SB

218

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/9/06

FURTHER: Finance

Date of 5-Day Notice: ___ _____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: _____

Judiciary Committee considered SENATE BILL NO. 218

SB 218 CRIMINAL SENTENCING AND POLYGRAPHS

"An Act relating to periodic polygraph examinations for sex offenders released on probation or parole and to sentencing for sex offenders and habitual criminals."

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

CS Senate Bill:
[ ] Same Title
[ ] New Title

SCS House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
			X	
	✓			
				✓
				✓
CHAIR:			X	

24-LS1307\I.2
Luckhaupt
1/20/06

AMENDMENT #1

OFFERED IN THE SENATE BY SENATOR GUESS

TO: CSSB 218( ), Draft Version "I"

Page 7, line 18:

Delete "Act"

Insert "section"

Page 7, line 19:

Delete the second occurrence of "Act"

Insert "section"

Page 7, line 20:

Delete all material and insert:

"*** Sec. 9.** Sections 2 and 7 of this Act take effect July 1, 2007.

*** Sec. 10.** Except as provided in sec. 9 of this Act, this Act takes effect immediately under AS 01.10.070(c)."

24-LS1307\I.1
Luckhaupt
1/20/06

AMENDMENT #2

OFFERED IN THE SENATE BY SENATOR GUESS

TO: CSSB 218( ), Draft Version "I"

Page 1, line 3:

Delete the first occurrence of "**and**"

Insert "; **relating to sexual abuse of a minor; relating**"

Page 1, following line 5:

Insert a new bill section to read:

"* **Section 1.** AS 11.41.436(a) is amended to read:

(a) An offender commits the crime of sexual abuse of a minor in the second degree if,

(1) being 16 years of age or older, the offender engages in sexual penetration with a person who is 13, 14, or 15 years of age and at least three years younger than the offender, or aids, induces, causes, or encourages a person who is 13, 14, or 15 years of age and at least three years younger than the offender to engage in sexual penetration with another person;

(2) being 16 years of age or older, the offender engages in sexual contact with a person who is under 13 years of age or aids, induces, causes, or encourages a person under 13 years of age to engage in sexual contact with another person;

(3) being 18 years of age or older, the offender engages in sexual contact with a person who is under 18 years of age, and the offender is the victim's natural parent, stepparent, adopted parent, or legal guardian;

(4) being 16 years of age or older, the offender aids, induces, causes, or encourages a person who is under 16 years of age to engage in conduct described in

AS 11.41.455(a)(2) - (6); [OR]

(5) being 18 years of age or older, the offender engages in sexual contact with a person who is under 16 years of age, and

(A) the victim at the time of the offense is residing in the same household as the offender and the offender has authority over the victim; or

(B) the offender occupies a position of authority in relation to the victim;

(6) being 18 years of age or older, the offender engages in sexual penetration with a person who is 16 or 17 years of age and at least three years younger than the offender, and the offender occupies a position of authority in relation to the victim; or

(7) being under 16 years of age, the offender engages in sexual penetration with a person who is under 13 years of age and at least three years younger than the offender."

Page 1, line 6:

Delete "**Section 1**"

Insert "**Sec. 2**"

Renumber the following bill sections accordingly.

Page 7, following line 14:

Insert a new bill section to read:

"*** Sec. 9.** AS 11.41.438(a)(2) and 11.41.438(a)(3) are repealed."

Renumber the following bill sections accordingly.

Page 7, line 17:

Delete "Sections 3 - 6"

Insert "Sections 1, 2, 4 - 7, and 9"

Page 7, line 18:

Delete "secs. 3 and 5"

Insert "secs. 4 and 6"

Alaska State Legislature
Senator Con Bunde
Senate District P
Vice Chair: Senate Finance Committee
Chair: Senate Labor & Commerce Committee

Sponsor Statement for SB 218

"An Act relating to periodic polygraph examinations for sex offenders released on probation or parole and to sentencing for sex offenders and habitual criminals."

Senate Bill 218 increases sentencing times for the most egregious Unclassified and Class A sexual felonies to a minimum sentence of 25 years. It also restructures and increases the sentencing for Class B and Class C sexual offences. SB 218 requires periodic polygraph testing for sex offenders on probation and implements needed changes in sex offender registering and reporting. This bill is necessary not only to ensure Alaska is part of the national effort to curb sexual abuse and violence against children, but also to combat our ever-increasing sexual assault rates in this state.

According to the Federal Bureau of Investigation (FBI) Uniform Crime Report (UCR), *Alaska has the highest per capita rate of reported rapes* ("rapes" in this case refer to child sexual abuse as well as adult assaults). Alaska's per capita rape rate is nearly 71% greater than that of the next highest state.

To date, we have 4300 registered sex offenders in our Alaskan communities. However, sexual abuse reporting rates are low (16% of victims report the assault, *Kilpatrick Rape in America Report*, 1992) and arrest rates are also low (27% of reported sex crimes result in an arrest, Snyder, 2000). Thus, the number of sex offenders in Alaska is most likely significantly higher than 4300 individuals.

While there is no record of any sex offender treatment or therapy having significant effects on recidivism rates (SOTEP Report, 1995), there are steps we can take in this state to reduce sexual abuse and assault. Longer sentences work. By ensuring that the most dangerous offenders are kept away from our children, sexual assault numbers will eventually go down. Regular polygraph testing for all sexual offenders has also been proven to have an effect on sexual behavior. Supervision of sex offenders with polygraph tests led to a 69% compliance with probation requirements, while supervision without polygraph tests led to a 26% compliance rate (Abrams and Ogard, 1986). Requiring a probation period as part of a sentence, along with mandating regular polygraph tests will make our State safer.

This legislation is imperative to changing our position as the number one state in the nation for sexual assault and sexual abuse and providing a safer place for our residents. I urge your support.

AMENDMENT

OFFERED IN THE SENATE BY

TO: SB 218

Page 1, line 2:

Delete the first occurrence of "**and**"

Insert "**; relating to sexual abuse of a minor; and relating**"

Page 1, following line 3:

Insert a new bill section to read:

"* **Section 1.** AS 11.41.436(a) is amended to read:

(a) An offender commits the crime of sexual abuse of a minor in the second degree if,

(1) being 16 years of age or older, the offender engages in sexual penetration with a person who is 13, 14, or 15 years of age and at least three years younger than the offender, or aids, induces, causes, or encourages a person who is 13, 14, or 15 years of age and at least three years younger than the offender to engage in sexual penetration with another person;

(2) being 16 years of age or older, the offender engages in sexual contact with a person who is under 13 years of age or aids, induces, causes, or encourages a person under 13 years of age to engage in sexual contact with another person;

(3) being 18 years of age or older, the offender engages in sexual contact with a person who is under 18 years of age, and the offender is the victim's natural parent, stepparent, adopted parent, or legal guardian;

(4) being 16 years of age or older, the offender aids, induces, causes, or encourages a person who is under 16 years of age to engage in conduct described in

AS 11.41.455(a)(2) - (6); [OR]

(5) being 18 years of age or older, the offender engages in sexual contact with a person who is under 16 years of age, and

(A) the victim at the time of the offense is residing in the same household as the offender and the offender has authority over the victim; or

(B) the offender occupies a position of authority in relation to the victim;

(6) being 18 years of age or older, the offender engages in sexual penetration with a person who is 16 or 17 years of age and at least three years younger than the offender, and the offender occupies a position of authority in relation to the victim; or

(7) being under 16 years of age, the offender engages in sexual penetration with a person who is under 13 years of age and at least three years younger than the offender."

Page 1, line 4:

Delete "**Section 1**"

Insert "**Sec. 2**"

Renumber the following bill sections accordingly

Page 6, following line 21:

Insert a new bill section to read:

"* **Sec. 7.** AS 11.41.438(a)(2) and 11.41.438(a)(3) are repealed."

Renumber the following bill section accordingly

Page 6, line 24:

Delete "Section 2 of this Act applies"

Insert "Sections 1 and 3 of this Act apply"

Page 6, line 25:

Delete "sec. 2"

Insert "sec. 3"

24-LS1307\I
Luckhaupt
1/17/06

CS FOR SENATE BILL NO. 218( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS BUNDE, Guess, Dyson, Elton, Kookesh, Green, Olson, Hoffman

A BILL

FOR AN ACT ENTITLED

"An Act relating to sex offenders; relating to reporting of sex offenders and child kidnappers; relating to periodic polygraph examinations for sex offenders released on probation or parole and to sentencing for sex offenders and habitual criminals; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 11.56 is amended by adding a new section to read:

Sec. 11.56.767. Failure to report sex offender or child kidnapper. (a) A person commits the crime of failure to report a sex offender or child kidnapper if the person

(1) recklessly disregards the fact that a sex offender or child kidnapper has not complied with the requirements of AS 11.56.840; and

(2) knowingly fails to report the location of that sex offender or child kidnapper to the Department of Public Safety.

(b) Failure to report a sex offender or child kidnapper is a class C felony.

* **Sec. 2.** AS 12.55.100 is amended by adding a new subsection to read:

(e) While on probation and as a condition of probation for a sex offense, the defendant shall be required to submit to regular periodic polygraph examinations. In this subsection, "sex offense" has the meaning given in AS 12.63.100.

* **Sec. 3.** AS 12.55.125(i) is amended to read:

(i) A defendant convicted of

(1) sexual assault in the first degree or sexual abuse of a minor in the first degree may be sentenced to a definite term of imprisonment of not more than 99 years and shall be sentenced to a definite term within the following presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(A) if the offense is a first felony conviction, [AND] does not involve circumstances described in (B) of this paragraph, **and the victim was**

(i) less than 13 years of age, 25 to 30 years;

(ii) 13 years of age or older, 20 to 30 [EIGHT TO 12] years;

(B) if the offense is a first felony conviction and the defendant possessed a firearm, used a dangerous instrument, or caused serious physical injury during the commission of the offense, **25 to 35** [12 TO 16] years;

(C) if the offense is a second felony conviction and does not involve circumstances described in (D) of this paragraph, **30 to 40** [15 TO 20] years;

(D) if the offense is a second felony conviction and the defendant has a prior conviction for a sexual felony, **35 to 45** [20 TO 30] years;

(E) if the offense is a third felony conviction and the defendant is not subject to sentencing under (F) of this paragraph or (*l*) of this section, **40 to 60** [25 TO 35] years;

(F) if the offense is a third felony conviction, the defendant is not subject to sentencing under (*l*) of this section, and the defendant has two prior convictions for sexual felonies, **99** [30 TO 40] years;

(2) attempt, conspiracy, or solicitation to commit sexual assault in the

first degree or sexual abuse of a minor in the first degree may be sentenced to a definite term of imprisonment of not more than **99** [30] years and shall be sentenced to a definite term within the following presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(A) if the offense is a first felony conviction, [AND] does not involve circumstances described in (B) of this paragraph, **and the victim was**

(i) under 13 years of age, 20 to 25 years;

(ii) 13 years of age or older, 15 to 25 [FIVE TO EIGHT] years;

(B) if the offense is a first felony conviction, and the defendant possessed a firearm, used a dangerous instrument, or caused serious physical injury during the commission of the offense, **25 to 35** [10 TO 14] years;

(C) if the offense is a second felony conviction and does not involve circumstances described in (D) of this paragraph, **25 to 35** [12 TO 16] years;

(D) if the offense is a second felony conviction and the defendant has a prior conviction for a sexual felony, **30 to 40** [15 TO 20] years;

(E) if the offense is a third felony conviction, does not involve circumstances described in (F) of this paragraph, and the defendant is not subject to sentencing under (*l*) of this section, **35 to 50** [15 TO 25] years;

(F) if the offense is a third felony conviction, the defendant is not subject to sentencing under (*l*) of this section, and the defendant has two prior convictions for sexual felonies, **99** [20 TO 30] years;

(3) sexual assault in the second degree, sexual abuse of a minor in the second degree, unlawful exploitation of a minor, or distribution of child pornography may be sentenced to a definite term of imprisonment of not more than **99** [20] years and shall be sentenced to a definite term within the following presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(A) if the offense is a first felony conviction, **10 to 15** [TWO TO FOUR] years;

(B) if the offense is a second felony conviction and does not involve circumstances described in (C) of this paragraph, **10 to 25** [FIVE TO EIGHT] years;

(C) if the offense is a second felony conviction and the defendant has a prior conviction for a sexual felony, **15 to 30** [10 TO 14] years;

(D) if the offense is a third felony conviction and does not involve circumstances described in (E) of this paragraph, **20 to 35** [10 TO 14] years;

(E) if the offense is a third felony conviction and the defendant has two prior convictions for sexual felonies, **99** [15 TO 20] years;

(4) sexual assault in the third degree, incest, indecent exposure in the first degree, possession of child pornography, or attempt, conspiracy, or solicitation to commit sexual assault in the second degree, sexual abuse of a minor in the second degree, unlawful exploitation of a minor, or distribution of child pornography, may be sentenced to a definite term of imprisonment of not more than **99** [10] years and shall be sentenced to a definite term within the following presumptive ranges, subject to adjustment as provided in AS 12.55.155 - 12.55.175:

(A) if the offense is a first felony conviction, **three to 12** [ONE TO TWO] years;

(B) if the offense is a second felony conviction and does not involve circumstances described in (C) of this paragraph, **eight to 15** [TWO TO FIVE] years;

(C) if the offense is a second felony conviction and the defendant has a prior conviction for a sexual felony, **12 to 20** [THREE TO SIX] years;

(D) if the offense is a third felony conviction and does not involve circumstances described in (E) of this paragraph, **15 to 25** [THREE TO SIX] years;

(E) if the offense is a third felony conviction and the defendant has two prior convictions for sexual felonies, **99** [SIX TO 10] years.

