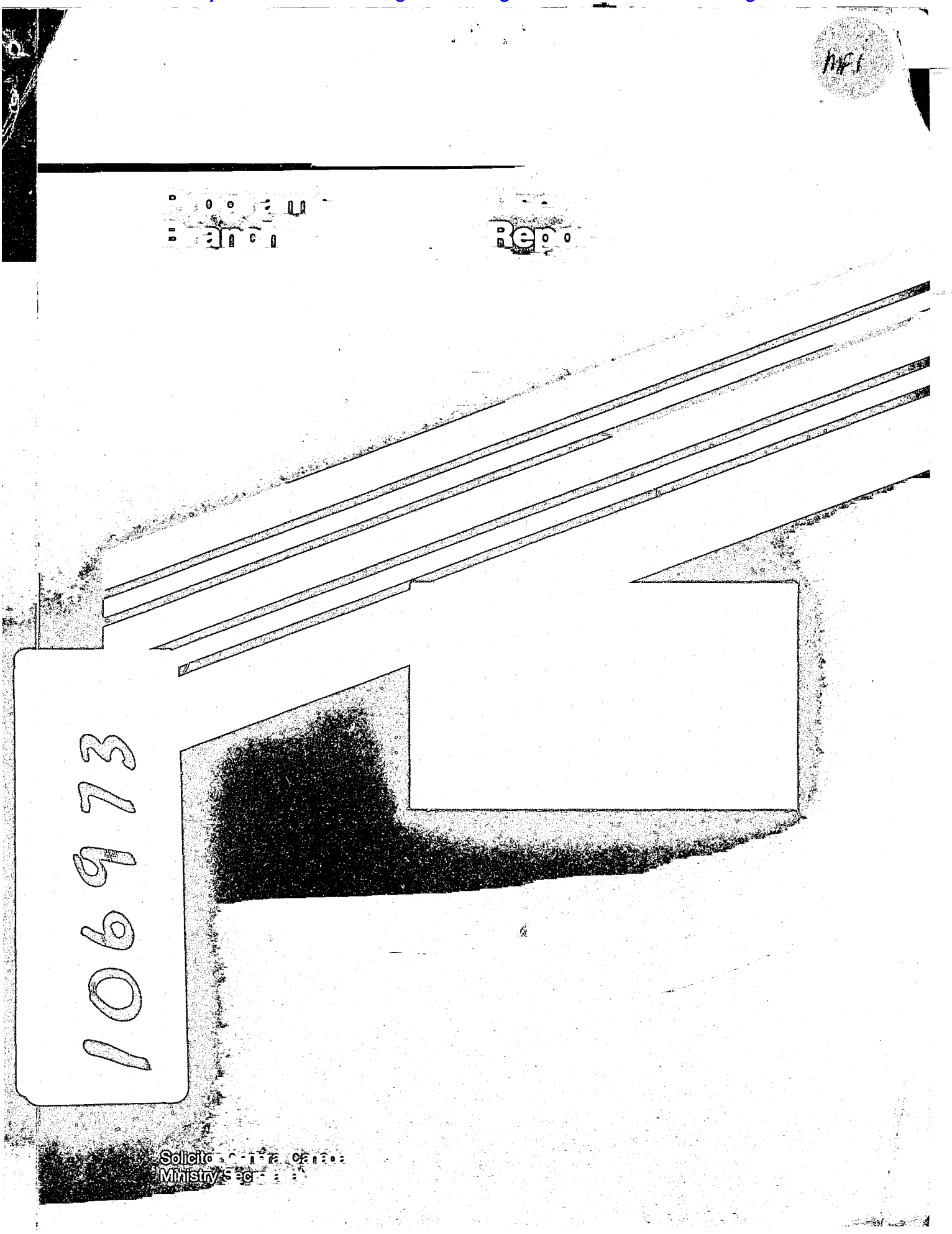

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A SURVEY OF STATE-RUN SEX OFFENDER TREATMENT PROGRAMS IN THE UNITED STATES

NO. 1984-72

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INTRODUCTION

Coincident with heightened public concern and media coverage of sex offenses, the Research Division of the Ministry of the Solicitor General (Canada) has identified the assessment and treatment of sexual offenders as a topic for further research. Studies investigating the potential of various treatment regimens for sex offenders have been undertaken. The aim of these studies, and others investigating the characteristics of sex offendes, is the introduction of a comprehensive and effective program of treatment for this target population.

As part of this research initiative, the present report provides a survey of sex offender treatment programs offered by state correctional and related mental health agencies in the United States. Because some of the initial and most well known studies have been done in Canada at such facilities as the Clarke Institute of Psychiatry (Freund, 1980), The Mental Health Centre at Pentanguishene (Quinsey, Bergerson & Steiman, 1976) and Queen's University (Marshall & Barbaree, 1978), this is one field where we have not had to go south of the border to examine the leading research. Hence, with the exception of some of the most well known programs, such as Fort Stellicoom (Brecher, 1978) and those reported by Abel and colleagues (Abel, Blanchard & Brecher, 1976), our knowledge of the American scene tends to be limited.

In early 1983, letters were sent to the administrators of each state correctional department in the United States. Information was requested concerning any sex offender treatment program being used within the state prison system or ancillary facility to which offenders can be referred. Documentation pertaining to research carried out with this specific offender population was also requested.

The nature and method of response differed tremendously. Furthermore, replies often occured through a process of referral and rereferral as opposed to a direct response. As a result, a large and varied body of literature was amassed. In order to meaningfully analyze this diffuse collection, a standard form was designed so that relevant aspects of the different programs could be captured. A copy of the evaluation form is appended (Appendix A).

