Offender Programs Report

Social and Behavioral Rehabilitation in Prisons, Jails and the Community

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Incorporating Electronic Monitoring into the Principles of Effective Interventions

by Edward J. Latessa, Ph.D.

The Failure of Electronic Monitoring to Have an Effect on Recidivism

A great deal has been written over the years about the use and effectiveness of electronic monitoring of offenders. Much of this literature has focused on examining the utility of this sanction as an alternative to incarceration. While some have argued that electronic monitoring was not designed as a stand-alone intervention, there is little doubt that many jurisdictions rely on electronic monitoring as a correctional alternative to jail or detention without the benefit of treatment or intervention. When this is the case there is scant empirical evidence that electronic monitoring will have much effect on offender behavior. As Petersilia and Turner (1990, p. 34) concluded in their study of intensive supervision, "more supervision, without a substantive treatment component, evidently had little effect on offenders' underlying criminal behavior." Indeed, a recent meta-analysis that included an examination of the research on electronic monitoring found that on average the effect size was .05, indicating that on average electronic monitoring *increased* recidivism about five percent over comparison groups (Gendreau, Goggin, Cullen, and Andrews, 2000).

The question is not why this is the case, but rather, why we would expect electronic monitoring to have any effect on offender behavior? Given what we

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Research Evaluation

STOP IT NOW! VERMONT: A Four-Year Program Evaluation, 1995–1999

by Joan Tabachnick and Elizabeth Dawson

STOP IT NOW! VERMONT is a program jointly managed by STOP IT NOW! in Haydenville, Massachusetts and the Safer Society Foundation, Inc. in Brandon, Vermont. STOP IT NOW! designed the program on two key premises. First, we know that child sexual abuse can be prevented through the powerful tools of public health. Second, we know that we need to take the burden of prevention from children's shoulders and put it where it belongs, with adults. Because most abused children are dependent on their abusers, putting children on the front lines of prevention will not stop the abuse. Teaching children about appropriate touch is an important, but limited, first step. Current research tells us that only 16% of the cases of sexual assault are ever reported. We must do more to reach the 84% of victims and abusers that have never come forward. We also must do more to reach these situations before the abuse occurs. The next step is for adults to hold abusers directly accountable by encouraging them to stop, by reporting the abuse when it occurs, and by helping abusers and victims get the help and treatment they need.

Our social marketing approach is based upon the success of other campaigns to stop drinking and driving, to stop smoking in public places and to promote "safer sex practices." Much like Mothers Against Drunk Drivers (MADD) and others who have changed the way we think and act around those who drink and choose to drive, STOP IT NOW! has used this approach to stop the sexual abuse of children. From September 1995 to December 1999, the pilot program in Vermont, STOP IT NOW! VERMONT, has tested these innovative concepts by working with the media and with community-based organizations to reach adults in high-risk situations.

STOP IT NOW! VERMONT has gained tremendous recognition statewide for increasing the amount of exposure, media attention, and information available on the issue of child sexual abuse. STOP IT NOW! VERMONT has also begun to change individual attitudes and behaviors. This evaluation report documents the extensive media and outreach efforts of STOP IT NOW! VERMONT (process criteria) and begins to analyze the effectiveness (outcome criteria) of this groundbreaking campaign. Conclusions are outlined below.

Methods

To evaluate the program, STOP IT NOW! VERMONT commissioned Market Street Research of Northampton, Massachusetts to conduct a random digit dial telephone survey of public opinions and attitudes towards child sexual abuse. They conducted surveys of 200 Vermonters in each of 1995, 1997 and 1999 with a margin of error

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of 4.2% to 6.9%. Market Street Research also monitored public opinions through a survey of key stakeholders in Vermont in 1997 and 1999. These data points were supplemented by data collected through help line tracking, media tracking, a survey of state attorneys, and a survey of clinicians working with sex offenders in Vermont, in cooperation with the Vermont Center for the Prevention and Treatment of Sexual Abusers.