*** Sec. 4.** AS 12.55.125(j) is amended to read:

(j) A defendant sentenced to a (1) mandatory term of imprisonment of 99 years under (a) of this section may apply once for a modification or reduction of sentence under the Alaska Rules of Criminal Procedure after serving one-half of the mandatory term without consideration of good time earned under AS 33.20.010, or (2) definite term of imprisonment under (*l*) of this section may apply once for a modification or reduction of sentence under the Alaska Rules of Criminal Procedure after serving [THE GREATER OF (A)] one-half of the definite term [OR (B) 30 YEARS]. A defendant may not file and a court may not entertain more than one motion for modification or reduction of a sentence subject to this subsection, regardless of whether or not the court granted or denied a previous motion.

*** Sec. 5.** AS 12.55.125(*l*) is amended to read:

(*l*) Notwithstanding any other provision of law, a defendant convicted of an unclassified or class A felony offense, and not subject to a mandatory 99-year sentence under (a) of this section, shall be sentenced to a definite term of imprisonment of [AT LEAST 40 YEARS BUT NOT MORE THAN] 99 years when the defendant has been previously convicted of two or more most serious felonies [AND THE PROSECUTING ATTORNEY HAS FILED A NOTICE OF INTENT TO SEEK A DEFINITE SENTENCE UNDER THIS SUBSECTION AT THE TIME THE DEFENDANT WAS ARRAIGNED IN SUPERIOR COURT]. If a defendant is sentenced to a definite term under this subsection,

(1) imprisonment for the prescribed definite term may not be suspended under AS 12.55.080;

(2) imposition of sentence may not be suspended under AS 12.55.085;

(3) imprisonment for the prescribed definite term may not be reduced, except as provided in (j) of this section.

*** Sec. 6.** AS 12.55.125 is amended by adding a new subsection to read:

(o) In addition to the sentence imposed under (i) of this section on a defendant convicted of a sexual offense, the court shall impose a period of probation of (1) 10 years if the defendant was convicted of an unclassified or class A felony, or (2) five years if the defendant was convicted of a class B or class C felony. The period of

probation is in addition to any sentence received under (i) of this section and may not be suspended or reduced. Upon a defendant's release from confinement in a correctional facility, the defendant is subject to this probation requirement and shall submit and comply with the terms and requirements of the probation.

*** Sec. 7.** AS 33.16.150(a) is amended to read:

(a) As a condition of parole, a prisoner released on special medical, discretionary, or mandatory parole

(1) shall obey all state, federal, or local laws or ordinances, and any court orders applicable to the parolee;

(2) shall make diligent efforts to maintain steady employment or meet family obligations;

(3) shall, if involved in education, counseling, training, or treatment, continue in the program unless granted permission from the parole officer assigned to the parolee to discontinue the program;

(4) shall report

(A) upon release to the parole officer assigned to the parolee;

(B) at other times, and in the manner, prescribed by the board or the parole officer assigned to the parolee;

(5) shall reside at a stated place and not change that residence without notifying, and receiving permission from, the parole officer assigned to the parolee;

(6) shall remain within stated geographic limits unless written permission to depart from the stated limits is granted the parolee;

(7) may not use, possess, handle, purchase, give, distribute, or administer a controlled substance as defined in AS 11.71.900 or under federal law or a drug for which a prescription is required under state or federal law without a prescription from a licensed medical professional to the parolee;

(8) may not possess or control a firearm; in this paragraph, "firearm" has the meaning given in AS 11.81.900;

(9) may not enter into an agreement or other arrangement with a law enforcement agency or officer that will place the parolee in the position of violating a law or parole condition without the prior approval of the board;

(10) may not contact or correspond with anyone confined in a correctional facility of any type serving any term of imprisonment or a felon without the permission of the parole officer assigned to a parolee;

(11) shall agree to waive extradition from any s[illegible] or territory of the United States and to not contest efforts to return the parolee to the state;

(12) shall provide a blood sample, an oral sample, or both, when requested by a health care professional acting on behalf of the state to provide the sample or samples, or an oral sample when requested by a juvenile or adult correctional, probation, or parole officer, or a peace officer, if the prisoner is being released after a conviction of an offense requiring the state to collect the sample or samples for the deoxyribonucleic acid identification system under AS 44.41.035;

(13) from a conviction for a sex offense shall submit to regular periodic polygraph examinations; in this paragraph, "sex offense" has the meaning given in AS 12.63.100.

*** Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. Sections 3 - 6 of this Act apply to offenses committed on or after the effective date of this Act. References to prior offenses or convictions in secs. 3 and 5 of this Act include offenses committed before, on, or after the effective date of this Act.

*** Sec. 9.** This Act takes effect July 1, 2007.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB218-DPS-AST-1-18-06
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Public Safety
Title: An Act relating to periodic polygraph examinations for sex offenders and an increase in sentencing
RDU: Alaska State Troopers
Component: AST Detachments
Sponsor: Senator Bunde
Requester: Senate Judiciary Committee
Component No.: 2325

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

The first section of this bill provides for the implementation and continued use of periodic polygraph examinations as a condition of probation or parole for sex offenders. This provision will have little or no impact to the Department of Public Safety, but will directly impact the Department of Corrections.

This bill also significantly increases sentences for convictions under sexual assault and sexual abuse. When a defendant is faced with a longer term of imprisonment, it is reasonable to expect that they may mount a more aggressive defense. It is difficult to predict if extra court testimony will be required as a result of this legislation or whether it increases the complexity of an investigation. At this juncture the department will absorb any unforeseen expenses associated with this legislation.

Prepared by: Lieutenant James Helgoe
Phone 907-269-4532
Division: Alaska State Troopers
Date/Time 1/18/06 4:23 PM
Approved by: Commissioner William Tandeske
Date 1/18/2006
Agency: Department of Public Safety

(Revised 9/23/2004 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB218-LAW-CJL-1-18-0
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: LAW
Title "An Act relating to periodic polygraph examinations for sex offenders released on probation..."
RDU CRIMINAL
Component Criminal Justice Litigation
Sponsor Senator Bunde
Requester Senate Judiciary
Component No.

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING						
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL						

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill significantly increases presumptive sentencing for convicted sexual offenders. Passage of this legislation will have a fiscal impact on the Department of Law because convicted offenders will be less likely to plead to charges and will instead be willing to risk a jury trial as a result of facing much longer prison sentences than is reflected in current legislation. The fiscal impact is difficult to measure with any precision.

Prepared by: Kathryn Daughhetee, Director
Phone 465-3673
Division Administrative Services Division
Date/Time 1/18/06 1:21 PM
Approved by: Kathryn Daughhetee for David Márquez, Attorney General
Date 1/18/2006
Agency Department of Law

(Revised 9/7/2005 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 218
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title: An Act relating to periodic polygraph examinations...
RDU: Legal and Advocacy Services
Component: Office of Public Advocacy
Sponsor: Senator Bunde
Requester: (S) Finance
Component No.: 43

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	*	*	*	*	*	*
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	*	*	*	*	*	*
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	*	*	*	*	*	*
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type–Do not abbreviate)						
TOTAL	*	*	*	*	*	*

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This act increases the periodic presumptive sentencing ranges for a certain sex offense; this includes a 99-year mandatory penalty for individuals with two prior sex felony convictions. This bill also requires individuals convicted of sex offenses to submit to a polygraph examination.

Due to the penalty increases, this bill will likely result in pressures that tend to increase criminal trials and increase the work necessary to prepare a case for trial or plea negotiation, thus putting an upward pressure on our case costs. The increased pressure, however, is indeterminate but may be mitigated by factors external to the Office of Public Advocacy, such as an offsetting plea bargaining policy. The Office of Public Advocacy, therefore, submits an indeterminate fiscal note.

Prepared by: Joshua P. Fink, Director
Phone: 907.269-3500
Division: Office of Public Advocacy
Date/Time: 1/18/06 12:16 p.m.
Approved by: Mike Tibbles, Deputy Commissioner
Date:
Agency: Administration

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 218
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Administration
Title: An Act relating to periodic polygraph examinations...
RDU: Legal and Advocacy Services
Component: Public Defender Agency
Sponsor: Senator Bunde
Requester: (S) Finance
Component No.: 1631

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services	*	*	*	*	*	*
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	*	*	*	*	*	*
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	*	*	*	*	*	*
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type–Do not abbreviate)						
TOTAL	*	*	*	*	*	*

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

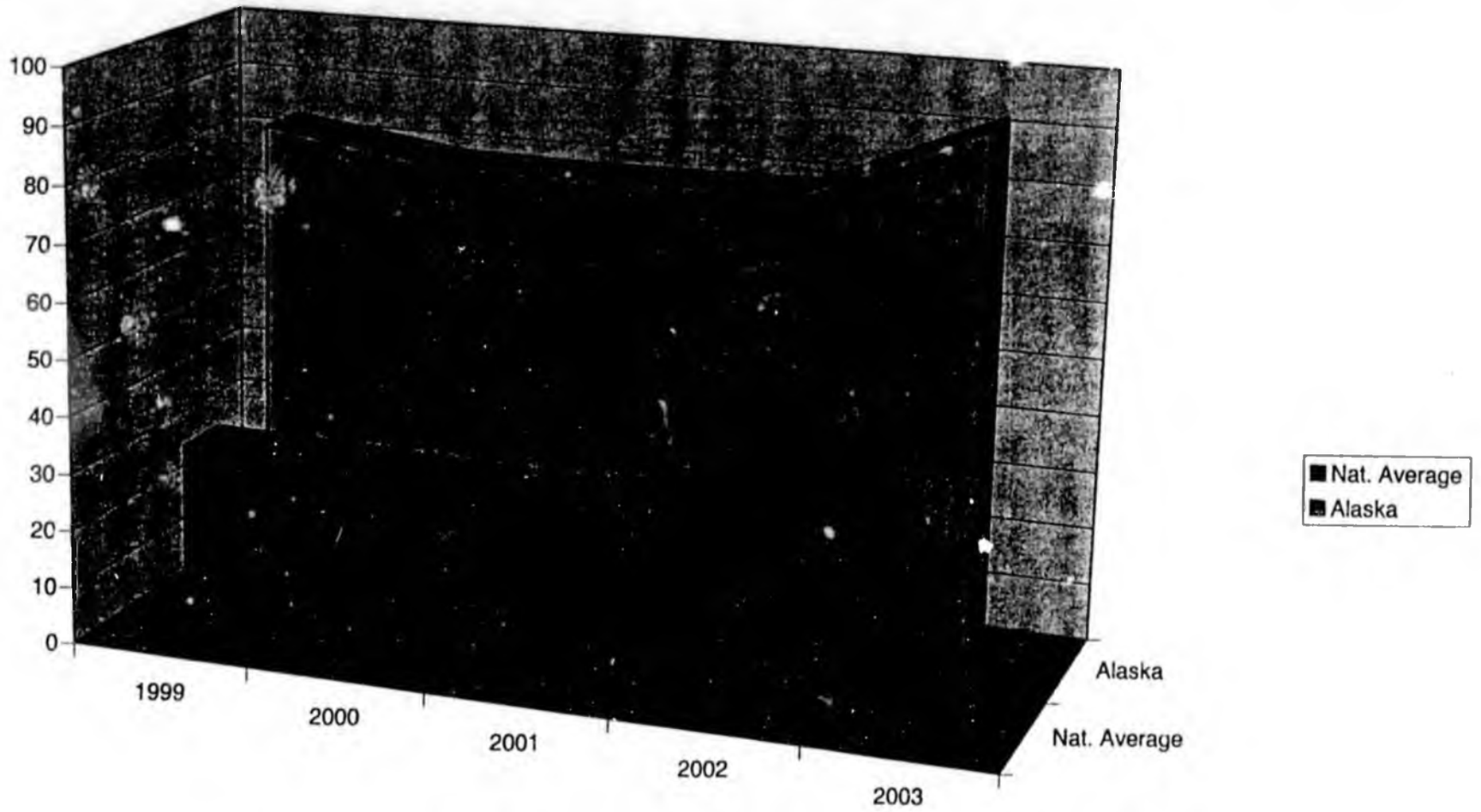
This act increases the periodic presumptive sentencing ranges for a certain sex offense; this includes a 99-year mandatory penalty for individuals with two prior sex felony convictions. This bill also requires individuals convicted of sex offenses to submit to a polygraph examination.

Due to the penalty increases, this bill will likely result in pressures that tend to increase criminal trials and increase the work necessary to prepare a case for trial or plea negotiation, thus putting an upward pressure on our case costs. The increased pressure, however, is indeterminate but may be mitigated by factors external to the Public Defender Agency, such as an offsetting plea bargaining policy. The Public Defender Agency, therefore, submits an indeterminate fiscal note.

