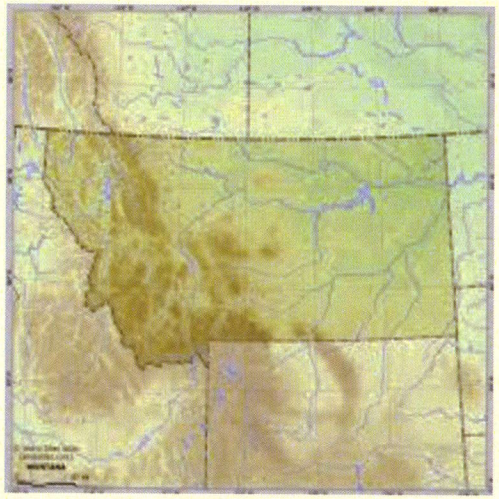
SERVING MONTANA FOR A SAFER TOMORROW

The Montana Sex Offender Treatment Association's (MSOTA) mission is to promote community safety and education by maintaining professional standards for the evaluation and effective treatment of sexual offenders, individuals with sexually abusive behaviors, and/or sexual behavior problems. MSOTA promotes education and training throughout the state and region.



Our partnership with you is vital in Montana's fight against sexual abuse!

We ask that you take just a few moments to learn about our mission and what we want to achieve for our great state.

Provider Contact Info:

www.msota.org

MSOTA

MONTANA SEX OFFENDER TREATMENT ASSOCIATION

ESTABLISHED IN 1986

A number of MSOTA clinical members are recognized nationally for their work and expertise in the area of evaluation and treatment of sexual offenders. The relatively small population of Montana has enabled the association to coordinate efforts and provide consistency of services throughout the state.

The association has a number of committees to address specific concerns including:

- Education/Public Relations
- Legislative
- Ethics
- Membership
- Evaluation & Treatment Standards

MONTANA SEX OFFENDER TREATMENT ASSOCIATION

MSOTA was one of the first state organizations of its kind. Other states have followed its lead in establishing their own state chapters. Most MSOTA members are also members of The Association for the Treatment of Sexual Abusers (ATSA), the international association for the treatment of sexual abusers.

MSOTA CLINICAL MEMBERS:

Professionals who are qualified to perform independent evaluations of sex offenders as well as direct treatment. MSOTA members are required, at a minimum, to have a master's degree in social work, psychology, or counseling and an appropriate state license to perform mental health therapy.

Clinical members are required to have 2000 hours of supervised experience in the evaluation and treatment of sex offenders. They must pass written and oral examinations and submit work samples which are reviewed by the membership committee. All MSOTA clinical members must be licensed within their respective disciplines.

MSOTA ASSOCIATE MEMBERS:

Mental health professionals who are not certified as a clinical member or professionals who perform non-therapeutic services in working within the field of sexual abuse. This includes case management, probation and parole, social services, etc.

Associates members are required to apply for membership and must provide letters of recommendation as well as documentation of education and training.

All members of the association are held to ethical standards which are outlined in the Code of Ethics.

MSOTA BOARD MEMBERS:

MSOTA's Board is composed of professionals throughout the state. This presently includes professionals from a variety of disciplines such as corrections, judicial, attorneys, mental health, etc. The Board provides additional input, support, and direction to the association. Board members serve two year terms.

MSOTA invites you to learn more about our association, our members, and the work we do by visiting:

www.msota.org

COMMUNITY SEX OFFENDER ISSUES

Practical Applications for Evidence Based S O Public Policy: Community Safety

Risk Evals, Treatment, Monitoring, Public Education & Prevention

Andy Hudak III, Mike Sullivan & Brenda Erdelyi

MSOTA MISSION

Promotion of community safety and education by maintaining professional standards for the evaluation and effective treatment of sexual offenders, individuals with sexually abusive behaviors, and/or sexual behavior problems.

WHO IS MSOTA?

