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The Impact of Voluntary Aftercare on Recidivism Rates for Adult Male Sex Offenders

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THE IMPACT OF VOLUNTARY AFTERCARE ON RECIDIVISM RATES FOR ADULT MALE SEX OFFENDERS

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Abstract:

The recidivism rate of eighteen sex offenders participating in Stepping Up, a voluntary aftercare program, was compared to the overall recidivism rate of convicted sexual offenders in California in order to determine the effectiveness of voluntary participation in a post-mandated treatment program. Attendance for a minimum of six months in Stepping Up was required for inclusion in the study, and recidivism rates were calculated by a review of records. Although participants in the Stepping Up aftercare program had a re-offense rate of 0%, results were not statistically significant when compared with California's overall recidivism rates. While a 0% recidivism rate is noteworthy when compared with the statewide average of 9.1%; the small size of this initial study is a barrier to meaningful statistical analysis. Additional studies of larger similar groups are recommended in order to determine the potential value of aftercare as a protective factor against recidivism. The electronic version of this dissertation is accessible at the Ohiolink ETD center, http://www.ohiolink.edu/etd

Keywords: sex offender, voluntary, aftercare

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Chapter 1: Introduction

Psychological treatment for those convicted of sexual crimes is intended to lower the risk of re-offense. Progress in this area may seem difficult to measure, but those clients that are mandated to complete therapy demonstrate significantly lower rates of re-offense than those that don't participate in treatment (Andrews & Bonta, 1998; Bourget & Bradford, 2008; Hanson & Harris, 2001). However, once clients have completed their allotted time in treatment, there are few resources available. For those that wish to continue to address their risk factors in therapy, options are limited to individual treatment or becoming a voluntary member of an otherwise mandated group. Stepping Up's aftercare program offers an alternative: voluntary group aftercare.

Current Approach

Sexual offenses provoke a strong social response. Individuals who have committed serious sexual offenses (referred to within the criminal justice system as high-risk sex offenders, or HRSOs) are both feared and scrutinized by our society. This group includes all parolees and probationers who are considered as 290s (California Penal Code 290, 2012), meaning those who are mandated to register as 290 sex offenders for the duration of their lives and to be supervised and attend therapy for such a period as determined by a judge. 290 registrants are supervised more closely upon release than perhaps any other criminal population.

All of California's registrants are monitored by the California State Sex Offender Management Board, or CASOMB (California Penal Code 9001, 2012). CASOMB's guidelines for supervision and treatment of 290 registrants are informed by four governing statutes. The first of these is California Penal Code Section 9000-9003 (2012), which defines the shape and expectations of CASOMB's program. The second is California Penal Code 290 (2012), which mandates individuals convicted of particular sexual crimes to register. CASOMB's third governing statute is Proposition 83 (Sexual Predator Punishment and Control Act [hereafter, SPPCA], 2006), better known as Jessica's Law, which increases the penalties for violent or habitual sexual offenders, mandates Global Positioning Monitors to be worn by registrants convicted of a sexual felony, and expands the definition of predatory sexual behavior. CASOMB's final influential statute is California Assembly Bill 1015 (2005), which further defines the role and responsibilities of the CASOMB board. 290 registrants are monitored closely. The research that supports this degree of supervision (Lösel & Schmucker, 2005; Seto & Barbaree, 1999) indicates that not only are sexual offenders four times as likely to re-offend within a three-year period following their release from incarceration than their non-offending inmate peers (Hanson & Bussiere, 1998), but also that sexual offenses present as unique criminal behavior with specific and idiomatic risk factors (Hanson, 1998). The current study defines a post-treatment sexual offender as a man that has been

convicted of serious sexual offenses, has completed his jail or prison term, and has fulfilled his obligatory therapeutic commitment during his conditional release. As comparatively few women have been convicted of sexual offenses, and as there are comparatively few studies about female offenders, the current study is focused on the approximately 95% of this population that is male (Tewksbury, 2004). Having fulfilled the expectations of supervision, the sex offender is no longer on probation or parole and is no longer obligated to attend treatment.

In California, HRSOs are mandated to participate in one or more of a variety of treatment programs upon returning to the community. All state-approved treatment of sex offenders in California is based upon the containment model, which was implemented as part of Chelsea's Law in 2010. The containment model is represented by four domains: parole or probation, polygraphers, treatment providers and victim advocates. The primary client is the community, not the person receiving treatment (Glaser, 2003), as the prevailing rationale for mandating men into therapy is to achieve a lower recidivism rate, which translates as fewer victims and a safer community overall. Within this model the registrant is a secondary consumer of treatment. The containment model is intended to address issues of community safety, to monitor the treatment and supervision of the client in question, and to increase or maintain awareness of the victims of sexual crimes (Andrews & Bonta, 1998). Long-term supervision is typically ordered in conjunction with treatment, and some offenders are given

lifetime supervision. Upon release, they are ordered to attend weekly meetings of both group and individual therapy, and are often further monitored by use of a Global Positioning System (GPS) monitor ankle device and by regular administrations of the polygraph and other assessments of risk. These programs are designed not only to ensure continued containment of high-risk individuals, but to identify and address the underlying causes of offending behavior, such as violent or deviant sexual urges, poor interpersonal and coping skills, and/or an inability to control impulsive behaviors (Bonta, 2007). The social impact and cost of such supervision is considerable, particularly in light of the fact that the number of parolees mandated to therapy may soon increase considerably. There is a bill pending in California that will require *all* parolees with a sexual offense on their record to attend mandated relapse-prevention therapy upon release, as compared to the current requirements that mandate treatment only for those who are considered high-risk or are obliged to register as sex offenders under Penal Code 290. This is in compliance with Megan's Law (State of California Department of Justice, 2012), which allows for the home addresses and criminal histories of convicted sexual offenders to be made available to the public. At this time Stepping Up aftercare is offered only to high-risk clients, as they are considered overall to be at greater risk of recidivism (Bonta, 1999; Bourget & Bradford, 2008).

As comprehensive as these legal measures might appear, these precautions are only effective if an individual's unique risk factors are carefully assessed and monitored. The public perception of sex offenders is one of volatility and menace (Levenson, Brannon, Fortney & Baker, 2007). This threat is often heightened by news stories that seem calculated to induce panic (Levenson et al., 2007). While the effect of sensational media coverage on the public perception of 290 registrants is debatable, there are understandable reasons to fear, given the likelihood that an offender on parole or probation will re-offend. There are more registered sex offenders in the State of California than in any other state in the nation (California Department of Corrections and Rehabilitation [hereafter, CDCR], 2012). A variety of factors have been identified that impact the likelihood of a sex offender committing a new offense and/or violating the terms of conditional release. These include sexual preoccupation, the effect of significant social influences, general social rejection, impulsivity, negative emotionality, and others (Thornton, 2002). These are the factors addressed in mandated therapy, and remain the focus of treatment at Stepping Up.

Assessing Risk

It is a fundamental assumption of supervision that a monitored offender is less likely to relapse (Hanson & Bussiere, 1998). However, the efficacy of mandated treatment is difficult to assess and even harder to quantify. Once an individual has completed treatment and the terms of probation or parole, he is no

longer monitored or subject to supervision. Studies indicate that mandating sexual offenders to therapy has a positive effect on their level of risk (Hanson, Helmus & Thornton, 2009; Langan, Schmitt, & Durose, 2003). Cognitive behavioral therapy, or CBT, has been shown to be effective at reducing the rate at which treated offenders recidivate (Moster, Wnuk, & Jeglic, 2008), and is the most common therapeutic approach within the containment model for treating HRSOs. Some programs incorporate additional clinical modalities, such as the Risk-Needs-Responsivity Model (Bonta, 2007) or Ward, Mann, and Gannon's (2007) Good Lives Model (GLM), into their CBT interventions. However, a CBT-structured approach is the common baseline in all mandated treatment. Not all sex offenders are the same, nor are they equally likely to relapse. Many different studies have attempted to quantify the degree of risk at which an offender may present. Combinations of risk assessments are applied in order to distinguish offenders that are high-risk, i.e., more likely to recidivate, from other, lower-risk offenders (Witt & Schneider, 2005). This involves an assessment of two types of risk factors: dynamic and static. Dynamic risk is a rapidly shifting series of factors that affect an offender's activities of daily living and his immediate levels of stress, such as housing stability, the presence or lack of pro-social support relationships, etc. Static risk measures factors that are more enduring, and difficult if not impossible to shift, such as an offender's prior number of arrests and convictions, age at release, and other factors.

An HRSO with significant risk levels of both dynamic and static characteristics is considered to be at high risk of re-offending (Bonta, 1999). However, sex offenders released in California are currently assessed only for static risk factors, via the administration of the assessment the Static-99r (State Authorized Risk Assessment Tool for Sex Offenders, revised, 2012). The California Department of Corrections and Rehabilitation now requires additional measures (CDCR, 2012). Beginning in 2012, all the assessments for all sex offenders released on probation or parole will include an additional assessment of dynamic risk: the Structured Risk Assessment, Forensic Version Light, or SRA-FVL (SARATSO, 2012). Treatment conceptualization of sexual offenders is in the midst of a gradual shift, influenced on one level by an increased emphasis on containment and monitoring of paroled offenders, and on the other by a renewed emphasis on a rational, rather than a reactive; approach. While California has yet to acknowledge the persistent and enduring aspects of the risk factors its government and law enforcement seeks to assess, research related to longitudinal data on relapse and recidivism is likely to expand in conjunction with the new laws.

Enforcing Restrictions

Participation in therapy is only one factor among many that impact risk of relapse. As prisoners that have been convicted of a sexual offense are considered and treated as social pariahs (Tewksbury & Copes, 2013) even among other ex-

convicts, they remain a difficult population to treat and monitor even after the conditions of release have been fulfilled. Inmates who are released under California's 290 conditions are expected to maintain an unusually exacting degree of compliance. Many of the conditions of release can seem designed, ironically, to increase the situational stressors that contribute to an increase in dynamic risk. For example, Jessica's Law stipulates that 290 registrants may not live within 2,000 feet of a school, park, or place where children commonly gather, such as an amusement park, child-focused restaurant, or other attraction (SPPCA, 2006). This significantly complicates a Penal Code 290 registrant's ability to secure housing that is in compliance with the law. Paroled individuals convicted of a sexual offense may not leave the county in which they were convicted, so moving to a less-populated area is rarely an option. In congested urban areas, such as Los Angeles and San Francisco, many registrants are homeless. Being homeless does not lessen the expectations of probation: rather, it increases them. Homeless 290 registrants must speak with their parole officers by telephone at least once per day, see them in person at least once per week, and must secure stable, uninterrupted access to an electronic outlet for a minimum of two hours per day, every day, in order to maintain an adequate charge on their GPS monitoring device. Should the GPS battery reserve begin to dwindle, an alert is automatically forwarded to their parole officer's cell phone. Clients who trigger their GPS alarm even one time can be returned to jail or prison for failing to comply with the

conditions of their release. The Division of Adult Parole Operations stipulates that homeless 290 registrants are not permitted to loiter or to accept shelter in non-compliant housing, and are obligated to change locations every two hours, twenty four hours a day (CDCR, 2012). This prevents all homeless registrants from experiencing regular sleep and can significantly impact their stress levels and by extension, their likelihood of engaging in high-stress behaviors that increase their risk of re-offense.

Dynamic risk is a constantly shifting and unpredictable issue. One of the benefits of obligatory therapy is that an offender's immediate stressors can be observed and engaged with. Dynamic risk is affected by more than the basic conditions of release. As Megan's Law makes the offender's history and address of record available to the public online, 290 registrants are vulnerable at any time to being publicly "outed". In Los Angeles County, housing restrictions for registrants are unusually stringent, which means that a motel or apartment building that offers housing in compliance with the law may be inhabited by a number of 290 registrants at once. This effectively marks the address as a perceived neighborhood threat. In 2011, one such transitional housing site was fire-bombed (bottles of gasoline stuffed with burning rags were thrown through the windows) and a few weeks later was strafed with bullets in the middle of the night (L. Chankin, personal communication, May 11, 2011). Some clients from

this site subsequently moved onto the streets, preferring the risks of homelessness to the immediate threat of injury or death.

