Lessons Learned

The Revised Coalinga State Hospital
Sex Offender Treatment Program

A Strength-Based Self-Regulation Model

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Brief History of the CSH SOTP

- Relapse Prevention (RP) Program initially started at Atascadero State Hospital
- Relapse Prevention (RP) was most established program at that time even though there was *no empirical evidence* for its efficacy
  - Good "face validity"
  - Nothing else available that seemed to work
  - Had proven successful in alcohol *maintenance* programs
- The Sex Offender Treatment and Evaluation Project (SOTEP) completed and published in 2000 (Marques, Nelson, Alarcon, & Day, 2000). Results indicated program was ineffective
- "SOTEP researchers critiqued problems of RP (2005) – Overmechanized and rigid

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Brief History - continued

- ASH SVP patients transferred to CSH starting in 2005
  - Any thoughts of changes delayed until after the transfer of all individuals was completed.
  - Selected therapists from CSH were trained at ASH
  - Research regarding what works in treatment and how best to implement treatment were subsequently published. New research exposed some limitations of strict RP programs
  - "Enhancement Plan" implemented with oversight by Federal Government required a rehabilitation philosophy (Wellness & Recovery)
  - Enhancement Plan became focus of program treatment changes
  - Compliance with EP was essentially met and energy refocused on program revision (2011)

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Why Change?

Improve Efficiency
Improve Effectiveness
Incorporate Research Developments
Increase Treatment Engagement

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Important Research Developments Suggesting Change

- Limitations of RP Model
- Risk, Need, Responsivity (Andrews & Bonta, 2006)
- Research on aging and recidivism (Prentky & Lee, 2007; Hanson, 2005)
- The Self-Regulation Model (SRM)
- Evolution of Strength-based Models

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Some Limitations of Traditional RP

- Limitations:
  - Designed for alcohol *maintenance* programs, not sex offenders. Assumption is that individuals are motivated to avoid offending.
  - Fails to account for heterogenity of sex offenders. One size fits all, not individualized. Assumes one pathway to offending
  - Focuses on risk factors (avoidance based) at the exclusion of strength factors and positive goals
  - Doesn't identify the existence of explicit approach goals, active offense planning, or active pursuit of deviant sexual interests.

*(Kingston, Yates, & Firestone, 2011)

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Positive Aspects of RP

- The required autobiography helps identify predisposing factors and some dynamic risk factors
- Helps identify precipitating factors
- Helps identify high risk behaviors and situations and teaches avoidance techniques and/or methods to cope with high risk situations

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- **Research Influencing Change**

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IMPORTANT RESEARCH DEVELOPMENT:

Risk, Need, Responsivity (RNR)

- Andrews & Bonta's (2006) research on criminal recidivism found three treatment principles consistently reduced recidivism
  - **Risk, Need, Responsivity Principles**
    - ***Andrew's & Bonta suggest several principles but these are the three primary ones considered important for all offender programs**
- Subsequently, Hanson, Bourgon, Helmus, and Hodgson (2009) found that the same principles that worked for criminal behavior also worked for sex offender treatment

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RNR Theory

- RNR are components of treatment but the theory itself doesn't provide a specific framework for providing treatment
- RNR Principles provide guidelines for other models of treatment
- Encourages individualized treatment based on each individual's identified risk factors
- Recommends focusing treatment on those factors shown to be related to recidivism

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RNR Principles

- **Risk:** Match the intensity of treatment to the risk level. (Static + Dynamic Risk Factors)
- Conversely, don't provide treatment for an individual who doesn't need it
- **Need:** Treatment should target dynamic risk factors associated with recidivism that can be changed through intervention. Other factors are discretionary
- **Responsivity:** Refers to the treatment programs ability to teach concepts based on individual learning styles, motivation levels and in a manner that engages the individuals being treated.
- These principles are now standard guides for evaluating treatment programs.
- Research indicates that the success of a treatment program is directly related to the degree of adherence to these principles (Hanson, Bourgon, Helmus, and Hodgson (2009).

