender served by the program, interventions should be guided by a comprehensive, individualized, assessment-driven, and formally documented treatment plan which is characterized by the following:*
 - *Developed jointly by the case management team (composition to minimally include clinical director, primary treatment provider, line/custody staff, and others as specified by vendor) and the offender;*

- *Summary of assessment findings as outlined above and to include other assessment data as specified by the vendor;*
 - *Specific, observable, measurable short- and long-term goals;*
 - *Needed interventions and modalities to address each goal (linked to assessment findings);*
 - *Program staff responsible for respective interventions; and*
 - *Target dates for goal attainment.*
- *Recommendation 38: Furthermore, the case management team is expected to conduct and document quarterly reviews with each offender; these reviews should include a detailed treatment progress review and other key performance indicators (to be specified by vendor), a reassessment using the battery of approved general and sexual risk/need instruments at least twice a year (or more frequently should conditions warrant), and a resulting modification to the treatment/case management plan as needed.*

RECOMMENDATIONS REGARDING DISCHARGE PLANNING

- *Recommendation 39: Within a minimum of 6 months of a sex offender's anticipated release date – based on objectively measured progress toward attaining treatment plan goals – discharge planning should be initiated. Discharge planning should be designed to address the unique needs of sex offenders (e.g., exacerbated housing and employment challenges, continuity of sex offender treatment, community support networks) and should include the supervision officer who will be assuming responsibility for the sex offender post-release.*
- *Recommendation 40: Prior to an offenders' exit from the facility, regardless of the specific reasons for the exit (e.g., successful completion, termination, revocation), a designated clinical services provider or caseworker should prepare a discharge report that summarizes and provides final documentation of the following key issues:*
 - *Overall adjustment within the facility;*
 - *Level of participation in treatment services, including treatment refusals;*
 - *Progress toward the treatment program goals outlined above, including the exit ratings from the research-supported, objective, sex offender-specific measure(s) of treatment*

- progress and other instruments as adopted by and/or through mutual agreement with the DOC;*
 - *Anticipated intervention needs, identified dynamic risk factors that are present, and estimates of risk (based upon the findings from research-supported, objective, sex offender-specific risk assessment and other instruments as adopted by and/or through mutual agreement with the Department); and*
 - *An approved release plan that takes into account residence/placement, sex offender registration requirements and fulfillment, any special conditions that the program believes should be considered, and any special conditions that have been otherwise imposed (e.g., by the courts, BOPP).*
- *Recommendation 41: The discharge summary should be reviewed and approved by the program's clinical director and/or program staff in an administrative role and distributed prior to the offender's release to relevant stakeholders who have jurisdiction over and will otherwise assume responsibility for providing services to the offender (e.g., P&P officer, community-based treatment provider) – within the parameters of Departmental policies for information-sharing and release of records.*

RECOMMENDATIONS REGARDING DOCUMENTATION IN OFFENDERS' FILES

- *Recommendation 42: While certainly not unique to sex offender treatment programs, clear and consistent documentation of assessment findings, interventions provided, progress made, and overall conduct/adjustment within the facility is critical to effective programming. The DOC should expect, at a minimum, the following information to be maintained in offenders' files:*
 - *Informed consent for treatment;*
 - *Notice of confidentiality limits (e.g., mandated reporting, HIPAA requirements, interagency communication);*
 - *Relevant current and historical records (e.g., police reports, court orders, prior treatment records);*
 - *Assessment data (e.g., pre-sentence investigation, psychosexual evaluation, risk assessment);*
 - *Signed treatment contract;*
 - *Individual treatment plan;*
 - *Summaries of each treatment encounter;*
 - *Key communications with other stakeholders (e.g., P&P officers, prison-based staff, the courts);*

- *Treatment completion or termination summary; and*
- *Discharge summary.*

However, particularly germane to documentation and information-sharing policies for sex offender treatment programs is the manner in which additional disclosures that arise through the course of treatment are addressed. In some instances, mandated reporting laws apply, while in others, new disclosures may not reach the threshold for mandatory reporting. In anticipation of this potential, the DOC is encouraged to further explore policy and practice implications prior to the facility start-up, if it has not been addressed to date.

RECOMMENDATIONS REGARDING STAFFING PATTERNS AND SEX OFFENDER-SPECIFIC TRAINING

- ***Recommendation 43: In collaboration with the Department, the successful vendor should establish staffing patterns/ratios that meet or exceed the minimum standards for adequate supervision and care within prison-based programs and correctional residential treatment facilities (see American Correctional Association 2003, 2004, 2005, and/or the National Commission on Correctional Health Care, in press, 2008).¹⁰***
- ***Recommendation 44: With respect to training, program staff providing sex offender treatment are expected to meet and maintain MSOTA standards and any other minimum qualifications established by the DOC through administrative rule, with the vendor providing certification/attestation and supporting documentation. In addition, the vendor should include a plan for ensuring routine clinical supervision for treatment staff (the vendor should specify the minimum number of hours required per month, varying based on staff experience and at the discretion of the clinical director).***
- ***Recommendation 45: To ensure that all non-clinical staff understand the target population and the sex offender-specific nature of interventions, specialized training should be provided prior to the facility start-up and should address the following:***
 - ***Etiological theories of sex offending;***
 - ***Diversity of sex offenders;***

¹⁰ MnSOST-R, Epperson, Kaul, & Hesselton, (2000); SORAG, Quinsey, Harris, Rice, & Cormier (2006); RRASOR, Hanson (1999); Static-99, Hanson & Thornton (1998).