Given their status as social outcasts, 290 registrants are often ostracized by friends and family and experience significantly higher levels of social isolation than do other paroled populations. As they are not permitted to be in the presence of minors unless another adult is present and aware of their 290 status, they are obligated to continually declare themselves as sex offenders to both strangers and family alike. The shame associated with their status can be considerable, and offenders often seek to avoid this painful experience by withdrawing from society. Unfortunately, social isolation has been identified as another significant dynamic risk factor that can negatively impact an offender's level of risk and potentially increase the likelihood of relapse (Hanson & Harris, 2001; Witt & Schneider, 2005).

The Role of Aftercare

Given that mandated therapy provides a pro-social setting for offenders to address risk factors both immediate and enduring, what are the ramifications for relapse once therapy has been completed? A fundamental assumption of Stepping Up is that deviant sexual arousal that has resulted in significant criminal behavior is a lifetime issue; one that cannot be assumed to resolve itself within the arbitrary timeline established by mandated punishment and care. Occasionally, a client is able to recognize that he is still at risk of relapse and will seek to continue therapy

on his own. Previously, there have been two options available for clients at this juncture: private individual therapy or joining a therapy group composed of members who are still mandated to attend. In terms of one-on-one treatment, the cost can be prohibitive, particularly as post-mandated treatment offenders may be struggling financially. The option to join a group of mandated clients is more cost-effective, but is not a peer group, and therefore an imperfect match at best. The distinction between clients that are forced to attend therapy and clients that willingly seek treatment is substantial. This is the issue that voluntary group aftercare was developed to address, as deviant thoughts, urges and behavior do not typically resolve themselves in conjunction with the end of an offender's parole. Long-term recidivism studies are few, and those that exist are limited only to offenders that have been sentenced to lifetime supervision, as only clients that are still within the system may be tracked. There are nearly ten thousand 290 registrants in California at this time (CDCR, 2012), and that number will rise with the enforcement of Assembly Bill 1015 (2005), which governs the qualifications that define a 290 candidate. For the thousands of California sexual offenders that have completed therapy and are no longer monitored, there is no means to assess or quantify the impact of termination of services. A Step Forward's support group, Stepping Up, offers a new option to address this missing piece: post-treatment offenders are given the opportunity to participate in group therapy with peers, voluntarily and free of charge, as Dr. Haverty offers her services pro-bono.

The group is designed to allow clients to address both immediate and potentially enduring risk factors. The element of choice may substantially alter a client's approach to treatment in positive ways. Mandated therapy is defined by obligation, which can limit or slow the development of a therapeutic bond. The limits of confidentiality in a mandated setting can inhibit disclosure and increase mistrust; however, in post-treatment there is more freedom to share candidly. Naturally, clinicians are still mandated reporters and must report any disclosure as regards previously undisclosed victims, and all clear threats to self or others, but probation does not monitor this group, nor are clients obliged to attend. This is an essential distinction, and one that strongly colors the therapeutic relationship. Cognitive behavioral tools are taught and resourced throughout aftercare. Treatment within a setting that combines both practical skill-building and a strong therapeutic bond is thought to be the most effective environment for cognitive behavioral work (Marshall, 1996).

Background and Rationale for the study

The body of research related to sex offenders is fairly small in comparison to the existing research related to other criminal populations, but it is expanding rapidly (CDCR, 2012). Interest in treatment of offenders has increased dramatically over the past twenty years, as they are regularly released back into the community and their numbers are steadily growing (California Sex Offender Management Board, 2010). Treatment of post-incarceration offenders focuses on

intervention designed to impact factors that affect recidivism. California has the highest percentage of sex offenders in the United States, and regularly implements ever-stricter guidelines to monitor them. New laws have been proposed that will mandate every sexual offender to registration and long-term therapy upon release. When compared with current standards, which affect just high-risk and/or 290 registrants, the increase is likely to be considerable (CDCR, 2012). California is at the beginning of a new wave of treatment obligations, as the population of mandated offenders may soon increase up to four-fold (CDCR, 2012). The importance of all types of aftercare cannot be understated. As treatment providers are already obliged to meet state-certified standards of care no later than July 1st, 2012, the state is bracing for an unprecedented level of scrutiny regarding the usefulness and necessity of treatment for high-risk sex offenders. A Step Forward's aftercare group, Stepping Up, raises questions about treatment for sexual offenders beyond the scope of what is currently prescribed. When mandated care is over, risk is likely to remain. The clients of Stepping Up may identify the group meetings as a significant factor that continues to lessen their risk of recidivating. An evaluation of this program will help to identify new areas for future research, and may carry significant implications for long-term treatment planning for sexual offenders. It is assumed that those convicted of sexual offenses would refuse optional treatment. Mandating these individuals to therapy is the current extent of our society's approach, and the idea that members of this

population might seek to maintain a therapeutic relationship of their own volition is unprecedented. As successful therapy in this context means a decrease in the number of victims of sexual violence, the value of exploring this new treatment model is clear. If continued voluntary aftercare continues to lower risk of recidivism for men that have previously been convicted of sexual offenses, other similar treatment centers may wish to consider adding a voluntary aftercare component to their program.

The Stepping Up group exists to function as a continuation of treatment for men that have completed their term of mandated care but still struggle with deviant sexual arousal. While in theory these clients have already received sufficient treatment, they continue to experience problems related to risk of relapse such as poor emotional identification, limited emotional tolerance, and maladaptive self-soothing behaviors. The opportunity to participate in group therapy with willing peers is new. As men with these deficits tend to isolate and avoid intimacy, they are encouraged through the group to begin forming appropriate, healthy, pro-social relationships: first with one another and then with other people in their lives. The first priority is community safety, understood in this context as relapse-prevention: no more offenses. Does after-care work? In order to answer this, the primary focus of treatment is a reduction in rates of recidivism for clients participating in aftercare, based on a comparison of the relapse rates of sexual offenders who attend aftercare versus their peers who do

not. The other priorities of treatment are social support, increased insight and awareness related to self and triggers, the forging and maintenance of a positive therapeutic bond, and pro-social engagement with other group members. However, this study is focused on answering only the primary question: is there a reduction in recidivism for clients in this program? If mandated therapy has been proven to lower the risk of recidivating, the benefit of extending the therapeutic arc may mean demonstrably lower levels of relapse, which would in turn mean fewer victims of sexual violence.

Chapter 2: Review of the Literature

This review is intended to offer an overview of five domains: the definition of a sexual offense under California law, the types of risk factors that 290 registrants typically present with, current approaches to treatment, the issue of trust within the mandated client-therapist relationship, and recidivism. While research related to sexual offenses, relapse, and risk has been intermittent for many years, it has only become a significant research presence over the past two decades and is a much more recent addition to the field of research when compared with other psychological issues, such as schizophrenia or depression.

Defining Sexual Offenses

Definitions vary as to what qualifies as a sexual offense. This study defines sexual offenses as criminal behavior that results in the perpetrator being obligated to register as a sexual offender in the State of California. There are 169 sexual offenses that require registration in the State of California (State of California Department of Justice, 2012), all of which are associated with under Penal Code 290. This category consists of a broad range of charges, from rape and sexual battery to indecent exposure, possession of child pornography, or annoyance of a minor. The penal code distinguishes between minor victims older or younger than age 14. Charges related to offenses against minors younger than 14 are associated with increased penalties and restrictions, although all persons

under the age of 18 are considered to be minors under the law. Most sexual offenses are considered felonies in California, although there are some charges that may be prosecuted as misdemeanors depending on severity, such as sexual battery. Not all 290 Sex Offenders are considered high risk. But all 290s are mandated to treatment. High risk is determined by either: the presence of two or more lesser sexual offenses such as indecent exposure or annoying a minor, or a history that includes at least one more serious sexual offense, such as sexual battery or possession of child pornography.

There are a variety of complex laws that govern sentencing and post-incarceration parole or probation for all sexual offenders, with additional restrictions for those who are convicted of sexual crimes where a minor is the victim. Approximately 8,000 people, mostly men, are convicted of sex offenses that require registration in California each year. Of these, approximately 2,000 are considered high-risk (CDCR, 2012). High-risk sex offenders are considered to be more at risk to commit a new offense within the community than are other offenders (Thornton, 2002; Someda, 2009). Risk is determined by the assessment of a variety of factors, including: previous conviction for a sexual offense, age at time of release, and general social stability or lack thereof. These factors are measured by validated risk assessment tools, reviews of an offender's known criminal history, and additional criteria established by the California Department

of Corrections and Rehabilitation (2012), based on Penal Code section 290. This code defines requirements for sex offender registration as follows:

> The following persons shall be required to register: Any person who, since July 1, 1944, has been or is hereafter convicted in any court in this state or in any federal or military court of a violation of Section 187 committed in the perpetration, or an attempt to perpetrate, rape or any act punishable under Section 286, 288, 288a, or 289, Section 207 or 209 committed with intent to violate Section 261, 286, 288, 288a, or 289, Section 220, except assault to commit mayhem, Section 243.4, paragraph (1), (2), (3), (4), or (6) of subdivision (a) of Section 261, paragraph (1) of subdivision (a) of Section 262 involving the use of force or violence for which the person is sentenced to the state prison, Section 264.1, 266, or 266c, subdivision (b) of Section 266h, subdivision (b) of Section 266i, Section 266j, 267, 269, 285, 286, 288, 288a, 288.3, 288.4, 288.5, 288.7, 289, or 311.1, subdivision (b), (c), or (d) of Section 311.2, Section 311.3, 311.4, 311.10, 311.11, or 647.6, former Section 647a, subdivision (c) of Section 653f, subdivision 1 or 2 of Section 314, any offense involving lewd or lascivious conduct under Section 272, or any felony violation of Section 288.2; any statutory predecessor that includes all elements of one of the above-mentioned offenses; or any person who since that date has

been or is hereafter convicted of the attempt or conspiracy to commit any of the above-mentioned offenses. (California Penal Code § 290, 2012)

According to the California Department of Corrections and Corrections (2012), high-risk sex offenders are mandated to mental health treatment upon completion of their jail or prison sentence as a condition of release. Some sex offenders are not sentenced to time incarcerated, but are sentenced instead to a period of monitored home confinement in conjunction with regular group and individual therapy.

There are more than ten thousand 290 registrants currently on parole. This number is expected to rise sharply in the coming years. It is essential that the role and benefit of treatment be continually assessed, in order to best increase therapeutic efficacy and prevent a rise in the number of victims of sexual violence. In addition to Sharper Future, The San Francisco Forensic Institute, A Step Forward, and other California programs, Stepping Up exists to treat men that have been convicted of registrable 290 offenses.