Program Results

Finding No. 1: Abusers Will Call for Help. "*Will an abuser call for help?*" was the most common question asked of STOP IT NOW! VERMONT before we launched the pilot program. We can now answer with a resounding yes! In the first four years of operation, STOP IT NOW! VERMONT received 657 calls to our helpline. The helpline provides unique information to adults who recognize that abuse may have occurred or is likely to occur, are willing to take some form of action (e.g., call the helpline), and do not know what to do in the situation.

Who called? Fifteen percent of callers were abusers, 50% of callers were people who knew the abuser and/or victim. Thirty-two percent of callers were men, compared to an average of 10% male callers on other helplines.

Abusers calling for help contrasts sharply with our view of the "typical" abuser. But we also received calls from others who know the abuser and typically the victim as well. We view these as equally important calls since no one calls a child sexual abuse help line without a valid reason. Many of these calls began with "*I may be over-reacting but . . .*" and then described a behavior that is at least a warning sign that someone may have sexually abused a child. Over seventy-two percent of the friends and family calls to the helpline were from immediate family members of the abuser and the victim. The callers were clearly dealing with the abuse, the shame, and the fear of exposure to their extended family or community.

How did they hear of the helpline?

- 24.5% from traditional media (radio 12.3%, newspapers 8.5%, and television 3.7%);
- 28.8% from the STOP IT NOW! web site;
- 25.2% from professionals in the field, other help lines and agencies; and
- 5.8% from friends, presentations, workshops, or were not willing to share their source.

Finding No. 2: Increase in Adults Who Can Talk About Sexual Abuse. "Breaking the silence" is a call to action endorsed by everyone working in the field of child sexual abuse prevention–everyone from victim-based advocacy groups to sex offender treatment providers.

We all agree that if we change the way people talk, we can change the way people respond to this issue. Over the past four years, we have begun to change the way people talk about child sexual abuse. In fact, there has been a 40% increase in the number of Vermonters who could explain or define child sexual abuse. Although four years is not adequate time to shift public attitudes on an issue, it is enough time to find indicators of awareness and change. Consider the following:

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- *Talk About Abuse:* Vermonters who can explain child sexual abuse have increased dramatically (44.5% in 1995 to 84.8% in 1999).
- *Awareness*: Overall awareness is high in Vermont (78% think of child sexual abuse as a problem in Vermont).
- *ID Sexual Abuse:* Vermonters were able to correctly identify scenarios as "definitely sexual abuse" or "might be sexual abuse." (90.0% of the respondents answered correctly).
- *Abusers Live in Community:* Vermonters who recognize that abusers are likely to live in their communities increased over five percent (67.0% in 1995 to 73.7% in 1999).

Through the survey of key decision-makers in this field, results indicate that most people who were initially skeptical, suspicious, and confused about the program are far less so now. As one person said: "I see now how having programs to treat offenders can be as important as those that treat victims. If you get to the offenders and treat them, then maybe there won't be any more victims. It's attacking the problem at its source."

Finding No. 3: Adults Need Better Skills to Stop Abuse. *"All of the signs were there, but no one bothered to ask me about them. . ."* was said during our first interview with a sex offender in prison. Since that interview, STOP IT NOW! VERMONT has been trying to determine:

- What are the warning signs of abuse and do people recognize them?
- Do people feel they have the knowledge and "permission" to say something and confront these behaviors?
- Why aren't more Vermonters taking advantage of the services now available?

We determined that:

Warning Signs: In 1999, only 38.0% of Vermonters could name at least one warning sign in an adult or juvenile with sexual behavior problems. However, this represents a 10% increase from 27.5% in 1995 of persons who could name a warning sign.

Skills: In 1999, 66.1% of Vermonters were willing to take some direct action (e.g., report suspected abuse, talk to person who may be abusing, or talk with the child who may be abused) if they suspected sexual abuse. In most calls to the helpline, callers were unsure of what action to take and were unable to consider confronting the situation without significant coaching. This contrasts with 96.1% who would take direct action if they thought someone was drunk and trying to drive.

