[Restorative Justice Program]

THE RESTORATIVE JUSTICE PROGRAM EVALUATION

A PROGRAM EVALUATION OF A 12 MONTH

RESTORATIVE JUSTICE PROGRAM FOR FAMILIES

IMPACTED BY SEXUAL ABUSE

Program Evaluation Overview

Sexually violent behavior is a recognized problem of significant proportions in our society. While statistics vary, on average, there are approximately 150,000 new cases of reported child sexual abuse each year (Putnam, 2003; van der Kolk, Crozier, & Hopper, 2009). In addition, The Center for Offender Management cited a 7% increase in imprisoned sex offenders each year since 1980 (Center for Sex Offender Management, 2001). The effects of childhood sexual abuse are extensive for offenders, survivors and communities. The National Institute of Justice's most recent study suggests that children who experience childhood abuse and neglect are 5 times more likely to be arrested as a juvenile, 10 times more likely to be arrested as an adult, and 3.1 more times likely to commit a violent crime (Center for Sex Offender Management, 2001; English, Widom, & Brandford, 2001; Stein, 2007). Many researchers suggest that experiencing childhood sexual abuse is an important precursor to future sexually abusive behavior (Cartwright, 2000; Center for Sex Offender Management, 2001; Stein, 2007; van der Kolk, Crozier, & Hopper, 2001; van der Kolk, Crozier, & Hopper, 2009). In fact, sex offenders are about four times more likely to be arrested for a sex crime after release from prison (Bureau of Justice Statistics, 2003; Center for Sex Offender Management, 2001). Recidivism (being charged with a new sexual offense) rates range between 4% and 40% with the highest rates of recidivism for offenders who committed a new sexual offense within one to five years of leaving treatment and/or prison. These rates vary widely across individual studies and study populations. Research suggests the need for development of effective measures to assess this critical issue (Ahlmeyer, English, & Simons. 1999; Bureau of Justice Statistics, 2003; Center for

Sex Offender Management, 2001; Marshall & Barbaree, 1990; Prentky, Knight & Lee, 1997; Quinsey, Lalumiere, Rice, & Harris, 1995).

In terms of emotional problems, prolonged child abuse has been associated with complex, interpersonal problems and psychiatric diagnoses such as: posttraumatic stress disorder (Brown, 2008; Curtois & Ford, 2009; Gold, 2000, Gold, 2009; Herman, 1992b; van der Kolk, 2005), depression, suicide, unstable personal relationships, communication problems, sexual problems, offending/victimization behavior, conduct disorders, isolation and trust issues, stress and anger management problems (Giaretto, 1982; Macintosh & Johnson, 2008; Paolucci, Genious, & Violato, 2001; Spatoro, & Mullen, 2004), dissociative disorders (Moskovitz, 2004a; Moskovitz, 2004b; Stein, 2007), and personality disorders (Brown, 2009; Sroufe, Egeland, Carlson, & Collins, 2005).

Traditional treatment approaches aimed at dealing with sexual abuse have focused separately on survivor or offender therapy. Most survivor work is either trauma focused, aimed to work through Post Traumatic Stress Disorder symptoms, personality disorder symptoms or learning problem solving and daily living skills (Brown, 2008; Courtois & Ford, 2009; Dolan, 1991; Gold, 2000; Gold, 2009; Linehan, 1993). Offender therapy has primarily focused on the sexual abuse act, public safety, and learning cognitive behavioral techniques to deal with faulty thinking and behaving (Altschuler, 2001; Center for Sex Offender Management, 2001; Stein, 2007). However research on treating offenders solely with cognitive behavior therapy cites little to no positive effect in lowering recidivism (Center for Sex Offender Management, 2001, Mcalinden, 2006).

Very few programs have paid attention to collaboratively treating survivors, offenders, and their family members in order to help heal from abuse and lower recidivism. The lack of

effective collaborative treatment programs is especially problematic when we examine post incarceration behavior. There is a tendency for offenders and survivors to reunite after incarceration. Further, offenders may develop new relationships where sexual abuse could occur when treatment is ineffective (Giaretto, 1982; Koss & Achilles, 2008; Peterson & U.S. Department of Human Services, 1993; Stulberg, 1989). To add to the problem, the goal of many State Departments of Human Services is to provide effective treatment aimed towards family reunification for abuse and neglect cases, before looking at termination of parental rights. However, these same agencies often refuse to pay for treatment for family members who have offended.

