



Sex Offender Treatment Program: Preliminary Description

Report prepared for the
Alaska Department of Corrections

by

Alaska Justice Statistical Analysis Unit
Justice Center
University of Alaska Anchorage

May 10, 1995

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Contents

I. Introduction	1
II. Sex Offender Treatment in Alaska	3
A. History	3
B. Relapse Prevention Model	5
C. Program Description	6
1. The LCCC Sex Offender Treatment Program	6
2. THE HMCC Sex Offender Treatment Program	7
3. Community Based Treatment Programs	9
III. Literature Review	11
A. Recidivism Definitions	11
B. Treatment—Voluntary vs. Involuntary, Treated vs. Untreated	12
C. Treatment—Types, Levels, Evolution, Relapse Prevention and Cost/Benefit Analysis	13
1. Types and Levels of Treatment	13
2. Types of Treatment Pre- and Post-1980	14
3. Relapse Prevention Techniques and Their Benefit to Society	15
4. Cost of Treatment Programs Mentioned in Literature	15
D. Treatment and Recidivism as it Relates to Various Types of Sexual Offenders	16
E. Other Factors Possibly Involved in Reoffense Potential	17
Conclusion	17
IV. Methodology	19
V. Results	21
A. Descriptive Information	
1. Offense Category and OBSCIS Offense Code	22
2. Presumptive Sentencing	23
3. Length of Sentence	25
4. Race	27
5. Education	28
6. Location of Court of Conviction	30
7. Occupation	31
8. Substance Abuse History	32
9. Stage at Discharge	33
10. Reason for Discharge	34
11. Projected Year of Release	35
B. Reoffense Information	
12. Remands to Prison for Parole or Probation Violations	38
13. Remands to Prison for New Sex Offenses	39
14. Remands to Prison for Non-Sexual Offenses	40
VI. Conclusion and Recommendations	41
VII. Bibliography	43

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Antonia Moras, the information officer at the Justice Center, and Melissa S. Green, the Justice Center publication specialist, reviewed and produced the final drafts. Cassie Atwell conducted the data entry, verification, and cleanup. She also did the preliminary SPSS runs. Richard Curtis, Justice Center research associate, was instrumental in converting the original data into an SPSS readable format and provided other technical database services.

The current report also contains a lengthy history and description of the DOC sex offender treatment efforts written by Rose Munafo and Dr. Anthony Mander. They also reviewed and edited other sections of the report and made numerous valuable contributions. The amount of information potentially available for a report of this nature was overwhelming. They each spent many hours focusing our efforts onto the most salient concerns.

Ms. Munafo deserves special credit for obtaining all the remand/recidivism information. This was an extremely time-consuming and tedious task which called upon not only her experience and expertise with sex offender treatment, but with OBSCIS and the larger criminal justice system processing as well. Ms. Munafo was the overall project coordinator for DOC and helped resolve many questions through countless phone calls and staff meetings. It is through her efforts that the project has been kept alive and to the extent the knowledge gained will help reduce these types of offenses, we all appreciate her effort and concern.

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Although Ms. Munafo and others have graciously reviewed, revised, and contributed to this report, any errors or omissions must be placed with me, and I would appreciate any and all constructive comments.

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Sex Offender Treatment Program: Preliminary Description

I. Introduction

During Fiscal Year 1993, the Department of Corrections had contracted with a private vendor who was to prepare a computerized database for ongoing compilation of data on the sex offender programs operated by the Department. The contractor was also responsible for summarizing the demographic characteristics of offenders who had participated in the Hiland Mountain Sex Offender Treatment program during the period of January 1987 to March 1993.

When the private vendor failed to fulfill his contractual obligations, the Department representative contacted the University of Alaska Anchorage Justice Center for assistance in compiling the preliminary statistical information, as well as for consultative services which would help in the development of an ongoing recidivism study of offenders receiving sex offender treatment services. As part of this agreement, a review of the existing literature on sex offender recidivism issues was conducted by students enrolled in a research methods class at the University. The Justice Center also provided expertise in constructing a computerized data base for use by the sex offender treatment programs. The database construction is proceeding according to plan and will be fully operational by the summer of 1995.

This report begins with a summary of the history of sex offender treatment in Alaska, which includes the current status of the programs offered by the Department as well as a summary of the treatment philosophy to which all of the Department's treatment programs adhere.

In order to best assess treatment efficacy, researchers typically begin by reviewing the work that has gone before them. This document contains an abridged version of the more technical and comprehensive review that was completed.

The report next presents a summary of the descriptive characteristics of those individuals who came into contact with the Hiland Mountain SOTP between January 1987 and March 1993. The HMCC program is the most comprehensive program in the continuum of care from pretreatment to aftercare. The actual stages of treatment through which these individuals progressed varied considerably. A large number of individuals were still incarcerated when this information was obtained and others had only been released for a short period. Thus, the reader should not view our description as a complete evaluation of the Hiland Mountain treatment program, but rather a description of participants during a given time period.

2 Introduction

It appears that most of the sex offenders who came into contact with the program were tried in the Third Judicial District for a case involving the sexual abuse of a minor, with about half serving a presumptive sentence. They were mostly white, with high school or better education, working in unskilled jobs. Alcohol alone or a combination of alcohol and drugs played a role in almost two-thirds of the cases but, surprisingly, in about one-third neither played a role. Slightly over half of the men dropped out of treatment in the beginning stages. None of the men who had completed the program successfully had been returned to prison in Alaska as of March 1994. (The only outcome or recidivism variable available at the time this descriptive information was processed was an OBSCIS-based determination of the number of times the individual had been returned to a correctional facility in Alaska. Future data collection will include a more comprehensive rearrest check.)

Finally, this report closes with a proposal for further study of the efficacy of sex offender treatment in the Alaska correctional system. The Department would like to conduct further research during the upcoming fiscal years. It is projected that the Department would continue to pursue a collaborative agreement with the Justice Center in future research efforts.

II. Sex Offender Treatment in Alaska

A. HISTORY

The sex offender treatment program (SOTP) has been developed, over a number of years, by the Alaska Department of Corrections in conjunction with a variety of individual contractors. DOC has attempted to develop the programs along a continuum of care in a number of regions throughout the State.

The first program was opened in 1979 at Lemon Creek Correctional Center (LCCC), Juneau, Alaska. The program was established via a small Law Enforcement Administration Act (L.E.A.A.) grant of approximately \$18,000.00 and worked with 10 and later 15 sex offenders, at any given time. The program received L.E.A.A. funds for two years and was then funded by the Department of Corrections for another one and a half years. The program participants were housed in the general population and received individual and group therapy without the benefit of a treatment milieu.

The program at LCCC was re-established in 1985 and was revised in 1989 and again in 1992. The program currently houses 24 inmates in a milieu setting and provides pre-treatment and pre-release services.

The second institutional program was developed in 1981 at Fairbanks Correctional Center (FCC) and housed 32 inmates in a milieu program setting. This program was closed in 1992. The make-up of the FCC population is largely unsentenced felons (60%) and misdemeanants (15%). Thus when the institution reached population caps there was a natural tendency to transfer program participants rather than short term prisoners or those who would need to be available for court. This created an atmosphere of instability for the programmers and the program itself. The Department followed the recommendations of a special task force and closed the program, transferring continuing programmers to other institutional programs. Community based programs for sex offenders continue in the Fairbanks area and have been increased from 15 to 20 openings.

A third institutional program was established in 1982 at Hiland Mountain Correctional Center (HMCC) in Eagle River just outside of Anchorage. This program currently houses approximately 100 sex offenders in a milieu setting. Seventy of these are involved in intensive treatment programming and 30 are involved in pre-treatment programming/screening and pre-release services. The HMCC program is currently the only institutional treatment program for sex offenders in Alaska and offers specialized services to the developmentally disabled sex offender as well as to female sex offenders. This program uses specially trained correctional officers as wing counselors. These wing counselors work as part of a treatment team alongside professionally trained therapists and other professional staff to provide an intensive therapeutic

4 Sex Offender Treatment in Alaska

environment. There are presently four contract therapists, one of whom provides clinical supervision in addition to direct services to inmates. There is also a contract plethysmograph technician.

For a period of time in the evolution of sex offender programs in Alaska there were three distinct treatment programs operating simultaneously. At their peak these three programs provided for 124 offenders at any given time (80 at HMCC, 32 at FCC and 12 at LCCC). Having programs operating in Juneau, Eagle River and Fairbanks offered the advantage of making treatment available in institutions in the three main regions of the state. Unfortunately, maintaining consistency between programs was an ongoing problem. The programs in the three facilities were not closely linked and offered very diverse programs. There were somewhat different expectations and procedures causing confusion and frustration for those programmers who, for one reason or another, had to transfer between institutions. DOC hired several consultants in 1991 to evaluate the sex offender programs. One of the recommendations stemming from these evaluations was to create a continuum of services rather than duplicating services in several areas. Since this time DOC has developed and implemented the centralized services model. Efforts towards coordination continue as pre-treatment and treatment programs in the institutions and communities strive to provide the relapse prevention model in a consistent manner. DOC sponsored professional workshops on relapse prevention (RP) in 1991 and 1994 to enhance the knowledge of providers and to encourage consistency of approach. Additionally, in 1992, the DOC established a process to review and approve therapists to provide sex offender treatment consistent with the Department's model. There are currently 54 pre-treatment openings (24 at LCCC and 30 at HMCC) and 70 treatment openings for a total of 124 institutional program beds.

Community based treatment for sex offenders in Alaska originally was conceptualized as "aftercare" or follow-up counseling for offenders who had participated in the institutional programs. In reality most offenders in community programs have not received institutional treatment. The reasons for this are several. Many offenders do not receive sufficient sentences to enable them to enter the institutional treatment program. Some sex offenders receive no jail time at all. Others refuse treatment in prison but agree to participate once they are released from prison. Currently in community programs anywhere from 45-90% of the participants have had no prior institutional treatment. DOC attempts to maintain a consistency of approach not only between institutional programs but also between institutional and community programs. The adoption of the Relapse Prevention Model of treatment has helped to standardize treatment between programs and program sites.

The programs named above are the only programs currently recognized by the Alaska Department of Corrections as approved sex offender treatment programs.