Unsure of Abuse: When presented with four scenarios of sexual abuse, 42.5% of respondents either did not know if the case was sexual abuse or thought it "might be abuse." This uncertainty when faced with a credible case of sexual abuse is echoed by many helpline calls that begin with the callers telling us *"I may be overreacting, but. . ."* and then go on to explain a situation of sexual abuse.

Disclosure: Although Vermonters were significantly more likely to disclose sexual abuse than the rest of the country, two- thirds (66.2%) never disclosed their own sexual assault and therefore the abuse was unlikely to ever have been reported.

Resources: Only 54.4% of Vermonters knew where to refer someone with sexual behavior problems compared to 77.2% of Vermonters who knew where to refer someone with a drinking problem.

Belief in Treatment: Many Vermonters doubted the abuser's willingness and ability to change—19.0% of Vermonters agreed that abusers could stop if they want to, but believed significantly more in the effectiveness of treatment programs; 68.8% of Vermonters agreed abusers could stop with appropriate treatment.

The data suggests that if an adult has direct evidence that sexual abuse has occurred, he or she will take direct action and report the sexual abuse. In fact, Vermonters are significantly more likely in 1999 than in 1997 to say they will report or take direct action when presented with scenarios of sexual abuse. If the respondent is sure of abuse they were ten percent more likely to report in 1999 (80.2%) than in 1997 (70.2%). (This set of questions was not asked in the 1995 survey.)

However, in most realistic situations one can only suspect that there might be sexually abusive activities. In these cases of suspected abuse, adults still do not know what to look for or what to do when faced with these realistic cases of potential sexual abuse. Only 43.3% said they would report the abuse, a 6% increase since 1997. Adults do not seem aware of their potential role in preventing child sexual abuse: identifying emerging problems, confronting difficult situations, reporting suspicions of sexual abuse, or referring someone to a qualified treatment provider.

Finding No. 4: Abusers Stopping the Abuse. Until quite recently society has responded primarily to one kind of child sexual abuse case–cases where a child discloses sexual abuse by an adult or older child. Programs have been developed to teach the child to speak up. The legal protocols have been developed to respond to the child who reports abuse. Policies have been established to ensure that once an abuser is caught, he or she will remain visible for the rest of his or her life.

Many Vermonters believe that no one who sexually abuses will take responsibility for their sexually abusive acts. This belief may, in part, be due to the fact that no agency has any record of these individuals. Anecdotes from people who work with child protective services, clinicians, or district attorney's offices suggest that there are individuals who have taken responsibility for their actions, but no one formally records this data. Through a survey of clinicians and individual telephone interviews in each county prosecutor's office, STOP IT NOW! VERMONT was able to uncover encouraging data for the four years from 1995 through 1999.

Through clinicians, STOP IT NOW! VERMONT identified 118 people who have voluntarily sought out help for sexual behavior problems (20 adults and 98 adolescents to date).

Through states attorneys and victim advocates, STOP IT NOW! VERMONT has identified 15 adults and 10 adolescents who have turned themselves in to the legal system as well as others who have entered treatment without needing to enter the legal system.

This data demonstrates that some people who abuse are willing to reach out for help. These cases also represent situations where the victim is offered an opportunity to get the help he needs to heal.

Future Challenges Facing STOP IT NOW! VERMONT

Give a Voice to People Who Have Not Been Heard. Until quite recently, the only stories heard in the media were the stories of survivors who had the courage to speak about this difficult issue. More recently, the stories of those claiming to be falsely accused of sexual abuse have surfaced in the media. One of the most successful components of STOP IT NOW! VERMONT has been the program's ability to give other people who have lived through the abuse a safe environment to tell their stories. These include:

- Parents of sexually abusing youth who speak out on what they and their children have done to stop the abuse and on what they need from their family, friends, and community.