- *Risk factors associated with recidivism;*
 - *Contemporary models of treatment;*
 - *Treatment outcomes; and*
 - *Supervision and other key sex offender management strategies.*
- ***Recommendation 46: Ongoing training (including on-site) for all staff should be provided semiannually, with the minimum training hours, topics, and trainers to be identified by the vendor and with the approval of the Department. Clinical staff should participate in (and, if appropriate, assist with providing) the training to ensure that all program staff have a common framework. In addition, treatment program representatives should assist with public education or other training initiatives pertaining to sex offender management in the state as mutually agreed upon by the vendor and the Department.***

RECOMMENDATIONS REGARDING PERFORMANCE AND OUTCOME MEASURES

Throughout the course of this review process, the DOC provided multiple sources of data pertaining to the sex offender program at MSP (as well as other valuable agency-specific information). The types of current and historical data include, but are not limited to, the following:

- Number of sex offenders served by the MSP sex offender treatment program;
 - Some statistical profile data about the offenders;
 - Tier designations of the offenders;
 - Phase I and Phase II program entrances and exits, including completions and non-completions;
 - Wait list information for Phase I and Phase II (for both ITU and OP);
 - Treatment refusals;
 - Phase II program entrances and exits, including completions and non-completions;
 - Prison releases of Phase II completers and non-completers (for both ITU and OP groups);
 - Prison returns (for violations or sexual reoffenses) for Phase II completers and non-completers (for both ITU and OP groups); and
 - Type of release/level of care for Phase II completers (for both ITU and OP groups), such as intensive supervision, parole, discharge, and pre-release.
- ***Recommendation 47: The DOC should expect the vendor to collect similar data for the minimum security sex offender treatment***

facility. More specifically, the following routine program operations indicators should be considered when designing performance measures for the facility (see Appendix III for an example of a sex offender data collection instrument):

- *Number of referrals/screenings for the treatment facility;*
 - *Number of offenders served in the treatment facility;*
 - *Offender demographics;*
 - *Risk-need profiles (i.e., scores from the validated assessment instruments, both general and sex offender-specific);*
 - *Objective measures of treatment progress at intake and 6 month intervals (e.g., Sex Offender Treatment Needs and Progress Scale and other measures as specified by the vendor);*
 - *Average number of treatment contact hours;*
 - *Average length of stay for program completers and non-completer exits;*
 - *Successful completion, non-completion, and termination rates;*
 - *Sentinel events/critical incidents; and*
 - *Recidivism (sexual and nonsexual):*
 - *Technical violations*
 - *New crimes.*
-
- *Recommendation 48: In addition to the statistical indicators outlined above, the DOC is also advised to require the vendor to provide performance measures that reflect the fidelity of implementation – specifically with respect to adhering to the multiple domains of evidence-based principles and practices for correctional programs (see Andrews & Bonta, 2006). This appears to be a standard expectation for vendors who provide contracted programs for the Department, with the following program evaluation elements having been noted in other RFPs and executed contracts:*
 - *Structure*
 - *Leadership and program implementation;*
 - *Assessment and classification;*
 - *Program design;*
 - *Qualification and practices of staff; and*
 - *Evaluation and quality control.*
 - *Process*
 - *Intensity of services and method of service delivery;*
 - *Depth of educational information provided;*
 - *Implementation of behavioral strategies by qualified staff;*

- ***Targeting of criminogenic needs;***
- ***Responsivity;***
- ***Disruption of criminal networks; and***
- ***Victim awareness.***

Taken together, these data can provide extremely valuable information for internally monitoring and evaluating the facility, demonstrating accountability for performance and outcomes to external parties, and engaging in data-driven strategic planning efforts relative to ongoing sex offender management efforts in the state.