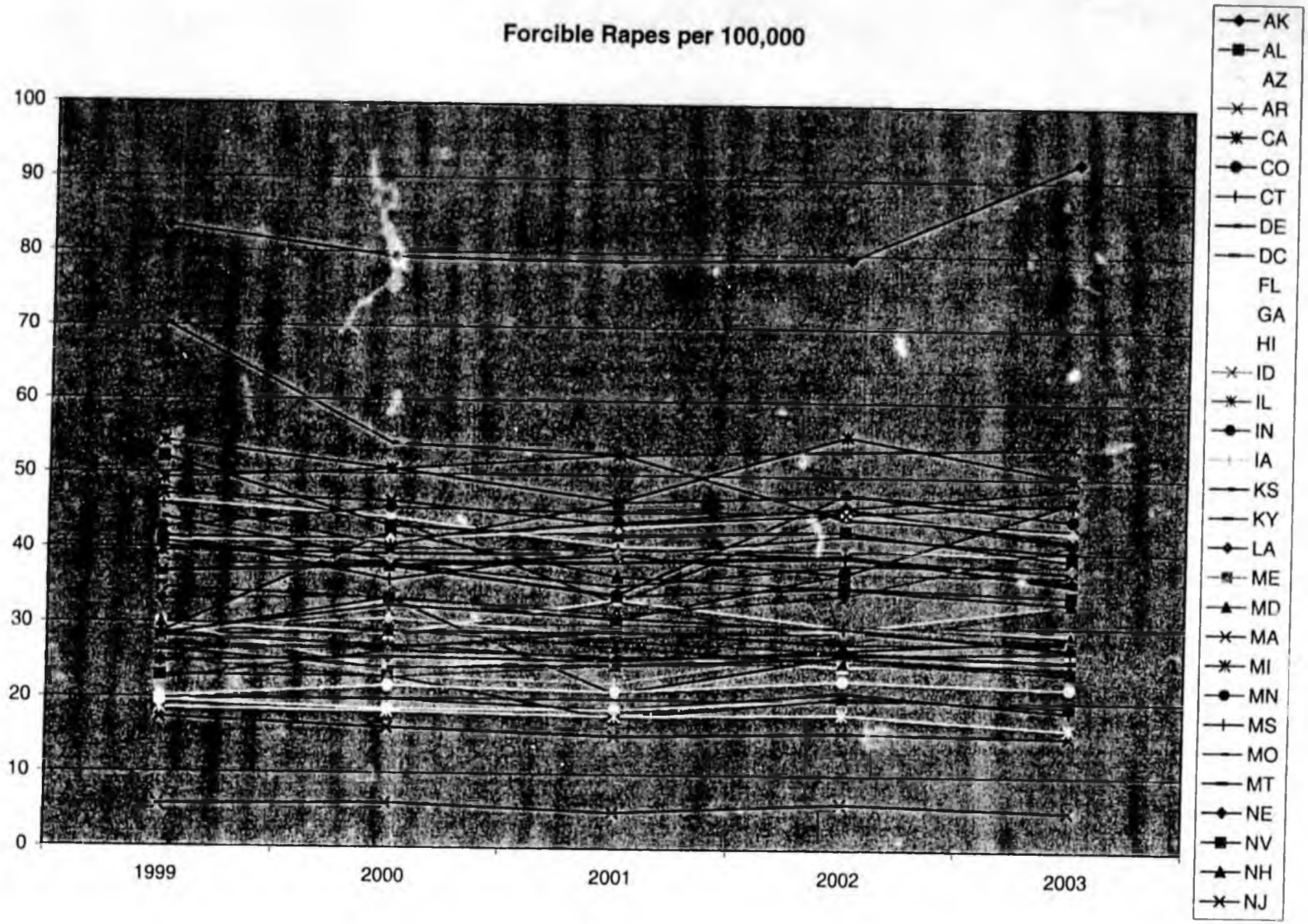
Prepared by: Quinlan Steiner, Director
Phone: 907.334.4414
Division: Public Defender Agency
Date/Time: 1/17/06 1:00 p.m.
Approved by: Mike Tibbles, Deputy Commissioner
Date:
Agency: Administration

(Revised 9/7/2005 OMB)

Forcible rapes per 100,000



	1999	2000	2001	2002	2003
Nat. Average	34.16538462	33.42692308	32.62115385	34.08846154	33.68846154
Alaska	83.5	79.3	78.9	79.4	92.5

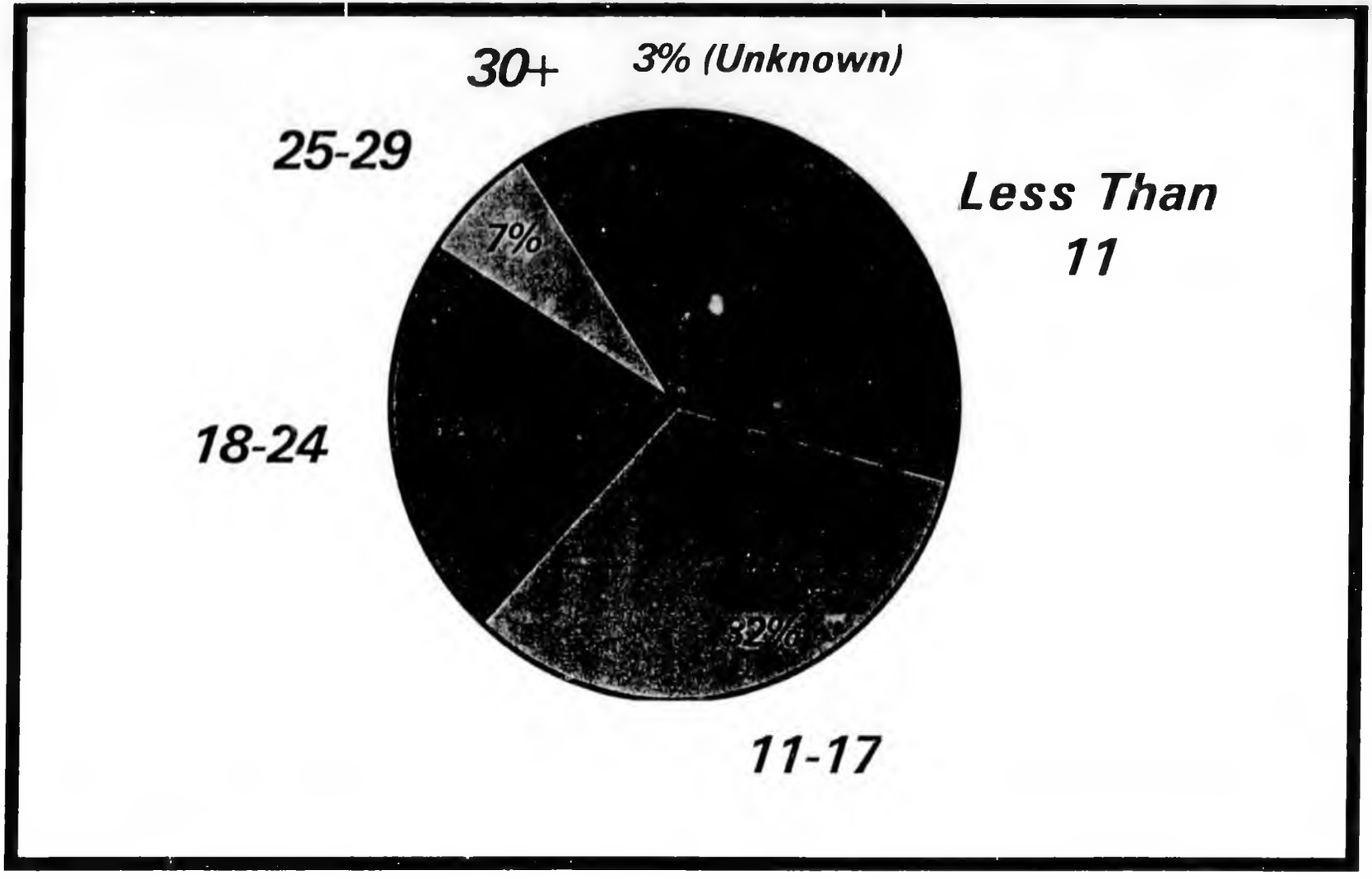

Forcible Rapes per 100,000
100
90
80
70
60
50
40
30
20
10
0
1999
2000
2001
2002
2003
AK
AL
AZ
AR
CA
CO
CT
DE
DC
FL
GA
HI
ID
IL
IN
IA
KS
KY
LA
ME
MD
MA
MI
MN
MS
MO
MT
NE
NV
NH
NJ

Forcible Rapes in Western States, 2003

State	Population	Forcible Rapes	Rapes per 100,000 Inhabitants
Alaska	648,818	600	92.5
New Mexico	1,874,614	937	50.0
Washington	6,131,445	2,864	46.7
Colorado	4,550,688	1,893	41.6
Nevada	2,241,154	874	39.0
Utah	2,351,467	892	37.9
Idaho	1,366,332	508	37.2
Oregon	3,559,596	1,218	34.2
Arizona	5,580,811	1,856	33.3
Hawaii	1,257,608	367	29.2
California	35,484,453	9,994	28.2
Montana	917,621	246	26.8

Source: Federal Bureau of Investigation, *Uniform Crime Report*, Table 5: "Crime in the United States, by State, 2003;" available online at *www.fbi.gov/ucr/03clus.htm*.

Age of Victim at Time of Rape



National Women's Study (n=714)

Forcible Rapes ↑ Increased 21.7%

Reported rapes in Alaska increased 21.7% from 2000 to 2003

Although greatly underreported, there were 521 reported forcible rapes and 54 reported attempted rapes in 2003.

There are approximately 4300 registered sex offenders in Alaska communities.

Alaska Dept. of Public Safety Uniform Crime Reporting

Only 16% of victims in the *Rape in America* study reported the rape.

Kilpatrick, et al.,1992. Medical University of South Carolina.
N=4008 *Rape in America: A Report to the Nation.*

Arrest Rates are Low

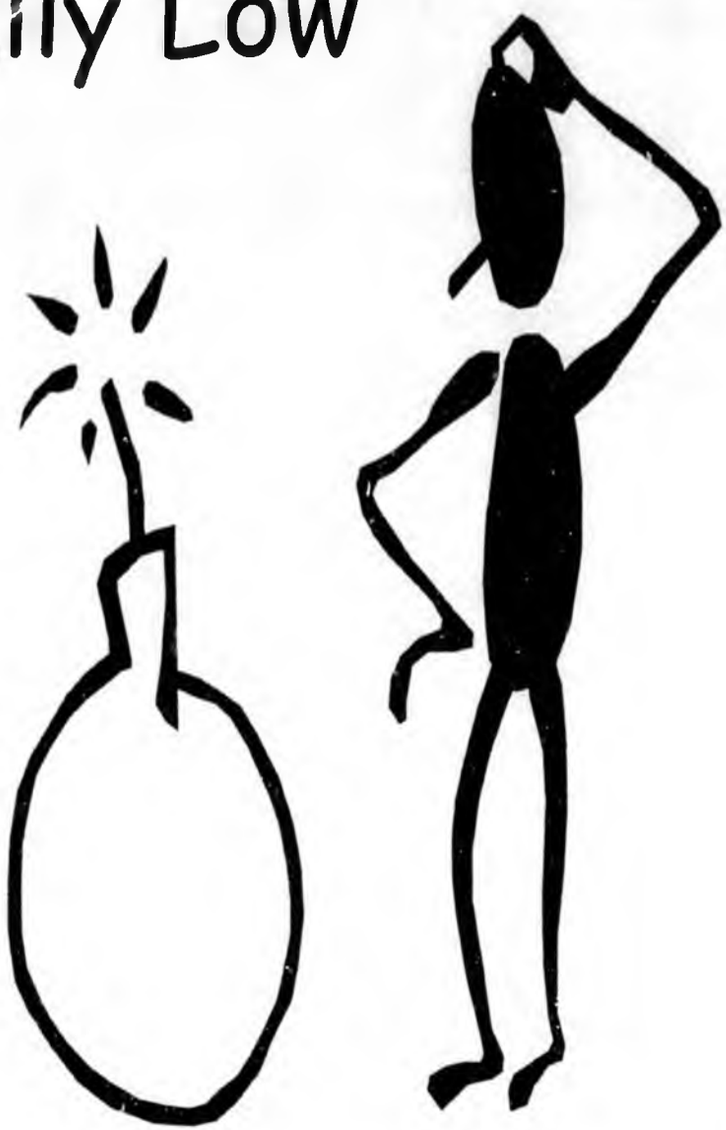
27% of reported sex crimes resulted in an arrest

NIBRS 1991-1996, Snyder, 2000

In Colorado, between 1994-98, 54%-70% of those charged with a felony sex crime were convicted of a sex crime.

Sex Offender Recidivism Rates: Artificially Low

- Incest: 4-10%
- Rapists: 7-35%
- Child Molesters with female victims: 10-29%
- Child Molesters with male victims: 13-40%
- Exhibitionists: 41-71%



Marshall and Barbaree (1990)

Crossover Admissions Pre & Post Polygraph N =223

(Heil, Ahlmeyer, Simon, 2003)

Type of Crossover	Official records	Admissions after Treatment and polygraph testing
Both Adult & Child Victims	7.2%	70.0%
Both Male & Female Victims	8.5%	35.9%
Victims from 2 or more Relationship types	16.6%	79.8%

Secrets Revealed

Polygraph Research at the Colorado DOC

Comparing Court Information v. Polygraph

	# of victims	# of offenses
Information at Sentencing	2 (1)	7 (1)
Sex History	83 (21)	394 (50)
1st Polygraph	165 (24)	511 (95)
2nd Polygraph	184 (26)	528 (95)

Alhmeyer et al., 2000, studied 35 sex offenders in treatment and polygraph testing at the CO Dept. of Corrections.
Average admission (median) of contact & noncontact offenses

Polygraph Research at the Colorado DOC

Comparing Court Information v. Polygraph

Admissions of Hands-on Crossover Offending

223 Sex Offenders Participating in SOTMP TC at the Colorado Department of Corrections

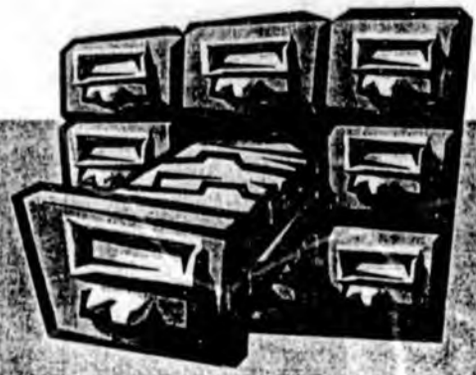
Type of Crossover	Court	Polygraph
Adult & Child Victims	7%	70%
Male & Female Victims	9%	36%
Multiple Relationships	20%	86%

Heil, Ahlmeyer, Simons (2003)

180 convicted sex offenders on probation and parole in TX, WI, OR

Current Conviction Crime: Incest

n=80



Ever assaulted...