Furthermore, most treatment programs have neglected the voice of survivors. These survivors have become vocal in their demands for rights in the justice process including needs for reunification programs and restorative justice practices. (Altschuler, 2001; Coates, Umbreit & Vos, 2004; Hurley, 2009; Koss & Achilles, 2008; Kurki, 1999; Sarnof, 2001; Umbreit & Amour, 2011; Walker, 2004; Walker & Hayashi, 2007, Walker & Hayashi, 2009; Walker, Sakai & Brady, 2006; Zehr, 2002). Restorative justice is "a process to involve, to the extent possible, those who have a stake in a specific offense and to collectively identify the harm, needs, and obligations, in order to heal and put things as right as possible" (Zehr, 2002, p.37). The purpose of restorative justice is to provide all stakeholders who are impacted by the sexual abuse (survivors, offenders, family members, criminal justice members and community members) to gain justice and healing by providing the opportunity to dialogue about the sexually violent crime and its ramifications, negotiate, problem solve and address harm, needs and obligations. Survivors are able, often for the first time, to regain their voice and personal authority by expressing their feelings about the offense and the losses associated with the abuse as well as

stating their current and future needs and how to best repair the harm; including strengthening their relationship with the offender. To be effective, this process must make a substantial contribution to the healing process and have a positive effect on lowering recidivism (Umbriet & Amour, 2011). Research suggests that restorative justice as part of the therapeutic approach achieves these goals (Coates et al., 2004; Hurley, 2009; Umbriet & Amour, 2011; Walker, 2004; Walker & Hayashi, 2007; Walker & Hayashi, 2009; and Walker et al., 2006). In fact, the Office of Juvenile Justice and Delinquency Prevention currently use restorative justice in its Model Programs Guide.

Therefore, there seems to be a general consensus between the criminal justice and therapeutic community that effective treatment programs designed to work with families of abuse must be developed. These programs, in order to help families heal from the abuse and lower recidivism, must use a collaborative approach that utilizes everyone involved with the problem/solution context (Anderson, 1995, Anderson, 1997; Anderson & Goolishian, 1988; Goolishian, 1992; Aponte, 1992; Clark, 2001; Duncan, Miller & Sparks, 2004; Fraenkel, Hameline & Shannon, 2009; Giaretto, 1982; Madsen, 2007; Rogers, 1957, Rogers, 1961; Nichols, 1995; Snyder & Anderson, 2009; Stulberg, 1988; Stulberg, 1989; Sullivan, 1953; Yalom, 2002). In addition, long-term outcome research is non-existent. This program hopes to achieve an evidence-based approach that becomes a replicable model.

The Birmingham Family Therapy Clinic (BFTC) Restorative Justice Program began in 1993 as a response to this great need. Based on the work of The Giaretto Model, the first prominent model for treating families of sexual abuse developed by Dr. Henry Giaretto in the 1970's; Dr. Stulberg's extensive collaborative therapy and restorative justice experience with offenders, survivors, their families and the systems in which they are embedded dealing with the

effects of sexual abuse and physical violence; and the needs expressed by these clients and members of the criminal justice system, the program was developed to help offenders, survivors, and their family members heal from the effects of sexual abuse and lower sexual recidivism.

To date, the outcome research in restorative justice is limited (Fraenkel, Hameline, & Shannon, 2009; Hurley, 2009; Koss, & Achilles, 2008; Kurki, 1999; Walker, 2009). Furthermore, increasingly researchers cite the need for more studies focused on the skill development and behaviors of individuals and families impacted by sexual abuse (Brown, 2009; Brown, 2008; MacIntosh & Johnson, 2008; Snyder & Anderson, 2009; Walker, 2009).

The BFTC Restorative Justice Program evaluation has three overarching research questions a) the experience of the families as it relates to counseling, b) the impact of the counseling factors related to coping, behavior and recidivism, c) The ability to develop empathy and strengthen relationships.

Method

A program evaluation design was implemented using a mixed design. The implementation of the program was completed with a pre-treatment and post-treatment design over a one-year period at the Birmingham Family Therapy Clinic (BFTC) in collaboration with research faculty at Oakland University. The program evaluators analyzed clinical records collected by Dr. Tracey Stulberg grant recipient (2009-D1-BX-0094). Inclusionary criteria at the BFTC include families that have experienced sexual abuse. Exclusionary criteria includes family members currently in prison or on a tether with restrictive activity that precludes contact with minors, children under 9 years old, emancipated youth, and any participant with an identifiable and documented disability rendering them unable to understand BFTC consent procedures.

Program evaluators were provided de-identifiable clinical records to analyze. Demographic data included only age range, family unit description and gender.

Protocol

Participants starting the Restorative Justice Program at BFTC completed a standard intake process required by the policies of the Clinic. Dr. Stulberg contacted each referral source to discuss case details, procedures and referral source goals. In addition, Dr. Stulberg provided monthly reports, case conferences and periodic court testimony for these families. The researchers analyzed the clinical records at a pre-treatment and post-treatment interval. Table I (see Appendix A) provides the list of the clinical assessments, a brief description, the inclusionary information and the estimated length of time to complete the clinical assessments. Participants were permitted to complete the clinical assessments over the course of two sessions at each of the intervals to avoid fatigue. Following completion of the assessments, the data was given a code and Dr. Stulberg removed all identifying information.

Participants

A total of 18 family units participated in the Restorative Justice Program. Adult ages ranged from 20 to 62 with a mean age of 44 years. Sixty percent of the participating adults were female and 40 percent male. Child ages ranged from 9-14 with a mean age of 12. Children under 9 years of age were provided therapy but not included in the program evaluation. One challenge in this program evaluation is that some participants did not fully complete each post-test and each item, therefore, the sample size varies.

Therapeutic Intervention

On average, each participant received one group a week specialized for the non-offending parents, offenders, adolescent males and females, or a children's group as appropriate.

