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Treatment, Supervision, and Recidivism of Individuals Convicted of a Sex Offense in the United States: A Pilot Study

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Treatment, Supervision, and Recidivism of Individuals Convicted of a Sex Offense in the United
States: A Pilot Study

A Thesis Presented in Partial Fulfillment of the Requirements
for the Masters in Forensic Psychology
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City University of New York

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Abstract

Although, previous research has shown that treatment programs for individuals convicted of a sex offense have the potential to lower sexual recidivism rates (Hanson & Bussiere, 1998; Hanson et al., 2002; Losel & Schmucker, 2005), there is some pause as to the methodological strength of these studies (Furby, Weinrott, & Blackshaw, 1989; Rice & Harris, 2003).

Additionally, the literature is mixed regarding which elements of supervision for individuals convicted of a sex offense contribute to lower sexual recidivism (Aos, Miller, & Drake, 2006; Aytes, Olsen, Zakrajsek, Murry, & Ireson, 2001; Buttars, Huss, & Brack, 2016; McGrath, Cumming, Hoke, & Bonn-Miller, 2007; Stalans, Seng, & Yarnold, 2002). The proposed study aimed to examine the relation between sexual recidivism and several elements of treatment and supervision for individuals convicted of a sex offense while they are incarcerated, as well as while they are being supervised in the community. Recidivism data included information found in empirical studies, as well as state data provided by participants. Sixteen states across the United States were analyzed as a part of this study. Using independent sample t-tests, no significant differences were found to indicate a relation between any specific component of treatment or supervision and lower sexual recidivism. However, the relation between sexual recidivism and some elements of treatment while incarcerated (i.e. relapse prevention, mandated/optional participation in individual treatment) approached significance. The results of this study are discussed in reference to the ways in more research is needed to decipher which specific elements of treatment and supervision programming can assist in assuaging sexual recidivism, thus keeping communities safe.

Keywords: individuals convicted of a sex offense; intensity; recidivism; sexual recidivism; supervision; treatment

Treatment, Supervision, and Recidivism of Individuals Convicted of a Sex Offense in the United States: A Pilot Study

Using data from the 2015 Census, a total of 859,500 individuals convicted of a sex offense are registered in the United States and its territories (National Center for Missing and Exploited Children, 2016). With many of these individuals out on parole or probation, such a large population raises substantial concern in the community. The public views the actions of individuals convicted of a sex offense as “qualitatively” different from the acts of other types of violent and serious offenders (Brown, Deakin, & Spencer, 2008). These views often lead to moral outrage, fear, and disgust (Olver & Barlow, 2010). Brown et al. (2008), found that one of the aspects contributing to feelings of insecurity, fear, and anger toward individuals convicted of a sex offense was the participants’ tendency to overestimate the reconviction rate of these offenders specifically.

According to one of the largest single studies of the recidivism of individuals convicted of a sex offense, 5.3% of these individuals were rearrested for another sex crime within a three-year follow up period (Langan, Schmitt, & Durose, 2003). Langan et al. (2003) also found that within this low rate of reoffending, individuals convicted of a sex offense are four times more likely to be rearrested for a sex crime compared to offenders of other types of crime. Due to such a higher propensity for individuals convicted of a sex offense to commit another sex offense compared to other offenders, the importance of effective treatment and supervision offered to individuals convicted of a sex offense is paramount.

Previous research has shown that individuals convicted of a sex offense who receive treatment recidivate less than those who do not (Duwe & Goldman, 2009; Hanson & Bussiere, 1998; Hanson et al., 2002; Losel & Schmucker, 2005; Olver, Nicholaichuk, Gu, & Wong, 2013;

Scalora & Garbin, 2003), but there is considerable pause from some individuals within the field regarding this conclusion (Berliner, 2002; Marques, Wiederanders, Day, Nelson, & Van Ommeren, 2005; Prentky, 2003). Additionally, the literature surrounding the effectiveness of different types of specialized supervision for individuals convicted of a sex offense is mixed (Aos, Miller, & Drake, 2006; Aytes, Olsen, Zakrajsek, Murry, & Ireson, 2001; Buttars, Huss, & Brack, 2016; McGrath, Cumming, Hoke, & Bonn-Miller, 2007; Stalans, Seng, & Yarnold, 2002). The current study aimed to provide a better idea of sexual recidivism rates throughout the nation and to further investigate the relation between treatment and sexual recidivism, as well as the relation between supervision and sexual recidivism, by examining different elements of treatment programs and supervision protocols offered to individuals convicted of a sex offense throughout the United States.

Treatment for Individuals Convicted of a Sex Offense

Beginning in the 1980s, as the number of individuals convicted of a sex offense grew, studies examining different treatment programs for these individuals started to flourish. Through individual treatment studies (Duwe & Goldman, 2009; Olver et al., 2013; Scalora & Garbin, 2003) and meta-analyses (Furby, Weinrott & Blackshaw, 1989; Hanson & Bussiere, 1998; Losel & Schmucker, 2005), researchers focused on assessing the effectiveness of treatment programs for individuals convicted of a sex offense, using recidivism rates as a lens to evaluate success. With the establishment of this manner of evaluating treatment, researchers began to obtain conflicting results regarding the effectiveness of treatment.

Furby and colleagues (1989) were among the first to study the effectiveness of treatment for individuals convicted of a sex offense through meta-analysis. After analyzing and comparing 42 studies, the authors concluded that treatment did not reduce the level of recidivism among

individuals convicted of a sex offense. However, as research continued, researchers began to find that their results contradicted with Furby et al.'s (1989) findings regarding treatment effectiveness. For example, in 1998, Hanson and Bussiere (1998) examined 61 studies in order to identify the factors that were most strongly related to recidivism of individuals convicted of a sex offense. The authors evaluated sexual, general, and violent recidivism and found that there was, in fact, an association between treatment and sexual recidivism, as well as treatment and general recidivism, but no association was found when examining violent recidivism. These findings suggested that individuals who participated in treatment were less likely to recidivate, both sexually and nonsexually, than those offenders who did not receive treatment. While this positive assessment of treatment effectiveness has continued to proliferate in the research literature (Hanson et al. 2002; Losel and Schmucker, 2005), some researchers are still skeptical of the merit of this conclusion.

