Sex Offender Treatment in Georgia: An Exploratory Analysis of the RNR Model and Provider Perceptions

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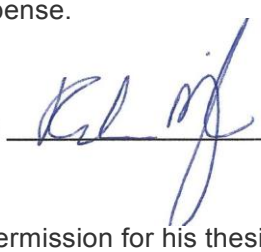
Signature 

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ABSTRACT

This study was a qualitative examination of the current treatment practices for sex offenders across the state of Georgia and support for the RNR model. It established the risks for recidivism and treatment needs that are associated with sex offenders, what treatment features are required by the state, where treatments are being offered, what treatment programs are being offered, and what features these different programs entail. It examined examine the use of the RNR model and the use of risk assessment tools for determining recidivism risk and level of treatment. Additionally, it examined treatment providers' perceptions of sex offender treatment. Two overarching themes were found, Community Reentry and Treatment Program, indicating therapists include many additional aspects in their treatment than the minimums required by the state. The results of this study support use of the RNR model and cognitive behavioral therapy in Georgia. Many respondents indicated the need for additional services, and access to treatment may be a problem for many offenders. This exploration provided a better understanding of how released sex offenders' treatment needs are being met in the State of Georgia.

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Chapter I

INTRODUCTION

There is no question that the impact of sexual offending is great, and few other crimes receive the same outrage. Public concern over sexual offenders tends to be heightened due to the media coverage of a small number of crimes perpetrated by previously convicted sex offenders (Borzecki & Wormith, 1987; CSOM, 2008; Collins, Brown, & Lennings, 2010; McGrath, Cumming, Livingston, & Hoke, 2003; Sandler, Freeman, & Socia, 2008; Schmucker & Lösel, 2008). The Human Rights Watch (2007) suggests this media phenomenon is primarily due to misconceptions that sexual crimes are primarily being committed by convicted sex offenders or by strangers. Sandler and colleagues (2008) explored these assumptions and found that 95.9% of all registerable sex offenses were committed by first-time sex offenders. Contrary to the media stories, Berzosky, Krebs, Langton, Planty, and Smiley-McDonald (2013) found 78% of offenders are a family member, partner, or other acquaintance, not an unknown assailant. Nonetheless, the impact of sexual assault on victims, families, and neighborhoods garners concern at all levels of government and has resulted in several policies and practices aimed at those who commit sex offenses (CSOM, 2008).

There are numerous crimes an offender can commit to be labeled a sex offender; the definitions of which vary considerably by wording, location, culture, medical usage,

legal statute, etc. (e.g., Adam Walsh Child Protection and Safety Act of 2006; Holmes & Holmes, 2009; Merriam-Webster Inc., 2018; Stedman, 2008). Although evidence suggests there are some similarities between sexual offenders and other offenders, sex offenders have been found to have recidivism rates, recidivism risks, treatment needs, and community reentry restrictions that differ from non-sex offenders, and these differences vary by type of sexual offender as well (Abracen, Looman, Ferguson, Harkins, & Mailloux, 2011; Andrews & Bonta, 2010; Bates, Falshaw, Corbett, Patel, & Friendship, 2004; Ducro & Pham, 2006; Hanson, Lunetta, Phenix, Neeley, & Epperson, 2014; Hanson & Morton-Bourgon, 2005; Hanson & Morton-Bourgon, 2009; Hanson, Thornton, Helmus, & Babchischin, 2016; Holmes & Holmes, 2009; Mercado, Alvarez, & Levenson, 2008; Smallbone & Rallings, 2013). For example, common policies for sex offenders re-entering the community range from employment and housing restrictions to notification laws, and these ultimately affect familial relationships, mental states, technical violations, recidivism, and more (Bench & Allen, 2013; CSOM, 2008; Mercado et al., 2008; U.S. Department of Justice, 2018).

The myriad of legislation, recidivism risks, and treatment needs distinct to sex offenders has led to the use of a variety of actuarial tools designed to assess the prediction of recidivism, both general and sexual (Barbaree, Langton, & Peacock, 2006; Hanson & Morton-Bourgon, 2009). Many actuarial tools, such as the Level of Service Inventory-Revised (LSI-R), were created to measure offenders' risks for recidivism, but most do not successfully predict sexual offenders' risks nor assist in determining their needs (Andrews & Bonta, 2010). The LSI-R was found to successfully predict general

reoffending in sex offenders, but it was worse than chance in the prediction of sexual reoffending (Ragusa-Salerno, Ostermann, & Thomas, 2013). To account for this issue, the creation of tools specifically designed for sexual reoffending have been created. For example, Hanson and Thornton (2000) created the Static-99 which experienced better predictive accuracy in sexual reoffending than two previous tools, the RRASOR and SACJ-Min. Such tools not only assist in the prediction of recidivism, but they have also been used in determining and evaluating treatment needs (Abracen et al., 2011; Andrews & Bonta, 2010; Bates et al., 2004; Craissati, South, & Bierer, 2009; Hanson, Broom, & Stephenson, 2004; Harkins, Flak, Beech, & Woodhams, 2012).

Understanding an offenders' treatment needs is just as important as understanding their risks of recidivism (Andrews & Bonta, 2010). Evidence supports the effectiveness of treatment for sex offenders. Reductions between 5%-15% have been observed between treated and nontreated offenders, and some studies have shown reductions upwards of about a third (Craissati et al., 2009; Hanson, Gordon, Harris, Marques, Murphy, Quinsey, & Seto, 2002; Schmucker & Lösel, 2008). The use of cognitive-behavioral therapies has become one of the most influential treatment methods and has produced the greatest reductions in recidivism between treated and untreated offenders (Andrews & Bonta, 2010; Borzecki & Wormith, 1987; Craissati et al., 2009). These treatments experience the greatest successes because they focus on multiple risk factors related to criminal activity, such as antisocial cognitions, maladaptive personality patterns, and criminal behavior (Andrews & Bonta, 2010).

Just as the type of treatment offered to offenders results in different treatment effects, where the treatment is received–in prison or within the community–may be of significance as well. Although the majority of correctional facilities offer some form of treatment to offenders, their focus tends to be on custody, resulting in less effective treatments being offered (Holmes & Holmes, 2009). As treatments in the United States have primarily been offered within the prison setting, rather than within the community or in mental health facilities as other countries often do, many evaluations of treatment programs focus on offender treatment within prisons (Borzecki & Wormith, 1987; Collins et al., 2010). For example, Borzecki and Wormith (1987) found the majority of available treatments within the U.S. were in prisons with only a few programs specified as out-patient or hospital services. However, as Craissati and colleagues (2009) noted, it is arguably more important to evaluate the effectiveness of community treatments in reducing sexual recidivism in offenders. Considering the majority of offenders will return to the community, it is paramount that treatment is being offered to offenders returning to, and remaining within, the community (Collins et al., 2010; McGrath, et al., 2003).

To ensure sexual offenders within the community receive adequate treatment, it is important to first establish what risks for recidivism and treatment needs are associated with sex offenders, what treatment features are required by the state, where treatments are being offered, what treatment programs are being offered, and what features these different programs entail. To that end, this study will first conduct a review of the current literature to establish an understanding of sexual offenders and

offending, the laws surrounding sexual offenders and their effects, and sex offender interventions. This will include an examination of the Risk-Need-Responsivity (RNR) model as it is a widely utilized means of intervention for all offenders. Additionally, the treatment requirements for registered sex offenders in the state of Georgia as per the Department of Community Supervision standards will be reviewed including therapist qualifications.

Finally, this study aims to answer a number of questions regarding treatment in the state of Georgia. It will first examine the use of the RNR model by the state. Specifically, it will explore the use of risk assessment tools for determining recidivism risk and level of treatment. Then, it intends to establish the programming and features of the programming that is being offered. Next, availability of treatment will be considered by determining the locations for all community treatment programs within the state of Georgia. Finally, an examination of treatment providers' perceptions of sex offender treatment will be conducted. This exploration will offer a better understanding of how released sex offenders' needs are being met in order to enable successful reintegration in the State of Georgia.

Chapter II

LITERATURE REVIEW

There is an overall perception that sex offenders are high-risk offenders that cannot be treated. These offenders illicit fear from the public, and they receive harsher penalties than most offenders. Whether or not such fears and penalties are justified is of concern, but of greater concern is whether or not these offenders are receiving adequate treatment within the community despite these perceptions. This chapter will bring a better understanding of sexual offenders and sexual offending as well as the perceptions related to sexual offending.

First, this chapter will delve into what constitutes a sexual offender. In order to better understand sex offenders, it is imperative to understand who sex offenders are and how sex offenders differ from other offenders. Second, this chapter will explore sex offender related legislation and policy. This is important to understanding sexual recidivism as these policies can affect many factors related to sexual reoffending. As such, the application of policy, balancing legislation and rehabilitation, residency restrictions, and policy validity will also be discussed.

Next, the theoretical foundations of sex offender interventions will be investigated. The most effective interventions follow the Risk-Need-Responsivity (RNR) model of intervention (Andrews & Bonta, 2010). The principles and application of RNR

will be discussed, and the use and validity of actuarial devices will be explored. Then, the management of sex offenders will be examined. Specifically, the treatments that have been shown to be the most effective in reducing sexual recidivism (cognitive-behavioral therapies), what factors affect treatment success, and treatment success within the community, in particular, will be explored (Andrews & Bonta, 2010; Holmes & Holmes, 2009).

Finally, the Georgia Department of Community Supervision (DCS) requirements for treatment and treatment providers within the state of Georgia will be examined. Georgia DCS has established certain criteria that therapists treating sex offenders must adhere to (DCS, 2018). These criteria include therapist qualifications, professional conduct, fees, sex offender evaluations, sex offender treatment, and polygraphing, among others. DCS guidelines are updated periodically, and the most recent guidelines, as of July 2018, will be utilized for these purposes (DCS, 2018).

Defining Sex Offenders

A sex offender is anyone who has committed a sex offense. More specifically, a person is labelled a sex offender by the state if they have been convicted of any one of a number of sexually deviant acts that have been labelled criminal by legislators (Holmes & Holmes, 2009). The acts that result in criminal sanctions vary by culture and location; such acts include, but are not limited to, sexual assault, incest, rape, pedophilia, and child pornography (Holmes & Holmes, 2009). Additionally, the definition of the act itself may produce different outcomes. For example, Koss (1993) found the prevalence rates

of rape varied greatly dependent upon a number of inclusion factors, including the definition of rape.

Sex offenders are obviously known for having committed a sexual offense; however, this may not be, and likely is not, the only criminal offense that an offender commits. Numerous studies consider the recidivism rates of sex offenders and find that sex offenders commit general and violent crimes just as often, if not more, than sexual crimes (Andrews & Bonta, 2010). For example, Ducro and Pham (2006) found recidivism rates of 33.1% for general offenses and 17.1% for violent offenses. Hanson and Morton-Bourgon (2004) found recidivism rates of 58.2% for general offenses and 43.6% for violent offenses.

These findings, and many more, indicate there are similarities between sex offenders and non-sex offenders; however, there are also clear differences between those who commit sexually motivated offenses and those who do not (Andrews & Bonta, 2010; Holmes & Holmes, 2009). Sex offenders have been found to have differences in risks of recidivism and treatment needs than non-sex offenders. They are also more likely to recidivate with sexually related offenses than non-sex offenders, and different types of sex offenders have a greater risk of recidivating sexually than others (Andrews & Bonta, 2010). For example, Alexander (as cited in Holmes & Holmes, 2009) found none of the treated incest perpetrators recidivated while 5.3% of the untreated incest perpetrators recidivated, and 7.8% of the treated child molesters recidivated while 25% of untreated child molesters recidivated. Additionally, regardless of offense type, sex offenders are subject to numerous legislative restrictions that other offenders

are not (Bates, et al., 2004; Bench & Allen, 2013; Hanson & Morton-Bourgon, 2009; Hanson, et al., 2016; Harkins, et al., 2012; Holmes & Holmes, 2009; Mercado, Alvarez, & Levenson, 2008; Seabloom, Seabloom, Seabloom, Barron, & Hendrickson, 2003). In recent years, there has been an expansion in registration and notification policies across the United States.

Sex Offender Policy

Public concern and media attention of high-profile cases and known sex offenders within communities has led to legislative concerns (Borzecki & Wormith, 1987; Schmucker & Lösel, 2008; Sloas, Steele, & Hare, 2012). This has resulted in the implementation of legislation such as the Jacob Wetterling Crimes Against Children Registration Act (1994), Megan's Law (1996), and the Adam Walsh Child Protection and Safety Act of 2006 (AWA). Despite such legislation, there continues to be a lack of consistency across states (Borzecki & Wormith, 1987; Schmucker & Lösel, 2008; Sloas et al., 2012).

Specific Policies

The Jacob Wetterling Act (1994) was named after eleven-year old Jacob Wetterling, following his abduction and murder (Human Rights Watch, 2007). It was the first legislation to implement sex offender registration and notification (Office of Justice Programs, n.d.). The Act instituted state standards for registration, established higher classes of sexually violent criminals, and it required address verifications and registration for life for these offenders (Office of Justice Programs, n.d.). Additionally, public notification was authorized but not required (Human Rights Watch, 2007).

Megan's Law (1996) was passed by Congress to amend the Jacob Wetterling Act (Office of Justice Programs, n.d.). This legislation was in response to the rape and murder of seven-year old Megan Kanka (Human Rights Watch, 2007). It required registered sex offenders to provide public notice, making public notification no longer discretionary, and it expanded policy to include all sex offenders, not merely the sexually violent (Office of Justice Programs, n.d.; Human Rights Watch, 2007). It also mandated that information in state registration programs could be disclosed as per state laws (Office of Justice Programs, n.d.).

These policies have been expanded upon to include further restrictions and notification requirements through the implementation of the Adam Walsh Act. This Act is a comprehensive, nationalized sex offender registration and notification statute named after kidnapped and murdered Florida boy, Adam Walsh. It establishes a national sex offender registry with a three-tier classification system. The Act advocates state conformity by dictating what information is to be collected from registrants, how long they are to remain on the registry, and the penalties for failing to register. Each offender is also required to notify their community when they move into an area and adhere to any residency restrictions. Under these policies, society has gained unfettered access to large amounts of data on convicted sex offenders through registries (Human Rights Watch, 2007).

The United States is not alone in their concern of sexual offenders within communities; however, it does have some of the most restrictive and encompassing legislation compared to other countries (Human Rights Watch, 2007). Only six other

countries around the world have some form of sex offender registration laws. This includes the United Kingdom, Australia, Canada, Japan, Ireland, and France; however, none of these countries have encompassing community notification policies. Australia, Ireland, and United Kingdom have determined that there is no evidence to support mandatory community notification laws. Today, the United States is the only country, aside from South Korea, that requires community notification and no other country requires residency restrictions (Human Rights Watch, 2007).

This has called into question the validity, integrity, and constitutionality of such legislations. The Human Rights Watch (2007) argues sex offender legislation often discounts the rights of returning offenders. Admittedly, the perpetration of a crime inherently limits certain rights, but they argue legislation should be the least restrictive to accomplish public safety goals (Human Rights Watch, 2007). Although Sample and Kadleck (2008) found many public officials believe legislation has not gone far enough, the Human Rights Watch (2007) argues current legislation is too broad, too restrictive, and overlong in duration (as for registration). They also believe access to information is too accessible, allowing for abuse toward registrants, and states should not have the ability to implement legislation even more restrictive than federal laws (Human Rights Watch, 2007).

