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A Historical Comparison of Treatment Between Male and Female Sex Offenders in the Correctional System

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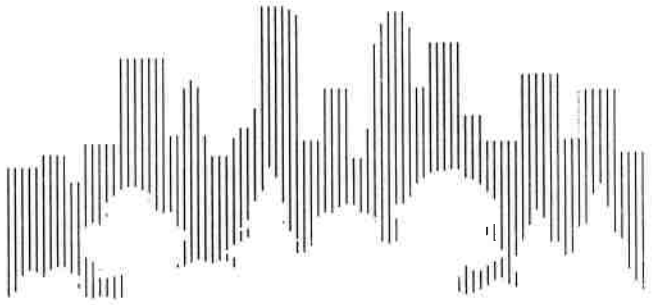

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MASTERS IN SOCIAL WORK THESIS

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A Historical Comparison of Treatment Between Male and Female Sex Offenders in the Correctional System

2000

A HISTORICAL COMPARISON OF TREATMENT BETWEEN MALE AND FEMALE SEX OFFENDERS IN THE CORRECTIONAL SYSTEM

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DEDICATION

I dedicate this thesis to my grandfather, the late Eugene C. Butler, Sr., who instilled in me the value and importance of an education; my mother, the late Matilda Susan, and grandmother, the late Mary Ellen, women of color who demonstrated to me their strength and courage; and to my dad, William, who has always believed in me.

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My daughters and son-in-law, who believed in me and, without their support, this degree would have been almost impossible.

KARRIÉ, SHANTORIE, BRANDY, MARION, CHERENA

My grandchildren that had to take a back seat to the long hours that I spent studying.

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My aunt who listened to all my frustrations and complaints. She kept telling me that no matter what, "I would make it."

FAMILY MEMBERS

To the rest of my family that encouraged and provided me with inspiration and hope.

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My thesis advisor who offered guidance and encouragement and also challenged me to do my best work.

TONY BIBUS, SUZANNE TUTTLE

My thesis readers. Thanks for all your time.

Finally, to: Noel, Sharon, Nancy, Sharon R., Sandi, Leslie and Kristine . . . MY CONSCIENCE.

THE NIGHT HAS BEEN LONG,

THE PIT HAS BEEN DEEP,

THE NIGHT HAS BEEN DARK,

AND THE WALLS HAVE BEEN STEEP.

THE HELLS WE HAVE LIVED THROUGH

AND LIVE THROUGH STILL,

HAVE SHARPENED OUR SENSES AND

TOUGHENED OUR WILL.

THE ANCESTORS REMIND US, DESPITE

THE HISTORY OF PAIN,

WE ARE A GOING-ON PEOPLE WHO

WILL RISE AGAIN.

AND STILL WE RISE!!

MAYA ANGELOU

ABSTRACT OF THESIS

COMPARISON OF TREATMENT BETWEEN MALE AND FEMALE SEX OFFENDERS IN THE CORRECTIONAL SYSTEM

The purpose of the historical research study is to explore the correctional system's rehabilitation and treatment perspective for both male and female sex offenders. Treatment has been deemed essential for all offenders; while it might not mean a cure, it does give offenders some tools that could prevent further offenses.

Literature emphasizes the importance of treatment and rehabilitation for the sex offender. Historically, the female offender has been ignored in the area of treatment and rehabilitation. Sexual offenses are generally perceived as a male phenomenon.

This study will give an in-depth view of treatment process and the research on the effectiveness of current programs offered in the correctional facility. It will also analyze differences, offer conclusions, and make recommendations.

WEIDA Y. ALLEN

MAY 2000

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CHAPTER I – INTRODUCTION

Treatment for male sex offenders in the correctional system has a long history. However, in the literature it is revealed that historically the female offender has been ignored, forgotten, and merely footnoted when it comes to treatment and rehabilitation in the correctional facilities (Ruth Zaplin, 1994). Literature also emphasizes the importance of treatment and rehabilitation for the sex offender. Although treatment might not mean a cure, it does give the offenders some tools that could prevent further offenses.

This thesis is a historical study of sex offenders' treatment for the period from 1948 to the present. However, the main focus of this historical study will focus on the treatment period of 1980 to the present. This historical research will also examine the different approaches of treatment for the sex offenders and whether or not correctional facilities are committed to rehabilitation and treatment equality of men and women.

Female offenders have been steadily increasing in our correctional facilities (Whitcomb, 1992) Whitcomb states that the increase from 1980 to 1990 has been 25%. This also means that the correctional population of the female sex offenders has increased. Because crime, including sexual offenses, is generally perceived as a male phenomenon, rehabilitation may also be perceived from that perspective. However, the rapid increase from 1980 to 1990 of the number of women inmates is provoking interest in and concern for this historically invisible segment of the prison population.

According to Figueria and McDonald (1981), demographics data show that the contemporary female offender is desperately in need of treatment intervention. Correctional facilities have a relatively short period of time in which to attempt the

rehabilitation of the female offender. A study of women in prison from 1968 to 1978 showed that most female prisoners spent less than two years in prison for their convictions (Figueria/McDonough, 1981). One theme in this thesis is what can be done in a typical sentencing (two-year) period to reverse the effects of a history of offending.

Society's tendency to protect females contributes to the failure of courts and agencies to identify, assess, and treat the female sex offender. Because of the patriarchal structure of our society, which perpetuates the roles of males as aggressive and dominant and views females as passive and submissive, identification of female sex offenders is further inhibited (Scaro, 1989). This thesis addresses two questions: **1) are the United States correctional facilities committed to rehabilitation and treatment equally of men and women? And, 2) what evaluation is used to assess the offenders' readiness to live back in the community?**

Since less than 15% of sex crimes actually lead to incarceration, the majority of sex offenders remain within the community (Abel & Rouleau, 1990). Thus, outpatient treatment settings tend to be more representative of the general population of sex offenders even though client selection procedures and low apprehension rates significantly skew towards any population of sex offenders receiving treatment (Abel & Rouleau, 1990). Of the 15% that are incarcerated, what type of treatment, if any, is offered and who are the recipients of that treatment, male and female?

SUMMARY:

This chapter has given an overview of the historical plight of the female sex offender and the rapid increase in the number of inmates in our prison population. This chapter also contains a discussion of how crime, including sexual offenses, is generally

perceived as a male phenomenon, and that treatment and rehabilitation may also be perceived from that perspective. This issue will be revisited in the review of the Literature (Chapter 3).

In Chapter 2 this writer will examine the methodology and the correctional facilities and their ability to make available treatment for male and female sex offenders. The contents of Chapter 3 will include the research questions, the definition of historical research, the research design, the subjects and procedures, the data analysis, and the strengths and limitation of historical research. In the final Chapter 4 this writer will identify findings and offer conclusions with special reference to implications for social work.

CHAPTER II - METHODOLOGY

INTRODUCTION:

The conceptual framework for this thesis incorporates the historical review and the role of the correctional facility and its ability to make available treatment for male and female sex offenders on an equal basis. Historical research will be defined and described for the benefit of the readers, and will give them a better understanding of the model of this study.

This chapter includes the following sections:

- Research questions
- Definition of historical research
- Research design
- Subjects
- Procedure
- Data analysis
- Strengths and limitations of historical research

THESIS RESEARCH QUESTIONS:

Study Research Questions:

- Are treatment and rehabilitation offered equally to male and female sex offenders?
- Are treatment and rehabilitation offered in the correctional facilities for sex offenders?

- What type of treatment is offered to the sex offender?
- What evaluation is used to assess the offenders' readiness to live back in the community?
- When do assessment, treatment, rehabilitation, and evaluation occur?

HISTORICAL RESEARCH DEFINED:

Historical research addresses the meaning of events by attempting to reconstruct the past, often in relation to a hypothesis (Leedy, 1993). Historical research is a methodology pertaining to past events and is used as a means for establishing facts and arriving at judgments based on past events (Shafer, 1959).

Historical research looks at current and past events and seeks to unravel the changes of human life with hopes of adding rationality and meaning to the whole. It is not just the accumulation of facts, but also the interpretation of the facts (Leedy, 1993). Leedy (1993) describes historical research as a study of cause and effect that makes facts in history meaningful.

DESIGN:

The research design selected uses written records and accounts of studies of past happenings and events. The design will look for events and patterns of action and will seek a logical explanation for them using primary and secondary data.

Primary data is the original source, such as reviewing key documents such as sentencing guidelines and the rate of recidivism, and legislative documents. Secondary data includes, but may not be limited to, research studies, books and professional journals and articles. History will be reconstructed in such a manner using primary and secondary data to reflect the established trends and patterns in correctional systems' treatment

programs.

SUBJECTS:

Using primary and secondary data, the study will look at treatment modes in the correction system, with the age range of 16–70 plus. The study will use the historical research method in order to study the research questions posed and will not be using subjects.

PROCEDURE:

Primary data collection sources for the research include Office of the Legislative Division, State of Minnesota, and Methods and Models, A Safer Society Research Action Tool.

Secondary data sources include research studies, books, professional journals and articles. These items were searched to reconstruct events in the past. Data search systems in the library used are: Psychological Abstracts and Social Work Abstracts. These searches produced books, studies, dissertations, and professional journal articles. Secondary data were also collected from the sources mentioned in the primary data collection.

DATA ANALYSIS:

The design for analysis of the study includes a review of the selected time periods and how they influenced the treatment modes and trends, and the rate of recidivism with treatment and without treatment for sex offenders in the correction system. The data will be separated into categories to allow for a chronological order of the data and into time periods as follows. Placing the data in chronological order will provide for a time-line and give a picture of historical development (Shafer, 1969).