It should be noted that since state correctional agencies were contacted, the initial polling did not include sex offender centres operated under mental health auspices or by federal authority such as the Federal Bureau of Prisons. To illustrate, the 1978 United States Department of Justice publication "Treatment Programs for Sex Offenders" (Brecher, 1978) lists 32 centres across the United States where treatment services are available. This number is greater than that covered presently. Hence, the reader should not be misguided into the belief that there are very few treatment outlets available. Nevertheless, many of the country's major programs are included. Responses did include a description of mental health-based programs when such

facilities were available to offenders. Therefore it is suggested that a reasonable sample of state-run corrections programs is offered. For example, 15 of the 25 states listing treatment programs for sexual offenders in Geer and Stuart's (1983) recent edition of The Sexual Aggressor are included in the current survey.

Results

A summary of treatment program characteristics for each individual state is presented in a series of tables. Elaboration on these results follows.

Reponse Rates

Out of the 50 states to which letters were sent, 31 replies were received, yielding a 62% response rate. However, only 21 or 68% of the 31 responding states reported an established sex offender program, or one that was in the latter stages of planning.[1] A 'formal' program was defined as one in which services are available on a statewide basis, under the auspices of state departments, and are geared specifically toward sex offenders. Nonspecific therapy, whereby sex offenders received the same services as regular inmates as part of a prison program, did not qualify as a formal sex offender program.

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[1] In one case, program existence was indeterminable from the literature provided.

Year of Implementation

Reported implementation dates are listed in Table 1. Wisconsin was the first to introduce sex offender treatment, this being in 1951. Massachusetts inaugurated treatment in 1958, Washington in 1965, Michigan in 1971, and Maryland in 1972. The remaining states, comprising the majority, introduced their current services in the late 1970's or early 1980's. Hence, the specific treatment of sex offenders is a relatively recent undertaking in most states. Indeed many have yet to start such programs.

Target Population

As shown in Table 1, there is considerable diversity with regard to the type of sex offender given selection priority. Eight programs will consider all sex offenders, eight will consider habitual and/or violent sex offenders, and two will accept only nonviolent sex offenders. It is stressed that those programs accepting only nonviolent offenders tend to be outpatient intensive programs using therapy in lieu of incarceration.

It is also noted that most programs do not admit offenders with histories of psychotic disorders, as these inmates become the legal wards of state mental health authorities. A prevalent opinion regarding these psychotics is that the commission of the sex offense was only one manifestation of a deeper psychiatric problem more adequately dealt with in a psychiatric hospital.

TABLE 1

Characteristics of Sex Offender Treatment Programs, Presented by Individual State[a,b]

State	Year Implemented	Program Coordination	Target Population
Arizona	1980	state corrections, limited service	not stated
California	1978	by facility, unsystematic	all sex offenders
Colorado	1983	state corrections	all sex offenders
Connecticut	1978	state corrections	all sex offenders
Florida	not stated	state corrections and mental health	repeaters motivated to change
Hawaii	1983	state corrections, limited service	not stated
Illinois	not stated	state corrections	"sexual psychopaths", judged habitual
Iowa	1981	by facility, systematic (non-state)	all sex offenders
Maryland(1)	1972	state corrections and mental health	repeater and violent sex offenders
Maryland(2)	1975	state corrections and mental health	repeater and violent sex offenders
Massachusetts	1958, 1979	state corrections and mental health	repeater and violent sex offenders
Michigan	1971	state corrections	all sex 'deviates', sex charge not needed
Minnesota	1978	state corrections	all sex offenders, good prison record
Missouri	1980	state corrections	nonpsychiatric sex offenders
New York	1983	state corrections (in planning)	nonalcoholic, violents and repeaters
North Dakota	1979	state corrections	all sex offenders
Oklahoma	1982	state contracted, limited outpatiency	repeat, nonviolent sex offenders
Oregon	not stated	state corrections	habitual sex offenders
South Carolina	not stated	state corrections, limited service	not stated
Vermont	1982	state corrections	nonviolent, nonpsychiatric sex offenders
Washington	1965	state corrections and mental health	repeaters and potential repeaters
Wisconsin	1951-1980	state corrections and mental health	all sex offenders deemed treatable

Notes. [a]The following states corresponded with us, but indicated that they have not implemented treatment programs specifically for sex offenders:

Alabama
Delaware
Georgia
Louisianna
New Hampshire
Ohio
Pennsylvania
Washington, DC
Wyoming

The state of Nebraska also corresponded with us, but the literature provided was such that program existence was indeterminable.

[b]Maryland (1) refers to the Special Offender Clinic in Baltimore.
Maryland (2) refers to the Biosexual Psychohormonal Clinic at the Johns Hopkins Hospital in Baltimore.

Referral

Seventeen (17) states described their means of referral (Table 2). The most common referral method was through the judiciary. Upon violation of state sexual offense statutes, pending their previous record, offenders may be required by court to undergo screening by a program's clincial staff. Upon their recommendation, the individual will either be admitted to treatment or receive a regular prison commitment. In many cases, typically the violent and/or habitual sex offender, parole eligibility will be determined by program participation and progress.

Program admittance does not always coincide with the commencement of sentence, but may occur when space is available, or at a specific point in time before the individual's anticipated parole date. The Minnesota program is one example of this approach, where all sex offenders with 12 months remaining in their sentence are automatically considered. In still other states, treatment may be in lieu of incarceration, as previously noted.