Assaulted strangers	35%
Assaulted from position of trust	57%
Assaulted adult victims	36%

Colorado Division of Criminal Justice, ORS 2000. NIJ grant D97LBVX0034

Average Age of Onset

Study	Type of Offender	Age of Onset
Freeman-Longo(1985)	Rapist	18
	Child Molester	15
Elliot (1984)	Juvenile Rapists	16 peak
Emerick & Dutton(1993)	Juvenile Child Molesters	13 median
Ahlmeyer et al.(2000)	Inmates	12
English et al.(2001)	Supervised on Parole or Probation	12

Average Lag Time in Detection

Study	Type of Offender	# of Years
Freeman-Longo (1985)	Rapist	6
	Child Molester	13
Elliot (1986)*	Paraphiliacs	10
Ahlmeyer et al.(2000)	Rapists and Child Molesters	16

* as cited by Abel, Wisconsin Training Tapes

Polygraph as a Deterrent

Abrams and Ogard, 1986

Studied the deterrent effect of polygraph on offenders on probation:

- Supervision **with** polygraph - **63%** successful compliance with probation
- Supervision **without** polygraph - **26%** successful compliance with probation

Sexual Abuse: A Journal of Research and Treatment, Vol. 17, No. 1, January 2005 (© 2005)
DOI: 10.1007/s11194-005-1212-y

Effects of a Relapse Prevention Program on Sexual Recidivism: Final Results From California's Sex Offender Treatment and Evaluation Project (SOTEP)

Janice K. Marques,[1] Mark Wiederanders,[1,3] David M. Day,[1] Craig Nelson,[2] and Alice van Ommeren[1]

Final results from a longitudinal investigation of the effectiveness of cognitive-behavioral treatment with sexual offenders are presented. The study was a randomized clinical trial that compared the reoffense rates of offenders treated in an inpatient relapse prevention (RP) program with the rates of offenders in two (untreated) prison control groups. No significant differences were found among the three groups in their rates of sexual or violent reoffending over an 8-year follow-up period. This null result was found for both rapists and child molesters, and was confirmed in analyses using time to reoffense as the outcome and those controlling for static risk differences across the groups. Closer examination of the RP group's performance revealed that individuals who met the program's treatment goals had lower reoffense rates than those who did not. Although our results do not generally support the efficacy of the RP model, they do suggest a number of ways in which this kind of treatment program can be improved. This study also emphasizes the importance of including appropriate control groups in treatment outcome research. Additional controlled investigations are needed to address the many questions that remain about when and how treatment works for sexual offenders.

KEY WORDS: randomized clinical trial; sexual offender treatment; relapse prevention; treatment outcome; recidivism.

[1]California Department of Mental Health, Sacramento, California.
[2]Atascadero State Hospital, Atascadero, California.
[3]To whom correspondence should be addressed at California Department of Mental Health, 1600 Ninth Street, Sacramento, California 95814; e-mail: mwiedera@dmhhq.state.ca.us.

Fifteen years ago, Furby, Weinrott, and Blackshaw (1989) conducted a thorough review of existing studies of sexual offender treatment, and concluded that, "There is as yet no evidence that clinical treatment reduces rates of sex offenses in general and no appropriate data for assessing whether it may be differentially effective for different types of offenders" (p. 27). They also called upon researchers and fu ding agencies to devote the time and resources necessary to conduct methodologically sound investigations of sexual offender recidivism and efforts to reduce it through treatment.

Since that time, dozens of outcome studies have been completed, many of which have found significant reductions in recidivism among treated groups (e.g., Borduin, Schaeffer, & Heilblum, 2000; Huot, 2002; Looman, Abracen, & Nicholaichuk, 2000; McGrath, Cumming, Livingston, & Hoke, 2003; Nicholaichuk, Gordon, Gu, & Wong, 2000; Zgoba, Sager, & Witt, 2003). As a result, recent reviews and meta-analyses have come to more optimistic conclusions about treatment effects (e.g., Craig, Browne, & Stringer, 2003; Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Grossman, Martis, & Fichtner, 1999), and there appears to be a growing consensus that current treatment approaches can indeed lower an offender's risk of sexual reoffense. Perhaps the strongest evidence of this comes from the recent collaborative outcome data project conducted by Hanson et al. (2002). Although few of the studies in this meta-analysis used true randomized designs, data were included from a wide range of treatment programs and a total of over 9,000 sexual offenders. Overall, the sexual reoffense rate was lower for the treated offenders (12.3%) than for those in the comparison groups (16.8%). More importantly, studies of contemporary treatment approaches (cognitive behavioral or systemic) reported a reduction in sexual recidivism from 17.4 to 9.9%.

Despite this developing sense of optimism about sexual offender treatment, not everyone in the field is convinced. For example, Rice and Harris (2003) reviewed the studies in the Hanson et al. (2002) meta-analysis and indicated that most had designs that were too weak to support conclusions about treatment effects. Others (Berliner, 2002; Prentky, 2003) have emphasized that important questions remain about the size, significance and stability of treatment effects over time, and about whether current research results can be generalized to the highest risk offenders. Even those reporting positive findings have pointed out significant gaps in our knowledge base and have called for vigorous research to improve our understanding of how and when sexual offender treatment works (Gallagher et al., 1999; Hanson et al., 2002).

The study described here, California's Sex Offender Treatment and Evaluation Project (SOTEP), was a longitudinal investigation that was specifically designed to add to our developing knowledge base on treatment effectiveness. By rigorously testing the impact of a contemporary treatment approach on sexual offenders who volunteered for treatment, we hoped to provide at least some answers to the question, "What kinds of treatment work for what kinds of

offenders under what conditions?" This project represents the first true randomized trial of modern cognitive-behavioral approaches with incarcerated adult sexual offenders.

OVERVIEW OF SOTEP

In the early 1980s, the California State Legislature ended the state's Mentally Disordered Sex Offender commitment program and required that a new state hospital program be established for sexual offenders who volunteered for treatment during the last 2 years of their prison terms (California Laws, 1981). It was further mandated that this was to be a small (less than 50 beds) program that was "established according to a valid experimental design in order that the most effective, newest and promising methods of treatment of sex offenders may be rigorously tested." (California Laws, 1981, 1982). These requirements, along with the fact that there were over 16,000 sexual offenders in California prisons at the time, provided the conditions under which a random assignment study of treatment effectiveness could be conducted.

In 1984, the California Department of Mental Health's proposal for the innovative treatment program and its evaluation was accepted and subsequently funded by the Legislature. Important features of this new project included (a) an experimental design that included random assignment of volunteers to either treatment or no-treatment conditions; (b) an intensive, cognitive-behavioral inpatient treatment program designed specifically to prevent relapse among sexual offenders; (c) a 1-year aftercare program in the community; and (d) a program evaluation that measured both in-treatment changes and long-term outcomes, including a follow-up period in which recidivism rates for treated and untreated participants were tracked for at least 5 years. SOTEP's treatment program operated at Atascadero State Hospital from 1985–1995; data collection for the program evaluation began in 1985 and continued for 6 years after the treatment unit closed.

Although we have published findings from several earlier panels of outcome data (Marques, Day, Nelson, Miner, & West, 1991; Marques, Day, Nelson, & West, 1994; Marques, Nelson, West, & Day, 1994; Marques, 1999), these have been in the form of preliminary studies or progress reports. The analyses that we present here are based on the last panel of SOTEP outcome data (collected in 2001), and represent our final results.

METHOD

Design

The impact of SOTEP's treatment program was determined by comparing the postrelease activities of three matched groups of participants:

Relapse prevention (RP) group. Sexual offenders who volunteered to participate and were randomly assigned to treatment at Atascadero State Hospital.

Volunteer control (VC) group. Sexual offenders in prison who volunteered but were randomly selected for no treatment. This was the primary comparison group for the treatment outcome study.

Nonvolunteer control (NVC) group. Inmates who qualified for the project but chose not to participate. This was a secondary comparison group that allowed us to track sexual offenders who did not want treatment as well as those who did.

Procedure

Study participants were involved in four phases of the project:

Selection

Between 1985 and 1994, SOTEP staff regularly visited California prisons to identify and interview eligible inmates, and to collect background information from their records. In the interview, the study's methods were explained (including the randomized group assignments, the program's assessment and treatment methods, and the program evaluation data to be collected), a brief mental status exam was conducted, and consent forms were signed by inmates who agreed to participate. Then, pairs of those who volunteered were matched on the variables of age (over or under 40 years), criminal history (prior felony conviction or not), and type of offender (rapist, molester with male victim, molester with female victim, or molester with victims of both sexes). One member of each matched pair was then assigned at random to the RP group, and the other assigned to the VC group. Matched offenders for the NVC group were selected later, also at random, from the pool of inmates who did not volunteer for the study.

Treatment

During this phase, members of the treatment group participated in an intensive 2-year treatment program at Atascadero State Hospital, a licensed and JCAHO accredited secure forensic treatment facility in California's central coast region. Members of the two control groups remained in prison and did not receive any treatment services from project staff. It should also be noted that although California prisons employed clinicians and offered some counseling to inmates (such as anger management and substance abuse groups), there was no organized sexual offender treatment program in the state's Department of Corrections during the time that SOTEP's program operated (1985–1995). Shortly before their release from either hospital or prison, all study participants were scheduled for

an interview with SOTEP research staff, and were asked to complete several assessment measures.

Aftercare

Following their hospital stays, RP group members participated in the Sex Offender Aftercare Program (SOAP) for 1 year. These services, which were provided in the offender's community by contract clinicians who were trained in RP by SOTEP clinical staff, were a condition of the participants' parole. This meant that failure to attend SOAP could result in a parole revocation and return to prison. Members of the two control groups were also supervised by parole agents after their release from prison. With the exception of several small pilot programs during the 1990s, the Department of Corrections had no sexual offender treatment programs for inmates leaving prison during our study period. At the end of the aftercare phase, SOTEP research staff conducted interviews with all RP group members and with control group members who volunteered to be interviewed.

Follow-Up

This phase overlapped the aftercare phase, and continued until the end of June 2000, when all but a few study participants had been at risk for at least 5 years. During follow-up, SOTEP staff regularly reviewed a variety of official records on all participants and recorded new offense information. Because of the lag in the posting of reoffense data, it was necessary to continue data collection into 2001 to detect all of the reoffenses that had occurred during the follow-up period. In addition to official record information, we collected some follow-up information from interviews with participants during this period.

Participants

All of the sexual offenders in this study were men from institutions within the California Department of Corrections, where they were serving sentences for child molestation or rape. Inmates who had offended in concert (e.g., gang rape) or only against their biological children (incest) were excluded from eligibility. In addition, participation was limited to inmates who (a) were within 18–30 months of release, (b) were between the ages of 18 and 60 years, (c) had no more than two felony convictions prior to their instant offenses, (d) admitted committing a sexual offense, (e) did not have pending immigration holds or felony warrants, (f) had estimated IQs above 80, (g) spoke English, (h) did not have a psychotic or organic mental condition, (i) were not so medically debilitated as to require skilled nursing care, and (j) had not presented severe management problems in prison.

Over the course of the project, SOTEP collected information from the prison records of over 1,400 men who were eligible for the study. Nearly three quarters (72.4%) of the eligibles were serving terms for child molestation, and the remainder (27.6%) were convicted rapists. Approximately one third of the eligible inmates interviewed for the project volunteered to participate. Although the most common reasons inmates gave for volunteering were to understand themselves or get help for their problems, discomfort as sexual offenders in prison was also reported as a factor. Similarly, although many of the nonvolunteers indicated that they did not want treatment, others refused because they had good job assignments, were located near family, or did not want to become state hospital patients. Overall, volunteers did not differ from the nonvolunteers on demographic and criminal history factors, with the exception of offender type. Child molesters were more likely to volunteer than rapists, $\chi^2(1, N = 1407) = 10.67$, $p = .001$; among child molesters, those with male victims were more likely to volunteer than those with female victims or victims of both sexes, $\chi^2(2, N = 1018) = 6.98$, $p = .030$.

Our study sample consisted of 704 offenders: 259 assigned to the treatment (RP) condition, 225 assigned to the volunteer control (VC) condition, and 220 selected for the nonvolunteer control (NVC) condition. Differences in the *n*'s were due primarily to RP group attrition, which is addressed below. In terms of offender types, each of the three groups was approximately 50% molesters with female victims, 20% molesters with male victims, 8% molesters with female and male victims, and 22% rapists (with adult victims). Over a third (39.9%) of the sample had prior felony convictions, 22.4% had prior arrests for sexual crimes, and 18.4% had prior convictions for sexual crimes. The major racial/ethnic groups were White (70.2%), African American (15.2%), and Hispanic/Latino (12.6%). The RP group did not differ from the control groups except that (a) more (12.8%) of the RP group members had previously been committed for treatment as mentally disordered sex offenders (MDSOs) than had the control group members (6.4%), $\chi^2(1, N = 694) = 8.20$, $p = .004$; and (b) a larger proportion (66.3%) of the RP group members were unmarried than were control group members (58.7%), although this difference did not quite reach significance, $\chi^2(1, N = 680) = 3.81$, $p = .051$.

Attrition

A total of 259 individuals were randomly assigned to the treatment (RP) condition. Of these, 55 withdrew their consent after they learned of their selection but before they were transferred to Atascadero State Hospital. Of the 204 men admitted to the treatment program, 167 (82%) completed their sentences there and were discharged to our aftercare program. The remaining 37 (18%) did not complete the program; 27 of these voluntarily withdrew and 10 were returned to prison because they presented severe management problems in the hospital. The 37 dropouts consisted of 24 child molesters and 13 rapists. Fourteen of the

dropouts (10 child molesters and 4 rapists) left the program before completing 1 year of treatment (approximately half of the program); another 23 (14 child molesters and 9 rapists) left after completing over 1 year of treatment.

Comparisons between the 167 treatment completers and the 37 dropouts revealed that they did not differ significantly on our measures of static risk (described in the section on covariates below) or treatment need (described in the section on treatment subgroups below), or on demographic variables other than age. We did find that treatment dropouts were significantly younger than completers (34.1 years vs. 37.4 years), $t(202) = 2.25$, $p = .025$ (two-tailed). The dropout rate for rapists (27%) was higher than that for child molesters (15%), but this difference did not reach statistical significance, $\chi^2(1, N = 204) = 3.38$, $p = .065$. Within the dropout group, comparisons between those who left the program early (before a year) and those who left late (after a year) revealed no significant differences on static risk, level of treatment need, psychopathy, age, or any other demographic variables.