Significant events in the evolution of sex offender treatment in Alaska are presented below:

- 1979 A pilot sex offender program opens at LCCC
- 1980 Alaska initiates presumptive sentencing for class A, B or C felonies (2nd offense)
- 1981 An institutional program is established at FCC
A community aftercare program is established in Fairbanks
- 1982 The LCCC program closes
A pilot program is established at HMCC
Alaska moves Class A felonies to Unclassified status and initiates Presumptive Sentencing for a first offense of Sexual Assault and Sexual Assault of a Minor

- 1984 A community aftercare program is established in Anchorage
The HMCC SOTP expands
- 1985 Plethysmograph assessment and behavioral treatment begin at HMCC
LCCC program reopens
Juneau community program established
- 1986 Social Skills wing is established at HMCC
Pre-program (pre-treatment) wing is established at HMCC
- 1989 LCCC SOTP is revised
- 1990 DOC sponsors statewide training for probation officers
- 1991 DOC hires national experts to evaluate Alaska's sex offender programs
DOC sponsors training in Relapse Prevention for treatment providers
- 1992 The LCCC SOTP is reorganized into a pre-treatment program
The FCC SOTP is closed
Community treatment openings in Fairbanks are increased
A community sex offender program is established in Ketchikan
An Approved Provider process is established and DOC begins contracting with individual approved providers rather than agencies
- 1993 A community program is established in Kenai
- 1994 DOC sponsors a training workshop for treatment providers
A safety-net training manual is written
- 1995 A community treatment program is established in Bethel

B. RELAPSE PREVENTION MODEL

The operation of a sex offender treatment program can draw from several models and treatment approaches that are currently used in the treatment of sexual aggression. One particular model, the relapse prevention (RP) model has been used for a number of years and has been demonstrated to be effective in the treatment of sexual aggression. This model, adapted by Pithers, et al. (1983) from a substance abuse model developed by Marlatt and Gordon (1980), is a cognitive-behavioral approach to treatment.

RP is defined as a maintenance oriented self-control program that teaches sex offenders how to determine if they are entering into high risk to re-offend situations, self destructive behaviors, their deviant cycle patterns, and a potential reoffense. RP is based on the reality that sex offenders are responsible for their behaviors and can control them. It helps them explore factors which lead up to committing sexual assaults and teaches them a variety of interventions to use in the community as a part of their personal maintenance program. The RP model teaches sex offenders that they must make a commitment to abstain from participating in future deviant sexual behavior. In doing so it teaches them how to cope with those situations which can lead to relapse. The offender learns new behaviors to substitute for the old and destructive ones they have engaged in previously. Abstinence from sexually deviant, criminal, and other abusive and destructive behavior is promoted as the primary goal for all sex offenders who enter treatment.

RP's main purpose is to identify the events and processes that lead up to the deviant behavior and cause the individual to move toward relapse (Marlatt, 1985). The prevention of relapse is a program that combines behavioral arrangement skills with cognitive processes to "intervene" and thereby modify the specific behavior that has been targeted. Sexually deviant behavior is defined as any inappropriate sexual behavior that involves non-consenting partners (this includes partners under the age of 18 years old or

6 Sex Offender Treatment in Alaska

individuals judged by the Alaska Court System as being adult but unable to be responsible for personal decisions), or behaviors that present a danger to the individual or others, and as defined by Alaska Statute. The focus is not to “cure” or remove all temptation, but to develop ways to manage and cope with the ongoing sexual desires, to teach the individual to be responsible to internal and external stressors (Salter, 1988).

C. PROGRAM DESCRIPTION

Depending on an offender’s custody status, sentence length and readiness for treatment, programming may be provided in the institutional pre-treatment and treatment programs, as well as in community programs. The nature of treatment itself varies according to the offender’s readiness for treatment, the nature of the offense and other factors.

1. The LCCC Sex Offender Treatment Program

An intensive pre-treatment program is housed in the Lemon Creek Correctional Center in Juneau. LCCC is a maximum security prison and is therefore able to provide screening and pre-treatment services to close and maximum security prisoners. The pre-treatment program is housed in one of four modular dormitories. The pre-treatment “mod” houses 24 men in 12 semi-private rooms. There are toilets in each room and shower facilities in the mod. In the center of the mod is a dayroom in which groups and educational classes are held. Outside of the mod itself is a counselor’s office which is used by contract staff for individual therapy or assessment sessions and for administrative work. All pre-treatment activities are held in the mod or the counselor’s office. The offenders use the same cafeteria as the general population and have access to all other programs, recreational activities and work opportunities that are available to the rest of the population.

There is no minimum time requirement for the pre-treatment program. Offenders who do not have enough time left to serve to receive treatment at HMCC can receive pre-treatment services at LCCC. The pre-treatment program evaluates these offenders and determines their amenability to treatment. Offenders who are amenable are oriented to the treatment process in preparation for treatment in the community.

Pre-treatment groups are a combination of didactic education and group process. Offenders are assigned to one of two groups. Each group meets twice weekly. Offenders also receive individual treatment on a monthly basis. Offenders undergo psychological testing and their social, family and sexual histories are reviewed in detail. Institutional behavior is evaluated and observations are made of the offenders behavior and attitudes while in program. This results in an assessment of the offender’s amenability to treatment and the establishment of an individualized pre-treatment and management plan. Ordinarily, amenability assessments are completed within 90 days. Offenders generally remain in pre-treatment for 12 months or less.

The LCCC pre-treatment program houses offenders who are on two different tracks. One group of offenders are being evaluated for and oriented to treatment at HMCC. These men meet the necessary time requirements and other eligibility criteria for the institutional treatment program. The second track of offenders are evaluated for treatment in the community and are assessed for and oriented to this treatment

setting. Some offenders are not amenable to treatment in either setting. Offenders who, after receiving pre-treatment, continue to accept no responsibility for their offense(s) are an example. A thorough assessment is made of these offenders and recommendations are made regarding management strategies. This assists the field probation officer in the supervision of these high risk offenders.

Progress in pre-treatment is monitored by a pre-treatment team. This is composed of contract staff (therapists) as well as DOC staff (e.g., probation officer, work supervisor, mental health clinician, correctional officers). The pre-treatment team consults and coordinates with the Clinical Supervisor and the Correctional Officer III from HMCC regarding potential transfers to the HMCC program.

There is also a pre-treatment program at HMCC. This program serves the same function as the LCCC program and evaluates and orients offenders to treatment at HMCC or in the community.

2. THE HMCC Sex Offender Treatment Program

The SOTP is housed within the Hiland Mountain Correctional Center. HMCC is classified as a medium security facility. The architectural structure of the facility lends itself to the therapeutic community treatment model. There are four housing units, each consisting of four 10-man wings surrounding a recreational dayroom. Each wing consists of 10 individual rooms, bathroom and shower facilities, a Wing Counselor office, and a small dayroom for group sessions and other activities. Two of the four housing units are designated as sex offender program houses. The physical setting lends itself to a unique blending of both sex offender populations and generic inmate populations. To date the blending has worked quite successfully.

The SOTP is available for adult male sex offenders who have been convicted and sentenced for sexual offenses and who have 18 months to 6 years remaining until release or a possible parole date. Sex offenders must meet several other eligibility criteria before being admitted into program. These include a willingness to participate in programming, an ability to benefit from the program, and a willingness to accept responsibility for the offense(s). Specific eligibility requirements are listed in DOC's Standards of Care and the HMCC Clinical Manual.

The majority of sex offenders within DOC are male. Adjacent to HMCC is the women's facility at Meadow Creek. The two institutions have administratively been one for several years. Female sex offenders housed at Meadow Creek who meet program eligibility requirements may receive sex offender treatment services on an individual basis. These women are not treated in treatment groups with male offenders.

The SOTP also works with other special needs populations. These include offenders with various cognitive impairments, learning disabilities, physical handicaps and mental illness. These individuals must meet the same general eligibility requirements as other offenders but program components may be altered or augmented to compensate for particular disabilities.

The SOTP consists of the following four treatment phases: Pre-Treatment, Beginning Treatment, Intermediate Treatment and Advanced Treatment. Each phase has specific goals which are outlined in a Pre-Treatment or Treatment Plan. In general, the goals of Pre-Treatment include screening, assessment, orientation to treatment and education. The goals of Beginning Treatment involve learning the basic concepts and skills needed to prevent relapse and maintain healthy and safe living patterns. During Intermediate Treatment the focus is on the application and internalization of skills learned in the preceding phase. Finally

8 Sex Offender Treatment in Alaska

the Advanced phase focuses on the generalization of skills to new situations. With the exclusion of Pre-Treatment each phase is a minimum of 6 months. Each phase may take 12 or more months depending upon the offender's individual resources, problem areas, skills and motivation. After completion of all stages, the offender may leave his original wing group and enter an Independent Study status. There is no time limit for Independent Study. An offender will remain in this status until his release from prison to a community care program.

An offender's Treatment Plan and progress in treatment is monitored by the Treatment Team. The Treatment Team is composed of the offender, the offender's wing representative, the wing counselor, the program director, the institutional probation officer, the clinical supervisor, and the contract therapist. The team may include others who have special knowledge of the offender, e.g., a family member, clergyman, potential employer, a field probation officer, or other institutional staff.

The staffing of the SOTP is a unique blend of both public (DOC Correctional Staff) and private (Contract) treatment providers. A Probation Officer III administratively supervises all institutional programs and has general oversight of the SOTP. A Correctional Officer III supervises the wing counselors, supervises housing units, coordinates program development with DOC Policy and Procedure, trains new wing counselors, maintains program records, acts as a liaison with victims groups and the public, and provides training on sex offender issues to DOC staff. The wing counselor is a Correctional Officer II. These individuals maintain wing files on each group member. They also conduct individual counseling sessions with each wing member bi-weekly to monitor compliance with a Treatment Plan and regularly attend the daily wing group counseling sessions held in each wing. Wing counselors also perform many security functions including operational relief and coverage and other duties as may be assigned.

There are DOC staff assigned to the institution to provide general mental health counseling and treatment to those inmates who require it. The Mental Health Clinician provides a referral service from the SOTP for individuals who display a need for further assessment or treatment, crisis intervention and monitoring of those on psychotropic medications. A Probation Officer is assigned a specialized case load of sex offenders who are involved in the SOTP. The P.O. is responsible for the custody and classification of all offenders as well as their furlough and parole eligibility. The P.O. is a member of the SOTP treatment team and works closely with other treatment staff to coordinate all efforts in providing relevant treatment and management. The P.O. is housed within one of the program wings to increase accessibility. A Clinical Supervisor (Ph.D. psychologist) has responsibility for the overall clinical management of the program. He supervises the contract staff, which includes Individual Wing Therapists and a Behavioral Treatment Technician. Individual Wing Therapists supervise clinical activities of the Wing Counselors and are responsible for the treatment of the 10 men on their wing. Therapists provide individual, group, and family therapy (when appropriate). Therapists also provide a number of educational components including victim clarification, empathy and behavioral self-control, behavioral treatment (in conjunction with the behavioral technician), crisis intervention and staff training. Therapists are responsible for writing a summary of progress in treatment at the time of discharge. The Behavioral Treatment Technician operates the plethysmograph, performing regular assessments and treatment under the supervision of the Clinical Supervisor.

The treatment program at HMCC is an extremely intense and sophisticated process. The treatment plans are highly individualized based upon in-depth assessment and observation of the program participants. Close observation by a multitude of staff leads to an in-depth and more thorough picture of each particular offender. This allows not only for very specific treatment but also for a more thorough assessment of risk as well as the development of appropriate management strategies. This information is made available to field probation officers and community treatment personnel when offenders are released from prison. This allows for the continuation of appropriate treatment and management strategies which can help reduce the risk of reoffense.