- Approximately40 MEMBERS
- Clinical = 27;
- Associate Members = 6

MSOTA AGENDA

-- EVALUATION

-- COMMUNITY TREATMENT

-- TRANSITION ISSUES

--PREVENTION

-- PUBLIC EDUCATION

-- PUBLIC POLICY/LEGISLATIVE

Community Based Treatment

- A Note On Our Limbic Brains
- Forty Years of Sex Offender Treatment- A Brief Hx
- Who are these people & where do they come from?
- ACE'S Study
- Research : Adult SO Community Recidivism
  ("The Redemption Curve" – Hanson Harris 2014)
- Adolescent Treatment
- Adolescent Recidivism & S O Registry Impacts
- Public Policy and Legislative Implications

Limbic Brains & Social Policy

Purpose = Survival

i.e. FIGHT/FLIGHT

"TRIGGERED" -> Unmet or threat to needs and/or disengagement in an environment

Eg. = Threat to self, loved ones & values

Starts with attachment figure, then "wars"

(About our limbic brains, cont…)

CHARACTERISTICS of LIMBIC THINKING:

- Us/Them; B/W; All/Nothing
- External Focus/Emotional Reasoning
- <u>Failure to see differences with-in categories (e.g.'s = prejudice;SO's vs Types Tier)</u>
- No Empathy (War -> override affiliation needs)
- Present (unaware of future consequences)

S O Treatment History

-- Marlatt, RP, and the Chem. Dep. Field

(Harsh Confrontation Style + ZERO tolerance)

-- Rise of CBT in 70's/80's + Managed Care

-- SO Relapse Prevention (Laws; '89), and Manualized Treatment Approaches

(Problem: only 18-23% of SO's were compulsive!)

Treatment History (cont…)

-- The SO Evaluation and TX Project (SOTEP) (2005) 1985 - 1995 (Marques, et al., 2005)

(NO DIFFERENCE Treated vs Non-treated SO's)

-- Motivational Interviewing (MI; Miller & Rollnick, 1992)

-- Self Regulation (Ward, Hudson, & Keenan, 1998)

(Both approaches in 60's/70's; Then Ins. Co.'s + meds

-> Brief Therapy, CBT's + Amnesia for axis 2 Tx)

-- The Risk-Need-Responsivity Model (RNR)

(Andrews, Bonta, & Hoge, 1990 Andrews, Bonta, & Wormith, 2011)

RNR- 3 core principles

#1 Higher risk offenders require higher levels of service. (Lower = *Less tx)

#2 "Need" principle = focus on dynamic risk variables

NOTE: Static factors can change, but very slowly. (e.g. = 10 years)

* Registry and other challenges have mitigated.

RNR- 3 core principles

#3 "Responsivity"

Styles and modes of services need to be matched to the learning styles and abilities of offenders.

Respectful, Collaborative, Strength Focused

(Authoritative Re-Parenting Approach)

RESEARCH on RNR TX

***Treated vs Non Treated**

Sexual Recidivism = 10.9% vs. 19.2%;

General Recidivism = 31.8%, vs. 48.3%;.

***Meta-analysis of 23 recidivism outcome studies**

(Hanson, Bourgon, Helmus, & Hodgson, 2009)

*GOOD LIVES MODEL

-- Interpersonal Relationship Skills Building

-- Includes aspects of RNR (Especially Responsivity)

-- Internal Locus of Control

-- NOT Recommended for Hi Risk

***OVERALL FOCUS = Well-being + quality of life improvements**

Judgments made by clients re specific behavioral plans rooted in THEIR values for who they want to be. Authoritative Parenting + Motivational Interviewing integrated into behavioral plans + CBT

SO TREATMENT *EFFECTIVENESS

*37 - 50% less sexual recidivism in sex-offender treated groups vs. controls

(THINK ABOUT EACH RISK TIER SEPERATELY)

* FROM TWO OF THE MOST AUTHORITATIVE META-ANALYSIS

WHO ARE THESE SO's ?

