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Definitions/Acronyms

- **ARC – Arrowhead Regional Corrections**
- **CSTS – Court Services Tracking System**
- **MSG – Minnesota Sentencing Guidelines**
- **MSGW – Minnesota Sentencing Guidelines Worksheet**
- **ISH – Institute for Psychological and Sexual Health**
- **RMH – Range Mental Health**
- **UMMH – Upper Mississippi Mental Health**
- **F – Felony**
- **GM – Gross Misdemeanor**
- **M – Misdemeanor**
- **VOP – Violation of Probation**
- **CSC – Criminal Sexual Conduct**
- **SR – Supervised Release (Parole)**
- **LSI-R – Level of Service Inventory-Revised**
- **YLS/CMI – Youth Level of Service/Case Management Inventory**

Sources of Information

- **CSTS**
 - Sex offender sentences
 - Sex offender demographics
 - Re-offense information
- **MSGC**
 - Departure information
- **Pre-Sentence Investigation Forms**
 - Plea Negotiation information

Summary of Findings

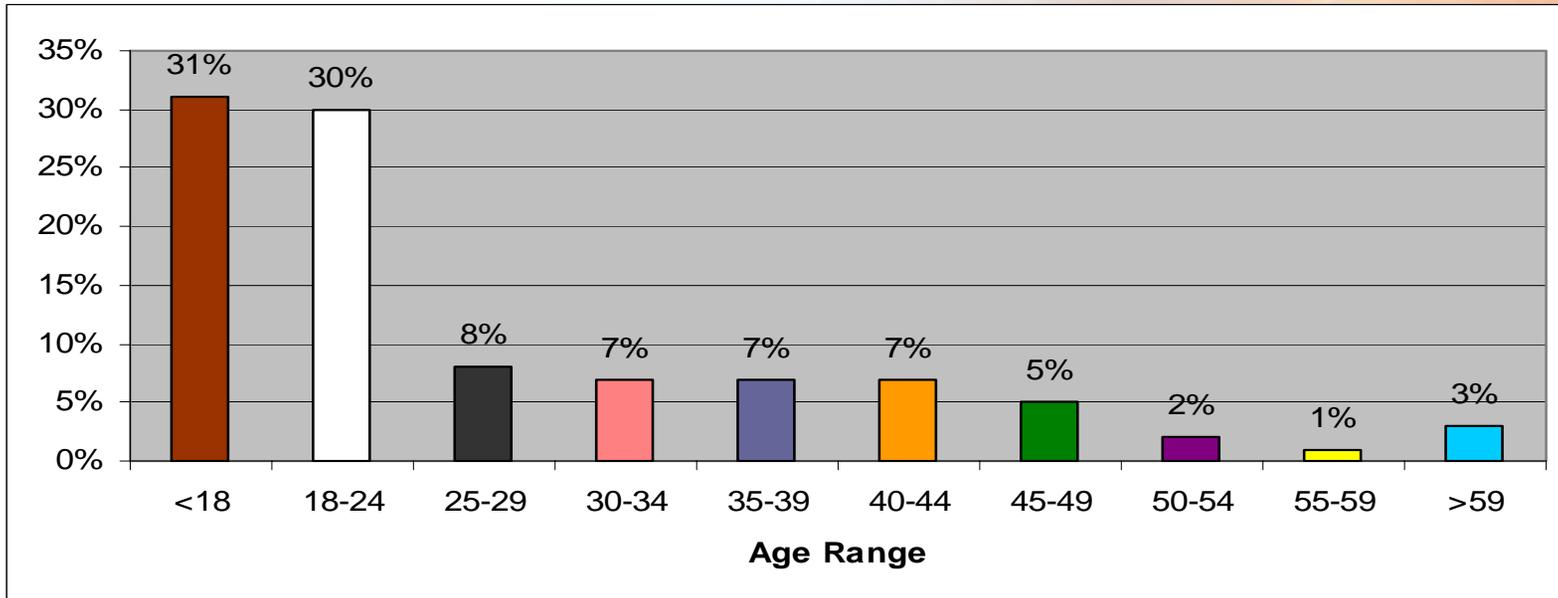
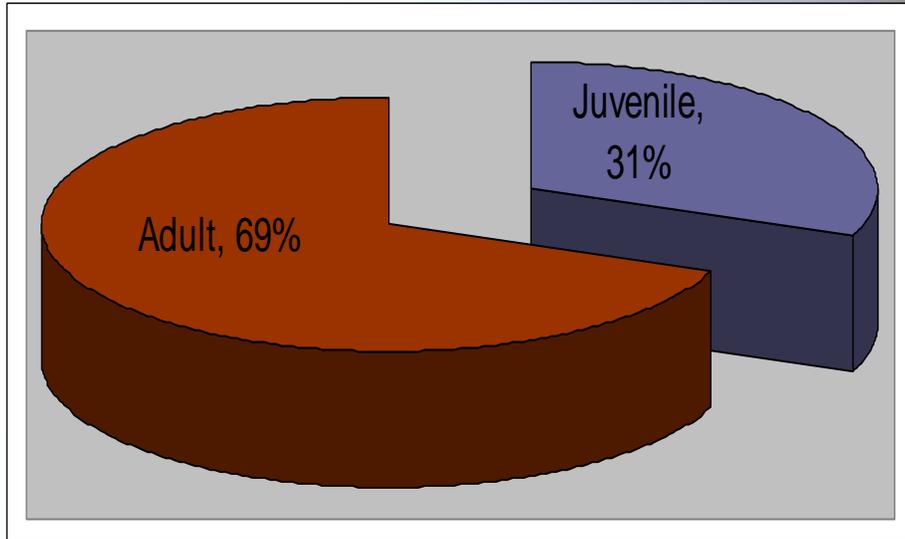
- **Totals**

- Between 1/1/2002 and 12/31/2004, there were 177 sex offenders convicted in the ARC region.
- In addition, 58 convicted sex offenders were accepted for supervision due to transfers in and supervised releases from prison.
 - **Detail:**
 - Transfers in from other counties: 16
 - Supervised releasees: 42

Demographics

•Age

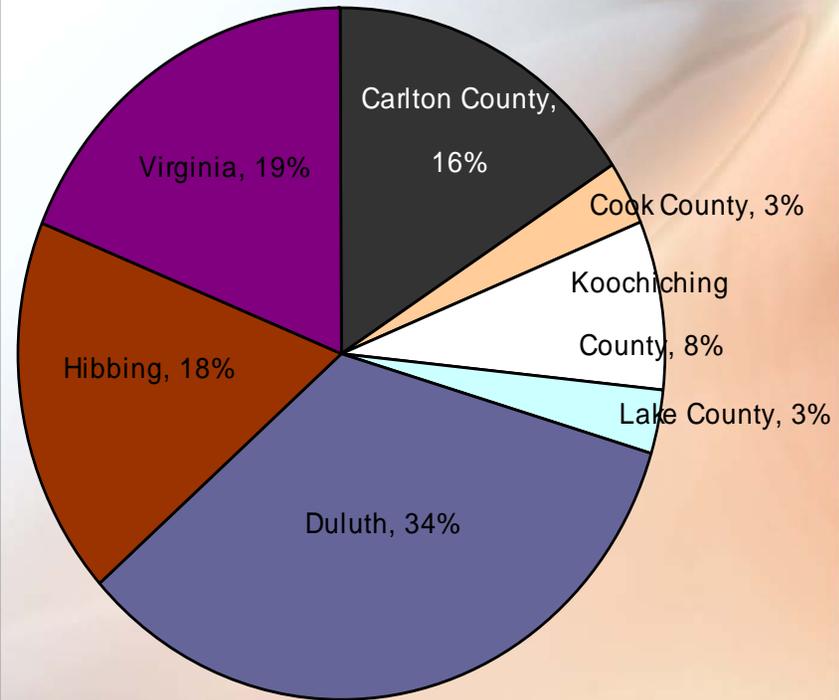
- Average age: 26
- Juveniles: 55 (31%)
 - Average age: 14
- Adults: 122 (69%)
 - Average age: 31
- Age Groupings:



Demographics (cont.)