3. Community Based Treatment Programs

Community based treatment for sex offenders is provided in several areas. There are a total of 90 community treatment openings. Currently there are 30 openings available for community based treatment in Anchorage, 20 in Fairbanks, 10 in Juneau and 10 each in Kenai, Ketchikan and Bethel. Efforts are currently underway to establish community programs in Nome and Kodiak. The number of community treatment openings has more than doubled since 1992. The community programs are provided through contract with private providers. All providers are approved by the Department to provide services to sex offenders using the Relapse Prevention model. The Department is committed to community treatment and management programs for sex offenders and continues to strive for the development of these programs.

The methods and goals of community treatment are the same as those of the institutional programs. The institutional programs differ significantly, however, in that they provide pre-treatment and treatment within the context of a treatment milieu. This is much more intensive than treatment provided in the community as an offender's behaviors can be closely monitored and evaluated and interventions can be effected on an ongoing basis. Recently DOC has developed a Safety-Net training manual in conjunction with the University of Alaska Anchorage. This manual trains persons close to the offender to recognize and report pre-relapse signs. This is an attempt to create a structure around the offender similar to that which is provided by the institutional treatment milieu. Community treatment can never duplicate the intensity of the institutional milieu, however.

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III. Literature Review

All correctional program evaluations, and particularly evaluations of sex offender treatment programs, are faced with a number of obstacles. The evaluation of a program usually begins by asking such questions as “Does it work?” or “Is it cost effective?” and may even include something specific such as “Does it meet our criteria for Goal A?” When we are asked if a program works, we need to know the definition of “works,” and when we are asked if it is cost effective we may need to ask “compared to what?” Thus, the initial questions generate a host of additional questions and answers that must also be addressed, considered, and then decided upon.

We have broken the literature review into sections which reflect the initial interests of the Department of Corrections officials involved: recidivism, the issue of voluntary vs. involuntary treatment, various aspects of sex offender treatment, differences with respect to the various types of offenders, and, finally, other factors associated with reoffense potential.

It must be noted that any effort at a literature review concerning such a broad topic must be considered a temporary product which reflects only current thinking and previous research. This is an area in which research continues and theory is developing.

A. RECIDIVISM DEFINITIONS

The study of recidivism and sex offender treatment programs calls for the review of several areas of the corrections literature. Possible areas which need to be researched in order to assess the effectiveness of sex offender treatment programs are: the different working definitions of recidivism that are used in the literature; the differences in recidivism between sex offenders who have attended a treatment program versus those not treated; the optimal levels or types of treatment cited in the literature; and other factors which possibly affect recidivism.

Previous study of sex offender recidivism generally has not portrayed the sex offender as a serious recidivist. Sturup (1968) wrote that “very few sex offenders recidivate with a new sexual crime” (p. 9). However, more recent research on sex offender recidivism provides a basis for questioning the accuracy of this impression. Many of the more recent studies reviewed concluded that much of the confusion in research literature can be attributed to differences in measuring the recidivism of a sex offender.

Romero and Williams (1980) found in their research that the concern with sex offender recidivism is exacerbated by evidence that very few sex offenders are permanently incarcerated. Ultimately, sex offenders are returned to the community and little conclusive information is available on the risk they pose to society.

Because there is no common standard by which recidivism is determined, many problems arise when attempting to compare studies on the recidivism of sex offenders (Greenstein, 1990: 2). In a study presented in 1989 by Furby, Weinrott, and Blackshaw, several possible methods of defining recidivism were cited:

... reconviction for the same type of offense; recommission of the same type of offense, even if [the offender] is not convicted for it; recommission of any sex offense, even if different from the original one; and recommission of any criminal offense, even if it is not a sex offense.
(p. 8)

The most widely used definition, however, is “conviction of another sex offense during a specified follow-up period” (Furby, et al., 1989: 21). The Romero and Williams ten-year follow-up study (1985) recognizes the prevalent usage of the Furby definition, but acknowledges the underestimation of the extent of recidivism due to lack of convictions (i.e., attempts, arrests, acquittals, plea bargains) after a sex offense.

Many of the studies dealing with reoffense note the unreliability of convictions and arrest records, indicating a need for a self-reporting system for sexual offenders in order to measure recidivism (Hall & Proctor, 1987; Weinrott & Saylor, 1991; Groth, Longo, & McFadin, 1982). In these studies, sex offenders admitted to committing two to five times as many sex crimes, indicating that arrest records are not the most reliable measure of sexual reoffense. Romero and Williams (1985) found that most researchers agree that long-term follow-up is crucial in sex offender research, given the low rate at which the offenses of sex offenders are detected and prosecuted and the tendency of sex offenders to have crime-free periods.

After reviewing the recidivism literature, several generalizations can be made: first, there is no consistently used definition of recidivism. Second, there is a difference in sex and non-sex reoffense rates based on type of sex offense. Third, until victims start reporting all counts of victimization, a more accurate form of data collection than just arrest and conviction records is needed. And lastly, an appropriate recidivism time period for each type of sex offense is needed. The wide variation in reported time periods for evaluation makes comparison nearly impossible.

This latter point raises the possibility that an alternative to the fixed recidivism window may be needed to capture the complex relationship between treatment and recidivism. A survival analysis of sex offender treatment data would address the question: “Does treatment extend the time between release and reoffense?” (Kalbfleisch, 1980; Lawless, 1982; Miller, 1981).

B. TREATMENT–VOLUNTARY VS. INVOLUNTARY, TREATED VS. UNTREATED

Although it seems likely that involuntary, court-referred sex offenders would be less optimum candidates for treatment than those volunteering for treatment, little documentation has been published on this assumption. Maletzky (1980) addressed the difference in outcome and compliance between self-referred and court-referred patients. This study consisted of 100 male patients divided into four categories: self-referred and court-referred homosexual pedophiles (p. 38), and self-referred and court-referred exhibitionists (p. 62). There was a significant decrease in self-reported behaviors in all four groups, as measured by standard *t*-tests. However, the results showed no significant differences among the groups in covert and overt frequency records. Except for a slight superiority of response in the self-referred versus the court-

referred groups, there were no significant differences in court-referred and self-referred compliance and outcomes.

A more recent “meta-analysis” reported by Alexander in a November, 1993 speech, compared 63 sex offender studies. Based on 17 studies with 1470 subjects, those receiving mandatory treatment had a 10.5 percent recidivism rate, while those voluntarily receiving treatment (based on 29 studies with a total of 2,296 subjects) had a 12.4 percent recidivism rate. Since the rate was slightly lower for mandatory treatment, Alexander suggests that legislating treatment would probably be beneficial (Alexander, 1993, p. 11).

Several studies identified three factors necessary in determining amenability to treatment: 1) Offender must acknowledge he committed the offense and accept responsibility for his behavior; 2) Offender must consider his sexual offending a problem that he wants to stop; and 3) Offender must be willing to enter into and fully participate in the treatment (McGrath, p. 329).

C. TREATMENT-TYPES, LEVELS, EVOLUTION, RELAPSE PREVENTION AND COST/BENEFIT ANALYSIS

1. Types and Levels of Treatment

Society’s treatment of sex offenders has moved from the early desire to cure those afflicted with an insane desire to commit heinous crime to the general goal of management and control of sex offenders (Marques, 1991). The notion that sex offending is a curable illness is on the wane, and methods of slowing the rate of recidivism through behavior modification are on the increase.

There are four types of therapeutic approaches, of which three are acceptable in the United States. The four fields are: psychotherapy; behavioral therapy; biological therapy, including castration and psychosurgery; and medication therapy. All four types of therapies have supporters and detractors, but castration and psychosurgery, as possible biological therapies, are opposed as being invasive and possibly unethical techniques (Berlin & Meinecke, 1981; *Management and Treatment of Sex Offenders*, 1990; Heim & Hirsch, 1979).

Psychotherapy was the original treatment used for sex offenders. Psychotherapy is a process involving introspection by the sex offender to control undesirable behavior. Treatment methods include: individual and group counseling, family therapy, milieu therapy, victim empathy, female identification, accountability, sexual education, reality therapy, psycho-drama, victim confrontation, value clarification and cognitive therapy. Evaluating the results of psychotherapy is complicated and there are no common standards of measurement (Becker & Hunter, 1993). Many have reported disappointing results when psychoanalysis or psychotherapy is the sole treatment, especially in cases of deviant sexual behavior.

Behavior modification treatments apply learning theory in an attempt to extinguish undesirable behavior and replace it with socially approved responses through classical conditioning, operant conditioning and modeling. All of these methods involve changing the offender’s deviant arousal patterns. Methods included in this category are: assertiveness training, aversive conditioning, biofeedback (plethysmography-instrument for measuring penile tumescence), covert sensitization, masturbating satiation, modeling-roleplay, orgasmic

reconditioning, relapse prevention, relaxation/anger management, social skills acquisition, systemic desensitization, thinking error discernment and thought stopping (Sapp & Vaughn, 1991: 59).

Antonowicz and Valliant (1992) maintain that “cognitive-behavioral” treatment models hold the most promise for treatment of sex offenders. Programs have become multi-dimensional and target deviant sexual arousal patterns and cognitive distortions as change agents (p. 222). The promise of these types of programs is that offenders are learning skills to recognize the chain of events and specific risk factors that have led up to their offenses. This method of treatment allows the offenders to interrupt the chain of events in order to avoid reoffense (Marques, 1991).

The organic treatments tend to be the most controversial. These treatments manipulate hormone levels in order to alter the offender’s libido. Research indicates that the level of the male hormone testosterone can affect sexual aggressiveness and that reduction of the hormone can be accomplished by surgery or drug therapy.

Medication therapy includes the use of estrogens administered orally or by implantation to curb the desire to continue sexual deviancy (Murray, 1987). Drug therapy can produce negative side effects, such as weight gain, headaches, insomnia, fatigue, depression. Proper duration for treatment is not known due to lack of long term studies (Murray, 1987).

Some of the programs surveyed by Sapp and Vaughn (1991) used Depo-Provera, while others used androgens (CPA, or Cytoproterone Acetate). The courts have ruled that offenders cannot be forced to use the drug, and it could be considered “cruel and unusual punishment” (p. 22). However, this drug treatment is gaining increased judicial acceptance and may become an important addition to the treatment of certain sex offenders. Depo-Provera poses few legal and ethical issues when given to fully informed individuals on a voluntary basis (Peters, 1993: 327).

So, of the three types of acceptable treatments, medication and behavioral therapy are the most widespread and well-respected. Of these two we may conclude that although each has their respective place in the treatment arsenal, behavioral therapy, especially the relapse prevention programs, currently appears to have a great potential for success.