Therapists specialized in collaborative work with families involved in multiple systems provided group therapy. The therapists and group members collaboratively created therapeutic goals. In addition, Dr. Stulberg provided individual, couple or family therapy sessions weekly. Finally, each family participated in at least one type of restorative justice meeting: Restorative Conference: The offender, survivor, therapist and supporters of both parties meet in a group to discuss how they have been affected by the sexual abuse and how harm may be repaired; Restorative Dialogue: The offender, survivor and therapist meet without family or friends and enter into a restorative dialogue agreement; Restorative Session: The survivor is unwilling to meet with the offender, the offender is deceased or not allowed to attend and therefore the survivor and/or the offender meet separately with the therapist and are encouraged to bring supporters to prepare a restorative plan.

By sharing their common experiences, group members were able to hear suggestions, gain support, and begin the healing process through dialogue and healthy confrontation. In each group, members became mentors for one another encouraging their continual success in goal attainment and termination from the legal systems in which they were embedded.

In individual, couple and family therapy, clients reached their collaboratively created goals intended to strengthen their relationships, effectively heal from the sexual abuse trauma and learn skills necessary to maintain emotionally healthy lifestyles. These skills were tested and fine-tuned through weekly homework assignments. Clients reported that their relationships became stronger and they felt more confident as they increased their skills and achieved their goals. In addition, these clients reported that they saw marked improvement in one another's behavior and attitudes. Finally, as their goal attainment increased, clients were more responsive to one another and the members of the legal systems in which they were involved.

The program implemented the restorative justice sequence for 16 of the 18 families. The two remaining families had a juvenile offender and an adult offender who had already participated in a restorative justice intervention with the victims and their families during the court process. For the 16 families that received the restorative justice sequence, nine of them used multiple types of restorative justice interventions. In these families, members had been impacted in more than one way in the sexual abuse trauma. For example, in some families, a survivor was also an offender. Therefore, there were instances where an offender, in a restorative session, addressed the harm experienced by their own childhood sexual abuse and then participated in a restorative dialogue with the survivor or a conference with the survivor and other family members to repair the harm they them self had caused. Clients reported that each type of restorative justice intervention was helpful in reducing feelings of fear, guilt, anger, shame and sadness related to the abuse. In addition, many reported a sense of what was described as a “weight lifting off” their shoulders or chest. They were able to put the memories and associated feelings in a place where they did not play such an important role in their behavior and attitude. In turn, clients reported a renewed sense of confidence in their ability to make healthier decisions.

In addition to clients reporting positive change in themselves and family members, referral sources, including the court system, foster/protective service workers and probation agents continued to report significant behavior change in their clients. In fact, 16 out of 18 families, or 89% successfully completed treatment. Of these 16 families, 100% of our juvenile probationers were released from juvenile probation. Parents, juveniles and their probation agents have recognized consistent behavior changes that continue to be fine-tuned. These juveniles have taken full responsibility for their behavior and show consistent and effective decision-making. In

terms of referrals from the Oakland County Department of Human Services, 100% of these cases were closed and children returned. These families consisted of parents whose children had been sexually abused and many of who had themselves been childhood victims of sexual abuse. For all of these parents, the Oakland County Family Court had been in the process of terminating their parental rights. Of our 16 successfully terminated families, 100% of adult probation cases referred to our program have had significantly lowered probation requirements (to the extent the law allows). The probation agents involved with these families are seeing clear and consistent behavioral and attitudinal change. In addition, there have been no reported or substantiated incidents of sexual abuse for 32 adults and 18 children. This number includes the two families that withdrew from treatment, a total of four individuals (one offender, one parent, and two juveniles).

Instruments

Five instruments were implemented as a pre and post-test measure for the 18 family units participating in the restorative justice program. The focus of the program evaluation is the impact of a Restorative Justice Program on overall symptom reduction, coping, counselor and client alliance and recidivism rates.

Adult Measures

The Coping Inventory for Stressful Situations for Adults (CISS) is a 48 item self-report measure of coping along 3 dimensions task-oriented, emotion-oriented and avoidance-oriented (Endler & Parker 1999). The instrument uses a 1 (*not at all*) to 5 (*very much*) Likert scale to indicate how much they engage in an activity when under stress. The higher the score the increase in participating in task, emotion or avoidance approaches to stressful situations.

The Vermont Assessment of Sex Offender Risk Manual (VASOR) was used to assess risk of re-offense by participants with a prior sexual offense (Mcgrath & Hoke, 2001). This is an assessment instrument administered and completed by a clinician. The VASOR has two scales a re-offense risk scale assessing the likelihood to re-offend and a violence scale assessing the offense severity and violence history.

Child Measures

The Child Behavior Checklist (CBCL/6-18) is a 120 parent checklist to rate a child's behavior and social competence (Achenbach, 1991). The instrument may be used to measure behavior over time. Responses are based on a Likert scale from 0 (Not True), 1 (Somewhat or Sometimes True) and 2 (Very True or Often True). In this particular program evaluation, parents and guardians completed the Child Behavior Checklist. A higher score indicates increase in behaviors such as aggression and social problems.