Dynamic and Static Assessments of Risk

It is incumbent upon members of the treatment and containment team (ie probation/parole officers, clinicians, and polygraphers) to determine a client's level of approximate risk, to act to positively affect the most salient concerns, and to continually reassess for signs of increased high-risk behavior:

> Differentiating higher risk offenders from lower risk offenders is important for the police, courts, correctional workers, and the general public. Risk assessments answer two general concerns. First, how likely is an offender to commit a new offence? Second, what can be done to decrease this likelihood? Although perfect prediction is an unattainable goal, the serious consequences of incorrect risk decisions justify careful attention to the most appropriate methods of risk assessment. (Bonta, 1999, para. 1)

The Static-99 is the most commonly applied assessment (CDCR, 2012). It assesses fixed and persistent risk factors such as criminal history, age at release, and prior convictions for violent crime. While an assessment of long-term contributing risk factors is certainly relevant, new legislation in California underscores the importance of enhancing current assessments of dynamic risk. California Assembly Bill 813 notes that:

> Existing law requires every person who is required to register as a sex offender to be subject to assessment with the State-Authorized Risk Assessment Tool for Sex Offenders (SARATSO) and specifies that the SARATSO for adult males shall be the STATIC-99 risk assessment scale. Existing law establishes the SARATSO Review Committee, and requires the committee, on or before January 1, 2008, to determine whether the STATIC-99 should be supplemented with an actuarial instrument that

> measures dynamic risk factors or whether the STATIC-99 should be replaced with a different tool. Existing law requires the committee, on or before January 1, 2012, to select an actuarial instrument that measures dynamic risk factors and an actuarial instrument that measures the risk of future sexual violence. (2011, para. 4)

As the state continues to expand monitoring of risk levels of 290 registrants, the efficacy of Stepping Up's program is increasingly relevant.

The legislative focus on risk and relapse continues to grow. Assembly Bill 813 will require the California Sex Offenders Management Board to select "an empirically derived instrument that measures dynamic risk factors and an empirically derived instrument that measures risk of future violence" (2011, para. 5). California's new emphasis on assessment of dynamic risk is likely to emphasize the importance of therapy as an aspect of mandated treatment. Dynamic variables are typically the focus of mandated therapy. Their changeable nature renders them more likely to be positively affected by clinical therapeutic interventions. In 2005, Witt & Schneider noted the importance of considering both stable and dynamic risk factors together when assessing for the possibility of recidivism, and emphasized the positive correlation between the presence of both types of risk and an increased likelihood of new offenses. Stepping Up's program is designed to offer support and continued treatment related to stable risk factors, while at the same time offering a framework via the monthly meeting to address

more dynamic and potentially changeable stressors. Risk factors like intimacy deficits, problems with sexual self-regulation, personality disorders and intentional or unintentional victim access are examples of risks that can remain present in an offender's life after the completion of mandated care. Clients that participate in voluntary aftercare at Stepping Up continue to address these same risk factors in a group therapy setting.

Treatment of Sexual Offenders

A variety of different treatment interventions are thought to positively impact sex offenders in treatment and to lower their risk of recividating, to varying degrees. Approaches vary. Regarding the impact of therapy, "The consensus is that a well designed relapse-prevention, cognitive-behavioral program combined with well implemented community supervision can indeed lower recidivism (see Janus & Prentky, 2003, at 1481)" (Witt & Schneider, 2005, p.54). As noted by Bourget and Bradford (2008), the options are considerable. Some treatment plans include a pharmacological approach that recommends prescription of selective serotonin reuptake inhibitors (SSRIs) in order to lower sexual drive (Thiebaud, 2011). Hypersexual clients that struggle with self-regulation may be prescribed one of a variety of anti-androgenic hormones, in order to achieve chemical castration (Thiebaud, 2011). Offenders are also given regular administrations of the Abel Assessment of Sexual Interest, the Penile Plethysmograph, and/or the polygraph, among other assessments, in order to

monitor congruence between their professed sexual interests and their physical arousal response to deviant stimuli (Kokish, Levenson, & Blasingame, 2005). Psychological treatment is typically mandated in conjunction with one or more of these interventions, as the results of these can (and often should) be processed with the client. Clients at Stepping Up are invited to continue monitoring their risks by participating in polygraph assessments voluntarily. As of this writing, all participants have agreed to participate, however; polygraph assessments are not scheduled to begin until later in the year. Adams Polygraph is a local company that works primarily with mandated 290 registrants. The company has offered to provide each member of Stepping Up a polygraph administration free of charge, although this is still in the early phases of planning and is not scheduled to begin until 2013. Clients will be tested in order to measure their honesty related to deviant sexual thoughts, urges, and/or behavior.

Relapse-prevention-focused therapy requires a particular clinical approach. Cognitive Behavioral Therapy, or CBT, has been found to be particularly effective in treatment of sexual offenders and in lessening the risk of relapse CBT has the advantage of being empirically supported (Grubin, 2004; Someda, 2009). When reviewing Hall's 1995 meta-analysis of 12 treatment studies, Bourget and Bradford (2008) noted the efficacy of interventions that combined cognitive behavioral therapy, relapse-prevention targets, and pharmacological prescriptions. They emphasized Hanson et al's 1998 meta-

analysis of 43 studies as a more in-depth study of the effects of CBT on recidivism rates, which indicated a 4.5% lower rate of re-offense among clients treated with CBT when compared with clients that did not participate in treatment. “Hanson et al. conclude that their analysis indicated the overall effectiveness of psychological treatment in reducing recidivism of sex offenders, but note the need for conclusive evidence based on results of well-designed and methodologically sound studies” (Bourget & Bradford, 2008, p. 140). The authors noted that Hanson et al. were careful to acknowledge that overall relapse rates for men convicted of sexual offenses were low, but emphasized that a general assessment was inadvisable, as certain intra-group populations were at much higher risk of re-offense: men with notable deviant interests and/or a history of multiple sexual offenses. These are precisely the types of clients that Stepping Up is designed to serve.

A cognitive behavioral approach to sexual offending is focused on the connections between thought and action, and between urge and behavior. Clients are encouraged to identify the thinking errors, or cognitive distortions, that precipitated their offense behaviors and allowed them to justify their actions. Once these distortions have been identified, they are processed and are ultimately challenged. The goal is to increase insight related to a client’s offense chain. In 2009, Someda emphasized the importance of identifying risk factors as a necessary step preceding the development of pro-social, non-deviant ways of

thinking and behaving. He noted that the fundamental CBT approach produces demonstrably positive results, based on treatment that is focused on identifying and challenging cognitive distortions, emphasizing the consequence of maladaptive behavior, and exploration of alternative positive options (Someda, 2009).

Clients of Stepping Up are encouraged to be mindful not only of their own triggers and risk factors, but those of other group members as well. The group encourages clients to alert one another to perceived 'red flag' issues that may otherwise go unnoticed. Lösel and Schmucker's massive 2005 survey was:

> A meta-analysis on controlled outcome evaluations of sexual offender treatment. From 2,039 documents published in five languages, 69 studies containing 80 independent comparisons between treated and untreated offenders fulfilled stepwise eligibility criteria (total $N = 22,181$). Despite a wide range of positive and negative effect sizes, the majority confirmed the benefits of treatment. Treated offenders showed 6 percentage points or 37% less sexual recidivism than controls. Effects for violent and general recidivism were in a similar range. Organic treatments (surgical castration and hormonal medication) showed larger effects than psychosocial interventions. However, this difference was partially confounded with methodological and offender variables. Among psychological programs, cognitive–behavioral approaches revealed the most robust effect. (117)

Cognitive behavioral therapy is typically implemented as part of a psychoeducational model, although the emphasis may vary from program to program. Stepping Up's aftercare program is grounded in cognitive behavioral technique. The primary goal is tangible and easily identified: no new victims. Members of Stepping Up are focused on the fulfillment of this goal above all others, in keeping with California's standards that mandate treatment to programs certified by CASOMB to provide appropriate care. While Stepping Up is a new format for treatment after mandated responsibilities have been fulfilled, the program goals are to maintain and expand the goals of earlier treatment through A Step Forward's CBT-based program of care.

"The majority of convicted sex offenders are eventually released back into the community. Consequently, effective treatment interventions that can lower the recidivism rates of sexual offenders are needed" (Moster et al., 2008, 109). Stepping Up's program is designed to complement the existing treatment to which a registrant is mandated upon release. "Cognitive behavioral interventions based on the principles of risk, needs, and responsivity, are the most common form of treatment used with sex offenders. To date, there is preliminary evidence that suggests that treatment using cognitive behavioral techniques decreases subsequent sex offender recidivism" (Moster et al., 2008, 109).

This model provides information about the basics of emotional expression and tolerance, healthy sexuality, and deviant behaviors, and is intended to allow

for change in the way that clients interpret events. For example, a client that may once have frequently found himself driving past a local school where he once exposed himself to children may be encouraged to view the initial decision to go for a drive as a seemingly unimportant decision that may result in deviant sexual thoughts, urges, or behaviors. Sexual offense behaviors are understood within this context as maladaptive responses to cope with difficult or demanding stimuli. CBT is most effective when it is used in conjunction with both individual and group therapy where there is a good therapeutic bond between client, therapist, and other members of group (Marshall, 1996).

Negotiating Trust in a Mandated Setting

The relationship between a positive therapeutic bond and a lowered risk of re-offending is an essential component of after-care therapy at A Step Forward. There are a variety of challenges to clinical work in a mandated setting. While issues such as lack of trust or limited confidence may be common to all new therapeutic relationships, negotiating the limits of confidentiality in mandated work can seem like an ethical minefield. Glaser's approach to mandated therapy is blunt:

> Ethics is very much about making appropriate decisions in particular contexts. It is no good trying to make decisions about treatment interventions if what you are offering is not treatment at all. It is also hypocritical for professionals to make a public commitment to an ethical

> code which stresses the privacy of the client when, all along, their true concerns may be anything but the client's welfare. (2009, pp. 254)

Glaser goes on to underscore the importance of transparency in the mandated-care setting, and encourages practicing clinicians to be honest in order to speak clearly and frankly to the importance and relevance of care within the containment model (2009). This clinical transparency is essential to Stepping Up's treatment approach.

While this approach is certainly honest, it may overstate the punitive nature of the relationship between a therapist and client that is mandated to therapy. It is important to remember that the person who attends sessions is not, in fact, the central focus of treatment. In traditional (i.e. non-mandated) therapy, the client is by definition the focus of his or her sessions. The primary client when treating a sex offender is the community into which the probationer or parolee has been released, rendering the client is a secondary focus within his own therapy (CASOMB, 2010). Relapse prevention and community safety are the primary goals of treatment. Insight, increased self-regulation, and a better ability to function pro-socially are all positive but less privileged side effects of mandated care (Andrews & Bonta, 1998; Langan et al., 2003). Confidentiality within mandated therapy is complex: beyond the usual boundaries of what and when a clinician is required to report or intervene, treatment providers for mandated sex offenders are required to report the disclosure of any new (previously unreported)

victims in a client's history, even if there is little to no identifying information. Clinicians are also called upon to negotiate the relationship between members of probation and the client. Probation agents are permitted to read progress notes, psychological evaluations, and the results of any and all assessments. Some agents drop by group or individual sessions in order to check in on their probationers. This presents an unusual challenge for clinicians who seek to build and maintain a trusting therapeutic bond, as clients are naturally wary of a therapist who presents as a mouthpiece to probation. While there is no research that examines the difficulties related to mandated therapy specific to sex offenders, there is corresponding research that examines the psychological impact and ethical considerations of mandated therapy for other types of offenders, such as batterers and substance abusers (Bonnie, 2006).

In every instance, mandated therapy is shown to lessen a client's chances of relapse or recidivism (Buchbinder & Eisikovits, 2008). Successful treatment also depends on a strong therapeutic bond between therapist and client (Mauser, Van Stelle, & Moberg, 1994). The research supports the correlation between a good therapeutic bond and positive progress in treatment, as Levenson, Prescott, and D'Amora noted in 2010 during their evaluation of a successful Connecticut program. They connected the strength of the therapeutic bond between mandated clients and their treatment providers directly to their successful completion of the program, and emphasized a strong correlation between satisfaction with services

and engagement in therapy. They went on to note that while a focus on relapse-prevention is the primary motivation for treatment, there are clear collateral benefits to a positive bond between client and clinician. The authors noted that increased interpersonal skills and coping tools may render clients "less likely to engage in abusive behavior" (Levenson, Prescott, & D'Amora, 2010, p. 307) overall. Stepping Up's aftercare program is based on this assumption.