Six programs accept voluntary inmate referrals, pending approval by the selection committee. Screening is necessary since the potential exists for inmates wishing to "burn time" through therapy participation, with no real inclination toward being rehabilitated. However, a major problem with such voluntary referrals is that many who are in need of services, but are poorly motivated for whatever reason, will elect to bypass treatment opportunities. This is the same problem encountered in

Table 2

State	Referral	Assessment
Arizona	not stated	not stated
California	court	not stated
Colorado	not stated	social history, clinical interview, plethysmographic measures
Connecticut	volunteer	legal and medical history, psychological test battery
Florida	court on clinical recommendation	legal history, psychiatric interview
Hawaii	not stated	not stated
Illinois	institutional psychiatrists	legal history, psychiatric interview
Iowa	institutional counselors	legal history, psychiatric interview, psychological test battery
Maryland (1)	court on clinical recommendation	psychiatric interview, psychological test battery
Maryland (2)	court on clinical recommendation	legal history, complete physiological assessement
Massachusetts	court on clinical recommendation	psychiatric interview, psychological test battery
Michigan	voluntary	psychological test battery, clinical interview
Minnesota	automatic consideration	psychological test battery, prison behavior record
Missouri	voluntary	clinical interview, psychological test battery
New York	psychologists re: offense record	social history, clinical interview, test battery, plethysmography
North Dakota	voluntary	legal history, clinical interview, psychological test battery
Oklahoma	court	legal history, clinical interview, psychological test battery
Oregon	voluntary	legal history, psychological test battery, plethysmography
Sourth Carolina	not stated	not stated
Vermont	voluntary	legal record, clinical interview, psychological tests, plethysmography
Washington	court on clinical recommendation	legal status, clinical interview, psychological test battery
Wisconsin	court on clinical recommendation	legal and medical history, clinical interview, psychological tests

nonvoluntary referrals where clinical staff select only those offenders whom they feel are "treatable" or "motivated to change", which is the case in Florida and Vermont. However, with the limited bedspace and funding, the inclination toward accepting just such clientele is high.

To summarize, being convicted of a sex offense does not guarantee participation in a sex offender treatment program in any state. In general, violent and/or repeat offenders seem to receive priority admittance, since they represent the greatest risk to the community. Moreover, individual motivation to rehabilitate is given considerable weight where program enrollment is limited and staff are looking for optimal results. Data presented elsewhere (Wormith 1983) suggest that individual motivation is also a relevant factor in the selection of Canadian sexual offenders for existing programs.

Assessment

As noted previously, participants for all of the cited programs are screened by clinical staff, either prior to admittance or during the orientation phase of the regimen.

As seen in Table 2, there was a consensus among states regarding methods of assessment. The procedure appears to be threefold and is generally comprised of social history documentation (which includes legal record), a psychiatric interview, and a psychological test battery. Only Minnesota provided a detailed list of psychological tests administered, but

five others note the use of intelligence tests such as the Wechsler Adult Intelligence Scale (WAIS), and use of the Minnesota Multiphasic Personaltiy Inventory (MMPI).

Four states reported use of physiological assessment, specifically plethysmography, to measure deviant and nondeviant sexual arousal. As noted by Abel, Blanchard and Becker (1978), this is an extremely important area of assessment since it can later be used as an objective interim measure of treatment progress--that is, the extent to which deviant arousal is being extinguished and nondeviant arousal is acquired. Certainly the importance of plethysmographic assessment cannot be underestimated where behaviour therapy techniques are employed.

A final type of assessment which, according to the literature provided, is used only at the New York Psychiatric Institute and the Johns Hopkins Hospital in Baltimore, is the measurement of blood levels of testosterone. Research is beginning to establish a link between elevated testosterone levels and certain patterns of sexually aggressive behaviour (see Berlin, 1982, for review). Furthermore, the research from Johns Hopkins, although not methodologically "tight", indicates that certain individuals will benefit more from the administration of medroxyprogesterone acetate (MPS or Depo-Provera, T.M.), which directly acts to reduce testosterone levels, than other treatment modalities. Hence this represents a relatively unused, yet potentially important area of assessment.

In short, comprehensive evaluation should include social history documentation, psychiatric interviews, a psychological

test battery and hormone (testosterone and its associated luteinizing hormone and follicle stimulating hormone) level readings. Although this may be an expensive process, it will give a fair indication as to optimal courses of treatment.

Capacity and Staffing

General characteristics of the programs are presented in Table 3. In absolute terms, capacity ranged from 9 (Hawaii) to 200 (Washington). In addition, the California Men's Colony rendered psychotherapy services to 305 sex offenders in 1979. However, treatment there followed a private practice model and all inmates, regardless of charge, received similar therapy. In all, program enrolement was quite varied.

A modest relationship was noted between program capacity and volunteerism. Those programs which allowed voluntary referrals, such as Connecticut and Missouri, seemed to have the greatest capacity (125-160), Vermont being the one exception (21). Those which accepted clientele through court referral, particularly where habitual and violent offenders were the target population, seemed to have the lesser capacity, for example Maryland and Massachusetts (40-70); Washington was the one exception (200). Hence, the state correctional agency's committment to treatment (in terms of bedspace) is important, where high risk cases are given priority.