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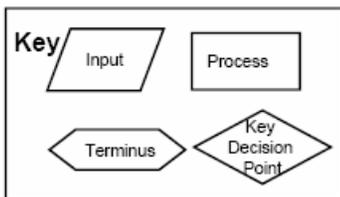
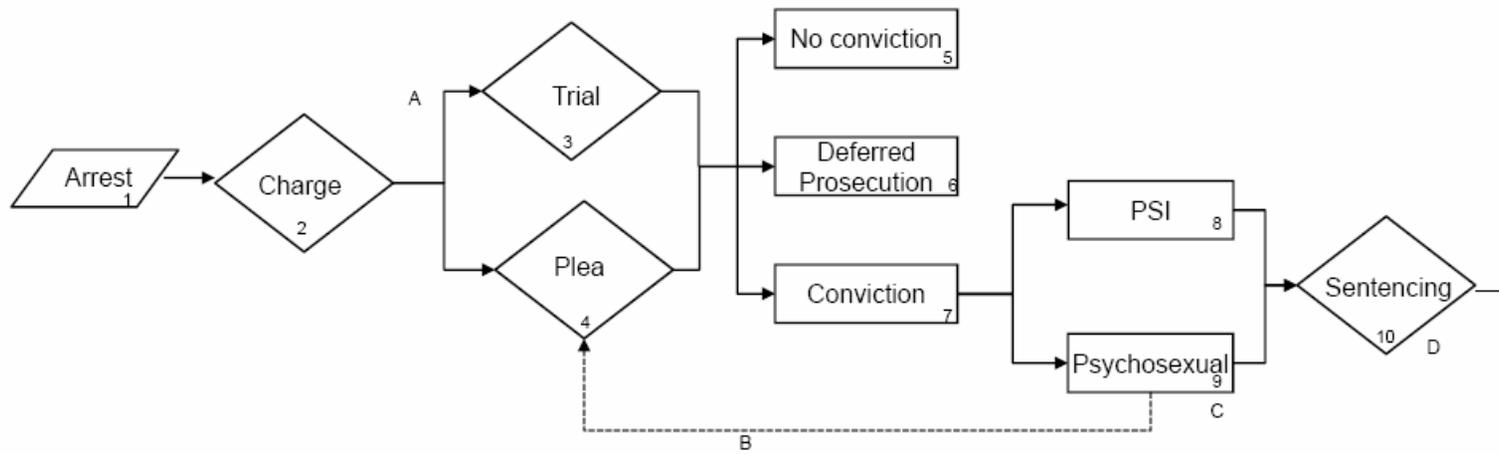
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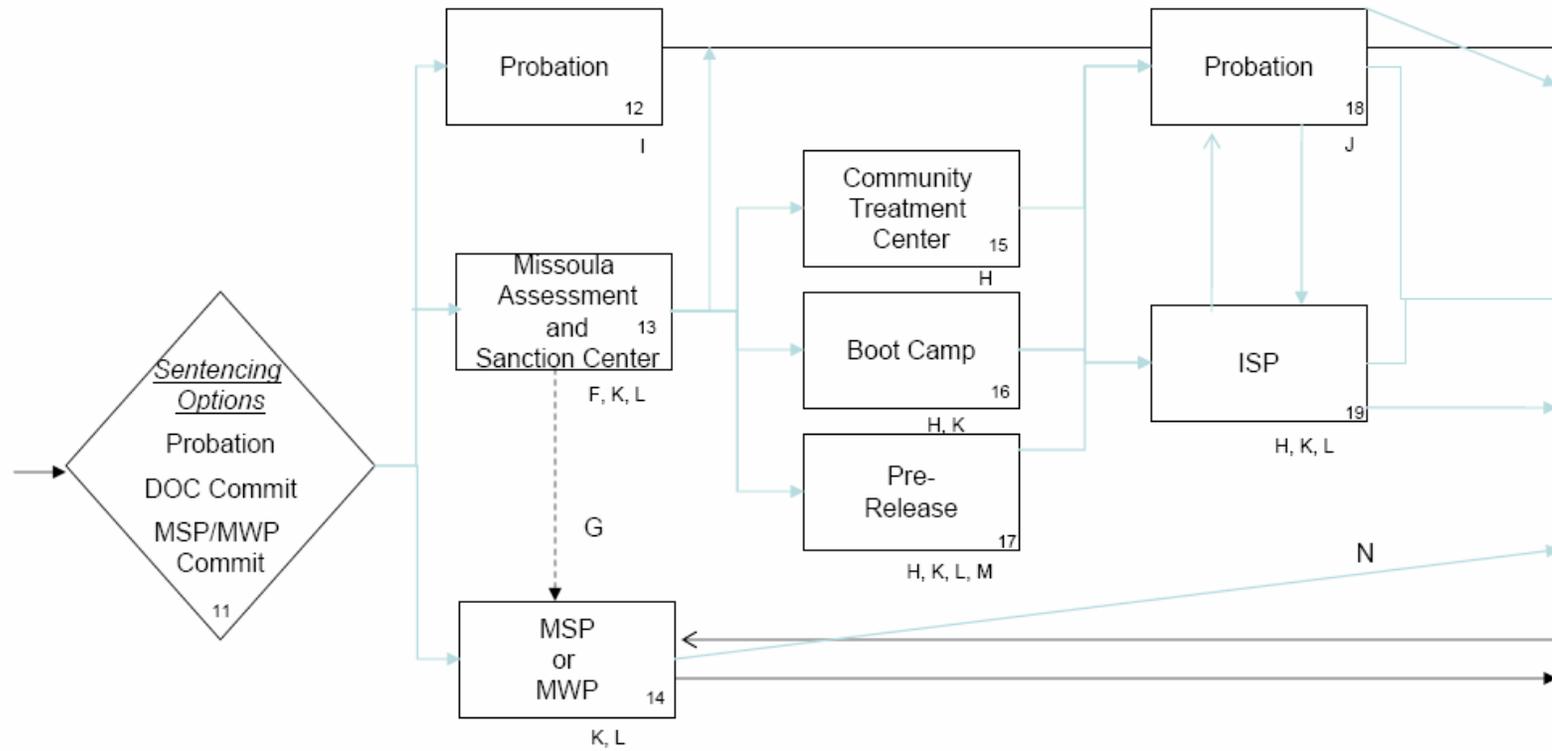
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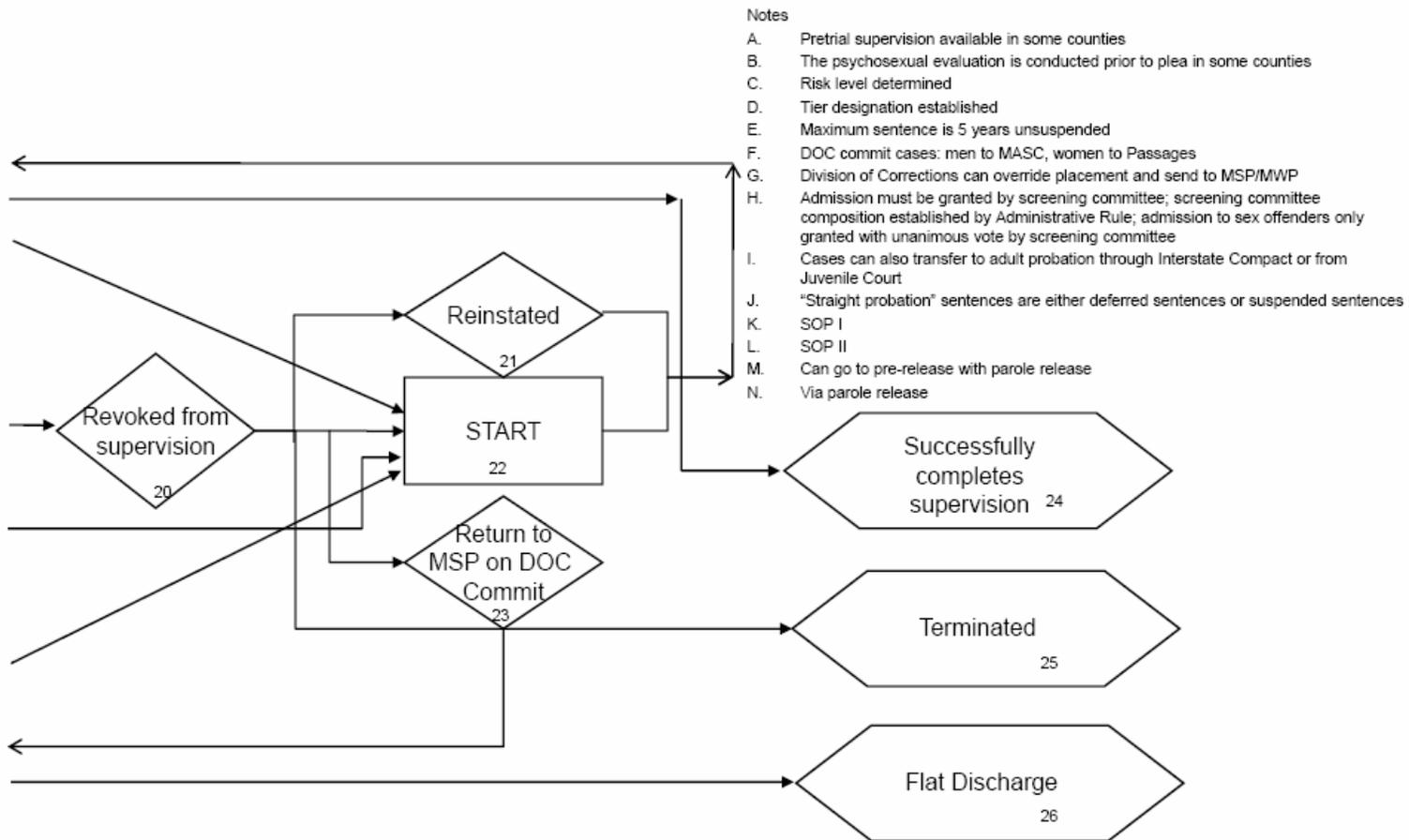
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**APPENDIX I:
THE FLOW OF SEX OFFENSE CASES IN MONTANA**