The Juvenile Sex Offender Assessment Protocol-II is a checklist assessing risk factors with juvenile sex offenders. The J-SOAP-II score uses a 0 to 2 scale with 0 referring to an apparent absence of the item and 2 always associated with a clear presence of the item (Prentky & Righthand, 2003). A score of 1 implies the presence of some information that suggests the presence of the item. The JSOAP-II has two main subscales Static and Dynamic. The Static subscale are characteristics which are not able to be altered (i.e. offense, historical characteristics), where as, the Dynamic subscale include characteristics which are sensitive to change (i.e. attitudes, circumstances). The JSOAP-II is assessed by a trained clinician to assess risk.

Family Measures

The Systemic Therapy Inventory of Change is a systemic based family functioning assessment tool (Pinsof et al.,2009). The STIC assesses change in individual adult, marital-couple, family/household and child functioning. Secondly, the instrument measures the integrative psychotherapeutic alliance. The instrument consists of two instruments the Initial STIC completed at intake and a shorter intercession form completed during the therapeutic process. Items in the STIC uses a five to seven point Likert scale ranging from *Never* to *All The Time*. The subscales include demographics, individual problems and strengths, family of origin, relationship and partner, family household examining family function, child problems and strengths.

Data Analysis

Each pre-test and post-test were inputted into *SPSS*. Tests of significance differences between means were completed at the *.05* level. A basic assumption of hypothesis testing, including dependent sample t tests, is that observations (e.g., scale scores) are independent of one another within each condition (e.g., pre test or post test). To not violate this assumption, I did not include multiple family member raters in a single analysis. In other words, if there was a male and female rater of one child's anger, I used only the primary rater. That way, the assumption of independence was preserved. Due to the small number of participants, further analyses were completed analyzing effect size to explore the meaning of the results.

Results

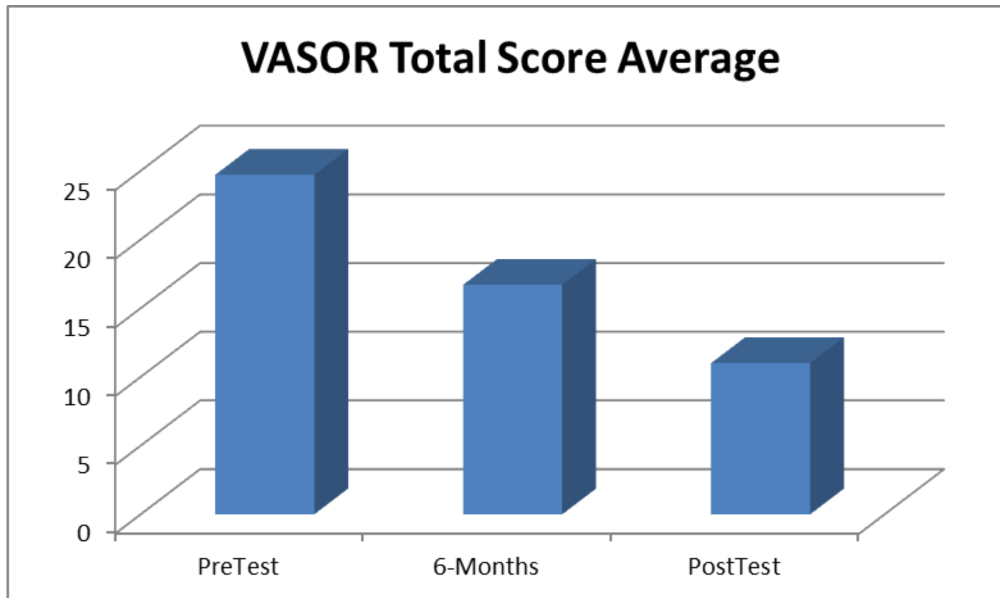
Adult Measures

<u>Coping Inventory for Stressful Situations</u> ***N=15***

Coping		*Mean*	*SD*	*M Difference*	*t*
Pair 1	Task (Pre)	54.13	8.34		
	Task (Post)	56.80	8.46	2.67	-.936
Pair 2	Emotion (Pre)	40.53	9.86		
	Emotion (Post)	39.60	8.66	-.93	.356
Pair 3	Avoid (Pre)	49.67	11.15		
	Avoid (Post)	47.40	10.28	-2.27	.988
Pair 4	Distract (Pre)	22.60	7.01		
	Distract (Post)	21.53	5.19	-1.07	.868
Pair 5	Diversion (Pre)	18.40	4.91		
	Diversion (Post)	17.13	5.51	-1.27	1.145

The scales Task, Emotion, Avoidance-Oriented were found to be non-significant at the *.05* level for the Coping Inventory for Stressful Situations. The Distract and Diversion subscales of Avoidance-Oriented scales were found to be non-significant at the *.05* level. Further analysis of the means found adult participants in the study to show mild decreases in Emotion-Oriented Coping (mean difference of .93) and Avoidance-Oriented Coping (mean difference of 2.27). Within Avoidance Oriented Coping the participants decreased in Distraction-Oriented (mean difference 1.07) and Social Diversion-Oriented Coping (mean difference 1.27). The participants increased between pre and post-test in the Task-Oriented Coping (*m* difference 2.67). Participants showed mild improvement in their ability to use cognitive-behavioral problem solving skills to deal with stressful situations. In summary, participants decreased their negative coping strategies such as emotional outbursts, distracting by doing other tasks and self-pre-occupation and increased their cognitive-behavioral problem solving skills.