While the importance of the therapeutic bond is clear, gaining a client's trust takes time. Transparency and patience are essential. Sessions can be difficult, as resistance may be significant. A client's willingness to disclose may take considerable time to develop, as post-incarceration offenders may present with a variety of issues that are obstacles to open communication: having completed a term in jail or prison during which they most likely concealed their deviant crime with a false history, most offenders are unaccustomed and resistant to discussing their past actions.

Shame is another significant impediment to treatment, as are the three most common tools of deflection: minimization, denial, and blame (Ward, Hudson, & Marshall, 1995). At the beginning of treatment many clients are in the early stages of beginning new lives post-incarceration. They are often just beginning to process the changes that their actions have brought about in their lives: their relationships or marriages are often destroyed, they are alienated from their families, children and friends, and their jobs or careers are either gone or are

seriously damaged. Add to this a long list of expectations and restrictions that they must fulfill and comply with in order to meet the conditions of probation, and the overall stress level is quite severe. As Marshall (1996) notes, clinicians seek to establish a balance between challenging their clients and displaying compassion. He acknowledged the need to emphasize not only the primary benefit of fewer victims of sexual crimes, but also the benefit of treatment for the client himself. The collateral benefits of focused cognitive behavioral therapy can be significant, and can enrich the lives of clients in treatment in a number of ways. When a man that has spent his entire life blaming others and deflecting challenges with angry outbursts begins to take responsibility for his own experience, the change is dramatic. Treatment goals at Stepping Up emphasize the importance of working toward a positive, pro-social engagement with life for all mandated clients, and highlight the advantages of living life without concealment or shame. The goal of Stepping Up is a higher-functioning, happier, and better-adjusted client overall. Marshall writes:

> They will be able to enjoy the company of others and develop satisfying social relationships, they will feel better about themselves and be better able to cope with life, they will be able to participate in various activities without constant temptations, and their feelings of alienation from others will disappear. We also need to develop ways of relating to our clients that challenge them to present themselves honestly and to change their views

> and behavior, but in a way that respects their dignity, encourages hope for the future, and does not collude with their avoidant style. (1996, pp. 328)

It is no surprise that the average length of treatment hovers around two years at California's primary sex offender treatment centers (Sharper Future, A Step Forward, San Francisco Forensic Institute), as months can be necessary in order for a client's new life to begin to feel normal, and for his relationships with his treatment provider(s) and fellow group members to begin to warm. While eventual engagement and participation in treatment is positive, it is also essential that clients maintain regular attendance and eventually complete and graduate from their respective programs, as current research indicates that clients convicted of sexual offenses who drop out of mandated therapy are at a higher risk of reoffense than clients that complete therapy (Hanson, Harris, Scott, & Helmus, 2007; Lösel & Schmucker, 2005). Several studies have sought to single out specific characteristics of clients that drop out of treatment, in the interest of increasing awareness for clinicians related to high-risk traits or characteristics, as the non-completion rate for mandated clients is between 15% and 86% (Larochelle, Diguer, Laverdière, & Greenman, 2011).

Completion of the program is essential. This is one of the reasons that progression from A Step Forward to Stepping Up is not offered as a matter of course. Even thriving provisional members are not eligible for full membership

until the appropriate completion of their training modules, as successful graduation from treatment cannot be assumed.

The Matter of Recidivism

Sexual offenses provoke an understandable and significant negative reaction. Sexual crime violates sociocultural taboos. Those who perpetrate are viewed as having undergone a fundamental loss of control, and as unable to peacefully uphold the social contract. They are frequently presented as monsters, and as inherently different and dangerous. This shift in perception may account for the vehemence with which sex offenders are limited in terms of conditional release. However, the offer of rehabilitation is a fundamental assumption of our penal system. While all prisoners are (technically) given a chance at a new start, it can be challenging for sexual offenders to comply with the conditions of parole once their time has been served. In California, they are obliged to cooperate not only with the specifics of their own conditional release, but with overlapping laws intended to restrict them far more specifically: Megan's Law, Jessica's Law, and Chelsea's Law. Named for young women or girls who died from sexually motivated attacks, these three laws serve to control nearly every aspect of where and how a sex offender may live his life after jail or prison.

Megan's Law was named for Megan Kanka, who was seven years old when she was raped and murdered by a neighbor with two prior (but undisclosed) sexual assault convictions. Megan's Law allows for the home addresses of sexual

offenders to be made a matter of public knowledge, in order for parents and others to be aware of sex offenders that may live nearby: As California's official Megan's Law website states:

> This site will provide you with access to information on more than 63,000 persons required to register in California as sex offenders. Specific home addresses are displayed on more than 33,500 offenders in the California communities; as to these persons, the site displays the last registered address reported by the offender. An additional 30,500 offenders are included on the site with listing by ZIP Code, city, and county. (State of California Department of Justice, 2012)

Chelsea's Law was named for Chelsea King, a high school student who was raped and murdered by a man already on probation with a history of sexual attacks. Chelsea's Law stipulates that offenders submit to GPS monitoring and to the administration of regular polygraphs. It included a stipulation that parolees convicted of violent sexual attacks on children receive life sentences (Assembly Bill 1844, 2010). Chelsea's Law specifically enumerates the idea of the containment model, in which offenders are monitored on 'all sides' by probation, mental health care providers, polygraph examiners, and others, in order to ensure total supervision and communication (Assembly Bill 1844, 2010).

In 2005, nine year old Jessica Lunsford was abducted from her home. She was raped and killed by a man later identified as a neighbor. Jessica's Law,

enacted in 2006, bars sex offenders from living within 2,000 feet of a school, park, or place "where children congregate" (CDCR, 2012; SPPCA, 2006). The combination of these three laws, when enforced, can make beginning a new life after prison exceptionally challenging. As recidivism statistics related to parole violations are not always distinguished in the literature from re-offending, which means committing a new offense, the percentage of recidivism cases that result from an unwillingness or inability to comply with terms of probation is unknown at this time. However, a survey of current studies indicates that approximately 85% of incidents of recidivism (at most) are related to parole or probation violations and only 15% or less are a result of new crimes (Hanson & Bussiere, 1998; Hanson et al., 2007) . All recidivism statistics should be considered with this caveat in mind, as the bulk of clients that return to custody have committed new sexual offenses.

A review of the literature related to sex offender recidivism assessments and violence indicates that risk assessment studies have typically been divided into two types: those that rely on clinical guides and those that prefer comparative actuarial instruments. It has been suggested that actuarial assessments should supplant clinical judgment as a more effective predictor of risk (Barbaree, Langton, & Peacock, 2000). To replace the experience and knowledge of an experienced clinician with a simple risk-comparison percentage is insufficient and potentially irresponsible. Sawyer's (1966) frequently referenced study indicated

that clinicians are worse at predicting risk than statistics alone. However, that study, Measurement and Prediction, Clinical and Statistical, was from 1966, and the field has changed greatly since that time. “More recent research in this area has shown that clinicians have been able to predict at moderate levels of accuracy shorter-term risk for assaultive behavior” (Sreenivasan, Kirkish, Garrick, Weinberger, & Phenix, 2000, p. 438).

There are a variety of idiosyncratic factors that may impact a client’s risk that are not able to be quantified or measured by statistical comparison:

> For example, a patient suffering from a delusion that red-headed women were out to harm him and who attempted to assault a red-haired woman on a bus, would have this delusional belief as a violence risk factor...(but) an atheoretical actuarial scheme such as the Violent Risk Appraisal Guide does not identify delusional beliefs as risk factor; therefore it would not place great weight on this variable. (Sreenivasan et al., 2000, pp. 439)

Additional factors that may negatively impact an offender’s level of risk may include comorbid psychiatric disorders, developments or crises in personal relationships, situational responses to stress or anxiety, and/or a limited ability to self-soothe. It is necessary that treatment providers appreciate the importance of their interventions, and it can be helpful to process the research with clients, as a means of underscoring treatment validity and strengthening the clinical bond.

Clients often present for treatment with the same attitude they approached incarceration: as a necessary evil or as a punishment to be endured. At the beginning of treatment, clients are often simultaneously at their most vulnerable and most defended. The transition from prison back into the community can be jarring. Strategizing with clients in order to address and meet immediate issues of clinical need, such as management of deviant sexual urges or high levels of stress, is an excellent way to build rapport and smooth the transition from prisoner to probationer. In the same manner, Stepping Up aims to address the reintegration from criminal supervisee to normal life. As Willis and Grace noted, the period of transition from incarceration to community life is in itself a risk factor for recidivism: "The quality of reintegration planning was retrospectively measured for groups of recidivist (n = 30) and non-recidivist (n = 30) child molesters who were individually matched on static risk level and time since release" (2009, p. 494). In keeping with the results of their previous study on the same subject, Willis and Grace (2009) found that clients who recidivated were shown to have significantly lower planning scores than those clients who did not.

A successful reintegration into the community capitalizes on both the goals of treatment and on the personal goals of the client. A sex offender invested in his own progress and treatment is less likely to re-offend. While that may seem obvious, it is a crucial distinction between viewing therapy as something that is 'applied' and viewing it as a collaboration to be participated in. McGrath,

Cumming, Livingston, and Hoke's 2003 study indicated markedly lower sexual recidivism rates among participating clients who received aftercare:

> Over a mean follow-up period of almost 6 years, the sexual re-offense rate for the completed-treatment group was 5.4% versus 30.6% for the some-treatment and 30.0% for the no-treatment groups. Lower sexual recidivism rates were also found among those participants who received aftercare treatment and correctional supervision services in the community. (pp.15)

A successful transition from prison or jail, through therapy and supervision, can smooth the eventual path to a more fulfilling, better-regulated life.

When Treatment Is Over, What Happens to Risk?

While mandated therapy post-incarceration is intended to reduce the risk of recidivating, there is strikingly little information as to long-term risk assessment of offenders after the completion of treatment. There are several programs in California that offer treatment for clients post-incarceration. The largest program, Sharper Future, is based in the Bay Area and has offices across the state. Sharper Future's program is based on CBT, as are all of the service providers in California, in keeping with CASOMB requirements. There are no long-term studies that measure Sharper Future's efficacy, and research related to the effectiveness of California's programs is exceptionally limited. There are no post-treatment programs offered in California. The need for non-mandated

aftercare has not yet been critically explored, and research has focused on the efficacy of mandated care.

Upon graduation clients are occasionally offered the opportunity to continue as guests, but there are no sites that offer continued group services for men who are not obligated to attend. For the client that desires to continue treatment in a group setting, he may be permitted to participate as a non-mandated member among a group of otherwise mandated men. This can dramatically alter the tone and topics of group discussion. Most men in treatment present with significant resentment related to the idea that they are 'forced' to attend therapy as part of their conditional release. The ethical ramifications of this are frequently a topic for group discussion. The presence of a group member that voluntarily attends treatment is therefore something of an anomaly, as it is often assumed that no client would desire to continue the treatment process once he is no longer obligated to attend therapy. However, there are many men that experience tangible benefits from a strong therapeutic bond and positive relationships with group members. For these men, once treatment is over their resources have been limited to individual therapy or to being the 'odd man out' in a group of mandated clients.