Many individuals in the field have been quick to point out the methodological shortcomings of the aforementioned research. Citing reasons such as recidivism being inadequately defined, variability in the length of follow up periods used in the meta-analyses, differing sample sizes, and other design flaws (Furby et al., 1989; Rice & Harris, 2003), researchers believe that it is difficult to interpret the results of this research with confidence. In an attempt to address some of these shortcomings using a true randomized trial, Marques et al. (2005) found no significant differences in recidivism for those individuals convicted of a sex offense receiving treatment and those who were not. While this study adds to the literature, it only focuses on one specific treatment program offered in California. Due to the dearth in the literature regarding treatment programs offered throughout the nation, as well as the methodological deficiencies of several meta-analyses, more research is needed to improve our

understanding of the sexual recidivism rate of individuals convicted of a sex offense who are participating in treatment programs nationwide, as well as how this relates to the types of treatment being offered.

Methods of Treatment

There are several kinds of rehabilitative programs available to individuals convicted of a sex offense. In 2008, the Vera Institute of Justice issued a report regarding the treatment options that were, at the time, being utilized for individuals convicted of a sex offense who were incarcerated or under community supervision across the United States (Daly, 2008). It was found that a majority of both prison and community based treatment programs were grounded in evidence-based practices such as cognitive behavioral therapy (CBT) and relapse prevention therapy (RPT). CBT is designed to teach offenders to identify their deviant thought processes and beliefs, as well as intervene in their own irregular arousal pattern, providing neutral, non-sexualized controls to individuals so that they can maintain a behavioral and cognitive change when treatment comes to an end (Aytes et al., 2001). Accordingly, RPT is specifically designed to help individuals handle high-risk situations using self-management strategies, emphasizing the acquisition of effective coping responses that can be employed when an individual is feeling at risk of relapsing (Serran & Marshall, 2006).

Whereas evidence-based practices were found to be widely utilized, the Vera Institute of Justice report stated that these same treatment programs were found to be reluctant to use drug therapy (e.g. chemical castration, hormone therapy; Daley, 2008). Unlike the cognitive or behavioral skills that other treatments seek to build, the aim of drug therapy is to change the level of hormones or neurotransmitters that are associated with sexual drive, allowing recipients better control of deviant sexual urges (Hill, Briken, Kraus, Strohm, & Berner, 2003; Miller, 2003).

Although these methods may be the most widely or scarcely used in the treatment of individuals convicted of a sex offense, it is useful to keep in mind that many programs encompass several different treatment methods at once and do not just focus on one method (Abracen, Looman, Ferguson, Harkins, & Mailloux, 2011; Daly, 2008; Scalora & Garbin, 2003).

With a plethora of rehabilitative treatment methods available, and many of them being offered in conjunction with one another, treatment programs for individuals convicted of a sex offense are left to decide what kind of treatment will be the most effective and thus, what methods will help attenuate recidivism. In a meta-analysis, Hall (1995) concluded that cognitive behavioral and hormonal treatments were significantly more effective than behavioral treatments on their own. In support of Hall (1995), Losel and Schmucker (2005) concluded that CBT and hormonal treatment were two of the most effective treatments when compared to other methods such as classic behavioral or insight oriented treatment. These meta-analyses postulate that cognitive behavioral or hormonal treatment methods may have the greatest success at lowering sexual recidivism, even though the hormonal therapy has been shown to be not as widely implemented (Daley, 2008). There is clearly a disconnect between what the research is saying and what treatment providers choose to offer in their treatment programs. More research is sorely needed to help parse out which mechanisms of treatment are leading to lower sexual recidivism rates in order to provide more knowledge and bridge the gap between research and practice.

Supervision Protocol

As with treatment, supervision encompasses several different elements such as specialized caseloads, the use of actuarial risk and needs assessments, and other specialized provisions tailored to individuals convicted of a sex offense. In addition to reporting about treatment programming, the Vera Institute of Justice also reported the most common aspects of

supervision (i.e. probation or parole) used throughout the nation for individuals convicted of a sex offense (Daley, 2008). It was found that over 50% of the states participating in the study used actuarial needs assessments during supervision and almost all used actuarial risk assessments. Additionally, parole and probation officers in most states had specialized caseloads (they only supervised individuals convicted of a sex offense) and enforced specialized provisions. These special provisions can include, but are not limited to, the use of polygraph examinations, not having contact with minors, or the requirement of participation in re-entry programs.

Although specialized supervision and provisions seem to be common, the general conclusion regarding their effectiveness is extremely mixed. Research has shown that elements such as Circles of Support and Accountability (COSA)/faith-based programs (Aos et al., 2006), specialized caseloads (Aytes et al., 2001), field surveillance, daily logs of activities, restrictive conditions, and the use of psychological assessments (Stalans et al., 2002) can lead to more effective supervision. However, other studies have found that elements such as substance monitoring, the use of the penile plethysmograph, and GPS monitoring are unable to provide this same effective outcome on sexual recidivism (Buttars et al., 2016). One of the more contested components of supervision is the use of polygraph testing, as some research has found it to be effective in reducing sexual recidivism when coupled with treatment (Aytes et al., 2001), while other research has not revealed this significant effect (McGrath et al., 2007). Due to the divergent findings in the literature, additional research is necessary to help provide clear empirical evidence regarding which aspects of supervision contribute to lower sexual recidivism for individuals convicted of a sex offense.

State Treatment and Supervision Programs for Individuals Convicted of a Sex Offense

Using information from these studies regarding sexual recidivism and treatment effectiveness, in conjunction with other sources such as in-house data sources, state governments across the United States enact programming for individuals convicted of a sex offense with the hope that these programs will reduce future sex crimes and improve the safety of their communities. West, Hromas, and Wenger (2002) conducted a study regarding treatment for individuals convicted of a sex offense across the United States, identifying 39 states that were currently conducting formal treatment programs for these individuals. Of those that did not hold formal programming for individuals convicted of a sex offense, several states had programs that were under consideration, projected, or informal (West et al., 2002). All with the goal of lowering sexual recidivism, these programs vary in duration, treatment methods, eligibility requirements, and program components. Nuanced differences among these programs could potentially account for differing sexual recidivism rates for each state.