Arrangement of a chronological time scale will allow for the reader to have insight into the research questions. The issue of sex offender treatment in the corrections system will be analyzed and interpreted according to the research questions asked using the conceptual framework of this thesis. To aid in the analysis of the research, internal and external criticism will be used with regard to the data. External criticism determines whether the document is genuine. Internal criticism looks at the meaning of the document (Leedy, 1993).

STRENGTHS AND LIMITATIONS OF HISTORICAL RESEARCH:

Historical research can show the effects that certain events have upon individuals and the environment in which they live (Leedy, 1993). The strength of this study will lie in the interpretation of events and how the lives of the sex offenders may be changed through treatment. By studying a chain of events, the cause and effect of the history of treatment for sex offenders in the correction system will also lend some insight into the influence of social change within the correctional facilities.

A historical researcher does not have the opportunity of the quantitative or qualitative researcher to generate their own research with fresh data. A limitation of historical study may result due to the inferences and interpretations that will occur when using documents, books, and studies conducted by another researcher.

SUMMARY:

This chapter explained the historical research methodology for studying treatment for male and female sex offenders in the correctional system.

In Chapter 3 primary and secondary material will be used to analyze historical trends regarding sex offenders' treatment in the correction system.

CHAPTER III – LITERATURE REVIEW & HISTORICAL DATA

The literature review will define sex offender, give a brief background history of treatment for the sex offender, male and female from 1948 to present time, discuss theoretical frameworks used in the literature, and report on studies that describe current treatment programs.

The definition of a sex offender is, "Anyone who forces a coercive sexual contact, makes substantial threats of sexual contact, any sexual contact with a child, nonconsensual sexual behavior violating conventional standards" (Smith & Monaskersky, 1986). The reality is that the population that commits sexual offenses is extremely heterogeneous: "There is no succinct profile that describes the sex offender," says Irwin Dreiblatt (1982).

BACKGROUND:

Literature reflects that the first intensive sex offenders program for men started in California in 1948 (Freeman/Long/Wall 1986). Male programs in Minnesota began in 1978 when Minnesota offered its first transitional sex offenders program at their Lino Lakes Facility. A few years later, a sex offenders program was established in the Minnesota security facility for males in Stillwater, Minnesota. Upon release from the sex offenders program, the males are sent to one of the five halfway houses in Minneapolis, Minnesota (Steele, 1981). According to Iglehart and Stein (1995), from 1948 to 1994, once women were in the correctional system, no treatment was offered or available.

Primarily defense attorneys encouraged Genesis II for Women Inc., a Minnesota agency, to establish an outpatient female sex offender program in 1984, which would serve as an alternative to incarceration. Community-based alternatives had existed for

some years for the male sex offenders, and there was a growing concern that the absence of such programs for women constituted disparity. Female sex offenders create a very serious problem that has been overlooked. Most social service agencies have ignored female sex offenders as a treatment population; therefore, very little information exists (Smith & Monaskersky, 1986). From 1948 to 1986, 18 intensive state-run treatment programs for imprisoned male sex offenders have been opened, including the two-and-a-half year program at the Oregon State Hospital. According to The Safer Society Program, as of August 1987, nationwide:

- 310 (63%) of all 490 juvenile sexual abuser services provide some form of treatment to females.
- 187 were community-based outpatient
- 28 were residential
- 95 were located in three states (CA/15, WA/30, FL/12)
- 199 (54%) of all 367 adult sexual abuser services provided some form treatment to females
- 129 were community-based outpatient
- 16 were residential
- 54 were located in four states (CA/15, FL/13, TX/13, MN/13).

THEORETICAL FRAMEWORK USED IN THE LITERATURE:

Offenders are seen as individuals who lack the ability to cope emotionally, and by the time these individuals reach adulthood they have exhibited a "constellation of cognitive and behavioral patterns" that cause great harm to those around them.

The pioneer sex offender treatment programs were based primarily on the

traditional medical or psychiatric model. From 1948 to 1978, the preferred forms of treatment involved one-on-one individual psychotherapy sessions plus group psychotherapy led by one therapist, usually male. These traditional approaches proved unsatisfactory because of the badly understaffed hospitals overcrowded with psychotic patients. The sex offender was either segregated on maximum-security wards, or was distributed throughout the hospital among psychotic patients on a locked ward with no available specialized treatment (Brecher 1978). In today's specialized sex offender assessment and treatment programs, it is rare to find offenders "diagnosed" in conventional psychiatric terms or treated by such traditional modes (Groth 1983). Groth (1983) also states that sex offenders are perceived as requiring a highly "eclectic and multidisciplinary approach," determined by the sex offender's patterns and perceived needs and reflective of the multiplicity of issues surrounding the offense.

The new sex-offender discipline includes a variety of psychodynamic, behavioral, cognitive, and biomedical elements and incorporates a wide range of educational training components (Berlin, 1983). According to the literature, the concept of treatment is an integrated one. Assessment of the sex offender, for example, is perceived not only as an initial part of treatment but also as a continuing strategy. Similarly, on the other end of the spectrum, post release treatment for residential clients is viewed as an extension of the offender's total treatment.

Sex offender treatment specialists do not claim that treatment programs will end the problem of the sex offender but merely recommend that sex offenders be provided with the appropriate and necessary interventionary skills and tools for controlling their behaviors. Orville Pung, Minnesota's Commissioner of Corrections, who has established

programs at three Minnesota state prisons and has access to a private neighborhood-based, residential treatment center for sex offenders as well as a range of outpatient programs, has said that the programs do not have a bottled and labeled "Cure for Sex Offenders"; to think in those terms would set the programs up for failure. Pung believes that, as long as the people who go through the programs will be less of a threat to the public than when they came into the system, the treatment efforts are worthwhile. "Don't we have a responsibility to try," he asks, "if there is at least some evidence to indicate that it might moderate behavior (Voss, 1983)."

Treatment cannot erase what has happened already; it can, however, prevent recurrence for both the victim and, by treating the offender, for future victims. Treatment also acts as prevention for other problems. The primary focus of treatment then is as much prevention as rehabilitation. The focus of the criminal justice system could well be treatment and prevention as well as punishment.

Sex offenders, however, traditionally have not been diagnosed in terms of psychopathology. Rather, the behaviors of male perpetrators have been interpreted as inherent in the male gender, therefore shifting responsibility back to the victim to keep the male impulses within manageable boundaries (Groth & Birnbaum, 1989). The transition from victim to offender is a phenomenon that has generated much debate. One empirically derived theory suggests that a significant percentage of males were sexually abused as children will become offenders (O'Brien, 1989).

Cognitive and Educational Factors:

The cognitive theory represents the processing of information into long-term storage, so that it can be retrieved at a later time. It also examines mental processes such

as creativity, perception, thinking, problem solving, memory, and language. It addresses the unfolding of our thinking capacities, our "knowing," our ability to think critically, and to develop conceptual understanding of the "other."

The most widely practiced cognitive theories adapted for sex offender treatment programs are drawn from the "standard" clinical techniques for changing cognition as described by cognitive and cognitive behavior pioneers (Beck, 1976, Ellis & Grieger 1977, & Meichenbaum, 1977). The emphasis on cognition in various treatment programs may range from a primary and causal factor in sexual deviancy to a secondary symptom of deviant sexual behavior. But most, if not all, sex offender programs incorporate a cognitive component. Cognitive factors are seen as playing a significant and highly interactive role in the perpetration of sexual offenses (Murphy, 1990).

More recent research has demonstrated that sexual offending is a multidetermined phenomena and that treatment paradigms should include other components such as cognitive restructuring, social skills training, and anger management.

Behavioral Treatment:

The behavior theory has a tendency to work because it makes an observable change in behavior or an increase in the probability that behavior will change as a result of instructions. Thus, behavioral treatment has evolved to include these dimensions in a more comprehensive model that is both cognitive and behavioral (Correctional Service Canada, 1995).

Cognitive and Behavioral Treatment:

According to the goals of cognitive behavioral treatment, it includes the modification of deviant sexual behavior and preferences, cognitive restructuring, and the

cultivation of improved social adjustment. Cognitive restructuring, like empathy and social skills training, is usually adjunctive to other treatment methods (Correctional Service Canada, 1995a). Treatment of cognitive distortions proceeds by training offenders to develop an awareness of cognitive and affective processes that sustain criminal sexual behavior. Subsequently, these cognitions and affects are replaced with more appropriate and adaptive ones. This can be accomplished through modeling, behavior rehearsal, and direct confrontation. The concept of cognitive restructuring and cognitive distortions deals with the ways in which individuals process information, misperceive environmental cues, and fail to evaluate the impact of their behavior on others by showing empathy and or emotions. Cognitive distortion in sex offenders refers to the self-statements used to minimize, rationalize, justify, and maintain their behavior.

Techniques used to challenge cognitive distortions and identify the cognitive components that maintain perpetuation of the deviant cycle of behavior are heavily interwoven with educational materials (Knoop, 1984). Cognitive restructuring techniques employ a wide range of cognitive behavioral interventions involving written assignments, guided visualization, relaxation exercise, and practices such as thought stopping, thought shifting, and impulse charting. These techniques are designed to help identify anger signals and intervene upon distorted thinking patterns before they escalate into full-blown deviant fantasies, plans to act out, and the recommission of a crime (Knoop, 1984).

The long-term goal of treatment is to help offenders develop the capacity for empathy. Through education and cognitive interventions, offenders are given the tools and the opportunity to address emotional deficits and to continue their emotional

development (Larson & Maison, 1995).

Differences between male and female offenders have been found in clinical diagnoses. Male sex offenders are often diagnosed as having paraphilias or an antisocial personality disorder. Female offenders are more typically diagnosed with a personality disorder of the dependent, borderline, passive-aggressive, or avoidance type (Metzner, 1988).