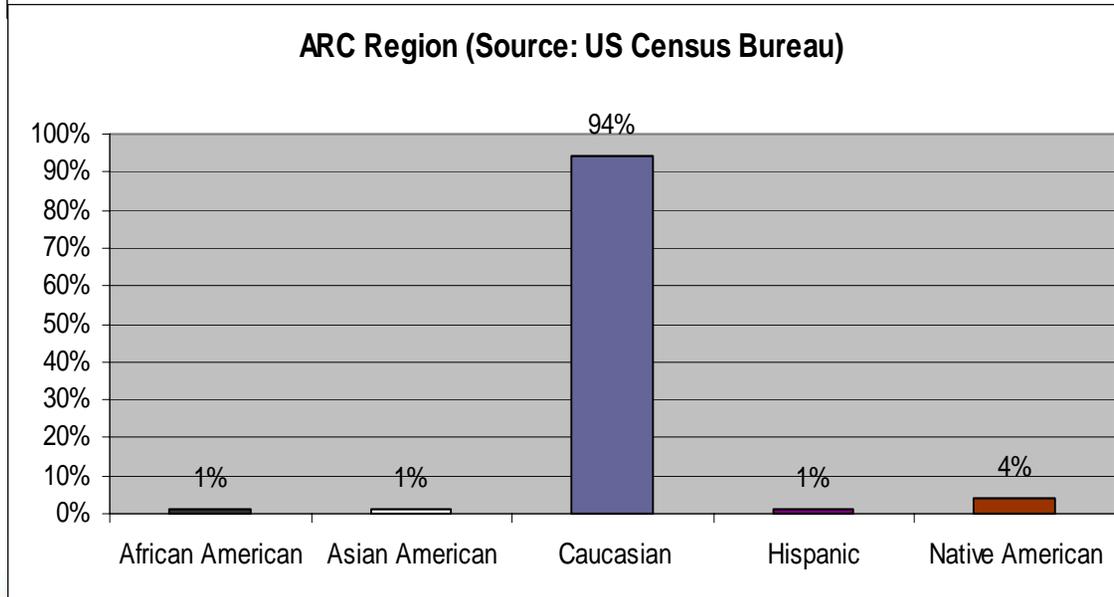
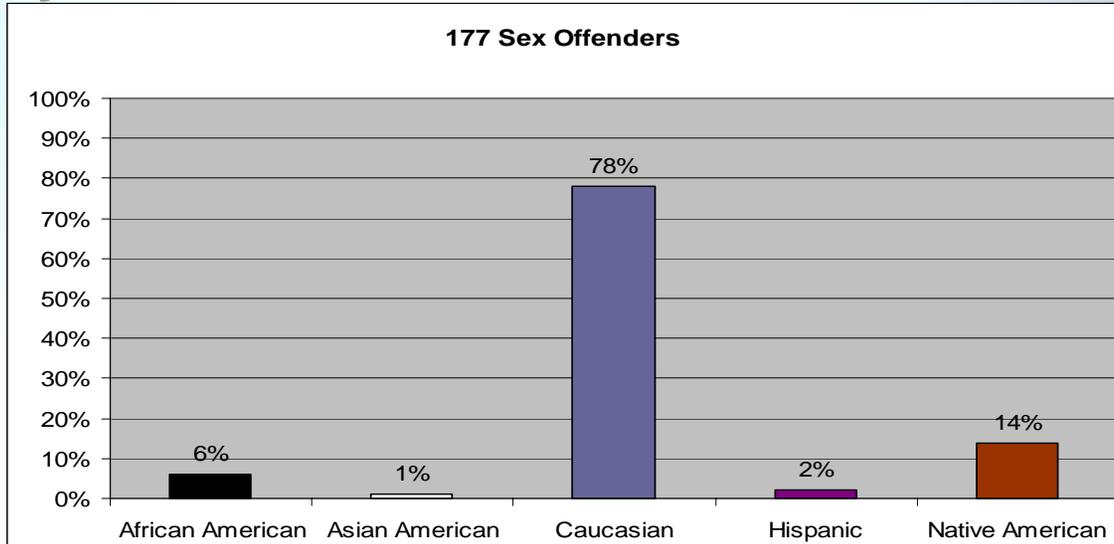
Region

Region	#	%
Carlton County	28	16%
Cook County	5	3%
Koochiching County	15	8%
Lake County	5	3%
Duluth	60	34%
Hibbing	31	18%
Virginia	33	19%



Demographics (cont.)

- Ethnicity

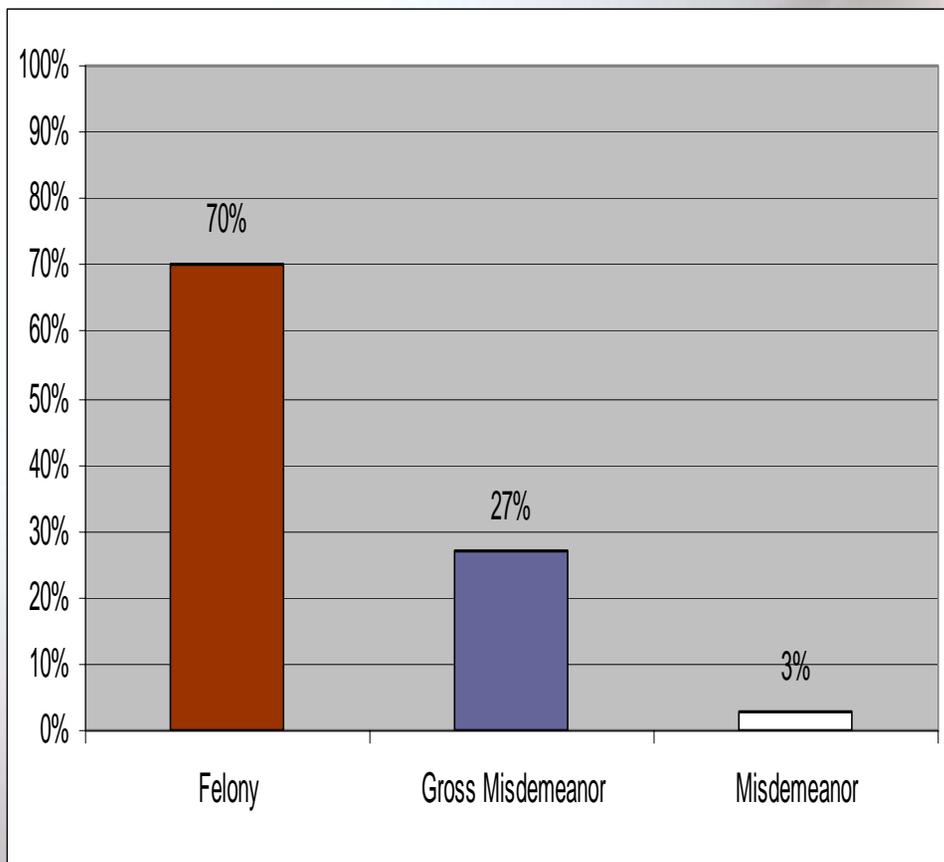


Offense Characteristics

- **Offense Level**

- 70% of the CSC offenses committed were felonies.

	#	%
Felony	124	70%
Gross Misdemeanor	48	27%
Misdemeanor	5	3%

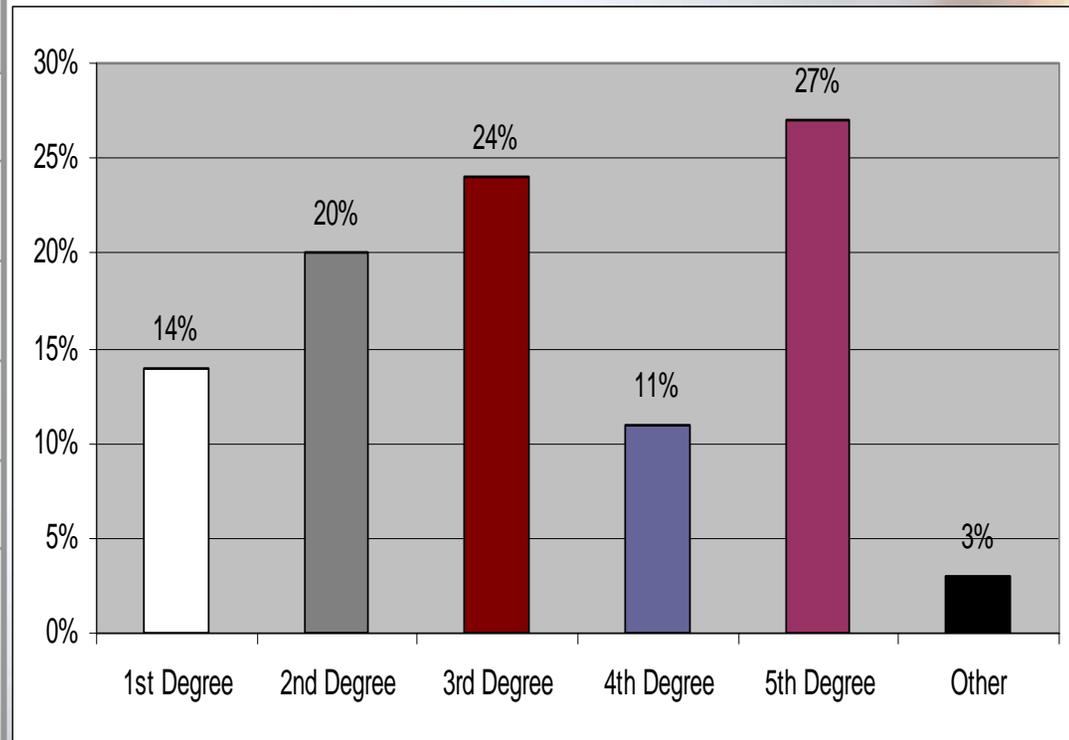


Offense Characteristics (cont.)