Staffing was also quite varied in terms of numbers, but generally there was at least one psychiatrist, one psychologist, and one psychiatric nurse on clinical staff. Typically,

Table 3

State	Capacity	Staff	Duration
Arizona	70	not stated	not stated
California	0-305, depends where	unclear	not stated
Colorado	not stated	not stated	not stated
Connecticut	125	1.5 psychologists, 10 volunteers, 4 clinical trainees	sentence dependent
Florida	63	7 therapists, 29 shift custodians (includes nurses)	2-4 years
Hawaii	9	not stated	not stated
Illinois	40	2 psychiatrists, 1 psychologist, 1 social worker	not stated
Iowa	not stated	3 psychologists (clinical)	not stated
Maryland (1)	40	4 psychologists, 5 cotherapists (correction counselors)	40 weeks
Maryland (2)	not stated	unclear	not stated
Massachusetts	50-70	9 psychologists, 2 psychiatric nurses, 1 social worker	5 years
Michigan	60-70	6 psychologists	9 months
Minnesota	25-30	3.5 psychologists	1 year minimum
Missouri	160	2.5 psychologists, 1 correctional caseworker	not stated
New York	80-100	2.5 psychologists, 2 psychiatric nurses, 1 caseworker	6-12 months
North Dakota	26	2 psychologists, 2 correctional counselors	3 years
Oklahoma	25	6 therapists (nonspecific)	2 years
Oregon	33	not stated	23 months
South Carolina	not stated	not stated	not stated
Vermont	21	unclear, but use volunteers and inmates as counselors	9-12 months
Washington	200	3 psychiatrists, 6 psychologists, 12 inmate counselors	4 years
Wisconsin	978 from 1954 to 1963	1.5 psychiatrists, 2 psychologists, 1 psychiatric nurse	14 months

Table 3 cont'd....

Table 3 cont'd

State	Treatment Intensity	Location	In/Outpatiency	Community Resources
Arizona	not stated	not stated	both (planned)	with outpatiency
California	2.5-3 hours/week	prison, nonsegregated	inpatiency	not stated
Colorado	not stated	not stated	not stated	not stated
Connecticut	2-3 hours/week	max. security prison	inpatiency	community discussion groups
Florida	8-10 hours/week	hospital forensic unit	both	in transitional stage (4)
Hawaii	not stated	prison	inpatiency	not stated
Illinois	not stated	psychiatric prison hospital	inpatiency	in-facility volunteers
Iowa	3-4 hours/week	prison	not stated	halfway house (parolees)
Maryland (1)	3 hours/week	offender community clinic	outpatiency	sex abuse family centre
Maryland (2)	program dependent	hospital forensic unit	inpatiency	not stated
Massachusetts	not stated	segregated prison hospital	both	5 regional CRC's
Michigan	3 meetings/week	prison	both	not stated
Minnesota	4.5+ hours/week	segregated prison unit	both	crisis hotline, drop-in place
Missouri	not stated	prison	not stated	not stated
New York	not stated	segregated prison unit	both	parole board aftercare
North Dakota	not stated	max. security prison	not stated	community discussion groups
Oklahoma	2 hours/week	community centre	outpatiency	community-based to start
Oregon	25 hours/week	hospital forensic unit	both	not stated
South Carolina	not stated	not stated	not stated	not stated
Vermont	not stated	prison	both	family & others meetings
Washington	25 hrs/wk (inpatient) 3-6 hrs/wk (outpatient)	hospital forensic unit	both	work program (in outpatiency)
Wisconsin	varied	max. security prison, later program moved to hospital forensic unit	both	social worker aftercare

psychiatrists would be employed on a part-time consulting basis, whereas clincial psychologists would be on staff full-time. Only Connecticut and Vermont made extensive use of volunteers. The several programs which maintained segregated (from the general prison population) inpatient facilities utilized "therapeutic supervisors", inmates who were in the latter stages of therapy and were verbally skilled. In 1977, Washington had 12 such therapy supervisors.

Client-to-professional therapist ratios ranged from a low of 18:1 (Michigan), to a high of 30:1 (New York). Deciding on what is an optimal ratio is at best difficult, since the quality, quantity, and diversity of services are so interrelated. Since there was little evaluation and follow-up data provided, the question of staffing adequacy cannot be properly addressed.

Treatment Duration and Intensity

Once again there was little consensus among states concerning duration and intensity of treatment (Table 3). However, with exceptions duly noted, it is apparent that this lack of consensus can be attributed to the programs' target populations. Where habitual and/or violent offenders receive priority admittance, programs run at least 2 years (except in New York and Maryland), and clients receive as much as 25 hours per week of counselling. Programs where all sex offenders are considered run approximately one year, and provide no more than 5 hours of therapy per week. Hence, a sensible philosophy exists in many programs wherein those clients who are at greater risk

participate in more treatment. Importantly, in their attempt to include all sex offenders, the voluntary referral programs may be undertreating the more sexually deviant participants by offering the same quantity of therapy to all, regardless of risk. However, such a statement is speculative since limited evaluation and follow-up date were provided.

Location

Treatment location (Table 3) was largely influenced by the individual program's target population. Generally, the habitual and/or violent sex offenders were treated in segregated inpatient facilities--either a forensic psychiatric ward of a hospital (for example, the East Washington State Hospital), or a psychiatric prison hospital located on the grounds of a state correctional institute (for example, Bridgewater, Massachusetts). It is stressed that the psychiatric prison hospitals are effectively sealed off from their adjacent correctional facilities.

The larger programs accepting all sex offenders are typically conducted within state maximum security prisons which maintain designated treatment areas. Unfortunately, except in the case of Minnesota, it was indeterminable whether the participants were segregated from the general prison population on a full-time basis, through residency in the treatment centre, or just during treatment hours.