Jane Matthews and Ruth Mathews, in designing their program at Genesis II for Woman, Inc., made a conscious effort to draw on their experiences with male sex offenders while in no way assuming that the offender dynamics and treatment needs of female offenders would be the same as those of males. However, female sex offenders are infrequently prosecuted because women in general do not fit the stereotype of the sex abuser. Statistics show that this was still the case in 1992, according to Jane Matthews (1993).

Matthews and Mathews (1985) created a preliminary typology for female sex offenders and in order to treat female sex offenders determined one must examine the "why and how." One would need to examine whether the offense was self-initiated by the woman offender or whether a man was somehow involved. However, their research reveals that mostly all female offenders commit sexual acts against children, and most involve male co-offenders. The treatment and supervision of female sex offenders depends on their personal characteristics, the nature of their sexual offending, and their unique release plan. Effective treatment depends, therefore, on the accuracy of the match between the chosen intervention and the specific needs of the offender (Atkinson, 1995).

SUMMARY:

To summarize, we know that treatment for sex offenders in the correctional facilities, especially male facilities, has a historical component from 1948. We also know that since that time, the types of treatment interventions have changed from a traditional medical or psychiatric model to a multidisciplinary approach that includes a variety of psychodynamic, behavioral, cognitive, and biomedical elements that incorporate a wide range of educational training components.

From 1948 to 1970 very few studies were completed regarding the linkage between treatment and recidivism rates. However, during this time period there were several studies regarding physical castration and the 20-year study in Europe. According to the data, at least 102 had been castrated in Norway, 121 in Switzerland, 900 in Demark, and 932 in Germany. Recidivism data based on official records shows remarkably low rates of sexual reoffending in those who were castrated across all these countries (0% to 7.4%, Bradford, 1990).

Studies have shown that sexual offenders, however, traditionally have not been diagnosed in terms of psychopathology. Differences between male and female offenders have been found in clinical diagnoses. Male sex offenders are often diagnosed as having paraphilias or an antisocial personality disorder. Female offenders more typically are diagnosed with a personality disorder of the dependent, borderline, passive-aggressive, or avoidance type (Metzner, 1988).

This chapter also took a look at the literature background history of treatment for sex offenders. The literature reflects that the first intensive sex offenders program for men started in California in 1948, and the first treatment for women started in 1985. Writers suggest that one of the reasons for the huge gap in treatment for men and women

sex offenders in our correctional facilities is because society had a difficult time accepting women as sex offenders and because crime, including sexual offenses, is generally perceived as a male phenomenon. Therefore, the literature reflects that sex offender programs for males were offered in maximum-security facilities, and upon release men were sent to halfway houses. According to the literature, the first female sex offender programs were outpatient treatment during 1985 to the early 1990s. Minnesota provided treatment for females in a correctional setting in 1994.

The next section will use primary and secondary material to analyze historical trends regarding sex offenders' treatment and rehabilitation in the correctional system.

CHAPTER IV - FINDINGS

The purpose of this section is to present the findings of four research questions using primary and secondary data. The research questions will be addressed using the following chronological order: (1) 1948 to 1968, (2) 1969 to 1989, and(3) 1990 to present. Findings will be presented within the chronological time frame for each research questions

Research Questions: (1) Is treatment and rehabilitation offered equally to male and female sex offenders? (2) Is treatment and rehabilitation offered in the correctional facilities for sex offenders? (3) What type of treatment is offered to the sex offender? (4) What evaluation is used to assess the offender's readiness to live back in the community? (5) When do assessment, treatment, rehabilitation, and evaluation occur?

1948-1968

Treatment and Rehabilitation:

Treatment and rehabilitation for many sex offenders in the early stages of sex offender treatment was difficult because most states enacted sexual psychopath or mentally disordered offender statutes which typically provided for indefinite civil commitment of the sexually dangerous persons to mental health treatment in lieu of imprisonment. The literature reflects that because sex offenders were placed in mental health facilities and committed as a sexually dangerous person, it could not be determined if treatment worked. Therefore, there is no data on what the rate of recidivism was or how that program reduced sexual offenses. However, in the early 1960s the public became more concerned because the population of convicted sex offenders had grown so that most states repealed their sexual psychopath laws; hence,

there has been less use of civil commitment and greater use of incarceration for sex offenders (Veneziano & Veneziano 1987).

Literature reflects that the first intensive sex offenders program was designed for men only. The first intensive program started in California in 1948. The pioneer sex-offender treatment programs were based primarily on the traditional medical or psychiatric model. The pioneer treatment programs, instituted before the development of the cohesive women's movement, were to a large degree captives of the prevailing myths and attitudes based on rapists being sexually unfulfilled men carried away by sudden urges of uncontrollable anger, control, and sexual desire. It was believed that provocative victims might have unleashed these desires, and that rapists were psychologically sick men or part of a criminal subculture (Knoop, 1976).

Since the first program for sex offenders was launched in California in 1948, treating the sex offender grew out of the growing recognition that imprisonment alone is ineffective in preventing deviant sexual behavior.

Prisoners who volunteered to participate in programs knew that it had many psychologically difficult features, that their participation would not hasten their release.

As an aid in selecting the best possible client for the sex offenders program, most institutions and prisons relied heavily on psychological and physiological assessment. One of the most difficult aspects of assessing and treating imprisoned sexual offenders was developing adequate behavior measures of their deviance patterns and how these are affected by treatment (Freeman/Longo, 1986).

According to Dr. Wiederholt (1991), a sexual offense crime is a defense against a threat or disintegration of the Ego-identity "against a wrong person, at the wrong time, at

the wrong place, with the wrong method out of a wrong motivation." Writers suggest that sexual offense crimes are physically and psychologically brutal, aggressive acts with the purpose of feeling superior and/or feeling protected by the victim. Writers also believe that the offender seeks proximity, self-confidence, and trustful satisfaction of emotional needs in the human interaction and commits a crime when these needs are not fulfilled.

In a society intimidated by sexual taboos and conditioned to respond punitively to deviancy, the word "sex" and the word "offender" are both potent linguistic symbols. Separately, they evoke beliefs that are oversimplified and distorted; together they are likely to conjure up images of "sex fiends" or dirty old men in the alley (Sgroi, 1978).

From the late 1940s to the late 1970s misconceived notions about sex offenders were held among professionals as well as laypeople. These popular beliefs offered the advantage of making the sex offender as different and unlike the ordinary person as possible (Groth, 1978). "The myths, the stereotypes, the generalizations are easier to understand and accept, and therefore, more satisfying than the reality," says Groth (1978, p.4). The literature reflects that during this time period those sex offenders were usually male and very few females.

In the late 1970s there was speculation among some treatment providers that sexual abuse by women is much greater than originally estimated. Like all sexual abuse, it is probably grossly underreported; however, sexual abuse by women probably occurs in about 5% of the cases of girl victims and possibly as high as 20 % in the case of boys (Finkelhor/Russell, 1983). Therefore, because of the misconceived notions about sex offenders in general, treatment was inpatient with males within the correctional facility

and also based on the medical model.

Physical castration was widely practiced in Sweden, Denmark, Norway, and other European countries as late as 1959 to 1979. Studies involving over 2,000 men with follow-up periods of up to 20 years have produced recidivism rates as low as 7 % and according to Marshall, 1991, provided some of the most impressive results to date. However, problems with these studies do exist. For example, the population of castrated offenders is not specified in sufficient detail to know the number of each type of offender involved, and castration was being practiced when consenting homosexual acts between adult partners was still a crime. It is not known how many of these men are represented in these studies. Nor is it known how many were first-time offenders or what the nature of their crime might have been in many instances (Marshall et al, 1991).

Pharmacological interventions received substantial attention in the 1960s to the treatment of offenders. Medroxyprogestrone acetate (MPA) has been studied in the treatment of compulsive sex offenders in studies dating back to 1968 (Knoop, 1984; Hucker & Bain, 1990; Meyer, 1991; Marshall, Jones, Ward, Johnston & Barbaree, 1991). MPA and other antiandrogens act by lowering testosterone levels and reducing sexual arousal and activity. In evaluating the benefits of MPA and other antiandrogens, it is important to note that these pharmacological agents are used in conjunction with psychological counseling, and that few if any clinicians expect these medications will eliminate sexual offending nor serve as the limited role in the treatment of compulsive sex offenders (Hucker, & Bain, 1990, Marshall, et al, 1991).

1969 – 1989

For the majority of Americans, social control of the sex offender usually equated

with imprisonment. Incarceration is perceived as a means of both punishing the offending party and insuring safety for the community. Sex offender treatment specialists, however, contend that "discovering what goes on in the offender's mind may promote some methods of control than years of unconstructive detention, leading to the eventual release of men in a state more embittered and antisocial than when they were first sentenced (West, Roy, & Nichols, 1978)."

By 1970, the progress of sex offender treatment was impeded intermittently by both punitively oriented legislators and inconsistent funding. However, by 1976 the 10 sex offender treatment programs (described in this chapter) demonstrated the profound changes in treatment approaches that had occurred. Treatment for sex offenders became a rapidly evolving, multimodal, self-defining, and promising discipline.

According to the literature, by 1976 practitioners shaped their programs by selecting various combinations of assessment and treatment approaches from this broad repertoire of behavioral, psychodynamic, and biomedical components. In the majority of programs, guided peer-group therapy, usually co-led by a woman and a man, formed the core of the program's design, supplemented by individual, and, when possible, family therapy.

In 1984 the Safer Society Program completed research of 10 male treatment programs. At the time of the research, no female sex offender treatment program was available. The goal of the treatment was to teach the sex offender how to intervene in and control his sexually abusive or assaultive behaviors. However, in 1985 an outpatient treatment program was provided for women in the state of Minnesota. The goal was to create new therapeutic and educational intervention with the capability of controlling and

drastically reducing the high incidence of the damaging and unacceptable behaviors.