VASOR N=3



The VASOR was used to assess risk with 3 adult participants with sexual offense histories. Over the course of 12 months the participants reduced risk to re-offend.

Child Measures

Participants completing a pre and post-test Child Behavior Checklist (CBCL) improved on each of the 9 subscales analyzed. The most meaningful difference was in the externalizing subscales with participants reducing checklist behaviors from 17 to 8.

Child Behavior Checklist ***N=11***

9 Pre – Post pairs		***Mean***	***SD***	***M Difference***	***T***	***p***
Pair 1	Anxious/Depressed (Pre)	4.64	4.31			
	Anxious/Depressed (Post)	2.64	2.56	2.00	2.000†	.067
Pair 2	Withdrawn/Depressed (Pre)	2.43	2.41			
	Withdrawn/Depressed (Post)	1.29	1.07	1.14	2.511*	.026
Pair 3	Somatic Complaints (Pre)	2.07	2.81			
	Somatic Complaints (Post)	.79	1.37	1.29	1.678	.117
Pair 4	Social Problems (Pre)	3.71	3.12			
	Social Problems (Post)	2.64	3.08	1.07	1.293	.218
Pair 5	Thought Problems (Pre)	2.93	2.92			
	Thought Problems (Post)	1.64	1.65	1.29	1.591	.136
Pair 6	Attention Problems (Pre)	7.93	4.91			
	Attention Problems (Post)	4.93	3.50	3.00	2.454*	.029
Pair 7	Rule-Breaking Behavior (Pre)	5.71	5.94			
	Rule-Breaking Behavior (Post)	3.00	2.45	2.71	1.847†	.088
Pair 8	Aggressive Behavior (Pre)	10.79	9.60			
	Aggressive Behavior (Post)	6.36	5.30	4.43	2.188*	.048
Pair 9	Other Problems (Pre)	3.57	2.95			
	Other Problems (Post)	1.57	1.28	2.00	3.055**	.009

† $p < .10$. *$p < .05$. **$p < .006$ ($p = .05/9$).

Although the mean comparisons did not reach the level of significance, several clinical areas improved in a meaningful way. For example, Rule-Breaking Behavior decreased by 47% and showed a Cohen's *d* effect size of .60, which is considered a medium-to-large size effect. Aggressive Behavior decreased by 41% and showed a Cohen's *d* effect size of .57. Attention Problems fell by 38%, a Cohen's *d* effect size of .70. Somatic Complaints dropped by 68%, a Cohen's *d* effect size equal to .68. The Withdrawn/Depressed scale was reduced by 47% and had an effect size of .61. Anxious/Depressed similarly fell by 43%, an effect size of .56. In

summary, observation of behavioral issues by caregivers decreased during the course of the Restorative Justice Program. The Child Behavior Checklist Competence Subscales were also analyzed.

CBCL Profile for Boys & Girls -- Competence Scales ***N= 11***

		Mean	*SD*	***M Difference***	***T***
Pair 1	Activities (Pre)	6.53	4.13		
	Activities (Post)	7.65	4.25	1.13	.815
Pair 2	Social (Pre)	5.17	2.67		
	Social (Post)	4.73	2.53	-.45	-.578
Pair 3	School (Pre)	2.37	2.02		
	School (Post)	**4.73**	**2.53**	**2.36**	**3.018***
Pair 4	Total (Pre)	10.83	7.74		
	Total (Post)	15.59	7.58	4.76	1.768

† $p < .10$. *$p < .05$.

The Child Behavior Checklist Competence subscales showed mixed results. There was a significant improvement in academics with a t score of 3.018, $p = .013$. There was minimal increase in participation in sports but not at a significant level. There was also a minimal decrease in positive association with others not at a significant level. In summary, participants increased in performance in academics as signified by the School Scale. An analysis taking in consideration of the effect size of the primary scales of the CBCL was completed.

Primary Scales		Mean	SD	M Difference	T	Effect Size Cohen's d
Pair 1	Total Scale Score (Pre)	43.79	32.60			
	Total Scale Score (Post)	24.86	11.59	18.93	2.300*	.77
Pair 2	Internalizing (Pre)	9.14	8.58			
	Internalizing (Post)	4.71	3.77	4.43	2.231*	.67
Pair 3	Externalizing (Pre)	16.50	15.10			
	Externalizing (Post)	9.36	7.23	7.14	2.063†	.60
Pair 4	C (Pre)	18.14	11.71			
	C (Post)	10.79	6.33	7.36	2.362*	.78

† $p < .10$. *$p < .05$.