The Flow of Sex Offense Cases in Montana





Center for Sex Offender Management
July 2008

**APPENDIX II:
VERMONT TREATMENT PROGRAM FOR SEXUAL ABUSERS:
PROGRAM OVERVIEW**

Vermont Treatment Program for Sexual Abusers

Program Overview

Vermont's specialized response to sex offenders began in 1980 when a statewide task force began examining strategies to deal with the state's growing sex offender population. After a year and a half of study, the task force recommended that the Department of Corrections (DOC) develop both prison and community-based programs for treating sex offenders.

In 1982, following completion of this study, passage of a child sexual abuse reporting statute, and spurred by public outrage about two particularly brutal local sex offenses, the Vermont Legislature appropriated funds for the development of the Vermont Treatment Program of Sexual Abusers (VTPSA). These funds supported the opening of a 16-bed treatment program within the correctional facility in South Burlington. A small number of outpatient treatment programs were started about a year later. Within a few years, Vermont became the first state in the nation to have a statewide coordinated network of prison and community-based sex offender treatment programs.

In 1988, the legislature appropriated funds to create the Vermont Center for the Prevention and Treatment of Sexual Abuse (VCPTSA) to provide statewide coordination of all sexual abuse victim and sex offender prevention and treatment services. The VCPTSA was the first of its kind in the United States and is administered jointly by the Department of Corrections (DOC) and the Division of Child and Family Services (DCF). The VTPSA is under the umbrella of the VCPTSA, but remains administratively under the DOC.

The VTPSA now provides treatment services each year to approximately 425 adult male sex offenders in three prison and 12 community-based treatment programs located throughout the state.

Several studies have examined the effectiveness of VTPSA programs. For example, in a study of a VTPSA community-based program using an average follow-up period of five years, the sexual reoffense rate for men who completed the program was 1.4% versus 13.7% for those who refused, dropped out, or were terminated from the program (McGrath, Hoke, & Vojtisek, 1998). The pre-treatment characteristics of each of these groups were very similar. In another study, over an average follow-up period of almost 6 years, the sexual reoffense rate for men who completed the VTPSA intensive prison treatment program was 5% versus 30% for those who refused, dropped out, or were terminated from treatment (McGrath, Cumming, Livingston, & Hoke, 2003). There were not pre-treatment differences between these groups in terms of their risk for sexual recidivism as measured on two established actuarial risk measures.

VTPSA Mission Statement

“The mission of the VTPSA is to enhance community safety by providing quality, victim-sensitive, evidence-based treatment to individuals who have committed sexual offenses.”

Guiding Principles

The VTPSA takes into consideration the fact that sex offenders are not all the same. Sex offenders differ from one another in a variety of ways. They differ in their motivations for committing sexual offenses. They differ in terms of the age and gender preferences of their victims. They differ in terms of the types of sexual behavior that they find most sexually appealing. They differ in the intensity of their sex drive. They differ in their attitudes about their sexual offending behavior; whether they view it as a problem and whether they want to control it. And perhaps most importantly, sex offenders differ in their degree of risk to reoffend and their supervision and treatment needs.

Three principles of effective correctional services that take differences among sex offenders into consideration provide a framework for guiding program development, admission, and placement decisions in the VTPSA. These are the risk, need, and responsivity principles (Andrews, Bonta, & Hoge, 1990; Andrews & Bonta, 2007; Hanson, 2006).

Risk Principle: Who to Treat

The risk principle concerns the fact that the effects of intervention are typically found to be greater among higher risk cases than lower risk cases (Andrews & Bonta, 2007). Consequently, the VTPSA assess each individual using several validated assessment instruments in order to match the intensity of services to his risk level. Higher risk cases are generally referred to more intensive services and lower risk cases referred to less intensive services. In essence, the risk principle helps decide “who” should receive the most intensive services. It allows staff to allocate available treatment and supervision resources to those offenders who are at greatest risk to reoffend and for whom services can make the greatest impact on reducing victimization rates. Conversely, it helps staff identify lower risk offenders for whom intensive services may be contraindicated, such as long-term incarceration which actually may produce slight increases in recidivism (Gendreau, Goggin, & Cullen, 1999; Gendreau, Goggin, Cullen, & Andrews, 2000).