One way in which 20 states and the District of Columbia have attempted to reduce sexual recidivism is through Sexually Violent Predator (SVP) civil commitment laws (ATSA Executive Board of Directors, 2010). SVP laws, while widely controversial, are based on the belief that individuals will most likely re-offend if they are not detained and kept from re-entering the into the community. Individuals who are civilly committed are often held indeterminately until the state deems that they are no longer likely to commit a new sex offense. Once an individual is civilly committed, release typically does not occur in a timely manner. A majority of states with SVP laws have released less than 20% of the individuals that have been civilly committed since the law in that state went into effect (Washington State Institute for Public Policy, 2005). SVP laws in each state have been compared and cataloged to better understand what kind of treatment, if any, and supervision these individuals are receiving (DeMatteo, Murphy, Galloway,

& Krauss, 2015; Washington State Institute for Public Policy, 2007); however, due to indeterminate sentencing and thus, low rates of release, it is difficult to determine if SVP civil commitment truly leads to lower recidivism of these individuals.

Presently, while some research has attempted to estimate the recidivism of individuals civilly committed under SVP statutes (Neller & Petris, 2013), there has been no comprehensive state by state analysis regarding whether SVP laws are successfully leading to lower sexual recidivism. SVP programs are expensive, costing an average of \$94,017 per individual per year (Washington State Institute for Public Policy, 2007). With such high costs, it is important to determine whether or not these programs are lowering sexual recidivism rates for those who are released, because if they are not effective, the money used in these programs could go toward other effective tools such as treatment and some elements of community supervision. More research regarding how the components of state treatment and supervision programs, including SVP programming, relates to sexual recidivism is needed to increase the effectiveness of the programs offered.

Current Study

When it comes to treatment (Berliner, 2002; Duwe & Goldman, 2009; Hanson & Bussiere, 1998; Hanson et al., 2002; Losel & Schmucker, 2005; Marques et al., 2005; Olver et al., 2013; Scalora & Garbin, 2003) and supervision (Aos et al., 2006; Aytes, et al., 2001; Buttars et al., 2016; McGrath et al., 2007; Stalans et al., 2002) effectiveness for individuals convicted of a sex offense, the literature is inconsistent regarding if and what elements are effective in reducing recidivism. This discrepant information limits policy-makers and developers of treatment programs from creating successful treatment methods and supervision protocols, and enacting effective legislation. Additionally, there are very few public reports of the sexual

recidivism rates of individuals convicted of a sex offense throughout the nation that also provide details regarding how these rates were collected (e.g. definition of recidivism, length of follow up period). Without these reports, it is hard to effectively evaluate the current treatment programs and supervision protocols. The aim of this study is to address these gaps and to help provide government and policy makers with information that they can use to make evidenced-based decisions, and shape effective programs for individuals convicted of a sex offense, with the goal of reducing sexual recidivism state by state.

A wide range of treatment programs and supervision protocols for individuals convicted of a sex offense were examined to better understand the potential relation between the components of these programs and the recidivism rates of individuals convicted of a sex offense. As this study was exploratory in nature, no specific hypotheses were made.

Method

Design

This pilot study compiled recidivism rates for 16 of the states in the United States and analyzed the elements of treatment and supervision offered to individuals convicted of a sex offense in these states using self-report data. Further, this study focused on treatment programs and supervision protocols available to offenders during incarceration and in the community. Interviews were conducted with knowledgeable personnel from each state to properly evaluate the treatment programming and supervision protocol in the state in which they are employed. Further details on this process are enumerated below.

Procedure

Step 1: Identification of participant contact information. Public websites were searched to obtain contact information for personnel (e.g. parole officers, treatment providers,

treatment directors) in each state in the United States who were knowledgeable about the treatment programming or supervision protocols offered to individuals convicted of a sex offense; only official government or state run websites were included in this search. A comprehensive list of appropriate telephone numbers was compiled and organized by state.

Step 2: Contacting participants. Phone calls to potential participants were conducted by myself and one Research Assistant using the contact information gathered in Step 1. Using a script (see Appendix A), interviewers introduced themselves and explained the nature of the phone call and purpose of the study. Individuals were informed that participation was voluntary and that responses would be coded by the state in which they were employed, making each participant anonymous. Further, potential participants were informed that there would be no compensation for their participation and that they could stop participating at any time without penalty. Lastly, they were given contact information for any future questions and/or concerns. If the individual agreed to participate, they were asked to provide verbal consent so that the interview could begin. If participation in the study was declined, the individual was thanked for their time and asked if they could provide contact information for another individual who would be better suited to participate.

Step 3: Conducting the interview. Myself and one Research Assistant conducted all interviews. During these interviews, participants were asked a series of questions regarding legislation, treatment, and supervision of persons convicted of a sex offense in their state (e.g. Does your state have any civil commitment laws?; What kind of rehabilitative treatment programs are available to sexual offenders in your state?; How often are sex offender parolees required to report to you?). The interview questions were constructed based on relevant literature regarding existing treatment options and supervision protocols for individuals convicted of sex

offenses, as well as relevant information believed to be necessary for this study (see Appendix B). The questionnaire included questions about supervision protocols and both treatment for individuals who are incarcerated, as well as treatment for individuals being supervised in the community; however, participants were only asked to answer questions that pertained to their knowledge of these programs.

Some individuals who were contacted requested to answer the interview questions at their leisure and email their responses to the interviewers. If this occurred, the interviewers emailed the consent form and interview questions to the participant from an email created specifically for the purpose of this research project. Only myself and the Research Assistant had access to this email.

In order to ensure that the information collected was illustrative of the programming across the entire state, participants were also asked if their answers were representative of the state or just the jurisdiction in which they were employed. If the participant stated that their answers were only representative of their jurisdiction, the interviewer asked the participant if he/she knew of anyone in the state who is knowledgeable and potentially willing to participate in the study. These individuals were then contacted with the hopes of gaining representative answers. If the participant from the original wave of data collection did not provide representative answers, nor an alternate individual to contact, the interviewers went back to the aforementioned websites to find additional personnel to contact. Individuals from these subsequent interviews were asked the same questions using the same script and questionnaire from the previous interviews. When information provided during the interviews regarding a given state's policies, procedures, and programming was inconsistent (e.g. program information

was incongruent or statistical information did not match), the information that could be corroborated by the state's Department of Corrections website was used for this study.