Although the mean comparisons did not reach the level of significance, the total score and three subscale clinical areas improved in a meaningful way. The Total Scale Score dropped by 43% and yielded a Cohen's *d* effect size of .77, considered a high amount of change. The Internalizing scale revealed a decrease of 48% and an effect size of .67. Similarly, the Externalizing scale decreased by 43% and showed a .60 effect size. The subscale focused on social, thought, attention and other problems labeled simply as the C Subscale, decreased by 41% and had a large sized effect (.78).

The above results yielded improvements in pre-test and post-test for Total Score, Internalizing Scale, Externalizing Scale and C Scale. The results are based on analytically small samples ($n < 20$). In general, behavioral scientists are encouraged to report effect sizes in addition to tests of significance. This is partly because large samples may show statistical significance but not practical significance; conversely, small samples may fail to show statistical significance but demonstrate strong practical effects. Because the sample size was necessarily small (due to nature of the clinical problem), analyses are vulnerable to Type II error (i.e., fail to

find significance when a significant effect is present). Therefore, analyses where probability values were lower than .20, Cohen's d effect size procedure was used (Cohen, 1988). "Cohen's d" effect sizes behavioral science research results categorized as either small effects (*d* = .20), medium effects (*d* = .50), or large effects (*d* = .80). In addition, these effects were also analyzed to provide a percentage change. That is, the decrease in clinical symptom levels was divided by the initial symptoms level of per clinical area, thus yielding the percent change. In further analysis, effect sizes and percent change was thus used to complement the results of the CBCL.

Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) ***N=5***

Scales Pre-Post Change		*Mean*	*SD*	***M Difference***	***T***
Pair 1	Sum 1 (Pre)	4.00	2.92		
	Sum 1 (Post)	3.60	2.30	.40	.590
Pair 2	Sum 2 (Pre)	5.00	4.30		
	Sum 2 (Post)	3.60	2.61	1.40	1.121
Pair 3	Sum 3 (Pre)	5.20	3.83		
	Sum 3 (Post)	3.00	2.00	2.20	1.354
Pair 4	Sum 4 (Pre)	3.20	2.68		
	Sum 4 (Post)	3.00	3.46	.20	.302
Pair 5	Static (Pre)	9.00	5.70		
	Static (Post)	7.20	2.17	1.80	.943
Pair 6	Dynamic (Pre)	8.40	4.93		
	Dynamic (Post)	5.60	4.04	2.80	1.510
Pair 7	Total (Pre)	17.40	9.48		
	Total (Post)	12.80	6.06	4.60	1.769

† $p < .10$. *$p < .05$. **$p < .007$ ($p = .05/7$).

A total of 5 adolescents completed the JSOAP II. Only adolescents with a record of sexual offenses completed the J-SOAP II. A review of the mean of each of the Pre and Post test show a decrease in risk assessment to re offend. The Dynamic subscale indicates a decrease of 2.80 between pre and post indicating improved dynamic factors such as ability to take responsibility, internal motivation for change, understands risk factors and empathy. Further study will include tracking recidivism rates over time. Within the 12 months of the study, no participant reported or was found to have recidivated. The effect size for the total score was .58, a medium sized effect, which indicates that if the sample size was larger (i.e., there were even more clients counseled), the effect would likely reach the level of statistical significance.

Family Measures

STIC: Individual Therapy Alliance subscale *N*=12

Subscales	*N*	*Mean*	*SD*
Agreement on Tasks of therapy	12	6.21	1.34
Agreement on Goals of therapy	12	5.88	1.06
Feeling of Bond and Trust with therapist	12	6.13	1.03
Therapist accepts, cares, & understands	12	6.33	1.07
Important people would trust & approve of therapist	12	5.17	1.79
Therapist helps with important relationships	12	5.59	1.50
Important people would accept & understands therapy goals	12	5.77	1.32

Participants viewed the individual therapy alliance as high with ranges from 5.17 to 6.33. Therapist Accepts, Cares, & Understands Subscale rated the highest at a mean of 6.33 with Important People would Trust & Approve of Therapist the lowest with a mean of 5.17. The results reveal a positive association with a strong therapuetic alliance.

STIC: Couple Therapy Alliance Scale *N=9*

	N	*Mean*	*SD*
Therapist cares about client, client partner, tasks & goals of therapy	9	6.33	0.92
Client partner feels accepted and agrees with therapy method	9	5.89	1.36
Client & partner accept and respect each other during therapy	9	6.18	1.25

Participants also indicated a high couple alliance with the subscales ranging from 5.89 for Client Partner Feels Accepted and Agrees with Therapy method to 6.33 Therapist Cares about Client, Client partner, Tasks & Goals of Therapy. A score of 7 indicates a high level of alliance as a couple.

STIC: Family Therapy Alliance Scale *N*=10

	N	*Mean*	*SD*
Family Therapy Task and goals agreement; Therapist understands.	10	6.69	0.65
Therapists cares about and skillfully helps all family members	10	6.39	1.02
Family members feel safe and supportive of one another in therapy	10	6.30	0.96

The Family Therapy Alliance revealed above a 6 with 7 being the highest in perception of the families and the family therapy component of the treatment.