Need Principle: What to Treat

The second principle, the need principle (Andrews & Bonta, 2007; Andrews et al., 1990), highlights the fact that intervention is most effective if it targets the “needs” of offenders that are most directly linked to their offending behavior. These are called “criminogenic needs” or “dynamic risk factors.” In essence, the needs principle helps providers decide “what” types of problems to treat.

Responsivity Principle: How to Treat

The third principle is the responsivity principle. It states that programs should be offered in a format to which an offender can successfully respond (Andrews & Bonta, 2007; Andrews et al., 1990). In essence the responsivity principle concerns “how” to deliver services to offenders. Services are most effective if they are delivered in a manner that matches the motivation, ability, learning style, and personality of the offender (Andrews & Bonta, 2007; Serin & Kennedy, 1997). Responsivity factors considered by the program include level of denial, intelligence, reading and writing ability, mental illness, and degree of psychopathy.

Program Eligibility

All VTPSA programs have the following general admission criteria. An offender must:

- Have been convicted of a sexual or sexually-related offense
- Admit responsibility for committing the index sexual offense
- Be willing to follow program requirements
- Have an adequate sentence structure to complete the program
- Have the emotional, cognitive, and behavioral ability to benefit from the program
- Have satisfactorily participated in other recommended programs

In the community, the probation or parole officer and outpatient treatment provider make these eligibility determinations. In prison settings, the VTPSA treatment teams make these determinations.

If an offender does not meet eligibility criteria for sex offender treatment, DOC staff develop strategies, when possible, to help the offender meet these criteria. If the offender is suffering from an emotional, cognitive, or behavioral problem that severely compromises his ability to benefit from a sex offender treatment program, DOC staff refers the offender to the appropriate available rehabilitation services, such as mental health or substance abuse services.

Assessments Methods

Individuals who meet VTPSA program eligibility criteria are placed in available programs that best match their risk level, treatment needs, and learning style. Staff use the following five assessment instruments to make program placement decisions.

- LSI-R (Level of Service Inventory-Revised) (Andrews & Bonta, 1995)
- RRASOR (Rapid Risk Assessment for Sex Offense Recidivism) (Hanson, 1997)
- Static-99 (Hanson & Thornton, 2000)
- VASOR (Vermont Assessment of Sex-Offender Risk) (McGrath & Hoke, 2001)
- TPS (Sex Offender Treatment Needs and Progress Scale) (McGrath & Cumming, 2003)

Responsibility for completing these assessments varies depending on the client's status. For incarcerated offenders, the facility caseworker completes the initial LSI-R, RRASOR, Static-99, and VASOR. VTPSA clinicians complete the TPS. For offenders who have been placed in the community, the PO completes the LSI-R and the treatment provider completes the RRASOR, Static-99, VASOR, and TPS.

VTPSA clinicians administer the following two additional instruments to incarcerated offenders who have committed particularly violent offenses and who have LSI-R scores in the moderate risk range or higher, that is, scores between 24 and 47. These instruments are:

- PCL-R (Psychopathy Checklist-Revised) (Hare, 1995)
- VRAG (Violence Risk Appraisal Guide) (Quinsey, Harris, Rice, & Cormier, 2006)

Additional assessment methods are used in several programs in the VTPSA. The penile plethysmograph is used to assess sexual interests in the high-intensity prison program and with selected individuals in community programs. Polygraph exams are used state wide to monitor clients' compliance with supervision and treatment conditions in community programs.

Program Placement

Program placement guidelines are designed to place higher risk/need offenders in the more intensive treatment programs and lower risk/need offenders in less intensive treatment programs.

Prison Programs

Program placement guidelines for incarcerated sex offenders are summarized in Table 1. As shown in this Table, a client's degree of risk/need is designated as either A, B, or C and this designation determines to which program he is referred. Of particular note, the VTPSA prison program at Springfield provides specialized services to sex offenders with developmental disabilities. With respect to female sex offenders, no validated risk instrument exists and women who are incarcerated with a minimum sentence of 8 months or more receive individualized treatment at Southeast State Correctional Facility.

Community Programs

Program placement options in the community vary somewhat across the state. Higher populated areas typically have more program options, whereas rural areas tend to have fewer. Treatment providers take into consideration the risk, need, and responsivity principles in order to place clients in the most appropriate available program. Four types of community programs typically exist throughout the state.

Standard Sex Offender Groups. Most sex offenders under community supervision receive treatment in a standard sex offender treatment group. Typically, these groups are "mixed" in that child molesters, rapists, and hands-off offenders are treated together. The length of the program is, on average, two years of weekly treatment group sessions and one year of once monthly group treatment sessions.

Special Needs Groups. Sex offenders who have intellectual deficits or problems with reading and writing are best served in treatment groups that are responsive to their special learning needs. Most areas of the state have specialized groups for this population. In areas that do not, individual treatment is generally preferred over placing individuals with marked intellectual deficits in groups with normally functioning clients.

Statutory Rapist Groups. Statutory rape refers to cooperative sexual activity between an adult and a minor under the age of consent. The sexual contact is illegal and the individual over the age of consent has been convicted of a sexual offense. Some statutory offenders may not need traditional sex offender treatment if they are close in age to the minor and the act was cooperative and noncoercive. These offenders' treatment needs can generally be met in short-term individual or psycho-educational group services that focus on areas such as dating skills, appropriate sexual boundaries, and effective decision-making. Placement of these individuals in treatment groups with higher risk sex offenders is not recommended as it may actually increase their risk to commit crimes (Andrews & Bonta, 2007). However some statutory offenders have a pattern of manipulating and preying on vulnerable teenagers. These or other sexually aggressive characteristics (e.g., use of bribes; offers of shelter, drugs, or alcohol) can justify referral to a standard sexual offender treatment group (see above).