Community Resource Outlets

Fifteen states noted the use of community services (Table 3). Unfortunately, in those cases where such services were noted, few details were provided. In seven cases, it was simply stated that community resources were made use of during the transitional phase of treatment or during outpatiency. The parole board was charged with the coordination of such services where they were provided after release.

Despite the prevalent lack of detail, several states did allow some elaboration on community services. Massachusetts listed a network of 5 community resource centres to which offenders are assigned during the latter stages of their program. These centres coordinate offender reintegration in terms of vocation and family. Massachusetts was the sole state documenting such a coordinated, statewide system. Deleware, Maryland, North Dakota, Oklahoma and Vermont all noted inmate participation in family oriented sexual abuse discussion groups. Attendance at the well-known Parents Anonymous by pedophiles and those charged with incest is one example. Connecticut has an interesting approach in that program clients must participate in community meetings to increase public knowledge concerning sex offenders. Hence, an offender will often be required to actively participate at rape crisis centre meetings. Where empathy and/or victim awareness training is considered an objective by clinical staff, such an approach may be valuable. Lastly, Minnesota was the only state to note the use of a 24-hour crisis hotline for

participants in outpatiency and program graduates either on or off parole. Phones are staffed by therapists and other program graduates maintaining exemplary postrelease records. In view of the heavy use of this service, it is recommended that it be incorporated into any sex offender treatment scheme.

Theoretical Orientation and Therapeutic Services Offered

The therapeutic orientations of the different programs, as described by their administrators, are prsented in Table 4. They include behavioural, psychodynamic, therapeutic community, and multidisciplinary approaches. Despite this variability, there was considerable commonality with regard to the type of services offered. One notable exception is the biopsychological approach of the Johns Hopkins Hospital in Baltimore, where chemotherapy and psychosurgery are the two preferred modes of treatment.

In specific terms, virtually all programs provide group counselling and sometimes individual counselling, where requested. The focus of such counselling is typically on the offender's accepting responsibility for his actions, and the understanding of factors which precipitated commission of the offense. Self-disclosure is highly reinforced, and as treatment progresses, the group is increasingly looked upon to initiate and maintain discussion without explicit directives from the therapist. Some states have labelled this the "guided self-help" approach. However, one is cautioned about exclusive use of the guided self-help method wherein self-disclosure is typically

Table 4

State	Therapeutic Services Offered
Arizona	grp. counseling, interpersonal skills training, time management
California	grp. counseling, vocational, academic, recreational (as per CA prison regulations)
Colorado	arousal conditioning, assertiveness training, sex education, life skills
Connecticut	grp. counseling, sex education, socialization education
Florida	grp. counseling, sex education, assertiveness, stress management, vocational, academic
Hawaii	grp. counseling
Illinois	grp. counseling, assertiveness, stress management, interpersonal skills building
Iowa	grp. counseling, social skills, academic, vocational, recreational (as per prison regs.)
Maryland (1)	grp. counseling, life skills, sex education
Maryland (2)	limited psychotherapy, chemotherapy, psychosurgery
Massachusetts	psychotherapy, vocational, academic, work, recreational, authorized absences
Michigan	"reality" therapy, impulse control, sex education, stress management
Minnesota	grp. counseling, assertiveness, industries program, social skills, sex education
Missouri	high structure counseling, life and social skills, sex and 'affect' education
New York	grp. counseling, sociosexual education, vocational, alcoholic treatment, recreational
North Dakota	grp. counseling, empathy training, arousal conditioning, family therapy, work program
Oklahoma	peer and family grp. counseling, vocational (all on outpatiency basis)
Oregon	grp. counseling, arousal conditioning, sociosexual education, stress management
South Carolina	grp. counseling (nonspecific)
Vermont	grp. counseling, life skills, assertiveness, sex education, family therapy
Washington	grp. counseling, victim awareness training, vocational, recreational
Wisconsin	insight oriented psychotherapy, family therapy, prison in-house activities

Table 4 cont'd....

Table 4 cont'd

State	Orientation	Evaluation and Follow-Up
Arizona	unclear	none
California	private practice model	client rated helpfulness of groups (more structure desired)
Colorado	behaviorist	none
Connecticut	unclear	reoffenses: 19% treatments, 36% general prison population
Florida	humanist & behavioral	in planning
Hawaii	no indication	none
Illinois	multidisciplined	none
Iowa	multidisciplined	none
Maryland (1)	behaviorist	see text of article under evaluation and follow-up section
Maryland (2)	biopsychological	3-9% sexual reoffense rate for treatments
Massachusetts	psychodynamic	in planning
Michigan	therapeutic community	125 graduates, 50 have no parole violations after one year, 9 after two years
Minnesota	therapeutic community	descriptive statistics, noncomparative baserates
Missouri	unclear	9% attrition rate
New York	therapeutic community	in planning
North Dakota	behavioral	9% recidivism rate (no baserates given)
Oklahoma	unclear	none
Oregon	behavioral	none
South Carolina	unclear	none
Vermont	behavioral/therapeutic community	none
Washington	unclear	25% attrition rate; 22.1% reoffense rate over 7 years
Wisconsin	psychodynamic	treatments vs. controls: 25%, 36% parole violation; 16%, 22.5% criminal violations; 717 graduates out of 978 entrants, 1954-1963

reinforced at a high rate. For among these disclosed statements, many deviant sentiments may be included and the group may inadvertently be reinforcing their expression. Thus, in addition to the social reinforcement of self-disclosure, it is imperative that prosocial sentiments be reinforced with the concurrent disapproval of antisocial expressions (e.g., Andrews, 1980).