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IMPORTANT RESEARCH DEVELOPMENT

- SELF-REGULATION MODEL

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Important Development:

Evolution of The Self-Regulation Model

- Devised specifically to address limitations of RP model.
  - RP treatment assumes that everyone wants to avoid offending (related to it being developed as a *maintenance* program) and feels bad about it when they do offend
  - SRM research (Laws et al., 2000; Hudson, Ward & McCormack, 1999; Ward, Louden, Hudson, & Marshall (1995) found that many offenses involve careful, systematic planning and are followed by a positive emotional state

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Self-Regulation Model (SRM)

- Ward & Hudson (1998) developed the SRM to better explain the offense process and to guide treatment
  - SRM is derived from theories of:
    - ***Goal directed behavior***
    - ***Decision making***

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Self-Regulation Model Determining Offense Pathway

The pathways used to avoid offending or to offend involve all of the following:

- Self-Regulation Style
- Goals with Respect to Offending
- Strategies to Achieve Goals
- Role of other goals involved in Offending Behavior

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SRM
Two Possible **Goals** Related to Offending

- Offending Goals:

Avoidance Goals: Goal is to *avoid offending*

Approach Goals: Goal is to *offend*

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SRM
2 Types of **Strategies** to Achieve Offending Goals

- Dysfunctional Strategies
  - Under-regulation
  - Mis-regulation
- Intact Regulation
- *The combination of goals (approach-avoid) and strategies used (dysfunctional and intact) creates 4 pathways to offending

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Avoidant Pathways

- Avoidant-Passive Characteristics
  - Avoidance goals
  - Under-regulated – lacks skills to prevent sex offending
  - Passive and/or automatic strategies
- Avoidant Active
  - Avoidance Goals
  - Mis-regulated strategies

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APPROACH PATHWAYS

- Approach-Automatic
  - Approach goal to offending
  - Under-regulated strategy (impulsive)
  - Generally feels satisfaction after offending
- Approach-Explicit
  - Approach goal to offending
  - Intact self-regulation strategies
  - Feels satisfaction after offending

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SRM PATHWAYS TO OFFENDING

Pathway	S-R Style	Description
Avoidant-Passive	Under-Regulation	Desire to avoid offending but lacks coping skills to prevent it
Avoidant-active	Mis-regulation	Attempts to control deviant thoughts and fantasies but uses ineffective strategies
Approach-automatic	Under-regulation	Overlearned sexual scripts for offending, impulsive and poorly planned behavior
Approach-Explicit	Intact - regulation	Desire to sexually offend and offenses are carefully planned

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What Pathway Did Mr. A follow?

- Mr. A has been convicted of 2 sexual offenses against boys less than 10 y/o. A previous charge for a similar offense was dismissed. All offenses involved fondling and fallatio and were committed when Mr. A was between the ages of 15 & 23. He received probation for the 1st offense and a prison sentence for the 2nd offense. He has no other criminal history.
- Mr. A. has a stable family history and supportive parents. He has never had a long-term intimate relationship with an adult. He reports he has never engaged in sexual intercourse with an age-appropriate female and that he is not sexually attracted to adult males. He indicates he is shy and reluctant to establish age-appropriate relationships.
- The offending incidents were similar. In the first, he encountered a prepubescent male whom he manipulated to go to a park and then fondled and fellated him. He reported that at that time he was unemployed and felt worthless. The 2nd offense was committed against a neighbor's child whom he was babysitting. He reported the 1st incident to a school counselor after which he "just wanted to forget" about the incident. Prior to the offenses he had begun to masturbate to fantasies of boys and think about age appropriate females. This strategy failed and he felt guilty about his sexual attraction to boys.

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Mr. A Characteristics

- Under-regulated – Desires to avoid offending but lacks skills to prevent it
- He experienced a situation that induced a negative affective state which created a desire to offend
- Disinhibition occurred and he lacked strategies to cope with the situation that would have prevented him from offending.
- *This pathway is often found in individual's with low self-efficacy expectations about their ability to avoid offending

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What Pathway Does Mr. B Follow?