Prison Aftercare Groups. Higher risk sex offenders who are released from prison ideally are seen in intensive aftercare treatment for the first 6-9 months they are in the community. These groups typically meet twice a week and focus on helping clients make a healthy transition back to society. If an intensive aftercare group is not available, these individuals are typically referred to a Standard Sex Offender Group (described above). In all cases, men who have been released to the community after participating in prison treatment are generally required to complete, on average, two years of weekly aftercare treatment group sessions and one year of once monthly aftercare group treatment sessions.

Program Descriptions

Each VTPSA program is designed to manage the risks and needs of a specific subgroup of adult sex offenders. As described before, VTPSA programs are located at three prison and 12 geographically dispersed community sites. Programs vary in focus, length, and the number of hours of treatment delivered per week.

A description of each of the primary program for male sex offenders is as follows:

- **High-Intensity Prison Program.** This program is for persons who score moderate to high risk on one or more risk assessment instruments, have a prior sexual or violent offense conviction, or have an extensive criminal history. The program has 48 beds and is located at the Northwest State Correctional Facility (NWSCF). The program is typically 24 to 36 months long and individuals receive about eight hours of treatment per week.
- **Moderate-Intensity Prison Program.** This program is for persons who score moderate to high risk on one or more risk assessment instruments, do not have a prior sexual or violent offense conviction, and do not have an extensive criminal history. The program has 27-beds and is located at the Southern State Correctional Facility (SSCF). The program is typically 12 to 18 months long and individuals receive about four hours of treatment per week. This program also provides treatment to sex offenders who have developmental disabilities.
- **Low-Intensity Prison Program.** This program is for persons who score in the lower range on all risk assessment instruments, do not have a prior history of sexual or violent offense convictions, and do not have an extensive criminal history. The program has 20 beds and is located at the Southern State Correctional Facility (SSCF). The program is 6 months long and individuals receive about two hours of treatment per week.
- **Community Programs.** This program is for persons sentenced to probation and those returning to the community from prison on supervised release. It is made up of 12 community programs located throughout Vermont. Each community program has probation and parole officers who are assigned to supervise sex offenders in their communities. Each program typically provides one group session per week for about 24 months followed by monthly aftercare meetings for about 12 months.

Sex offenders who have other treatment needs, such as in violence, substance abuse, and mental health, may be eligible and referred to programs that address these concerns. Female sex offenders are treated on an individual basis, both in prison and the community, unless their numbers allow for group treatment.

Table 1. Prison Program Placement Criteria

Level	Risk/Need	Risk Scores	Sentence Structure and Other Criteria
A	<ul style="list-style-type: none"> • Low • Moderate-low 	All of the following: <ul style="list-style-type: none"> • LSI-R = 0-23 • RRASOR = 0-1 • Static-99 = 0-2 • VASOR-Risk = 0-40 	<u>Low Intensity Prison Sex Offender Program</u> <ul style="list-style-type: none"> • Has minimum to serve of at least 8 months, • Does not fit profile of rapist or predatory offender, • Has no prior sex offense convictions, and • Has lower risk/need
			<u>Community Sex Offender Program</u> <ul style="list-style-type: none"> • Refer for treatment following incarceration
B	<ul style="list-style-type: none"> • Moderate-high • High 	Any of the following: <ul style="list-style-type: none"> • LSI-R = 24-47 • RRASOR = 2-6 • Static-99 = 3-12 • VASOR-Risk = 41-125 	<u>Moderate Intensity Prison Sex Offender Program</u> <ul style="list-style-type: none"> • Has minimum to serve of at least 14 months, • Does not fit profile of rapist or predatory offender, • Has no prior sex offense convictions, and • Has moderate risk/need
			<u>High Intensity Prison Sex Offender Program</u> <ul style="list-style-type: none"> • Has minimum to serve of at least 26 months, • Fits profile of rapist or predatory offender, • Has prior sex offense convictions; or • Has higher risk/need
			<u>High Intensity Prison Sex Offender Program and/or Cognitive Self Change Prison Program</u> <ul style="list-style-type: none"> • Has minimum to serve at least 34 months, and • Has history of significant non-sexual violence, or • Has high psychopathy (PCL-R = 28-40), or • Admits violent offending but denies sex offending
			<u>Special Needs Prison Sex Offender Program</u> <ul style="list-style-type: none"> • Has minimum to serve of at least 14 months, • Has borderline or lower intellectual functioning • Has lower risk/need
			Aftercare Services <u>Community Sex Offender Program</u> <ul style="list-style-type: none"> • Refer for treatment following incarceration
C	<ul style="list-style-type: none"> • Very high and violence level extreme 	All of the following: <ul style="list-style-type: none"> • LSI-R = 24-47 • VRAG = 7-9 • Violence level high • Substantial victim harm • Crime particularly cruel, brutal, or callous 	<u>Cognitive Self Change Prison Program; and/or High Intensity Prison Sex Offender Program</u> (determined after a central office staffing) Treatment typically takes place near the end of the offender's maximum sentence date. Focus is on long-term confinement. Offender must demonstrate significant positive long-term behavioral change and psychological stability to be considered for furlough.

Modes of Treatment

Cognitive-behavioral group treatment is the primary treatment method in the VTPSA. As well, this is the most common model used in other sexual offender treatment programs throughout the United States (Association for the Treatment of Sexual Abusers, 2005; McGrath, Cumming, & Burchard, 2003). Cognitive therapy is based on the premise that how we think determines how we act, and that by changing how we think, we can change how we act. Behavior therapy rests on the premise that behavior is learned and that we can learn to modify our behavior by using a variety of skill practice and conditioning methods.

Although group treatment is the primary method used in the VTPSA, other methods such as individual, family, and drug therapy are utilized as well. Each is described below.