For our comparison groups, 225 of the volunteers were assigned to the VC group, and 220 were selected from the pool of nonvolunteers to be the NVC group. None of the control participants dropped out of the study.

As we have noted previously (Marques, Day, et al., 1994) we have been concerned about attrition in our treatment sample since the study began, and have attempted to minimize its impact on our design. First, we tried to limit the number of treatment dropouts by terminating participation only when an individual created severe management problems in the hospital (such as serious contraband violations, assaultive behavior, or interfering with the treatment of others).

Men who were not disruptive, even if their progress was not substantial, were retained in the RP group. We gave participants who asked to leave the program 24 hr in which to reconsider their decision and stay in treatment. We also decided early in the study to retain in the RP group those participants who left the program after receiving a substantial dose of treatment (1 year, about half of the program). Finally, 4 years into the study we changed our selection-phase procedure to minimize the design problems caused by participants dropping out of treatment before they arrived at the program. From that point on, control group members were not matched to RP group members until the treatment participant was actually transferred to the program.

Despite these attempts, we still had a number of RP group members who dropped out of the study before they received a substantial dose of our intervention. Our method for handling this problem is described in the Results section below.

Treatment Program

From the beginning (Marques, 1984), SOTEP was designed to provide a comprehensive cognitive-behavioral treatment program that was based on our

adaptation (Marques, 1982) of Marlatt's RP model (Marlatt, 1980; Marlatt & Gordon, 1985). The program embraced the basic theoretical concepts of RP, emphasized the long-term risk of reoffending, and explicitly targeted the problem of relapse. All of the program's components, which included a variety of cognitive, behavioral and skill-training elements, were organized around the RP framework. Both assessment and treatment procedures focused on the individual's specific risk factors for reoffense, from broad lifestyle factors and cognitive distortions to deviant sexual arousal patterns and deficits in coping skills. Overall, the program's goals were to have participants show (a) an increased sense of personal responsibility and decreased use of justifications for sexual deviance; (b) a decrease in deviant sexual interests; (c) an understanding of, and ability to apply, the basic concepts and techniques of RP; (d) an improved ability to identify high-risk situations, and (e) better skills in the areas of avoiding and coping with high-risk situations.

SOTEP's primary treatment structure was the core RP group, which met for three 90-min sessions each week throughout the program. This highly structured group was the setting in which each participant's cognitive-behavioral offense chain was constructed and was used to identify the risk factors and patterns that his RP program needed to address. Core group members worked on accepting responsibility for their offenses, modifying their cognitive distortions, examining how they set up their past crimes and learning what they had to do differently to avoid reoffense.

In addition to this intensive group work, RP group members participated in other components that addressed factors associated with sexual offending. The project's specialty groups were designed to provide the specific knowledge, attitudes and skills that the offender needed to identify and cope with potential high-risk situations. These included groups on sex education, human sexuality, relaxation training, stress and anger management, and social skills. All participants also completed a prerelease class designed to prepare them for "life on the streets" and were scheduled for weekly individual sessions with their assigned clinicians and nursing staff. Other program components were offered on a prescriptive basis. Participants with significant alcohol or drug abuse histories (about 69% of the treated group) were required to complete an RP-based substance abuse group. Individuals who showed patterns of deviant arousal in their phallometric assessments were offered behavioral treatment, usually olfactory aversion or orgasmic reconditioning. To maintain consistency and fidelity in the program, all treatment services (with the exception of individual sessions) were guided by manuals that specified the goals and treatment procedures for the group sessions, as well as the homework assignments to be completed by participants. All group sessions were videotaped; the tapes were randomly selected and reviewed in clinical supervision sessions, but program fidelity was not formally monitored in the program.

Measures

In-Treatment Measures

RP group members completed a variety of psychological tests and other instruments during their hospital stays, including pre–post tests in specialty groups and a battery of measures at intake and release from the program. Some of these were used primarily by clinicians for treatment planning, some were used to evaluate specific treatment components, and others were used to determine if RP group members were reaching the overall treatment goals described above (see Marques et al., 1991 for a complete description of the instruments used). For the outcome study presented here, only measures directly related to treatment needs and goals were considered. These included (a) one pretreatment self-report, SOTEP's motivational questionnaire; (b) two pre–post tests, phallometric assessment of deviant sexual interests and the Multiphasic Sex Inventory (MSI; Nichols & Molinder, 1984); and (c) two posttreatment measures, clinician ratings of how well the participant performed on two RP exercises. Although data from another pre–post measure, the Sex Offender Situational Competency Test (Miner, Day, & Nafpaktitis, 1989) were collected, they had not been coded and analyzed in time for inclusion here.

Outcome Measures

Study participants were followed in the community for a minimum of three and a maximum of 14 years. In each year of follow-up, we collected data from both the FBI and the California Department of Justice concerning criminal activity ("rap sheets") and from the state's Department of Corrections concerning parole violations and returns to prison. When there were indications that an offense had occurred, we attempted to obtain the actual arrest and investigation reports that described the crime. Staff then rated the offense descriptions along a number of dimensions, including certainty that the offense occurred, type of offense (sexual, other violent, or other), and various levels of offense severity. Interrater agreements from year to year were evaluated using randomly selected samples of cases with reoffense activity. The overall agreements for the ratings were acceptable (89% for offense type, 100% for certainty of offender guilt, and 84% for sexual offense severity).

Possible sexual offenses were categorized as "hands on" (e.g., child molestation, rape, attempted rape), "hands off" (e.g., possession of child pornography, propositioning a minor, indecent exposure) or "high-risk behavior" (e.g., being in the presence of minors or loitering, behaviors that we considered risky or possible offense precursors but that were not sexual offenses per se). In the analyses presented here, "sexual reoffenses" included both hands-on and hands-off behaviors,

but did not include the group of high-risk behaviors. In terms of offense certainty, we only included crimes that were rated as at least "possible." In some cases then, offenses were counted if there was evidence that the crime occurred, even if charges were dropped or the offender was returned to custody for violating his parole conditions.

RESULTS

Our final panel of SOTEP data was analyzed in several steps. First, we conducted a set of main effects analyses, comparing the reoffense rates of our treated participants with those of our two control groups. We started with broad analyses that included treatment dropouts as well as completers, and used both sexual recidivism and nonsexual violent recidivism as outcomes. Next, we narrowed our focus to the major outcome of interest, sexual reoffending, and looked more closely at our groups and outcomes to determine if there were some types of offenders that did better with treatment, and if there were differences in the severity of the offenses that were committed by treated and untreated offenders. We also determined if our experimental groups differed in terms of their reoffense risk, and conducted main effects analyses that took levels of risk into account by including a measure of static risk as a covariate. Finally, we examined effects that were unique to the treatment group. The focus here was on our in-treatment measures, specifically whether they predicted outcome and whether they could be combined to identify subgroups of offenders who were more likely to succeed after discharge.

Main Effects Analysis

Table I presents the reoffense rates for all SOTEP study groups, with the group assigned to RP broken down into several subgroups: (a) those who withdrew before transfer to the treatment program, (b) those who left treatment before 1 year, and

Table I. Sexual and Violent Reoffense Rates for All Study Groups

Group	*n*	Years at risk *M*	Sexual reoffense %	Violent reoffense %
Relapse prevention (all assigned)	259	8.3	22.0	16.2
Withdrew prior to treatment	55	7.9	20.0	12.7
Relapse prevention < 1 year	14	8.4	35.7	28.6
Relapse prevention > 1 year	190	8.4	21.6	16.3
Volunteer control	225	8.4	20.0	11.6
Nonvolunteer control	220	8.3	19.1	15.0

Note. Relapse prevention group is broken down to show various subgroups that resulted from attrition.

(c) those who completed the program or left after a year or more of treatment. In addition to our primary outcome events (new sexual offenses), the table shows what percentage of the participants committed new crimes involving nonsexual violence. It should be noted that we avoided duplication in the table by using a hierarchical system for these data, that is, violent offenses were only counted if the individual did not have a new sexual offense.

The attrition in our RP group has complicated our analyses of treatment effects. For example, do we identify as our experimental group all participants randomly assigned to treatment or only those to whom treatment was delivered? Our solution to this problem was to collect recidivism data on all study participants, and then to test hypotheses in two ways, "treatment as assigned" and "treatment as delivered" (see Marques, Day, et al., 1994). In the first of these analyses, the randomization was preserved, and the RP group consisted of all individuals randomly selected for treatment, whether they entered the program or not. This was our broadly defined "intent to treat" sample. In the second analysis, only RP group members who actually participated in treatment were included, and the reoffense rates of those who received a substantial dose of treatment were compared with those who dropped out as well as those in the control groups. We expected that any conclusion regarding treatment effectiveness would be based on converging evidence from both of these tests.

Treatment as Assigned

This analysis compared the proportion of the RP intent to treat group who reoffended with the proportions who reoffended in the volunteer control (VC) and nonvolunteer control (NVC) groups. Because SOTEP participants had varying times at risk, recidivism incident data were analyzed using the LIFETEST survival rate analysis program (SAS Institute, 1999). In this procedure, time until recidivism, specifically the number of days between each participant's release from incarceration and the date of apprehension for a new offense, was the dependent variable rather than the simple presence or absence of reoffense. Although methods are sometimes used to adjust time-at-risk by subtracting temporary incarcerations for other offenses from total follow-up time, we essentially used calendar time until recidivism in our analyses. Specifically, each participant's reoffenses were tracked until (a) the end of our follow-up period (June 30, 2000), (b) the date of his death, or (c) the date he was incarcerated for a period of time that included the last date of follow-up.

Wilcoxon tests of the differences in the survival distributions across experimental groups failed to approach significance in the treatment as assigned analysis for both sexual reoffense, $\chi^2(2, N = 704) = 0.28$, $p = .870$, and nonsexual violent reoffense, $\chi^2(2, N = 704) = 0.66$, $p = .719$. For our primary outcome, sexual reoffense, the Kaplan–Meier display of the survival curves showed remarkably

Table II. Cumulative Failure Rates (Sexual Reoffense) Over 6 Time Gates

Group	Rate at given time gate					
	1 year	2 year	3 year	4 year	8 year	12 year
Relapse prevention < 1 year	21.4	28.6	28.6	28.6	28.6	35.7
Relapse prevention > 1 year	6.8	10.5	14.7	15.3	19.5	21.6
Volunteer control	6.2	10.7	13.3	16.0	19.1	20.0
Nonvolunteer control	5.5	11.4	13.2	15.9	18.2	19.1

Note. Relapse prevention includes all participants who were admitted to the treatment program.

similar patterns across all three groups, with reoffenses occurring steadily for the first 3 years after release, after which the rates of reoffense slowed, then almost leveled off at the 5-year point and beyond.

Treatment as Delivered

For this second comparison of the reoffense rates of our treated and untreated participants, we excluded the 55 men who dropped out before transfer to the hospital, and focused on the 204 in the RP group who had some treatment exposure. As Table I shows, these were further divided into two groups, those who left before 1 year and those who completed a year or more of the program. Wilcoxon tests of the differences in the survival distributions across experimental groups failed to reach significance in the treatment as delivered analysis for sexual reoffense, $\chi^2(3, N = 649) = 2.66$, $p = .448$. Kaplan-Meier survival curves appeared very similar across groups, except for the group of early treatment dropouts who demonstrated visually poorer survival times until sexual offending. As Table II demonstrates, early dropouts tended to reoffend in their first year after release. Because of the very small size of this group ($n = 14$), however, this difference was not statistically significant as was noted earlier.

When the outcome criterion was changed to nonsexual violent reoffense, the survival distributions of the groups were similar to those for the outcome of sexual reoffense. However, the pattern of early reoffense among the early dropouts was more pronounced, achieving statistical significance when time-until-violent offense was the criterion, $\chi^2(3, N = 649) = 8.76$, $p = .033$.

Treatment Interactions

Even without an overall treatment effect, it is possible that a subset of offenders did better with treatment than without. Our next set of analyses addressed this possibility, by examining the outcomes for offender subgroups. First, we calculated reoffense rates within the various types of offenders in our sample (molesters of females, molesters of males, molesters of males and females, and rapists), and

Table III. Sexual Reoffense Rates by Experimental Group for Various Offender Types

	Child molesters				
	All molesters	Female victim	Male victim	Male and female victim	Rapists
Group	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)
Relapse prevention	21.9 (32/146)	17.8 (16/90)	30.0 (12/40)	25.0 (4/16)	20.4 (9/44)
Volunteer control	17.2 (30/174)	14.2 (16/113)	22.7 (10/44)	23.5 (4/17)	29.4 (15/51)
Nonvolunteer control	20.6 (35/170)	14.8 (16/108)	37.2 (16/43)	15.8 (3/19)	14.0 (7/50)

Note. Relapse prevention includes all participants who completed at least 1 year of treatment.

compared these rates across the RP, VC, and NVC groups (see Table III). None of the observed differences between the treated and untreated groups approached statistical significance in either simple tests of proportions or in comparisons across survival distributions. It should be noted that the early dropout group was omitted in this and subsequent tables and analyses because of its small size, $n = 14$.

Next, we examined our results to determine if there were other subject characteristics that interacted with treatment, such as demographic variables or criminal history. To test for interactions we ran a logistic regression analysis with sexual reoffender (yes/no) as the dependent variable. In each equation, experimental group, a subject characteristic, and the group-by-subject characteristic interaction term were tested for significance. The subject characteristics entered in these equations were offender type (molester/rapist), age (under 40/40 plus), racial identification (White/non-White), prior MDSO status (yes/no), prior sexual offense felonies (yes/no), intoxicated at time of the instant offense (yes/no), physically injured victim (yes/no), and victim was a stranger (yes/no).

The interaction term was statistically significant in only one of these calculations, namely, intoxicated at the time of the offense, $\chi^2(1, N = 390) = 5.23$, $p = .022$. RP participants who were intoxicated at the time of the instant offense had a lower rate of sexual reoffense than RP participants who were not intoxicated (12.1% vs. 28.6%), whereas VC participants showed the reverse pattern (22.4% reoffense if intoxicated and 18.8% if not intoxicated). This significance, however, was eliminated when we applied a Bonferroni correction for multiple comparisons. A second test for interactions using Cox regression with survival hazard rate as the dependent variable yielded the same result as the logistic regression.