Although federal legislation is in place, the majority of legislation occurs at a local level which allows for confusion and over-breadth of legislation (Human Rights Watch, 2007). Legislation at the federal, state, and local levels are oriented toward harsh punishments and incarceration, to the point of civil commitment, with minimal

regard for offender's rights to privacy and safety or access to treatment and other factors related to reductions in recidivism (Human rights Watch, 2007; Schmucker & Lösel, 2008; Sloas et al., 2012; U.S. Department of Justice, 2018). The lack of uniformity, despite laws, such as the aforementioned, may potentially produce more harm than good (Human Rights Watch, 2007). The sheer number of registered sex offenders, over 600,000, makes it difficult for police to supervise offenders, and the restrictive nature of legislation hampers rehabilitative efforts (Human Rights Watch, 2007; Levenson & Tewksbury, 2009).

Policy Compliance

In order to balance the restrictive and rehabilitative goals of different policies, multiagency cooperation should occur at all levels of government (CSOM, 2008; Day, Carson, Boni, & Hobbs, 2014; Human Rights Watch, 2007; Sloas et al., 2012; U.S. Department of Justice, 2018). The Center for Sex Offender Management (2008) suggests a comprehensive approach to sex offender management. Strategies should integrate all aspects of the criminal justice process, from investigation, sentencing, and assessment to supervision, treatment, registration, and more. The "Comprehensive Approach" is designed to encourage a collaborative response aimed at management and recidivism reduction, but this is only possible if key entities at all levels are involved in the process (CSOM, 2008).

The use of registry and notification legislation is a perfect example of an aspect that would be more effective with collaboration (CSOM, 2008). The Sex Offender Registry is generally limited to those convicted of sexually related offenses; however,

there are exceptions, such as some child custody related offenses (U.S. Department of Justice, 2018). Registries are conducted and maintained on a local level feeding a national registry with information from these localities. Policies and procedures involving the registration and notification process vary by locale and may lack consistency across jurisdictions (CSOM, 2008; U.S. Department of Justice, 2018). Although these policies stem from the federal measures concerning minimum standards for registration and notification, each jurisdiction also retains the ability to create policies that are even harsher and restrictive than federal standards (Human Rights Watch, 2007).

To promote consistency, federal policies can withhold state funding if they are not implemented (U.S. Department of Justice, 2018). For example, states that do not implement the Sex Offender Registration and Notification Act (SORNA), Title 1 of the AWA, risk losing 10% of their Edward R. Byrne Justice Assistance Grant funds that would otherwise be allocated to the state (Human Rights Watch, 2007; U.S. Department of Justice, 2018). Should a jurisdiction require assistance in order to meet compliance, federal statute allows for grants to encourage implementation.

There are other federal statutes involved in managing sex offenders. For example, rapists are prohibited from having visitation rights to children fostered through rape, and there are a series of statutes depicting the requirements of sex offenders when traveling (The Omnibus Crime Control and Safe Streets Act of 1968). Failure to comply with these statutes or not register can result in various penalties, also varying by state, including being criminally liable (U.S. Department of Justice, 2018).

Despite these federal measures toward standardization, the majority of legislation remains on a local level where specific implementation varies greatly (CSOM, 2008; Day et al., 2014; Human Rights Watch, 2007; U.S. Department of Justice, 2018).

Validity of Sex Offender Policy

Sex offender legislation is often steeped in good intentions; however, they do not necessarily have the empirical evidence to support their implementation (Day et al., 2014; Göbbels, Willis, & Ward, 2014; Levenson & Tewksbury, 2009; Sandler, Freeman, & Socia, 2008; Schmucker & Lösel, 2008). Mercado and colleagues (2008) and Levenson and Tewskbury (2009) found detrimental effects for both sex offenders returning to the community and their families, from employment and residential issues to stigmatization and violence toward sex offender's family members. Sandler and colleagues (2008) found no significant impacts on sexual reoffending with the enactment of New York State's Sex Offender Registration Act (SORA); however, Day and colleagues (2014) noted there has been mixed results as to the effectiveness of the many registration and notification statutes. Additionally, they argued residency restrictions have found no evidence to suggest any effectiveness (Day et al., 2014). Göbbels and colleagues (2014) found that although treatment measures had positive impacts on recidivism, re-entry was adversely affected by lack of resources and restrictive legislations.

The Human Rights Watch (2007) suggests the nullification, or at the very least reevaluation, of such laws is warranted. There is a lack of empirical evidence to support such legislation, and the impairments to stable employment, social supports, and treatment is concerning (Human Rights Watch, 2007). As treatment has been found to

be essential in reducing sexual recidivism, efforts to develop policy based on empirical evidence is imperative (Craissati et al., 2009; Human Rights Watch, 2007; Schmucker & Lösel, 2003; Hanson, et al., 2002). Research that focuses on the factors associated with treatment refusal, offender behaviors, cognitive functioning, risks for recidivism, and treatment needs of sexual offenders is necessary in order to better assist with the assessment and treatment of offenders (Borzecki & Wormith, 1987; Brown & Tully, 2014; Collins et al., 2010; Craissati et al., 2009; Hanson & Bussière, 1998; Hanson & Morton-Bourgon, 2005; Kraemer, Salisbury, & Spielman, 1998; Schmucker & Lösel, 2008). These efforts not only allow practitioners to understand risk factors associated with the offender but also provides pertinent information that can be used to provide on-going services and interventions offered for successful reintegration.

Sex Offender Intervention

In the wake of legislation aimed specifically at sexual offenders re-entering the community, the question remains if these policies help or hinder the rehabilitation efforts of these offenders. The goal of the criminal justice system is to promote the safety of the public; therefore, implementation of practices that best support this goal should be paramount (Holmes & Holmes, 2009). Some of the most effective interventions are found in the use of the RNR model for the assessment and treatment of offenders (Andrews & Bonta, 2010).

Theoretical Framework of the RNR Model

The RNR model assists in all efforts of crime control, not merely in the identification of risks and needs of offenders (Andrews & Bonta, 2010). As outlined in

the Principles of Effective Intervention (PEI), there are a multitude of principles designed to assist with effective correctional assessment and crime prevention. Among these are respect for the person, professional discretion, and organizational structures, among others. A main focus of the RNR model, which is a part of the PEI, is the identification of who should be offered services, the most appropriate services to target the reduction in criminal behaviors, and how the services should be employed. This process begins with the risk principle (Andrews & Bonta, 2010).

Risk Principle

The first key principle in the RNR model encapsulates the concept of risk (Andrews & Bonta, 2010). This includes the ideas that criminal behavior can be predicted, and treatment of offenders should be matched to the risk level associated with that prediction. The risk principle implies that those offenders that are evaluated at a higher risk of reoffending require more intensive interventions to prevent recidivation (Andrews & Bonta, 2010).

The risk of recidivism is captured by using actuarial risk assessment tools. There have been several tools created specifically for sex offenders. Some of the most frequently used actuarial tools for this population include the Violence Risk Appraisal Guide (VRAG), the Sex Offender Risk Appraisal Guide (SORAG), the Rapid Risk Assessment for Sex Offense Recidivism (RRASOR), and the Static-99.

VRAG. The VRAG was designed for use in the prediction of violent offending (Harris, Rice, & Quinsey, 1993). It has since been used in the assessment of violent and sexual offending in sex offenders (Harris, Rice, Quinsey, Lalumière, Boer, & Lang, 2003;

Rice, Harris, & Lang, 2013). Evaluations of the VRAG have found contradicting evidence as to the validity of use with sexual offenders ranging from no predictive ability to moderate predictive accuracy (Harris et al., 2003; Lofthouse, Lindsay, Totsika, Hastings, Boer, & Haaven, 2013). Harris and colleagues (2003) found moderate effects sizes for sexual recidivism using the VRAG in a study of 396 male sex offenders; however, they found large effects sizes for violent and general recidivism. Lofthouse and colleagues (2013) found no predictive validity for use in those with intellectual disabilities.

SORAG. Quinsey (as cited in Looman, 2006) defined the SORAG as a 14-item actuarial tool designed for the purposes of predicting violent reoffending in sex offenders. It has been found to have moderate to large predictive accuracy (Ducro & Pham, 2006; Harris, et al., 2003; Looman, 2006). In a study of 147 male sex offender patients in a maximum-security psychiatric hospital in Belgium, Ducro and Pham (2006) found larger associations with general and violent recidivism than sexual recidivism, but overall moderate to large predictive accuracy was found. They also found greater associations to the prediction of recidivism for rapists than any other subgroup. Looman (2006) evaluated 258 sex offenders in Canada and found predictive validity for both sexual and violent recidivism, and Harris and colleagues (2003) found moderate effects sizes for sexual recidivism in a Canadian sample using the SORAG.

RRASOR. The RRASOR is a 4-item actuarial risk assessment tool designed to predict sexual recidivism (Hanson, 1997). Overall predictive validity of the RRASOR has been found to be moderate to large (Allan, Dawson, & Allan, 2006; Hanson & Thornton, 2000; Lehmann, Hanson, Babchishin, Gallasch-Nemitz, Biedermann, & Dahle, 2013;

McGrath, et al., 2003; Smid, Kamphuis, Wever, & Van Beek, 2014). For example, Lehmann, Hanson, Babchishin, Gallasch-Nemitz, Biedermann, and Dahle (2013) found the RRASOR to have significant predictive accuracy for sexual, violent, and general recidivism. The RRASOR performed with moderate to large predictive accuracy for sexual recidivism in two Dutch subsamples during a 5- to 10- year follow-up study (Smid et al., 2014). However, Harris and colleagues (2003) only found small to moderate predictive accuracy, a significant deviation from the majority of published studies, and Langstrom (2004) found the tool had no predictive accuracy for African-Asians. Allan and colleagues (2006) found the RRASOR to predict recidivism poorly for Indigenous Australians; however, for non-Indigenous Australians results were similar to other studies.

Static-99. Hanson and Thornton (2000) created the Static-99 as means of predicting sexual recidivism by combining static factor components of the RRASOR and the Structured Anchored Criminal Judgement–Minimum (SACJ-Min). It produced greater predictive accuracy than both its predecessors (Hanson & Thornton, 2000; Hanson et al., 2014). Although Harris and colleagues (2003) only found small to moderate predictive accuracy with the Static-99, since its creation, the Static-99, as well as its revised editions, has consistently been found to have comparable predictive accuracy or greater predictive accuracy than many other tools for sexual recidivism (Allan et al., 2006; Ducro & Pham, 2006; Hanson et al., 2014; Hanson & Thornton, 2000; Langstrom, 2004; Lehmann et al., 2013; Lofthouse, et al., 2013; Looman, 2006; McGrath,

et al., 2003; Rettenberger, Haubner-Maclean, & Eher, 2013; Smallbone & Rallings, 2013; Smid et al., 2014; Stadtland, Hollweg, Kleindienst, Dietl, reich, & Nedopil, 2005).

Allan and colleagues (2006) found the Static-99 to be effective in the classification of sexual offenders. Ducro and Pham (2006) found the predictive validity of the tool to be moderate with the greatest associations seen in the prediction of recidivism for child abusers. Of note, Langstrom (2004) found predictive accuracy of the Static-99 varied by ethnicity with Nordic and European subgroups having moderate predictive accuracy and the African subgroup experiencing no predictive accuracy.

Summary. These tools are used to determine the risk classification of sex offenders. Each of the risk assessments explore different risk factors, or criminogenic needs, related to each sex offender. Those offenders who have more criminogenic needs are designated as higher risk for recidivism. Decades of research has gone into the creation and testing of these tools to effectively determine those risk factors most applicable to sex offenders.

Need Principle

The need principle refers to the criminogenic needs associated with the offender (Andrews & Bonta, 2010). Criminogenic needs are those dynamic factors that, when changed, lower the risk of an offender's recidivism. For the general offender, these factors include antisocial behavior, antisocial cognitions, family support, employment, and more. In total, Andrews and Bonta (2010) suggest eight criminogenic factors, referred to as the "Central Eight," that should be targeted to promote effective

treatment (Andrews & Bonta, 2010). Sex offenders have been shown to have some overlapping needs but present risk factors specific to their sexual offending.

In their meta-analysis of 61 studies, Hanson and Bussière (1998) found small effects for the demographic variables of age (young) and marital status (single); however, they found moderate to large effects in the prediction of sexual recidivism for antisocial personality disorder, total number of prior offenses, sexual criminal history, sexual deviancy, failure to complete treatment, and negative relationship with mother with sexual deviancy demonstrating the greatest effects (Hanson & Bussière, 1998).

Hanson and Morton-Bourgon (2004, 2005) found that common variables leading to general and violent recidivism were related to antisocial orientation, similar to many offenders. Sexual deviancy, intimacy deficits, and antisocial orientation were the major predictors of sexual recidivism (Hanson & Morton-Bourgon, 2004; Hanson & Morton-Bourgon, 2005). The use of a combination of variables to predict risk demonstrated the most predictive ability (Hanson & Bussière, 1998). Actuarial tools use combinations of variables related to risk, and they are some of the most common measures used to determine risk of recidivism and treatment needs (Andrews & Bonta, 2010).

Responsivity Principle

The final key principle in the RNR model is the responsivity principle which involves the treatment delivery (Andrews & Bonta, 2010). This can be further divided into two parts: general responsivity and specific responsivity. Specific responsivity considers the offender characteristics that go beyond general recidivation concerns, such as offender empathy and maturity. The goal here is to minimize individual barriers

to treatment. General responsivity refers to the treatment types that are the most effective, despite offender type. Strategies, such as cognitive-behavioral therapy, that include modeling, reinforcement, modification, and cognitive restructuring, among other features, are the most effective no matter the type of offender (Andrews & Bonta, 2010).

Summary

When taken as a whole, the RNR model promotes the ideals of the criminal justice system by focusing on the most pertinent factors associated with recidivism and the best means to reduce the chances of recidivism through effective treatment (Andrews & Bonta, 2010; Holmes & Holmes, 2009). This model has been used across the United States as a framework for effective interventions. It can also be used to address the needs of special populations including sex offenders.

Sex Offender Treatment

Understanding the risk and needs of each offender is crucial in the determination of supervision methods and treatment needs (i.e. the responsivity principle) (Abracen et al., 2011; Andrews & Bonta, 2010; Bates et al., 2004; Hanson & Bussière, 1998; Hanson et al. 2014; Hanson, et al., 2016; Holmes & Holmes, 2009; Pflugradt & Allen, 2014; Schmucker & Lösel, 2008). Treatments for sex offenders have centered on medical and cognitive-behavioral interventions with cognitive-behavioral therapies producing the most effective results (Andrews & Bonta, 2010; Holmes & Holmes, 2009). These treatment modalities greatly differ in terms of ethics and effectiveness.

Medical Interventions

A historically common approach to reducing sexual recidivism has focused on decreasing arousal to prevent deviant sexual acts (Andrews & Bonta, 2010; Holmes & Holmes, 2009). Initially, common practice included the use of physical castration (Andrews & Bonta, 2010). Although not actively used, castration methods have been found to be effective to a degree; however, ethical concerns over physical castration have led to a decline in use, replaced with pharmaceutical castration, or antiandrogen treatment (Andrews & Bonta, 2010; Borzecki & Wormith, 1987; Schmucker & Lösel, 2008).