Dr. Caprice Haverty's program, A Step Forward, offers pre-trial treatment and post-incarceration therapy based on a model of cognitive behavioral interventions that is similar in structure to that of Sharper Future. However, A

Step Forward also offers an after-care group therapy program that may be the first of its kind. The group is called Stepping Up, and is comprised of approximately 25 members. As the years passed, Dr. Haverty observed a need among men that had finished treatment; a need for continued interaction with their clinicians and a pronounced desire for continued group support. Stepping Up was started in 2008 with eight post-treatment offenders, all of whom remain active members of the group. It is an assumption of Stepping Up that clients who have experienced deviant sexual arousal to such a degree that their behaviors have brought them into contact with the criminal justice system will never be entirely free of deviant thoughts or urges. While their behavior can be modified, their interior experience requires ongoing therapy to treat the root causes of acting out. Stepping Up members' monthly meeting lasts three hours, and is a forum for treated offenders to address ongoing issues of risk and deviant arousal. While offenders occasionally continue in group or individual therapy after the completion of their mandated treatment, there is no record of a voluntary therapy group comprised entirely of non-mandated (i.e. voluntary) sex offenders. A sex offender who desires to continue in treatment at the close of his mandated time in therapy is offered two choices: he may either seek individual counseling, preferably with a clinician experienced in treating issues relevant to relapse and recidivsim, or he may be encouraged or allowed to continue treatment with a group of mandated offenders who are serving out their required time in treatment. A wholly

voluntary group is an entirely different clinical population. There are no known equivalents to Stepping Up. To offer treatment to those who seek services unbidden, beyond the constraints and limitations of mandated treatment, is an unprecedented development in the field of clinical aftercare. Dr. Haverty's program, based in Concord, CA, began providing this format in 2008, based on a previously identified need for a peer-group support structure that would allow offenders to continue to receive sex-offender-specific treatment in a group setting that addressed their specific needs. As issues of both stable and dynamic risk can fluctuate considerably over a lifetime, Dr. Haverty decided to create a program that would allow her previously mandated clients to remain engaged in treatment, in order to continue to address their risk factors as they arise.

Main Research Question

1. Are recidivism rates lower for sex offenders who participate in Stepping Up lower than the rates of their peers that did not attend Stepping Up?

Hypothesis:

1. There will be a significant inverse relationship between participation in Stepping Up and rates of recidivism.

Chapter 3: Research Design and Methodology

Description of Research Design

The focus of this study was the effectiveness of the post-treatment aftercare program, Stepping Up. Effectiveness in this context is defined by the desired long-term output of the program: a lower rate of recidivism on the part of convicted sexual offenders that participate in Stepping Up. A binomial t-test was chosen for this research in order to best determine if the relapse rate of the members of Stepping Up is statistically different than the average relapse/recidivism rate. A binomial t-test "evaluates whether the proportions of individuals who fall into the categories of a two-category variable are equal to hypothesized values" (Green & Salkind, 2005, p. 350).

The effect of one data set upon another can present as a non-linear relationship, and efficacy of long-term treatment can be difficult to identify. However, as Khoo notes, "There is an advantage to evaluating intervention programs using longitudinal data: when the intervention(s) is/are designed to effect long-term changes that may take time to manifest and be observable" (2001, p. 252). The current study was informed by a philosophy of empiricism, and as such was focused on establishing an initial comparative measure that will allow for future research. The Stepping Up program was assessed for evidence of the clinical benefit of voluntary group treatment, which is unique in that it is

provided beyond the standard scope of mandated care. The program was evaluated for effectiveness, as it is thought to be the first group of its kind. There are no other programs of this sort in California. A review of professional articles, journals and studies and an extensive search for an online presence indicated that there are no similar programs in the country. There are no voluntary group treatment programs for sexual offenders that have completed mandated treatment. While voluntary aftercare currently exists for sexual offenders, it consists either of individual private treatment or of participation in a group setting with offenders who are mandated to treatment (CDCR, 2012). As a potentially new treatment modality that may complement the existing containment model, Stepping Up must first be examined for effectiveness at a fundamental level. A study of Stepping Up is essential as preliminary research that will provide a foundation for future experimentation, as it may establish a possible correlation between aftercare and lowered rates of recidivism. The statistical relapse rates of the members of Stepping Up will be compared to their peer group of adult male sex offenders that have not participated in Stepping Up. As there are no other discoverable aftercare programs with which to compare effects, the question this study seeks to answer is whether or not participation in Stepping Up may be correlated with lower recidivism rates than the statewide average.

Should research indicate a positive association between participation in Stepping Up and a rate of relapse lower than the general population of post-

treatment sexual offenders, it is important to consider the possibility of an unknown third and unrelated variable that may impact results. A positive association between participation and lowered relapse rates should not be assumed, as the presence of a correlation does not necessarily imply causation (Meltzoff, 2006). In other words, the success of Stepping Up may be attributable to something else; an unknown factor. Involvement in Stepping Up may have positively impacted recidivism rates, but other factors may also contribute to a lower rate of recidivism overall. However, confirming the presence or lack of a correlation between treatment and relapse rates is the first step needed to establish effectiveness.

Selection of Participants

The Stepping Up group is comprised of male members who have been convicted of a serious sexual offense, have completed their jail or prison sentences, completed their probation or parole supervision requirements, were mandated to post-incarceration therapy at A Step Forward for an average of 20 months, and satisfactorily completed their treatment with significant participation, insight, self-disclosure and accountability sufficient to merit an invitation to take part in Stepping Up. A Step Forward's initial core treatment curriculum consists of 13 distinct modules, each designed to address a specific area of need. Module 8 is focused on risk assessment. During this phase, clients learn to identify their specific and personal risk factors. By the time they reach Module 8 of treatment,

they have satisfactorily completed at least 12 months of group and individual therapy and have demonstrated an increased ability to appropriately self-regulate. At this stage, clients are reviewed as candidates for Stepping Up, and those deemed appropriate are invited to participate provisionally, in addition to their ongoing treatment for the remaining five modules of A Step Forward. Those that seem appropriate for membership must be capable of addressing their offense behaviors without minimization, denial, or blame. They must demonstrate a willingness to be challenged and the capacity and drive to challenge other members, in addition to an ability to self-identify and disclose their issues with deviant sexual arousal. This may confound broader extrapolations from the data, as the group is, to a degree, self-selected. However, as clients invested in treatment are more likely to succeed, the point may be moot. The efficacy of A Step Forward's treatment significantly impacts the likelihood that they may wish to participate in additional therapy. The aftercare group began in December of 2008. All eight of the original founding members continue to participate, and group has grown to approximately 20-25 members, approximately 15-20 of whom attend each monthly meeting on a regular basis.

Continued participation is based on appropriate self-disclosure, engagement with group, and regular attendance. However, clients that continue to struggle with denial or resistance related to these issues are not summarily removed from group. It is assumed that these men will continue to occasionally

manifest denial, aggressive behaviors, and disinterest in self-reflection. While combative or violent behaviors are not tolerated, membership is extended with an open-door policy. Dr. Haverty and the group acknowledge that certain clients are simply not appropriate for membership, and define the group as self-selected to a limited degree. The benefit of this system is twofold: first, the mentor/mentee relationship between newer clients and older members is a pro-social step toward building a supportive post-treatment community. Second, clients still in treatment are able to interact with men who have been through the same program and faced the same challenges. The appeal of maintaining a bond with a peer group of understanding members can not be overstated, as loneliness and shame are common issues in treatment of sexually deviant behavior.

A foundational assumption of Stepping Up is that men who have experienced deviant sexual arousal to such a significant degree that their behavior brought them into contact with the criminal justice system are likely to struggle with such arousal patterns for the remainder of their lives. While their future behavior may conform to societal expectation, their sexual thoughts, urges, and arousal patterns may continue to be affected by deviant attraction. Behavioral compliance fulfills the expectation of the courts, and satisfies the intent of the sentences they received. However, studies of recidivism and criminality indicate that the presence of certain factors beyond surface compliance are necessary in order to effect significant and lasting change, such as a sense of increased insight,

personal relevance, and social belonging. Programs that support a personal connection to the work, known as a cognitive component, have efficacy rates more than twice as high as programs without this factor (Izzo & Ross, 1990). Psychological growth cannot be mandated. The purpose of group is to encourage such growth, and to provide a place where reintegration into society can successfully occur, while addressing ongoing issues related to deviant stimuli, self-regulation, and intimacy deficits. There were also opportunities to compare and contrast data related to age of client, ethnicity, and type of offense, in addition to answering the primary question of relapse rates. While intermittent attendance does not affect a member's standing in terms of membership, for the purpose of this study those members that attend only occasionally were omitted. This study focused on the core group of approximately twenty members that have maintained regular attendance in Stepping Up for at least six months.

Description of Instrumentation

The instrument in this study was a review of records, comparing whether or not the men in the group have re-offended based on a direct comparison of the statistical norms of relapse for all other adult male post-treatment sexual offenders in the state. As of October 2012, the State of California estimates that approximately 69.1% of 290 registrants that are released back into the community will be returned to custody within three years (CDCR, 2012). However, 86.9% of those returns to custody are based on violations of parole. Only 13.1% of released

sex offenders commit a new crime (sexual or otherwise) or commit the crime of failure to register. Therefore, only 13.1% of the 69.1% of 290 registrants commit new sex crimes, yielding a value of 9.1%. This statistic applies to all released sex offenders, regardless of their parole status. Stepping Up group data was compared to CDCR's statistics, as all full members of Stepping Up were out of jail or prison for at least three years. As all members of Stepping Up have completed parole, their recidivism rates were compared to 9.1% of California's 10,781 290 registrants. While a review of the public record is certainly the most direct and empirical manner of confirming an absence (or presence) of new convictions, there is always the possibility that clients may have committed new offenses without having attracted the attention of the law.

Procedures

The members of Stepping Up were invited to participate and were read the participant script, during which they were advised of the potential risks associated with participation. Of the group, 18 members of Stepping Up agreed to submit to an assessment of their criminal histories and to allow their current legal status to be verified against the public record. These clients read and signed the consent form, thus granting their formal consent to participate. All results will be shared with the participants. After the releases were signed, their legal histories were examined for evidence of contact with the criminal justice system during their time in treatment with Stepping Up. All data returned via a review of the public

record is included in this study, including evidence of new criminal convictions and/or returns to custody for any reason.

Data Processing Techniques

Data was analyzed using STATA Version 12. Quantitative research is useful because it assumes that a demographically representative sample will provide results that are indicative of the general population (Svajl, 2012). Quantitative research is objective, reliable, and has a specific and replicable methodology (Bernard, 2000). This type of research is especially useful for a correlational study, but is not without its limitations. These concerns are addressed in the following section. As the data is presented in the form of a correlational study, results have been interpreted as having either a positive correlation, negative correlation, or no demonstrable correlation at all. Results will either affirm aftercare's role as a mitigating factor in relapse prevention, or may contraindicate aftercare as a contributing factor to relapse. It is also possible that the results may be mixed, should the statistical comparison yield identical results. I hypothesize that group members will demonstrate lower risk than their peers that did not attend aftercare. Should they demonstrate a comparable level of recidivism, it may indicate that aftercare is less effective than assumed. A higher rate of relapse than their statistical peers could point to an unintentional confounding effect on the part of aftercare providers.

Methodological Assumptions and Limitations

There are three assumptions that shape this study. The first is that deviant arousal patterns that have resulted in illegal sexual conduct are a lifetime treatment issue for clients and does not resolve with the conclusion of mandated treatment. The second is that voluntary aftercare lowers the risk of relapse or re-offense for previously mandated offenders. The third is that the aftercare program impacts the outcome and risk level of clients in some way, whether positive or negative. Results will be compared to available statistics of relapse and recidivism among adult male sex offenders.

There are a number of potential limitations for this study. First, the small number of participants may render results difficult to generalize. Also, not all clients that complete treatment are invited to join the Stepping Up group. This may indicate that Stepping Up is a self-selected group of treatment-minded individuals that are unsuitable to compare against broad recidivism statistics. Finally, there is exceptionally limited longitudinal data regarding the relapse rates of adult male sex offenders.