In addition to the type of counselling noted above, most programs include: sociosexual eduation, which incorporates sex-education and hetersocial-hetersexual skills training; life skills training, which will include assertiveness training, and some stress and time management instruction; vocational training; academic instruction at the secondary school level; and alcohol treatment where applicable. Traditional in-house recreational activities are also provided. Programs which adopt a behavioural approach (e.g., New York, North Dakota) utilize behavioural conditioning techniques to decrease deviant sexual arousal and increase nondeviant arousal. As noted earlier, plethysmography is an integral part of these procedures. Lastly, six states make use of 'victim awareness' training, where the offender is taught to empathically regard his victim(s).

In summary, a comprehensive multifaceted treatment would include group counselling to confront the sex offender with responsibility for his act, teach the offender empathy towards his victims, provide social and life skills training, apply

behavioural techniques to decrease deviant and increase nondeviant sexual arousal, and where applicable, utilize chemical interventions, surgical methods, and substance abase programming.

Evaluation and Follow-up

Programs were weakest in this area. Since many programs were relatively new or in a start-up phase, evaluation data generally were not available. Moreover, many of the programs which had been in existence either had not conducted an evaluation, or provided inadequate data. A typical problem was the provision of recidivism statistics where the specific measure of recidivism was not noted, and the population baserates were not listed. A control group rate would sometimes be noted, but the controls did not appear comparable to the treatment group due to differing legal and/or demographic characteristics. Moreover, completion rates and process measures were notably absent. Where evaluations were conducted, the only program to include an attrition rate, and both process and outcome measures of program effectiveness was Maryland's Sex Offender Clinic (SOC).

Considering completion rates, Maryland and Missouri each stated that 90% of their entrants successfully complete the course of treatment. Washington and Wisconsin cited a 75% graduation rate.

With regard to process measures, California, although without a systematic program, surveyed client and therapist ratings of program helpfulness. It was found that the rated

helpfulness was low, and more structure was desired by clients. The SOC in Baltimore, Maryland assessed the significance of changes in psychological test scores and social adjustment ratings from pretreatment to posttreatment; no significant differences were obtained. Minnesota supplied only descriptive statistics of their treatment and control groups, hence these cannot be considered suitable process measures of program effectiveness.

Clearly, the outcome measure of choice is recidivism. However, the rates provided were not very helpful in evaluating the programs because appropriate comparisons could not be made. Nevertheless, Connecticut reported a 19% reoffense rate for program participants, and a 36% rate for the general prison group (here reoffense is not necessarily a sex offense). The Baltimore SOC found that 28% of program clients violated parole from the start to the finish of treatment (the SOC is a post-release program, a condition of parole), yet only 9.8% violated in the 18 month post-treatment period. Michigan conducted a follow-up of 125 graduates, finding that 50 clients were released in one year without any kind of violation, and 9 achieved the same success over two years. These results may be misleading in that many of the 125 cases it is not stated how many had actually been on parole for a complete year at the time of the data collection.

Elsewhere, Washington lists a 22.1% recidivism rate over 7 years, yet no indication is given as to what kind of recidivism measure was used. Lastly, Wisconsin provided data from the

period of 1954 to 1963, where program participants violated parole at a rate of 25% and nonparticipants at a 36% rate. Furthermore, in terms of criminal violations, the rates were 16% versus 22.5% for treatments and regulars, respectively. In addition, only 9% of the participants' criminal violations were sex offenses.

In short, evaluation data are scarce and methodologically weak. Nevertheless, there is some indication that programs are effective, but the data provide no indication as to which components might be most important or even essential to program success. Furthermore, it has yet to be determined whether the improvements in reoffense statistics justify the expense involved in running sex offender treatment programs. From the documentation provided, it is apparent that several very good evaluation studies are currently being conducted in concert with programs, yet results are still pending.

Summary and Recommendations

It is clear that there is some diversity in the treatment programs surveyed. However, much of this diversity is due to the differing target populations, and secondarily to the differing therapeutic orientations. At a more fundamental level, the diferences in target populations can likely be attributed to the governing bodies' commitment of funds, where those offenders representing the highest comunity risk will be given priority.

Based upon the findings of the current survey, the following recommendations are made concerning the implementation of sex offender programs.

Target Population. A priority list should be drawn whereby violent repeat offenders receive top priority admittance, followed by first time and occasionally violent offenders, followed by nonviolent recidivists, followed by all other sex offenders. In terms of waiting list order, the placement of a violent habitual case would have to supersede the placement of all others, as per the order noted above, even if others had been on the list longer. Those cases with an impending discharge should obviously take precedence over those whose release is not for some time. However, currently there is only speculation as to the optimum point in a sentence for treatment. Volition and motivation of the offender should also be considered although it is acknowledged that assessing these attributes is, at times, difficult.

Referral. The judiciary, with the cooperation of the clinical staff at the potential host setting, should be the primary referral source since violence and repetition are legal concepts set forth and described in legislation. For these individuals, parole eligibility should be made incumbent upon participation and progress.

There should also be an avenue available whereby sex offenders, who feel they are at risk to repeat, can be

referred--in other words, voluntary referral. However, the final decision here should be in the hands of the professional staff who would determine the offender's level of risk. Lastly, institutional case workers should be allowed to refer sex offenders whom they feel are potential repeaters. Once again, clincial staff would have final say in placements.