- Mr. B is a 40 y/o man who plead guilty to 6 counts of sexual assault committed over a period of 8 years against one victim, a boy between ages 10 & 18. He maintained the abuse by convincing the boy that no one would believe him if he reported the events.
- He was previously arrested at age 19 when he sexually assaulted a 14 y/o boy and again when he was 26 and assaulted a teenaged boy. While incarcerated in prison, he coerced sexual activity from other inmates in exchange for helping them in completing paperwork.

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What Pathway Does Mr C Follow?

- Mr. C was arrested and convicted of two counts if indecent exposure following an incident in which he touched two girls on a train, during which he also masturbated to ejaculation. He left the train an approached another girl, with his penis exposed. He intended to have the girls perform fellation on him. Prior to the offenses, Mr. C had been drinking in a bar and left when he was rejected by a female in the bar. He subsequently boarded the train knowing that there would be girls traveling on the train after school.

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What Pathway Does Mr. D Follow?

- Mr. D was convicted of touching his biological daughter when she was 10 y/o. At the time he was working in a country with a very hot, humid climate where family members were frequently partially clothed as a result of the weather. One day, in this situation, he became aroused to his daughter. He realized his arousal was inappropriate and attempted to avoid high risk contact with her. He was usually successful but on some occasions engaged in fondling his daughter.

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Treatment Implications of Pathways

- Different treatment recommendations are recommended for different pathways
- Offense Progression steps replaces cycle of abuse used in RP
- Research indicates that the risk is higher for those who have approach pathways compared to those who have avoidance pathways

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Offense Progression - 10 Steps

Purpose: Examines Offense pathways in detail

Replaces RP cycles of abuse

Step 1: Preconditions to offending
Step 2: Life Event
Step 3: Desire in response to life event
Step 4: Goal Establishment
Step 5: Strategy Selection
Step 6: Opportunity to Achieve Goals
Step 7: Pre-Offense Behaviors
Step 8: Commission of Sexual Offense
Step 9: Post Offense evaluation and adjustment of future offending plans
Step 10: Future intentions and adjustments of future goals

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10 Step Process Example Avoidant-Passive

- Mr. Z was very shy and interpersonally awkward growing up but eventually married. **(Predisposing).** However, Mr. Z was recently separated from his spouse after being convicted for child sexual abuse. He attends treatment and is avoiding high risk situations. But, he has an argument with his girlfriend and feels rejected by her **(life event).** As his moods worsens he begins to fantasize about having sex with a teenage girl down the road **(desire for deviant sex).** He realizes these thoughts are not good for his goal of not offending **(avoidance goal established)** but continues to have the fantasies which makes him very anxious. He decides to avoid the thoughts by watching television **(strategy selected).** This doesn't work and he feels out of control. Over the next few days he goes on daily walks down the girl's street for "exercise" and one day "accidentally" runs into the girl and strikes a conversation with her **(high-risk situation).** He feels anxious and out of control and suggests to the girl that they go for a walk in the park **(lapse).** He is now filled with pleasurable anticipation. He molests the girl **(relapse).** Afterward, he is filled with remorse and self-disgust **(post offense evaluation)**. He resolves to never offend again **(attitude toward future offending).**

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Treatment Interventions
Avoidant Passive

- Develop coping skills that allow for regulation of emotions and dis-inhibited behaviors and cognitions that accompany loss of emotional control
- Adjust treatment plan to address attributions of powerlessness
- Develop pro-social ways to achieve goals associated with offending

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Treatment Interventions
Avoidant Active

- Strengthen and improve ineffective coping skills
- Re-work treatment plan to increase awareness of flawed perceptions of effectiveness
- Develop pro-social ways to achieve abstract goals associated with offending

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Treatment Interventions
Approach Automatic

- Develop coping skills for self-regulation
  - Emotional regulation
  - Behavioral regulation
  - Cognitive regulation
- Address issues of hostile/entitled or criminal schemas
- Rework treatment plan to address offense supportive beliefs associated with impulsive behavior
- Develop ways to achieve secondary goals associated with offending (e.g., relatedness)