TEN MALE PROGRAMS AND ONE FEMALE PROGRAM:

1965-1985

- Northwest Treatment Associates (1977)
- Forensic Mental Health Services of Connecticut (1982)
- Alpha Human Services, Inc. (1974)
- Western State Hospital (1965)
- Oregon State Hospital (1978)
- Minnesota Security Hospital (1975)
- Massachusetts Treatment Center (established in 1959 but was reorganized in 1976)
- Minnesota Correctional Facility (1978)
- Connecticut Correctional Institution (1978)
- Adult Diagnostic & Treatment Center, New Jersey (1976)
- Genesis II for Women, Inc. (1985)

In the eleven programs above, the methods for assessing and treating sex offenders are variously interpreted and applied.

1. Northwest Treatment Associates, Seattle, Washington:

Northwest Treatment Associates (NWTA) is believed to be one of the largest and most comprehensive outpatient sex offender evaluation and treatment programs in the United States. More than 85 % of NWTA's clients are attached to the criminal justice system through either court-ordered evaluations or sentences of probation with conditions of treatment (NWTA, 1982).

The NWTA treatment program consists of two major components: a confrontive, guided-group model modified for community use; and a range of behavioral treatment approaches. Behavioral treatment is very important but not sufficient by itself. According to R. Wolfe (1981), both group and individual counseling to deal with offenders' characterological problems are needed.

2. Forensic Mental Health Services of Connecticut, New London, Connecticut:

The Forensic Mental Health Service (FMHS) is a private program providing evaluation and treatment to adolescent and adult sex offenders and victims and their families. They operate with a strong emphasis on education and prevention of sexual assault. The FMHS agenda includes training, education, networking, and consultation services to mental health and criminal justice professionals and law enforcement personnel. The initial evaluation takes up to four weeks; however, "no formal testing is done," says Ross (1984), "because testing does not help determine treatability, nor does most sexually aggressive behavior show up on any test." Group therapy is highly structured, with a strong self-help, peer-oriented culture. All sex offender groups, with the exception of the rapists, are co-led by a therapy team of both sexes.

3. Alpha Human Services, Inc., Minneapolis, Minnesota:

Alpha Human Services, Inc. opened in 1971. It was a traditional halfway house for offenders leaving state prisons, but in 1973 it became a totally treatment-focused program. The first sex offender was admitted in 1974 on an experimental basis, and currently all of the men served at Alpha are convicted sex offenders or have been involved in sexually offensive behaviors. Alpha's treatment methods are based on staff's

belief that most behavior is learned, and that inappropriate behavior can be replaced by alternative behavior. Therapeutic methods are eclectic in orientation and encompass behavioral, affective, and cognitive techniques. Alpha relies heavily on group therapy supplemented by individual psychotherapy (Matthews, 1981).

4. Western State Hospital, Fort Steilacoom, Washington:

Western State Hospital (WSH) is one of the oldest and most replicated mental health models for treating sex offenders. The 19-year-old program is unique for its intensive, guided self-help philosophy and graduated-release procedure. WSH began in 1955, and through 1958 sex offenders were committed to understaffed hospitals overcrowded with psychotic patients. It was not until 1958 that sex offenders were brought together for specialized, staff-directed group therapy (Brecher, 1978). The core of the treatment model revolves around peer-group therapy. The peer-group method provides multiple opportunities to demonstrate care and concern for others as well as taking responsibility for the group's collective action (Saylor, 1979). Saylor (1979) notes that treatment is only half over at the end of inpatient treatment and, therefore, is involved with the outpatient care of the offender. This program is also addressing some of the offender's skill deficits by providing training in anger management and strengthened modules in social skills and sex education.

5. Oregon State Hospital, Salem, Oregon:

The Sex Offender Unit (SOU) at Oregon State Hospital is modeled on the sex offender program at Western State Hospital. SOU is a voluntary program offered to imprisoned sex offenders during the last two-and-one-half to three years of their sentence, and is one of three residential programs provided to sentenced sex offenders

through the unique administrative structure of OSH's Correctional Treatment Programs (CTP). CTP was established in 1978. The program is described as transitional since it serves males in the last few years of their incarceration.

6. Minnesota Security Hospital, St. Peter, Minnesota:

The Intensive Treatment Program for Sexual Aggressive (ITPSA) at Minnesota Security Hospital (MSH) is modeled largely on the Sex Offender Program at Western State Hospital. Not only is the hospital famous for its several innovative program components but also for its invaluable annual reports (Walbek, 1979, 1979a, 1980, 1981, 1982). In September 1980, ITPSA was acknowledged when the American Psychiatric Association's 32nd Institute on Hospital and Community Psychiatry presented a Significant Achievement Certificate to the program for its innovative treatment approach to adjudicated, sexually aggressive patients. ITPSA received another award in the spring of 1984 when the Joint Commission of Accreditation of Hospitals found it to be in substantial compliance with all standards outlined by the organization. The reviewer praised ITPSA for representing the "state of the art in treating sex offenders (Seely, 1982a)." According to Seely (1981), it takes a great deal of time to complete evaluations because they conduct a full assessment, including psychiatric, psychological, social history, educational, vocational, and chemical use. They include nutritional, nursing, medical, and leisure-time assessment. Seely (1982a) concludes that their work is concentrated on modifying cognitive behavior utilizing cognitive rehearsal in changing sexual object choice or diminishing the role of aggression in the person's sexual response cycle.

7. Massachusetts Treatment Center, Bridgewater, Massachusetts:

Established in 1959, Massachusetts Treatment Center (MTC) was known as "The Center for the Diagnosis and Treatment of Sexually Dangerous Offenders" and in 1975 was called by its current name. MTC is involved in some phase of a long-term process of carefully monitored, gradual reintegration into the community. MTC is the only facility serving the entire Commonwealth of Massachusetts in "treatment and rehabilitation" of sex offenders (Boucher, 1982).

8. Minnesota Correctional Facility, Lino Lakes, Minnesota:

Minnesota Correctional Facility at Lino Lakes, Minnesota has offered a program called The Transitional Sex Offender Program (TSOP) since 1978. TSOP is an effort to bridge the gap between prison incarceration and release by providing specialized treatment to sex offenders. Components include the core therapy groups, family and couples groups, and three educational groups, all of which focus on (1) assertiveness training, (2) sex education and values, and (3) social roles and relationships (Knoop, 1981).

9. Connecticut Correctional Institution, Somers, Connecticut:

The Sex Offender Program (SOP) at Connecticut's only maximum-security prison for convicted adult male felons is a component program within the Mental Hygiene Unit (MHU). The SOP is unusual among sex-offender treatment programs operating in prisons for its extensive outreach exclusionary criteria. If the sex offender does not apply to the program, "We will seek him out and talk with him about his conviction and incarceration," says Groth (1983a). The program makes it a policy to accept even those persons who are psychiatrically troubled and have some difficulty in functioning. The program goals and treatment perspective of the SOP are rooted in the perception that

sexual assault is a behavior problem rather than a symptom of a psychiatric disorder, and the offender's pattern of sexual abuse is more the reflection of stress and conflict in his troubled life than it is pleasure or desire (Groth, 1984a). Group treatment, which operates on a guided self-help and mutual-aid concept, is the primary modality, with various counseling groups and individual treatment sessions used as a form of crisis intervention or where the offender is too intimidated by the prison experience to begin treatment in a group setting.

10. Adult Diagnostic & Treatment Center, Arenel, New Jersey:

Adult Diagnostic & Treatment Center (ADTC) is the only independent prison facility in the United States exclusively devoted to the evaluation and treatment of convicted sex offenders (Mintz, 1982). The treatment staff is composed of psychologists and social workers directly involved in the inpatient treatment of the sex offenders. At ADTC, the treatment staff will use any method found to be worthwhile to the offender as he engages in a change process. This eclectic therapeutic approach is benefited by the incorporation of audiovisual technology and group and individual therapy. Group and individual therapy represents the major treatment component of the program.

11. Genesis II for Women Inc., Minneapolis, Minnesota:

Primarily defense attorneys encouraged Genesis II for Women, Inc. to establish an outpatient sex offender program as an alternative to incarceration. The program began serving clients in mid-1985. The sex offender program provides for the special therapeutic needs of female sex offenders. In designing the program, a conscious effort was made to draw on the experiences from the male sex offenders program while in no way assuming that the dynamics and treatment needs of female offenders would be the

same as those of male sex offenders (Matthews & Mathews, 1989). This program uses a victimization model and emphasizes the relationship between the offender's own sexual and physical abuse experiences and abusive behavior. It also uses group therapy relapse prevention goals similar to those used with male offenders. However, treatment providers also emphasize the importance of the offender's own history of abuse, and address related treatment issues. Matthews & Mathews (1989) created a preliminary typology for female sex offenders and stated that in order to treat the female sex offender one must examine the why and the how.

Matthews' & Mathews' (1989) research reveals that most all acts of sexual abuse committed by women involve male co-offenders. The average age of the female offender is 22.1 compared to 29.4 for men (Matthews & Mathews, 1989).

The treatment and supervision of female sex offenders depends on their personal characteristics, the nature of their sexual offending, and their unique treatment plans. Effective treatment depends, therefore, on accuracy of the match between the chosen intervention and the specific needs of the offender. It is important not to overlook issues such as substance abuse, dissociation, self-injury, and inappropriate sexual attitudes that may arise from victimization experiences.

Although the 11 programs above are different in their methods of treating and assessing sex offenders, they collectively **(1) provide us with a comprehensive agenda for fulfilling the offender's assessment and treatment needs, and (2) allow us to outline six comprehensive treatment goals for the new sex-offender discipline.** The goals are:

- Each sex offender needs a complete, individualized assessment and

treatment plan.