- **Offense Degree**

- **5th degree CSC is the most prevalent at 27% due to the fact that it includes all Gross Misdemeanor offenses.**

	#	%
1st Degree	25	14%
2nd Degree	35	20%
3rd Degree	43	24%
4th Degree	19	11%
5th Degree	48	27%
Other (Indecent Exposure)	6	3%



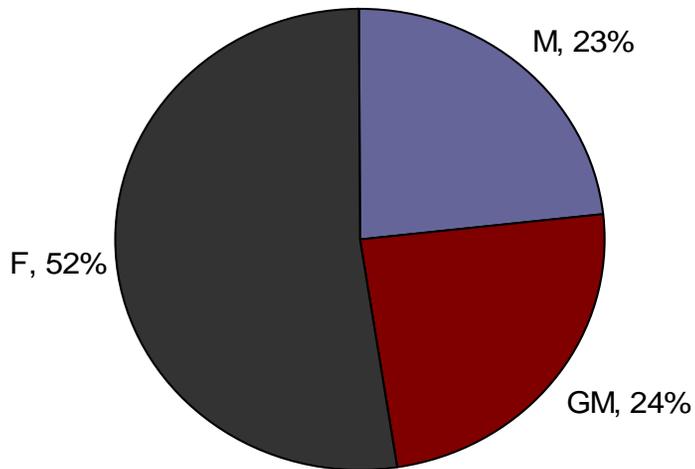
***See handout “Criminal Sexual Conduct Degrees” for descriptions of degrees.**

Offense Characteristics (cont.)

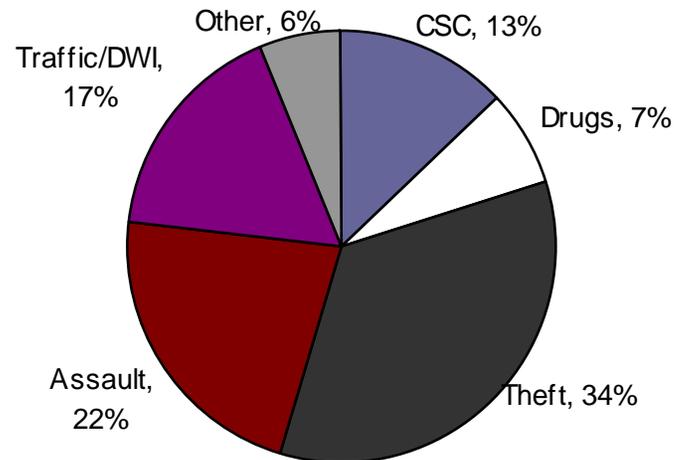
•Prior Offenses

- 73 (41%) of the 177 sex offenders had a prior criminal record in CSTS. (Total of 90 priors)
- 12 (<1%) had a prior Criminal Sexual Conduct charge in CSTS.
- Breakdown of the 90 priors by level and type:

Prior Offense Level



Prior Offense Type

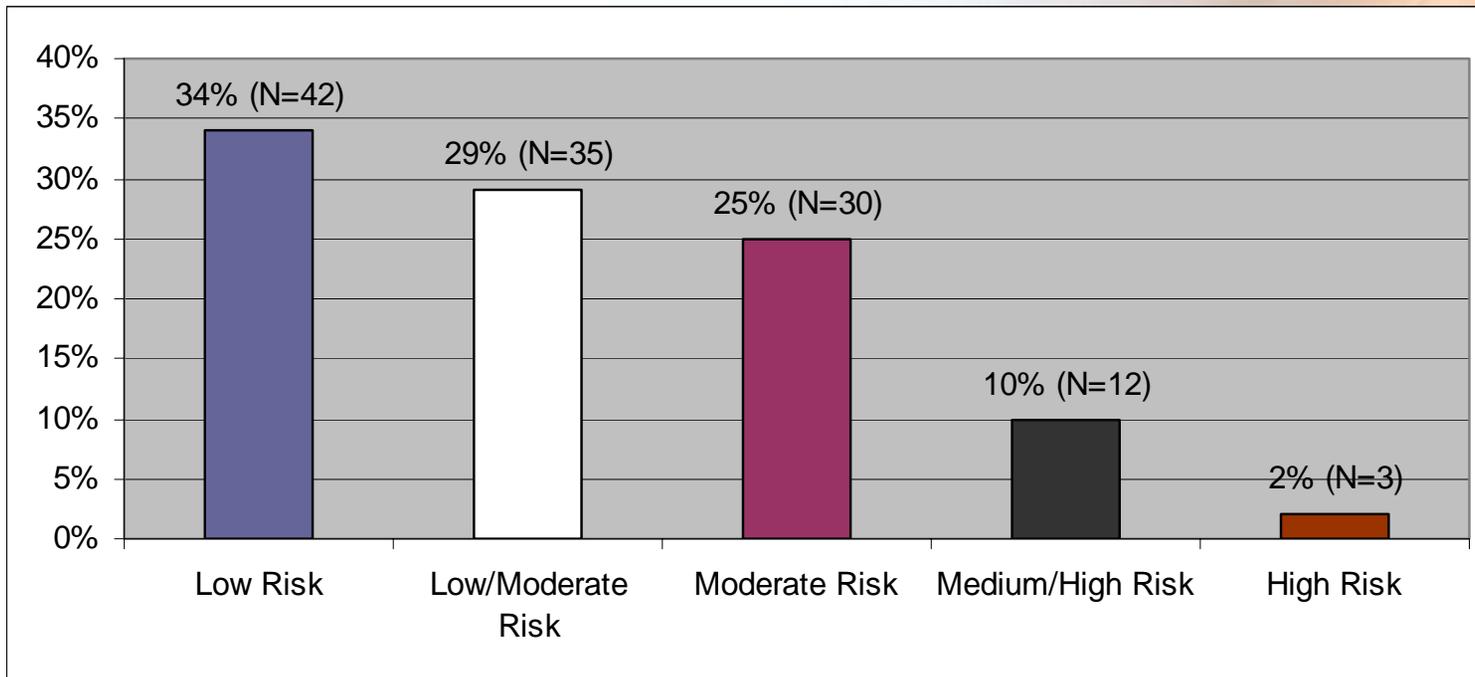


LSI-R & YLS/CMI

The LSI-R and YLS/CMI are the adult and juvenile risk assessment tools used by ARC to assess criminogenic needs and risk of re-offense.

- LSI-R distribution

- Adult offenders (N=122) had an average LSI-R score of 20.
 - This falls in the low/moderate risk category.

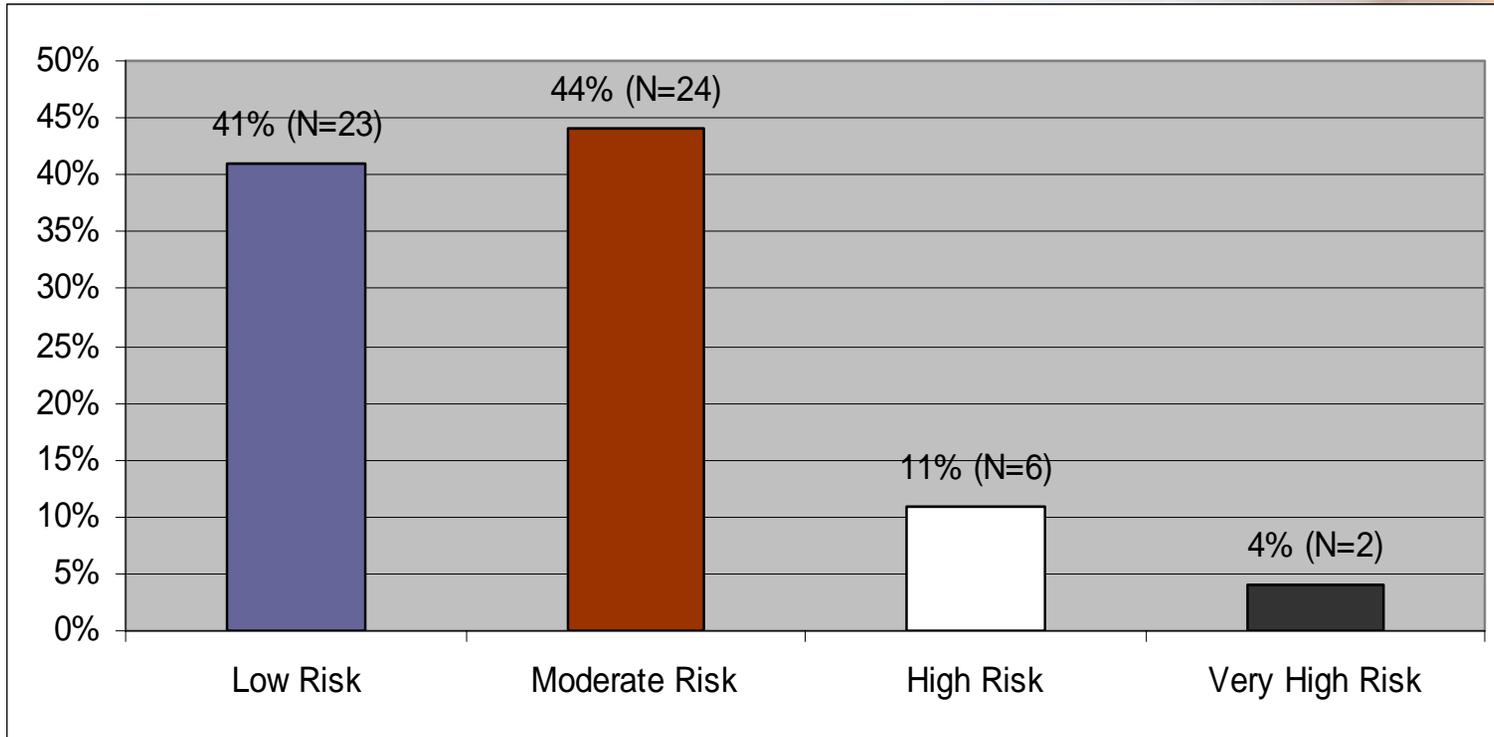


LSI-R & YLS/CMI (cont.)