Step 4: Identification of recidivism studies for inclusion. Internet searches of PsychINFO, Google, Google Scholar, John Jay College of Criminal Justice Lloyd Sealy Library's online archival database, and individual state websites were conducted in order to obtain sexual recidivism rates of individuals convicted of a sex offense for each state analyzed in this study. The following key terms were extracted from the relevant literature and used for these searches: *recidivism, recidivism rates, sex(ual) offender, and the names of each state analyzed in this study (e.g. Alaska, Washington, etc.)*.

Inclusion criteria for the present study were as follows: (a) the sexual recidivism rate of individuals convicted of a sex offense within a particular state was incorporated; (b) the length of the follow-up period used to evaluate recidivism was explicitly stated; and (c) the definition used to measure recidivism was clearly defined (i.e. reincarceration, reconviction, rearrest).

When more than one study was found for a particular state, one study per state was chosen to represent the recidivism rate for that state. The study was chosen based on two criteria: (a) the study contained the strongest methodology and (b) it was the most recently published study. To obtain recidivism rates for states where no public data could be found, participants were asked to provide any reports and/or research papers that included sexual recidivism rates of individuals convicted of a sex offense in their state that fit the aforementioned inclusion criteria.

Data Analysis

For this research, the independent variables were defined as the components of supervision for individuals convicted of a sex offense in the community and the components of treatment programming offered to individuals convicted of a sex offense while they are

incarcerated, as well as while they are being supervised in the community. The dependent variable was defined as the sexual recidivism rate of offenders convicted of a sex offense in each state analyzed in this study.

T-tests were used to see if there were any differences in sexual recidivism between the different elements of treatment and supervision. The following elements were evaluated for treatment while incarcerated: the presence or absence of civil commitment, cognitive behavioral therapy, relapse prevention therapy, drug therapy, the Good Lives Model, group treatment, individual treatment, faith-based treatment, or substance abuse treatment, as well as whether or not treatment was mandatory and the use of risk assessment tools for treatment decisions. The following elements were evaluated for treatment/supervision in the community: the presence or absence of cognitive behavioral therapy, relapse prevention therapy, drug therapy, the Good Lives Model, group treatment, individual treatment, faith-based treatment, or drug screening, as well as whether or not treatment/supervision was mandatory, the use of risk assessment tools for treatment decisions, polygraph examinations, electronic monitoring, or the penile plethysmograph. For some specific elements that were offered, but not mandatory, separate t-tests were run to see if there was a difference in recidivism rates between the component being optional or mandatory.

Additionally, correlations were run to see if there was any relation between sexual recidivism and the number of individuals on a parole/probation officer's caseload, the length of treatment offered (for both prison based treatment and community based treatment), and the minimum amount an individual is polygraphed per year while in the community.

Results

States for Analysis

Through a process of purposive and snowball sampling, relevant and representative data was collected for 18 states regarding treatment while incarcerated, treatment while in the community, and supervision protocol. Representative data was also found regarding prison based treatment for 6 additional states and regarding community based treatment and supervision protocol for 1 additional state. After extensive searches for sexual recidivism rates for each state for which representative data was collected, sexual recidivism rates were only found for 14 states. Additionally, sexual recidivism rates found in confidential reports and/or research papers could be provided by participants to represent 3 additional states. Studies reporting sexual recidivism rates that fit the aforementioned inclusion criteria could not be obtained for the remaining 8 states for which representative data was collected. Due to one state's follow-up period being a significant outlier, it was removed for all further analyses. Thus, recidivism rates for this study were based on an average follow up period of 36.94 months, with a range of 24 months to 60 months. Statistically significant differences were not found between the remaining states using different follow up periods. Overall, a total of 16 states were analyzed for the purposes of this study: 12 states for which data was collected regarding treatment programs during incarceration, as well as community treatment and supervision, 3 states for which data was only collected regarding treatment programs during incarceration, and 1 state for which data was only collected regarding treatment programs during community supervision and supervision protocol.

Treatment and Supervision Components

Independent-samples t-tests were run to investigate whether there were differences in sexual recidivism between the aforementioned treatment and supervision components. There were no statistically significant findings for these components for either treatment while

incarcerated, treatment in the community, or supervision (see Tables 1 and 2). However, the relation between sexual recidivism and relapse prevention therapy offered during prison based programs approached significance, with programs that offer this therapy having slightly higher recidivism rates than programs that do not (see Table 1). Additionally, no statistically significant differences were found regarding whether or not the state enforces SVP civil commitment or whether or not treatment or supervision programming is mandatory.

T-tests were also run to examine whether there were differences in sexual recidivism between programs in which some of these treatment and supervision components are mandatory for all participating individuals compared to programs in which they are either optional or only offered to certain individuals. Again, no statistically significant differences were found for these components (see Table 3). However, the relation between sexual recidivism and whether or not individual treatment while incarcerated is mandatory or optional approached significance, with states that mandate individual treatment having slightly lower sexual recidivism rates than states that offer individual treatment as an option.

Pearson's correlations between sexual recidivism and other components of treatment and supervision were run (i.e. number of individuals on a caseload, length of treatment while incarcerated, length of treatment while under community supervision, the minimum number of occasions an individual is polygraphed per year while in the community). None of these additional components of treatment or supervision were shown to have a statistically significant correlation with sexual recidivism (see Table 4).

Discussion

This study aimed to examine the relation between sexual recidivism and various elements of treatment programs and supervision protocols offered to individuals convicted of a sex offense

while they are incarcerated, as well as while they are supervised in the community. Although this was an exploratory pilot study and thus, no specific hypotheses were posited, several important conclusions can be drawn. Overall, the results reveal that more research is needed regarding the components that comprise treatment and supervision for individuals convicted of a sex offense. In addition, this study emphasizes the need for states to analyze the efficacy of their programming and protocols, specifically looking into whether or not the policies and procedures regarding individuals convicted of a sex offense are helping to keep the community safe.