Severity of Reoffense

Our offense severity-coding data were used to examine qualitative differences in the reoffenses that were committed by individuals in our study groups. For these comparisons, a severe sexual offense was defined as one involving (a) sexual

penetration, (b) victim injury, (c) use of a weapon, or (d) incapacitation of the victim. We found that the VC group tended to commit more severe offenses than the RP or NVC groups, with the differences among the three groups being significant on two variables, sexual penetration, $\chi^2(2, N = 178) = 6.48$, $p = .039$ and victim injury, $\chi^2(2, N = 155) = 7.51$, $p = .023$. Again, however, applying Bonferroni corrections due to multiple tests had the effect of eliminating the significance of these two findings.

To explore the severity findings more closely, we focused on comparing the reoffenses of our RP group with those of the primary control (VC) group. Inspection of the data revealed that the RP group had a lower percentage of crimes that were rated as severe on three of the four indicators, sexual penetration (15.3% for the RPs vs. 33.3% for VCs), weapons (2.0% vs. 10.0%), and victim injury (7.6% vs. 14.6%). To avoid the multiple-tests problem and to more efficiently test these relationships we calculated a stepwise logistic regression in which offense severity variables were predictors and group was the dependent variable. In this equation two variables emerged as significant predictors, sexual penetration $\chi^2(1, N = 101) = 4.68$, $p = .031$, and incapacitation of the victim, $\chi^2(1, N = 101) = 4.85$, $p = .028$), with victim injury approaching significance, $\chi^2(1, N = 101) = 3.50$, $p = .062$. We also constructed composite measures of severity by combining the four indicators, but because the variables were not significantly correlated with each other this approach did not prove to be meaningful.

Main Effects Analysis with Covariates

Our matching variables (age, type of offense, and prior felony convictions) and randomization procedures were designed to create groups that were not significantly different from each other on important variables such as pretreatment risk. As noted above, however, we detected some differences in the experimental groups; for example, compared with the control groups, more of the RP participants were single or had a history of commitment as a mentally disordered sex offender. As a result, it has been necessary for us to conduct additional survival analyses to control for differences in pretreatment reoffense risk.

Although today's array of actuarial risk assessment instruments was not available when we designed our study in 1984, we did collect enough information on our participants to later score them on a shortened version of the Static-99 (Hanson & Thornton, 2000). It should be noted that the Static-99 combines items from the RRASOR (Hanson, 1997a) and the SACJ-Min (Grubin, 1998), and that an earlier panel of SOTEP data was used in the development of the RRASOR. Our adaptation of the Static-99, which we called "Static-Lite," included the following seven items from the Static-99: prior sex offenses, convictions for noncontact sex offenses, any unrelated victims, any stranger victims, any male victims, young, and never married.

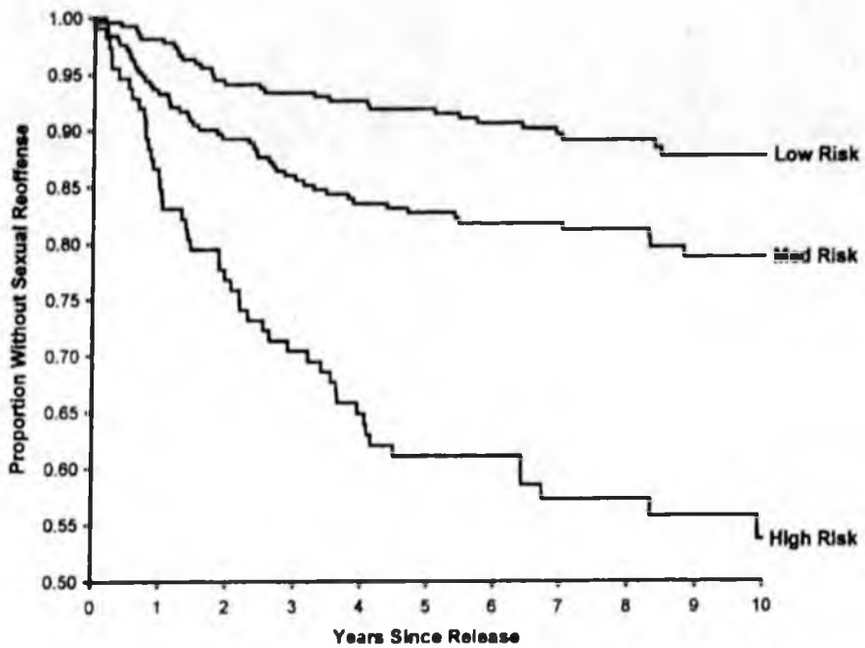


Fig. 1. Survival curves for groups differing on static risk (Static-Lite) scores.

Even though our sample did not include some of the highest risk offenders (e.g., those with three or more prior felony convictions), Static-Lite proved to be an adequate measure of risk, showing moderate predictive accuracy for sexual recidivism (ROC area = .68). As Fig. 1 demonstrates, there were clear differences in the rates of survival for high, medium and low risk individuals in our sample, $\chi^2(2, N = 635) = 54.9$, $p < .0001$.

Despite random assignment, the mean risk score of the RP group ($M = 2.25$) was significantly higher than the mean scores of the VC group ($M = 1.88$) and the NVC group ($M = 1.88$), $F(2, 635) = 3.71$, $p = .025$. To determine if this difference resulted from a nonrandom source, particularly attrition, we compared the Static-Lite scores of the various subgroups of offenders who were originally assigned to RP. No differences were found among the risk scores of the 167 treatment completers ($M = 2.28$), the 23 late dropouts ($M = 2.09$), the 14 early dropouts ($M = 2.21$), and the 55 individuals assigned to treatment who never showed up ($M = 2.11$), $F(3, 257) = .19$, $p = .904$.

As Table IV shows, when the groups were stratified by risk level, the RP group tended to have somewhat lower reoffense rates than the primary comparison group, the VCs. RP participants also appeared to fare better than NVC participants, with the exception of the medium risk group. In Table V, the reoffense rates of the two comparison groups have been adjusted to reflect what they would be if those

Table IV Sexual Reoffense Rates for Different Risk Groups

	Risk group[a]		
	Low	Medium	High
Group	% (*n*)	% (*n*)	% (*n*)
Relapse prevention	11.0 (8/73)	21.6 (16/74)	39.5 (17/43)
Volunteer control	11.1 (11/99)	21.9 (21/96)	43.3 (13/30)
Nonvolunteer control	12.1 (12/99)	14.6 (12/82)	46.2 (18/39)

Note. Relapse prevention includes all participants who completed at least 1 year of treatment.

[a] Risk groups were defined by scores on Static-Lite, an abbreviated version of the Static-99 (Hanson & Thornton, 2000). Low includes scores of 0–1, medium includes scores of 2–4, and high includes scores of 5 and above.

groups had the same higher risk scores that the RP group did. These adjustments were made by calculating the odds ratio associated with an increase by one point in Static-Lite score, then using observed Static-Lite group means to determine the amount of hypothetical recidivism-increase to add to the VC and NVC group means. When static risk was controlled for, the RP group appeared to have the lowest reoffense rate, but this difference did not approach significance in either a simple test of proportions or in a Cox regression equation testing the survival hazard rate of the RP group versus that of the combined control groups.

Because the research literature and particularly meta-analyses of sexual offender treatment studies often describe findings in terms of effect size, an analysis was also conducted to derive effect size of the recidivism comparison between the two most conservatively defined and randomly assigned groups after controlling for risk. Specifically, survival times until recidivism of the 259 offenders originally assigned to treatment and the 225 VCs were entered into a Cox equation after first entering Static-Lite score. The odds ratio for Assigned RP versus VC was .965, between 95% confidence limits of .650 and 1.433. This again indicates (nonsignificantly) lower odds of reoffending among the RP group after controlling for risk.

Further inspection of Static-Lite scores showed that risk was unequally distributed across types of offenders when viewed by experimental group. To

Table V. Sexual Reoffense Rates Adjusted[a] for Static-Lite Scores

Group	*n*	Static-Lite *M*	Observed rate	Adjusted rate
Relapse prevention	190	2.25	21.6	21.6
Volunteer control	225	1.88	20.0	23.8
Nonvolunteer control	220	1.88	19.1	23.0

Note. Relapse prevention includes all participants who completed at least 1 year of treatment.

[a] For Static-Lite differences using odds ratio to compute hypothetical increases (or decreases) in recidivism given static risk differences in groups.

Table VI. Adjusted[a] Sexual Reoffense Rates for Various Offender Types

Group	Child molesters				Rapists (%)
	All Molesters (%)	Female victim (%)	Male victim (%)	Male and female victim (%)	
Relapse prevention	21.9	17.8	30.0	25.0	20.4
Volunteer control	21.3	16.4	33.2	22.9	30.2
Nonvolunteer control	24.4	17.5	42.8	16.5	17.2

Note. Relapse prevention includes all participants who completed at least 1 year of treatment.
[a]For Static-Lite differences using odds ratio to compute hypothetical increases (or decreases) in recidivism given static risk differences in groups.

investigate the extent to which risk may have affected results within offender type, we calculated adjusted recidivism rates for each offender type and experimental group in the same way we made hypothetical adjustments for main effects, specifically by using odds ratios to compute expected group recidivism rates given observed Static-Lite scores. Results (Table VI) show that these adjustments changed the picture of relative recidivism rates within offender types when compared with the observed (unadjusted) recidivism rates that were presented in Table III. However, tests of the differences across experimental groups in (adjusted) proportions of reoffenders found none approaching statistical significance.

RP Group Analyses

We conducted several sets of analyses on our RP group only, to examine the relationship between treatment progress and reoffense. We first examined whether our in-treatment measures were useful in predicting outcomes (sexual reoffenses). Next, we determined whether offenders with higher initial needs in areas that our program was designed to address had better outcomes than those with lower needs. Finally, we analyzed the extent to which participants who met treatment goals had better outcomes than those who did not.

In-Treatment Measures

Our first set of analyses was conducted to update our preliminary work (Marques, Nelson, et al., 1994) on the relationships between treatment measures and recidivism. As in the earlier study, we focused on a small set of in-treatment measures that were related to the SOTEP goals of having participants show (a) increased personal responsibility and decreased use of justifications for sexual abuse, (b) decreased deviant sexual arousal, and (c) an understanding of and ability to apply the techniques of RP. The measures we used were from two tests administered pre- and posttreatment (the MSI and a phallometric assessment) and

from two posttreatment only tests (both of which were clinician ratings of RP skills).

Pre–post comparisons were made on two scales from the MSI (the Justifications scale and the Cognitive Distortions and Immaturity scale) and on three indicators of deviance from the phallometric assessment (arousal to stimuli depicting female children, male children, and rape). The mean scores on both MSI scales were significantly lower at discharge than at intake; for Justifications, $t(168) = 5.55$, $p < .0001$ (one-tailed), and for Cognitive Distortions and Immaturity, $t(168) = 4.78$, $p < .0001$ (one-tailed). Significant pre–post changes were also found on the mean phallometric responses to stimuli of female children, $t(170) = 9.31$, $p < .0001$ (one-tailed); male children, $t(170) = 6.76$, $p < .0001$ (one-tailed); and rape, $t(170) = 8.14$, $p < .0001$ (one-tailed). Bonferroni corrections for multiple tests were applied to these pre–post comparisons; all reported in this paragraph remained significant at $p < .001$.

The relationship between our in-treatment measures and reoffense was examined by comparing the in-treatment scores of participants who sexually reoffended with those of participants who did not sexually reoffend. On the pretreatment measures, the scores differed significantly on only one measure, arousal to male children, $t(189) = 2.61$, $p = .005$ (one-tailed), with reoffenders having the higher scores. On the posttreatment measures, reoffenders had higher scores on two phallometric measures, arousal to male children, $t(163) = 2.73$, $p = .004$ (one-tailed), and arousal to female children, $t(163) = 1.70$, $p = .046$ (one-tailed). Neither the MSI scales nor the clinician ratings of participants' RP skills (see next section for more on these ratings) differentiated between reoffenders and those who did not reoffend. Bonferroni corrections for multiple tests applied to the statistics in this paragraph had the effect of eliminating the significance of posttreatment arousal to female children as a predictor of sexual reoffense. Pre- and posttreatment measures of arousal to male children remained as significant predictors of reoffense at $p < .05$.

Treatment Subgroups

In our final set of analyses, we identified several clinically relevant subgroups and determined how they responded to treatment. The three groups we were particularly interested in were treated individuals who (a) had the treatment needs that our program addressed, (b) learned the RP skills taught in the program, or (c) reached the program's overall treatment goals.

For the first analysis, we used our pretreatment measures to create a simple additive scale of 8 items designed to measure the participant's level of need. It should be noted that this "Need It" scale was developed a priori on the basis of our program's treatment targets rather than a posteriori on the basis of findings. Points were given for one item from our motivational questionnaire (subject blames others

for offending); three phallometric scores (arousal greater than 20% to stimuli of boys, girls or rape), and four MSI scores (above our sample median on Justifications, Cognitive Distortions and Immaturity, Child Molest or Rape scales). When the Need It scores of sexual recidivists were compared with those of nonrecidivists, no significant difference was found, $t(188) = -.09$, $p = .466$ (one-tailed). We also defined a "Needed It" subgroup (those with scores above 4) and compared their sexual reoffense rates with those of participants with fewer treatment needs. These rates, 20.7 and 25.4% respectively, did not differ significantly.

For the second analysis we divided our treatment group on the basis of how well they learned the RP model. Near the end of their hospital stays, participants completed two written RP exercises, a Decision Matrix (DM) that examined the consequences of offending versus abstaining, and a Cognitive-Behavioral Chain (CBC) that described the series of steps leading to their offenses and how they could intervene. These products were rated by the participant's primary clinician on a 7-point scale with 7 representing *highest quality*. We then defined High DM and High CBC subgroups as including individuals who scored above the mean on each of these measures. Sexual reoffense rates were very similar for High DM (20.3%) and Low DM (22.2%) participants. Although High CBC participants reoffended at a somewhat lower rate (16.9%) than did the low scorers (22.4%), this difference also failed to approach significance.