- **YLS/CMI distribution**

- Juvenile offenders (N=55) had an average YLS/CMI score of 13.

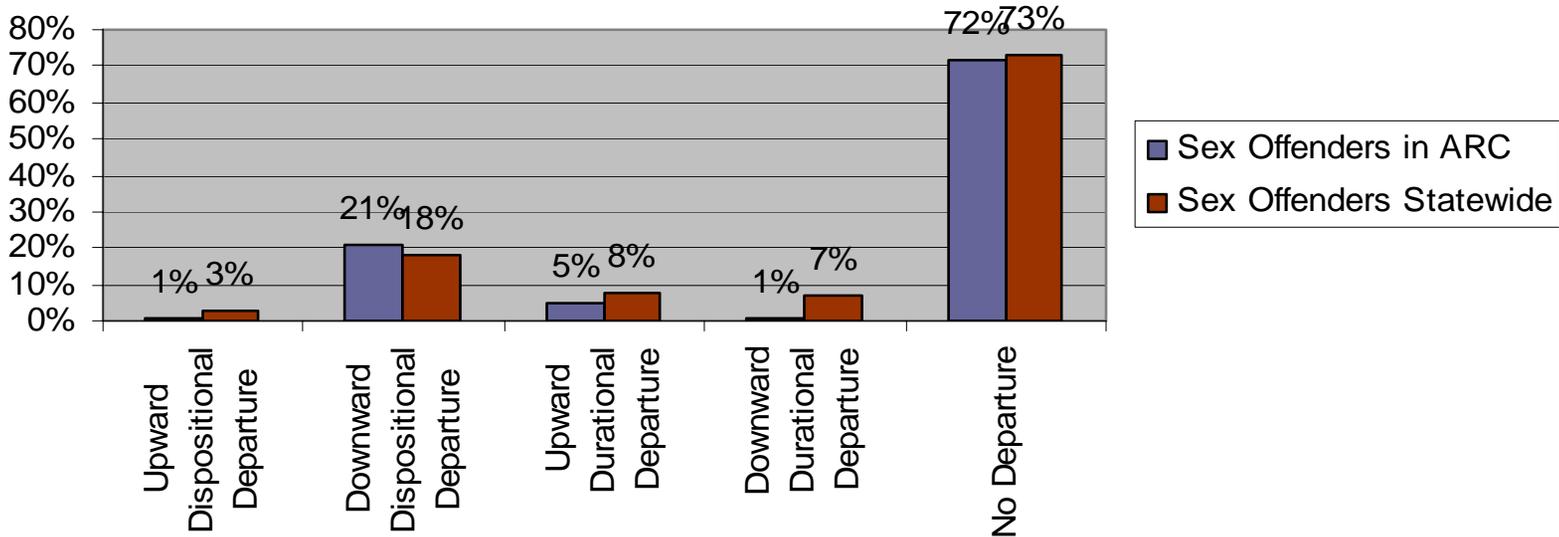
- This falls in the moderate risk category.



Departure Rates

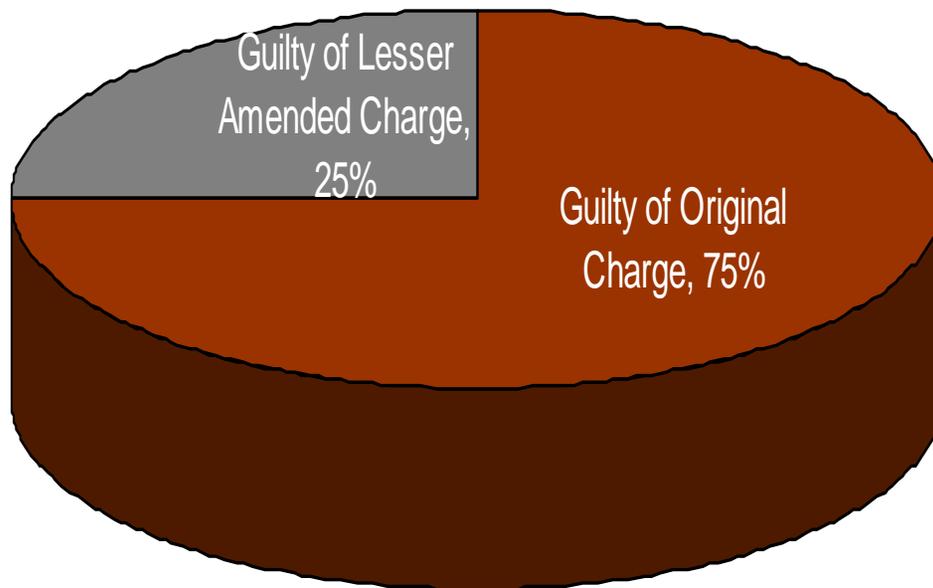
- A MN Sentencing Guidelines Worksheet (MSGW) is completed for every adult felony offense (N=85).
- This worksheet suggests a presumptive sentence based on offense severity and criminal history (See MSGW handout).
- Judges possess the ability to depart (upward or downward) from the presumptive sentence on both disposition and duration. Departures occurred in 24 (28%) of the 85 cases in ARC.

Departure Rates for ARC vs. Statewide



Plea Agreement Rates

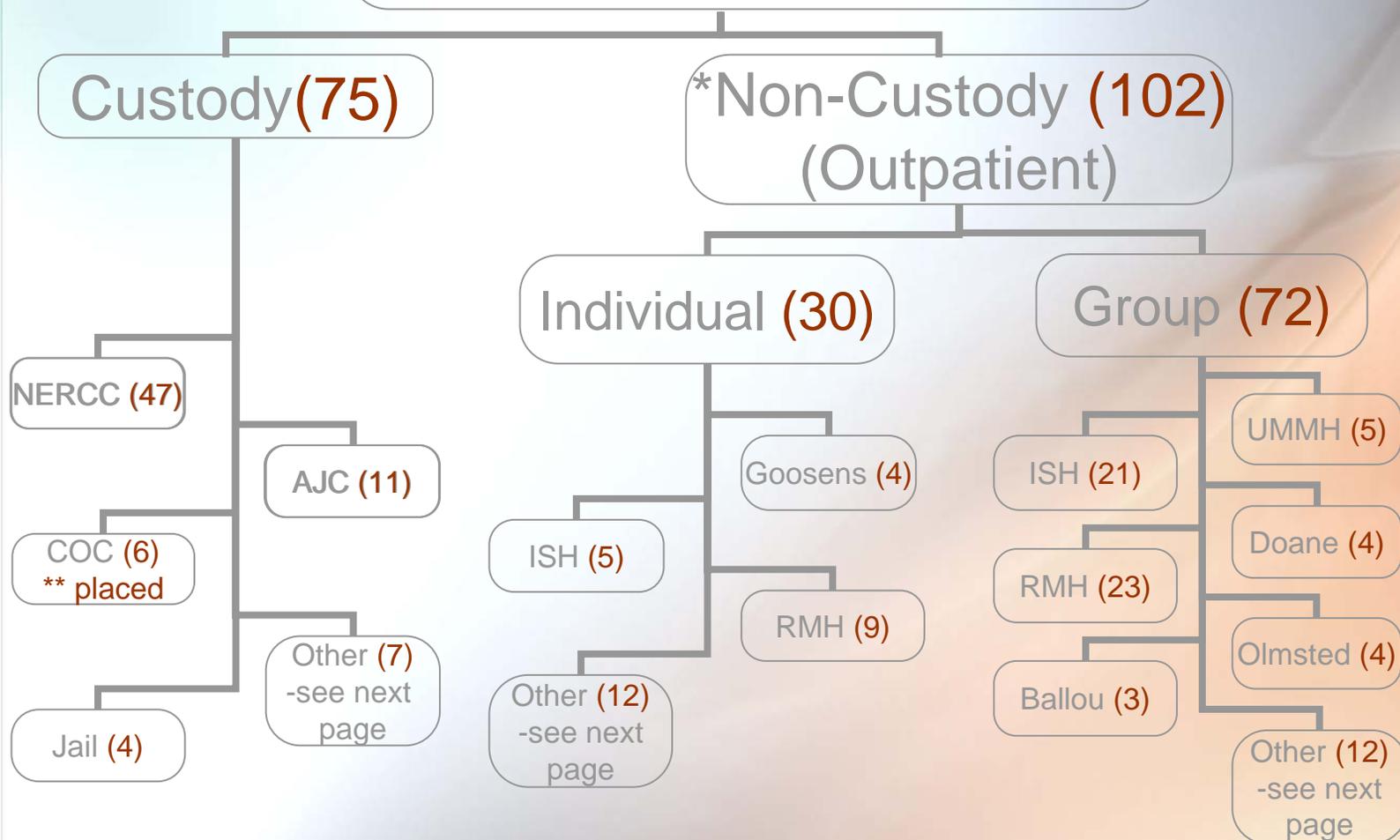
- 45 (25%) of the offenses were plead down.
- 41 offenders (23%) had additional counts dismissed. (Number dismissed = 60 counts)



- On average, plea negotiations “moved” down between 1 and 2 degrees. (i.e. – From 3rd to 5th degree CSC, or from 1st to 3rd degree CSC)

Sentences/Conditions

Total Sentences (177)



* "Non-Custody" does not necessarily mean the offender did not receive jail time. In most cases the offender did spend a number of pre-trial days in local jails.