Pharmaceutical castration uses drugs to lower testosterone levels and decrease sexual urges (Andrews & Bonta, 2010; Holmes & Holmes, 2009). For example, Depo-Provera is a common synthetic hormone used to produce lowered testosterone levels (Holmes & Holmes, 2009). Although preferable to physical castration, the use of pharmaceutical drugs is also controversial due their possible short- and long- term side effects. Additionally, a decrease in sexual drive does not equate to a change in behavior; therefore, once these drugs are no longer administered, the offender may resume their previous offending behaviors (Andrews & Bonta, 2010; Holmes & Holmes, 2009).

Cognitive-Behavioral Interventions

Behavioral therapies attempt to modify behavior while cognitive therapies seek to alter an offender's cogitations or perceptions (Holmes & Holmes, 2009). Cognitive-behavioral therapies target specific behavioral patterns and cognitive functions

together; they focus on education, skills, roleplaying, recognizing triggers, learning how to avoid dangerous situations, and more (Andrews & Bonta, 2010; Allam & Browne, 1998; Holmes & Holmes, 2009). In their application for sex offenders, they specifically target those behaviors and functions that are associated with sexual offending such as dealing with intimacy deficits or appropriately expressing affection. As with other offenders, CBT has been found to be most effective when used in conjunction with the other principles in the RNR model, including aspects such as interpersonal problem-solving and ensuring the treatment type matches the risk level of the offender (Andrews & Bonta, 2010; Holmes & Holmes, 2009; Lipsey, Landenberger, & Wilson, 2007).

Treatment Effectiveness

Evaluation of treatment programs can isolate and identify the specific treatment components that produce positive outcomes in offenders (Allam & Browne, 1998). Ethical concerns aside, as castration methods do not target the behavioral, attitudinal, and cognitive functions, such as sexual deviancy, that have produced more lasting results, the use of medical interventions has become less popular (Allam & Browne, 1998; Andrews & Bonta, 2010; McGrath, et al., 2003; Schmucker & Lösel, 2008; Sloas et al., 2012). In its place, psychoeducational programs, psychological and behavioral therapies, and cognitive-behavioral therapies have become the major focus for treatment (Andrews & Bonta, 2010; Borzecki & Wormith, 1987; Craissati et al., 2009). Cognitive-behavioral treatments have been found to produce the greatest reduction in recidivism for both general offenders and sexual offenders, even after longer follow-up

periods (Allam & Browne, 1998; Andrews & Bonta, 2010; Holmes & Holmes, 2009; McGrath, et al., 2003; Schmucker & Lösel, 2008; Sloas et al., 2012).

Recidivism rates are often used as a means of evaluating treatment success. Treatment completion, whether in prison or within the community, often results in lower sexual recidivism rates than offenders that leave the treatment program early or receive no treatment (Allam & Browne, 1998; Bench & Allen, 2013; Craissati et al., 2009; Hanson & Bussière, 1998; Hanson, et al., 2002; Holmes & Holmes, 2009; McGrath, et al., 2003; Pflugradt & Allen, 2014; Schmucker & Lösel, 2008; Seabloom et al., 2003). Schmucker and Lösel (2008) found consistent reductions in recidivism of about 5% with treatment, even after longer periods of follow-up. Hanson and colleagues (2002) found higher recidivism rates for those who either received no treatment or dropped out of treatment. McGrath and colleagues (2003) found 5.4% of those who completed treatment recidivated; whereas 30.6% of those who completed some treatment and 30.0% of those who completed no treatment recidivated.

Significant changes in program outcomes, such as increasing victim empathy and decreasing deviant sexual fantasies, would also constitute program success (Collins et al., 2010). Participants of such programs have noted intrinsic motivations to change, understandings of the effects of their abuse on victims, learning behavioral controls, and achieved significantly better adherence to the program (Collins et al., 2010; Craissati et al., 2009). Allam and Browne (1998) observed deficiencies in problem-solving abilities and victim empathy, among other treatment needs, showed marked improvements with cognitive-behavioral treatment.

Finally, the type of treatment an offender receives may include group versus individual therapies, producing different results (Looman, Abracen, & Fazio, 2014). In a study comparing group versus individual therapies, no sexual recidivism differences were found between group types. Caution may be warranted, however, as Looman and colleagues (2014) also found acute differences in responsivity issues, intellectual impairments, and diagnoses between groups.

Other Factors Affecting Effectiveness. As Sloas and colleagues (2012) note, treatment type alone cannot fully explain treatment outcomes; other factors also affect treatment completion, treatment results, and recidivism. McGrath, Cumming, Hoke, and Bonn-Miller (2007) suggested use of polygraphs may affect community treatment effectiveness; however, their study of 104 polygraphed and 104 non-polygraphed sex offenders produced no significant differences between groups. Age and impulsivity have been linked to the prediction of program completion in juveniles with impulsivity having the strongest predictive effects (Kraemer et al., 1998). Harkins and colleagues (2012) used attrition rates, pre- to post- treatment changes, and facilitator perceptions in their evaluation. Collins and colleagues (2010) discussed the value of considering motivation and commitment to treatment, and McGrath and colleagues (2003) argued the need to study motivation and dynamic risk factors in regard to treatment effectiveness.

Borzecki and Wormith (1987) noted that the treatment target population and voluntarism of the program may affect treatment results and subsequently recidivism. Spatial access to treatment within the community and neighborhood family

characteristics have been found to significantly affect program participation (Sloas et al., 2012). The capacity of a facility as well as the treatment length and intensity may also contribute to program success (Borzecki & Wormith, 1987).

Community Treatment

Finally, as more offenders receive less time incarcerated and experience more community supervision-based sentences and post-prison supervision, the need to study community treatment services grows (Borzecki & Wormith, 1987; Collins et al., 2010). Although Hanson and colleagues (2004) found no recidivism differences between treated and untreated sex offenders in their study of a community sex offender treatment model in Canada, Jung and Gulayets (2011) found moderate changes in a group of Canadian sex offenders following completion of an outpatient program.

Craissati and colleagues (2009) found some treatment success in their evaluation of both structured (such as cognitive-behavioral therapy) and unstructured (such as relapse prevention) community treatments in London. They found overall low sexual and violent reconviction rates, and sexual and violent re-offending was lowest among those who completed treatment programs. The highest levels of sexual and violent re-offending were found with those who did not complete treatment (Craissati et al., 2009). In a study of 195 sex offenders, McGrath and colleagues (2003) found only four of the 45 sexual recidivists offended while in a community treatment atmosphere, and the longer participants were in an outpatient treatment the less likely they were to recidivate. Kraemer and colleagues (1998) noted there have been similar treatment completion results for juveniles, and Seabloom and colleagues (2003) found similar

results with no sexual rearrests and fewer non-sexual rearrests 24-years post treatment completion.

Summary

Craissati and colleagues (2009) suggest it is important to continue researching treatment effectiveness in order to influence future treatment goals and success. This should include treatment programs where goals do not focus solely on sexual offending rather on all types of criminal behavior (McGrath, et al., 2003). The evidence suggests that community treatment has a positive impact on offenders and offending, and Allam and Browne (1998) suggest the costs of not implementing treatment are too great to ignore for offenders and potential victims.

If this is the case, then it could be argued that ensuring offenders have access to effective treatment is a cost worth paying. As Sloas and colleagues (2012) argued, access to treatment is affected by more than merely availability; it is also related to the distance of travel required to access these treatments. Additionally, access to effective treatment is also imperative as reductions in recidivism indicate the treatment type produces varying results (Allam & Browne, 1998; Andrews & Bonta, 2010; McGrath, et al., 2003; Schmucker & Lösel, 2008; Sloas et al., 2012). Collins and colleagues (2010) found effective treatments were not only dependent upon the type of treatment (cognitive-behavioral), but also the structure (frequency of sessions) and facilitator characteristics (mixed genders) were crucial aspects to program success. These findings indicate the importance of access to treatment and the type of treatment available; however, they also indicate the features of the programs themselves are just as

important to program success. With this in mind, examining program requirements set forth by the state is beneficial to determine if the minimum program requirements set by the state of Georgia for offenders within the community adhere to the current literature.

Georgia DOCS Sex Offender Treatment

The Georgia Department of Community Supervision has a unit explicitly intended for the supervision of sexual offenders, the Sex Offender Administration Unit (DCS, 2018). These supervising officers work closely with both the sex offender treatment providers and the polygraph examiners that are certified with the state (DCS, 2018; DCS, n.d.). Treatment providers must meet specific qualifications and follow specific procedures. These rules range from educational and training requirements, informed consent, and relationships with clients to fees, professional conduct, and treatment requirements for the treatment provider. Treatment must target offender risks and needs, and it must include cognitive-behavioral therapies. If provider qualifications or treatment requirements are not met or if the policies are not followed, then a therapist's contract with the state may be revoked (DCS, 2018).

Therapist Qualifications

Therapists who wish to work with sex offenders must be certified with the state of Georgia and sign a contract with the state (DCS, 2018). Therapists must provide documentation that they are satisfying the requirements of the state upon applying for a contract, during their annual contract renewal, and whenever requested by the state. Documentation may include changes or updates to treatment programs, changes to

appropriate licensing, verification of continuing education, and more. They must also inform the Department of newly hired therapists and their qualifications (DCS, 2018).

In order to be a qualified sex offender treatment provider, therapists must establish they meet a list of education-related qualifications (DCS, 2018). Therapists are required to be licensed in the state of Georgia by an appropriate licensing board. Graduate studies, training, and experience should be completed in 19 topics, which include, but are not limited to, counseling and psychotherapy, etiology of sexual deviance, psychometric assessment, risk assessment, sexual arousal assessment and reconditioning, human sexuality, relapse prevention, cognitive restructuring therapy, federal and state abuse statutes, and others. Therapists must provide a minimum of 2000 clinical hours with clients. These are to be face-to-face contacts, and the client must have committed sexual abuse. Additionally, at least ten hours of Continuing Education Units (CEUs) must be obtained every year in the field of sexual abuse and five hours in evaluation, treatment, and/or management of sexual abusers (DCS, 2018).

Treatment providers have a variety of other standards that are required to be maintained (DCS, 2018). An active clinical membership is required to be held with a professional organization in their discipline, and an active membership with the Association for the Treatment of Sexual Abusers (ATSA) is required. Malpractice or proof of liability insurance in the amount of at least $1,000,000 will be carried. Lastly, criminal background checks are to be conducted every two years on every employee (DCS, 2018).

The penalties for not maintaining qualifications and policies can range from suspension of certification to debarment (DCS, 2018). If any employee is arrested or convicted, the DCS must be notified within 24 hours. Changes or updates to treatment programs are required to be documented within 30 days of the change. Therapists are not to have been convicted of a felony or sexual offense; if any criminal charges arise, they must be reported immediately. Revocation of state licensing for any reason must be reported within five business days. Failure to demonstrate compliance with these requirements or provide appropriate documentation can result in suspension or immediate revocation of certification. Therapists are notified in writing and provided 30 days to comply and/or respond before their contract is terminated. If therapists fail to submit documents, immediate decertification may occur as well. A therapist is debarred from the DCS provider list for two years if revocation occurs (DCS, 2018).

DCS Policies

There are a series of guidelines that are expected to be followed by treatment providers both before and during treatment (DCS, 2018). Informed consent must be obtained before evaluation and subsequent treatment of clients can be performed. This includes the limits to confidentiality, applicable reporting laws, and duty to warn requirements. Waivers must be signed by the client, and the therapist must retain copies, storing them in such a manner as to ensure confidentiality. Written permission must be obtained to share any information, including sharing information with the supervising officer and polygraph examiner (DCS, 2018).

An open line of communication between the therapist and the supervising officer as well as the polygraph examiner is essential (DCS, 2018; DCS, n.d.). The evaluation report of an offender must be submitted no more than 30 days post evaluation, and status reports updating supervising officers of an offender's progress must be submitted by the 15th of every month (DCS, 2018). The supervising officer should be notified within 24 hours should an offender miss a scheduled appointment. Therapists should also be available to meet with polygraph examiners and supervising officers, testify at all subpoenaed revocation hearings, and attend mandatory conference meetings (DCS, 2018).

In addition to periodic communication, therapists should maintain a professional relationship with supervisory officers and the DCS, polygraph examiners, and other professionals (DCS, 2018; DCS, n.d.). Unprofessional behavior is not tolerated and will result in a review of certification (DCS, 2018). Professional behavior includes consulting other treatment providers before offering services to an offender under that therapist's care. Should the therapist discover a client is/was in treatment with another provider, they should consult with that provider in a timely fashion. Therapists are encouraged to promote interdisciplinary cooperation; however, payment for referrals is prohibited. Additionally, treatment providers cannot direct clients to specific polygraph examiners nor schedule their exam appointments. Communication is required between therapist and the chosen examiner as the therapist must have access to polygraph testing results (DCS, 2018; DCS, n.d.).

As therapists must maintain professional conduct with the other professionals, they must also maintain professional conduct with clients (DCS, 2018). Therapists should not engage in any unofficial activities, such as personal relationships, with offenders. Sexual harassment and/or sexual relationships with clients is not permitted. Therapists may not discriminate against potential clients, nor will therapists diagnose or treat clients in manners outside their competence. Bartering between therapists and offenders for treatment services is not permitted (DCS, 2018).

The fees for services will be disclosed to the client and arrangements for payment made prior to services rendered (DCS, 2018). The amount to be charged will also be reported to DCS. Changes to fees or additional fees for new services must be provided to offenders prior to the change. The use of sliding fees for those offenders in need should be utilized, and a minimum of one per twenty paying offenders must be provided services pro bono. Additionally, if a paying offender falls behind in payment by two weeks or if termination/disruption of treatment is anticipated, therapists are required to notify supervising officers (DCS, 2018).

Pre-Treatment Evaluation

Prior to beginning treatment, the therapist must perform an evaluation of the offender (DCS, 2018). The evaluation focuses on risks and needs by identifying factors related to sexual deviancy from the offender's social and sexual histories. Information that may be garnered through the evaluation process include intellectual and cognitive functioning, medical history, personality characteristics, interpersonal relationships,

impulse control, sexual behavior, and deviant sexual behavior, among other information (DCS, 2018).

Therapists will include a review of written documentation from all available sources to garner this information (DCS, 2018). A clinical interview, sexual deviance test, psychological functioning test, intellectual assessment, physiological assessment, and risk assessment must be conducted. Interviews of the offender are utilized; however, offender self-report has known limitations. Recommendations cannot be based solely on offender interviews. Should victim interviews be conducted, extreme caution should be utilized to prevent additional harm. Physiological assessments may be obtained through penile plethysmography, polygraph, or a viewing time measure, such as the Abel Assessment for Sexual Interest. Risk assessments must be conducted using an adequately researched tool, such as the Static-99. All tests must take into account the cognitive functioning and reading and writing ability of the offender, and they should be administered in adherence to the test developer/supplier instructions. From the evaluation, therapists will determine their recommendations for intensity of intervention, identified risks, and specific treatment protocols (DCS, 2018).

Treatment

Therapists must offer treatment that is appropriate to the offender based upon the pre-treatment evaluation (DCS, 2018). Treatment of offenders is designed to assist in managing thoughts and feelings, attitudes, and behaviors and should be updated periodically based on the current literature and therapist educational training. The use of structured, cognitive-behavioral, and skills-oriented interventions are used as the

primary intervention methods in order to target dynamic risk factors and criminogenic needs. The offender's level of treatment intensity should be appropriate to match the risk of recidivism. Unstructured and insight-oriented programs may be utilized in addition to the primary intervention method; however, they are less likely to be effective on their own and cannot be the primary intervention (DCS, 2018).