- Each sex offender needs to accept responsibility of the offense(s).
- Each sex offender needs to learn how to (a) intervene in or break into this offense pattern at its very first sign and (b) call upon appropriate methods, tools, or procedures he has learned.
- Each sex offender needs to engage in a re-education and resocialization process in order to (a) replace antisocial thoughts and behaviors with prosocial ones, (b) acquire a positive self-concept, and (c) learn new social and sexual skills.
- Each residential sex offender needs a prolonged period during his treatment when he can begin to test safely his newly acquired insights and control mechanisms in the community without the risk of affronting or harming members of the wider community.
- Each sex offender needs (a) a post treatment support, peer, or "rap" group, and (b) continual post release access to therapeutic treatment.

In this author's review of the literature, 10 of the above programs addressed six goals regarding assessment and treatment modalities used in their programs. This information will provide a general perspective on how the field of sex-offender treatment functions in regard to the six goals.

Goal One:

Evaluation and assessment of the sex offender are crucial not only for determining individual treatment needs but also for assessing risk to the community in terms of selecting appropriate settings for treatment. Groth (1983) views assessment as

the first step in the treatment of the sex offender in that it is in part a kind of therapeutic intervention. "When you are doing treatment," he says, "you are continually refining your assessment." The two go hand in hand: The methods used to determine the treatment needs of individual sex offenders generally include a lengthy personal interview with the client and family; a review of criminal justice, social work, and mental health agency reports; the use of a substance-abuse checklist, and some of the following test procedures: Psychological and Psychosocial Testing, Intelligence and Ability. Psychological tests include the Minnesota Multiphasic Personality Inventory (MMPI);the Millon Clinical Multiaxial Inventory (MCMI); the California Psychological Inventory ((CPI); the Adjective Checklist (ACL); the CAQ Part II; the 16 PF Form C; the Motivation Analysis Test; the Pacht Hostility/Guilt Inventory; the Spence-Helmreich Attitudes toward Women Scale; the Bender-Gestalt Test (which detects damage to the cortical area of the brain); the Shipley Institute of Living Scale; and the Wechsler Adult Intelligence Scale (WAIS). Psychosexual testing includes the Clark Sexual History Questionnaire, the Thorne Sexual Inventory, and various sexual inventories formulated by the program.

Ongoing Guided Sex-Offender Groups:

Requiring an offender to spend a period of time in such a group is particularly prevalent among correctional facilities and residential treatment programs, where the offender is subjected to a 30- to 60-day evaluation and assessment period. Peer-group members often are considered more keen evaluators of fellow sexual aggressiveness than professional staff. According to the literature, group work became popular within the correctional facilities and residential treatment programs in the late 1970s because it

allowed the offender to be governed by their peers and also be confronted by their peers.

Autobiographies:

Since assessment is an ongoing process, a full autobiographical account of the sex offender's life may provide the therapist and the client with insight into some of the familial, characterological, and other factors that may have contributed to the offense and may require special focus in the treatment plan. According to the Strengths Perspective, you must demand a different way of looking at individuals, families, and communities. The strengths approach requires an accounting of what people know and what they can do; however, in chaos that may sometimes seem an impossible task (Saleebey, 1996).

Social and Empathy Skills Testing:

Through various tests, role plays, self-report inventories, and the use of videotapes, the offender's social and empathic skills can be tested. Self-report inventories on shyness, fear of rejection, social anxiety, and distress are used in several programs.

Groups, social modules, individual counseling, and outside consultants and resource materials help the offenders to gain the ability to feel empathy for their victims and understand the effects of their actions on others. They also teach the kinds of skills needed to build meaningful relationships. Peer-group methods provide multiple opportunities for learning and demonstrating care and concern for others.

Many sex offenders have been found to be deficient in social and cognitive skills. These include basic assertive skills such as refusing and making requests, expressing negative emotions, solving problems, and resolving conflicts, and broader communications skills such as expressing positive and tender feelings and accepting

compliments. Interpersonal and heterosocial or homosocial skills, including initiating conversations and dating, are also included.

Physiological Penile Assessment:

Richard Laws (1981), a pioneer in the development of the penile assessment, states that these behavioral procedures operate on two premises: First, that all sex offenders, irrespective of whatever may be wrong with them, have problems with deviant sexual arousal; and second, that all sex offenders have problems with self-control of that arousal. Laws further states that sex offenders are impulsive, that they do not think about consequences, and generally do not even care about such things. The sex offender only cares about the gratification involved in the commission of the offense, and this makes him violent and dangerous.

The penile plethysmograph measures the erection response to various stimuli. In the assessment procedures, Laws uses the erection response to get a profile of the kinds of things that arouse a particular individual, the kind of deviant stimuli or nondeviant stimuli that will "turn a person on." The assessment procedures described here include (1) videotape assessment procedures for rapists, (2) audiotape assessments for rapists and pedophiles, (3) slide assessment for pedophiles, and (4) the Abel or Laws 260 card-sort of sexual preferences. Laws (1981) believes the physiological measurements are crucial to treatment because one cannot rely entirely on self-report from offenders: "They tend to deny, rationalize, and minimize everything they have done to make themselves appear as nondeviant as they possibly can."

Goal Two:

Offense Responsibility:

Given the tendency of sex offenders to deny, minimize, rationalize, or lie about their sexually assaultive behaviors, getting them to own and accept responsibility for their acts is one of the first elements on the treatment agenda. Some programs will not accept offenders if, during their orientation periods, they refuse to be honest and continue to shift blame elsewhere.

The confrontive, guided-therapy groups with their strong peer cultures are usually instrumental in getting the offender to take responsibility of his behavior. In many groups, a first procedure is for each member to introduce himself and give a description of his behavior.

Understanding Offense Antecedents:

Whether or not the offenders are incarcerated or nonincarcerated and voluntary participants in treatment, there is a need to identify the antecedents to sexually aggressive behaviors, if only for the purpose of learning the key points at which behavioral intervention can disrupt the chain reaction. A combination of (1) psychosocioeducational modules, (2) insight, cognitive and rational-emotive therapies, and (3) behavioral approaches is employed in getting the offender to become familiar with the sequence of thoughts, feeling, events, circumstances and arousal stimuli that comprise his offense syndrome - the chain of factors that he activates prior to his offending.

Goal Three:

The first step in breaking into the offense pattern is to recognize the earliest link in the chain of thoughts, feelings, and events that lead to offending.

Control techniques range from the least intrusive to the most intrusive methods. They sometimes can be called into play autonomously; in other instances they may

require assistance. If, for instance, heightened stress, anxiety, or tension are the warning signals that have been identified as the feeling preceding the sexually aggressive thoughts and fantasies, as a first step the offender might call upon the relaxation methods and stress-management techniques he has learned through the use of relaxation instructional tapes, biofeedback, and relaxation groups. If his thoughts persist, he can engage in a range of interventions beginning with cognitive deterrents.

Depo-Provera:

Depo-Provera (Medroxyprogesterone Acetate, or MPA) is a treatment intervention suggested for selected compulsive sex offenders. Berlin (1982) contends that the weekly injections of the drug provide the potential for compulsive offenders to curb their sex drive and sexual fantasies through the suppression of production of the male hormone testosterone. The reduction in testosterone is perceived as increasing their capacity for control and diminishing "obsessive ruminations and preoccupations that they are unable to extrude from their minds." Berlin (1982) also states that the injections do not create impotence but reduce sperm production.

Berlin, psychiatrist, is the Codirector of the Biosexual Psychohormonal Clinic at John Hopkins Hospital in Baltimore and administers approximately 500 mg of the drug to about 80 sex offenders weekly. All were voluntary candidates (Berlin, 1982).

Controversies over the use of Depo-Provera are wide ranging. Questions have been raised about:

1. Its short-range negative effects
2. Its potential for more harmful long-range effects
3. Its potential for use under conditions that are nonvoluntary, unmonitored,

and indiscriminately punitive rather than remedial

4. Its efficacy in controlling sexually aggressive behaviors (Seely, 1984).

According to Richard Seely (1984), Depo-Provera was not considered for their Intensive Treatment Program in Minnesota because the ITPSA staff labeled the use of Depo-Provera as intrusive therapy, for which it would be impossible to obtain informed consent from an incarcerated population. They were concerned about the carcinogenic risk of Depo-Provera, especially at the dose necessary for significant reduction of sexual drive. Seely and his staff expressed concerns regarding the noted side-effect of depression with treating sex offenders using the drug.

Goal Four:

The re-education and resocialization agendas in sex offender treatment programs are implemented through a wide array of restorative interventions that can be called upon to meet the offender's individual needs and deficits. These opportunities include (1) changing culturally rooted stereotypical notions about the roles of women and men in our society; (2) overcoming myths and misperceptions about human sexuality and increasing positive sexuality; (3) learning how to increase nondeviant sexual arousal; (4) dealing with sexual, physical, and emotional victimizations the offender may have suffered personally as a youth; (5) learning how to become empathic persons and build caring relationships with others; (6) learning how to become assertive people who can appropriately manage and express anger, aggression, and other negative or positive feelings; (7) learning family and care taking skills; (8) learning how to increase self-esteem; (9) increasing living, educational, and vocational skills; and (10) learning strategies for controlling alcohol and drug abuse.

Goal Five:

Some residential programs have no mechanism for the gradual release of the sex offender into the community. Programs that incorporate gradual release strategies into the treatment agenda provide the opportunity for the offender to be pulled back into the program when he begins to exhibit early warning signals or old preoffense patterns.