Sentences/Conditions (cont.)

- “Other” Categories
 - Inpatient (Custody) **(7)**
 - Juvenile long-term residential placements
 - Transfers out
 - Outpatient (Non-custody), Individual **(12)**
 - Refusals to comply, usually resulting in VOP
 - Transfers out
 - Unspecified
 - Outpatient (Non-custody), Group **(12)**
 - Refusals to comply, usually resulting in VOP
 - Transfers out, i.e. Alpha House

Recidivism

- **General Recidivism (N=177)**

- **Definitions:**

- **Conviction, not arrest!**

- **Time period*:**

- **Non-Custody = From date of CSC conviction to 11/1/2005.**

- **Custody = From date of discharge from facility to 11/1/2005.**

*** Different offenders had different times post-conviction ranging anywhere from 1 year to 4 years.**

Recidivism (cont.)

•General Recidivism (cont.)

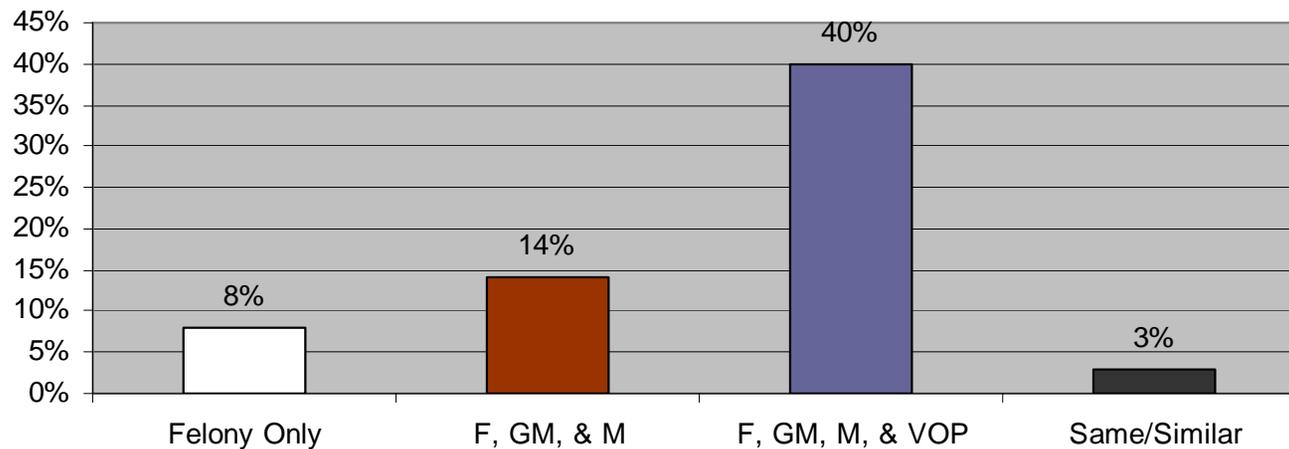
–Recidivism by offense level:

*Only 6 out of the 177 offenders committed a new CSC offenses.

	Number	Percent
Felony Only	15	8%
F, GM, & M	25	14%
F, GM, M, & VOP	70	40%
Same/Similar	*6	3%

* All 6 were felonies

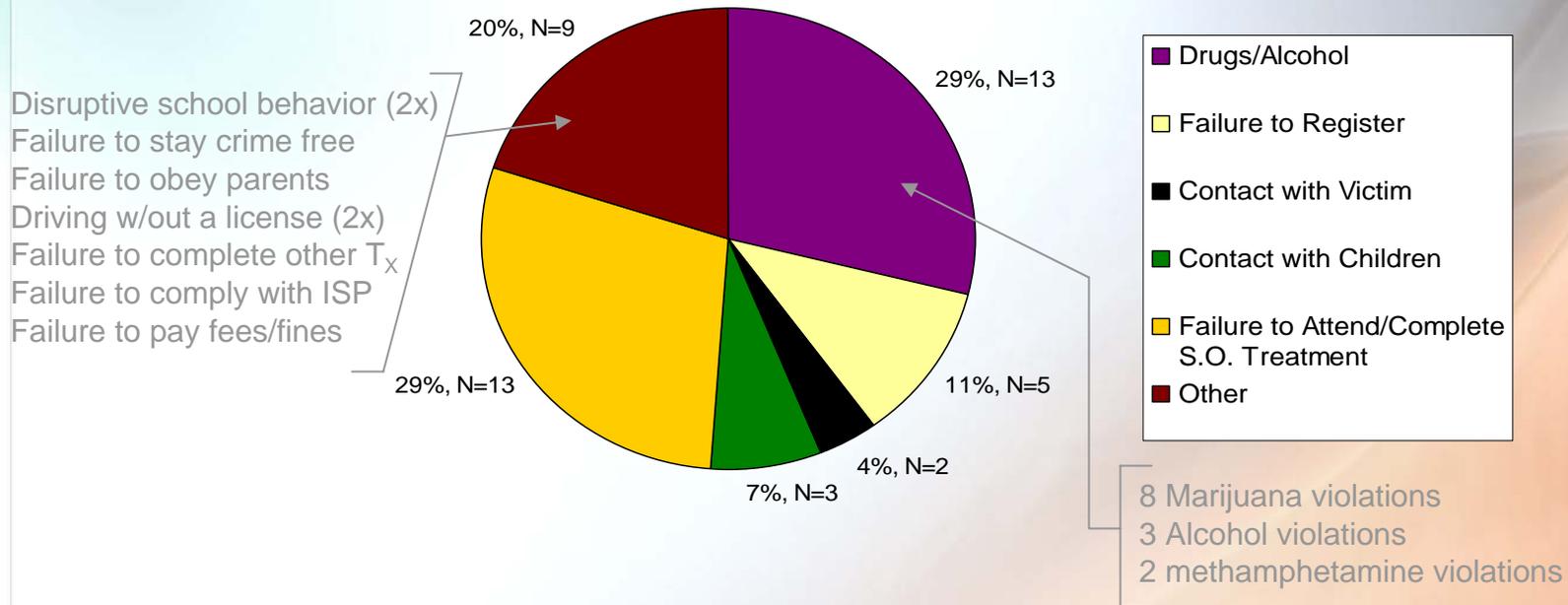
Recidivism Rates for Entire Population (N=177)



Recidivism (cont.)

•General Recidivism (cont.)

– Reasons for Violations of Probation



– 30 of the 45 VOPs were committed by adult offenders. The other 15 were juvenile.

– For the juvenile violators, the vast majority of their VOPs were for failure to complete treatment, disruptive school behavior, and using marijuana.

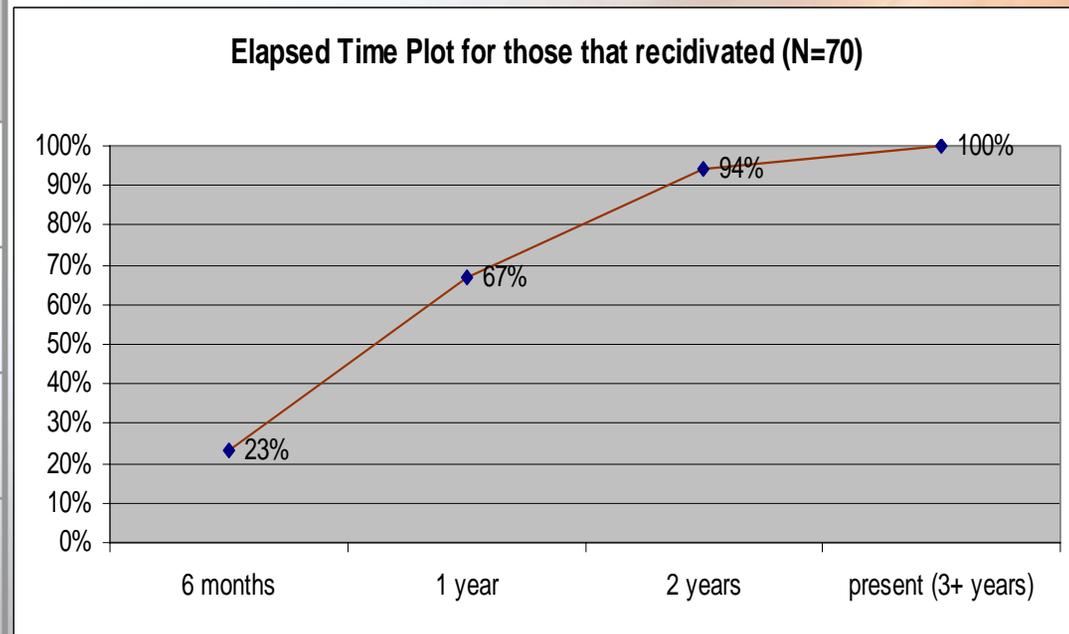
Recidivism (cont.)

•General Recidivism (cont.)