Active Phase

Treatment consists of two phases: active and maintenance (DCS, 2018). The active phase is the initial treatment phase. Cognitive-behavioral approaches are required to be used by therapists. Other programming may be used in addition to cognitive-behavioral therapies, such as pharmacological therapies, educational programming, and substance abuse treatment. Treatment can be provided to offenders via group therapy, individual therapy, or both; however, group therapy is the recommended method of treatment. The active phase will not be considered complete until the client has completed a minimum of 52 treatment sessions *and* has achieved all treatment goals as outlined clearly in the written treatment plan (DCS, 2018).

Treatment contracts with offenders are designed and used to determine treatment progress (DCS, 2018). It will include the nature of treatment, program rules, expected frequency and duration, and noncompliance consequences. Frequency and duration will be dependent upon session type. If use of individual therapy is determined appropriate and is the only mode of treatment, 50-minute sessions will be required on a weekly basis. Group sessions are required to meet weekly for 90 to 120 minutes and are limited to 10 to 12 offenders per group (DCS, 2018).

The nature of treatment will include (as necessary) sexual arousal controls, denial diminishment, empathy enhancement, cognitive restructuring, relapse prevention, emotional management, family and social support, and interpersonal skills training (DCS, 2018). If sexual arousal controls are necessary, the use of odor aversion, covert desensitization, verbal satiation, masturbatory satiation, or masturbatory reconditioning may be used. Denial diminishment is a gradual process that must be implemented throughout the treatment process; offenders who continue to deny their offenses cannot successfully complete treatment. Empathy enhancements must be tailored to the individual based on victim-specific empathy deficits or generalized empathy deficits (DCS, 2018).

Cognitive restructuring is a primary component of treatment (DCS, 2018). Treatment should target perceptions, attitudes, beliefs, and cognitive distortions that allow the offender to minimize, justify, or rationalize sexually deviant behaviors. Relapse prevention is another primary component in cognitive-behavioral therapies; it is a self-control model designed to assist offenders in maintaining behavioral changes. Relapse prevention techniques should be tailored to the individual and included in the treatment plan contract. High risk offenders will require more intensive treatments which may include all of the above as well as more frequent contact with the therapist, additional behavioral training, or more frequent polygraph testing, among other interventions (DCS, 2018).

Polygraph examinations are a required part of treatment (DCS, 2018). Polygraph examiners have their own set of guidelines to follow, such as the flat rate fee ($225), the

minimum length of a session (90 minutes), and the environment for testing the offender (DCS, n.d.). They must be conducted every six months during the active phase (DCS, 2018; DCS, n.d.). The therapist may consult with the supervising officer if they believe polygraphs should be given more frequently (DCS, 2018). Once an offender is moved to the maintenance phase, a polygraph is only required once a year (DCS, 2018; DCS, n.d.).

Maintenance Phase

The maintenance phase is a follow-up to the initial treatment once the offender has achieved treatment goals (DCS, 2018). Treatment is progressively de-escalated in frequency based on the successfulness of the offender to maintain treatment gains. Group therapy, individual therapy, or both may be utilized; however, group sessions remain at a 10 to 12 capacity. Clients are encouraged to continue in the same group as during the active phase. The length of maintenance is determined by the therapist, though the supervising officer should be consulted (DCS, 2018).

Chapter III

METHODOLOGY

This study aims to add to the literature surrounding sex offender treatment by examining the availability of treatment across the state of Georgia and determining what that treatment entails. Specifically, this study looks to establish the types of treatments being offered, the features of the programs offered, and the dosage of the treatment offered. By providing an analysis of the currently offered sex offender treatment programs within the state, this study will provide insight as to whether sex offenders in Georgia are receiving treatment that meets the needs of the offenders as established by the literature. Additionally, treatment providers perceptions on current treatment practices will be examined. This study received Institutional Review Board Exemption (see Appendix A).

Data Collection

The objectives of this study were accomplished through use of surveying. Surveying is a commonly accepted means of garnering data for the purposes of measuring perceptions of a sample of the population (Fowler, 2014). The mode for data collection was via telephone interview. Telephone interviewing is the optimal choice for data collection as the interviewer has the ability to answer questions regarding the purposes of the study and/or questionnaire when needed. It has the benefit of possibly

scheduling the interview for a convenient time for the interviewee, and it can be completed relatively quickly (Fowler, 2014).

The questionnaire was provided to licensed psychologists, clinical social workers (LCSW), and professional counselors (LPC). No identifying information was obtained from participants. The questionnaire contains a total of twenty-seven possible questions a participant may be asked (see Appendix B). Twenty-three of these questions were asked to all participants. Additionally, there are four questions that could potentially be asked to participants dependent upon previous answers. Except for questions that relate to the treatment facility and the provider's length of time in counseling services, all questions pertain to treatment information, including use of assessment tools, types of treatment, dosage of treatment, and recidivism information, among other features.

Sample

Participants for this study were garnered from the Georgia DCS Approved Sex Offender Treatment Provider Directory (see Appendix C). The Sex Offender Administration Unit's most recent update of this list included thirty-two practices, one of which was determined to have retired leaving thirty-one possible participating practices. All possible participants were initially contacted via email to inform prospective participants of the study aims and to request an interview. Follow-up telephone calls were utilized for those who did not respond to the initial email.

A total of 14 interviews were conducted. Although this sample size is smaller, it is common for qualitative research to utilize smaller sample sizes (Luborsky &

Rubinstein, 1995; Magilvy & Thomas, 2009; Malterud, Siersma, & Guassora, 2016). Luborsky and Rubinstein (1995) noted between 12 and 26 participants is preferred, but sample sizes of less than ten are common. Magilvy and Thomas (2009) state upwards of 20 participants is preferred; however, as few as three to five participants may be justified, especially for novice researchers. The current study's sample size falls within the minimum and preferred sample sizes. Additionally, when participants hold highly specific characteristics that meet the study's aim, only a smaller sample frame is needed (Malterud et al., 2016). This study was concerned with sex offender treatments, only for offenders being serviced within the community, and the treatment providers are required to be certified by the state, meeting specific requirements (as per the Georgia DCS guidelines) to treat said offenders (DCS, 2018). These parameters provide a highly specific target sample, justifying use of a smaller sample size.

All participants within the sample were apprised of all pertinent information regarding the study prior to completion and the minimum requirements to complete the questionnaire. There are only two considerations for participation in this study: 1) The counselor or psychologist must be an active therapist, providing services to sex offenders that are within the community, and 2) Participants were required to be a minimum of 18 years of age. Participants were advised of the purposes of the study, that participation is voluntary, and that their responses would not be associated with their identity. Although name and contact information was utilized to determine possible participants, no identifying information was listed on the completed interview

forms. Participants were provided the name and contact information of the researcher in the event they should have questions or concerns.

There are no known risks or benefits associated with participation in this study. Participation in this research was unlikely to place participants at any risk for civil or criminal liability nor damages to their employment, reputation, or financial standing. Should participants experience any physical, psychological, social, or economic harms, they were encouraged to contact the researcher with their concerns. Participation in this study did not provide the participant any benefits or compensation.

Research Questions

In order to meet the aims of the study, a number of research questions were established. In line with the RNR model, the first set of research questions were related to determining offenders' risk of recidivism, treatment program, and the availability of treatment. The second set of research questions were related to treatment providers perceptions of sex offender treatment.

The RNR model first focuses on identifying who should receive treatment by establishing a level of risk for reoffending (Andrews & Bonta, 2010). The use of risk assessment tools is common practice for determining level of risk. Research question one stated, "Are empirically-based risk assessment tools being used to determine the risk of reoffending for sex offenders within the community?" It was anticipated that treatment providers would utilize at least one assessment tool designed for determining risk of sexual recidivism.

The second aspect of the RNR model focuses on need by determining what services will be the most beneficial to reduce criminal behaviors by targeting dynamic risk factors, and the third aspect (responsivity) concerns how those services are employed (Andrews & Bonta, 2010). To address the need and responsivity aspects, four research questions were established. Research question two stated, "Are empirically-based risk assessment tools being used to determine the level of treatment for the sex offender?" The use of risk assessment tools was expected to be used for determining level of treatment. Research question three stated, "What treatment programs are being utilized by treatment providers for sex offenders?" As cognitive-behavioral treatments have been established as one of the most effective treatment types, regardless of offense, it was anticipated to be the primary treatment type utilized. The particular program features, dosage, and additional services were expected to vary by provider; however, group therapy was expected to be utilized by all providers.

Finally, the availability of treatment across the state was considered. Specifically, research question four stated, "How many treatment providers are available to sex offenders within the community?", and research question five stated, "Where are sex offender treatment providers located across the state?" This information was garnered through use of the DCS Provider Directory.

The second set of research questions were concerned with treatment providers perceptions. Research question six stated, "What affects treatment success for sex offenders?" It was anticipated that both amplifiers and barriers to treatment would arise. Lastly, research question seven stated, "How do treatment providers perceive sex

offender treatment?" It was expected that most providers would indicate an overall positive view of treatment, but the need for additional treatment services for sex offenders would also be indicated.

Analysis

The objectives of the study were fulfilled by first conducting the interviews. Although common practice for qualitative research is to utilize an empirical cycle– collecting data, analyzing, creating hypotheses, collecting more data, etc. until saturation occurs (Jansen, 2010). It is not entirely uncommon to use the one-shot survey method. Jansen (2010) suggests this may occur for a variety of practical reasons, including time and/or money constraints. For the purposes of this research, time was a limiting factor, resulting in the use of the one-shot method.

Next, coding the responses to the questionnaires was completed. The process of generating data in qualitative research is akin to opening a gift; through interviewing, observing, reading and re-reading the data, reviewing field notes, and reflecting, the findings reveal themselves as patterns and themes, much like opening the present reveals the gift within (Magilvy & Thomas, 2009). Responses to the survey were read through initially, allowing the researcher to note any responses that were expected, out of the ordinary, interesting, etc. Each note was then provided an initial "code" based on commonality within the responses. As Sandelowski (2001) notes, the use of numbers in qualitative research is just as valid as in quantitative research as patterns and themes are established though frequency. Therefore, these codes were the repeated words,

phrases, or responses with similar implications that were found throughout the data (Magilvy & Thomas, 2009).

As suggested by Magilvy and Thomas (2009), first the initial codes were determined. Then patterns within these codes were established to form categories. It is then suggested that the researcher look for common topics, grouping these categories into smaller boxes that become the theme. Similarly, categories in the data were determined based on patterns within the codes. Lastly, the categories were used to expose common themes within the data.

Chapter IV

RESULTS

This chapter will provide the results of the data collection; the following chapter will examine the implications of these results. The results will be divided into two sections: treatment provider demographics and provider perceptions. Treatment demographics will include information such as availability, caseloads, and program type. Provider perceptions will include respondents' overall view of treatment and the themes that arose from provider responses.

Treatment Provider Demographics

The DCS provider list was used to determine the number of providers and their locations across the state of Georgia. There was a total of 31 active practices listed. Practices could be small, independent practices or larger companies with multiple licensed therapists and locations in multiple regions. Of the 31 practices, offices within these practices were located in the Metro (Atlanta) (11), Northwest (10), Southeast (6), Central Georgia (6), Northeast (4), Southwest (3), and North (1). This allowed for a total of 41 possible practices located within one of seven areas. The greatest number of service providers are located in and/or service the Metro Atlanta area with more than half (26) of the practices servicing the Northern regions. The other 15 practices are located in the Central and Southern regions.

Table 1 Regional Office Locations

Region	All Practices	Interviewed Practices
Central	6	4
Metro (Atlanta)	11	3
North	1	0
Northeast	4	1
Northwest	10	3
Southeast	6	4
Southwest	3	3
Total	**41**	**18**

Source: DCS Provider List, surveyed participants

There were fourteen interviews conducted in total. All regions were represented in the study except North. Three of the practices had locations in two or more areas. Offices were located in the Southeast (4), Central Georgia (4), Metro (3), Northwest (3), Southwest (3), and Northeast (1). This provided a sample distributed evenly across the state (see Table 1). One respondent indicated they only had licensed psychologists at the facility, nine indicated they only had licensed counselors (this included LCP, LCSW, and LMFT), and four indicated they had at least one of each. These were then looked at by region (see Table 2). Of the four in the Central region, two indicated they had only licensed counselors and two indicated they had both. In the Metro region, one indicated they only had licensed counselors and two indicated they had both. The respondent in the Northeast was the only respondent to have only licensed psychologists. Two respondents in the Northwest indicated they had only licensed

counselors while one indicated they had both. In the Southeast region, three respondents indicated they had only licensed counselors and one respondent indicated that employed both. Lastly, the Southwest consisted of two respondents that had only licensed counselors and one respondent that had both.

Table 2 Licensed Practitioners by Region

Region	Licensed Psychologists	Licensed Counselors	Licensed Psychologists and Counselors	Total Licensed Practitioners in Region
Central	0	2	2	**4**
Metro (Atlanta)	0	1	2	**3**
North	0	0	0	**0**
Northeast	1	0	0	**1**
Northwest	0	2	1	**3**
Southeast	0	3	1	**4**
Southwest	0	2	1	**3**
Total	**1**	**10**	**7**	**18**

Source: DCS Provider List, surveyed participants

Of those interviewed, eight were male and six were female. Job title was based on the respondent's initial response, though many provided multiple descriptions. Six respondents indicated their job title was director of the program, four indicated they were a therapist or counselor, three indicated they were the owner, and one indicated they were an evaluator. These compared by gender (see Table 3). Three male respondents and three female respondents indicated they were directors. Three male respondents indicated they were a therapist or counselor while only one female respondent indicated such. Of those who responded they were the owner, one was

male and two were female. Only one respondent (male) indicated they were an evaluator.

Table 3 Job Title by Gender

Job Title	Male	Female	Total
Director	3	3	**6**
Therapist/Counselor	3	1	**4**
Owner	1	2	**3**
Evaluator	1	0	**1**
Total	**8**	**6**	**14**

Source: surveyed participants

The average time a provider had been in the psychological and counseling services was 26.07 years with the shortest being 14 years and the longest being 36 years (two providers). The average time a provider had been in sex offender-related counseling and psychological services was 21.14 years with the shortest being six years and the longest being 34 years.