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Treatment Interventions
Approach - Explicit

- Address pre-disposing issues that may have contributed to anti-social goals
- Modify hostile/entitled or criminal schemas
- Adjust treatment plan to address offense supportive beliefs related to anti-social behavior
- Expand scope of pro-social meaningful and pleasurable activities (Note VIA-IS tests)
- Develop ways to achieve secondary goals sought through offending in pro-social ways (e.g. mastery)

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Strength Based Approach

Implementing Strengths into Treatment

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RECENT DEVELOPMENTS

Integration of Normative Goals into Treatment

- The use of Wellness & Recovery philosophy is mandated by the Enhancement Plan. This model requires incorporation of strengths into treatment plans
  - Directs focus onto both addressing risks and strengths. Focus on the "future me" utilizing strengths, values, and interests
  - Strengths are identified by the Values In Action assessment
  - Increase attention to pro-social goals rather than focusing entirely on avoidance goals. The problem of "narrow scope"
  - Focus on benefits of positive treatment change

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Relationship of other goals to Offending

- Offending sometimes occurs in the process of achieving normal human goals in flawed ways. Individuals use inappropriate strategies to obtain goals
  - Narrow scope of interests
  - Conflicts among goals, e.g., wants a relationship but also wants to feel autonomous resulting in over-controlling relationships
  - Lack of internal or external capabilities (lack of skills or opportunities to achieve normal relationships)
- Treatment focuses on reducing risk via improving self-regulation, by targeting identified dynamic risk factors for treatment, and by increasing ability to achieve normal human goals in a pro-social manner
- Treatment is a means to improving personal functioning

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COMMON HUMAN GOALS

- Life
- Knowledge
- Excellence in work and/or play
- Excellence in agency (autonomy)
- Inner Peace
- Friendship
- Community
- Spirituality
- Happiness
- Creativity

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Problems in Attaining Goals

- Lacks means to attain goals
- Lacks scope of pleasurable activities in daily living
- Conflict among goals
- Lack of capacity to attain goals in acceptable manner

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Integrating Strengths into the Self-Regulation Model

- Yates and Laws:
  - Felt that the SRM didn't sufficiently address strengths but was the best cognitive behavioral program available
  - Integrated strengths and positive goals into the Self-Regulation Model with the dual goals of reducing risk and improving strengths
  - Postulates that this will increase treatment engagement and will improve treatment effects that will last longer since most people wont' want to pursue avoidance goals for the remainder of their lives.
  - Expected to increase treatment engagement

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Individualizing Treatment
Avoidant/Passive Pathway

- Assessment of stage of change prior to commencing treatment
- Target long-term vulnerability factors (DRFs)
- Identify high risk situations that trigger offense progression and the manner that the individual perceives these events based on core beliefs and the nature of the desire for offense-related behaviors
  - Increase the offender's awareness of the manner in which he interprets events
  - Determine what he desires to achieve
  - Link offense-related experiences to vulnerability factors
  - DRFs function as markers for problems in important domains
  - Reinforce avoiding offending

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Individualizing Treatment
Avoidant/Active Pathway

- This is a mis-regulation pathway. Strategies to avoid offending are ineffective
  - Strategies may increase risk of offending
- Treatment focuses on examining the factors that make the person vulnerable
- Identify individual's high risk situations
- Analyze the individual's interpretation of events based on core beliefs
- Case formulation should reflect the relationship between life events, DRFs, and the offender's life goals
- Treatment is focused on the strategies selected to achieve the goal of avoiding offending and expanding the individuals scope of interests
  - Generate strategies that would have been effective
  - Rehearse the strategies (role play)
  - Extinguish ineffective strategies
  - Improve problem solving

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Individualizing Treatment
Approach/Automatic Pathway

- Involves under-regulation or impulsivity with the desire to offend
- Individual responds to situational cues (opportunistic)
- Generally lacks interests in the needs of others
- Responds to long standing scripts
- Treatment focuses on raising awareness, altering over-learned cognitive and behavioral scripts
- Changing offense related goals