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- Survivors and recovering sex offenders who can talk together about the need for prevention.
- The family of the sex offender and the victim talking together about the need for more information, more community support, and more prevention strategies to stop the cycle of abuse.
- Recovering sex offenders who talk with adults and adolescents in treatment programs about the necessity of never abusing again (Alcoholics Anonymous model).

These stories are important vehicles of hope. One mother called the helpline to tell us that another mother "*should write a book about her experience. I want to know how she had the courage and sheer will to keep going.*" These stories, new stories to most of the public, will help change the hopeless feelings that many have about confronting the warning signs of sexual abuse.

Create a Language to "Break the Silence." Just as MADD and others developed a new language to stop drinking and driving (e.g., "designated driver" and "friends don't let friends drive drunk"), STOP IT NOW! VERMONT needs to work with others to develop a new language to stop the sexual abuse of children. Some of this language has already begun to evolve. Adult victims have claimed the term "survivor" of child sexual abuse and are beginning to seek a term that shows that they can heal and move beyond this trauma. STOP IT NOW! has coined the term "recovering sex offender" for someone who has successfully gone through treatment and has made a commitment to never sexually abuse a child again. But more is needed. Everyone who has dealt with child sexual abuse will agree that we need to "break the silence" surrounding this issue. To do so we need to be able to talk about sexual abuse. The 40% increase in the number of people who could offer an explanation of child sexual abuse is an important start. However, we need to go further. We need to be able to name the different kinds of abuse that have different impacts on children, based upon the sexual act, the trust that is broken, and other factors. The treatment of the abuser must also vary depending upon his or her crime. Adults need to be able to talk about and name the full spectrum of sexual crimes, from touching to non- touching offenses.

Develop Skill-Based Programs for Adults. We have learned from the telephone survey, the focus groups, and the questions presented to the helpline that adults do not have the skills or the knowledge to confront sexualized behaviors that make them uncomfortable. Unlike simple messages and concrete solutions to stop drinking and driving (e.g., either "offer a ride" or "take the keys"), we are not offering clear and consistent messages about what to do when one suspects sexual abuse.

Overall, the results of the evaluation suggest that further strategies are needed to give adults a clear understanding of the following:

- Vocabulary that people can use to talk openly about child sexual abuse, especially in situations in which they may need to confront an abuser.
- Sense of what to do if they suspect a child is being sexually abused or if they think an adult or older child they know is sexually abusing a child.
- Information and an action path for someone who reports child sexual abuse, but finds that he or she does not have sufficient information or evidence for the official to open a case.

These findings are supported by the conclusions of focus groups conducted in Vermont. The focus group results suggest that it would be easier for people to talk about child sexual abuse if they were more knowledgeable about the topic, felt more comfortable talking about sex in general, and had concrete examples of actions to take and the consequences of those actions. These realistic situations include the issues of how to confront suspicions when you may not see the abuse, how to talk with a family member or someone who is intimately connected to you, and how to seek help without threatening a family system that is already under stress.

In each solution offered to the public, the strategies must take into account the particularly difficult issues involved in confronting someone who is close. One woman in the focus group summarized the need for sensitivity: "*It's harder to confront a family member where the history and future connections are intimately connected to my own life.*"

Creatively Collaborate With the

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Help Line Protocols for STOP IT NOW! VERMONT

All callers to the help line are told about the limits of confidentiality surrounding the help line call. No "Caller ID" program is available in Vermont.

If a caller identifies him- or her-self as someone who has sexually abused a child (or is unsure if it is abuse) and clearly states he or she wants help, he or she is told about the STOP IT NOW! VERMONT protocols.

Step One. The staff member explains that the program is not an amnesty program, but is a unique opportunity for the caller to take responsibility for his actions and get help for everyone involved.