Treatment Components

Relation with sexual recidivism. Previous analyses that illustrate that treatment for individuals convicted of a sex offense has a positive effect on sexual recidivism rates (Hanson & Bussiere, 1998; Hanson et al., 2002; Losel & Schmucker, 2005) provide a good foundation for the research in this field, but they have also been noted as having major methodological shortcomings (Furby et al., 1989; Rice & Harris, 2003). One of these shortcomings is that these meta-analyses are comprised of individual studies that use diverse methods of treatment. Although this does not diminish the importance of the findings of these studies, it does make it hard to determine which aspects of these treatment programs are actually effective in reducing sexual recidivism. This study attempted to mitigate this methodological shortcoming by individually analyzing several aspects of treatment to see if they were contributing to the difference in sexual recidivism rates between the states.

The relation between sexual recidivism and two individual components of treatment approached significance. First, the data revealed that states which mandated individual treatment in addition to group treatment while incarcerated had lower recidivism rates than those states in which individual treatment was optional or only offered to some individuals. This finding

suggests that giving individuals the option to participate in individual treatment or only offering this element of treatment to some individuals is not as effective as simply mandating all individuals who are being treated to have individual therapy sessions.

The second element of treatment that is worth noting is relapse prevention therapy (RPT) offered to individuals convicted of a sex offense while they are incarcerated. Interestingly, states that incorporated RPT into their treatment programming had higher recidivism rates than states that did not incorporate this treatment modality. While this relation was not statistically significant, its direction is contradictory to what one might expect, as RPT has been shown to be positively influential for individuals convicted of a sex offense participating in treatment (Witt, Greenfield, & Hiscox, 2008). One explanation for this may be due to the tendency for treatment programs to only offer treatment to higher-risk offenders. For many states analyzed in this study, RPT was only made available to higher risk individuals or these higher risk individuals were required to participate in more RPT than lower risk individuals. This may have had an effect on the relation shown in this study.

It is also interesting that the aforementioned relations only approached significance for treatment while incarcerated and not for treatment in the community, suggesting that treatment programming during these two stages of an individual's sentence may hold differing relations with sexual recidivism. While research has shown that treatment can be successful in reducing sexual recidivism of those who participate (Duwe & Goldman, 2009; Hanson & Bussiere, 1998; Hanson et al., 2002; Losel & Schmucker, 2005; Olver et al., 2013; Scalora & Garbin, 2003), the lack of an ability for this study to find any specific elements that may be significantly contributing to this relation heeds the need for further investigation.

What is being offered. The current study found that both prison based and community based treatment programs are utilizing evidence-based practices such as cognitive behavioral therapy (CBT) and RPT more than drug therapy (see Tables 1 and 2). Although this is in line with previous research (Daly, 2008), it is interesting to note that the community based treatment programs reported the use of evidence-based practices less than prison based treatment programs. While this may simply be due to a lack of reporting by the participants who described the community based treatment programs, it could also be an important insight into the manner in which community based treatment programs are constructed. If they are using neither CBT, RPT, nor drug therapy, more investigation is warranted into what they are using instead. Lastly, future research should also delve into why neither prison based nor community based treatment programs are utilizing drug therapy in a majority of states as shown by this study and others (Daly, 2008), even though research has shown it to be more effective than just cognitive or behavioral treatment on its own (Hall, 1995; Losel & Schmucker, 2005).

Supervision Components

Relation with sexual recidivism. Research regarding what elements of supervision for individuals convicted of a sex offense help to assuage sexual recidivism rates is mixed (Aos et al., 2006; Aytes et al., 2001; Buttars et al., 2016; McGrath et al., 2007; Stalans et al., 2002). While the results of this study support the Vera Institute of Justice report regarding the common use of actuarial risk assessments and specialized provisions for individuals convicted of a sex offense (Daley, 2008), this study was unable to show that these elements had an effect on sexual recidivism. Although the results support the research regarding the lack of an effect on sexual recidivism by many supervision components such as substance monitoring, penile plethysmograph use, GPS monitoring (Buttars et al, 2016), and polygraph testing (McGrath et al,

2007), no definitive conclusions can be made. As this was a pilot study analyzing a small number of state supervision protocols, further research would be beneficial to help more clearly define what components of supervision work in helping to reduce sexual recidivism and keep the community safe.

SVP civil commitment. 20 states and the District of Columbia have passed SVP legislation. Capturing four of these states, this study is the first to compare sexual recidivism between states that enforce SVP laws and states that do not. Although no significant findings were revealed, it is interesting to note that those states with SVP laws had a lower mean sexual recidivism rate than states that did not. It is imperative that research continue to investigate the effectiveness of SVP laws in reducing sexual recidivism, despite the low release rate of these individuals (Washington State Institute for Public Policy, 2005). These programs are high in cost (Washington State Institute for Public Policy, 2007) and if when more thoroughly analyzed, these programs are not proving to lead to a significant difference in sexual recidivism, states may want to put their money and effort toward other treatment and supervision strategies that are empirically validated as effective (e.g. specific treatment elements and supervision tactics). Many aspects of SVP programs have been cataloged in the literature (DeMatteo et al., 2015; Washington State Institute for Public Policy, 2007). A more comprehensive state by state analysis of SVP recidivism is needed to further investigate the effectiveness of these programs and to see which, if any, components of these programs are leading to lower sexual recidivism.

Intensity

It is clear that the treatment and supervision programs included in this study and in previous research (Daley, 2008; West et al., 2002) vary in duration, program components, eligibility requirements, and participation. All of these aspects contribute to the intensity at

which each individual is receiving treatment or supervision. Treatment has been shown to be more effective when it is tailored to the individuals' risk (Andrews, Bonta, & Hoge, 1990; Hanson, Bourgon, Helmus, & Hodgson, 2009; Smid, Kamphuis, Wever, & Van Beek, 2014). Due to this link between intensity and treatment, I would hypothesize that intensity would be able to predict sexual recidivism on a state by state basis. However, this study did not adequately or reliably measure for intensity. Future research should consider intensity as a potential predictive variable when investigating which particular programming components may be contributing to sexual recidivism rates. In order to obtain this information, interviews are helpful, but can be swayed by social desirability. Intensity can be more reliably measured by obtaining state published documents describing treatment programming and supervision protocol, detailing the elements that lead to differing levels of intensity. With more empirically sound evidence of which elements of treatment and supervision are more effective than others, states can make the necessary changes to increase the success of their programming for the individuals participating and the community at large.