Ethical Assurances

The identities of all participants in this study were kept confidential. Their identities were not revealed or included in the study. They were asked to sign a release indicating that they were aware that the results of this program evaluation will be kept confidential and only in the interest of evaluating the efficacy of the program. All research with human participants met all appropriate and necessary

ethical standards as determined and defined by the American Psychological Association. Participants were treated with respect and integrity. All identifying information was anonymized to protect the identity of participants, and all resulting data was kept secured under lock and key according to HIPAA standards of practice, and every effort was made to protect the rights and welfare of participating group members. Confidentiality and privacy are of paramount concern. The men in the study participated of their own free will and received no form of payment or merit. Participants were able to remove themselves from the study at any time and for any reason, and need not provide an explanation had they chosen to exit the study. Participants were verbally informed of this as an introduction to the study, and were further advised of this writing as part of the informed consent notice. As they participated anonymously, there was minimal chance of being harmed by association with the study. Association with A Step Forward and Stepping Up does present some risk, in that there is a possibility that members of the community may discover this study and seek to prevent convicted sexual offenders from gathering in their neighborhood. All efforts were made to minimize any potential harm as a result of participation in this study.

Chapter 4: Results

Data indicates that released 290 registrants will reoffend 9.1% of the time. It was hypothesized that members of the Stepping Up program would reoffend at a lesser rate. Of the 18 members of the Stepping Up group that agreed to participate in this study, none were found to have committed a new offense of any type. None were returned to custody since beginning aftercare, and none were currently in custody. None of the members of Stepping Up had failed to register. The members of Stepping Up present with an overall recidivism rate of 0%. This is strikingly different from the statewide average of 9.1%. As SARATSO states, "The sexual re-offense rate for the typical sex offender is between 4% and 12% after 5 years from release from custody, and between 6-22% after 10 years (Hanson, et al., 2012)" (2012). It should be noted that there is no way of estimating the number of men who have independently sought to continue either group or individual treatment after the completion of their mandated treatment terms. To determine whether or not Stepping Up's relapse rate was statistically significant, a one-tailed, *z* approximation test was conducted to measure whether the population proportion for Stepping Up participants is less than .091. The observed proportion of .00 did not differ significantly from the hypothesized value of .091, one-tailed $p = .18$ (see Table 1).

Table 1. t-test Results for Stepping Up Versus California Sex Offender Recidivism Rates

Variable	Mean	SE	T
Stepping Up Participants	0	0	.1795
CA Sex Offenders	.091	.00277	

Post-hoc analyses were completed to assess whether Stepping Up members are representative of the general California sex offender population in terms of age, ethnicity, and type of offense. For members of Stepping up, there was a statistically significant relationship between offense and age, χ^2 (12, n = 18) = 24.81, $p < .05$ (see Appendix D, Table 2). For the general California sex offender population, the relationships between offense and ethnicity (see Appendix D, Table 3), χ^2 (15, n = 2611) = 261.88, $p < .001$, and offense and age (see Appendix D, Table 4), χ^2 (25, n = 2611) = 225.40, $p < .05$, were found to be significant. This suggests that both groups are significantly different with regards to comparisons between age and type of offense, and that age is a significant factor when considering sex offenders. Overall, the specific categories for which the two groups are similar are the proportion of 18-25 year old offenders who committed rape, the proportion of 26-35 and 56-65 year olds who were convicted of a lewd act with child crime, and the proportion of 56-65 year olds who committed other sex offenses. The categories for which the two groups differ are the proportion of 36-45 and 46-55 year olds who committed a lewd act with child, 36-45 year olds who committed the crime of penetration with object, and for 36-45 year olds who committed other sex offenses.

Chapter 5: Discussion and Conclusions

While the results of this study do not confirm the hypothesis that the members of Stepping Up demonstrate a lower rate of recidivism than that of the average, they are nonetheless compelling. There was no statistically significant difference between the recidivism rates of members of Stepping Up and the statewide average, as the small size of the *n* rendered results too small to be statistically useful. Despite a lack of statistically significant differences between participants in the Stepping Up program and the recidivism rate of all 290 registrants in California, this study nonetheless offers valuable information. The finding that none of the Stepping Up participants had recidivated is notable, particularly as compared to the statewide average of between four and twenty-two percent. This may be because the continued relationship to treatment serves as a protective factor against recidivism. The pro-social aspect of group care may also underscore a client's perceived connection both to treatment and treatment providers (Mauser et al., 1994). Ongoing encouragement to maintain awareness of risk factors, triggers, and deviant arousal may permit clients to address potentially dangerous criminogenic thoughts or urges before acting on them.

Additional testing was conducted in order to further evaluate and analyze the data. The age, ethnicity, and type offense of Stepping Up members (see Appendix B) were compared to all California sex offenders (see Appendix C).

This data was obtained with special permission from the Offender Information Services Branch of the California Department of Corrections Office of Research Mission (CDCR, 2013). Ages were put into ranges of 18-25, 26-35, 36-45, 46-55, 56-65, and 65 and up. Ethnicities were categorized by the state as White, Black, Hispanic, and other. Sex offenses of record were rape, lewd act with a child, oral copulation, sodomy, penetration with object, and other sex offenses.

One-way chi-square tests were conducted to assess whether members of Stepping Up were representative of the general sex offender population in the state of California. Ethnicity, type of offense, and age were compared in order to determine whether the Stepping Up group is an accurate representation of the general population.

Overall, data comparison of the two groups showed some similarities and some differences. Regarding new offenders versus re-offenders, Stepping Up is comprised of a higher number of men that have been convicted of a sex crime on more than one occasion, when compared to the statewide average; a statistically significant difference of proportions ($p = .002$). Participating members of Stepping Up had a recidivism rate of 44% (8 out of 18), while the California data averages an approximate re-offense rate of 14% (375 out of 2611). In terms of type of offense, there was no statistical difference between the group of Stepping Up participants and the group of California sex offenders, meaning that comparisons can be made between the two groups based on their crimes of

conviction. In terms of age, members of Stepping Up are slightly older on average than the general population of sex offenders in the state, although the difference is slight. Stepping Up has approximately twice as many members between the ages of 46-55 and 56-65 than the statewide range. Overall, there are fewer members of Stepping Up between the ages of 18-25 and 26-35. This may be a limitation of using an aftercare group as a comparison, as men that successfully complete treatment and begin participation in aftercare have necessarily taken some years to reach this point, and may typically present as somewhat older than the statewide norm. Regarding ethnicity, Stepping Up diverges significantly from the California data set ($p = .0031$). While the bulk of sexual offenses in California are committed by Hispanic males, Stepping Up's sample group of participating members does not include any Latino males. Overall, these results suggest that members of Stepping up are an accurate representation of sex offenders in the state of California with regard to type of offense, and to a lesser degree with regard to age, but not in terms of ethnicity or new convictions versus re-offense.

Limitations

With a larger sample size, results may have been significant. Were there more participants in the program, the comparison proportion of .091 would have yielded a larger value of participants that would be expected to reoffend. In this study, that value is only 18*.091, or 1.638. The larger the sample size becomes, the larger the difference between the previous value and zero, which is the

proportion of participants who did reoffend. A minimum sample size of 55 would be necessary in order to yield statistically meaningful results. This sample size was determined by using the expected-frequency-greater-than-five standard (Green & Salkind, 2005). As there are no known treatment groups comprised that are similar to Stepping Up, access to a larger sample size for future research may present a challenge. Significant efforts were made throughout the course of this study to identify similar treatment groups. Both SARATSO and CASOMB were contacted for referrals, in addition to Sharper Future and the San Francisco Forensic Institute. No governing body or California treatment provider was able to offer any information regarding the existence of a similar treatment group. While the small number of participants rendered the results difficult to generalize or meaningfully compare to another, much larger group is a distinct limitation, the uniqueness of the voluntary post-mandated group population is a valuable research opportunity for even a limited study. Also, no information could be found regarding the rates of relapse for the relatively few individuals that complete obligatory treatment and seek continued participation in therapy on their own: the men that continue to participate in a court-ordered therapy setting, with mandated clients, despite having completed their own mandate. These men are rare, and the author was unable to discover any research related to their specific rates of recidivism.

Another limitation is that not all clients that complete treatment at A Step Forward are invited to participate in the aftercare group. Reasons to withhold an invitation are varied, but include characterological traits that may render a client unsuitable for continued interpersonal work, an expressed disinterest in treatment, and other factors. For this reason Stepping Up may be a self-selected group of clients that are already inclined to utilize therapeutic tools, rely on pro-social connections, and to seek help when they feel themselves to be at risk of reoffending. Clients of this type may be more likely overall to successfully avoid relapse. Screening out the graduating members that present as disinterested, unsuitable for continued group work, or interpersonally inappropriate may automatically exclude a population at higher risk. These men may exhibit higher rates of relapse than their peers in aftercare. Thus the members of Stepping Up may be unsuitable for comparison with the general population of convicted sex offenders that have completed treatment, by virtue of their amenability to treatment, willingness to participate in extended and pro-social clinical contact, and overall desire to remain relapse-free. While it is likely that few convicted offenders wish to return to custody, these specific characteristics may not be typical of the general treated sex offender population.

There is an additional potential limitation for this study, as the longitudinal data regarding the relapse rates of adult male sex offenders is exceptionally limited. It is important to note that there is no way of knowing if a percentage of

the men that relapse have also participated in voluntary individual or group treatment. It is possible that many convicted sexual offenders that commit new crimes have already sought out clinical interventions of their own. The current research been limited by both time and practicality: sex offenders and relapse have not been a focus of significant research interest for more than a decade or two. Also, once an offender has completed parole, he is not monitored. There is no means of monitoring those offenders that complete treatment, complete parole or probation, and return to their lives and communities. The rate of relapse is monitored only by the rate at which these men return to custody, or have new contact with law enforcement. There is no means of estimating the number of new sexual offenses committed by these men that avoid detection by legal or criminal systems.

It is possible (if unlikely) that participation in outpatient treatment may serve to teach some men how to commit sexual crimes in ways that escape punitive attention. For example, the man convicted of downloading child pornography on his home computer may serve prison time and complete treatment, but may eventually resume his illegal activities. However, his preparation for such behaviors may reflect a change. Having learned that his home internet use is monitored, he may purchase online access anonymously from internet cafes or libraries, and may avoid exposing the hard drive of his home

computer or IP address to authorities. In this way he may escape detection indefinitely.

The 290 registration law is very recent. Before its' implementation, an offender who committed a new sexual offense may have never been connected to his original crimes, particularly as technology has been slow to modernize the caching of criminal history data. We know that repeat offenders are at greater risk for continued crimes, yet we have only just begun to assemble and make available accurate online criminal histories. The lack of substantive research in this area makes this type of study essential, despite the limitations of its small population size and limited scope. It is essential that a comprehensive online database be accessible to law enforcement nationwide (if not globally), in order to better track repeat offenders and to estimate, manage, and mitigate risk when possible.

Implications

The implications of this study are potentially meaningful. While the small number of participants strongly indicates the need for a larger, more comprehensive study of this kind, a 9.1% decrease in criminal recidivism among released sex offenders is striking nonetheless. As the laws that govern sentencing of sexual crimes continue to emphasize supervision and restriction, it is essential to maintain the possibility of rehabilitation. The impact of sexual violence on society is tremendous. The cost to taxpayers for the prosecution and incarceration of those convicted of sexual offenses is substantial. By implementing the

containment model, California is seeking a working template for safe, appropriate supervised release for the duration of parole. While it is well-considered, the containment model is a work in progress. Incorporating optional aftercare into the current model may significantly strengthen California's ability to deter and even prevent future sexual crimes. The open-ended nature of monthly aftercare meetings offers a means of extending the containment model beyond the current discrete period of two to five years; and could offer convicted offenders a means of managing their own risk over the course of a lifetime.