The typical caseloads for providers were determined for both their whole caseload and their sex offender caseload. There was one outlier that provided agency totals as opposed to individual caseload totals; this outlier was not included in the analysis. Additionally, two respondents provided ranges as opposed to a single number for both their total caseload and their sex offender caseload; the lower end of the range was utilized to provide a more conservative analysis. The average caseload for providers including all patients was 76 with the smallest caseload having seven patients and the largest caseload having 198 patients. The average caseload for providers

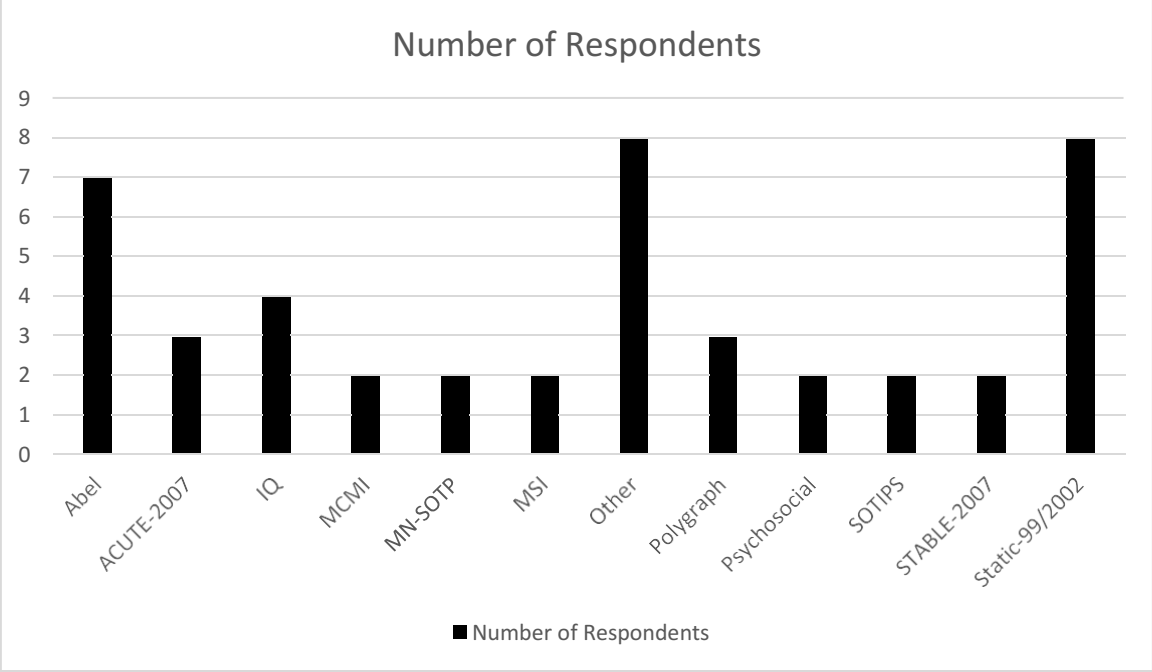
including only their sex offender patients was 39.77 with the smallest caseload having seven patients and the largest caseload having 100 patients.

All respondents indicated the use of assessment tools during evaluations which included a wide array of tools. One respondent did not provide the assessment tools used; however, the other thirteen provided an assortment of tests (see Figure 1). The most commonly cited tool was the Static-99 or updated 2002 assessments with eight respondents using one, the other, or both. Seven indicated using the Abel Assessment for Sexual Interest screening tool, and one indicated their facility was transitioning to the Abel. Four respondents mentioned IQ testing, three the ACUTE-2007, three included polygraphing, two mentioned the Sex Offender Treatment Intervention and Progress Scale (SOTIPS), two the STABLE-2007, two the MN-SOTP, two the Millon Clinical Multiaxial Inventory (MCMI), two the Multiphasic Sex Inventory (MSI), and two psychosocial assessments. All other tools and tests were mentioned only once with eight of the 14 indicating at least one other assessment.

Twelve of the fourteen indicated the assessment tools were used to determine both the risk of sexual recidivism and the level of treatment necessary. Two respondents indicated they were used for determining only the level of treatment necessary. None of the respondents indicated assessments were used to determine only the risk of recidivism. Although the questionnaire did not specifically ask providers why they utilize specific tools, one respondent indicated that it was important to determine if the offender could even utilize treatment, and another respondent stated, “The exact assessments depend on the client and the amount of information available.

Sometimes there is not enough information to do a thorough assessment." Future studies could delve into these choices.

Figure 1 Assessment Tools



All respondents indicated they utilized cognitive-behavioral therapies. All but one respondent indicated the use of group therapy, and all but one indicated the use of individual therapy. Twelve utilized psychoeducational programming, nine utilized mental health treatments, seven utilized psychotherapy, and seven utilized social support groups. Motivational interviewing (6), housing assistance (5), substance abuse treatments (5), job training/placement (4), and self-help groups (4) were the next most frequently cited as being employed by treatment providers. The least frequently cited were pharmaceutical treatments and therapeutic communities at two and one provider(s), respectively. Additionally, eight treatment providers indicated "other"

treatments/services (see Appendix D). Treatment program type was also looked at by region, excluding the "other" option (see Table 4).

Table 4 Licensed Practitioners by Region

Treatment Type	Central (4)	Metro (3)	Northeast (1)	Northwest (3)	Southeast (4)	Southwest (3)	Total by Region
CBT	4	3	1	3	4	3	**18**
Group therapy	4	3	0	3	4	3	**17**
Housing Assistance	1	1	0	2	1	0	**5**
Individual Therapy	3	2	1	3	4	2	**15**
Job Training	0	2	0	2	1	0	**5**
Mental Health Treatments	3	2	0	2	3	1	**11**
Motivational Interviewing	1	1	0	2	3	0	**7**
Pharma-ceutical treatments	0	0	0	0	1	1	**2**
Psycho-educational Programming	4	2	1	3	3	3	**16**
Psycho-therapy	3	1	0	2	3	1	**10**
Self-help Groups	1	2	0	2	1	1	**7**
Social Support Groups	1	2	0	2	3	1	**9**
Substance Abuse Treatment	1	1	0	1	3	0	**6**
Therapeutic Communities	0	0	0	0	1	0	**1**

Source: DCS Provider List, surveyed participants

Overall, there was an even distribution across the regions. For example, housing assistance was rarely mentioned across all regions; whereas psychoeducational

programming was reported by all or almost all respondents across regions. Nevertheless, there were differences noted, particularly for the Northeast as fewer treatment types were noted for this region in general. Caution is recommended, however, as data came from only one respondent in this region. Substance abuse treatment is an example of a treatment option that seemed to differ by region. Three of the four respondents in the Southeast indicated they utilized substance abuse treatment; whereas, either none of the respondents or only one respondent in the other regions indicated they utilized substance abuse treatment. Further studies should delve into this phenomenon.

Perceptions

An overall perception of sex offender treatment was determined by asking respondents to indicate how strongly they agreed or disagreed with the statement, "We are appropriately servicing the treatment needs of sex offenders." A five-item Likert scale was used for this question. All respondents indicated they either agreed or strongly agreed with the statement. This indicated an overall positive regard for treatment; however, many respondents provided additional services that they believed would benefit offenders. These services are included in the themes described below. For example, one respondent indicated the need to provide "preparation before release into the community," and another stated, "We need housing and employment services."

Themes and Subthemes

In total, 189 notes were coded, resulting in 67 individual codes (see Appendix E). Patterns in these codes led to eleven identified categories. From these eleven

categories, two themes emerged: Treatment Program and Community Reentry. Treatment Program will be discussed first followed by Community Reentry.

Treatment Program

Treatment Program was an overarching theme that emerged from the data. The categories that formed this theme included treatment phases, length, and requirements, among others. The length of the programs varied. Some respondents provided program minimums (from 12 months to 6 years), the average length (from 1.5 to 8 years), and the maximum length anyone has been in the program (4 to 20 years). Other respondents only provided one length, and still others provided two length options. An average length was mentioned 11 times, a minimum length was mentioned six times, and a maximum length was only mentioned four times. This indicates there is a variance in expected treatment length. It may also indicate these treatments are being tailored to meet the offenders' needs.

One subtheme of Treatment Program was program requirements. This was found seven times throughout the data. Polygraphing was mentioned the most often (4) with acceptance into the program, drug testing, and step-down requirements for aftercare only being mentioned once each. Active phase and aftercare phase categories were additional subthemes being referenced 15 and nine times, respectively. As aftercare was not mentioned by every respondent, these providers may not be offering a separate aftercare phasing. Future studies should delve further into the phases of treatment, especially considering Georgia has requirements for the aftercare phase.

Another subtheme was treatment type. This subtheme indicated there were certain aspects to treatment that promoted success in treatment. For example, three respondents indicated the need to maintain a present and/or future focus in treatment. Offense driven treatment was discussed with multiple respondents indicating the need for treatment to be based on the offender as opposed to a one-size fits all method. One respondent stated there was a need for "better treatment method distinctions between online versus in-person, physical offenders."

One of the largest subthemes within the theme of Treatment Program was the category cognitions. This category developed from the pattern of thought, behavior, and desire related codes. There were twelve times in which respondents discussed attributes to treatment around offender thought patterns. This was found to be the number one issue for facilities or offenders six times, and it was mentioned as an aspect that was needed in treatment another six times. Holding offenders accountable was mentioned four times, behavior identification was mentioned twice, the use of arousal reconditioning was mentioned once, and the selfishness of offenders was mentioned once. One respondent indicated that teaching offenders how to attain their wants and needs was both the facility's and the offender's number one issue.

Community Reentry

The second overarching theme was Community Reentry. Community Reentry consisted of four subthemes. One subtheme was barriers. The most prominent code to form this subtheme was a lack of individuality. Seven respondents indicated offenders were all treated the same once back in the community. One respondent stated, "Many

are young with young victims–the stigma lasts for the rest of their lives. They need help finding normalcy." They were labeled, they were all seen as the same, and the offenders were unsure how to get past this aspect. Lack of trust, poor treatment, negative therapists, and the training of therapists were all indicated as possible barriers to offender success. Though it would be no surprise that a negative therapist would likely hinder treatment success, what was surprising was the fact that one respondent believed there were more negative therapists than positive ones. Other barriers included money, access to adequate care, and various restrictions. Lack of money is of concern as most offenders must pay for treatment themselves. If they cannot pay for their treatment and it is terminated, the result may be them returning to prison for violating the terms of their release.

The second subtheme, community living, was found to be primarily associated with additional services and comments that treatment providers believe affect offenders' success, and it was also deemed the number one issue for offenders by five respondents. Reintegration issues and residency restrictions were mentioned six and four times, respectively. For example, one respondent discussed the 2006 residency restriction changes stating, "I cannot take anyone who's offense was after 2006" because there is a church within 1,000 feet of this residential practice. Another respondent was quoted saying, "The registry rules for offenders create problems and place limitations on these offenders that other offenders do not receive," and "the 1,000-foot rule and residential restrictions amount to more stress which leads to more dysfunctional coping."

Additionally, it was mentioned offenders need preparation before release to reintegrate effectively, they need to be embraced as returning citizens, and one respondent mentioned the need to evaluate for contact with children as well. These responses indicate the need to include additional features and provide services to offenders to help them as they return to community living. This study did not specifically consider what services offenders were receiving outside of those provided by the therapists; therefore, it would be beneficial for future studies to examine all services being provided.

The subtheme of self-care was by far the largest subtheme within Community Reentry. Mental health was the most prominent feature here. Ten respondents indicated they either addressed mental health issues in their treatment or it should be addressed in treatment. Four also noted that it was either the facility's or the offenders' number one issue. Prosocial skills and life skills were both features that were either addressed in respondents' treatments or should be included in treatment. For example, one respondent was quoted as saying, "Skills training gives them the ability [to right the wrong and improve] and tells them they can change." Handling addictions, taking control of their lives, and encouraging a healthy sexuality were also aspects that were mentioned by respondents. As the majority of respondents identified the need to address mental health issues, it would likely be prudent to include mental health treatment in the treatment of sexual offenders. Additionally, addressing prosocial and life skills in treatment would also be beneficial to offenders.

The last subtheme of Community Reentry was the smallest subtheme: treatment success. The client and therapist relationship was mentioned three times indicating the need for a strong relationship to promote success. Community support was also mentioned three times; each response indicated the offender would be more successful with support from and within the community. Treatment success could also be contingent on treatment oversight, therapist outlook, training, and even incentives (e.g. ability earn back voting rights), as well as additional aspects mentioned by respondents. This subtheme indicates that factors outside of the treatment itself may be beneficial to offenders in order to reintegrate into the community.

Other Results

Several codes and categories that did not align within the overarching themes are noted. Of the initial 189 notes, only 182 were categorized, leaving seven notes (or five codes) falling outside of these categories. These codes were as follows: offender management, sexual progression, restitution, offender behavior, and therapist behavior. Offender management and therapist behavior were both mentioned twice. Sexual progression, restitution, and offender behavior were all mentioned once. As patterns developed among the categories, only one category did not fall into either of the two overarching themes: support for the community. This category consisted of education (of the family and public) and family therapy (providing therapy for family members).

Chapter V

DISCUSSION AND CONCLUSION

This chapter will discuss the implications of findings and address the research questions. First, it will cover the use of assessment tools. Then, a discussion of the types of programs utilized in treatment will be had. This will be followed by a discussion of the availability of treatment across the state. Lastly, provider perceptions of treatment will be examined.

Assessment Tools

The first two research questions were addressed together. Twelve out of fourteen providers indicated they utilized assessment tools for determining the level of risk for recidivism. Although not all providers indicated they applied these tools for risk of recidivism, the majority seem to be adhering to the risk principle of the RNR model (Andrews & Bonta, 2010). Additionally, all fourteen respondents indicated assessment tools were used in the determination of level of treatment necessary for offenders. This is in line with the RNR model of treatment (Andrews & Bonta, 2010).

Program Type

The third research question was in regard to the treatment programs being utilized. Cognitive-behavioral therapy is required by the state of Georgia, and research has established it is the most effective treatment (DCS, 2018; Allam & Browne, 1998;

Andrews & Bonta, 2010; Holmes & Holmes, 2009; McGrath, et al., 2003; Schmucker & Lösel, 2008; Sloas et al., 2012). All respondents indicated the use of cognitive-behavioral treatments in either a group, individual, or mixed therapy format, indicating offenders are receiving the most effective treatment type. Additional features, services, and treatment types were also indicated by providers. The use of programming above the minimum may indicate extra effort on the part of providers to ensure offenders are receiving the best possible services to reduce the risk of recidivism and attain treatment success.

Availability

The fourth and fifth research questions were fulfilled via the DCS provider list. These questions were concerned with treatment availability, regardless of treatment type, features, services, etc. There are treatment providers located across the state of Georgia. The Department of Community Supervision divides the state into 7 regions. Every region has a minimum of one treatment provider with the Northern regions having the most locations for treatment. The number of available practices (31) and locations (41) across the state is limited. It was anticipated there would be more service providers available to sex offenders. This would seem to indicate the need for licensed sex offender therapists in the state of Georgia. This study was unable to determine if this is due to the requirements the state sets forth or if it is merely a lack of therapists trained in sex offender treatments. Further studies would be needed to assess this phenomenon.

Provider Perceptions

The final two research questions were regarding therapists' perceptions. These perceptions were teased out through a series of questions. Patterns and themes emerged from these responses resulting in 67 codes, 11 categories, and two primary themes. Overall, respondents had a positive outlook on sex offender treatment in Georgia. That said, many respondents indicated improvements could be made.

Treatment providers indicated success of offenders was affected by a myriad of factors. They provided additional services that they believe need to be provided to offenders or that they opt to provide in their servicing of offenders. Unsurprisingly, community restrictions was a subtheme noted multiple times that could hinder success, and many respondents indicated the need for services to assist with this aspect. For example, addressing registry restrictions was mentioned multiple times with one respondent stating, "Proximity laws should be case-by-case because they promote banishment." Another respondent stated, "Finding appropriate housing is difficult. They move frequently; they have no stable home" and " [it] impedes their ability to establish stability in life."

Another major subtheme was self-care, including mental health and life skills. Respondents consistently indicated the need to address these features to promote successful treatment. Addressing mental health, including anger issues, depression, stress, and more was mentioned numerous times. One respondent stated they utilized a "whole health model" addressing clients' mental and medical health, circles of support, job skills, education, and employment. Some responses exemplified how these

themes also intermingled. For example, one respondent stated, “The vast majority of crimes are motivated by stress, but proximity laws cause more stress.” This indicates that addressing one aspect with additional services could also assist in addressing other issues as well. Utilizing additional services goes above the minimum requirements set by the state. Although this study did not consider the effectiveness of treatment, these findings could indicate treatment would be more successful if the state included such aspects in the servicing of sex offenders within the community.