2. Types of Treatment Pre- and Post-1980

Ideas regarding the treatment of sex offenders have moved from a view of punishment as the only response to an act viewed solely as criminal towards the idea of “curing” offenders of their mental illness through psychotherapy (Marques, 1991). The move towards “curing” mental illnesses of sex offenders tapered off during the late 1970s when results from psychotherapy programs were not showing the promise once hoped. Many suggested that these early types of therapy did not reduce the amount of recidivism (Dix, 1976; Frisbie, 1969 as cited in Marques, 1991).

The success rates of these early programs were measured by asking the treated offenders whether or not they felt like committing any more crimes. Studies of the early treatment plans focused on the immediate outcome and recidivism rates for the long run were virtually ignored or the experimental groups were so

small that generalizations were not possible (Murray, 1987; Romero & Williams, 1983; Berlin & Meinecke 1981).

Sturupp found that the first-time sexual offender is generally not dangerous and seldom relapses (1968, as cited in Romero & Williams, 1985). This view has been discarded by most, if not all, in the field of sex offender therapy. The general consensus now is that the first-time offender can be dangerous and has a relatively high probability of recidivating; therefore treatment should be a minimum requirement of any sentence.

Post-1980s treatment has been overwhelmed with the need to measure and show success rates in changing sexual deviants habits. From this foundation many treatment models begin with the suggestion of follow-up periods of longer than the standard three-to-five years. The protection from relapses succeeds by making the offender aware of the steps which led them to the problem in the first place (Pithers, et al., 1988).

3. Relapse Prevention Techniques and Their Benefit to Society

Relapse Prevention (RP) is a self-control program for the treatment of addictive behaviors. RP is specifically designed to help clients maintain control over their problem behaviors in all situations (Pithers, et al., 1988). The use of RP techniques helps the offender focus on the big picture and not the immediate gratification gained from committing a sexual act. The program also prepares the offender for these relapses by showing them how to avoid problem situations.

RP for sex offenders focuses on the offender staying away from the persons and/or situations which caused them to get into trouble the first time (Marques, et al., 1991; Pithers, et al., 1988). For example, a homosexual pedophile is not supposed to play stick-ball with a group of young boys because that action puts him in a high risk situation.

Pithers, et al. (1988) stress that treatment does not end with formal therapy—maintenance is forever: “The client who has adequately learned the RP philosophy will continue his own therapy everyday for life.” The effectiveness level of RP is not clear because of the problems of measurement after the treatment. The short-term follow-up studies indicate that the treatment works well and should be studied further by following up the patients in the program over a period of more than three years and even beyond the ten years suggested.

4. Cost of Treatment Programs Mentioned in Literature

Prentky and Burgess (1990) outline the costs of treating an offender and the relative risk of reoffense compared to just the cost of incarcerating an offender and their probability of reoffense. Since Prentky and Burgess use 25 percent as the recidivism rate for treated offenders and 40 percent for untreated offenders the cost of one untreated offender multiplies faster because of the number of reoffenses. So, following this logic, the smart money is on treating all of the offenders because the costs of reoffending will add up over time.

D. TREATMENT AND RECIDIVISM AS IT RELATES TO VARIOUS TYPES OF SEXUAL OFFENDERS

The research literature reveals a number of studies which attempt to evaluate different types of offenders in relation to recidivism.

Prentky and Knight (1991) define rapist as “a man who sexually assaults a victim who is 16 years or older” (p. 643). According to Becker and Hunter (1992), pedophiles are “adults who have urges and fantasies involving sexuality with prepubescent children and have either acted on these urges or are distressed by them” (p. 75). Berlin and Meinecke (1981) discuss sexual deviation disorders called *paraphilias* and state they are syndromes which have three common threads: “recurrent sexual fantasies, . . . intense associated cravings, . . . and stereotypical behavioral responses” (p. 601, abstract).

Marshall and Barbaree (1988) as cited in Becker and Hunter (1992) looked at recidivism rates of treated and untreated pedophile offenders. The offenders were categorized based on incestual relations, non-familial female children and non-familial male children. Overall, 13.2 percent of treated and 34.5 percent of non-treated recidivated, although what constituted recidivism is not defined (Becker & Hunter, 1992: 87).

Becker and Hunter (1992) cited a study by Lang, Pugh and Langevin (1988) which reported on the response of incest offenders and heterosexual pedophiles to “group therapy” which included a wide variety of techniques. Recidivism information was obtained from several different agencies; however, the exact measures used are unclear. The results were 18 percent of pedophiles and 7 percent of incest offenders reoffended (1992: 83).

The current trend seems to be that in order for programs to be successful they will have to meet the specific needs of the offenders. No longer will grouping all offender types into one form of treatment be an acceptable way of treating sexual offenders. Prentky and Knight (1991) say that recidivism rates are so high because rapists have not been properly assessed. They believe treatments are ineffective because rapists are treated as a homogenic group when they are not. Rapists should be assessed to determine which typology they fit so that a more effective treatment can be administered.

Marshall, et al. (in press) discussed a cognitive behavioral program in Canada which based recidivism on official records. Inmates near the end of their sentence volunteered for the program. Results showed recidivism rates of eleven percent for treated and 35 percent for untreated inmates. The program appeared to have better results with pedophiles than rapists. A cognitive behavioral outpatient program had the same results in that it was found to be most effective with child molesters and exhibitionists. Self-help humanistic group treatment worked well with incest offenders. Less than one percent recidivism (undefined) was reported in the follow-up period (which is not specified).

Kilmann, et al. (1982) reviewed the literature on sex offenders. The authors discussed studies ranging from 1966-1978 of exhibitionists who were treated with behavioral or cognitive therapies. All studies reported success. The behavioral techniques produced results faster than traditional psychotherapy.

In looking at pedophiliacs, Kilmann reported on 11 studies. Nine were case studies, one was experimental without a control group and one was a double-blind study. Most of the studies used multiple

forms of treatment. All reported success to some degree but not with all subjects and not by all measures. Behavioral types of treatment appear to be the most effective with this type of offender.

Based on the literature reviewed here, the general consensus seems to be that there are many different types of treatments and many differences in the needs of offenders. Treatments need to be matched to the type of offender in order for the treatments to be effective.

E. OTHER FACTORS POSSIBLE INVOLVED IN REOFFENSE POTENTIAL

Popular belief suggests that family ties and/or social bonds mitigate against criminal behavior. Rowe, Lindquist, and White (1989), in a survey of 1,993 adult males and females, found that people are more concerned about losing their family's respect than about being arrested or even imprisoned.

The Gluecks (1937: 205-206) theorized that a successful marriage sometimes brings a criminal career to an end. A number of articles have indicated that strong family relationships are beneficial for prisoners (see Holt & Miller, 1972; Brodsky, 1978; Peck & Edwards, 1977; Nash, 1981; Swan, 1981).

CONCLUSION

Although not providing definitive answers, the literature review presents DOC policymakers with the wide range of issues it must face in evaluating its sex offender treatment effort. A literature review should guide the evaluator and suggest definitions and procedures which are appropriate to the unique features which characterize individual programs. Several general conclusions are clear, however.

First, the concept of recidivism is extremely complex, varying not only by definition of the reoffense event but also tied to the time period of the follow-up, the type of offender, and the type and length of program employed. Every program discussed here has had failures, and it is unrealistic to look for total success from any program. However, the definition of "does it work?" is tied to this ratio of success and failure.

Second, it appears that involuntarily treated inmates experience some benefit from treatment and that benefit has the potential of rivaling that of the volunteer group. However, one may need to vary the standard treatment to achieve this rival benefit.

Lastly, the issue of cost must include a discussion of the costs of not treating, and those costs may well extend into the larger, post-release society of the offender. New ways of understanding this relationship to costs, i.e., survival analysis, may be needed and explored. Whatever the final decision concerning the definitions employed, good research—good evaluation—should be a necessary precursor to good public policy.

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IV. Methodology

In early 1993, the Department of Corrections prepared a draft data collection instrument and hired an outside contractor to construct a database using PARADOX software. At the same time, a person was hired to compile sex offender information from inmate files at Hiland Mountain Correctional Center. The information gathered was then entered into the PARADOX database for analysis. Later, the Justice Center converted the data to a readable format for the Statistical Package for the Social Sciences (SPSS).

An initial review of the existing data revealed that cleaning would be necessary to correct some obvious data entry errors. It also showed that large amounts of information were missing. Obvious data entry errors were corrected based on the original information sheets and missing information was obtained by rechecking the files at Hiland Mountain Correctional Center and entered into the database.

The data were analyzed through SPSS, and preliminary findings were given to the Department of Corrections. The raw data sheets contained about fifty variables on each of the 284 inmates who have received some official sex offender treatment. Further analyses created even more variables, e.g., actual time served. The Justice Center worked with the Department of Corrections in determining which variables would be of greatest value in our preliminary description.

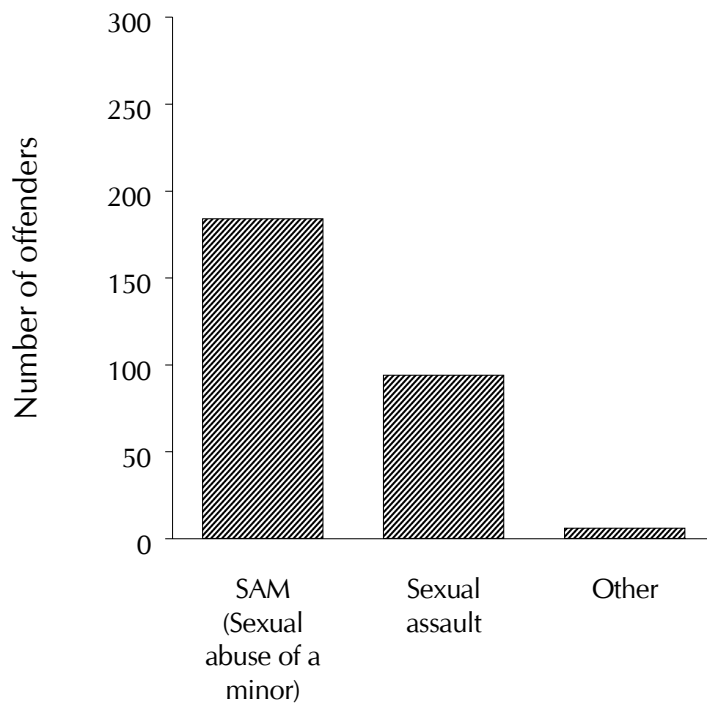
It should be noted that the information on reoffenses by offenders who had contact with the HMCC SOTP is limited in that the only outcome variable available at the time this descriptive information was processed was an OBSCIS-based determination of the number of times the individual was returned to a correctional facility in Alaska. Future data collection efforts will include a more comprehensive rearrest check. All data figures and tables reflect the characteristics of sex offenders who had contact with the Hiland Mountain SOTP and do not purport to define the characteristics of all sex offenders in the Department's custody.