Criminal Justice Implications

The results of this study extend beyond the research environment to the criminal justice arena. The public often forms "system attitudes" regarding law enforcement, corrections and justice, especially when these judicial facets are in the context of individuals convicted of a sex offense (Olver & Barlow, 2010). These attitudes can be displayed through the increase in concern when the public believes that many of these sex offenses should have been predicted and thus prevented (Helmus, Hanson, Thornton, Babschishin, & Harris, 2012). Therefore, identifying which characteristics of treatment and supervision are the most effective in reducing recidivism has the potential to assuage public concern regarding individuals convicted of a sex offense.

Although no significant findings regarding these characteristics were revealed in this study, this lack of findings is notable in and of itself. If these programs are not proving to lead to significant differences in sexual recidivism, treatment providers and program directors may want to re-think how they structure the treatment and supervision that they are offering.

Limitations

This study is not without its limitations. First, treatment programming and supervision information for the states analyzed in this study was obtained by interviewing knowledgeable personnel from each state. The information provided by the participants was assumed to be true based on their knowledge and experience regularly interacting with individuals convicted of a sex offense in these treatment programs and in the community. Additionally, the participants were following a questionnaire when answering questions, and while they could deviate from the specific questions asked, many may have only answered what was asked of them, limiting the information provided. Accounting for the fact that not all information given by the participants might be correct due to social desirability or genuine mistakes regarding the information about their state programming, an attempt was made to find other sources, such as state run websites, and talk to multiple participants who could validate the information put forth by those individuals who were spoken to first. While not all information provided by the participants could be corroborated by published studies or state run websites, no secondary source provided contradicting information. I believe that the consistency among the participant reports mitigates some of the potential that social desirability bias or misinformation dictated the information given by the participants; however, future studies should attempt to locate information that can be corroborated by several knowledgeable parties within the state, as well as unbiased sources.

Another limitation surrounding the collection of data is that representative data regarding treatment while incarcerated and treatment while in the community could only be collected from participants in 18 states. While representative data was also found regarding incarcerated treatment for six additional states and regarding community treatment for one additional state, over half of the states in the United States were unable to be represented in this study. Therefore, while the information that was collected and analyzed lays an informative foundation, future research should attempt to collect data that is more representative of the United States as a whole.

Lastly, public reports of studies regarding sexual recidivism rates that were methodologically sound and that provided the most reliable and encompassing data were unable to be found for 11 states for which representative data on either prison based treatment, community based treatment, or both was collected. In order to mitigate this limitation, participants were asked to provide this data to the interviewers. Only three additional states could provide this information, leaving eight states unable to be included in the analyses of this study. That so many states are either not accurately tracking recidivism rates for individuals convicted of a sex offense or are unwilling to publicly share this information is concerning. First, if the state is simply not tracking this data, this could mean that they are making uninformed decisions regarding treatment and supervision. Second, if the state is unwilling to share this information, one may wonder why this is, leaving many questions about the quality of the treatment programming and supervision offered to individuals convicted of a sex offense unanswered.

Conclusion

Overall, this study suggests that more research is needed regarding the individual components of treatment and supervision and how these elements can help to lower sexual

recidivism. The lack of sexual recidivism materials available for this study also calls for more initiatives to track this data and make it available to researchers in the public sector. This pilot study offers insight into some of the treatment and supervision protocols around the nation and provides a good foundation for future studies to continue to investigate treatment and supervision offered to individuals convicted of a sex offense while they are incarcerated and while they are in the community. The researchers involved in this study intend to take the information gained from the current pilot and tweak the study so that, going forward, many of the aforementioned limitations are addressed, intensity is measured more reliably, and generalizability is enhanced. With more generalizable research to clarify the efficacy of specific elements of treatment and supervision, policy makers and treatment providers can make more evidence-based decisions to effectively change the policies and programming provided to individuals convicted of a sex offense, ultimately helping to reduce the rate at which these individuals reoffend, and thus helping to keep communities safer nationwide.

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Table 1

Results of t-test between sexual recidivism and components of treatment while incarcerated

<u>Treatment Component</u>	<u>Yes</u> <u>M(SD)</u>	<u>No</u> <u>M(SD)</u>	<u>Test Statistic</u>	<u>95% CI for</u> <u>Mean Difference</u>
SVP Civil Commitment	n = 4 2.48(1.64)	n = 12 4.19(2.86)	$t(14) = -1.120,$ $p = .268$	-4.99, 1.56
Mandatory Treatment	n = 4 3.03(1.31)	n = 9 3.80 (2.84)	$t(11) = -.515,$ $p = .214$	-4.10, 2.55
Risk Assessment Used in Treatment Decisions	n = 9 3.17(2.05)	n = 4 4.45 (3.32)	$t(11) = -.866,$ $p = .302$	-4.54, 1.98
Cognitive Behavioral Therapy*	n = 13 3.56(2.44)	n = 0		
Relapse Prevention Therapy	n = 10 4.26(2.34)	n = 3 1.23(.51)	$t(11) = 2.158$ $p = .054$	-.059, 6.11
Drug Therapy	n = 5 2.34(1.67)	n = 8 4.33(2.61)	$t(11) = -1.506$ $p = .160$	-4.89, .917
Good Lives Model	n = 4 2.64(1.37)	n = 9 3.97(2.75)	$t(11) = -.905$ $p = .385$	-4.58, 1.91
Group Treatment*	n = 13 3.56(2.44)	n = 0		
Individual Treatment*	n = 13 3.56(2.44)	n = 0		
Faith-Based Treatment	n = 9 3.32(2.59)	n = 4 4.12(2.29)	$t(11) = -.530$ $p = .607$	-4.12, 2.52
Substance Use Treatment*	n = 12 3.48(2.52)	n = 0		

*Cognitive Behavioral Therapy, Group Treatment, Individual Treatment and Substance Use Treatment could not be analyzed, as all prison based treatment programs offer it

Table 2

Results of t-test between sexual recidivism and components of treatment and supervision while in the community