Step Two. The staff assigns a confidential I.D. number to the caller so that he can contact a qualified clinician. The staff also recommends two to three clinicians who work with the STOP IT NOW! VERMONT program and are qualified to conduct an evaluation of a potential sex offender. Without an I.D. number, anyone calling a doctor or clinician for help would be reported immediately to the child protective services or the police.

Step Three. The person with sexual behavior problems calls the clinician to ask any questions he may have (e.g., "Is there help available?," "What is treatment like?," "Can I learn to stop these thoughts and feelings?").

Step Four. If the caller wants to get into treatment he will begin the psychosexual assessment (evaluation) to determine whether he is amenable to treatment. Each caller must pay at least some portion of the evaluation and a sliding scale fee is currently offered by each clinician participating in the STOP IT NOW! VERMONT pilot program.

Step Five. With the results of the evaluation, the caller can contact an attorney. The attorney presents a "hypothetical" to the States Attorney to determine what is most likely to happen to his client if the client turns himself into authorities. The States Attorneys have clearly stated that if their subsequent investigation indicates any additional cases of abuse, the "hypothetical" is no longer valid.

Step Six. With information that shows he is amenable to treatment, the caller can choose to enter into the legal system with a recommendation for treatment and a sense of what is most likely going to happen to him within Vermont's legal system. ■

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Media. Most residents (81.7%) have listened to, seen, or read news reports or programs about child sexual abuse. However, this represents a significant drop from the 1995 findings, where 89.5% of residents had viewed a news report or program. As a result, STOP IT NOW! VERMONT will increase media exposure to bring this issue back into the public eye.

Given the results of the knowledge and attitude surveys, STOP IT NOW! VERMONT 's media efforts will:

- *Target Men More Than Women:*. Men are less likely than women to notice information in the media (76.2% vs. 86.9%) and less likely to discuss the issue of child sexual abuse with family or friends (34.9% vs. 57.7%).
- *Emphasize That Treatment Works*: In the last four years, Vermonters are less likely to acknowledge that the treatment of a sexual abuser can in fact reduce recidivism rates. (In 1995, 78.5% agreed that treatment can help compared to 68.8% in 1999.)
- *Provide the Warning Signs of Potential Abuse*: There has been no increase in the last four years in the knowledge of Vermonters of the warning signs of an adult who may be abusing children. About two-third (62.0%) thought there were no warning signs.

Looking at the Costs and Benefits of Taking Action. Most of the calls to the helpline are from family members who are not immediately connected with the abuser or victim, like an aunt or a friend. Many of the calls ask our staff what will happen to them, the people they love, and the community surrounding the abuse, if this abuse is reported. These calls raise the following questions:

- Is the "cost" of *getting help* in situations where sexual abuse is suspected too high for most families in Vermont? Can we increase the benefits of reaching out for help?
- Is the "cost" of *reporting* sexual abuse within the family too high for most families in Vermont?
- How could Vermonters increase the benefits to an abuser if he chooses to take responsibility for his crime and voluntarily steps forward?

Case Study 1

Caller Description. Mother of a 12-year-old boy with sexual behavior problems.

Caller Story. With the encouragement of a friend, the mother called the helpline about her 12-year-old son. A neighbor told her that her son had fondled a little girl in the neighborhood. The news shattered her. "My life felt like it had broken into little glass pieces at my feet." This mother also suspected that her son may have been sexually abused by an older boy in the neighborhood.

Before calling the helpline, the mother had called her HMO and two separate treatment centers. She was told it would be at least a three-month wait before her son could see a therapist. She then decided to report her own son to child protective services so that he could get some help.

Reason for Call. She did not want to wait three months to help her son. She told us, "My son is willing to talk about what happened. He has taken responsibility for his actions. This is a perfect time to reach out to him and turn this situation around. Why is no one helping us stay safe?" She had heard through her friend and on the radio that STOP IT NOW! VERMONT could help.