–Time period (post-conviction/discharge):

•The statistics below pertain only to those offenders that recidivated. As such, they should read, “Of those that recidivated, 23% did so in the first 6 months after conviction,” for example.

	#	%
6 months	16	23%
1 year	47	67%
2 years	66	94%
Present (3+ years)	70	100%



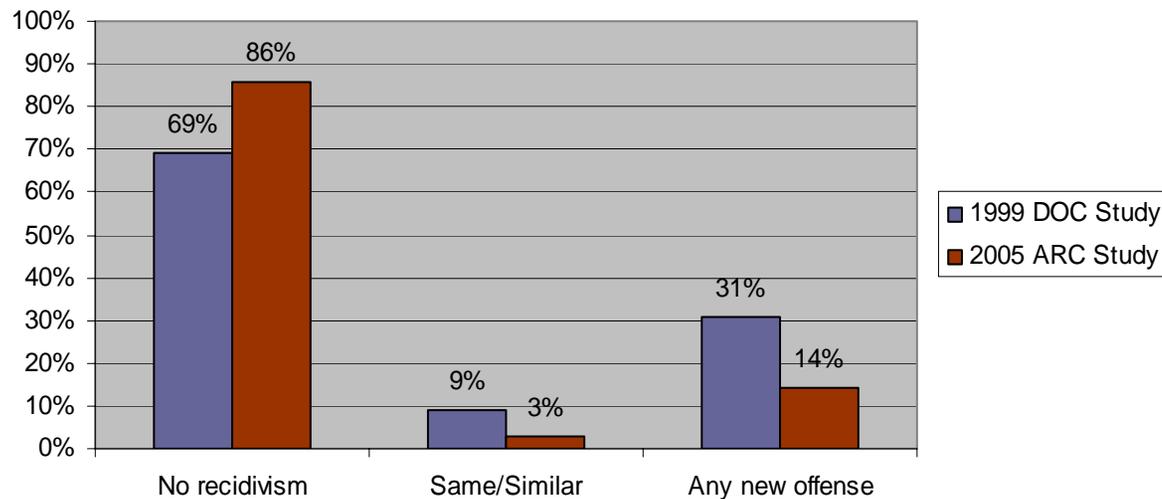
Recidivism (cont.)

• General Recidivism (cont.)

– For Comparison...

- MN DOC Community-Based Sex Offender Program Evaluation Project (1999)

- Sample size = 1407 probationers
- Time period = 7 years
- Re-arrest, not reconviction used!



Approximately ½ of offenders in the DOC study who ultimately recidivated did so in the first 2 years.

NERCC S.O. Program

- NERCC discharged 56 sex offenders from their program between 1/1/2002 and 9/1/2005.
- Movement post-discharge:

Treatment Destination	Number	Percent
Institute for Psy. & Sexual Health	14	25%
Range Mental Health	10	18%
Upper Mississippi Mental Health	2	4%
Other Group Providers (Doane, Ballou, Olmsted)	6	11%
Other (Transfers to other regions, refusals to comply, executed sentences, group homes)	14	25%
None/NERCC support only	10	18%

NERCC S.O. Program (cont.)

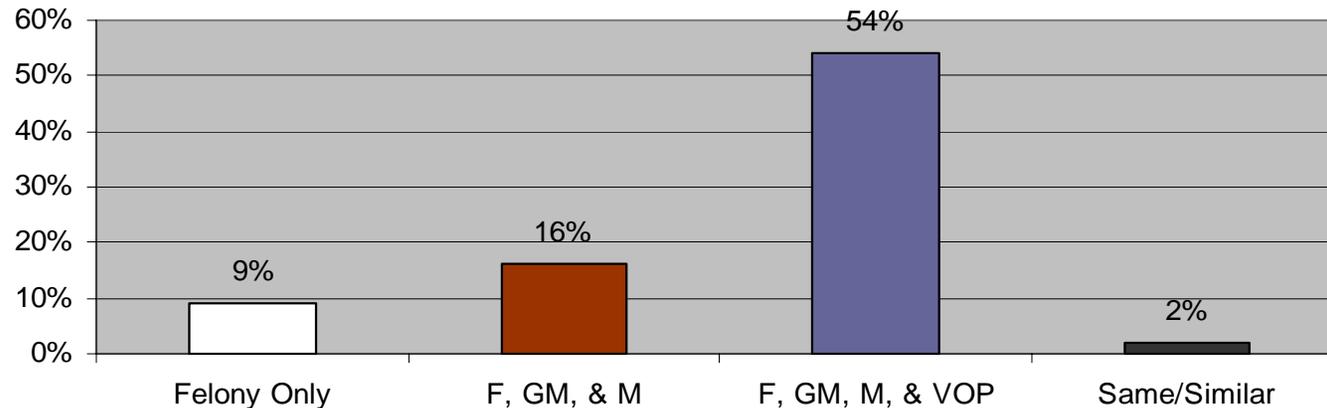
•Recidivism (N=56)

–Recidivism by offense level:

*Only 1 out of the 56 discharges committed a new CSC offense.

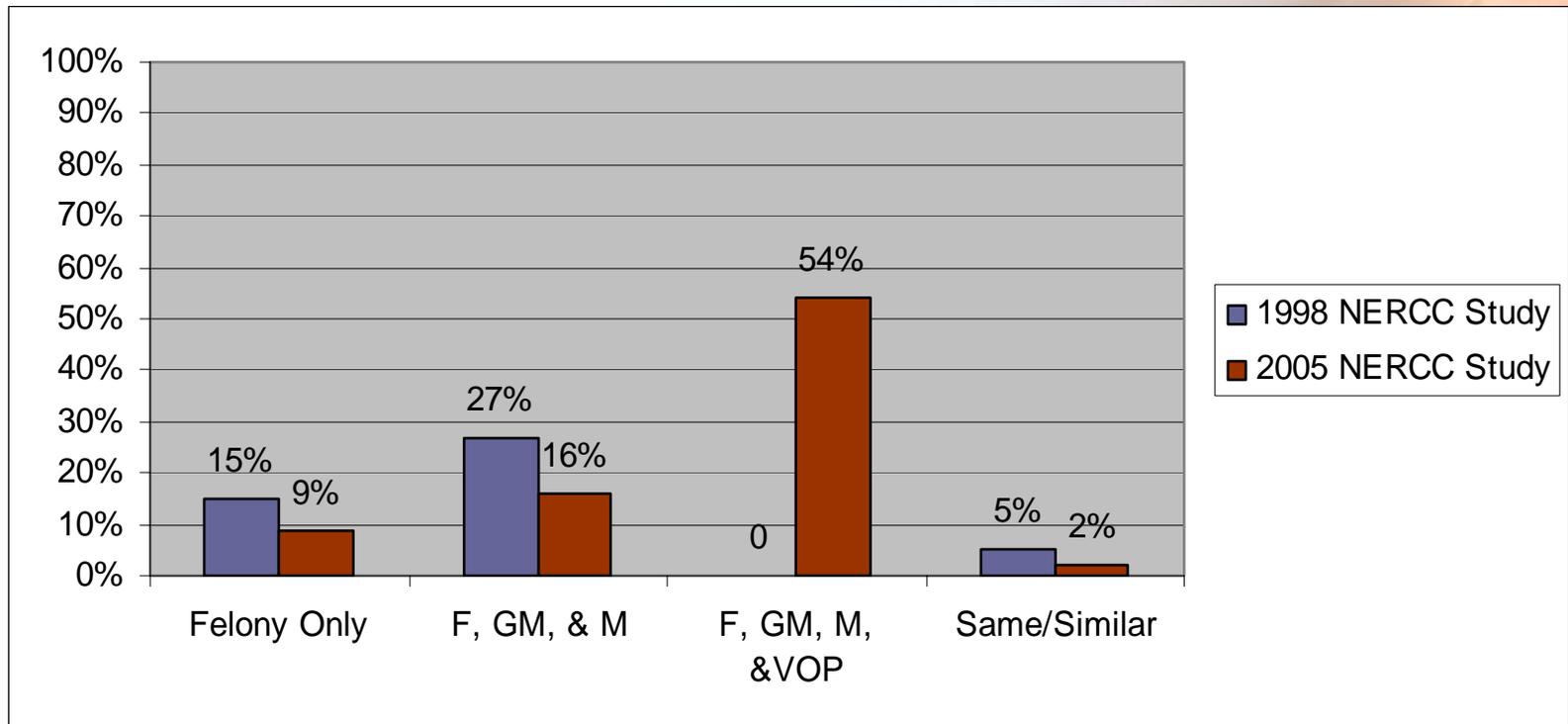
	Number	Percent
Felony Only	5	9%
F, GM, & M	9	16%
F, GM, M, & VOP	30	54%
Same/Similar	1	2%

Recidivism for NERCC S.O. Program Discharges Since 1/1/2002
(N=56)



NERCC S.O. Program (cont.)

- Comparison to recidivism data for NERCC S.O. clients from 1982-1996 (N=277).
 - Study conducted by Joyce Piispanen in 1998
 - Follow up period = Up to 12 years
 - Comparative recidivism:



NERCC S.O. Program (cont.)

•Recidivism (cont.)

–Time period (post-discharge):

•The statistics below pertain only to those offenders that recidivated. As such, they should read, “Of those that recidivated, 57% did so in the first 6 months after conviction,” for example.