A variety of formats are used to integrate the offender gradually into the community. One prison program bridges the gap between incarceration and community by providing a one-year transitional sex offender treatment program that incorporates an opportunity to attend a specialized sex offender outpatient group in the community six weeks prior to release. Some programs offer short-term prerelease groups that focus on the various skills needed to readjust to the community. Others provide opportunities for offenders to spend up to 18 months in intensive outpatient treatment after completing the residential portion of the program. One program involves almost one-quarter of its entire sex offender population in a long-term, carefully monitored release procedure that can take two to three years to complete (Safer, 1988).

Goal Six:

Most programs, with the exception of those prisons that cannot accommodate a sex offender re-entering the community, offer the offender therapeutic post treatment support through hot lines and meeting with an individual therapist and peer group.

The type of treatment provided at this point is generally determined by the philosophies or prior training of the program designers or therapist. It generally is agreed that (1) early intervention in these habituating patterns is the most important and useful (Abel, 1984' Groth, 1983; Jackson, 1984; Knoop, 1982); (2) offenders who have been

exposed to programs that provide the skills and tools for them to control and manage their sexually aggressive behaviors have a better chance of exerting such controls over impulse; and (3) sex offender treatment is a steadily evolving and important new discipline.

1990 – Present

There are three sex offenders programs that are very progressive in their sex offender treatment programs. They are leading the way for other facilities in their quest for sexual offenders' treatment in the 90s and beyond. These facilities are:

- Center for the Treatment of Problem Sexual Behavior; Connecticut.
- Correctional Services; Canada
- Minnesota Correctional Facility, Lino Lakes, Moose Lake, and Shakopee, Minnesota (see Appendix).

The women's movement has propounded an increased recognition that sexual offending presents a serious social problem, and sensitivity has been heightened to those who have been victimized. As a result, we have witnessed a tremendous increase in the reporting of sexual offenses over the last decade (Cooper, 1994). Concomitantly, more sex offenders have been identified and channeled into the criminal justice system. Moreover, the proportion of sex offenders relative to the total offender population has increased steadily over the past 10 years (Gorden & Porporino 1990; Motiuk & Belcourt, 1996).

Whenever possible, assessment information is garnered through a variety of modalities, including psychological and physiological testing, file review, behavioral observations, clinical interview, and collateral contacts (Motiuk, 1991; Leis, Motiuk, &

Ogloff, 1995). The multimodal assessment technique is necessary for two primary reasons: first, each source of information offers unique insight into past and present problems and potential avenues for intervention; and second, it helps to mitigate various forms of bias in reporting. This is especially pertinent to sex offenders who often distort, deny, or minimize their offense (Barbaree, 1991; Happel & Auffrey, 1995).

Most current treatment programs include some form of social skills training (Correctional Service Canada, 1995a). Accordingly, behavioral self-monitoring and stress and anger management are essential components of contemporary Cognitive-Behavioural/Relapse Prevention (RP) therapies (Marques, Day, Nelson, & West, 1994; Marshal & Pithers, 1994; Miner, Marques, Day, & Nelson, 1990). Although some of the treatment procedures are similar to treatment in the 1970s and 1980s, most facilities are designing the treatment to fit the individual offender.

Center for the Treatment of Problem Sexual Behavior:

Sex offender treatment in the 90s and beyond with increased attention paid to the importance of prevention measures directed toward both potential victims and potential offenders. Most correctional facilities have adopted a treatment philosophy on why treatment to the sex offender should be provided. First, we must provide a means by which offenders who are motivated and sincere in their efforts can work toward avoiding reoffending. The research suggests that specialized sex offender treatment offers the best chance for them to discontinue their inappropriate and deviant behavior. Second, treatment for offenders is a way to hold them accountable. The treatment process confronts perpetrators about the reality of their behavior and the impact it has had on others (D'Amora & Hobson, 1996).

D'Amora and Hobson (1996) believe that there are two cornerstones of specialized treatment; they are relapse prevention and victim empathy. Relapse prevention forces offenders to recognize that their offending was a choice for which they are responsible. Victim empathy requires offenders to appreciate the damage they have committed. It is also important to offer treatment for the sake of those who have been victims.

According to D'Amora and Hobson (1996), treatment of sex offenders today differs from traditional psychotherapy. It is a direct and highly educational approach. Treatment providers should adhere to strict standards in regard to reporting their clients, and communicate openly with probation and parole authorities. In doing specialized treatment, the effectiveness of probation or parole supervision is amplified. The interaction between treatment and supervision is a synergistic one in which both parties benefit from the collaboration. There are many common goals of treatment, supervision, and victim advocacy. To effectively combat a behavior so ingrained in our culture, we need to have the different systems that respond to sexual violence effectively join together to end its existence.

Correctional Services, Canada:

The goal of Canadian Correctional Services is the management of risk and its subsidiary, recidivism reduction. Evaluation of sex offender risk is accomplished through the identification and assessment of variables that contribute to sexually deviant behavior.

Pretreatment assessments should determine the timing, focus, format, and content of the treatment being delivered. This is paramount because a large body of research has

demonstrated that more serious, higher-risk offenders succeed in longer-term and more intensive programs, and lower-risk offenders fare better in less intensive programs (Fisher, 1995' Nicholaichuk 1996).

Post treatment, follow-up, and prerelease assessment information is especially important for the evaluation of treatment effectiveness and risk to reoffend. A comparison with the pretreatment assessments provides valuable information in regard to change in criminogenic need areas.

- Comprehensive evaluation of sexual offenders is crucial to effective programming and correctional management. Although there is no standardized assessment procedure specific to sexual offenders (Canada Working Group, 1990), there is consensus among researchers, clinicians, and treatment providers that all assessments should apply coverage on the principles of risks, need, and responsivity.
- Treatment for sexual offenders should begin while the offender is in the institution and continue following his or her release into the community (Canada Working Group, 1990). Although cognitive-behavioral therapy with relapse-prevention is currently the most prevalent, there are a variety of treatment approaches, each with its own theoretical rationale (Correctional Service Canada, 1995a; Freeman-Longo & Knoop, 1992; Marshall & Barbaree, 1990). Regardless of the treatment paradigm, programming is aimed at reducing the criminogenic needs identified during assessment.
- Because of the scarcity of female sex offenders and very little evidence that

female sexual offenders differ from their male counterparts, there is one fundamental objective of correctional assessment and classification to tailor treatment supervision strategies to the characteristics of the offender in Canada. It is the hope that customized classification, together with assessment results, will enhance offender rehabilitation thus providing protection to society through a greater ability to predict risk (Correctional Service Canada, 1995a). Canada's approach to treatment is based on strengths of the offender. Treatment modalities include high-, moderate-, and low-intensity institutional programs, community-based relapse prevention, individual counseling, and community-based self-help groups (Correctional Service Canada, 1995a).

Minnesota Correctional Facilities:

Minnesota Correctional Facilities: Lino Lakes, Moose Lake, and Shakopee. Currently, there is a number of correctional facilities that provide sex offender treatment, and information on some of those facilities have been provided. However, Minnesota Correctional Facilities are the primary focus of this research.

In Minnesota there were several state-operated sex offenders program in operation in 1994. (See Appendix A.) As shown in Appendix A, convicted sex offenders comprised 21 % of the total adult and juvenile correctional facility population, and treatment slots were available for 20 % of them at a given time. Appendix A also indicates that two state adult correctional facilities, at Faribault and Shakopee (for women), housed sex offenders but did not have sex offender treatment programs. However, the Department of Corrections began a psychoeducational group for women

sex offenders at Shakopee in 1995 (Sex Offender Treatment Programs, 1994).

Appendix B will show that the proportion of offenders accepted into treatment ranged from 40 to 61 % in the three correctional facilities for which data were available. It will also show that some offenders were placed on waiting lists until treatment slots became available (Sex Offenders Treatment Programs, 1994).

According to Robin Goldman, Sex Offender Director at Lino Lakes (1999), treatment and rehabilitation are offered in Minnesota Correctional facilities. According to the literature, the treatment programs at Lino Lakes and Moose Lake are designed for adult male offenders. The facility for women at Shakopee provides treatment to the female sex offender. Women participating in this program reside in the general inmate population and attend programming as scheduled. However, there are no follow-up services once the female is released from the correctional facility. There are halfway houses.

Treatment programming has been provided since 1978 for male sex offenders in Minnesota Correctional Facilities. During that period of time, Minnesota's facilities were modeled largely on the Sex Offender Program at Western State Hospital. Their focus for treating sex offenders was based on mental health models. This model was very unique for its intensive, guided self-help philosophy and graduated release procedure. However, since 1995 all sex offenders, male and female, entering the correctional facility are immediately assessed to determine programming needs and a number of different treatment approaches are provided.

The sex offender assessment unit for males is located at the St. Cloud facility. After sentencing, adult male sex offenders are sent to the department's reception center

at St. Cloud. After assessment, specific treatment programming recommendations and directives are determined.

- Psychoeducational programming is designed to deal with offenders who minimize or deny their offense, inmates whose sentences are too short to allow them to enter more intensive treatment, and as an adjunct to therapy provided in department programs.
- Intensive, long-term programming is designed for offenders who have ingrained patterns of sexual offending, chemical dependency issues, and/or long criminal histories.
- Alternative programming is designed for inmates of lower intellectual functioning.
- Transitional programming is provided for offenders serving their last nine months of incarceration to prepare them for return to the community.
- Aftercare programming is provided in the facility for offenders continuing to serve their sentence and for those on supervised release in the community who have completed a department program (Minnesota Department of Corrections, 1998; see Appendix C & D).
- Treatment programs at Lino Lakes and Moose Lake are designed for adult male offenders. Programming at Lino Lakes utilizes psychoeducation, group, individual, and family therapy. The goal of the program is to help the offender reduce his risk of reoffending though acceptance of responsibility for his problems; acquisition of new information, insight, cognitive and behavioral change; and development of a reoffense plan. The Moose Lake program is

designed for sex offenders in need of long-term intensive treatment as well as those with a history of low social and/or intellectual skills. Sex offender assessment, sexual assault education, and therapeutic groups are components of the program. Individual therapy is provided based upon the needs of the offender. The goal of the program is to reduce the risk of reoffense by helping the offender identify patterns of problematic behavior, take responsibility for those behaviors, and develop a relapse prevention plan that includes strategies to deal with future behaviors.