- Heterogeneous

ADULT: Developmentally Disabled, Mental Health, Mental Abnormality, Brain Damaged, Rapists, Sexual Assault, (Types: Statutory, Violent & Sadistic), Anti-Social, Psychopathic, Exhibitionist, Incest, (often inter-generational for both parents), Aggressive Fetishes, etc.

SOME Adolescents have above categories, but many are "Naive Experimenters", Dating disorders, TO ALL CATEGORIES ABOVE

- SO's = 4 Average ACE's

When is a Sex Offender No Longer a Sex Offender? Big Thanks! :) !!

Andrew J. R. Harris
and
R. Karl Hanson

ATSA 31st Annual Research and Treatment Conference
Denver, Colorado October 19, 2012

SUMMARY

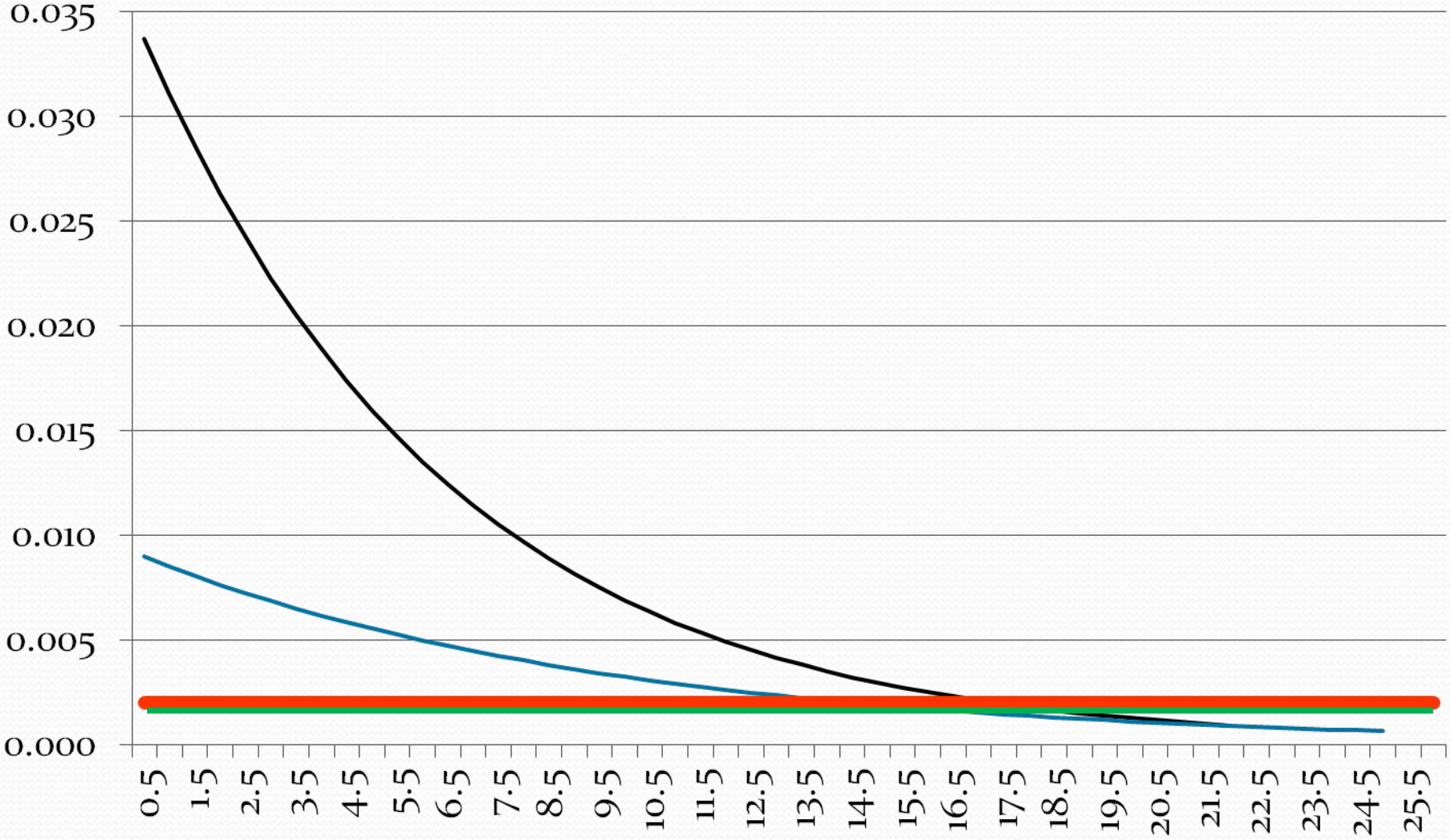
- N = 7,740 ; 21 SO samples
- 20-year follow-up period
- Recidivism rates used survival analysis.
- Sexual recidivism highest in first few years
- Risk substantially < the longer individuals remained sex offense free in the community.
- Particularly strong for high-risk SO's
- Adult SO's = Lowest rates BY FAR vs. Gen'l Recidivism