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V. Results

A. DESCRIPTIVE INFORMATION

Figure 1. Offense Category



Of the 284 inmates in the treatment program, the majority (64.8%) were convicted under the sexual abuse of minor statutes (SAM).

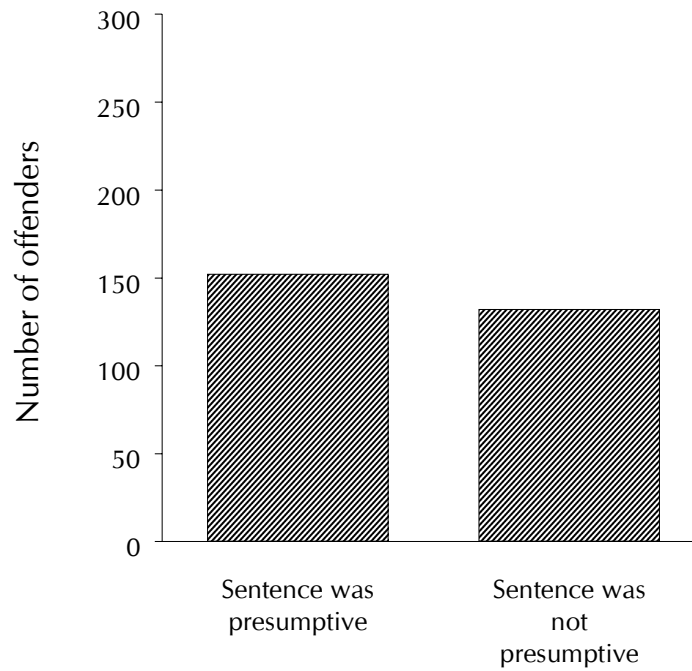
Table 1a. Offense Category

	N	%
SAM (Sexual abuse of a minor)	184	64.8%
Sexual assault	94	33.1
Other	6	2.1
Total	284	

Table 1b. OBSCIS Offense Code

Offense	Code	N	%
Offense against the person (old)	15.120	2	0.7%
Offense against the person (old)	15.160	1	0.4
Assault 4	41.230	1	0.4
Kidnapping	41.300	1	0.4
Sexual assault (SA) 1st	41.410	56	19.7
Sexual assault (SA) 2nd	41.420	18	6.3
Sexual abuse of a minor (SAM) 1	41.434	63	22.2
Sexual abuse of a minor (SAM) 2	41.436	76	26.8
Sexual abuse of a minor (SAM) 3	41.438	5	1.8
Sexual abuse of a minor (SAM) 4	41.440	9	3.2
Incest	41.450	2	0.7
Exploitation of a minor	41.455	2	0.7
Coercion	41.530	1	0.4
Attempted sexual assault (SA) 1st	A41.410	19	6.7
Attempted sexual assault (SA) 2nd	A41.420	1	0.4
Attempted sexual abuse of a minor (SAM) 1	A41.434	20	7.0
Attempted sexual abuse of a minor (SAM) 2	A41.436	6	2.1
Attempted sexual abuse of a minor (SAM) 3	A41.438	1	0.4
Total		284	

Figure 2. Presumptive Sentencing



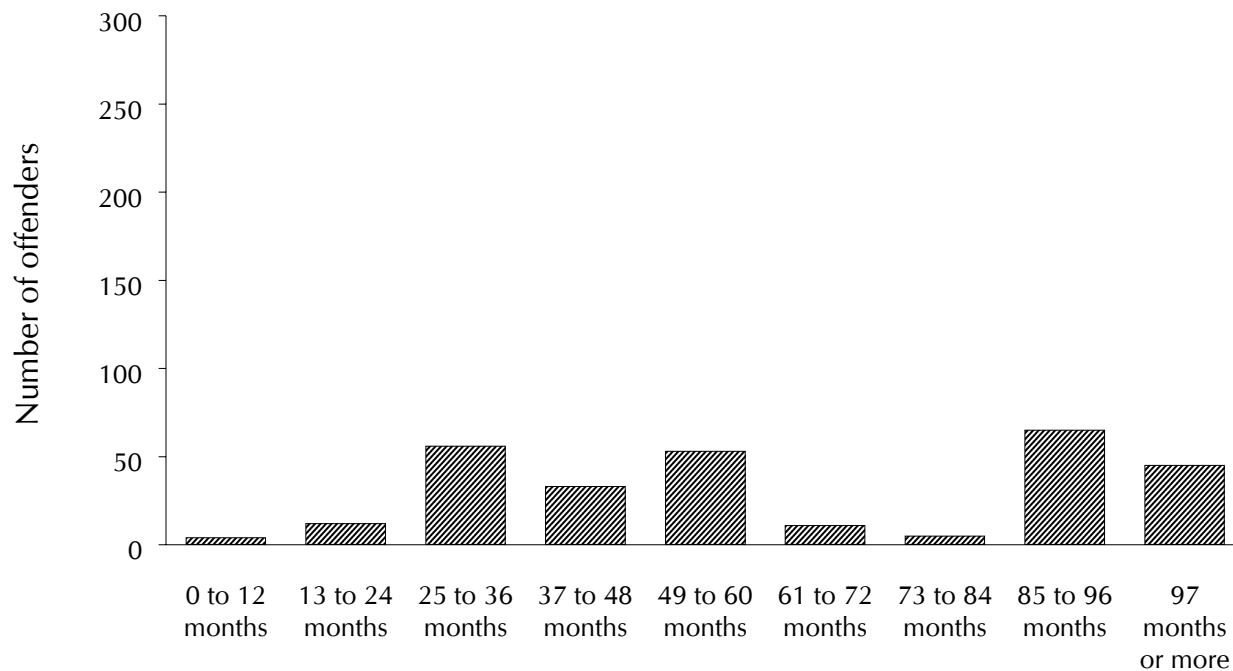
Approximately half (53.5%) of the inmates associated with the program were serving a presumptive sentence.

Table 2. Presumptive Sentencing

	N	%
Sentence was presumptive	152	53.5%
Sentence was not presumptive	132	46.5
Total	284	

Figure 3. Length of Sentence

12 month intervals



Approximately 95 percent of the inmates in this program are serving sentences of more than two years. Approximately 38 percent are serving sentences of more than seven years.

Table 3a. Length of Sentence

12 month intervals

	N	%
0 to 12 months	4	1.4%
13 to 24 months	12	4.2
25 to 36 months	56	19.7
37 to 48 months	33	11.6
49 to 60 months	53	18.7
61 to 72 months	11	3.9
73 to 84 months	5	1.8
85 to 96 months	65	22.9
97 months or more	45	15.8
Total	284	

Standard deviation = 42.0

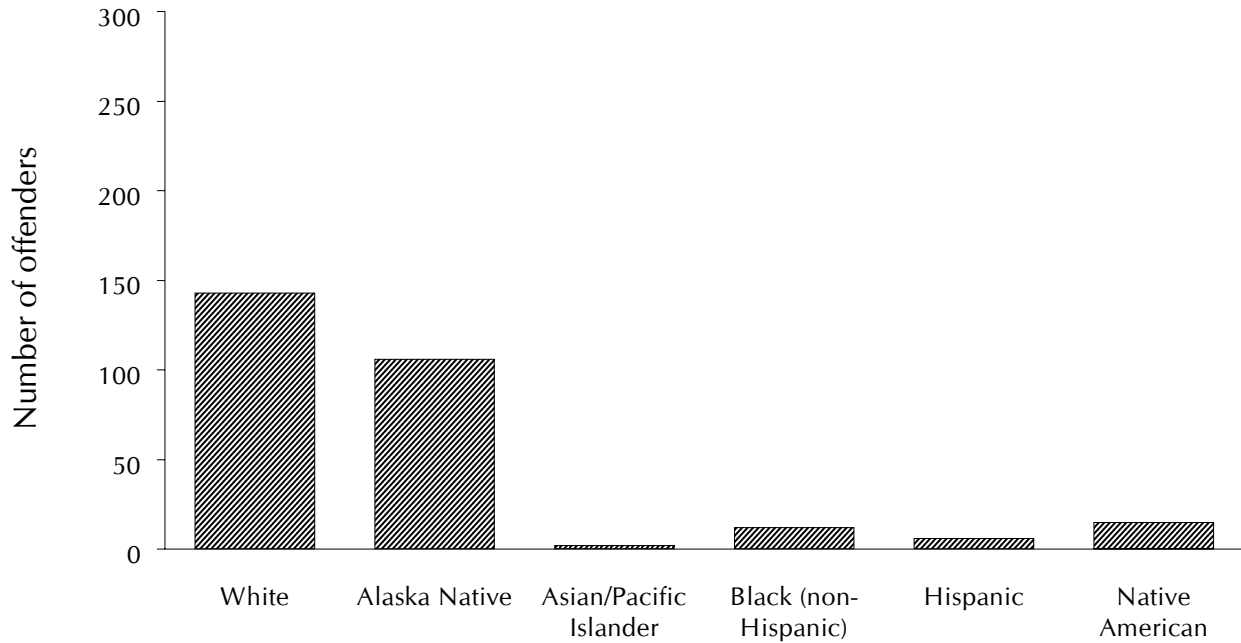
Mean = 72.9 months

Table 3b. Length of Sentence*Actual sentence length*

	N	%
6 months	1	0.4%
10 months	1	0.4
12 months	2	0.7
18 months	4	1.4
20 months	1	0.4
22 months	1	0.4
24 months	6	2.1
26 months	1	0.4
27 months	1	0.4
30 months	14	4.9
34 months	1	0.4
36 months	39	13.7
42 months	4	1.4
48 months	29	10.2
51 months	1	0.4
54 months	3	1.1
55 months	1	0.4
60 months	48	16.9
66 months	1	0.4
72 months	10	3.5
74 months	1	0.4
75 months	1	0.4
78 months	1	0.4
84 months	2	0.7
96 months	65	22.9
97 months	2	0.7
98 months	1	0.4
99 months	1	0.4
108 months	4	1.4
114 months	1	0.4
120 months	16	5.6
126 months	1	0.4
132 months	3	1.1
144 months	3	1.1
156 months	1	0.4
171 months	1	0.4
180 months	8	2.8
186 months	1	0.4
228 months	1	0.4
360 months	1	0.4
Total	284	

*Standard deviation = 42.0**Mean = 72.9 months*

Figure 4. Race



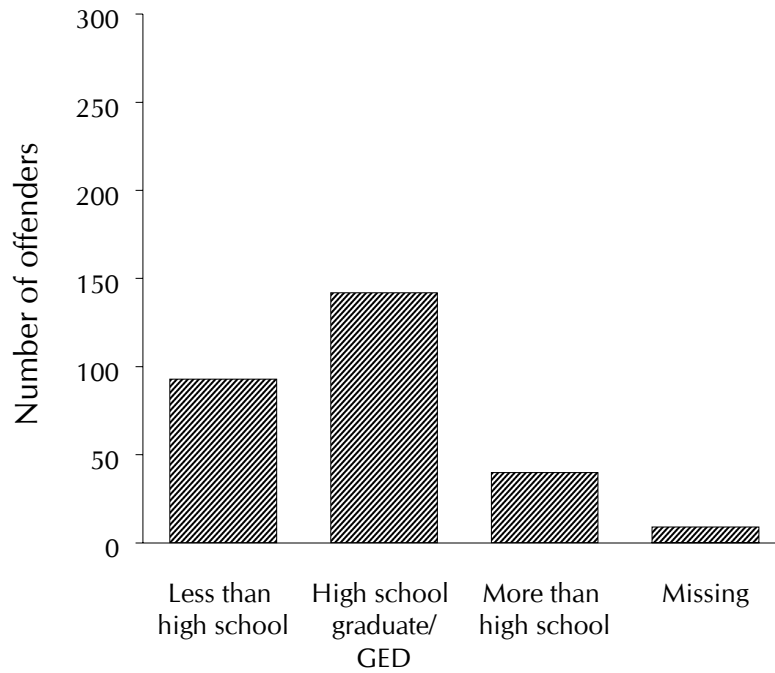
Approximately one-half of the inmates who came into contact with the program were white. The next highest racial group (37.3%) were Alaska Natives (this grouping includes individuals of Eskimo, Aleut, Tlingit, Athabascan, and Haida backgrounds).