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Individualizing Treatment
Approach/Explicit Pathway

- Has intact regulation
- Consciously and explicitly plans offenses with well-developed strategies
- Experiences positive emotional states from offending
- Cognitive scripts include a sense of entitlement, hostile attitudes toward a specific group or the world in general, beliefs that sexual abuse is acceptable.
- Treatment focus includes changing goals with respect to behavior
- Identify other human goals being sought when offending
- Raise awareness
- Exam historical events that led to beliefs that support offending
- Establish what needs the offender is trying to meet
- Motivate offender to instill the idea he can meet these needs in pro-social ways
- Cognitive therapy for changing belief system
- Reduce the sense of entitlement

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Treatment Program Revision Goals

- Improve EFICIENCY, EFFECTIVENESS, AND ENGAGEMENT of treatment program participants
  - Adhere to RNR concepts
  - Eliminate phases of treatment and replace with treatment targeted for each individual based on risk factors and needs (per RNR)
  - Focus on research supported treatment targets individualized for each individual (per RNR)
  - Follow established learning theory principles for skills acquisition (see learning principles)
  - Revise assessment procedures and eliminate unnecessary assessments, especially those shown not to predict recidivism (per RNR)
  - Include positive goals in treatment to increase treatment engagement (Responsivity of RNR principle)
  - Identify strengths (VIA-IS) and integrate into treatment (Responsivity)
  - Increase treatment engagement (currently 33% participate in phase treatment) via all of the above

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Goal: RNR ADHERENCE

- Risk: The risk level is identified by the administration of the Static 99-R to assess Static Risk factors and the administration of the SRA to assess dynamic risk factors. This combination along with overall history determines treatment intensity.
- Need: The identified dynamic risk factor (need) associated with recidivism become the primary treatment targets. Specialized groups are provided to address the various risk factors.
- Responsivity: The revised program provides several motivational modules at the beginning of treatment and sequences treatment in a manner designed to increase treatment engagement. Assessments are provided for strengths (VIA-IS), protective factors, and vocational interests along with the risk assessments. A separate manual is being constructed for those with learning difficulties that presents information in an easy to understand manner. The adopted model is specifically designed to individualize treatment and to increase motivation for treatment and engagement.

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Goal: Improve Efficiency of SOTP

WHY REMOVE PHASES?

- One size fits all, not individualized
- Risk oriented with no focus on positive goals
- Inefficient
  - Ignores learning theory principles for best ways to learn
  - Unnecessary tedious assignments not shown to enhance treatment outcomes
  - Targets factors that haven't been shown to be related to treatment outcomes

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Apply Principles of Learning

- **Readiness**
- **Exercise**
- **Effect**
- **Primacy**
- **Recency**
- **Intensity**
- **Freedom**
- **Requirement**

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Target Factors Related to Recidivism Empirically Identified Risk Factors

- Mann, Hanson, and Thornton (2010) – Identified meaningful and empirically supported risk factors for treatment
  - Sexual Preoccupation
  - Deviant Sexual Interest
  - Offense Supportive Beliefs
  - Emotional Congruence with Children
  - Lack of emotional Adult Intimate Relationships
  - Lifestyle Impulsivity
  - General Self-Regulation Problems
  - Poor Cognitive Problem Solving
  - Resistance to Rules and supervision
  - Grievance/Hostility
  - Negative social influences

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Target Factors Related to Recidivism Promising Risk Factors

- These factors are promising but insufficient research has not yet been established
  - Hostility toward woman
  - Callousness/ lack of concern for others
  - Dysfunctional coping
  - Sexualized coping

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Target Factors Related To Recidivism
Unsupported risk factors with some exceptions

- Denial* -
  - Thornton & Knight found denial to be a protective factor
  - Maruna & Mann (2006) noted that deniers in parole hearings have lower recidivism
  - Hanson & Bussiere (1998) found no relationship between denial and recidivism
- Low Self-Esteem* Studies that used SSES and SSEI found results to be predictive
- Major mental illness
- Loneliness

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Don't Target Factors Unrelated to Recidivism
NOT IDENTIFIED AS RISK FACTORS

- Social skills deficits
- Poor victim empathy
- Pre-treatment lack of motivation for treatment
- * CSH emphasizes social skills deficits and victim empathy in Phase treatment. I.e., it targets factors not shown to be related to recidivism. Make these groups optional based on clinical need.
- Lesson Learned: Ensure that treatment facilitators focus on relevant treatment targets.