We also investigated the possibility that relationships between DM and CBC scores and reoffense depended on a participant's level of risk. Inspection of the data suggested that at least among high risk offenders, High CBC scorers had a lower reoffense rate (17.6%) than did Low CBC scorers (58.3%). However, Cox regression equations investigating the effects of DM, CBC and risk level on survival hazard rate revealed no statistically significant effects due to DM score, CBC score, or their interactions with Static-Lite.

In the third analysis, we created a priori another simple additive scale, in this case a 9-point scale designed to identify participants who derived benefit from the program or basically "got" the treatment we provided. Items in this "Got It" scale were from posttreatment measures that were relevant to our treatment program goals. Points were given for three phallometric scores (arousal greater than 20% to stimuli of boys, girls or rape), four MSI scores (above our sample median on Justifications, Cognitive Distortions and Immaturity, Child Molest or Rape scales), and the two RP ratings (below the mean on our CBC and DM measures). In this scale, because points indicated deviance or a lack of RP skills, low scores indicated a better treatment response.

When the Got It scores of sexual recidivists were compared with those of nonrecidivists, no significant difference was found, $t(156) = -1.34$, $p = .092$ (one-tailed). However, when Got It scores were used to divide RP participants into "Got It" and "Did Not Get It" subgroups on the basis of a median split (<3 = Got It), the difference in recidivism rates of the two groups (13.5 and 27.2%

Table VII. Sexual Reoffense Rates for RP Participants Differing on Static Risk and Treatment Progress

	Static-Lite score			
	Low	Medium	High	Overall rates
Got It?[a]	% (*n*)	% (*n*)	% (*n*)	% (*n*)
No	16.2 (6/37)	21.0 (8/38)	50.0 (14/28)	27.2 (28/103)
Yes	4.6 (1/22)	25.0 (5/20)	10.0 (1/10)	13.5 (7/52)

[a]"Got It" scale included nine scores related to program goals, with scale scores above the sample mean indicating treatment progress.

respectively) approached significance, $\chi^2(1, N = 155) = 3.72$, $p = .054$. Further examination of this trend revealed that the relationship between our measure and sexual reoffense was not consistent across our three static risk groups. As Table VII shows, high-risk offenders who Got It reoffended at a significantly lower rate (10.0%) than did those who failed to reach treatment goals (50.0%), $\chi^2(1, N = 38) = 4.93$, $p = .026$ ($p = .028$, one-tailed, when Fisher's exact test was applied because of at least one cell having an expected count less than five). The differences in recidivism between those who Got It and those who did not failed to approach significance within the medium and low risk groups. However, in a Cox regression equation testing the effects of Got It and risk group on survival hazard rates Got It was a statistically significant predictor of time until reoffense, $\chi^2(1, N = 160) = 3.99$, $p = .046$, with the effect of risk level, $\chi^2(1, N = 160) = 7.26$, $p = .007$, also in the equation and thus "controlled."

Finally, examination of our Got It subgroup revealed that the predictive value of Got It was largely accounted for by the child molesters in our treated sample. Among rapists, the relationship between Got It and reoffense rates did not approach significance. Among molesters, however, those who Got It reoffended at a significantly lower rate (9.3%) than those who Did Not Get It (31.3%), $\chi^2(1, N = 126) = 7.57$, $p = .006$.

DISCUSSION

Unlike most outcome studies of "current" treatments (see Hanson et al., 2002), we did not find an overall treatment effect for our cognitive-behavioral treatment program. Sexual offenders who were randomly assigned to our hospital-based RP program did not reoffend at a lower rate than those who were randomly assigned to the in-prison control groups. This was the case for both rapists and child molesters, and for low-risk offenders as well as high-risk offenders. A number of comments on this outcome have already been offered, including the straightforward conclusion that SOTEP (along with other random assignment

studies) simply does not support the effectiveness of treatment for adult sexual offenders (Rice & Harris, 2003). In the context of growing optimism about the benefits of sexual offender treatment, this study's message is, "Not so fast, we are still far from understanding how and when treatment works."

Although we accept that this simple cautionary note may be SOTEP's "take home" message, we also believe that it is important to examine this study closely and explore possible explanations for its null results. We started this examination with a review of our study design. In the ideal test of treatment, the only difference between the treatment and control conditions is the intervention. In SOTEP, however, the experimental conditions differed in several ways other than the presence or absence of the RP program we were testing. Most importantly, the RP group lived in a hospital, whereas both control groups lived in prison. In the state hospital, offenders were surrounded by sexually deviant peers and therapeutic staff who expected them to openly discuss their crimes and deviant interests. In prison, control group participants most likely hid their backgrounds and were surrounded by people who were highly intolerant of sexual deviance. As a result of such differences in experimental conditions, SOTEP cannot be viewed as a "pure" test of treatment but rather as a more complex comparison of treatment in a state hospital setting versus confinement in a prison setting.

The randomized experiment is considered the gold standard in program evaluation, and is the design least likely to result in groups that differ in systematic ways. Randomization does not, however, guarantee equivalent groups. In our case, men assigned to the RP group tended to be higher risk than those assigned to the control conditions. It is possible, though unlikely, that random variation also resulted in an RP group that was less motivated or more sexually deviant in ways that our data were not sufficient to test.

Given that we were taking a new (in 1984) treatment model for addictive behaviors and applying it to a different group of clients, we decided to screen our study participants. For example, we did not accept individuals who categorically denied their offenses or had substantial criminal careers (three or more prior felony convictions). The criminal history screening no doubt eliminated some of the highest risk offenders from our study, resulting in a rather low base rate (20%) of sexual reoffending as well as a relatively small group of high-risk offenders for us to treat. It may be that our intervention was too intense for our group of mostly low to medium risk offenders. Some (e.g., Hanson, 2000; Nicholaichuk, 1996) have even suggested that intensive treatment may make low-risk offenders worse. It should be noted, however, that we also screened out the lowest risk group (those who molested only their biological children), and that we did not find that treatment made any subgroup of offenders more likely to reoffend.

One other aspect of our study design that may have affected the results is our management of attrition. To minimize this problem, we made an effort to keep RP participants in the program once they began treatment. We did not require

them to demonstrate motivation, fully engage in treatment, or show improvement to stay in the program. The only individuals who were terminated from treatment were those who presented severe management problems at the hospital. As a result, we had some participants who were quite comfortable just "programming," attending treatment activities but not really making the commitment to change that is important to the RP model (Marques, Nelson, Alarcon, & Day, 2000). SOTEP's minimal standard for treatment completion resulted in a low treatment dropout rate (18%) that is in sharp contrast with the rate in programs that set more rigorous performance standards, such as the 50% noncompletion rate reported by McGrath et al. (2003) in their RP program. It is possible that our results reflect in part our willingness to retain individuals with low motivation or performance.

The most obvious place to find explanations for our results is not in the study's design but in its treatment program. Twenty years ago the RP model was new and promising, and adapting it for use with sexual offenders trying to avoid relapse made a great deal of sense. Using RP as our framework, we designed a program that included the components found in programs at that time (e.g., sexual arousal modification, cognitive restructuring, social skills training, victim empathy, stress and anger management), and organized these around a core RP treatment group that focused on the individual's offense patterns, risk factors, and skills needed for avoiding relapse. We also included an aftercare component to help participants maintain treatment gains after discharge from the hospital.

Although this basic RP approach is still popular and considered "current" treatment in the field, in several ways our program did not reflect today's state of the art. First, because we only accepted individuals who admitted their offenses and volunteered for treatment, we did not emphasize the need to build and maintain motivation. As an RP program we were focused on the maintenance stage of behavior change, and our interventions were designed to provide skills participants could use to anticipate and avoid relapse. SOTEP did not have a treatment readiness phase or other components (such as motivational interviewing; Miller & Rollnick, 1991) designed to prepare individuals to change and to engage them in treatment. We also did not target the decrease in motivation that some treated offenders show after release to the community (Barrett, Wilson, & Long, 2003). We learned from interviews with reoffenders that a number of our treatment failures did not use the self-management skills they had acquired in the program, and some did not even accept the basic goals of self control and relapse avoidance (Marques et al., 2000). As Mann (2000) has pointed out, RP is unlikely to be successful with clients who do not accept its goals, model, and methods.

Our program included individual sessions and some prescriptive components (such as sexual arousal modification and substance abuse treatment), but most interventions were provided in groups by therapists using treatment manuals. Although manualized treatments enhance program integrity, they have the disadvantage of limiting the extent to which interventions are based on individual case formulations and treatment plans (Hollin, 2002). When asked about this, SOTEP

clinicians indicated that our highly structured approach did not allow them to do more intensive work with participants who needed it, such as those who were not committed to change or needed more sessions to practice coping skills (Marques et al., 2000).

Although we viewed each participant's RP program as "individualized" (on the basis of his offense chain and risk factors), core RP group sessions were essentially the same for all participants. Membership of the core groups was mixed, with most having molesters and rapists as well as individuals with different levels of risk, need and treatment involvement. It is possible that having some unmotivated and highly deviant members present may have negatively affected the engagement and expectations of other group members. Group diversity may also have limited the extent to which interventions were modified for different types of offenders. For example, we did not distinguish between "avoidance goal" molesters (who see molesting children as a problem behavior they want to stop) and "approach goal" molesters (who hold positive views regarding sex with children) (see Ward & Hudson, 1998, 2000), or adapt RP interventions to fit these different offense pathways (Bickley & Beech, 2003).

One important way that SOTEP differed from most current programs is that discharge was unrelated to treatment progress or perceived reoffense risk. We used in-treatment measures but these played no role in determining when a participant was released to the community. In fact our mandate (California Laws, 1982) required that the length of an offender's sentence was not to be affected by his participation in the program. On the positive side, this requirement helped us avoid the problem of individuals "faking good" to get released earlier. On the negative side, there was no pressure on participants to engage fully and actively pursue treatment goals. Although it is difficult to assess the importance of this factor, most current programs do provide clear external incentives for offenders to participate and advance in treatment (Seto, 2002).

Our aftercare component, SOAP, has been criticized for being too intensive (Marshall & Anderson, 2000), but in our in view it was too circumscribed. For one year after their release, RP group members were under standard parole supervision by the Department of Corrections and were seen twice a week by a SOTEP-trained clinician in group or individual sessions. These treatment providers were encouraged to communicate with parole agents, but this was not required unless the participant failed to attend treatment sessions. SOAP did not include maintenance polygraph examinations, GPS or other surveillance techniques, medications for individuals experiencing deviant arousal, or social and supportive services. It provided some continuity of care, but clearly fell short of the interdisciplinary, individualized, case management model of aftercare that is now recommended (Prentky, 2003). Although it has not been rigorously tested, this "containment approach" (English, 1998) represents the current thinking in the field (Association for the Treatment of Sexual Abusers [ATSA], 2004; California Coalition on Sexual Offending, 2001; Center for Sex Offender Management, 2000; Colorado

Sex Offender Management Board, 1999). As we learned in interviews with our treatment failures, a number of RP participants were facing high-risk situations soon after entering the community (Marques et al., 2000). It is possible that added surveillance and teamwork could have prevented some of these early failures.

In addition to comparing our program to current best practices in sexual offender treatment, we have examined it from the broader perspective of offender rehabilitation, or the "what works" literature (Gendreau & Andrews, 1990; Lösel, 1995; McGuire, 2002). Andrews and Bonta (1998, 2003) have provided a clear framework for this examination. They have determined that effective programs meet three principles: (a) *risk* (they treat higher risk rather than lower risk cases), (b) *need* (they target dynamic risk factors), and (c) *responsivity* (they use powerful behavior change strategies). First, SOTEP did not focus on high-risk offenders. Second, our treatment targets included some (e.g., deviant sexual arousal and cognitive distortions) but not all of the established dynamic risk factors for sexual offending. Finally, the program was based on cognitive-behavioral interventions and thus adhered to the general responsivity principle. At best, then, SOTEP was consistent with two of the principles; a more stringent view would be that it met only the responsivity principle. According to Andrews and Bonta (2003), programs adhering to all three principles can expect a 26% reduction in recidivism; those following two principles an 18% reduction, and those adhering to one component only a 2% reduction. From this perspective our null result is not at all surprising. Although hindsight based on currently available concepts cannot improve SOTEP results, the risk-need-responsivity model provides a framework that can be used now to build more effective treatment programs for sexual offenders.

SOTEP's 1984 treatment model may have fallen short of today's state of the art in some areas, but in others it was quite up to date, for example, our measurement of treatment progress. We found some interesting and encouraging trends in the data from our in-treatment measures, most importantly that RP participants who "got" treatment (had good posttreatment scores on a simple additive scale) reoffended at lower rates than those who didn't. This difference was significant for child molesters (over three quarters of our sample) but not for rapists, a finding that may reflect our scale's emphasis on deviant sexual interests. It also suggests that a one-size-fits-all measure of treatment progress should not be used with diverse groups of offenders.

Our "Got It" scale was also a significant predictor of sexual reoffense for the high-risk offenders in our sample. Within that subgroup, individuals who didn't "get" the treatment had a much higher sexual reoffense rate (50%) than those who did (10%). Although this finding was based on a small ($n = 36$) subgroup of treated offenders, it is consistent with other recent studies in which assessments made during or after treatment have been found to increase the accuracy of reoffense predictions made by actuarial assessments alone (Beech, Fisher, & Thornton, 2003; Beech, Friendship, Erikson, & Hanson, 2002; Thornton, 2001). It is also similar

to the finding reported by Langton, Barbaree, Seto, Harkins, and Peacock (2002) that their high-risk (psychopathic) offenders with poor treatment behavior had the highest risk of recidivism. In a broader sense, our results are supportive of the field's current emphasis on the measurement of dynamic factors that predict reoffense (Hanson & Harris, 2000) or indicate treatment benefit (Mann & Thornton, 2000; Thornton, 2002).