Outcome and Suggested Action Steps. STOP IT NOW! VERMONT was able to give the mother a referral to a therapist who could see the 12-year-old boy by the end of that week. Child protective services pursued the case; working with the mother to keep her son in treatment and with the therapist to identify both the victim of the 12-year-old boy and the possible abuser of the 12-year-old boy. The 12-year-old and his family have made a commitment to remain in therapy for the full program. Child protective services will be notified if the treatment program rules are violated in any way.

Case Study 2

Caller Description. Father of six children who sexually abused his adopted daughter.

Caller Story. Prior to the call, the father had gone to the police and turned himself in for sexually abusing his adopted daughter over six years ago. The caller explained that he had sexually abused his adopted daughter when he was at the lowest point of his life: he had lost his job, was at risk of losing his house, his wife was confined to bed rest as a result of a miscarriage, and he had other family stress. Although he had been able to get his life more together, he now saw the impact of what he had done to his adopted daughter. He told us, "I can't live with the fact that I have hurt my daughter so much. I need help and I want to get help for my daughter." He was adamant that he had not abused his daughter or anyone else since that time.

Reason for Call. Since going to the police, his attorney recommended that he not talk to anyone about the case or the sexual abuse. Although the caller understood the legal arguments, the caller did not want to go to prison. He called because he wanted help. He is terrified about what will happen to him and did not want to leave his family without any income.

Outcome or Suggested Action Steps. STOP IT NOW! VERMONT talked with the caller four times and got him in touch with a treatment provider that he could speak with. Through the special protocol set up in Vermont, the caller could discuss the case with a clinician confidentially. In the protocol, he can not begin treatment, but can get the psychosexual assessment that is the first step of any treatment program.

Case Study 3

Caller Description. Grandmother suspected her new son-in-law might be sexually abusing her granddaughter.

Caller Story. The grandmother called to say, "I am concerned about my granddaughter's new stepfather. He hugs and touches her all of the time. Hugging is OK, but in my gut it feels sexual in some way."

The grandmother described walking in on him touching her granddaughter's upper thigh on the outside of her leg, but under her shorts. These "attentions" made the grandmother uncomfortable. She ended by asking STOP IT NOW! VERMONT "Am I over reacting and being an old fashioned grandmother?"

Reason for Call. Grandmother wanted to say something before it went any further. When she saw the STOP IT NOW! VERMONT web site on the Internet, it prompted her to call the toll-free number for advice.

The grandmother and her daughter are very close and the grandmother did not want to do anything to alienate her daughter or her granddaughter by interfering in the family. She wondered whether she should say anything, and if she did, should she talk with her daughter or the stepfather first.

Outcome or Suggested Action Steps. STOP IT NOW! VERMONT suggested that she talk with her daughter first and express her concern. She should make clear that she is not accusing the stepfather of anything, but simply discussing certain behaviors that are not appropriate with a 13-year-old daughter. STOP IT NOW! VERMONT also discussed the possibility of reporting the case, but the grandmother would not consider this possibility without talking with her daughter first.

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The grandmother told STOP IT NOW! VERMONT that it was helpful talking about what was going on. She appreciated that we answered her questions about whether she was "over-reacting" and who should she talk to about her concerns.

Case Study 4

Caller Description. Police Officer called about his concern for his own family.

Caller Story. The caller recently found out that his wife, her sister and her brother were all sexually abused by their grandfather while they were growing up. As children, the wife's brother then sexually abused his wife and her sister. The caller's wife was the only one who had gotten any counseling. No one else in the family ever talks about the abuse.

Reason for Call. The caller was concerned because he and his wife were expecting a baby. He was wondering whether the baby should have any contact with the grandfather and his wife's brother. The caller admitted that he had no evidence that anyone had been abused in recent years, but the caller was aware that risks exist. The caller was afraid that his wife would not deal with the prior abuse and would not support him in confronting the brother. He was also concerned that his wife would not keep the baby away from either the grandfather or brother. The wife had said "no" to any further counseling.