STIC: Relationship with Partner Pre and Post *N* = 12

	Relationship with Partner	***Mean***	***SD***	***M Difference***	***T***	***p***
Pair 9	Positivity (Pre)	4.28	.99			
	Positivity (Post)	4.50	.80	.22	1.432	.180
Pair 10	Trust (Pre)	4.42	1.14			
	Trust (Post)	4.83	.58	.42	1.890†	.085
Pair 11	Commitment (Pre)	4.33	1.17			
	Commitment (Post)	4.50	.80	.17	.492	.633
Pair 12	Anger/Inequity (Pre)	1.63	.98			
	Anger/Inequity (Post)	2.00	.74	-.38	1.682	.121
Pair 13	Sexual Satisfaction (Pre)	4.27	1.17			
	Sexual Satisfaction (Post)	4.82	.60	.55†	1.789	.104
Pair 14	Substance Abuse (Pre)	1.23	.75			
	Substance Abuse (Post)	1.18	.60	-.05	-1.000	.341

† $p < .10$. * $p < .05$. ** $p < .006$ ($p = .05/8$).

A positive mean difference indicates positive change from pre to post test and a negative mean difference indicates a negative change. All mean scale scores are on a five-point Likert-type scale ranging from 1 to 5. For scales that reflect positive qualities/behaviors (e.g., resilience, open expression), 5 is the most positive score; for scales that reflect negative qualities/behaviors (e.g., Negative Affect, Disinihibition), 1 is the best score because it represents less of a negative attribute.

Four of the six relationship subscales indicates positive change from pre to post test. Trust and Sexual Satisfaction Subscales indicate significant positive change at the .10 level.

Positivity, Commitment and Anger/Inequity subscale showed improvement but not at the significant level. Participants also showed a small increase on the Substance Abuse Scale but not at a significant level.

The typical alpha level in behavioral sciences is set at the $p < .05$ level to indicate statistical significance. However, when multiple comparisons are made with the same data set, type I error rate increases (i.e., concluding significance when it is not significant). To control for type I error rate Bonferroni Correction is frequently used. Essentially, this procedure involves taking the usual .05 alpha level and dividing it by the number of significance tests run. In this case, 8 significance tests were run and therefore .05/8, or $p < .006$, is the more appropriate cutoff value for determining statistical significance. With this criteria, 1 of the analyses below reached significance. However, some of the effects are noteworthy.

STIC: Family/Household Subscale *N* = 13

Family/Household		***Mean***	***SD***	***M Difference***	***t***	***P***
Pair 1	Positivity (Pre)	4.12	.94			
	Positivity (Post)	4.46	.78	.35	1.043	.318
Pair 2	Decision Making (Pre)	3.75	1.23			
	Decision Making (Post)	4.42	.51	.67	1.750	.108
Pair 3	Negativity (Pre)	2.00	1.19			
	Negativity (Post)	2.42	1.38	.42	1.560	.147
Pair 4	Boundary Clarity (Pre)	4.29	.78			
	Boundary Clarity (Post)	4.50	.67	.21	.714	.490
Pair 5	Feeling Misunderstood (Pre)	2.38	1.51			
	Feeling Misunderstood (Post)	2.92	1.51	.54	1.080	.303
Pair 6	Abuse (Pre)	1.54	.89			
	Abuse (Post)	1.58	.90	.04	-.158	.878

† $p < .10$. *$p < .05$. **$p < .008$ ($p = .05/6$)

Each of the subscales related to Family/Household showed mild improvements from pre and post in positive subscales. Decision-Making revealed a Cohen's d effect size of .71. This particular subscale focuses on such items as Kids in My Family have a Right to Participate in Decision-making, I Know the Right Thing to Do in My Family, I Am Proud of My Family. Positivity and

Boundary Clarity also improved. Feeling Misunderstood and Negativity slightly increased between pre and post-test.

STIC: Child Problems/Strengths subscales *N* = 8

Pre – Post (6 Months into treatment)		***Mean***	***SD***	***M Difference***	***t***	***p***
Pair 1	Depression (Pre)	1.94	.86			
	Depression (Post)	1.88	.35	.06	.174	.867
Pair 2	Anxiety (Pre)	2.44	1.19			
	Anxiety (Post)	2.19	.70	.25	.764	.470
Pair 3	Antisocial (Pre)	2.50	1.07			
	Antisocial (Post)	2.13	.83	.38	.832	.433
Pair 4	Impulsivity (Pre)	3.25	1.34			
	Impulsivity (Post)	2.31	1.07	.94	1.622	.149
Pair 5	Parent-Child Alliance (Pre)	3.50	1.22			
	Parent-Child Alliance (Post)	4.00	.60	.50	-1.673	.138
Pair 6	Prosocial (Pre)	3.56	.94			
	Prosocial (Post)	3.94	.42	.38	-1.342	.222
Pair 7	Social-Academic (Pre)	4.00	.76			
	Social-Academic (Post)	4.19	.80	.19	-.664	.528

† $p < .10$. *$p < .05$. **$p < .007$ ($p = .05/7$)

Again, no scale showed statistically significant improvements, but some effect sizes were noteworthy. The greatest change was in parent-rated levels of the target's level of Impulsivity, which was a large size effect at .78. Parent-Child Alliance also showed medium sized improvement (Cohen's d = .52). Both Prosocial behaviors and Antisocial behaviors increased, showing Cohen's d effect sizes of, .52 and .39, respectively.