<u>Treatment Component</u>	<u>Yes</u> <u>M(SD)</u>	<u>No</u> <u>M(SD)</u>	<u>Test Statistic</u>	<u>95% CI for</u> <u>Mean Difference</u>
Mandatory Treatment	n = 9 4.47(2.93)	n = 4 3.07(2.89)	$t(11) = .802,$ $p = .917$	-2.45, 5.27
Mandatory Supervision	n = 3 4.27(4.10)	n = 13 3.64 (2.45)	$t(14) = .355,$ $p = .194$	-3.15, 4.40
Risk Assessment used in Treatment/ Supervision Decisions	n = 10 4.21(3.22)	n = 3 3.47(1.53)	$t(11) = .380,$ $p = .711$	-3.58, 5.07
Cognitive Behavioral Therapy	n = 5 4.57(3.46)	n = 8 3.71(2.64)	$t(11) = .512,$ $p = .619$	-2.86, 4.59
Relapse Prevention Therapy	n = 4 4.87(3.91)	n = 9 3.67(2.49)	$t(11) = .675,$ $p = .513$	-2.7, 5.09
Drug Therapy	n = 1 7.37(0)	n = 12 3.76(2.81)	$t(11) = 1.23,$ $p = .244$	-2.93, 10.06
Good Lives Model	n = 2 4.09(4.65)	n = 11 2.79(.84)	$t(11) = .023,$ $p = .982$	-5.03, 5.13
Group Treatment*	n = 13 4.04(2.87)	n = 0		
Individual Treatment*	n = 13 4.04(2.87)	n = 0		
Faith-Based Treatment	n = 8 4.68(3.41)	n = 5 3.02(1.51)	$t(11) = 1.013,$ $p = .333$	-1.94, 5.26
Drug Screening*	n = 13 4.04(2.87)	n = 0		
Polygraph Examination	n = 12 3.76(2.81)	n = 1 7.37	$t(11) = -1.23,$ $p = .244$	-10.06, 2.84
Electronic Monitoring	n = 11 4.24(3.07)	n = 2 1.27(.90)	$t(11) = .593,$ $p = .565$	-3.65, 6.35
Penile Plethysmograph	n = 7 4.35(3.27)	n = 6 3.68(2.26)	$t(11) = .406,$ $p = .693$	-2.98, 4.32

*Group Treatment, Individual Treatment, and Drug Screening could not be analyzed, as all community treatment and supervision programs offer it

Table 3

Results of t-test between sexual recidivism and optional versus mandatory treatment components

<u>Treatment Component</u>	<u>Mandatory</u> <u>M(SD)</u>	<u>Optional</u> <u>M(SD)</u>	<u>Test Statistic</u>	<u>95% CI for</u> <u>Mean Difference</u>
Individual Treatment While Incarcerated	n = 6 2.31(1.53)	n = 7 4.64(2.64)	$t(11) = -1.90$ $p = .085$	-5.03, .38
Community Group Treatment	n = 12 4.09(3.0)	n = 1 3.50	$t(11) = .188$ $p = .854$	-6.28, 7.45
Community Individual Treatment	n = 6 4.26(3.82)	n = 7 3.85(2.07)	$t(11) = 2.44$ $p = .811$	-3.26, 4.07
Drug Screening in the Community	n = 3 3.03(2.04)	n = 10 4.34(3.11)	$t(11) = -.676$ $p = .513$	-5.57, 2.95
Polygraph Examinations in the Community	n = 9 3.70(3.29)	n = 3 3.95(0.57)	$t(10) = -.129$ $p = .90$	-4.64, 4.13

Table 4

Pearson's Correlation results between sexual recidivism and treatment/supervision components

		<u>Sexual</u> <u>Recidivism</u>	<u>Caseload</u>	<u>LPT^a</u>	<u>LCT^b</u>	<u>MP^c</u>
<u>Sexual</u> <u>Recidivism</u>	Pearson	1	.317	.189	-.437	-.167
	Correlation					
	p		.292	.537	.240	.148
	N	16	13	13	9	11

a. LPT: Length of Prison Treatment; b. LCT: Length of Community Treatment; c. MP: Minimum time polygraphed per year

Appendix A*Recruitment Script and Consent*

My name is _____. I am a graduate student at John Jay College of Criminal Justice. I am working under the supervision of Dr. Thomas Kurcharski and Dr. Cynthia Calkins. I am investigating the effects of sexual offender programs on sexual recidivism rates. Would you be willing to give me 45 minutes of your time?

If yes:

Before we start I would like to inform you that you are being asked to participate because you are a parole officer employed in a correctional facility in one of the 50 United States, who currently and/or previously supervised sexual offenders on parole in the state in which you are currently employed. This proposed study aims to examine the relationship between intensity of sexual offender programs and sexual offender recidivism rates across the United States. You will be asked a series of questions regarding your state's typical post-incarceration supervision protocol for sexual offenders and the types of programs that they have access to. This survey will take approximately 45 minutes of your time. This study has the potential to improve the efficiency and success of sexual offender programs, in the United States, in reducing sexual offender recidivism rates. You will not receive any payment for participating in this research study. We will make our best efforts to maintain confidentiality of any information that is collected during this research study, and that can identify you. We will disclose this information only with your permission or as required by law. Your institution and personal information will remain confidential; answers will only be represented only by the state in which you work as a parole officer and this call will not be recorded. Only your answers to the interview questions will be transcribed and stored on a password-protected computer. Your participation in this research study is entirely voluntary. If you decide not to participate, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. You can decide to withdraw your consent and stop participating in the research at any time, without any penalty. If you are still willing to participate, please state your name and today's date.

Please answer the following questions to the best of your ability.

If no:

Thank you for your consideration. Is there anyone you know who may be interested in participating in this study? Do you have any documents that you could send us to assist in our search for this information or does your state have any public forum in which this information can be obtained?