Table 4. Race

	N	%
White	143	50.4%
Alaska Native	106	37.3%
Eskimo (unspecified)	56	19.7
Yup'ik Eskimo	21	7.4
Aleut	14	4.9
Tlingit	11	3.9
Athabascan	3	1.1
Haida	1	0.4
Asian/Pacific Islander	2	0.7%
Black (non-Hispanic)	12	4.2%
Hispanic	6	2.1%
Native American	15	5.3%
Total	284	

Figure 5. Education

Highest grade completed.



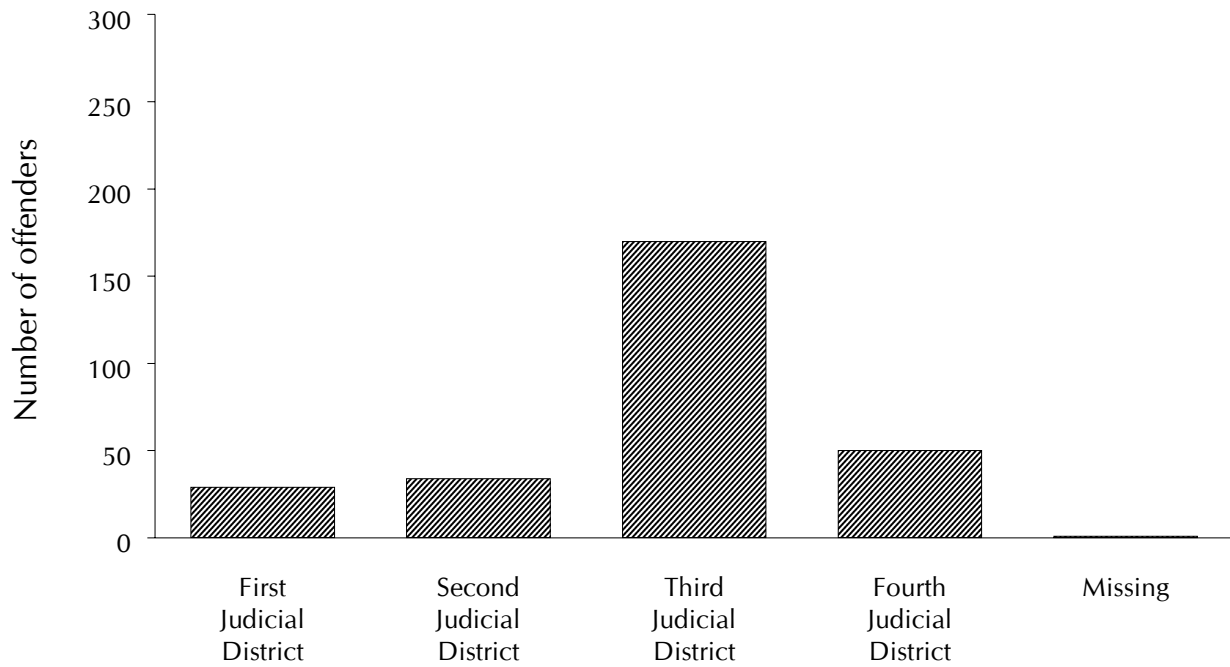
Two-thirds (67.4%) of the sex offenders who had contact with the program had an educational level of high school diploma/GED equivalency or higher.

Table 5. Education

Highest grade completed.

	N	%
Less than high school	93	32.7%
2 years	1	0.4
3 years	1	0.4
5 years	4	1.4
6 years	3	1.1
7 years	3	1.1
8 years	16	5.6
9 years	12	4.2
10 years	26	9.2
11 years	27	9.5
High school graduate/GED	142	50.0%
More than high school	40	14.1%
1 year of college	13	4.6
2 years of college	13	4.6
3 years of college	3	1.1
4 years of college (college graduate)	7	2.5
Graduate degree (M.A. or M.S.)	4	1.4
Missing	9	3.2%
Total	284	

Figure 6. Location of Court of Conviction

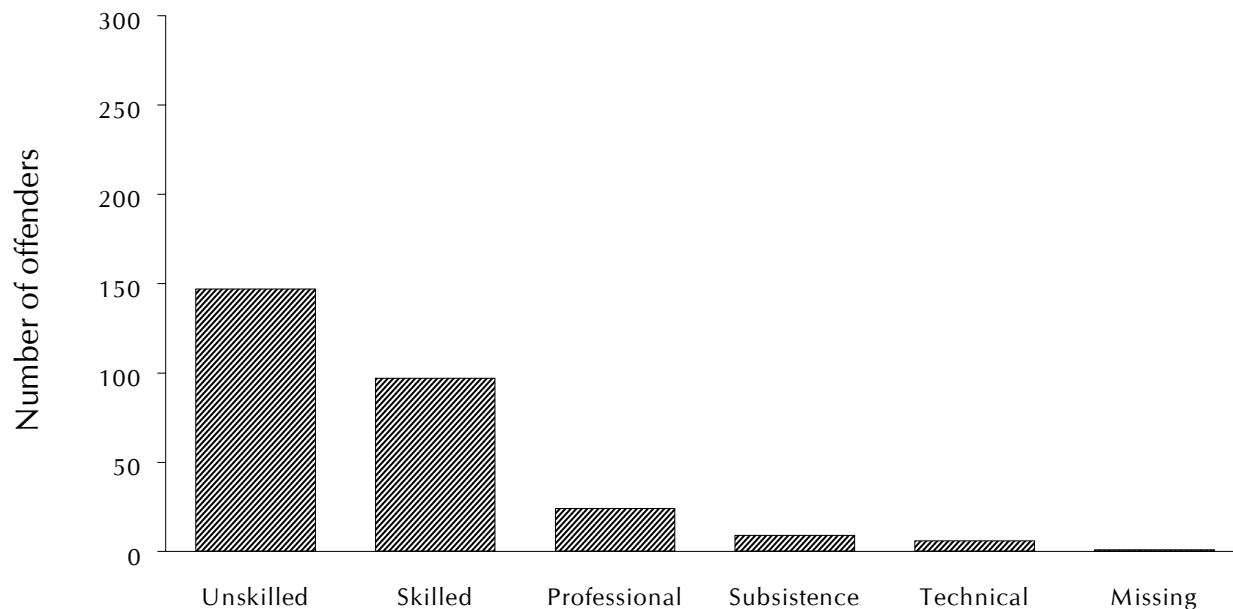


The highest number of participants in the Hiland Mountain Sex Offenders Treatment Program were tried in the Third Judicial District (59.9%).

Table 6. Location of Court of Conviction

	N	%
First Judicial District	29	10.2%
Second Judicial District	34	12.0
Third Judicial District	170	59.9
Fourth Judicial District	50	17.6
Missing	1	0.4
Total	284	

Figure 7. Occupation

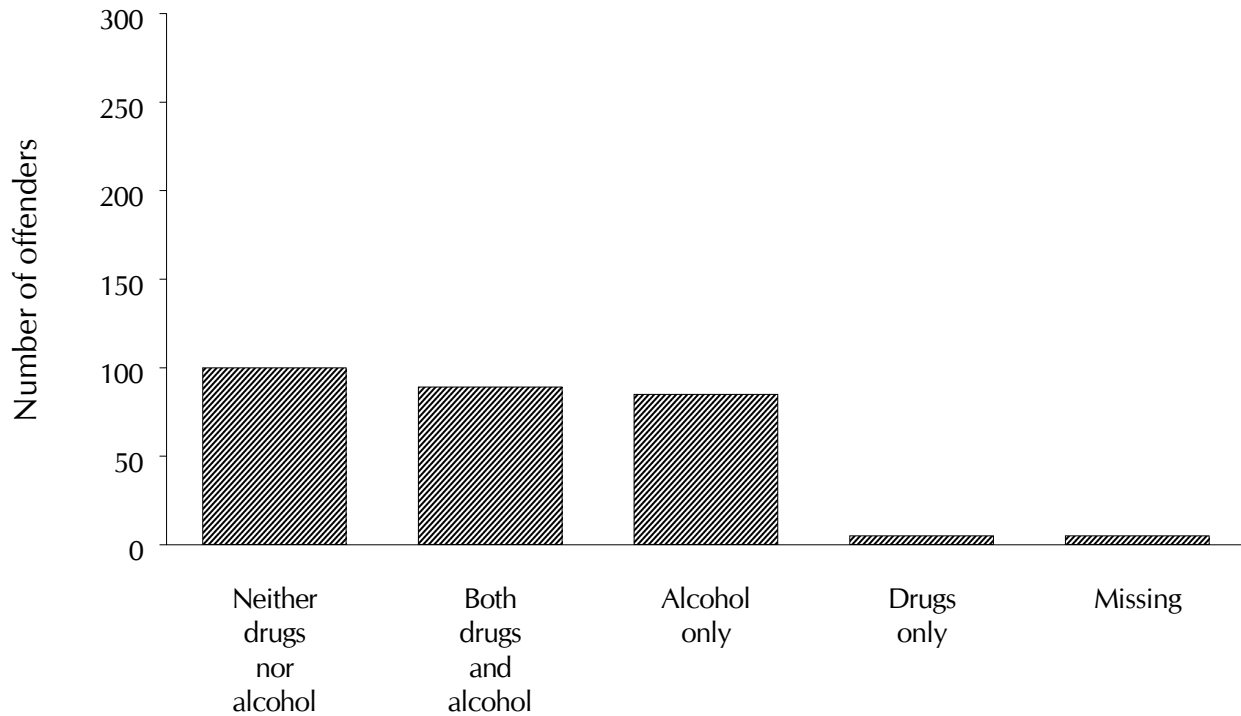


The greatest number of sexual offenders (51.8%) in the program were classified as unskilled labor.