Because "Got It" was composed of ad hoc measures and was not cross-validated, we do not recommend this home-grown measure for use elsewhere. We do, however, encourage others studying treatment outcomes to include relevant in-treatment measures in their designs. Standardized, empirically-validated measures of treatment progress are badly needed in this field to enhance our ability to understand the relationships between short-term and long-term treatment effects.

Although SOTEP was most concerned with measuring the effects of treatment, our strongest findings were in the area of static risk factors. Even our shortened version of Hanson and Thornton's Static-99 (2000) turned out to be a powerful predictor of sexual reoffense risk and an important covariate in our analyses. To avoid potentially misleading distortions in study results, we urge researchers who plan to assess the effects of treatment to control for prior risk by using an appropriate actuarial measure for both treatment and comparison groups.

The most important safeguard against misleading results, however, remains a randomized design. Some (e.g., Hanson, 1997b) have argued against investing heavily in longitudinal studies of small, innovative programs such as SOTEP, suggesting that it is probably more productive to conduct a range of less elaborate studies that can be combined to yield sound evidence regarding treatment effects. Although we have also encouraged real-world programs to collect outcome data and contribute to our developing knowledge base on treatment effectiveness (Marques, 1999), we do not agree that this all that is required. Our results underscore the importance of including adequate comparison groups in treatment outcome studies. It may be difficult to obtain funding and to conduct randomized clinical trials but we strongly believe that more of these are needed to move this field forward.

If we were to design a new test of treatment now, we would do some things differently than we did 20 years ago. We would make sure that the program (a) had treatment intensity and content that were tailored to offenders' risk levels, treatment needs and responsivity factors; (b) regularly monitored progress toward treatment goals to make sure that participants were "getting" the treatment provided; and (c) had an aftercare component based on an individualized, interdisciplinary case management model, not just on therapy sessions. We would also make some changes in the study design, such as (a) including more high-risk offenders; (b) conducting pretreatment assessments on all participants; and (c) increasing the sample size to shorten the follow-up period needed. We would not, however, design a study with a less rigorous evaluation component than

SOTEP. Questions about whether and when sexual offenders can be treated are extremely important, not just to our field but to victims, policy makers and the public. The only way to provide answers with confidence is to build a knowledge base on thoughtful and well-controlled studies of treatment effectiveness.

ACKNOWLEDGMENTS

SOTEP was supported by the California Departments of Mental Health and Corrections, and by Grant R01 MH46391 from the National Institute of Mental Health. This ambitious project was truly a collaborative effort and we are indebted to many who contributed to it over the years, including our research personnel, the treatment teams at Atascadero State Hospital, our aftercare providers and the men who served as our treatment and control group participants. Guidance was provided along the way by many colleagues, including James Breiling, Del Elliott, Mark Lipsey, Alan Marlatt, Vernon Quinsey, and Mark Weinrott in the early years, and more recently by Karl Hanson and David Thornton. We also received helpful comments on a draft of this paper from Mark Chaffin, Robert Prentky, and Marnie Rice. The views expressed are those of the authors and do not necessarily reflect the positions of the California Department of Mental Health or Atascadero State Hospital.

REFERENCES

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

Andrews, D. A., & Bonta, J. S. (2003). *The psychology of criminal conduct* (3rd ed.). Cincinnati, OH: Anderson.

Association for the Treatment of Sexual Abusers. (ATSA). (2004). *Practice guidelines for members of the Association for the Treatment of Sexual Abusers*. Beaverton, OR: Author.

Barrett, M., Wilson, R. J., & Long, C. (2003). Measuring motivation to change in sexual offenders from institutional intake to community treatment. *Sexual Abuse: A Journal of Research and Treatment, 15*, 269–283.

Beech, A., Fisher, D., & Thornton, D. (2003). Risk assessment of sex offenders. *Professional Psychology: Research and Practice, 34*, 339–352.

Beech, A., Friendship, C., Erikson, M., & Hanson, R. K. (2002). The relationship between static and dynamic risk factors and reconviction in a sample of U. K. child abusers. *Sexual Abuse: A Journal of Research and Treatment, 14*, 155–167.

Berliner, L. (2002). Commentary. *Sexual Abuse: A Journal of Research and Treatment, 14*, 195–197.

Bickley, J. A., & Beech, A. R. (2003). Implications for treatment of sexual offenders of the Ward and Hudson model of relapse. *Sexual Abuse: A Journal of Research and Treatment, 15*, 121–143.

Borduin, C. M., Schaeffer, C. M., & Heilblum, N. (2000, May). *Multi-systemic treatment of juvenile sexual offenders: A progress report*. Paper presented at the 6th International Conference on the Treatment of Sexual Offenders, Toronto, ON.

California Coalition on Sexual Offending. (2001). *Effective management of sex offenders residing in open communities*. Retrieved on June 1, 2004 from http://www.ccoso.org/papers/containment.html.

California Laws. (1981). Chapter 928, codified as California Penal Code, Sections 1364 and 1365.

California Laws. (1982). Chapters 1529 and 1549, amending California Penal Code, Sections 1364 and 1365.

Center for Sex Offender Management. (2000). *The collaborative approach to sex offender management.* Retrieved on June 1, 2004 from http://www.csom.org/pubs/collaboration.pdf.

Colorado Sex Offender Management Board. (1999). *Standards and guidelines for the assessment, evaluation, treatment and behavioral monitoring of adult sex offenders.* Denver: Colorado Department of Public Safety.

Craig, L. A., Browne, K. D., & Stringer, I. (2003). Treatment and sexual offence recidivism. *Trauma, Violence, and Abuse, 4*, 70–89.

English, K. (1998). The containment approach: An aggressive strategy for the community management of adult sex offenders. *Psychology, Public Policy and Law, 4*, 218–235.

Furby, L., Weinrott, M. R., & Blackshaw, L. (1989). Sex offender recidivism: A review. *Psychological Bulletin, 105*, 3–30.

Gallagher, C. A., Wilson, D. B., Hirschfield, P., Coggeshall, M. B., & MacKenzie, D. L. (1999). A quantitative review of the effects of sex offender treatment on sexual reoffending. *Corrections Management Quarterly, 3*, 19–29.

Gendreau, P., & Andrews, D. A. (1990). Tertiary prevention: What the meta-analyses of the offender treatment literature tell us about "what works." *Canadian Journal of Criminology, 32*, 173–184.

Grossman, L. S., Martis, B., & Fichtner, C. G. (1999). Are sex offenders treatable? A research overview. *Psychiatric Services, 50*, 349–361.

Grubin, D. (1998). Sex offending against children: Understanding the risk. *Police Research Series Paper 99*. London: Home Office.

Hanson, R. K. (1997a). *The development of a brief actuarial risk scale for sexual offense recidivism.* (User Report 97-04). Ottawa: Department of the Solicitor General of Canada. Retrieved on June 1, 2004 from http://www.psepc-sppcc.gc.ca/publications/corrections/199704_e.pdf.

Hanson, R. K. (1997b). How to know what works with sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 9*, 129–145.

Hanson, R. K. (2000). Treatment outcome and evaluation problems (and solutions). In D. R. Laws, S. M. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp 485–499). Thousand Oaks, CA: Sage.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., et al. (2002). First report of the Collaborative Outcome Data Project on the effectiveness of treatment for sex offenders. *Sexual Abuse: A Journal of Research and Treatment, 14*, 169–194.

Hanson, R. K., & Harris, A. J. R. (2000). Where should we intervene? Dynamic predictors of sexual offense recidivism. *Criminal Justice and Behavior, 27*, 6–35.

Hanson, R. K., & Thornton, D. (2000). Improving risk assessment for sexual offenders: A comparison of three actuarial scales. *Law and Human Behaviour, 24*, 119–136.

Hollin, C. R. (2002). An overview of offender rehabilitation: Something old, something borrowed, something new. *Australian Psychologist, 37*, 159–164.

Huot, S. (2002, October). *Recidivism, recidivism, recidivism! An update of several Minnesota recidivism studies.* Paper presented at the 21st annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, QC.

Langton, C. M., Barbaree, H. E., Seto, M. C., Harkins, L., & Peacock, E. (2002, October). *How should we interpret behavior in treatment?* Paper presented at the 21st annual meeting of the Association for the Treatment of Sexual Abusers, Montréal, QC.

Looman, J., Abracen, J., & Nicholaichuk, T. P. (2000). Recidivism among treated sexual offenders and matched controls: Data from the Regional Treatment Centre (Ontario). *Journal of Interpersonal Violence, 15*, 279–290.

Lösel, F. (1995). The efficacy of correctional treatment: A review and synthesis of meta-evaluations. In J. McGuire (Ed.), *What works: Reducing re-offending: Guidelines from research and practice* Chichester, UK: Wiley.

Mann, R. E. (2000). Managing resistance and rebellion in relapse prevention intervention. In D. R. Laws, S. M. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp. 187–200). Thousand Oaks, CA: Sage.

Mann, R. E., & Thornton, D. (2000). An evidence-based relapse prevention program. In D. R. Laws, S. M. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp. 341–350). Thousand Oaks, CA: Sage.

Marlatt, G. A. (1980). *Relapse prevention: A self-control program for the treatment of addictive behaviors*. Unpublished manuscript, University of Washington, Department of Psychology, Seattle, WA.

Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). *Relapse prevention*. New York: Guilford.

Marques, J. K. (1982, March). *Relapse prevention: A self-control model for the treatment of sex offenders*. Paper presented at the annual meeting of the Forensic Mental Health Association of California, Asilomar, CA.

Marques, J. K. (1984). *An innovative treatment program for sex offenders: Report to the Legislature*. Sacramento: California Department of Mental Health.

Marques, J. K. (1999). How to answer the question, "Does sex offender treatment work?" *Journal of Interpersonal Violence, 14*, 427–441.

Marques, J. K., Day, D. M., Nelson, C., Miner, M. H., & West, M. A. (1991). *The Sex Offender Treatment and Evaluation Project: Fourth report to the Legislature in response to PC 1365*. Sacramento: California Department of Mental Health.

Marques, J. K., Day, D. M., Nelson, C., & West, M. A. (1994). Effects of cognitive-behavioral treatment on sex offender recidivism: Preliminary results of a longitudinal study. *Criminal Justice and Behavior, 21*, 28–54.

Marques, J. K., Nelson, C., Alarcon, J. M., & Day, D. M. (2000). Preventing relapse in sex offenders: What we learned from SOTEP's experimental program. In D. R. Laws, S. M. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp. 321–340). Thousand Oaks, CA: Sage.

Marques, J. K., Nelson, C., West, M. A., & Day, D. M. (1994). The relationship between treatment goals and recidivism among child molesters. *Behaviour Research and Therapy, 32*, 577–588.

Marshall, W. L., & Anderson, D. (2000). Do relapse prevention components enhance treatment effectiveness? In D. R. Laws, S. M. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp. 39–55). Thousand Oaks, CA: Sage.

McGrath, R. J., Cumming, G. C., 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*, 3–17.

McGuire, J. (Ed.). (2002). *Offender rehabilitation and treatment: Effective practice and policies to reduce re-offending*. Chichester, UK: Wiley.

Miller, W. R., & Rollnick, S. (Eds.) (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford.

Miner, M. H., Day, D. M., & Nafpaktitis, M. K. (1989). Assessment of coping skills: Development of a situational competency test. In D. R. Laws (Ed.), *Relapse prevention with sex offenders* (pp. 127–136). New York: Guilford.

Nicholaichuk, T. (1996). Sex offender treatment priority: An illustration of the risk/need principle. *Forum on Corrections Research, 8*(2), 30–32.

Nicholaichuk, T., Gordon, A., Gu, D., & Wong, S. (2000). Outcome of an institutional sexual offender treatment program: A comparison between treated and matched untreated offenders. *Sexual Abuse: A Journal of Research and Treatment, 12*, 139–153.

Nichols, H. R., & Molinder, I. (1984). The Multiphasic Sex Inventory: A test to assess psychosexual characteristics of the sexual offender. Tacoma, WA: Nichols & Molinder.

Prentky, R. A. (2003). A 15-year retrospective on sexual coercion: Advances and projections. In R. A. Prentky, E. S. Janus, & M. C. Seto (Eds.), *Sexually coercive behavior: Understanding and management* (pp. 13–32). New York: Annals of the New York Academy of Sciences.

Rice, M. E., & Harris, G. T. (2003). The size and sign of treatment effects in sex offender therapy. In R. A. Prentky, E. S. Janus, & M. C. Seto (Eds.), *Sexually coercive behavior: Understanding and management* (pp. 428–440). New York: Annals of the New York Academy of Sciences.

SAS Institute. (1999). *SAS user's guide, version 8*. Cary, NC: SAS Institute, Inc.

Seto, M. C. (October, 2002). *Interpreting the treatment performance of sex offenders*. Paper presented at the 27th Annual Cropwood Round Table Conference, Cambridge, UK.

Thornton, D. (2001). Civil commitment of dangerous, personality-disordered offenders—Developing a model. In A. Schlank (Ed.), *The sexual predator: Legal issues, clinical issues, special populations* (pp. 6.1–6.12). Kingston, NJ: Civic Research Institute.

Thornton, D. (2002). Constructing and testing a framework for dynamic risk assessment. *Sexual Abuse: A Journal of Research and Treatment, 14*, 139–154.

Ward, T., & Hudson, S. M. (1998). A model of the relapse process in sexual offenders. *Journal of Interpersonal Violence, 13*, 700–725.

Ward, T., & Hudson, S. M. (2000). Self-regulation model of relapse prevention. In D. R. Laws, S. M. Hudson & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp. 39–55). Thousand Oaks, CA: Sage.

Zgoba, K. M., Sager, W. R., & Witt, P. H. (2003). Evaluation of New Jersey's sex offender treatment program at the Adult Diagnostic and Treatment Center: Preliminary results. *Journal of Psychiatry and Law, 31*, 133–164.