The latter two classes of referral are particularly important. This is due to the prevalent opinion that many sex offenders manage to avoid apprehension and/or prosecution in previous sex crimes, and hence will be serving a sentence based on a first prosecuted, but not first committed, offense. Legally, these individuals are not repeaters, yet they may themselves recognize the need to halt such recurring episodes. Similarly, the correctional case workers may feel that the individual is in fact a repeat offender, despite a differing legal status.

Assessment. Five components are proposed. The first is social history documentation. This would be important in placement decisions--for example, if highly unusual circumstance surround the offense, therapists can reasonably expect no repetition. Personal history will also be important in treatment, where the offender is taught to understand the contextual antecedents of his crime(s).

Second, a psychiatric interview is required to determine the prevalence of psychiatric disorders. As previously noted, psychotics are not well suited to many of the treatment regimens currently in use.

Third, a psychological test battery is proposed to determine the intellectual and personality attributes of the offender, as well as to assess criminal and sexual attitudes. These dimensions are particularly important in that certain deficits (e.g. social skills) and attitudinal abnormalities (i.e. sexual, interpersonal) may indicate a particular course of treatment, while other deficits (e.g. intellectual, verbal skills) and abnormalities (gross mental disorder) preclude one from the more common cognitively oriented or group programs. From the plethora of scales available, some strong choices would be the WAIS, MMPI, California Personality Inventory, Buss-Durkhee Hostility Scales, Desrogatis Sexual Functioning Inventory, Tolerance for Law Violations, Identification with Criminal Others, Attitudes Toward Law, Court and Police, and the Kinsey sexual attitude scales. As noted previously, pre- to post-treatment scale score changes can contribute greatly to the evaluation of program effectiveness as well as to the monitoring of a client's progress.

Fourth, plethysmography is crucial to the assesment of deviant and nondeviant sexual arousal. Where behavioural conditioning techniques are to be used in treatment, such assessment is a necessity (self-reported arousal has often been used, but it is quite unreliable; see Abel et al., 1978).

Fifth, laboratory analysis should include readings of blood levels of testosterone, luteinizing hormone and follicle stimulating hormone. Where elevated testosterone levels are found, with a particular recurrent pattern of sexual behaviour

(typically nonviolent, but with high frequency, see Berlin, 1982), individuals may be better treated with MPA than other methods.

Capacity and Staffing. As it was stated previously, capacity depends on the committment of funds to treatment and the number of offenders satisfying selection criteria.

There should be at least one consultant psychiatrist to conduct interviews and administer chemotherapy, and at least one chief clinical psychologist to coordinate therapeutic services. To defray costs, it is suggested that clincial psychology interns familiar with forensic settings be used as therapists, and that trained volunteers be used as well. The success encountered by Nicholas Groth (1979) in Connecticut, and the success of the Canadian Volunteers in Corrections (CaVIC) program (Andrews, 1980), tend to reflect favourably on the use of volunteers.

Client-to-principle therapist ratios should be approximately 20:1. There is no scientific basis for this number, just the fact that many programs in the United States work with this ratio and find it manageable. Client-to-intern and volunteer ratios should be somewhat lower.

Treatment Duration and Intensity. Since evaluation and follow-up data were so limited, it is difficult to say what amount of therapy is best, and for whom it is most appropriate. When in doubt, the inclination is toward offering more therapy, but more therapy costs money. Another possible approach would be

to consider offender risk in conjunction with the range of treatment durations typically provided, whereby highest priority offenders would undertake a 3 year course of treatment, with approximately 12 hours of therapy per week. These numbers would decrease as risk priority dropped. A still more reasonable approach would be the periodic monitoring of individual clients, with trial authorized absences for those showing suitable improvement. Measures such as psychological test change scores, and physiological arousal ratings would be important in the monitoring process. Also of importance would be the staff's clinical impressions; hence quite a degree of clinical expertise would be required in granting absences.

Location. Whereas it has been argued that the optimum treatment location for sexual offenders is in the community, there appears to be a consensus that, if incarceration is required, the most appropriate location for treatment would be external to the traditional prison setting (i.e. psychiatric facility) or a specialized treatment facility within the prison system. Whether in a psychiatric prison hospital or a designated prison treatment centre, it is recommended that participants be segregated from the general prison population. Furthermore, there is some indication (Wormith, 1983) that sex offenders would be more inclined to participate in treatment programs if they were removed from the traditional penitentiary setting.

Community Resource Outlets. As it was proposed in Massachussets, community resource centres should be erected for the purpose of offender reintegration toward the end of treatment. These centres could also serve as a 'fall-back' for graduates after release. Further to the concept of community support, Minnesota's example of a 24-hour crisis hotline should be followed.

Another community based service which should be utilized is the rape crisis centre discussion program. As practiced in Connecticut, sex offenders could be required to participate. Of course, both the offender and the discussion participants would have to be well prepared for such a meeting. Nevertheless, it is conceivable that benefits would be accrued from such encounters, with knowledge being exchanged in both directions.

Therapeutic Services. Judging from the earlier review, it is apparent that most states with programs offer a comprehensive list of services. To reiterate, services should include group counselling (to confront the offender with responsibility for his act, and teach the offender empathy toward victims), life and social skills training, conditioning techniques to decrease deviant and increase nondeviant sexual arousal, and vocational and academic instruction. Also, where applicable, chemical or surgical therapy should be administered.