- Programming for women is conducted at the Women in Transition Female Sex Offender Program at Shakopee. This two- to three-year program is divided into four phases. Phase I is the intake evaluation process; Phase II consists of individual counseling sessions; Phase III consists of group therapy and attendance of psychoeducational programs; and Phase IV is follow-up treatment with a community treatment program for 16 weeks after the inmate returns to the community. The program's focus is holistic with the philosophy that sexual abuse is a symptom or end result of dysfunction(s) in the inmate's life. As a result, the inmate will acknowledge sexually abusive behavior, take responsibility for her crime, make amends where possible, develop understanding of deviant behaviors patterns, learn socially acceptable living patterns, and provide an understanding of her self-worth so that she can provide for her restoration to society.

Summary:

In this chapter we took a look at the findings in a chronological time frame and

answered the research questions: (1) Is treatment and rehabilitation offered equally to male and female sex offenders? (2) Is treatment and rehabilitation offered in the correctional facilities for sex offenders? (3) What type of treatment is offered to the sex offender? (4) What evaluation is used to assess the offender's readiness to live back in the community? (5) When do assessment, treatment, rehabilitation, and evaluation occur?

According to the literature, there are three sex offenders programs that have been very progressive in treating sex offenders. Basically, they all provide similar treatment modes with some differences in their approach. Pre- and post assessment appear to be the keys to treating sex offenders. Although all three of these programs treat female sex offenders, they are still baffled on what type of treatment would prove best for female offenders. Is treatment and rehabilitation offered equally to male and female offenders? According to the literature, there are very few correctional facilities that offer sex offender treatment programs for females. The few correctional facilities that offered treatment for female sex offenders do not have a long-term program compared to the male programs.

Implications for Practice:

Treatment for sex offenders has a long history in our correctional facilities and given the findings of this research project, it will continue to have a long history for many years. This research study describes an overwhelming response by therapists in regard to treating sex offenders with a multimodal treatment approach. Historically, this has not always been true for the female sex offenders who were merely footnoted when treatment and rehabilitation of offenders were discussed.

We the people have an ethical responsibility to find out if current treatment for sex offenders is effective and equally offered to female sex offenders in our correctional facilities. Social workers will need to be strong advocates for the female offenders that are in the correctional system. Social workers would need to participate in the treatment process of the female offender to ensure a smooth transition back into their perspective communities.

As social workers, we need to assist in developing policies and practices for treating all sex offenders equally. It is critical that social workers develop a follow-up plan along with the correctional facilities before reunification with family is to occur. In the United States, women have struggled for equality but research has provided us with blatant sexism when it comes to treating female sex offenders in the correctional facility. There should also be follow-up plans by social workers that would include strategies for transcending sexism and racism within the community.

Social workers must educate judges, probation officers, correctional facilities and communities to see the offender as an individual. All must be seen the light of their capacities, competencies and values, however dashed and distorted they may have become. Kaplan and Girard (1994) state that people are motivated to change when their strengths are supported. As social workers, we also need to keep in mind the impact on victims of sex offenders and the difficulties that are displayed while in treatment. We have a responsibility to prevent damage and harm to the victims we work with, and a

responsibility to the sex offender by providing treatment that will meet their individual needs before they return to their communities. However, we must not forget that as social workers we must also help communities become more nurturing and promote mental health and basic resources for women. We need to advocate not only for each individual case but also the cause.

CHAPTER V- DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

Discussion:

Significant findings in this research study include the importance of sex offenders treatment for men and women. Literature emphasizes the importance of treatment and rehabilitation for the sex offender. From 1948 to present time, sex offender treatment was provided for males in the correctional system; however, the first female sex offenders program was an outpatient program that started in Minnesota in 1985. Why wasn't treatment offered to female sex offenders? (1) Female sex offenders were infrequently prosecuted. (2) Society's tendency to protect females contributes to the failure of courts and agencies to identify, assess, and treat the female offender. (3) Because of the patriarchal structure of our society, which perpetuates the roles of males as aggressive and dominant and views females as passive and submissive, identification of female sex offenders was inhibited. (4) Most social services agencies have ignored the female sex offender as a treatment population; therefore, very little treatment information exists. Today, there are more correctional facilities that offer sex offender treatment for males than female. Writers suggest that one of the main reasons why some correctional facilities do not offer sex offender treatment for females is because there are too few female sex offenders and providing treatment would not be cost effective. According to the Safer Society Program (1988), from 1948 to the early 1980s rehabilitation was more emphasized, but by 1982 the progress of sex offender treatment was impeded

intermittently by both punitively oriented legislators and inconsistent funding.

From 1948 to 1978, treatment for male sex offenders was based on the medical or psychiatric or disease models. The literature reveals that these models prove to be an unhelpful practice. Treatment focused on the popular notion that sex offenders were mentally ill and sex crimes were committed by persons who have psychotic illnesses (generally schizophrenia, manic-depressive disease, or organic brain syndromes). Abel (1992) states that treatment generally involves treating the psychiatric disease with drugs. However, the drugs did not assist the offenders in controlling aggressive sexual behaviors or their capacity to distinguish fantasy from reality. By 1980 sex offender treatment became a vehicle for various elements representing a variety of disciplines and perspectives, integrating them into a new and inclusive "sex offender assessment and treatment discipline."

The literature reflects that most correctional facilities have similar programs when it comes to preparing the offenders' readiness to live back in the community. Most programs provide a post release evaluation, which serves to address the management and supervision strategies for offenders in the community by assisting case managers with decision-making processes. Offenders are usually directed to community-based relapse-prevention programs, which aim to maintain prosocial behavior, and finally, post release assessments serve to monitor the maintenance of treatment gain and to ensure a level of community supervision that is commensurate with risk.

Since the late 1980s, assessment for sex offenders is completed when they enter the correctional facility, but treatment, rehabilitation, and the evaluation will start when there is available space in the treatment program. However, some correctional facilities will determine treatment with the length of time that the offender will be incarcerated and then provide treatment the last two years of the sentence.

The study found a link between the new sex offender discipline, which includes a variety of psychodynamic, behavior, cognitive, and biomedical elements that incorporate a wide range of educational and training components. In 1981, Watts and Courtoris stated that the treatment choice for sex offenders ideally should depend upon a number of variables including diagnoses, prognoses, overall treatment plans, case management, and the feasibility of implementation and monitoring.

Watts and Courtoris' (1981) study found no empirical evidence that treatment for sex offenders is effective in controlling sexually deviant behavior. However, the literature offers some general observations. First, recidivism studies suggest that many sex offenders will not be reconvicted of a new offense, regardless of the type of treatment they receive or whether they received treatment at all. Second, different types of sex offenders are likely to reoffend at different base rates, irrespective of whether they receive treatment. Some researchers believe just the opposite. Canadian psychologists R. Carl Hanson and Monique T. Bussiere recently reviewed 61 studies covering more than 23,300 cases of sex offenses, and found that only 13.4 % of the individuals identified in the studies went on to

commit another sex crime (Journal of Consulting and Clinical Psychology, 1998). They also found that individuals who did reoffend had committed more sexual offenses, had more deviant sexual interests - such as sex with boys or victimization of strangers - and did not complete their rehabilitative treatment programs. According to Hanson and Bussiere, "Treatment programs can contribute to community safety, we now have reliable evidence that those who attend and cooperate in treatment programs are less likely to reoffend than those who reject intervention." The majority of treatment providers agree that early intervention in sexually deviant behavior is most important and useful. Treatment providers also agree that offenders who have been exposed to programs that provide the skills and tools for them to control and manage their sexually aggressive behaviors have a better chance of exerting such controls over impulse. Most treatment professionals think that "curing" sex offenders may not be possible, but teaching them to control their behaviors is a realistic goal.

Treatment for sex offenders in a correctional facility has been offered to males since 1948. However, the first treatment provider for females was not in a correctional setting, but rather in an outpatient therapeutic sex offender program.

Because most correctional facilities provide sex offenders treatment programs for males, society has several responsibilities with regard to female sexual offenders: (1) They must recognize that female offenders exist. (2) Society must discard gender-biased stereotypes that depict females as passive and submissive, and understand that females are

capable of a wide range of behavioral traits. (3) Professionals would need to evaluate and treat female adolescents early; therefore, the cycle of abusive behavior can be stopped before the adolescent reaches adulthood and becomes more difficult to treat. (4) Social workers, therapists, and treatment providers must share information regarding treatment and the rehabilitation of female sex offenders.

Presently, there are available effective means for managing and treating sex offenders, and if governments and funding agencies can be persuaded to offer greater support for treatment and research efforts, the number of innocent victims who suffer at the hands of these offenders can be reduced. In the long term, however, treatment of offenders is not the solution to this problem, although it is part of the solution. The knowledge that we have gained in working with offenders must be added to research that will develop prevention strategies. Steps toward the prevention of these crimes will require courage to implement (e.g., social change that empowers the victims and provide equal treatment for all sex offenders). Since there are many victims, timidity must be set aside if we are to be taken seriously as a truly responsible society.