	Number	Percent
6 months	17	57%
1 year	30	100%

•Every offender who recidivated (30 total) did so in the first year after they were released from NERCC. 21 out of the 30 “re-offenses” were violations of probation.

Regional Comparison

CSC Offense Level

	F		GM		M	
	#	%*	#	%*	#	%*
Carlton Co.	22	79%	5	18%	1	4%
Cook Co.	2	40%	3	60%	0	
Koochiching Co.	13	87%	2	13%	0	
Lake Co.	3	60%	2	40%	0	
Duluth	45	75%	15	25%	0	
Hibbing	22	71%	9	29%	0	
Virginia	17	52%	12	36%	4	12%

*Percent of total CSC offenses in each region.

Regional Comparison (cont.)

CSC Offense Degree

	1 ^o		2 ^o		3 ^o		4 ^o		5 ^o		Other (IE)	
	#	%*	#	%*	#	%*	#	%*	#	%*	#	%*
Carlton Co.	7	25%	2	7%	6	21%	5	18%	6	21%	2	7%
Cook Co.	0		0		1	20%	2	40%	2	40%	0	
Koochiching Co.	2	13%	5	33%	5	33%	1	7%	2	13%	0	
Lake Co.	0		1	20%	2	40%	0		2	40%	0	
Duluth	12	20%	19	32%	10	17%	4	7%	12	20%	3	5%
Hibbing	3	10%	1	3%	12	39%	5	16%	8	26%	1	3%
Virginia	1	3%	7	21%	7	21%	2	6%	16	48%	0	

* Percent of total CSC offenses in each region

Regional Comparison (cont.)

Departures

N = # with completed MSGW (Adult felony offenders) 	Downward Dispositional Departure		Upward Dispositional Departure		Downward Durational Departure		Upward Durational Departure		Mean Severity Score (from MSGW)	Mean Crim. History Score (from MSGW)
	#	%*	#	%*	#	%*	#	%*		
Carlton Co. (N=13)	4	31%	0		0		1	8%	6	<1
Cook Co. (N=2)	0		0		0		1	50%	5	1
Koochiching Co. (N=12)	2	17%	0		0		1	8%	6	<1
Lake Co. (N=3)	0		1	33%	0		0		5	2
Duluth (N=27)	7	26%	0		1	4%	1	4%	6	1
Hibbing (N=17)	3	18%	0		0		0		5	<1
Virginia (N=11)	2	18%	0		0		0		5	1

* Percent of those with completed MSGW in each region

Regional Comparison (cont.)

• Plea Agreements

	Guilty of Original Charge		Guilty of Amended Charge		Offenders with Counts Dismissed	
	#	%*	#	%*	#	%*
Carlton Co.	19	68%	9	32%	12	43%
Cook Co.	5	100%	0		0	
Koochiching Co.	9	60%	6	40%	3	20%
Lake Co.	5	100%	0		0	
Duluth	43	72%	17	28%	19	32%
Hibbing	26	84%	5	16%	4	13%
Virginia	25	76%	8	24%	3	9%

*Percent of total offenders sentenced in each region

Regional Comparison (cont.)

- Sentences/Conditions**

 - In-Custody vs. Non-custody**

	In-Custody (Inpatient)		Non-Custody (Outpatient)	
	#	%*	#	%*
Carlton Co.	5	18%	23	82%
Cook Co.	1	20%	4	80%
Koochiching Co.	4	27%	11	73%
Lake Co.	2	40%	3	60%
Duluth	31	52%	29	48%
Hibbing	18	58%	13	42%
Virginia	14	42%	19	58%

***Percent of total offenders sentenced in each region**

Regional Comparison (cont.)

- **Sentences/Conditions**

- **Group vs. Individual Therapy**

N = # of offenders sentenced to outpatient treatment	Group Therapy		Individual Therapy	
	#	%*	#	%*
Carlton Co. (N=23)	15	65%	8	35%
Cook Co. (N=4)	3	75%	1	25%
Koochiching Co. (N=11)	6	55%	5	45%
Lake Co. (N=3)	3	100%	0	
Duluth (N=29)	22	76%	7	24%
Hibbing (N=13)	9	69%	4	31%
Virginia (N=19)	14	74%	5	26%

***Percent of total offenders sentenced to outpatient (non-custody) treatment**

Outpatient Treatment Survey

- **An one-to-one interview was conducted with eight group and individual outpatient treatment providers in the ARC region.**
 - **The Institute for Psychological & Sexual Health – Duluth**
 - **Range Mental Health – Hibbing/Virginia**
 - **Upper Mississippi Mental Health - Bemidji**
 - **Jeff Ballou, PhD (Lutheran Social Services) - Superior**
 - **Stephen Olmsted, PhD (Psychological Health Services) – Duluth**
 - **Mitzi Doane, PhD (Duluth Psychological Clinic) – Duluth**
 - **Paul Goosens, LP (Harbor City Psychological Associates) – Duluth**
 - **Kim Schmidt, PhD (Arrowhead Psychological Clinic) – Duluth**

Outpatient Treatment Survey (cont.)

- **“Summarize and describe the outpatient treatment services provided by your organization.”**
 - 6 providers conduct primary group therapy for a total of 14 groups in the Arrowhead region.
 - Group size ranges from 5 to 10 with an averages size of 8.
 - 3 of the 6 group therapy providers utilize a cotherapist.
 - Several group providers stated that the number of referrals drives the types of groups they can run. For example, if they have a large number (4+) of deniers at a given time, they will start a deniers intervention group to address specific needs.
 - 3 of the 6 group providers draw much of their therapy materials and written assignments from Pathways educational books published by Safer Society Press.

Outpatient Treatment Survey (cont.)

- **“Summarize and describe the outpatient treatment services provided by your organization.” (cont.)**
 - 6 providers offer individual therapy.
 - Individual therapy is utilized both as an adjunct to, as well as in lieu of, group therapy.
 - Clients are generally referred for individual as opposed to group therapy due to being developmentally delayed.
 - 5 of the 6 group therapy providers include aftercare or continuing care as a component of their programming.
 - Aftercare is typically delivered via a group format approximately 2 times per month.
 - 4 providers conduct psycho-sexual evaluations.
 - Evaluations generally consist of:
 - MMPI-2 (Minnesota Multiphasic Personality Inventory)
 - MSI (Multiphasic Sex Inventory)
 - Risk Assessment
 - Clinical Interview
 - Review of collateral information

Outpatient Treatment Survey (cont.)

- “What are your offender criteria for placement in primary treatment.”

- 1) Referral by probation/courts
- 2) Low risk, “30% or less chance of re-offending”
– Higher risk = referral to a custody setting
- 3) Some degree of compliance
- 4) Adjudication
- 5) Amenability to treatment
- 6) Mental health stability (no chronic mental illness)
- 7) Probation Officer who is invested in the treatment process
- 8) No weapons used during offense
- 9) Risk assessment on file

Top 3 most
common
responses

“We will accept almost anyone, even if they are in denial. If after 3 to 6 months, they are still not progressing, then we may consider either a referral to a different program, or possible violation of probation.”

Outpatient Treatment Survey (cont.)

- **“What are your offender criteria for placement in aftercare.”**

- 1) Completion of primary treatment
- 2) Completion of a relapse prevention plan
- 3) Completion of written assignments
 - 2 providers require the probation officer to sign off on all written assignments.
- 4) Still on probation
- 5) Passed polygraph
- 6) Low risk
- 7) Demonstration and internalization of:
 - Ownership of offending behaviors
 - Empathy
 - Offending Cycle

Top 3 most common responses

“Transitioning to continuing care not only calls for a completion of written assignments, but also an ability to internalize and demonstrate concepts learned in treatment. One must assess both task and process components.”

Outpatient Treatment Survey (cont.)

- “From your perspective as a treatment provider, have you witnessed any inconsistencies in sex offender sentencing practices across courts, geographic regions, etc.? If so, what are they?”
 - Rural/northern counties tend to refer more offenders to outpatient treatment vs. a custody setting.
 - “No rhyme or reason” as to what constitutes a probation or parole revocation once an offender is found to be in violation.
 - In comparing WI to MN, WI probation seems more authoritative and swift to deal consequences. (Quick to violate, lodge, etc.)
 - In certain cases, socioeconomic status seems to play a role in sentencing.
 - i.e. – Offender who can afford their own legal representation vs. a public defender.
 - Differences in sentencing practices for high profile cases.
 - 3 providers stated that they witness no inconsistencies.

“Internally, ARC probation seems fairly consistent in their recommendations, and I know the State is working towards increased standardization as well.”

Outpatient Treatment Survey (cont.)

- **“What is the average length of primary treatment for offenders in your program?”**
 - Responses ranged anywhere from 6 months to 3+ years.
 - 2 providers stated 6 months to 1 year.
 - 2 providers stated 18 months.
 - 3 providers stated 2 years.
 - For those who specialize in developmentally delayed offenders, a minimum of 3 to 5 years was average.
- **“What is your agency’s philosophy/practice regarding a generally appropriate length of primary treatment? Is this supported by research/evidence-based practice?”**
 - All providers agreed that research points to an average length of 18 to 24 months.
 - Several providers stressed that those with deeply entrenched denial will often take longer than 2 years to complete treatment.
 - 3 providers described their personal beliefs as “...the longer, the better.”