Concerning group counselling, a structured format is recommended in that sexual problems and other emotionally loaded

topics are frequently discussed. Therapists should point out (disapprovingly) antisocial or deviant sentiments, and encourage prosocial expressions. Moreover, they should encourage all group participants to do the same, and to be attentive to insincere statements, whereby a client merely mimics acceptable expressions. All this will ensure high quality counselling sessions.

Evaluation and Follow-up. As service components are planned, so should an evaluation be included. There should be three parts to an evaluation--attrition rate, process measures, and outcome measures (Andrews, 1983). Attrition rates are self-explanatory, and also easily determined although not often reported. Process measures should include plethysmographically recorded changes in sexual arousal, pre- to post-treatment changes on psychological tests, therapist ratings of social adjustment improvement, and client ratings of therapy helpfulness.

Outcome measures include various indicators of recidivism, and are typically collected during follow-up. Several indicators could be employed: 1) criminal parole violations (sexual and nonsexual), 2) postparole reoffense record (sexual and nonsexual), 3) self-reported sexual behaviour and 4) social status (e.g. marital, occupational).

Several comparative measures would also need be collected. The first would be the historical reoffense rates (baserates) for sex offenders and the general prison population,

in terms of both sexual and non sexual offenses. The second would be the establishment of suitable control groups for comparison with treatment groups. It is at this point where the greatest difficulties are encountered, in both ethical and methodological terms.

In principle, it would be a simple matter to take a treatment group, a waiting list group, and a demographically matched group from the general prison population. However, with the priority list mentioned earlier, it is obvious that the more dangerous offenders will always be found in the treatment groups. It is ethically untenable to deny treatment to high risk individuals for research purposes. Hence, the treatment and control groups would likely not be comparable. In view of this, some reliance would have to be made on historical baserate data for the target population, and comparisons with legally/demographically matched subjects from the regular prison populations.

REFERENCES

Abel, G.G., Blanchard, E.B., & Becher, J.V. (1978) An integrated treatment program for sex offenders. In R. Rada (ed.), Clinical Aspects of the Rapist. New York: Grune and Stratton, Inc.

Abel, G.G., Blanchard, E.B. & Becher, J.V. (1976) Psychological treatment of rapists. In M.J. Walker & S.L. Brodsky (Eds) Sexual Assault: The victim and the rapist. Toronto: Lexington Books.

Andrews, D.A. (1980) Some experimental investigations of the principles of differential association through deliberate manipulations of the structure of service systems. American Sociological Review, 45, 448-462.

Andrews, D.A. (1983) Assessment of outcome in correctional samples. In M.J. Lambert, E.R. Christensen & S.S. DeJulio (Eds) The Assessment of Psychotherapy Outcome. New York: John Wiley.

Berlin, F. (1982) Sex offenders: A biomedical perspective. IN Joann Greer and I.A. Stuart (eds.), Sexual Aggression: Current Perspectives on Treatment. New York: Van Nostrand Reinhold.

Brecher, E.M. (1978) Treatment Programs for Sex Offenders: Prescriptive package. Washington, D.C.: Law Enforcement Assistance Administration.

Freund, K. (1980) Therapeutic Sex Drive Reduction . Acta Psychiatrica Scandinavia, 62, (Supplement No. 287) 38 pg., Munksgaard, Copenhagen.

Greer, J.G. & Stuart, J.R. (Eds) (1983) The sexual aggressor: Current perspectives on treatment. New York: Van Nostrand Reinhold Co.

Groth, A.N. (1979) Men who rape: The psychology of the offender. New York: Plenum Press.

Marshall, W.L. & Barbaree, H.E. (1978) The reduction of deviant arousal. Criminal Justice and Behaviour, 5, 294-303.

Quinsey, V.L., Bergersen, S.G. & Steinman, C.M. (1976) Changes in physiological and verbal responses of child molesters during aversion therapy. Canadian Journal of Behavioural Science, 8, 202-212.

Wormith, J.W. (1983) A survey of incarcerated sexual offenders. Canadian Journal of Criminology, 25, 379-390.

Footnotes

The authors are indebted to Robert Joseph for undertaking correspondence with the state correctional agencies.

This report was conducted in partial fulfilment of service contract 7302-38 held by the first author.

Appendix A

STATE PROGRAMS FOR SEX OFFENDERS

State_____ Year of Documentation_____

When Implemented_____ Year of Overhaul(s)_____

Coordinating Agencies_____

Type of Therapeutic Services Offered: 1) Assessment/Treatment_____

2) Disciplinary Bent_____

Ancillary Programs (?) and Type_____

_____

Community Resource Outlets_____

Restitution Programs (?)_____

Number of Convicts Handled/Year_____

% of Convicts as Outpatients_____ as Inpatients_____

Potential Avenues of Placement within Institution (Type & Number)_____

_____

Predominant Characteristics of Offenders Receiving Special Placements

_____

_____

_____

_____

_____

_____

How Assessed_____

_____

Who Has Final Say in Placements_____

Staff: Type and Number (Psychiatric only)_____

_____

Appendix A
(cont'd)

Amount of Treatment (Hours per Week)_____

Locations (Prison, Hospital, etc.)_____

Services Available for Voluntary Admissions (Y/N and What)_____

_____

Evaluation (Y/N, Empirical or Subjective)_____

High Level Custodial or Rehabilitative_____

Completion and Drop-Out Rate_____

Outcome (re: Recidivism, Subjective Impression of Participants)_____

_____

Follow-up (Y/N and same information as per outcome)_____

_____