Also unsurprising was those responses that indicated the importance of the client-therapist relationship. It seems reasonable such relationships would promote a better response from the offender. For example, one respondent stated, “Once released, they’re automatically seen as untrustworthy, and they can’t trust the treatment providers because they are seen as a part of the system. We need to recognize the need to build the relationship.” What was surprising here was that a few respondents indicated there were not enough positive therapists to promote this sort of success. These respondents indicated they believed other therapists either treated offenders poorly or were not properly trained to promote effective changes. One respondent stated, “Providers aren’t trained properly; if they can’t talk about sex, they shouldn’t be providers. They should be highly trained in the field. They need more than just licensing.”

Policy Implications

The responses in this study provide multiple implications for policy. The most prominent inference revolves around community restrictions for offenders. As noted

above, this topic was mentioned by multiple respondents, and every response indicated the need for reevaluation of community restrictions. For example, one respondent stated, “Their biggest issues are residency restrictions.” Another respondent stated, “The type of crime should stipulate the restrictions” and because of existing practices “currently, it’s difficult to find employment.” Community restrictions appears to be a major barrier to sex offender treatment success, and policymakers should take this into consideration when evaluating policy.

Another policy implication revolves around the ability to obtain services. Access to effective treatment is not only hindered by residency restrictions, but it is also hampered by the ability to pay for services and the number of providers available. One respondent said, “They need homes and job training. They have nothing, but no one will pay for it.” Another stated the need for “a broad blanket for providers that provides funding for offenders no matter what” and “money should not be a barrier.”

The availability of qualified providers is an issue considering the approved provider list for the state is minimal, yet the number of registered sex offenders is numerous (Georgia Sex Offender Registry, n.d.). There are over 22,000 individuals listed on the registry and only 31 active practices. Each practice would need to service over 700 clients to provide adequate service to all offenders on the registry. This would be likely be impossible for some of the smaller practices. Additionally, this does not account for the physical locations of said practices nor locations of these offenders. In this examination, locations of practices revolved around regions; however, this would not mean an offender located in the region would have access to the treatment

provider if the practice itself was located too far from the offender's residency. Rather than considering lowering the standards for therapist qualifications, a possible policy response for this lack of adequate care could include the use of travelling therapists. One respondent services a large area, travelling to the offenders rather than maintaining a physical location for in-house servicing. This respondent stated they travelled "over 1,000 miles a week" to provide clients services. This respondent also had one of the largest caseloads of all the respondents which may indicate that utilizing such travelling methods could potentially provide services to more clients across the state. Policymakers should consider promoting such methods.

Study Limitations

This study has several limitations. A smaller sample size was employed. As the available sample population for this study was thirty-one potential cases, at least twenty respondents would have been preferable; however, a smaller sample size is common in qualitative studies. The sample size for this study fell above the generally accepted minimum, lending credence to these results (Luborsky & Rubinstein, 1995; Magilvy & Thomas, 2009). Additionally, Malterud and colleagues (2016) have noted that a sample population with a highly distinct skillset need only utilize a smaller sample frame. The training and licensing required to become a sex offender treatment provider in the state of Georgia would achieve that goal.

There are other limitations to this study related to sampling. One such limitation is that it is not representative of the whole state. Not every region was represented, nor all providers for every region. Additionally, only therapists that are licensed in and

service the state of Georgia are represented in this study; therefore, these results are not representative of the nation. It is likely that other states have similar licensing requirements; therefore, a nationally representative sample of licensed sex offender treatment providers would be beneficial.

Future Research Recommendations

Future studies should strive to achieve not only a higher response rate, but also should consider a nationalized sample for its basis. Additionally, as this study was designed to examine community-level treatment providers, it would be beneficial to include providers that service offenders within institutional corrections as well.

Additionally, future studies should consider investigating the perceptions of probation and parole officers as well as offenders. These additional perspectives could be beneficial in gaining a better understanding of how sex offender treatment is implemented and regarded overall.

This study was an exploratory study into the perceptions of sex offender treatment providers; however, it did not delve into why providers indicated their responses. Some respondents opted to provide their reasonings, but future studies should consider specifically why providers choose certain assessment tools, additional program features they utilize, and the additional program features they believe should be offered. Furthermore, future studies should consider asking providers if they would utilize cognitive-behavioral therapy if it were not required by the state and why. These additional observations could provide a valuable understanding of treatment providers' perceptions of sex offenders, treatment, and offender needs.

Conclusion

This study was a qualitative examination of the current treatment practices across the state of Georgia. The two overarching themes that were found indicate that therapists include many additional aspects in their treatment than the minimums required by the state. From the length of treatment to supplementary features that are shown to promote the greatest success, such as addressing dynamic factors in offenders' lives, many respondents appear to adhere to programming that is shown to be effective. For example, the results of this study indicate the use of the RNR model is supported by sex offender treatment providers in the state of Georgia and appears to be a driving factor in treatment. Additionally, cognitive behavioral therapy is utilized by all respondents which supports the literature. Many respondents indicated, however, that offenders need additional services than are currently provided. Additionally, access to treatment may be a problem for many offenders considering the small number of practitioners throughout the different regions.

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APPENDIX A:

Institutional Review Board Exemption

Institutional Review Board (IRB)
For the Protection of Human Research Participants

PROTOCOL EXEMPTION REPORT

Protocol Number: 03726-2018 **Investigator:** Rebecca Bingham

Supervising Faculty: Dr. Bobbie Ticknor

PROJECT TITLE: *You've Been Served (or not): Sex Offenders in GA and FL.*

INSTITUTIONAL REVIEW BOARD DETERMINATION:

This research protocol is **Exempt** from Institutional Review Board (IRB) oversight under Exemption **Category 2**. Your research study may begin immediately. If the nature of the research project changes such that exemption criteria may no longer apply, please consult with the IRB Administrator (irb@valdosta.edu) before continuing your research.

ADDITIONAL COMMENTS:

- *Upon completion of the research study all data (emails, data lists, notes, etc.) must be securely maintained (locked file cabinet, password protected computer, etc.) for a minimum of 3 years and only accessible by the researcher.*
- *Researcher must read the Research Statement to each participant at the start of the phone interview and confirm participant's understanding and willingness to take part in the interview.*
- *Phone interviews must be conducted out of the listening range of others.*

☒ ***If this box is checked, please submit any documents you revise to the IRB Administrator at irb@valdosta.edu to ensure an updated record of your exemption.***

Elizabeth Ann Olphie *1.30.2019*
Elizabeth Ann Olphie, IRB Administrator

Thank you for submitting an IRB application.
Please direct questions to irb@valdosta.edu or 229-253-2947.

Revised: 06.02.16

APPENDIX B:

Sex Offender Treatment Practitioners' Questionnaire

You are being asked to participate in an interview as part of a research study entitled "Sex Offenders in Georgia," which is being conducted by Rebecca Bingham, a graduate student in the Criminal Justice program at Valdosta State University, as a part of her thesis project. This study examines the current sex offender treatments offered at facilities across the state of Georgia. You will receive no direct benefits from participating in this research study; however, your responses may help us learn more about what services are being offered, the different program features, the dosage of treatment provided to offenders, and other pertinent information regarding treatment. There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life. Participation should take approximately 10-15 minutes. No one, including the researcher, will be able to associate your responses with your identity. Your participation is voluntary. You may choose not to participate, to stop responding at any time, or to skip any questions that you do not want to answer. You must be at least 18 years of age to participate in this study. Your participation in the interview will serve as your voluntary agreement to participate in this research project and your certification that you are 18 years of age or older.

Questions regarding the purpose or procedures of the research should be directed to Rebecca Bingham at rmwatkins@valdosta.edu. This study has been exempted from Institutional Review Board (IRB) review in accordance with Federal regulations. The IRB, a university committee established by Federal law, is responsible for protecting the rights and welfare of research participants. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 229-253-2947 or irb@valdosta.edu.

When was the facility at which you work founded?

_____

How many employees does the facility house?

_____

Of those employees, how many are licensed psychologists?

_____

Of those employees, how many are licensed counselors?

_____

What is your job title?

_____

How long have your worked for this facility?

_____

How long have you worked in counseling and psychological services?

_____

How long have you worked in sex offender-related counseling and psychological services?

_____

How many clients does your caseload typically include?

_____

How many of those clients are sex offenders?

_____

Do you use any assessment tools in the evaluation of sex offender patients? If so, which one(s).

- ☐ Yes _____
- ☐ No

(If **yes**) Is the use of assessment tools used to determine the risk of sexual recidivism, the level of treatment necessary, both, or neither? If neither, please indicate why the assessment tool is used.

- ☐ Risk of sexual recidivism
- ☐ Level of treatment necessary
- ☐ Both
- ☐ Neither _____

What types of treatment are available to sex offenders in your facility? Check all that apply.

- ☐ Cognitive-behavioral therapy
- ☐ Group therapy
- ☐ Housing Assistance
- ☐ Individual therapy
- ☐ Job training/placement
- ☐ Mental health treatments
- ☐ Motivational Interviewing
- ☐ Pharmaceutical treatments
- ☐ Psychoeducational programs
- ☐ Psychotherapy
- ☐ Self-help groups
- ☐ Social support groups
- ☐ Substance abuse treatment
- ☐ Therapeutic communities
- ☐ Other _____

How long is the typical length of the treatment program provided to sex offenders (e.g. number of years)? If these offenders have different treatment options available to them, please provide this information for each treatment type.

_____
_____
_____
_____
_____
_____

How often are treatment services provided to sex offenders (e.g. days per week X hours per day)? If these offenders have different treatment options available to them, please provide this information for each treatment type.

_____
_____
_____
_____
_____
_____

Of the treatment services that you provide to sex offenders, please identify as many additional aspects and features of those treatments.

_____
_____
_____
_____
_____
_____

What risk factors specific to sex offenders does your treatment program(s) target?

_____

Who pays for the sex offender services offered at your facility?

- ☐ Medicaid
- ☐ Private Insurance
- ☐ Individual
- ☐ Other_____

Does your facility track recidivism data for sex offenders?

- ☐ Yes
- ☐ No

(If **yes**) Is the recidivism data used for programming purposes? If yes, please specify program.

- ☐ Yes _____
- ☐ No

  (If **no**) What is the recidivism data used for?

  -

_____

  _____

_____

(If **yes**) Would you be willing to share recidivism data with the researcher, no identifying information for patients would be included?

- ☐ Yes
- ☐ No

What would you say is the number one issue your facility addresses?

_____

In your opinion, what is the number one issue associated with sex offenders?

_____

Indicate how strongly you disagree or agree with this statement.

We are appropriately servicing the treatment needs of sex offenders.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

(If answered **Agree**, **Neither**, **Disagree**, or **Strongly disagree**) What additional services should be offered to sex offenders within the community? Please list.

_____
_____
_____
_____
_____
_____

Do you have any other comments concerning sex offender treatment? If so, please specify.

_____
_____
_____
_____
_____
_____

Please provide the name and contact information of other sex offender treatment providers you are aware of.

_____
_____
_____
_____
_____
_____

Thank you for taking the time to complete this survey. Your assistance is greatly appreciated.

Questions regarding the purpose or procedures of the research should be directed to ***Rebecca Bingham*** *at* ***rmwatkins@valdosta.edu****. This study has been approved by the Valdosta State University Institutional Review Board (IRB) for the Protection of Human Research Participants. The IRB, a university committee established by Federal law, is responsible for protecting the rights and welfare of research participants. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at 229-253-2947 or irb@valdosta.edu.*

APPENDIX C:

Approved Sex Offender Treatment Provider Directory

DEPARTMENT OF COMMUNITY SUPERVISION

Approved Sex Offender Treatment Provider Directory

Updated: September 2018

Sex Offender Administration Unit

Approved Sex Offender Treatment Providers

Note:Offenders supervised by DCS should receive treatment services from only the providers contained herein.

Service Provider(s)	Organization	Area(s) Served
F. Tirrell Andrews Susan Bravo Shelia Walker	Peaceway Counseling and Mediation Services 2405 Bemiss Road Valdosta, GA 31602 Phone: (229) 333-1601 tandrews@peacewaycms.com	Southeast
Mzola U. Ahuama-Jonas	Georgia Counseling & Psychological Services, Inc. 4296 Memorial Drive, Suite D Decatur, GA 30032 Phone: (404) 403.4003 Fax: (404) 302.8492 mzolagcps5@hotmail.com	Metro
Tracy Alvord Sharon Segur	Northern Integrity Counseling Services 103 North Main Street LaFayette, GA 30728 222 Glen Milner Blvd, Rome GA 30161 Phone: 404.788.5297 Fax: 770.443.1988 tlalvord@gmail.com	Northwest
Rachael Bell	Bell & Associates 2591 US Highway 17, Suite 304 Richmond Hill, GA 31324 Phone: (912) 704-8262 Rachael_bell@hotmail.com	Southeast
Stephanie Bishop-Cullum	West Georgia Counseling Services 248 Coppermine Road Buchanan, GA 30113 Phone: (770) 646-9686 Fax: (770) 646-8010 Collum3@bellsouth.net	Northwest

Paul Cardozo	Dr. Paul Cardozo (*Treatment only*) 215 Hawthorne Park, Suite A Athens, Georgia 30606 PH- (706)546-9880 Fax-(706) 353-3772 pcardozo@att.net	Northeast
Gloria Smith Cissé Anthony Crawford Donald Collier Donterio Smith Tiffany Davis Jessica Tricoche	The Southern Center for Choice Theory, LLC 411 Holt Avenue Macon, GA 31204 Office: (478) 471-1268 Fax: (478) 471-1269 gcisse@thesoutherncenterforchoicetheory.com *Additional locations:* 7000 Storage Court Suite 8 Columbus, GA 31097 Office: (478) 471-1268 Fax: (478) 471-1269	Central
Matthew Connolly	A Better Tomorrow Counseling Services 3355 Lenox Road, Suite 300 Atlanta GA 30326 145 B North Main Street Jonesboro, GA 30236 905 Blackwell Road, Suite 521, Marietta, GA 30006 Office: (404) 467-2330 Cell: (404) 797-7710 Fax: (404) 467-2499 abettertomorrow@bellsouth.net	Metro
Stephanie Cruwys, LCSW	Southeast Second Chance, Inc. 600 G Street, Suite 6, Brunswick, GA 31520 6605 Abercorn, Suite 210 E Savannah, GA 31405 Tel 912.265.2055 Fax 912.265.2509 southeastsecondchance@gmail.com sesc.assistant@gmail.com	Southeast
Tommy Black, Ph.D. Melissa Maulden Jason Nietzke Christine Woodard Gabrielle Perry	Darsey, Black & Associates, LLC 215 East Court Street Hinesville, GA 31313 Phone: (912) 876.4010 Fax: (912) 369.2262 Cell: (912) 977-7703 *Additional locations:* 101 E. Memorial Drive, Hinesville, GA 31313	Southeast