Outpatient Treatment Survey (cont.)

- **“What is the average length of aftercare for offenders in your program?”**
 - Responses regarding length of aftercare varied greatly.
 - 3 providers stated 4 to 6 months.
 - 1 of these conducts 1 session per month for 4 months, followed in 3 months by a graduation.
 - 1 provider stated 26 sessions.
 - 2 provider stated 18 months.
 - 2 providers stated that their aftercare program is open-ended.
- **“What is your agency’s philosophy/practice regarding a generally appropriate length of aftercare? Is this supported by research/evidence-based practice?”**
 - Several providers stated they were unsure what research says.
 - 1 provider stated 6 months.
 - Several providers again upheld the belief that the longer treatment lasts, the better the chances are for no re-offense.

“Risk reduction research states that aftercare should span from 8 to 15 years.”

Outpatient Treatment Survey (cont.)

- **“What is your agency’s philosophy/practice on group vs. individual sex offender treatment? Is this supported by research/evidence-based practice?”**
 - All providers agreed that group therapy is the intervention of choice for the “average” sex offender.
 - 1 provider cited 2 research articles supporting group therapy:
 - Perkins DE, Hammond S, Coles D, and Bishop D (1998) Review of Sex Offender Treatment Programmes. Broadmoor Hospital: Report for HSPSCB.
 - Marshall WL (1996) Assessment, treatment and theorising about sex offenders: developments during the past twenty years and future directions. Criminal Justice and Behaviour, 23, 162-199.
 - Individual therapy is appropriate for the offenders who exhibit one of more of the following characteristics.
 - Low-functioning/intelligence
 - Developmentally delayed/mentally retarded
 - Multiple mental health diagnoses
 - Traumatic Brain Injury (TBI)
 - Patterns of sexual deviance in pre-adolescence

“Individual treatment perpetuates abuse by promoting secrets and providing ample opportunity for manipulation.”

Outpatient Treatment Survey (cont.)

- “Are risk assessment tools regularly used by your agency? If so, please list them.”

- 4 out of the 8 providers state they are currently using at least one of the following risk assessment tools:

- Adult
 - Static-99
 - SONAR (Sex Offender Need Assessment Rating)
 - MnSOST-R (Minnesota Sex Offender Screening Tool)
 - VASOR (Vermont Assessment of Sex Offender Risk)
- Juvenile
 - J-SOAP-II (Juvenile Sex Offender Assessment Protocol)
 - ERASOR (Estimate of Risk of Adolescent Sexual Offense Recidivism)
 - ROSS & LOSS Risk Assessment Interview

- Other assessment tools used include:

- ABEL Assessment
- MSI (Multiphasic Sex Inventory)
- MMPI-2 (Minnesota Multiphasic Personality Inventory)
- Rorschach Inkblot Test
- Polygraph

“There is danger in relying solely on a composite risk assessment score. Clinical conceptualization and evaluation must supplement the actuarial measures to provide a comprehensive assessment.”

Outpatient Treatment Survey (cont.)

- **“What role does sex offender risk assessment play in your acceptance/placement of referred clients?”**
 - For those providers actively implementing risk assessment tools, there are contradictory opinions regarding their applicability in acceptance/placement.
 - One provider stated that a high risk score did not necessarily preclude them from accepting clients.
 - Several others maintained that high risk clients were generally referred to a custody setting. One provider even stated that they would not take any client with a risk of re-offense higher than 30%.
- **“What role does sex offender risk assessment play in your decision to discharge a client or move him/her from primary treatment to aftercare?”**
 - Generally, providers agreed that clients must score as low risk across dynamic factors prior to being discharged from treatment.

“The SONAR is preferred to measure change at discharge and assess whether or not the client has integrated treatment.”

- Several providers stressed the need for a better attitudinal measure.
- All agreed that a tool measuring static factors will be of limited assistance in addressing discharge suitability.

Outpatient Treatment Survey (cont.)

- “Besides risk assessment, what other criteria/assessment information is used to determine discharge from primary treatment or aftercare?”
 - See slide 35 for a list of required tasks prior to completion of treatment.
 - Other factors to consider include:
 - Chemical dependency issues
 - Stability of living situation/relationships (family & spousal)
 - Duration of time post-offense
 - Nature of offense (i.e. – planning vs. impulse)
 - Existence of deviant arousal (monitor fantasy log)
 - Impulse control
 - Delinquency
 - Mental health stability

“A continuum of support and accountability throughout transition is essential for treatment efficacy. In my opinion, this is why ARC holds the key to a flawless treatment experience! Through collaboration, a comprehensive system including NERCC or AJC, outpatient treatment, and probation can accomplish this.”

Outpatient Treatment Survey (cont.)

- “At the point of discharge, what type of documentation is provided by your agency? Does this documentation cover prognosis, risk classification, etc.?”
 - 4 out of the 8 providers use a standard discharge form that is mailed to the probation officer.
 - Other providers will typically send out a discharge letter or summary.
 - One agency gives a type of certification diploma to the offender.
 - Topics generally stated to be covered in the discharge summary:
 - Level of participation/attendance
 - Narrative on prognosis
 - Narrative on risk classification
 - List of assignments completed
 - Discharge plan including “red flags”
 - Copy of apology letter
 - Narrative on accomplishments/gains

“Communication with probation at discharge is imperative in ensuring a smooth transition back into the community.”

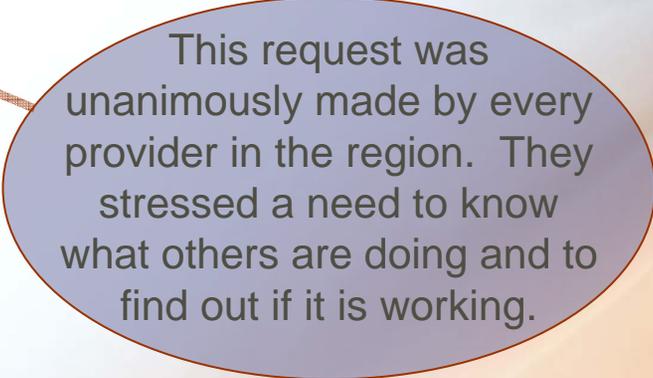
Outpatient Treatment Survey (cont.)

- **“Are you comfortable with your current relationship with the court system and probation in general? If ‘no,’ please describe why.”**
 - All providers agreed that they are comfortable with probation/courts.
 - Several stated that they enjoy co-facilitating with a probation officer when they get the opportunity.
 - One therapist thanked probation officers for educating her regarding the court system.
 - Despite the general satisfaction of providers, there were areas noted for potential improvement:
 - Need for scheduled meetings (i.e. – monthly or quarterly)
 - More collaboration and involvement (“never enough”)
 - Better communication between all parties when evaluations are ordered.
 - More immediate consequences.

“I maintain a holistic approach to recovery, and probation is an integral part of the recovery process.”

Outpatient Treatment Survey (cont.)

- **“In your opinion, is there anything that could be done to improve our current collaborative system for providing effective sex offender management/treatment? If so, what?”**
 - Develop/solidify a roundtable collaborative meeting for all sex offender treatment providers in the region.
Include:
 - Judges
 - Probation Officers
 - County Attorneys
 - Public Defenders
 - Therapists
 - Program Coordinators
 - Representative from Dep. Of Corrections
 - Shore up sentencing discrepancies (i.e. - NERCC vs. probation)
 - Probation Officers should be given more leverage to issue immediate consequences.
 - More training/education offered for treatment providers regarding how the court system operates.



This request was unanimously made by every provider in the region. They stressed a need to know what others are doing and to find out if it is working.

Outpatient Treatment Survey (cont.)

- “In your opinion, is there anything that could be done to improve our current collaborative system for providing effective sex offender management/treatment? If so, what?”
(cont.)
 - Look into alternative ways of classifying offenders/offense types. (“It is difficult to have Gross Misdemeanor offenders and Felony offenders in the same group.”)
 - Look into types of diversionary interventions for young (adolescent/pre-adolescent) offenders so as not to label them as “sex offenders.”
 - More money for, and access to, polygraph testing.

“The idea of collaboration often gets put on the back burner because providers, probation officers, whoever it may be, simply don’t agree across the board. Sadly, people forget what collaboration means. It does not call for agreement, but rather working together for the best interest of the client.”

Recommendations

- Continue to monitor minority populations not only in the specific class of sex offenders, but also throughout the correctional domain, keeping in mind the responsivity principle of effective interventions.
- Conduct a secondary level of analysis regarding sex offender's LSI-R and YLS/CMI scores. It would be beneficial to study the higher-risk domains within the assessments in comparison to what correctional practitioners are addressing in treatment and community supervision.
- For those considered "non-custody" in this report, determine the percentage of whom spent pre-trial days in local jails, and for how long.
- Re-assess recidivism for the same sample of offenders using a longer follow-up period (preferably 3-5 years).
- Revisit current ARC policies/procedures on transition from institutional to outpatient treatment.
- Convene a work-group that could report on current sex offender risk assessment and ultimately recommend one standard tool to be implemented by all treatment providers in the ARC region.
- Expand ARC's current body of sex offender research to also examine victimimology (age, gender, intrafamilial, etc.)