Appendix B*Survey Questions*

Survey

General Survey Questions

1. What is your job title?
2. What is your educational background?
3. How many years have you been a parole officer?
4. Did you receive any training to become a parole officer? If so, please describe your training. How many hours?
5. Do you have to get updated training after a certain period of time? If so, please describe this training.
6. Have you ever been trained to use certain instruments for establishing risk of the offenders that you supervise? If so, which ones?
7. What assessment measures are used in your state to determine risk for sexual offenders? Are you trained to use these specific assessment tools?
8. How many different states have you worked as a parole officer?
9. How many different corrections facilities have you worked in as a parole officer?
10. Have you worked with sex offenders in all of the above facilities?
11. In what state have you spent the majority of your time as a sexual offender supervisor?
12. What are your duties as a supervisor and/or parole officer in regards to sexual offenders?
13. What licensure or qualifications must you have as a parole officer, supervising sexual offenders, in the state you currently reside in?
14. Is any extra training required in your jurisdiction in order to supervise sexual offenders?
15. If yes, does the state mandate that you update this training after a certain amount of time?
16. What is the average caseload for a parole officer per year?
17. How many offenders do you typically supervise per year?
18. How many sexual offenders do you typically supervise per year?
19. How long on average do you supervise an offender?
20. What percentage of sexual offenders in your personal caseload do you think recidivated for any offense? For a sexual offense? For a violent offense? For a general offense that does not include the previous categories?
21. When you answered the previous questions, how were you defining recidivate? Rearrest, reconviction, reincarceration?
22. What is the recidivism rate in your state for general, violent, and sexual offending?
23. Does your state have any civil commitment laws? If so, at what levels do they operate (hospitalized civil commitment versus standard parole)? Please describe it to me.
24. Are there sexual offenders in your state that complete their sentence and are released into the community without any supervision?
25. How would you define sexual recidivism?
26. What would you say are the primary goals of the programs provided to sexual offenders while incarcerated and/or on parole other than reducing recidivism rates?
27. How successful do you think your state's program is in reducing recidivism rates? If you were to make any changes what would they be?
28. Is the information you are presenting us with representative of all state sexual offender protocols or specific to your jurisdiction?

29. Are there any non-confidential reports or research papers produced by the state that address recidivism, in particular, sexual recidivism that you are able to share with us for our research purposes?

Questions Regarding Treatment While In Incarceration

1. How many sexual offender inmates do you typically supervise at one time?
2. What kind of rehabilitative treatment programs are available to sexual offenders in your state? Please describe them in as much detail as you can.
3. How long are each of the sexual offender programs?
4. What is the rate of “graduation” or “completion” of these programs?
5. How successful do you think these programs are for sexual offenders who complete them? What about for those who fail to complete the entire program regimen?
6. Are there any programs specifically for high-risk sexual offenders versus low-risk sexual offenders?
7. Who is in charge of these programs and do you have licensed psychologists on staff to help with the programs?
8. Do you offer any of the following in your program? If so, what is the length of each treatment/rehabilitative program?

1. Group Counseling/ Sex Offender Counseling ____ / ____
2. Individual Counseling/Sex Offender Counseling ____ / ____
3. Sex Offender Specific Evaluation Reports ____ / ____
4. Family Counseling/Sex offender counseling ____ / ____
5. Sex Offender Treatment/Education groups ____ / ____
6. Cognitive Behavioral Therapy ____ / ____
7. Relapse Prevention Therapy ____ / ____
8. Any Organic Treatment Interventions ____ / ____
9. Religious Based Support ____ / ____
10. Vocational Training ____ / ____
11. GED ____ / ____
12. Aggression Management ____ / ____
13. Substance Abuse Treatment ____ / ____
14. Medication Administration ____ / ____

9. Are there any programs we have not listed that you offer? If so what are they and what is the length of each treatment/rehabilitative program?
10. Out of all of the programs we have talked about thus far, which programs are mandatory for all sexual offenders while incarcerated, which are optional, and which are the most highly recommended?
11. Which programs, if any, are sexual offender specific (a.k.a. rape, child molestation)?

Appendix C
Source Table

<u>State</u>	<u>Source</u>	<u>Published/Un-published</u>	<u>Recidivism Definition</u>	<u>Sexual Recidivism</u>	<u>Length of Follow Up (in months)</u>
Alaska	http://www.ajc.state.ak.us/reports/recid2011.pdf	Published	Reconviction	2%	24
Arizona	https://cvpcs.asu.edu/sites/default/files/content/projects/Rodriguez%20stevenson.pdf	Published	Rearrest	2.4%	36
Connecticut	http://www.ncdsv.org/images/CT_RecidivismAmongSexOffendersInCT_2012.pdf	Published	Rearrest	3.6%	60
Delaware	http://cjc.delaware.gov/sac/pdf/Corrections/2015_Recidivism_Report.pdf	Published	Rearrest	3.5%	36
Illinois	https://www.researchgate.net/publication/250940771_Are_Sex_Offenders_Dangerous	Published	Rearrest	4.8%	36
Maine	http://muskie.usm.maine.edu/justiceresearch/Publications/AdultSexual_Assault_Trends_and_Sex_Offender_Recidivism_in_Maine_2010.pdf	Published	Re-incarceration	3.8%	36
Michigan	https://www.womenagainstregistry.org/Resources/pdf/CAPPS-Paroling-people-who-committed-serious-crimes-11-23-14.pdf	Published	Re-incarceration	0.8%	39
Missouri	https://doc.mo.gov/Documents/publications/Offender%20Profile%20FY12.pdf	Published	Reconviction	1.6%	36

Appendix C continued
Source Table

<u>State</u>	<u>Source</u>	<u>Published/ Un- published</u>	<u>Recidivism Definition</u>	<u>Sexual Recidivism</u>	<u>Length of Follow Up (in months)</u>
New Mexico	https://www.womenagainstregistry.org/Resources/pdf/sex-offender-final-report.pdf	Published	Rearrest	1.8%	36
Ohio	http://www.drc.ohio.gov/Portals/0/Planning%20and%20Evaluations/Ten_Year_Recidivism.pdf?ve r=2016-08-02-132320-787	Published	Reconviction	7.37%	36
Oklahoma	Participant	Unpublished	Rearrest	9%	36
Oregon	Participant	Unpublished	Rearrest	1%	36
Utah	https://www.womenagainstregistry.org/Resources/pdf/sex-offender-final-report.pdf	Published	Rearrest	9%	36
Vermont	https://www.ncjrs.gov/pdffiles1/nij/grants/236217.pdf	Published	Rearrest	4.6%	36
Washington	http://www.doc.wa.gov/docs/publications/factsheets/500-FS001.pdf	Published	Re-incarceration	1.1%	36
Wyoming	Participant	Unpublished	Rearrest	3.76%	36