STATIC-99R Groups (**High, Moderate**)

Logistic Regression with "Redemption Bar"

STATIC-99 Low Risk Group – Base Rate Line

(Percent Recidivism by Time Interval (Years) [6 Month "gates"])



Conclusions

- Both "regular" offenders and SO's are less likely to re-offend over time in community. (SO's more so)

- Eventually, ALL SO's are less likely to reoffend sexually than a NON-sexual offender is to commit an "out of the blue" sexual offence (Equal Protection or Class Issues?)

- e.g. Moderate @ 7 yrs = Non SO's to commit sex crime

- Findings highlight risk fluidity for many SO's

- Implications for the Registry and the utilization of public resources

ADOLESCENT RECIDIVISM

#4: Sexual Re-offense rate at nine years of follow-up = 2.5%

#5: No significant difference across risk tiers

(In one study, highest tier risk had the lowest reoffense rate.)

ADOLESCENT RECIDIVISM

- Youth who participated in treatment had a sexual recidivism rate of 7.37% while youth in the control groups had a sexual recidivism rate of 18.98%.

  (Inflated due to all risk tiers)

- Higher rates of non-sexual recidivism = need to provide more comprehensive tx aimed at all forms of misconduct, not just sexual abuse.

REGISTRY RESEARCH

#1: Adults = NO discernible effect on sexual or nonsexual convictions or adjudications

#2: Identified negative effect of being charged (Called "surveillance effect")

#3: For Adolescents, no demonstrated deterrence effects (specific or general) n = 26,000 (S. Carolina)

Juvenile Sex Offender Registration Research

"There is no remaining requirement under SORNA that jurisdictions publicly disclose information about sex offenders whose predicate sex offense "convictions" are juvenile delinquency adjudications"

STATE by STATE BREAKDOWN

37 states provide for adjudicated juvenile registration

27 = mandatory

10 = discretionary

HUMAN RIGHTS WATCH

"CHILDREN REGISTERED AS SEX OFFENDERS"

Report released May 1, 2013

- Reviewed 500+ cases
- Interviewed 296 RSOs registered as youth
- 85% reported negative psychological impacts
- 20% reported suicide attempts

MSOTA & Public Policy

- Statutory Rape Amendment to the SIWOC Statute
- Return to Mt.'s original Adol. Registry Process
- Risk Fluidity = > Easier Registry Risk Change (OPD?)
- Discourage "Sex Offender Card" Use in campaigns (Many Unintentional Consequences & Huge Financial Costs!)

MSOTA & Public Policy cont…

- Low Risk Adults = Law Enforcement Registry Only
- ACCURATE public Ed.
- Re HI Risk, Low Recidivism, and Prevention

(Entrance Page on The Registry? … collaboration w all!)

- Flexible Conditions for SO's ; Transition = Establishing Pos Supports ; Check integration of Tx Tasks, Clarifications check WAY harder than treated inmates expect!)

QUESTIONS, ANSWERS, & FEEDBACK