Group Treatment. Group treatment has several advantages. Clients often feel more comfortable admitting and discussing their offenses in a treatment group where other clients are modeling openness. Clients often accept feedback about their behavior more willingly from other group members than from therapists. Group treatment is more economical than individual, couples, or family therapy. Finally, clients can practice social skills in group treatment settings.

Group treatment also carries some risks. Just as group members can be a prosocial influence on each other, they can also influence each other in antisocial ways. In general, low-risk sexual offenders should not be placed in treatment groups composed largely of high-risk offenders (Andrews & Bonta, 2007).

Individual Treatment. In the VTPSA, individual sessions are typically used for crisis intervention and treatment planning meetings. Individual sessions may also serve as the primary method of treatment for clients who are not a good match for available treatment groups, such as clients with intellectual disabilities who are residing in areas where groups do not exist to meet their special needs.

Family and Significant-other Involvement. Family and significant-other involvement in treatment is essential. The goals are to educate the client's support system in the relapse prevention model so that they can help him avoid high-risk situations, develop and maintain healthy interpersonal relationships and cope effectively with life's inevitable challenges. For clients who do not have any natural supports, staff help the client develop a network of volunteer supports.

Medication. Cognitive and behavioral treatments are not always effective in helping clients who have significant problems managing their offense-related sexual interests. For these clients, consulting physicians prescribe medications such as SSRI's and antiandrogens to help them reduce their sex drive and sexually obsessive thoughts.

Primary Treatment Targets

Eight broad treatment targets are the focus of intervention in the VTPSA.

Offense Responsibility. The first step in sexual offender treatment typically involves helping the client accept responsibility for his sexually abusive behavior. Most treatment interventions rely on the abuser's ability to identify and address offense precursors. This is difficult to do if he denies committing a sexual offense.

Cognitive Distortions. Sexual offenders typically use irrational or rationalizing thought processes to support or justify their sexually abusive behaviors. Cognitive restructuring helps abusers identify and counter these distorted thought processes.

Victim Awareness. A type of cognitive distortion engaged in by many sex offenders is their tendency to ignore, minimize, or misattribute the consequences for victims of their sexually abusive behavior. Treatment efforts designed to teach sexual abusers about the detrimental effects of sexual victimization and how to understand and value others may help reduce their risk to re-offend.

Intimacy and Relationship Skills. Problems in developing and maintaining satisfying intimate relationships with adults are related to some sexual abusers' tendencies to seek out sexual relationships with children and non-consenting adults. Intimacy and relationship skill development is an important treatment target for these offenders.

Lifestyle Stability. Sexual abusers often have a variety of life skills deficits linked to their risk for re-offending. These include impairment in the areas of emotion management, conflict resolution, problem solving, conversational skills, parenting, and use of leisure time. These problems are sometimes related to mental health disorders for which treatment is also required. Additionally, clients who have appropriate employment, housing, and financial resources can live more stable lives, thus reducing their risk to reoffend.

Arousal Control. The presence of abusive sexual interests is an important risk factor for committing sexually abusive acts. Behavior therapies and medication are employed to help selected clients control their abusive sexual fantasies and urges and replace them with more appropriate ones.

Relapse Prevention. Sexually abusive behavior is typically preceded by an identifiable and predictable pattern of emotions, thoughts, and actions. Relapse prevention training provides clients with a variety of cognitive and behavioral strategies for identifying and interrupting these patterns. These strategies are designed to help clients maintain treatment changes over time.

Social Support Networks. An informed network of family and friends can provide much needed social support to assist an abuser in leading a lifestyle that reduces his risk to re-offend. Prosocial support persons can reinforce prosocial attitudes, help secure stable employment, and assist abusers in avoiding and coping with high risk situations.

Treatment Completion

The definition of community treatment completion in the VTPSA is that the individual has completed all of the following:

1. The offender has substantially accepted responsibility for committing the sexual offenses for which he/she has been convicted.
2. The offender has meaningfully participated in treatment approved by the DOC that is specifically designed to reduce his/her risk to sexually re-offend.
3. The offender's participation in the treatment has been sufficient both to allow his/her specific treatment needs to be identified and to demonstrate through overt behavior a willingness to work diligently on addressing those needs.

4. The offender is able to demonstrate an understanding of the thoughts, attitudes, emotions, behaviors, and sexual arousal linked to his/her sexual offending and can identify when these occur in present functioning.
5. The offender demonstrates sufficiently sustained change in the thoughts, attitudes, emotions, behaviors, and sexual arousal linked to his/her sexual offending, such that it is reasonable to assume that he/she has reduced his/her risk to sexually re-offend.

Conclusion

Established in 1982, the Vermont Treatment Program of Sexual Abusers (VTPSA) currently provides evidence-based treatment services to over 425 convicted sex offenders in three prison and 12 outpatient sites each year. Treatment staff conduct individualized assessments to match treatment services to the risk level, treatment needs, and learning style of clients. Cognitive-behavioral group treatment is the main treatment method. The primary goal of the program is to reduce sexual victimization and program evaluations indicate that the program is effective in achieving this goal.

**APPENDIX III:
SAMPLE ADULT SEX OFFENDER DATA COLLECTION INSTRUMENT**



Sample Adult Offender Data Collection Instrument

Offender ID #:	Reason did not enter:
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Date of referral:	Age: (date of birth)
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Date collected:	Sex: male / female
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Intake worker: (data collector)	Income: (monthly household income)
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Date entered program:

Ethnicity (check one):

<input type="checkbox"/> African-American	<input type="checkbox"/> Native American
<input type="checkbox"/> Latino/Latina	<input type="checkbox"/> Caucasian
<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> Other: _____

Education at Offense (check one):

<input type="checkbox"/> Completed secondary school	<input type="checkbox"/> Received college degree
<input type="checkbox"/> Received GED	<input type="checkbox"/> Post-graduate education
<input type="checkbox"/> Some post-secondary school, training or education	<input type="checkbox"/> Highest grade completed: _____

Employment at Offense (check one)

Unemployed

Part-time employment < 32 hrs./wk.