Table 7. Occupation

	N	%
Unskilled	147	51.8%
Skilled	97	34.2
Professional	24	8.5
Subsistence	9	3.2
Technical	6	2.1
Missing	1	0.4
Total	284	

Figure 8. Substance Abuse History

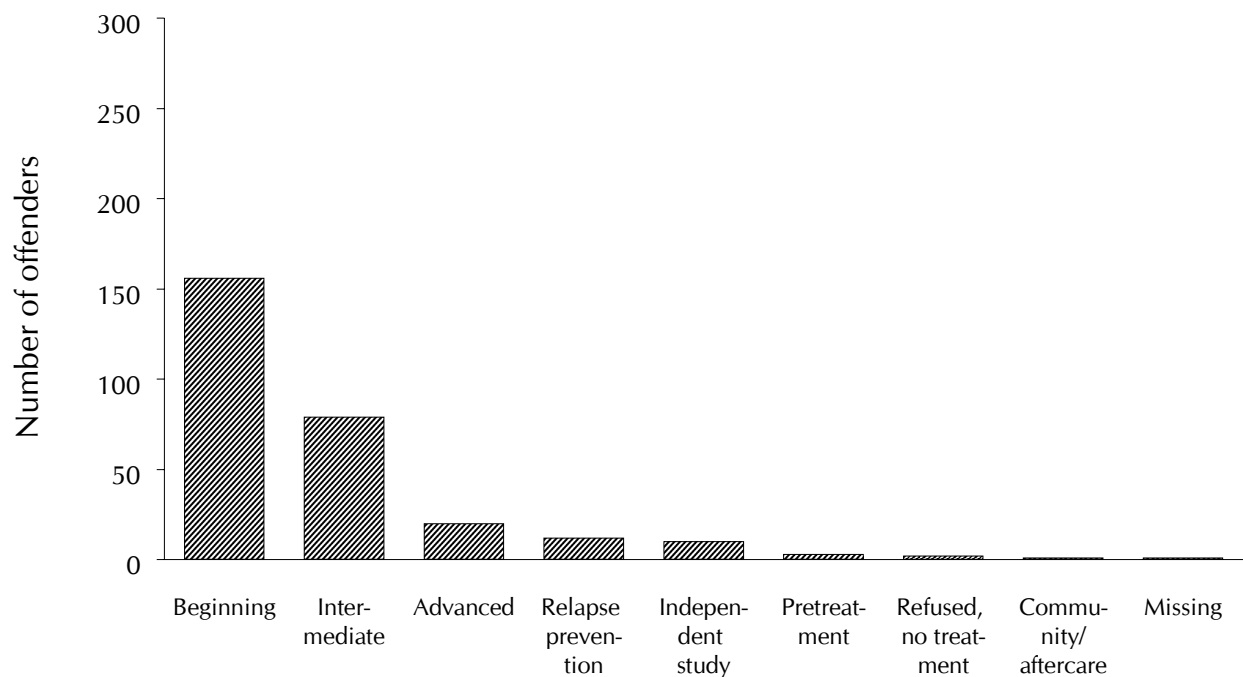


The majority of inmates in the program indicated a history of alcohol or drug abuse or both (63.0%). However, approximately one-third of the inmates (35.2%) reported no history of either drug or alcohol abuse.

Table 8. Substance Abuse History

	N	%
Neither drugs nor alcohol	100	35.2
Both drugs and alcohol	89	31.3
Alcohol only	85	29.9%
Drugs only	5	1.8
Missing	5	1.8
Total	95	

Figure 9. Stage at Discharge

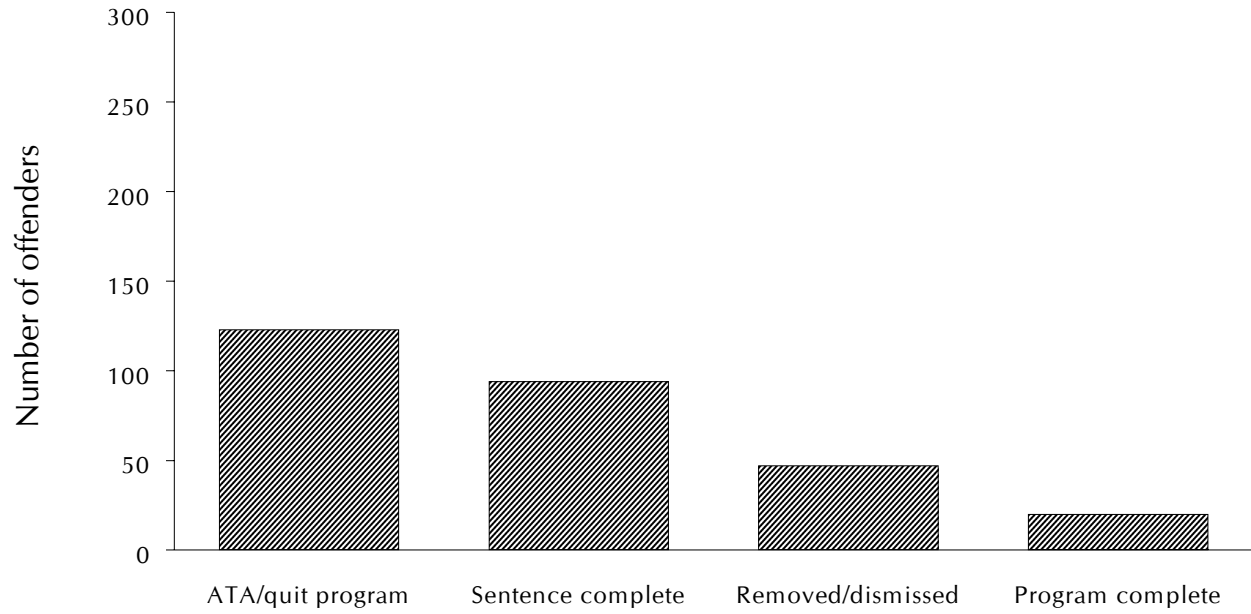


The greatest number of inmates were discharged from the program (54.9%) either during or just after completion of the beginning stage.

Table 9. Stage at Discharge

	N	%
Beginning	156	54.9%
Intermediate	79	27.8
Advanced	20	7.0
Relapse prevention	12	4.2
Independent study	10	3.5
Pretreatment	3	1.1
Refused, no treatment	2	0.7
Community/aftercare	1	0.4
Missing	1	0.4
Total	284	

Figure 10. Reason for Discharge

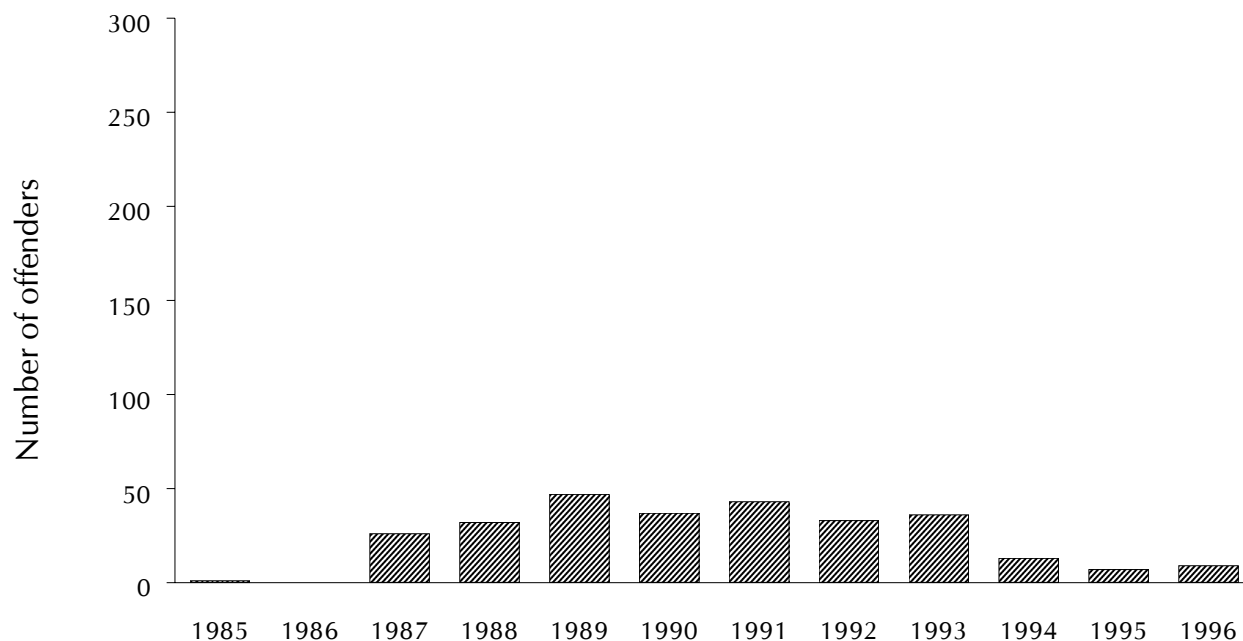


Only 7.0 percent of the inmates who started actually completed the program. About one-third of the inmates left the program because they had completed their sentence.

Table 10. Reason for Discharge

	N	%
ATA/quit program	123	43.3%
Sentence complete	94	33.1
Removed/dissmissed	47	16.5
Program complete	20	7.0
Total	284	

Figure 11. Projected Year of Release



Information about reoffenses described in the next section was collected in early 1994. Thus, only slightly more than one-third of the inmates in the current database had five years in the community. Almost one-quarter had not been released at the time the recidivism information was collected. It will still be several years before even a five-year recidivism “window” is met.