Recommendations for Future Research:

While the primary function of this study was to assess only the potential efficacy of aftercare, there are many questions to address in future research, in addition to identifying the contributing factors to short and medium-term results. What are the variables at the treatment level that create an interest on the part of the men to enter aftercare? What are the variables that support an ongoing commitment to remain in aftercare? It would be helpful to separate and identify the distinct components of aftercare: for example, positive relationship(s) with other clients, heightened emotional tolerance and increased use of coping tools, awareness of deviant arousal or fantasy, ongoing identification of triggers, and other aspects of the program. Clients could be asked to rate which of these aspects they experience to be the most (or least) compelling reasons for their continued attendance and abstinence from crime. Why is it important and valuable for men

who have committed sexual offenses to participate in aftercare? Has voluntarily attending aftercare post-treatment for previously mandated sex offenders contributed to a demonstrable lessening of clients' dynamic risk variables? Do participating clients perceive themselves to be a lower risk for recidivating due to their participation in this program? These questions were developed in order to better understand the contributing factors that influence successful participation in aftercare, in order to more clearly operationalize the aftercare model for replicability and future research. In order to repeat this in the future, it is clear that a larger group of participants will be needed in order to generate potentially significant statistical results. Participants should be classified by age, ethnicity, and type of offense if possible. Expanding aftercare to include a broader, less self-selected group of participants may also be useful, in that it may offer a more immediately comparable sample to contrast with the general data available from the state. Aftercare may prove more effective with certain age groups, ethnicities, and/or men with certain types of offense histories.

In terms of recommendation for practice, it is essential that this study be replicated, and that all resulting data be tracked. It may be useful to begin aftercare groups based on this model, and to track and observe the recidivism rates of these clients. For clinicians, the implications of expanding the containment model may significantly alter their relationship to their clients. As aftercare is open-ended, there is a possibility that clients may remain in facilitated

monthly meetings for years, or even for the rest of their lives. This is quite different than the current treatment arc of (on average) two to four years, and may represent a significant expansion of the therapeutic relationship. Some clinicians may welcome this idea, while others may wish to restore the more temporary nature of the mandated treatment arc. At this time, longitudinal data regarding relapse and/or recidivism for this population is scarce. Given the rarity and importance of this unusual group, relevant studies of any size are important, regardless of size limitations. In addition to conducting new studies with a larger group, it is recommended that future research measure recidivism rates over a span of years. For example, an aftercare group may be assessed for rates of recidivism at a given date, then checked and re-checked each year for a set period. While the constraint of time is its own deterrent, it is urgent that these statistics be monitored. Only with time will we be able to definitively identify (or reject) aftercare as a positive impact on rates of recidivism for sexual offenders. The goal is to eliminate recidivism among sex offenders, in order to create a safer community, a more effective criminal justice system, and to reduce the number of victims of sexual crimes.

Chapter 6: References

Andrews, D. A., & Bonta, J. (1998). *The psychology of criminal conduct* (2nd ed.). Cincinnati, OH: Anderson.

Assemb. B. 813, 2011-12 Reg. Sess. (Cal. 2011).

Assemb. B. 1015, 2005-06 Reg. Sess. (Cal. 2005).

Assemb. B. 1844, 2010 Reg. Sess. (Cal. 2010).

Barbaree, H. E., Langton, C. M., & Peacock, E. J. (2006). Different actuarial risk measures produce different risk rankings for sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 18*, 423-440. doi: 10.1007/s11194-006-9029-9

Bernard, H.R. (2000). *Social research methods: Qualitative and quantitative approaches*. Thousand Oaks, CA: Sage Publications, Inc.

Bonnie, R. J. (2006). Judicially mandated Naltrexone use by criminal offenders: A legal analysis. *Journal of Substance Abuse Treatment, 31*(2), 121-127. doi: 10.1016/j.jsat.2006.06.003

Bonta, J. (1999). Approaches to offender risk assessment: Static vs. dynamic. *Public Safety Canada, Research Summary, 4*(2). Retrieved from http://www.publicsafety.gc.ca/res/cor/sum/cprs199903-eng.aspx

Bonta, J. (2007). Risk-need-responsivity model for offender assessment and rehabilitation. Retrieved from securitepubliquecanada.gc.ca/res/cor/rep/_fl/Risk_Need_2007-06_e.pdf

Bourget, D, & Bradford, J. M.W. (2008). Evidential basis for the assessment and treatment of sex offenders. *Brief Treatment and Crisis Intervention, 8*(1), 130-146. doi:10.1093/brief-treatment/mhm022

Buchbinder, E. & Eisikovits, Z. (2008). Doing treatment: Batterers' experience of intervention. *Children and Youth Services Review, 30*(6), 616-630. doi: 10.1016/j.childyouth.2008.01.009

California Department of Corrections and Rehabilitation (CDCR). (2012). *Parole requirements*. Retrieved from Division of Adult Parole Operations website: http://www.cdcr.ca.gov/parole/Parole_Requirements/index.html

California Department of Corrections and Rehabilitation. (2013). Number of offenders required to register as a sex offender. Data Analysis Unit, Estimates and Statistical Analysis Section, Offender Information Services Branch.

California Penal Code, Section § 290 (2012). Retrieved from http://codes.lp.findlaw.com/cacode/PEN/3/1/9/5.5/s290

California Penal Code, Sections §§ 9000-9003 (2012). Retrieved from http://codes.lp.findlaw.com/cacode/PEN/3/3/9/3/s9001

California Sex Offender Management Board (CASOMB). (2010). Recommendations report. Retrieved from http://casomb.org/docs/CASOMB%20Report%20Jan%202010_Final%20Report.pdf

Glaser, B. (2003). Therapeutic jurisprudence: An ethical paradigm for therapists in sex offender treatment programs. *Western Criminology Review, 4*(2), p. 143-154.

Glaser, B. (2009). Treaters or punishers? The ethical role of mental health clinicians in sex offender programs. *Aggression and Violent Behavior, 14*, 248-255. doi:10.1016/j.avb.2009.04.007

Green, S. B., & Salkind, N. J. (2005). *Using SPSS for Windows and Macintosh: Analyzing and understanding data* (4th ed.). Pearson: Upper Saddle River, NJ.

Grubin, D. (2004). Sexual offending and treatment of sex offenders, *Psychiatry, 3*(11), 17-21. doi: 10.1383/psyt.3.11.17.53592

Hanson, R. K. (1998). What do we know about sex offender risk assessment? *Psychology*, *Public Policy, and Law, 4*, 50-72. doi:10.1037/1076-8971.4.1-2.50

Hanson, R. K., & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66*(2), 348-362.

Hanson, R. K & Harris, A. J. R. (2001). A structured approach to evaluating change among sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *13*(2), 105-122. doi: 10.1177/107906320101300204

Hanson, R. K., Harris, A. J., Scott, T., & Helmus, L. (2007). *Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project* (Vol. 5). Ottawa, Ontario, Canada: Public Safety Canada.

Hanson, R. K., Helmus, L., Thornton, D. (2009). Predicting recidivism amongst sexual offenders: A multi-site study of Static-2002. *Law and Human Behavior, 34*(3), 198-211. doi: 10.1007/s10979-009-9180-1

Izzo, R. L., & Ross, R. R. (1990). Meta-analysis of rehabilitation programs for juvenile delinquents: A brief report. *Criminal Justice and Behavior*, *17*(1), 134-142. doi: 10.1177/0093854890017001008

Khoo, S. (2001). Assessing program effects in the presence of treatment-baseline interactions: A latent curve approach, *Psychological Methods, 6*(3), pp. 234-257.

Kokish, R., Levenson, J. S., & Blasingame, G. D. (2005). Post-conviction sex offender polygraph examination: Client-reported perceptions of utility and accuracy. *Sexual Abuse: A Journal of Research and Treatment*, *17*(2), p. 211-221. doi: 10.1007/s11194-005-4606-x

Langan, P., Schmitt, E., & Durose, M. R. (2003). Recidivism of sex offenders released from prison in 1994 (Report No. NJC 198281). Retrieved from United States Department of Justice website: http://bjs.ojp.usdoj.gov/content/pub/pdf/rsorp94.pdf

Larochelle, S., Diguer, L., Laverdière, O., & Greenman, P. S. (2011). Predictors of psychological treatment noncompletion among sexual offenders. *Clinical Psychology Review, 31*, 554–562. doi: 10.1016/j.cpr.2010.12.004

Levenson, J.S., Brannon, Y.N., Fortney, T., & Baker, J. (2007). Public perceptions about sex offenders and community protection policies.

Analyses of Social Issues and Public Policy, 7(1), 137-161. doi: 10.1111/j.1530-2415.2007.00119

Levenson, J. S., Prescott, D. S., & D'Amora, D. A. (2010). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology*, *54*(3), 307-326. doi: 10.1177/0306624X08328752

Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, *1*(1), 117-146. doi: 10.1007/s11292-004-6466-7

Marshall, W. L. (1996). The sexual offender: Monster, victim, or everyman? *Sexual Abuse: A Journal of Research and Treatment, 8*(4), 317-335. doi: 10.1007/BF02260166

Mauser, E., Van Stelle, K. R., & Moberg, D. P. (1994). The economic impact of diverting substance-abusing offenders into treatment. *Crime & Delinquency, 40*(4), 568-588. doi: 10.1177/0011128794040004006

McGrath, R. J., Cumming, G., Livingston, J. A., & Hoke, S. E. (2003). Outcome of a treatment program for adult sex offenders: From prison to community. *Journal of Interpersonal Violence, 18*(3), 3-17. doi: 10.1177/0886260502238537

Meltzoff, J. (2006). *Critical thinking about research*, American Psychological Association Press: Washington, DC.

Moster, A., Wnuk, D. W., & Jeglic, E. L. (2008). Cognitive behavioral therapy interventions with sex offenders. *Journal of Correctional Health Care, 14*(2), 2008. doi: 10.1177/1078345807313874

Sawyer, J. (1966). Measurement and prediction, clinical and statistical. *Psychological Bulletin, 66*, 178–200.

Seto, M. C., & Barbaree, H. (1999). Psychopathy, treatment behavior, and sex offender recidivism. *Journal of Interpersonal Violence, 14*(12), 1235-1248. doi: 10.1177/088626099014012001

Sexual Predator Punishment and Control Act: Jessica's Law (2006).

Schaffer, M., Jeglic, E., Moster, A., & Wnuk, D. (2010). Cognitive-behavioral therapy in the treatment and management of sex offenders. *Journal of Cognitive Psychotherapy, 24*(2), 92-103. doi: 10.1891/0889-8391.24.2.92

Someda, K. (2009). An international comparative overview on the rehabilitation of offenders and effective measures for the prevention of recidivism. *Legal Medicine*, *11*(1), S82-S85. doi: 10.1016/j.legalmed.2009.01.064

Sreenivasan, S., Kirkish, P., Garrick, T., Weinberger, L. E., & Phenix, A. (2000). Actuarial risk assessment models: A review of critical issues related to violence and sex-offender recidivism assessments. *The Journal of the American Academy of Psychiatry and the Law*, *28*, 438-448.

State Authorized Risk Assessment Tool for Sex Offenders (SARATSO). (2012). *Risk instruments*. Retrieved from SARATSO website: http://www.saratso.org/riskIntsru.htm

State of California Department of Justice (2012). Megan's Law home. Retrieved from http://www.meganslaw.ca.gov/index.aspx?lang=ENGLISH

JM Svajl. (2012, March 14). Qualitative psychology & (some) diffficulties in quantitative methods [Web log post]. Retrieved from http://makersidiom.wordpress.com/2012/03/14/qualitative-psychology-some-difficulties-in-quantitative-methods/

Tewksbury, R. (2004). Experiences and attitudes of registered female sex offenders. *Federal Probation, 68*(3), 30-38.

Tewksbury, R., & Copes, H., (2013). Incarcerated sex offenders' expectations for reentry, *The Prison Journal, 93*(1), 102-122.