	18 Protor Street, Statesboro, GA 30458 113 Moody Circle, Lyons, GA 30436 613 Towne Park Drive W, Rincon, GA 31326 1st Johnson Street, Suite 8, Savannah, GA 31405 1892 S. Macon Street, Jesup, GA 31598 1327 Union Street, Burnswick, GA 31520 darseyblackandassociates@gmail.com	
George Deitchman, Ph.D. Raymond Mullis Robert Neil	STOP, Inc. 708 N. Third Street Jacksonville Beach FL 32250 Phone: (904) 568-8927 Fax (855) 553-7867 *Additional locations: (call for addresses)* Macon, Warner Robbins, Thomasville, Cordele, Albany, Tifton, Valdosta, Savannah, Dublin, Rincon,McRae & Waycross george@deitchman.com	Southwest
Shannon Dunlap Janice Garrett Lawrence Ross Scott Smith	Counseling Services, Inc. 610 Ridley Ave. LaGrange, GA 30240 Phone: (706) 884-5050 Fax: (706) 884-5056 Shkedu1962@gmail.com	Northwest
Randall "Randy" Fannin	Adaptive Coping Responses 102 W. LaFayette Square, Suite 209 LaFayette GA 30728 Phone: (706) 638-2998 randyacr@windstream.net	Northwest
Glenn Fraser, LPC	Glenn Fraser, LPC 30 Hidden Trace Drive Ringgold, GA 30736 Phone: (404) 819-3568 glennfraser@yahoo.com	Northwest
Kanya Irving Glymph	New Leaf 108 Colony Park Drive Suite 400 Cumming, GA 30040 Office: (678) 648-6021 kanyaglymph@gmail.com	North
Dennis Herendeen	The Psychology Center 6130 Prestley Mill Road, Suite A Douglasville, GA 30134 Phone: (770) 949-9675	Metro Northwest

	Fax: (770) 949-9676 Psychology6130@bellsouth.net	
Lisa Southerland Christy Merrett Jennifer Dalton Brittany Faircloth	North GA Behavioral Accountability, LLC 703 Grove Street, Gainesville, GA 30501 Phone: (770) 535-1073 Fax: (770) 287-1931 familyrecovery@bellsouth.net *Additional locations:* 1884 Lawrenceville Suwanee Road, Suite 1 Lawrenceville, GA 30043 215 East Church St. Suite B, Monroe, GA 30655 26 Milton Ave., Suite D, Alpharetta, GA 30009 10 Kiker Street, Ellijay, GA 30540-3700	Northeast
Ronald Hughley, LCSW Terrell Smith	The Noble Path 4500 Billy Williamson Drive Suite 23 Macon, GA 31201 Phone: (478) 361-4048 hughleyr@cox.net	Central
Sam Love	First Step Sex Offender Treatment 707 Bellevue Ave., Dublin, GA 31021 Phone: (478) 275-1125 Fax: (478) 275-7512 sllove15@bellsouth.net	Central Southwest
Julie C. Medlin	Medlin Treatment Center 698 North Marietta Parkway, Marietta GA 30060 Phone: (770) 919-9088 Fax: (770) 919-8708 juliemedlin@medlintc.com *Additional locations:* 240 Corporate Center Drive, Suite D Stockbridge, GA 30281 Phone: (770) 507-6044 Fax: (770) 507-5284	Metro Northwest Central
Jim Morton, LPC	ARP Counseling 970 Milstead Avenue, N, Conyers, GA 30012 Phone: (770) 860-8549 Fax: (888) 210-1269 jimmortonlpc@yahoo.com	Metro Northeast

Ben Neal, LPC	Georgia Forensic Counseling 335 Parkway 575, Suite 301 Woodstock, GA 30188 Phone: (678) 756-2073 Fax: (866) 264-2548 benneallpc@gmail.com	Northwest
Angela Craig	Sedona Counseling 38 E. Main Street Hampton, GA 30228 Under the Stars 672 Moore St, Oxford GA 30054 Phone: (770) 853-3352 Fax: N/A 23alcraig@gmail.com suncityrev@comcast.net	Metro
Dr. Deloris Roys	The Highland Institute-Macon 6416 Peake Road,Suite #6, Macon, GA 31210 Phone: (478) 836-9802 Fax: (478) 836-9803 PATROYS@pstel.net	Central
Robert L. Sanders	Renu Children and Family Counseling 119 Davis Road, Ste 3A, Martinez, GA 30907 Phone: (762) 994-0882 Fax: (762) 994-0885 rcfc12@gmail.com	Northeast Southeast
Daniel Serritella, Ph.D.	Daniel Serritella, Ph.D. 172 North Ave. Jonesboro, GA 30236 Phone: (770) 478-7802 Fax: (888) 471-8494 DrSerritella@yahoo.com *Additional locations:* 89 Hospital Circle, Suite 6 Ellijay, GA 30540 770-478-7802 or (706) 635-2640	Metro Northwest
Tod Lynch-Stanley, LCSW	Family Reconstructions S.O.A.P. 1520 Richmond Street Brunswick, GA 31520 Phone: (912) 342-7159 Cell: (912) 261-1248 Fax: (866) 476-6505 Soap995@gmail.com	Southeast

Susan Strickland, Ph.D.	Louise's House (*Inpatient Treatment only*) 2 residences in DeKalb County Phone: (770) 601-4086 susistrickland@gmail.com	Metro
Rex Tuten Kevin Baldwin	The Highland Institute 3530 Habersham @Northlake, Bldg C Suite 100 Atlanta, GA 30078 Phone: (770) 455-0835 Fax: (770) 234-9664 HIBC@mindspring.com	Metro Central Southwest
John T. Watkins, Ph.D.	Atlanta Center Cognitive Therapy 62 B Lenox Pointe Atlanta, GA 30324 Phone: (404) 842-0555 Fax: (404) 248-9776 drjohnwatkins@att.net	Metro
Caffee Wright	The Counseling Group 3026 Deans Bridge Road, Augusta, GA 30906 Phone: (706) 772-7500 2nd Office: 209 East 6th Street Waynesboro, GA 30830 Phone: (706) 554-0088 wcaffeew@comcast.net	Northeast Southeast
Jessie Yearta	Georgia Recovery Centers 140 Marble Mill Road Marietta, GA 30060 Phone: (770) 988-8333 Fax: (770) 988-8946 georgiarecoverycenters@hotmail.com	Northwest Metro

APPENDIX D:

Treatment Programs Offered

Appendix D Treatment Programs Offered

SOURCE #	CBT	GROUP THERAPY	HOUSING ASSIST	IND. THERAPY	JOB TRAINING	MENTAL HEALTH TREATMENTS	MOTIVATIONAL INTERVIEW	PHARM. TREATMENTS	PSYCHOEDUCATIONAL PROGRAMS	PSYCHOTHERAPY	SELF-HELP GROUPS	SOCIAL SUPPORT GROUPS	SUBSTANCE ABUSE TREATMENT	THEREAPEUTIC COMMUNITIES	OTHER
1	Y	Y	Y	Y	Y	Y	N	N	N	N	N	Y	N	N	Residential Model
2	Y	Y	N	Y	N	N	N	N	N	N	N	N	N	N	N
3	Y	Y	N	Y	N	N	N	Y	Y	N	N	N	N	N	Aversion Therapy
4	Y	Y	Y	Y	N	Y	Y	N	Y	Y	N	N	N	N	Choice Therapy, Relapse Prevention
5	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	Dialectical Behavior Therapy, Prolonged Exposure Therapy, Aversion Therapy
6	Y	Y	N	Y	N	Y	Y	Y	Y	Y	N	Y	Y	Y	Eye Movement Desensitization and Reprocessing
7	Y	Y	N	Y	N	Y	N	N	Y	Y	N	Y	N	N	N
8	Y	Y	N	Y	N	Y	N	N	Y	Y	N	N	Y	N	Working groups
9	Y	Y	Y	Y	Y	N	Y	N	Y	N	Y	Y	N	N	Stress Management
10	Y	Y	N	N	N	N	N	N	Y	N	Y	N	N	N	Good Lives Model, 12-step groups
11	Y	N	N	Y	N	N	N	N	Y	N	N	N	N	N	N
12	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	N	N
13	Y	Y	N	Y	N	Y	Y	N	Y	Y	N	Y	Y	N	N
14	Y	Y	Y	Y	N	Y	N	N	Y	Y	N	N	N	N	N

APPENDIX E:

Source Responses Code sheet

Appendix E

Source #	Note #	Question Reference	Yes/No	Years	Clients	R/T/B	M/P/I/O	SD/D/N/A/SA	Survey Quote	Code	Category	Theme
1	1	licensed psychologist	N									
1	2	licensed counselor	Y									
1	3	years counseling		30								
1	4	years SO counseling		30								
1	5	caseload			7							
1	6	SO caseload			7							
1	7	assessment tools	Y						Static-99, ACUTE-2007, STABLE-2007			
1	8	use of tool				B						
1	9	typical length							minimum 12 months	minimum length	length	Treatment Program
1	10	typical length							average two and half years before they mo	average length	length	Treatment Program
1	11	typical length							longest was five years to graduate	maximum length	length	Treatment Program
1	12	typical length							before they are allowed in the program, the	acceptance into program	program requirements	Treatment Program
1	13	how often							group is one and half hours weekly and ind	active weekly G/I	Active phase	Treatment Program
1	14	how often							aftercare group and individual to once a mo	aftercare monthly G/I	Aftercare phase	Treatment Program
1	15	additional aspects							focus on reentry skills like job skills, educati	life skills	self-care	Community Reentry
1	16	additional aspects							practice a whole health model: mental heal	mental health	self-care	Community Reentry
1	17	additional aspects							interpersonal relationships, mitigating risk,	prosocial skills	self-care	Community Reentry
1	18	risk factors							mental health			
1	19	payment					I					
1	20	facility number one issue							reentry into community	reintegration	community living	Community Reentry
1	21	offender number one issue							residential living	residency	community living	Community Reentry
1	22	agree/disagree						SA				
1	23	comments							embrace offenders as returning citizens	embracing offenders	community living	Community Reentry
1	24	comments							make decisions based on risk not the offen	individuality	barriers	Community Reentry
1	25	comments							if a church is within 1,000ft then cannot tak	residency restrictions	community living	Community Reentry
2	1	licensed psychologist	N									
2	2	licensed counselor	Y									
2	3	years counseling		30								
2	4	years SO counseling		20								
2	5	caseload			100							
2	6	SO caseload			50							
2	7	assessment tools	Y						Static-99/R/2002, ACUTE-2007, ROSAC, Abel, SOTIPS			
2	8	use of tool				B						
2	9	typical length							one year minimum	minimum length	length	Treatment Program
2	10	typical length							longest about 15 years, if they get locked u	maximum length	length	Treatment Program
2	11	typical length							work with a lot of poor clients and they can	barriers to success	barriers	Community Reentry
2	12	how often							once a week	active weekly	Active phase	Treatment Program
2	13	how often							clean polygraph	polygraphing	program requirements	Treatment Program
2	14	how often							step down program and move to every oth	aftercare every other week	Aftercare phase	Treatment Program
2	15	additional aspects							focus on psychodynamic factors like childh	mental health	self-care	Community Reentry
2	16	additional aspects							engage clients in healthy thinking skills so t	prosocial skills	self-care	Community Reentry
2	17	additional aspects							healthy sexuality	sexuality	self-care	Community Reentry
2	18	risk factors							cognitive distortions, relationships skills, life	skills		
2	19	payment					P/I					
2	20	facility number one issue							cognitive distortions are the core of recidiv	thought patterns	cognitions	Treatment Program
2	21	offender number one issue							1,000ft rule and residency restrictions	residency restrictions	community living	Community Reentry
2	22	agree/disagree						A				
2	23	additional services							address the registering of juveniles and cha	registrations	barriers	Community Reentry
2	24	additional services							registry rules for offenders create problems	residency restrictions	community living	Community Reentry
2	25	comments							relationship between client and therapist h	client/therapist relationship	treatment success	Community Reentry
2	26	comments							provider support is necessary	client/therapist relationship	treatment success	Community Reentry
3	1	licensed psychologist	N									
3	2	licensed counselor	Y									
3	3	years counseling		14								
3	4	years SO counseling		14								
3	5	caseload			100							
3	6	SO caseload			100							
3	7	assessment tools	Y						Static-99/2002, STABLE, ACUTE, depression scale, IQ, personality test, polygraph, sexual interest card sort			
3	8	use of tool				B						
3	9	typical length							2 year minimum	minimum length	length	Treatment Program
3	10	typical length							an average of three to five years	average length	length	Treatment Program
3	11	typical length							if they remain past five years they likely wo	optimal length	length	Treatment Program
3	12	typical length							sexual history polygraph	polygraphing	program requirements	Treatment Program
3	13	typical length							polygraph every six months	polygraphing	program requirements	Treatment Program
3	14	how often							once every week	active weekly	Active phase	Treatment Program
3	15	how often							step down to every two weeks then to once	aftercare step down	Aftercare phase	Treatment Program
3	16	additional aspects							focus on life skills and stress management	life skills	self-care	Community Reentry
3	17	additional aspects							evaluate for contact with children	child contact	community living	Community Reentry
3	18	additional aspects							anger management	mental health	self-care	Community Reentry
3	19	risk factors							anger control, motivations and triggers, cogn	itive functions		
3	20	payment					I/O (federal)					
3	21	facility number one issue							changing thought patterns	thought patterns	cognitions	Treatment Program
3	22	offender number one issue							change their world-view, their thoughts, to	thought patterns	cognitions	Treatment Program
3	23	agree/disagree						SA				
3	24	comments							managing the line between probation offic	offender management		
3	25	comments							there are more negative therapists than po	negative therapists	barriers	Community Reentry
3	26	comments							stay on top of the latest training for treatm	training	treatment success	Community Reentry
3	27	comments							proximity laws should be case-by-case	residency restrictions	community living	Community Reentry
3	28	comments							the vast majority of crimes are motivated b	mental health	self-care	Community Reentry
3	29	comments							you (therapists) need self-care to stay posit	therapist success	treatment success	Community Reentry
4	1	licensed psychologist	Y									
4	2	licensed counselor	Y									
4	3	years counseling		17								
4	4	years SO counseling		19								
4	5	caseload			100							
4	6	SO caseload			80							
4	7	assessment tools	Y						Static-99/2002, Abel, MN-SOTP			
4	8	use of tool				B						
4	9	typical length							minimum 18 months	minimum length	length	Treatment Program
4	10	typical length							maximum approximately 4 years	maximum length	length	Treatment Program
4	11	how often							90 mins once a week for the length of the p	active weekly	Active phase	Treatment Program
4	12	additional aspects							reality therapy - present and future focuse	present/future focused	treatment type	Treatment Program
4	13	additional aspects							focus on coping and trauma	mental health	self-care	Community Reentry
4	14	additional aspects							plan for the life they want to have and wor	life skills	self-care	Community Reentry
4	15	risk factors							relationships, prosocial behaviors			