Table 11. Projected Year of Release

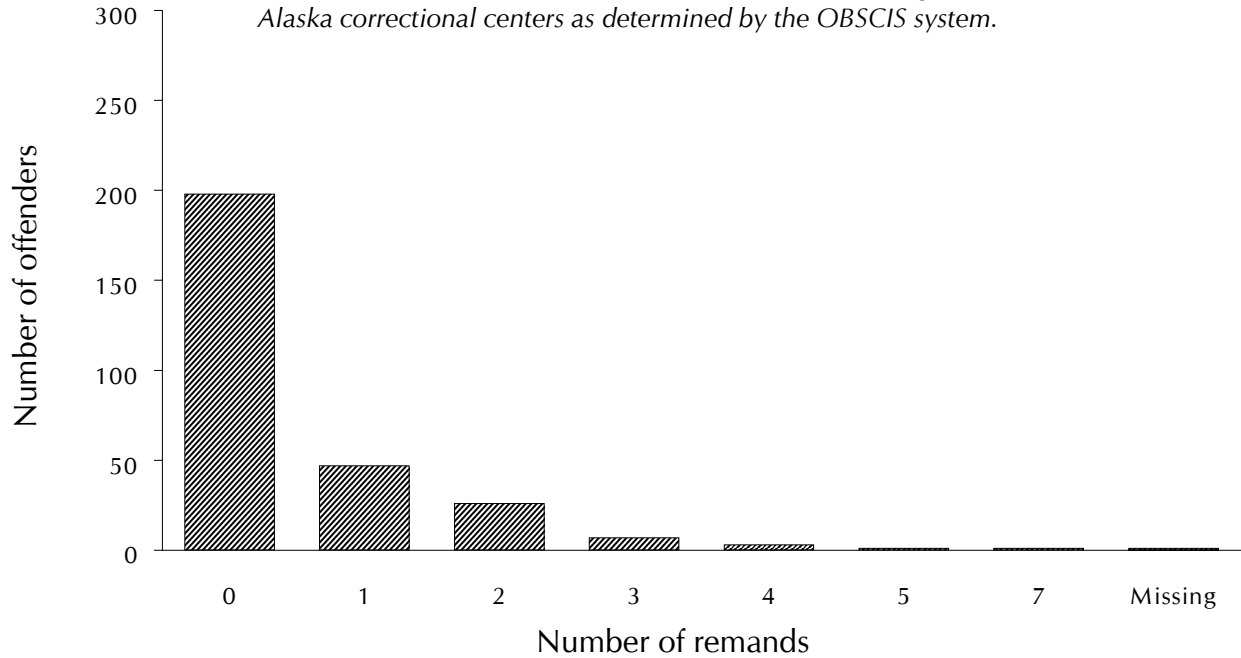
	N	%
1985	1	0.4%
1986	0	0.0
1987	26	9.2
1988	32	11.3
1989	47	16.5
1990	37	13.0
1991	43	15.1
1992	33	11.6
1993	36	12.7
1994	13	4.6
1995	7	2.5
1996	9	3.2
Total	284	

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B. REOFFENSE INFORMATION

Figure 12. Remands to Prison for Parole or Probation Violations

Remand information is limited to the number of rebookings into Alaska correctional centers as determined by the OBSCIS system.



Seventy percent of the inmates who participated in the program had not been remanded to an Alaska correctional facility for a parole or probation violation subsequent to their release from the program.

Table 12. Remands to Prison for Parole or Probation Violations

Remand information is limited to the number of rebookings into Alaska correctional centers as determined by the OBSCIS system.

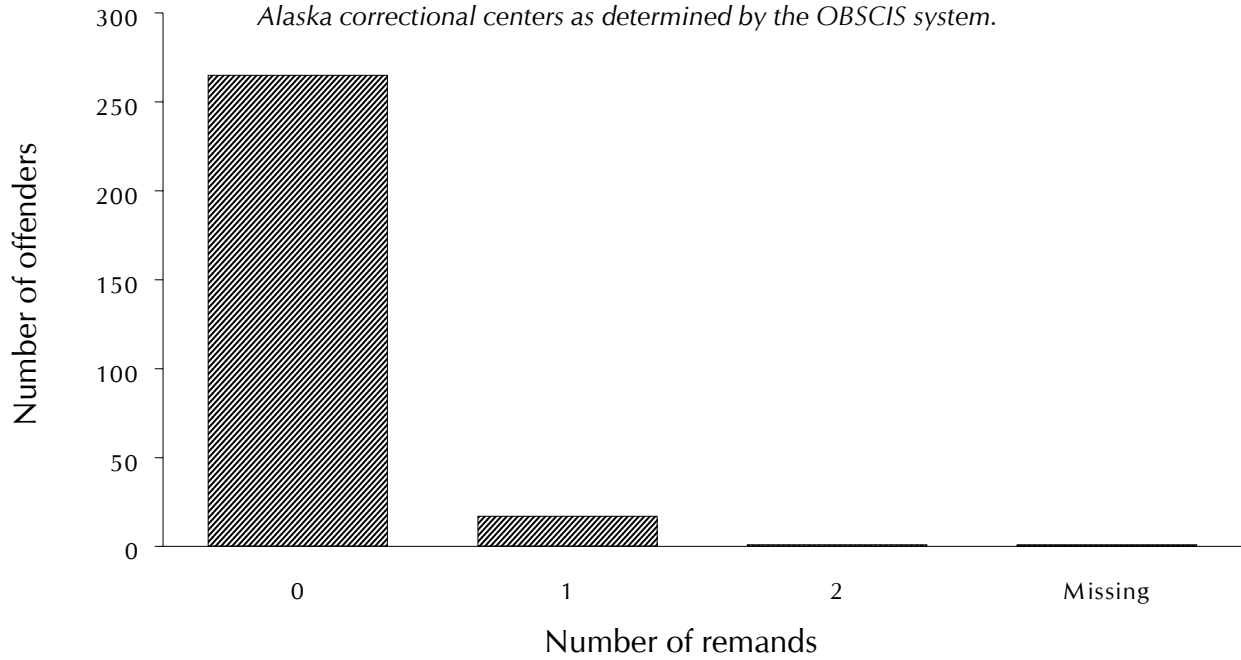
	N	%
0 times	198	69.7%
1 time	47	16.5
2 times	26	9.2
3 times	7	2.5
4 times	3	1.1
5 times	1	0.4
7 times	1	0.4
Missing	1	0.4
Total	284	

Standard deviation = .97

Mean = .50

Figure 13. Remands to Prison for New Sex Offenses

Remand information is limited to the number of rebookings into Alaska correctional centers as determined by the OBSCIS system.



Only a small percentage of inmates who had contact with the treatment program (6.4%) were remanded to prison for a new sexual offense subsequent to their release.

Table 13. Remands to Prison for New Sex Offenses

Remand information is limited to the number of rebookings into Alaska correctional centers as determined by the OBSCIS system.

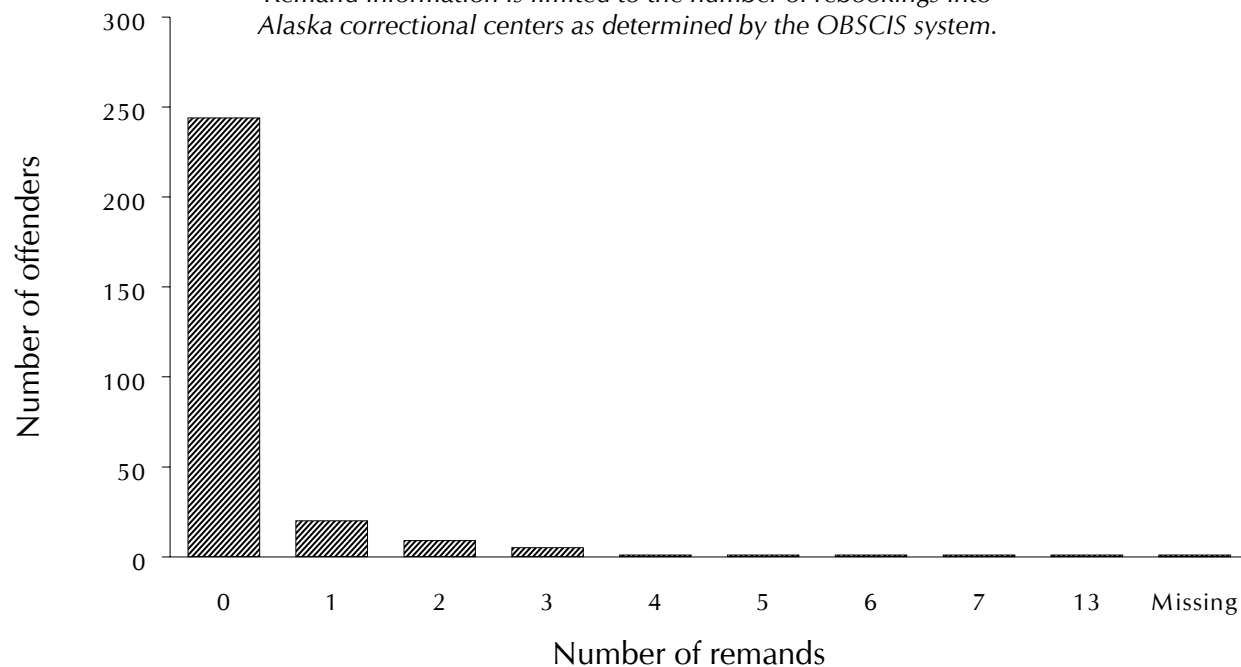
	N	%
0 times	265	93.3%
1 time	17	6.0
2 times	1	0.4
Missing	1	0.4
Total	284	

Standard deviation = .26

Mean = .70

Figure 14. Remands to Prison for Non-Sexual Offenses

Remand information is limited to the number of rebookings into Alaska correctional centers as determined by the OBSCIS system.



Approximately 86 percent of inmates who had contact with this program had not been remanded for a new non-sexual offense subsequent to their release.

Table 14. Remands to Prison for Non-Sexual Offenses

Remand information is limited to the number of rebookings into Alaska correctional centers as determined by the OBSCIS system.

	N	%
0 times	244	85.9%
1 time	20	7.0
2 times	9	3.2
3 times	5	1.8
4 times	1	0.4
5 times	1	0.4
6 times	1	0.4
7 times	1	0.4
13 times	1	0.4
Missing	1	0.4
Total	284	

Standard deviation = .11
Mean = .31

VI. Conclusion and Recommendations

It is far too early to make definitive conclusions about the efficacy of the DOC sex offender treatment effort. However, our preliminary look at the early participants has provided some very interesting observations. First, a large percentage of the program participants were convicted of sexual abuse of a minor, twice the percentage of those convicted of sexual assault. If this group of child molesters is indeed more difficult to treat and follow-up, then DOC is facing a significant challenge in its efforts to understand what works “best” with this group of offenders.

The DOC population contains a rather unique mix of a large percentage of various Alaska Natives and large numbers of offenders with fixed presumptive sentences. The literature provides very little clear direction concerning minority sex offenders, and this is further confounded by the varying treatment windows provided by the wide range and types of sentences. DOC is breaking new ground in this area.

Lastly, it is encouraging to see so little additional criminal behavior in these individuals and particularly for those who have successfully completed the program. On the other hand, the small number of individuals who have completed all stages and the large percentage who drop out in the beginning are disappointing and these issues need to be examined closely.

Several recommendations follow from these initial observations and our work with the information from the database:

- There should be a five-year minimum follow-up period for all participants. Ideally, there would be no time limit.
- The recidivism “event” should be routinely determined by arrest checks. This is relatively inexpensive, providing at least official information.
- The offender population contains a unique mix of cultures, educational and occupational levels, sentence types, substance abuse histories, and offenses. The evaluation of the treatment effort needs to accommodate this diversity through a comprehensive database.
- The DOC should consider improvements to OBSCIS such that it can provide more treatment-relevant information that is complete, accurate, and up-to-date.

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