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Improving efficiency

- Apply learning theory principles
- Phase 2 is called Skills Acquisition. This is primarily RP. Phase 3 is called Skills Application. Learning theory indicates that the best way to learn new skills is to practice skills while you are cognitively learning them. The new program will teach skills (formerly Phase 2) and have individual's practice and record their progress in applying skills at the same time. A separate "Core Group" (formerly Phase 3) will be conducted to discuss the application of skills and to receive feedback on their progress. Essentially, this is conducting the functions of Phase 2 and Phase 3 simultaneously.
- An additional benefit is that individuals will remain in the same group from matriculation to release. This will keep individuals from adjusting to new facilitators when they switch phases and will help facilitators have a better vantage point from which to judge improvement

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Improving Assessment Procedures

- Do not assess for traits that have not been shown to be related to recidivism (e.g., empathy)
- Include assessment of protective and strength factors
- Eliminate unnecessary and expensive assessment tools. Several of the assessments that were routinely administered are now used only as needed (eg., MMPI, MCMI,Empathy).
- Consider recent literature on the effects of aging when assessing risk.
- Pre and post-tests for all DRF groups.

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Summary of Goals For Revised SOTP

- Adhere to RNR concepts
- Reduce treatment elements not supported by research
- Follow learning theory principles for administering groups
- Focus research supported treatment targets individualized for each person
- Replace current RP model with Self-Regulation Model
- Conduct skills acquisition groups (currently Phase 2) with skills applications groups (aka,"Core Groups") (Formerly Phase3) during the same time periods.

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Assessment Procedure Goals Summary

- Minimize use of pathologically oriented tests not shown to relate to recidivism
- Add strength based assessments to help inform release planning and to increase treatment engagement
- Incorporate research evidence for the effects of aging when assessing risk
- Adopt SRA for DRF assessment to align with CDCR
- Complete periodic stages of change ratings for dynamic risk factors and incorporate into charts
- Adapt the SOTIP rating scales to the hospital population to get treatment improvement ratings for every 6 months
- Use the Therapist Ratings Scales (Marshall) to be used after one year and every two years thereafter
- Pre-post tests for all DRF and relevant groups

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Proposed Changes to Increase Efficiency

- Eliminate Phases
  - Phase 1 becomes treatment readiness group.
  - The Strength Based Self-Regulation Modules and Core groups replace Phase 2 and 3 which are essentially combined.
    - Unlike RP, the SRM is specifically designed for sex offender treatment.
    - Core groups are established at time of entry into treatment and essentially function as the Phase 3 application of skills groups. Core groups commence as soon as treatment is started and the individual stays in the same group for the duration of his treatment
    - Create targeted treatment that retains positive parts of phase program but individualizes treatment.
    - Current DRFs addressed in treatment are not shown to be related to recidivism.
  - Preparation for release begins after completion of the SRM modules and the majority of DRFs are successfully addressed. A group for planning for release will be established and will replace Phase 4.

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Release Criteria

- Completion of Self-Regulation Modules
- Demonstration of successful changes in dynamic risk factors
- Core facilitators and team have completed Treatment Rating Scales and have recommended release
- Utilize SOTIP scales for 6 month evaluations and to inform the TRS raters
- Measure stages of change for each individuals risk factors
- Prepare for release to CONREP
- CONREP program established and individual agrees to outpatient care

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Increasing Treatment Engagement

- Target both strengths and risks in evaluations
- Replace RP with Strengths Based SRM
  - Includes a focus on strengths and risks
  - Allows for better individualized treatment
  - Designed specifically for sex offenders

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QUESTIONS?

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