STIC: Relationship with Child $N = 7$

Pre – Post	*Mean*	*SD*	*M Difference*	*t*	*P*
Positivity (Pre)	4.43	.73			
Positivity (Post)	4.57	.45	.14	-.795	.457
Negativity (Pre)	2.43	.79			
Negativity (Post)	2.50	.96	.07	-.138	.895
Monitoring (Pre)	4.14	.63			
Monitoring (Post)	4.43	.53	.29	-.934	.386
Efficacy (Pre)	3.71	1.19			
Efficacy (Post)	3.93	.61	.21	-.478	.649

† $p < .10$. * $p < .05$. ** $p < .0125$ ($p = .05/4$).

Each Relationship with Child subscale showed a mild improvement between pre and post evaluation. The greatest increase was in the Monitoring subscale. Specifically, the parent is more knowledgeable of a child's activities. Overall, the STIC instrument was sensitive to change over the course of the Restorative Justice Program. In most reporting, the Subscales increased between pre and post treatment. Positive indices tended to improve at a higher rate than the negative behavior subscales.

Summary

The program evaluation of the Restorative Justice Program administered by BFTC found improvements in overall reduction in negative behavioral symptoms, improved family relationships and counselor/client relationships. These changes were reported by clients and their referral sources. In our follow up sessions with clients and their referral sources, there have been no new instances of reported sexual abuse. Participants completing the JSOAP and VASOR reduced risk indicators of re-offending. Further follow-up of recidivism will track new instances of reported sexual abuse. In addition, clients report a consistency in attitude and behavior changes as learned skills are tested and fine-tuned. We will continue to provide follow-up phone calls for these clients to assess progress and recidivism rates.

The program evaluation focused on three questions a) the experience of the families as it relates to counseling, b) the impact of the counseling factors related to coping and behavior, c) The ability to develop empathy and strengthen relationships. Families responded positively toward the collaborative family treatment approach of the BFTC Restorative Justice Program. The indices of the STIC focused on the therapeutic alliance and the family alliance found positive improvements in the Individual, Family and Couple Alliance subscales. The participants found the therapist to be empathic, helpful and congruent with goals.

The program evaluation also focused on the parents coping to stressful situations, children behaviors and family strengths. Adult participants completing the CISS increased their cognitive-behavioral coping strategies and decreased their reliance on avoidance and emotional coping strategies. Within the STIC the adult participants also improved in areas such as boundary clarity, decision making and positivity. The children also decreased their problem behaviors according to the results of the CBCL. Specifically, children were found to have an overall reduction in externalizing behaviors (less pro social behaviors) between the pre and post-tests.

Lastly, a summary of the STIC results demonstrated improvements in the overall family, couple and parent-child relationships. The overall efficacy of the parent-child relationship improved. The Family/Household Subscale also showed improved boundaries and family decision-making. The Partner Subscale also showed increases in positivity, trust and commitment.

One limitation of this study is the low number of participants limiting the overall statistical significance of the results. The Restorative Justice Program was able to show practical clinical improvements between pre and post-test but not at statistically significant levels. Further

research is needed to increase the overall sample size to investigate further statistical significance.

In summary, the Restorative Justice Program improved coping skills, reduced negative behaviors and improved the counselor/client and family relationships over the course of the intervention.

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Appendix

Table 1

Assessment Instruments	Type of Measurement	Age restriction	Approximate Time of Completion	Description
Adult Instruments				
Coping Inventory for Stressful Situations (CISS-Adult)	Self-Reporting coping style	18 +	10 minutes	48 item self-report measure of coping along 3 dimensions (task-oriented, emotion-oriented, & avoidance-oriented) (coefficient alpha: .73-.92; test-retest: .51-.73)
Child Behavorial Checklist (6-18)	Parent Checklist	6-18	15 minutes	Child Behavior Checklist (Ages 6-18): 120 item checklist self-administered to rate a child's behaviors (Inter-rater reliability .93-.96 and Internal consistency .78-.97)
Systemic Therapy Inventory of Change STIC Initial Background Information Form	Self-Report Relationships; completed at initial session	12 +	married w/ 1 child 45 minutes	153 item initial self-report measure using likert-type responses (reliability estimates not yet available)
STIC Intersession Inventory	Relationships Inventory	12 +	5-8 minutes	Shorter form of STIC given at the beginning of each subsequent session
Vermont Assessment of Sex Offender Risk	Risk Assessment of Male sex offenders	18 +	Completed by Dr. Stulberg	19 item risk assessment scale for adult male sex offenders to be completed by probation and parole officers (inter-rater reliability .83-.89)
Children Instruments (only children 9 and older)				
Juvenile Sex Offender Assessment Protocol-II (JSOAP-II)	Risk of reoffense	12-18	Completed by Dr. Stulberg	28 item checklist reviews risk factors associated with sexual and criminal offending (Inter-rater reliability .59-.91, .77 avg.; internal consistency .68-.85)
STIC Inventory Adolescent Portion	Relationships Inventory	12-18	15 minutes	