Outcome or Suggested Action Steps. STOP IT NOW! VERMONT suggested that the caller talk with a therapist with expertise in child sexual abuse and offender treatment. He could ask his wife to go with him for educational purposes and not for therapy. The organization suggested that both might benefit from such as meeting: they would both understand the potential for the brother to abuse and learn ways to talk about this as a family to keep the children safe. The caller agreed that he could call social services regarding the brother, and have them start an investigation on the children living with the brother. But the caller decided he would rather try meeting with the therapist first to avoid alienating his wife and the entire family.

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Restitution to the Community. Sex offenses affect more than the direct victim. They threaten the entire community's sense of safety. Sex offenders committed to public safety seek to restore this feeling of safety within the community. The SSOTR examines the extent to which offenders are actively taking steps to promote a sense of community well-being.

Relinquish Victim Stance. Offenders are expected to place the needs of the victim and/or community over their personal needs.

Results

After initial discussions and training with probation and treatment agencies, the SSOTR was implemented in the 20th Judicial District of Colorado. All treatment agencies were required to utilize it as part of their standard reporting format. Probation officers also used the SSOTR as a framework for staffing cases with treatment providers. Three benefits were immediately realized as discussed below.

Enhanced Case Plans. The treatment teams found the structure provided by the instrument focused the team on clarifying the goals of treatment. Both therapists and probation officers indicated the SSOTR provided the team with a "measuring rod" of the case plan. Treatment teams were better prepared to identify specific tasks required of the treatment team and the offenders. This specificity made it easier to prioritize the treatment tasks.

Treatment teams also found the structure of monitoring the 31 items exposed previously unnoticed areas where offenders were "backsliding." The process also revealed areas of offender progress that were masked by other, more noticeable, behaviors.

Clarifying Discrepancies. Upon implementation, treatment teams found they did not always agree on interpretation of the SSOTR elements or offender behavior. Team members reported that the ensuing discussions were remarkably productive in two ways.

First, the discussions were an educational process for both officers and therapists, which often revealed new information about the offenders. Where discrepancies existed, the team was able to discuss the evidence upon which individual interpretations were based. Information, which was considered common knowledge by one team member, was frequently news to others. The process of exploring differences in interpretation of SSOTR elements or offender behavior became an ad-hoc training for all team members.

Second, the end result was a building of consensus among team members regarding both treatment and management expectations and offender behavior. Sex offenders have a remarkable ability to split treatment teams. This is especially true when the team consists of both corrections professionals and therapists. The process of building consensus around the interpretation of the SSOTR sharply reduced the ability of the offenders to split the treatment team.

Clarification of Expectations. The treatment team and the offender were able to create a clear set of expectations. Using the completed SSOTR as a platform for discussions with the offenders, the treatment team was able to provide definitive goals and expectations. While many offenders were surprised they had not progressed as far in treatment as they had previously thought, all welcomed the clarity of expectations.

Some treatment teams asked the offenders to complete a self-report SSOTR. They then used a comparison of the offender's SSOTR with the team's SSOTR as a framework when staffing the case with the offender. Areas of agreement provided opportunity to confirm progress. Areas of disagreement supplied fertile ground for examination and discussion. When utilized this way, teams felt the offender benefitted by the process.

Conclusion

The SSOTR was developed to provide a systematic method of monitoring sex offender treatment on a routine basis across time. By answering a 31-item checklist, treatment teams are provided with a comprehensive view of offender performance. The tool comes in two forms, one for treatment agencies and one for probation/parole. The instrument was recently implemented in a judicial district in Colorado. Probation officers, therapists, and offenders indicated the tool was immediately beneficial.

The creators of the SSOTR are continuing research to establish cut points which may allow the tool to be used as a measure of community safety. However, the immediate and significant improvement in the management of sex offenders within the 20th Judicial District prompted them to release the instrument in its experimental form. Both forms of the SSOTR may be downloaded on the Internet at www.kbsolutions.com. The creators welcome feedback from agencies using the SSOTR. ■

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