Full-time employment 32 hrs./wk. or more

Marital Status at Offense (check one)

<input type="checkbox"/> Married	<input type="checkbox"/> Single
<input type="checkbox"/> Separated/divorced	<input type="checkbox"/> Widowed

Residence at Offense (check one)

<input type="checkbox"/> Living w/ spouse	<input type="checkbox"/> Living w/ parents or siblings
<input type="checkbox"/> Living alone stable	<input type="checkbox"/> Living w/ other family member(s)
<input type="checkbox"/> Living alone transient	<input type="checkbox"/> Living w/ partner (other than spouse)
<input type="checkbox"/> Living w/ friends	<input type="checkbox"/> Living in foster care

Employment Stability at Offense (check one)

<input type="checkbox"/> Change in employment in last 6 months	<input type="checkbox"/> No change in employment in last year
<input type="checkbox"/> Change in employment in last year	

Residence Stability—During the 2 Years Before Arrest for This Case (check one):

<input type="checkbox"/> Has continually resided at the same address	<input type="checkbox"/> Has moved 4 or more times
<input type="checkbox"/> Has moved 1–3 times	<input type="checkbox"/> Transient

Achieved Skill Level (check one)

<input type="checkbox"/> Unskilled; laborer or service	<input type="checkbox"/> Supervisor; managerial; foreman; self employed/ small business (other professionals; RN, teachers)
<input type="checkbox"/> Semiskilled; worker/operator	<input type="checkbox"/> High-level professional; doctor, lawyer
<input type="checkbox"/> Skilled; major sales, craftsman, technician	

Current Crime—Victim Characteristics—Principal Offense (check all that apply and fill in age)

<input type="checkbox"/> Victim(s) male	Age of victim(s): _____
<input type="checkbox"/> Victim(s) female	

Current Crime—Offender Relationship to Victim—Principal Offense (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Stranger | <input type="checkbox"/> Other relative |
| <input type="checkbox"/> Own child | <input type="checkbox"/> Neighbor |
| <input type="checkbox"/> Child of significant other | <input type="checkbox"/> Acquaintance |
| <input type="checkbox"/> Sibling | <input type="checkbox"/> Date |

Did Offender Live with Victim at Time of Offense?

- Yes No

Offender Legal Status at Offense—Principal Offense (check one)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> No relationship to criminal justice system | <input type="checkbox"/> On parole |
| <input type="checkbox"/> On bail/bond | <input type="checkbox"/> Work release |
| <input type="checkbox"/> On probation | |

Current Crime

Offense type: _____	Date of conviction: _____
Date of offense: _____	<input type="checkbox"/> Misdemeanor (conviction charge)
<input type="checkbox"/> Misdemeanor (arrest charge)	<input type="checkbox"/> Felony (conviction charge)
<input type="checkbox"/> Felony (arrest charge)	
Date of sentence: _____	Total number of current offenses: _____
Number of misdemeanors: _____	Number of sex offenses: _____
Number of felonies: _____	

Sexual Offense (Conviction/Adjudication) Behavior Past and Present (check all that apply)

<i>Did the Offense Include?</i>	<i>Current Offense</i>	<i># of Prior Offenses</i>
Exhibiting	Yes ___ No ___	_____
Frottage	Yes ___ No ___	_____
Peeping	Yes ___ No ___	_____
Obscene calls	Yes ___ No ___	_____
Stealing underwear	Yes ___ No ___	_____
Touching victim's breasts	Yes ___ No ___	_____
Masturbation of victim	Yes ___ No ___	_____
Fellatio on victim	Yes ___ No ___	_____
Cunnilingus on victim	Yes ___ No ___	_____
Penile vaginal penetration of victim	Yes ___ No ___	_____
Digital vaginal penetration of victim	Yes ___ No ___	_____
Object penetration of vagina of victim	Yes ___ No ___	_____
Sodomizing of victim	Yes ___ No ___	_____
Digital anal penetration of victim	Yes ___ No ___	_____
Object penetration of anus of victim	Yes ___ No ___	_____
Masturbation by victim	Yes ___ No ___	_____
Fellatio by victim	Yes ___ No ___	_____
Cunnilingus by victim	Yes ___ No ___	_____
Penetration by victim	Yes ___ No ___	_____
Bestiality	Yes ___ No ___	_____
Verbal coercion/manipulation	Yes ___ No ___	_____
Verbal threats of violence	Yes ___ No ___	_____
Physical force	Yes ___ No ___	_____
Weapons possession	Yes ___ No ___	_____
Weapons use	Yes ___ No ___	_____
Alcohol use	Yes ___ No ___	_____
Illegal drug use	Yes ___ No ___	_____
Other: _____		

Pre-sentence Assessment

- Pre-sentence report completed Sex offender clinical assessment completed

Sentence for Current Offense (check one)

- Diversion—deferred prosecution Prison
 Probation Prison and probation
 Jail Residential placement
 Jail and probation Other _____

Sentence length: _____

Criminal History

Type	# of Sex Offenses	# of Other Personal Offenses	# of Property Offenses	# of Drug Offenses	# of Other Offenses
Adult municipal violation	_____	_____	_____	_____	_____
Adult misdemeanor	_____	_____	_____	_____	_____
Adult felony	_____	_____	_____	_____	_____
Juvenile municipal violation	_____	_____	_____	_____	_____
Juvenile misdemeanor	_____	_____	_____	_____	_____
Juvenile felony	_____	_____	_____	_____	_____

If any prior sex offense, specify age of earliest offense: _____

Type of earliest offense: _____

If any prior sex offenses, please list: _____

Substance Abuse History (check all that apply)

- Is there evidence of substance abuse history? Yes ___ No ___
If yes, is there evidence of treatment? Yes ___ No ___
Is there evidence of alcohol abuse history? Yes ___ No ___
If yes, is there evidence of treatment? Yes ___ No ___