Thiebaud, F. (2011). Pharmacological treatment of sex offenders, *Sexologies, 20*(3), 166-168. doi: 10.1016/j.sexol.2011.02.003

Thornton, D. (2002). Constructing and testing a framework for dynamic risk assessment. *Sexual Abuse: A Journal of Research and Treatment, 14*(2), 139-153. doi: 10.1023/A:1014620214905

Ward, T., Hudson, S. M., & Marshall, W. L. (1995). Cognitive distortions and affective deficits in sex offenders: A cognitive deconstructionist

interpretation. *Sexual Abuse: A Journal of Research and Treatment*, *7*(1), p. 67 – 83. doi: 10.1007/BF02254874. ISSN: 1079-0632.

Ward, T., Mann, R. E., & Gannon, T. A. (2007). The good lives model of offender rehabilitation: Clinical implications. *Aggression and Violent Behavior, 12*, 87–107.

Willis, G. M., & Grace, R. C. (2009). Assessment of community reintegration planning for sex offenders: Poor planning predicts recidivism. *Criminal Justice and Behavior, 36*(5), 494-512. doi: 10.1177/0093854809332874

Witt, P.H. & Schneider, J. (2005). Managing sex offenders by assessing dynamic risk factors. *Sex Offender Law Report, 6*, 49, 54--57.

Appendix A

Informed Consent Form: Sexual Offense Recidivism Study And Review Of Stepping Up

Antioch University is committed to protecting your rights as a research participant. This form will provide you with information about those rights. This is a research study that may not directly benefit you. The purpose of this study is to learn more about relapse among adult males that have previously been convicted of a sexual offense, in light of your participation in the Stepping Up aftercare program. This study hypothesizes that participation in Stepping Up has had a positive effect on the group's rates of relapse. This study assumes that your rates of relapse are lower than among men with similar histories who don't attend Stepping Up.

It requires no time commitment on your part, and is completely voluntary. You don't have to participate. If at any time if you wish to stop participating in this study, you can do that without any negative consequence.

As a participant, you will be asked two questions about yourself (your name and birth date). Next, you will agree or decline to having your name and birth date be reviewed via the public record. This study is looking for any evidence of your contact with the criminal justice system (meaning either a parole or probation violation or a new offense conviction) since beginning participation in aftercare with Stepping Up.

There are some potential risks associated with your participation. The completion of this study may result in some level of increased public awareness of members of Stepping Up as men that have previously committed sexual offenses. That could be stressful. In order to protect your privacy, your name and birth date will be de-identified, and group meeting times, dates, and locations will be left out of

the study. Should you feel any psychological distress as a result of participation in this study, you will be provided with a list of mental health treatment referrals. You may stop participating in this study at any time, and you don't have to give a reason.

If you have any questions about the study, you may contact Alexandra Schmidt, doctoral student, or her dissertation supervisor, Dr. Salvador Trevino at 602 Anacapa St., Santa Barbara, CA 93101, (805) 962-8179. Should you experience any stress or worry related to being a part of this study, you may always contact the study investigators. They will take steps to connect you with local resources that can provide counseling and support.

Your participation is requested, and is completely voluntary. All information will be kept confidential. None of your identifying data will be linked with any of the results.

By checking yes below, you state that you are over 18 years old, have read this whole form and are able to give consent, agree to the terms of this agreement, and wish to participate.

All identifying information will be stored securely in accordance with the standards of the American Psychological Association for a period of 7 years, after which time it will be appropriately destroyed.

YES: _____

NO: _____

NAME: _____

DATE OF BIRTH: _____

SIGNATURE: _____

Appendix B

Demographic Data for Stepping Up Members

Age

	Frequency	Percent	Valid Percent	Cumulative Percent
18-25	1	5.56	5.56	5.56
26-35	2	11.11	11.11	16.67
36-45	4	22.22	22.22	38.89
46-55	8	44.44	44.44	83.33
56-65	3	16.67	16.67	100
65 and up	0	0	0	100
Total	18	100	100	

Offense

	Frequency	Percent	Valid Percent	Cumulative Percent
Rape	1	5.56	5.56	5.56
Lewd Act With Child	9	50	50	55.56
Oral Copulation	0	0	0	55.56
Sodomy	0	0	0	55.56
Penetration With Object	1	5.56	5.56	61.12
Other Sex Offense	7	38.88	38.88	100
Total	18	100	100	

Ethnicity

	Frequency	Percent	Valid Percent	Cumulative Percent
Other	1	5.56	5.56	5.56
Black	2	11.11	11.11	16.67
Hispanic	0	0	0	16.67
White	15	83.33	83.33	100
Total	18	100	100	

Appendix C

Demographic Data For 2012 Registered California Sex Offenders

Age

	Frequency	Percent	Valid Percent	Cumulative Percent
18-25	343	13.14	13.14	13.14
26-35	695	26.63	26.63	39.77
36-45	675	25.83	25.83	65.6
46-55	561	21.49	21.49	87.09
56-65	255	9.77	9.77	96.86
65 and up	82	3.14	3.14	100
Total	2611	100	100	

Offense

	Frequency	Percent	Valid Percent	Cumulative Percent
Rape	226	8.67	8.67	8.67
Lewd Act With Child	1324	50.7	50.7	59.37
Oral Copulation	88	3.37	3.37	62.74
Sodomy	32	1.22	1.22	63.96
Penetration With Object	65	2.49	2.49	66.45
Other Sex Offense	876	33.55	33.55	100
Total	2611	100	100	

Ethnicity

	Frequency	Percent	Valid Percent	Cumulative Percent
Other	148	5.67	5.67	5.67
Black	425	16.28	16.28	21.95
Hispanic	1242	47.57	47.57	69.52
White	796	30.48	30.48	100
Total	2611	100	100	

Appendix D

Post-Hoc Chi-Square Results

Table 2. Frequency (and Expected Frequency) for Parameters of Sex Offense and Age for Members of Stepping Up

	Age					
	18-25	26-35	36-45	46-55	56-65	Total
R	1.0	0	0	0	0	1.0
	(.1)	(.1)	(.2)	(.4)	(.2)	(1.0)
LAWC	0	2.0	1.0	5.0	1.0	9.0
	(.5)	(1.0)	(2.0)	(4.0)	(1.5)	(9.0)
PWA	0	0	1.0	0	1	1.0
	(.1)	(.1)	(.2)	(.4)	(.2)	(1.0)
OSO	0	0	2.0	3.0	2.0	7.0
	(.4)	(.8)	(1.6)	(3.1)	(1.2)	(7.0)
Total	1.0	2.0	4.0	8.0	3.0	18.0
	(1.0)	(2.0)	(4.0)	(8.0)	(3.0)	(18.0)

Note: R = Rape; LAWC = Lewd Act with Child; PWA = Penetration with Object; OSO = Other Sex Offense

$\chi^2 = 24.81$, $p < .05$

Table 3. Frequency (and Expected Frequency) for Parameters of Sex Offense and Ethnicity for California Sex Offenders

	Ethnicity				
	Other	Black	Hispanic	White	Total
R	12.0	58.0	111.0	45.0	226.0
	(12.8)	(36.8)	(107.6)	(68.8)	(226.0)
LAWC	82.0	95.0	775.0	372.0	1324.0
	(75.0)	(215.5)	(630.3)	(403.1)	(1324.0)
OC	8.0	20.0	34.0	26.0	88.0
	(5.0)	(14.3)	(41.9)	(26.8)	(88.0)
S	0.0	7.0	16.0	9.0	32.0
	(1.8)	(5.2)	(15.2)	(9.7)	(32.0)
PWA	6.0	6.0	31.0	22.0	65.0
	(3.7)	(10.6)	(30.9)	(19.8)	(65.0)
OSO	40.0	239.0	276.0	321.0	876.0
	(49.7)	(142.6)	(417.0)	(266.7)	(876.0)
Total	148.0	425.0	1243.0	795.0	2611.0
	(148.0)	(425.0)	(1243.0)	(795.0)	(2611.0)

Note: R = Rape; LAWC = Lewd Act with Child; PWA = Penetration with Object; OSO = Other Sex Offense; $p < .05$

Table 4. Frequency (and Expected Frequency) for Parameters of Sex Offense and Age for California Sex Offenders

	Age						
	18-25	26-35	36-45	46-55	56-65	65 and up	Total
R	65.0	72.0	50.0	32.0	3.0	4.0	226.0
	(29.7)	(60.2)	(58.4)	(48.6)	(22.1)	(7.1)	(226.0)
LAWC	177.0	364.0	374.0	225.0	126.0	58.0	1324.0
	(173.9)	(352.4)	(342.3)	(284.5)	(129.3)	(41.6)	(1324.0)
OC	21.0	25.0	29.0	9.0	3.0	1.0	88.0
	(11.6)	(23.4)	(22.7)	(18.9)	(8.6)	(2.8)	(88.0)
S	8.0	9.0	8.0	7.0	0.0	0.0	32.0
	(4.2)	(8.5)	(8.3)	(6.9)	(3.1)	(1.0)	(32.0)
PWA	16.0	20.0	12.0	8.0	7.0	2.0	65.0
	(8.5)	(17.3)	(16.8)	(14.0)	(6.3)	(2.0)	(65.0)
OSO	56.0	205.0	202.0	280.0	116.0	17.0	876.0
	(115.1)	(233.2)	(226.5)	(188.2)	(85.6)	(27.5)	(876.0)
Total	343.0	695.0	675.0	561.0	255.0	82.0	2611.0
	(343.0)	(695.0)	(675.0)	(561.0)	(255.0)	(82.0)	(2611.0)

Note: R = Rape; LAWC = Lewd Act with Child; PWA = Penetration with Object; OSO = Other Sex Offense; $p < .05$

Table 5. Frequency (and Expected Frequency) for Parameters of Ethnicity and Recidivism for California Sex Offenders

	Ethnicity				
	Other	Black	Hispanic	White	Total
New Offense	139.0	287.0	1138.0	672.0	2236.0
	(126.7)	(364.0)	(1064.5)	(680.0)	(2236.0)
Re-offender	9.0	138.0	105.0	123.0	375.0
	(21.3)	(61.0)	(178.5)	(114.2)	(375.0)
Total	148.0	425.0	1243.0	795.0	2611.0
	(148.0)	(425.0)	(1243.0)	(795.0)	(2611.0)

$\chi^2 = 157.72$, $p < .001$

Table 6. Frequency (and Expected Frequency) for Parameters of Age and Recidivism for California Sex Offenders

	Age						
	18-25	26-35	36-45	46-55	56-65	65 and up	Total
New Offense	319.0	572.0	594.0	458.0	217.0	76.0	2236.0
	(293.7)	(592.2)	(578.1)	(400.4)	(218.4)	(70.2)	(2236.0)
Re-offender	24.0	123.0	81.0	103.0	38.0	6.0	375.0
	(49.3)	(99.8)	(96.9)	(80.6)	(36.6)	(11.8)	(375.0)
Total	343.0	695.0	675.0	561.0	255.0	82.0	2611.0
	(343.0)	(695.0)	(675.0)	(561.0)	(255.0)	(82.0)	(2611.0)

$\chi^2 = 35.14$, $p < .001$

Table 7. Frequency (and Expected Frequency) for Parameters of Sex Offense and Recidivism for California Sex Offenders

	Type of Offense						
	R	LAWC	OC	S	PWA	OSO	Total
New Offense	207.0	1279.0	77.0	31.0	62.0	580.0	2236.0
	(193.5)	(1133.8)	(75.4)	(27.4)	(55.7)	(750.2)	(2236.0)
Re-offender	19.0	45.0	11.0	1.0	3.0	296.0	375.0
	(32.5)	(190.2)	(12.6)	(4.6)	(9.3)	(125.8)	(375.0)
Total	226.0	1324.0	88.0	32.0	65.0	876.0	2611.0
	(226.0)	(1324.0)	(88.0)	(32.0)	(65.0)	(876.0)	(2611.0)

Note: R = Rape; LAWC = Lewd Act with Child; OC = Oral Copulation; S = Sodomy; PWA = Penetration with Object; OSO = Other Sex Offense
$\chi^2 = 413.28$, $p < .001$