4	16	payment					I						
4	17	facility number one issue							trauma	mental health	self-care	Community Reentry
4	18	offender number one issue							poor interpersonal skills	prosocial skills	self-care	Community Reentry
4	19	offender number one issue							lack of locus of control	control of life	self-care	Community Reentry
4	20	agree/disagree						SA				
4	21	comments							think about how we provide services	offender management		
4	22	comments							we label them, not treating them as individ	individuality	barriers	Community Reentry
5	1	licensed psychologist	N									
5	2	licensed counselor	Y									
5	3	years counseling		15								
5	4	years SO counseling		6								
5	5	caseload			100							
5	6	SO caseload			24							
5	7	assessment tools	Y						battery of assessments			
5	8	use of tool				B						
5	9	typical length							approximately one and half years until risk	average length	length	Treatment Program
5	10	how often							utilizes double groups 2.5-3 hour sessions,	active twice a month	Active phase	Treatment Program
5	11	additional aspects							feel they are more than just a number	individuality	barriers	Community Reentry
5	12	risk factors							addiction, mental illness, past sexual abuse,	APD, ODD, internet/porn addiction		
5	13	payment					I					
5	14	facility number one issue							anxiety and depression	mental health	self-care	Community Reentry
5	15	offender number one issue							anxiety and depression	mental health	self-care	Community Reentry
5	16	agree/disagree						SA	I believe that I am			
5	17	additional services							need to offer skills learning, social skills	life skills	self-care	Community Reentry
5	18	additional services							skills training gives them the ability (right th	mental health	self-care	Community Reentry
5	19	additional services							stress management	mental health	self-care	Community Reentry
5	20	additional services							suicidal thought management	mental health	self-care	Community Reentry
5	21	additional services							support groups outside of just treatment	community support	treatment success	Community Reentry
5	22	comments							forced to talk about the same things over a	mental health	self-care	Community Reentry
5	23	comments							offenders are seen as source of revenue, no	oversight	treatment success	Community Reentry
5	24	comments							there needs to be oversight of all groups	oversight	treatment success	Community Reentry
5	25	comments							too many therapists treat them like garbag	poor treatment	barriers	Community Reentry
6	1	licensed psychologist	N									
6	2	licensed counselor	Y									
6	3	years counseling		22								
6	4	years SO counseling		10								
6	5	caseload			2200				agency-wide totals			
6	6	SO caseload			37				agency-wide totals			
6	7	assessment tools	Y						Static-99, Abel			
6	8	use of tool				B						
6	9	typical length							two years minimum	minimum length	length	Treatment Program
6	10	typical length							an average of 2.8 to 3 years	average length	length	Treatment Program
6	11	how often							one and a half hours one time a week	active weekly	Active phase	Treatment Program
6	12	how often							then to one time a month	aftercare monthly	Aftercare phase	Treatment Program
6	13	additional aspects							hold them accountable for their actions	accountability	cognitions	Treatment Program
6	14	additional aspects							skill teaching, recognize mismanagement o	life skills	self-care	Community Reentry
6	15	additional aspects							overview of what led them to their behavio	behavior identification	cognitions	Treatment Program
6	16	risk factors							unique to person - identifying client risk			
6	17	payment					I/O (federal)					
6	18	facility number one issue							substance abuse	addictions	self-care	Community Reentry
6	19	offender number one issue							hypersexuality	sexuality	self-care	Community Reentry
6	20	agree/disagree						A				
6	21	additional services							funding for offenders no matter what	treatment funding	barriers	Community Reentry
6	22	additional services							(funding for) group, individual, and family	treatment funding	barriers	Community Reentry
6	23	additional services							a distinction between types of offenses: int	distinction of offenses	treatment type	Treatment Program
6	24	additional services							levels of offense treatment: they need diffe	levels of offense treatment	treatment type	Treatment Program
6	25	additional services							currently all grouped as the same but they	individuality	barriers	Community Reentry
6	26	comments							can be reintegrated back into society with p	reintegration	treatment success	Community Reentry
6	27	comments							money should not be a barrier	barriers to success	barriers	Community Reentry
6	28	comments							type of crime should stipulate the restrictio	restrictions	barriers	Community Reentry
6	29	comments							restrictions - currently its difficult to find er	barriers to success	barriers	Community Reentry
6	30	comments							should be able to earn back voting rights	incentives	treatment success	Community Reentry
7	1	licensed psychologist	N									
7	2	licensed counselor	Y									
7	3	years counseling		36								
7	4	years SO counseling		17								
7	5	caseload			50							
7	6	SO caseload			12							
7	7	assessment tools	Y						FACE, Hanson Sexual Attitudes Questionnaire, MN-SOTP - transitioning to Abel			
7	8	use of tool				B						
7	9	typical length							average of two years and six months	average length	length	Treatment Program
7	10	how often							one session per week for 90 minutes	active weekly	Active phase	Treatment Program
7	11	additional aspects							responsibility taking - they rationalize their	accountability	cognitions	Treatment Program
7	12	risk factors							erroneous thought processes			
7	13	payment					I					
7	14	facility number one issue							mood disorders	mental health	self-care	Community Reentry
7	15	offender number one issue							thought processes, rationalization, and just	thought patterns	cognitions	Treatment Program
7	16	agree/disagree						SA				
7	17	comments							misunderstood and demonized	poor treatment	barriers	Community Reentry
7	18	comments							treated like they're not worth understandir	poor treatment	barriers	Community Reentry
7	19	comments							treated like they're not worth understandir	individuality	barriers	Community Reentry
8	1	licensed psychologist	N									
8	2	licensed counselor	Y									
8	3	years counseling		30								
8	4	years SO counseling		30								
8	5	caseload			20							
8	6	SO caseload			20							
8	7	assessment tools	Y						MCMI, MSI, SASSI, IQ, PDS			
8	8	use of tool				T						
8	9	typical length							average of two plus years	average length	length	Treatment Program
8	10	how often							weekly- group is 2 hours, individual is 1 hou	active weekly G/I	Active phase	Treatment Program
8	11	additional aspects							change their thinking and behavior	thought patterns	cognitions	Treatment Program
8	12	risk factors							thinking errors			
8	13	payment					I/O (federal)					
8	14	facility number one issue							thinking errors	thought patterns	cognitions	Treatment Program
8	15	offender number one issue							lack of boundaries	prosocial skills	self-care	Community Reentry

8	16	agree/disagree						SA				
8	17	comments							they have nothing but no one will pay for it	barriers to success	barriers	Community Reentry
8	18	comments							providers aren't trained properly	training	barriers	Community Reentry
8	19	comments							if they can't talk about sex, they shouldn't b	training	barriers	Community Reentry
8	20	comments							they should be highly trained in the field; th	training	barriers	Community Reentry
9	1	licensed psychologist	N									
9	2	licensed counselor	Y									
9	3	years counseling		35								
9	4	years SO counseling		34								
9	5	caseload			60							
9	6	SO caseload			60							
9	7	assessment tools	Y						Abel, polygraph			
9	8	use of tool				B						
9	9	typical length							(all group) two years once a week, two yea	average length	length	Treatment Program
9	10	how often							group is 1.5-2 hours dependent on group a	active 2-2-1	Active phase	Treatment Program
9	11	additional aspects							focus on the now, not the past	present focused	treatment type	Treatment Program
9	12	additional aspects							identify thinking errors that may have led t	thought patterns	cognitions	Treatment Program
9	13	additional aspects							education, problem-solving, conflict resolut	prosocial skills	self-care	Community Reentry
9	14	additional aspects							money management, long-term approache	life skills	self-care	Community Reentry
9	15	risk factors							sexual interest, inability to form appropriate	relationships		
9	16	payment					I					
9	17	facility number one issue							sexual interest	sexuality	self-care	Community Reentry
9	18	offender number one issue							adequate housing and employment	reintegration	community living	Community Reentry
9	19	agree/disagree						A				
9	20	additional services							systematic issues: need to work with famili	barriers to success	barriers	Community Reentry
9	21	additional services							no money available for treatment initially	barriers to success	barriers	Community Reentry
9	22	additional services							they need preparation before release	pre-release	community living	Community Reentry
9	23	comments							address trust issues and interpersonal conf	lack of trust	barriers	Community Reentry
9	24	comments							address trust issues and interpersonal conf	prosocial skills	self-care	Community Reentry
9	25	comments							they can't trust the treatment providers be	lack of trust	barriers	Community Reentry
9	26	comments							We need to recognize the need to build the	client/therapist relationship	treatment success	Community Reentry
9	27	comments							teach them how to take control of their life	control of life	self-care	Community Reentry
9	28	comments							they believe their lives are ruined due to th	barriers to success	barriers	Community Reentry
9	29	comments							they cant get past that (label) - how to begi	individuality	barriers	Community Reentry
9	30	comments							the system works against them (was provid	barriers to success	barriers	Community Reentry
10	1	licensed psychologist	Y									
10	2	licensed counselor	Y									
10	3	years counseling		26								
10	4	years SO counseling		26								
10	5	caseload			8				eight to twelve			
10	6	SO caseload			8				eight to twelve			
10	7	assessment tools	Y						Static-99R/2002R, BARR-2002R, IQ, Abel, penile plethysmograph, psychosexual assessment, measure of personality, sexual interest, sexu			
10	8	use of tool				B						
10	9	typical length							average 18-24 months to graduate	average length	length	Treatment Program
10	10	how often							with individual and group (2 hour group ses	active weekly G/I	Active phase	Treatment Program
10	11	how often							after graduation reduced to group once a n	aftercare step down	Aftercare phase	Treatment Program
10	12	additional aspects							gain control of arousal using aversion thera	arousal reconditioning	cognitions	Treatment Program
10	13	additional aspects							(provide) group for non-offending spouses	family therapy	support for the community	
10	14	additional aspects							address anger and trauma	mental health	self-care	Community Reentry
10	15	risk factors							all dynamic factors			
10	16	payment					I/O (federal)					
10	17	facility number one issue							need to learn how to go about obtaining it	attaining desires	cognitions	Treatment Program
10	18	offender number one issue							need to learn how to go about obtaining it	attaining desires	cognitions	Treatment Program
10	19	agree/disagree						SA				
10	20	comments							residency restrictions, finding appropriate l	residency restrictions	barriers	Community Reentry
10	21	comments							they have no stable home	barriers to success	barriers	Community Reentry
10	22	comments							find ways to treat better through research	training	treatment success	Community Reentry
11	1	licensed psychologist	Y									
11	2	licensed counselor	N									
11	3	years counseling		36								
11	4	years SO counseling		29								
11	5	caseload			70							
11	6	SO caseload			20							
11	7	assessment tools	Y						Abel, Static-99/2002R, related supplemental	questionnaires		
11	8	use of tool				B						
11	9	typical length							average of 15 months followed by six mont	average length	length	Treatment Program
11	10	how often							weekly to every two weeks for 60 mins	active weekly/bi-weekly	Active phase	Treatment Program
11	11	how often							monthly once in maintenance	aftercare monthly	Aftercare phase	Treatment Program
11	12	additional aspects							focus on emotional and interpersonal relat	prosocial skills	self-care	Community Reentry
11	13	additional aspects							future based	future focused	treatment type	Treatment Program
11	14	additional aspects							sexualized coping, cognitive distortions, co	thought patterns	cognitions	Treatment Program
11	15	risk factors							deviant sexual interest, sexual preoccupation			
11	16	payment					I/O (federal)					
11	17	facility number one issue							insurance company issues	insurance	barriers	Community Reentry
11	18	facility number one issue							disruptive behaviors	behavior identification	cognitions	Treatment Program
11	19	offender number one issue							housing and employment	reintegration	community living	Community Reentry
11	20	agree/disagree						A				
11	21	additional services							we need housing and employment services	reintegration	community living	Community Reentry
11	22	additional services							better treatment method distinctions betw	levels of offense treatment	treatment type	Treatment Program
12	1	licensed psychologist	Y									
12	2	licensed counselor	Y									
12	3	years counseling		25								
12	4	years SO counseling		20								
12	5	caseload			25				twenty-five to twenty-eight			
12	6	SO caseload			25				twenty-five to twenty-eight			
12	7	assessment tools	Y						MMSI, psychosexual assessment, drug/alcohol screening			
12	8	use of tool				T						
12	9	typical length							minimum of about six years normally	minimum length	length	Treatment Program
12	10	typical length							average of six to eight years	average length	length	Treatment Program
12	11	typical length							maximum of 20 years	maximum length	length	Treatment Program
12	12	typical length							drug test monthly	drug testing	program requirements	Treatment Program
12	13	typical length							polygraph two times a year	polygraphing	program requirements	Treatment Program
12	14	how often							group one time a week for one and a half h	active weekly G/monthly I	Active phase	Treatment Program
12	15	how often							(after two years) group moves to twice a m	aftercare step down	Aftercare phase	Treatment Program
12	16	how often							after two years without missing any group	step down requirements	program requirements	Treatment Program
12	17	additional aspects							learning sympathy and empathy	thought patterns	cognitions	Treatment Program

12	18	additional aspects							owning the offense	accountability	cognitions	Treatment Program
12	19	risk factors							sexual deviancy, understanding what they did was wrong, consent issues			
12	20	payment					I					
12	21	facility number one issue							drug and alcohol addiction	addictions	self-care	Community Reentry
12	22	offender number one issue							sexual offenses are progressive, much like a	sexual progression		
12	23	offender number one issue							sexual offenses are progressive, much like a	addictions	self-care	Community Reentry
12	24	agree/disagree						A				
12	25	additional services							sex offenders are selfish - its always about t	selfishness	cognitions	Treatment Program
12	26	additional services							programming that allows offenders to give	restitution		
12	27	additional services							focus on ways of thinking - that's the only v	thought patterns	cognitions	Treatment Program
12	28	comments							offenders are good at manipulating	offender behavior		
12	29	comments							therapists must be wary, we have to think s	therapist behavior		
12	30	comments							be a voice for the victim	therapist behavior		
12	31	comments							educating the community on offenders is in	education	support for the community	
12	32	comments							offenders need to humble themselves to su	accountability	cognitions	Treatment Program
12	33	comments							(offenders need to) show empathy	thought patterns	cognitions	Treatment Program
13	1	licensed psychologist	Y									
13	2	licensed counselor	Y									
13	3	years counseling		21								
13	4	years SO counseling		21								
13	5	caseload			150							
13	6	SO caseload			50							
13	7	assessment tools	Y						RIAS, DSM-V, MSI-II			
13	8	use of tool				B						
13	9	typical length							about three years	average length	length	Treatment Program
13	10	how often							weekly for one and a half hours	active weekly	Active phase	Treatment Program
13	11	how often							transfer down to every other week then to	aftercare step down	Aftercare phase	Treatment Program
13	12	risk factors							age, type/# of victims, substance abuse, family support, sexual deviance, relationships			
13	13	payment					I/O (federal)					
13	14	facility number one issue							staffing - working in rural areas	staffing	barriers	Community Reentry
13	15	offender number one issue							the stigma lasts for the rest of their lives	individuality	barriers	Community Reentry
13	16	agree/disagree						A				
13	17	additional services							community support services like family gro	community support	treatment success	Community Reentry
13	18	additional services							education for the family members about sa	education	support for the community	
13	19	additional services							more resources for offenders outside of th	community support	treatment success	Community Reentry
14	1	licensed psychologist	N									
14	2	licensed counselor	Y									
14	3	years counseling		28								
14	4	years SO counseling		20								
14	5	caseload			198							
14	6	SO caseload			61							
14	7	assessment tools	y						Abel, polygraph, IQ, MCMI, Static-99, SONAR			
14	8	use of tool				B						
14	9	typical length							active until they have a years worth of non	length poly-based	length	Treatment Program
14	10	typical length							active until they have a years worth of non	active poly-based	Active phase	Treatment Program
14	11	how often							sessions once a week	active weekly	Active phase	Treatment Program
14	12	how often							step down to every other week, then once a	aftercare step down	Aftercare phase	Treatment Program
14	13	additional aspects							mental health aspects of offender; if menta	mental health	self-care	Community Reentry
14	14	risk factors							mental health, support systems			
14	15	payment					I					
14	16	facility number one issue							identify high risk factors and adaptive copir	thought patterns	cognitions	Treatment Program
14	17	offender number one issue							trying to find appropriate housing and emp	reintegration	community living	Community Reentry
14	18	agree/disagree						A				
14	19	additional services							official apartment complexes (probation of	reintegration	community living	Community Reentry
14	20	comments							limited in providers	access to providers	barriers	Community Reentry
14	21	comments							a lot of mentally ill	mental health	self-care	Community Reentry