Recommendations:

There are many reasons for funding effective sex offender treatment programs. However, the two most important ones are: (1) It reduces crime, and (2) it reduces the number of victims. Several studies have demonstrated how effective sex offender

treatment saves taxpayers' dollars. One study demonstrated that treating sex offenders is more cost-effective than incarceration without treatment (Prentky, 1990).

The nature of sex offenders necessitates teamwork and cooperation. All parts of the system must work as a team for treatment to be successful. Therefore, we need to:

- Develop a plan for future research on the factors that can predict treatment success.

- Identify system gaps and develop a plan for future development of both institutional and community programs for sex offender treatment and management.

- Develop standards for external monitoring of sex offenders who are determined to be unamenable to treatment.

- Develop recommendations for changes needed in other branches of government, including possible statutory changes.

- Identify potential funding for further research and program development.

Case managers, probation and parole officers as well as therapists and social workers should become familiar with the specific treatment approaches currently in

use with sexually aggressive men and women. Traditionally, psychotherapy has been the most commonly used treatment modality with all clinical populations. These professionals are now aware of the limitations of one-on-one "talk therapy" for sex offenders.

Because more than often, female offenders are involved with child protection and their children are in foster care, social workers would need to advocate for treatment for the offender and also the child(ren). A plan would need to be developed with the offender before reunification can take place. Social workers and child protection workers would need to be part of the offender's therapeutic plan at the correctional facility and become strong advocates for the offender before and during the process of reunification with the child and transitioning back into the offender's community.

To revisit the research questions: 1) Are treatment and rehabilitation offered equally to male and female sex offenders? In Minnesota, there is only one facility that provides sex offender treatment for females and four facilities for male sex offenders. Some correctional facilities house the sex offenders away from the general prison population to provide safety for the offender. However, in Minnesota, the female offender is housed with the general population of the correctional facility. This can create a safety issue for the offender.

2) Are treatment and rehabilitation offered in the correctional facilities for sex offenders? Treatment and rehabilitation have been offered in the correctional system for males since 1948; however, treatment was offered to female sex offenders in an outpatient setting in 1985 in Minnesota. 3) What type of treatment is offered to the sex offender? From 1948 to 1978, the treatment programs for sex offenders were based primarily on the traditional medical or psychiatric model. During the late 1870s and early 1980s, the new sex-offender discipline was a multidisciplinary approach which included a variety of psychodynamic, behavioral, cognitive, and biomedical elements that incorporated a wide range of educational training components.

4) What evaluation is used to assess the offender's readiness to live back in the community? According to the literature, male sex offenders have several options such as the transitional sex offender in Minnesota, furloughs, work release, and halfway houses. In Minnesota, female sex offenders do not have these options; they are usually referred to individual treatment. However, halfway houses have been provided in Canada in the last five years for the female sex offenders.

5) When do assessment, treatment, rehabilitation, and evaluation occur? Since the late 1980s, assessment and evaluation occur when the offender enters the correctional facility. Treatment and rehabilitation happen when the offender is deemed appropriate for treatment. For males, this happens within a small time frame since the assessment process takes place in a correctional facility away from the correctional

facility where they would be placed. For women, the process of treatment and rehabilitation will take longer because there is only one facility that houses female sex offenders.

A broader systems approach and multifaceted strategy is needed. Social workers can be instrumental in nurturing such a system. We as a society have a moral and ethical responsibility to continue research and develop programs that will meet the individual needs for all sex offenders.

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APPENDIX A

Sex Offenders and Treatment Programs in Minnesota Correctional Facilities, as of January 3, 1994

	Total Facility Population	Number of Sex Offenders	Sex Offenders As Percent Of Total	Sex Offender Treatment Slots	Treatment Slots As Percent of Sex Offenders
ADULT FACILITIES					
Faribault	583	94	16.1%	0	0.0%
Lino Lakes	502	182	36.3%	57	31.3%
Oak Park Heights	395	79	20.0%	28	35.4%
St. Cloud	835	144	17.2%	30	20.8%
Shakopee	142	7	4.9%	0	0.0%
Stillwater	1,443	370	25.6%	45	12.2%
Other facilities	294	0	0.0%	0	0.0%
Subtotal	**4,194**	876	**20.9%**	**160**	**18.3%**
JUVENILE FACILITIES					
Red Wing	73	4	5.5%	0	0.0%
Sauk Centre	91	15	16.5%	20	133.3%
Subtotal	**164**	**19**	**11.6%**	**20**	105.3%
TOTALS	4,358	895	20.5%	180	

Source: Department of Corrections.

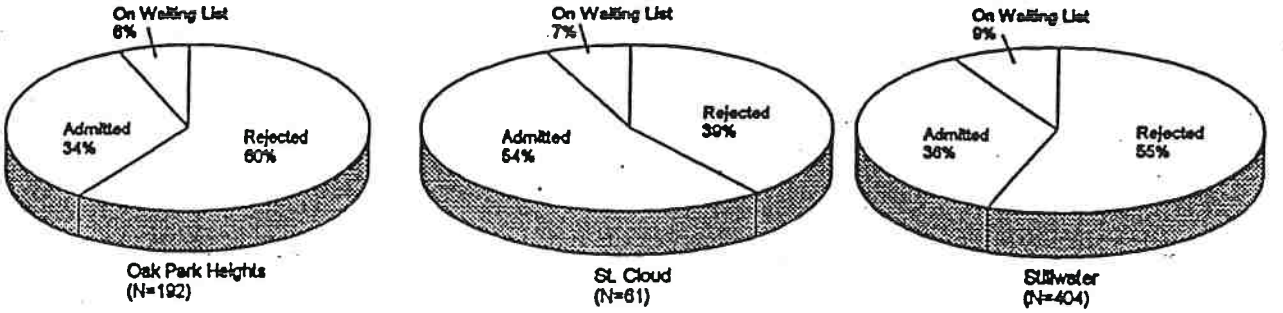
Inmates serving under a governing sex offense.

As of September 1993.

As of February 7, 1994.

APPENDIX B

Sex Offender Program Acceptance Rates
Minnesota Correctional Facilities
1992-93



Source: Program Evaluation Division analysis of data provided by Department of Corrections treatment officials.

APPENDIX C

PROGRAMS FOR SEX OFFENDERS
MINNESOTA DEPARTMENT OF CORRECTIONS

INTRODUCTION

Treatment programming has been provided since 1978 to sex offenders in Minnesota Department of Corrections' facilities. Sex offenders entering the department are immediately assessed to determine programming needs, and a number of different treatment approaches are provided:

- *Psychoeducational programming* is designed to deal with offenders who minimize or deny their offenses, inmates whose sentences are too short to allow them to enter more intensive treatment, and as an adjunct to therapy provided in department programs.
- *Intensive/long-term programming* is designed for offenders who have ingrained patterns of sexual offending, chemical dependency issues, and/or long criminal histories.
- *Alternative programming* is designed for inmates of lower intellectual functioning.
- *Transitional programming is* provided for offenders serving their last nine months of incarceration to prepare them for return to the community.
- *Aftercare programming is* provided in the facility for offenders continuing to serve their sentence and for those on supervised release in the community who have completed a department program.

SEX OFFENDER ASSESSMENT UNIT MCF-ST. CLOUD

After sentencing, adult sex offenders are sent to the department's reception center at the St. Cloud facility. After assessment, specific treatment programming recommendations and directives are determined.

Information contact: Maribel Torres-Bertram
MCF-St. Cloud
Box B
St. Cloud, Minnesota 56302-1000
(320) 240-3057

SEX OFFENDER PROGRAM MCF-LINO LAKES

This multi-track program is designed to meet the needs of both short- and long-term adult male offenders. It is housed in two living units with 150 beds. Following an intensive assessment and orientation phase, program participants are assigned to one of six therapeutic tracks.

Programming utilizes psychoeducation, group, individual and family therapy. Both chemical dependency and sexual offender treatment are provided. The goal of the program is to help the offender reduce his risk of reoffending through acceptance of responsibility for his problems; acquisition of new information, insight, cognitive and behavioral change; and development of a reoffense prevention plan.

Consistent with the goal of successful reintegration into society, transitional and aftercare services are provided or arranged for offenders completing the other program components. For those offenders exiting the facility, aftercare services are provided through contracts with agencies in the Twin Cities metropolitan area and outstate Minnesota.

Capacity: 150 adult males
Number participating annually: approximately 200
Staff: 16 clinical staff, 3 case managers, 10 custody staff
Information contacts: Robin Goldman
MCF-Lino Lakes
7525 Fourth Avenue
Lino Lakes, Minnesota 55014
(651) 717-6194

SEX OFFENDER PROGRAM MCF-WILLOW RIVER/MOOSE LAKE

This is a 60-bed unit at Moose Lake designed for sex offenders in need of long-term intensive treatment as well as those with a history of low social and/or intellectual skills. Referrals are received from other state-operated correctional facilities.

Sex offender assessments, sexual assault education, and therapeutic groups are components of the program. Individual therapy is provided based upon the needs of the offender.

The goal of the program is to reduce the risk of reoffense by helping the offender identify patterns of problematic behavior, take responsibility for those behaviors and develop a relapse prevention plan that includes strategies to deal with future behaviors.

Those offenders needing transitional and/or chemical dependency programming are referred to the sex offender program at Lino Lakes to complete the programming during their final nine months of incarceration.

Capacity: 60 adult males
Number participating annually: approximately 80-100
Staff: five full-time specialized personnel, nine custody corrections officers
Information contact: Nancy Stacken
MCF-Willow River/Moose Lake
1000 Lakeshore Drive
Moose Lake, Minnesota 55767
(218) 485-5039

WOMEN IN TRANSITION FEMALE SEX OFFENDER PROGRAM MCF-SHAKOPEE

This two- to three-year program is divided into four phases. Phase I is the intake evaluation process; phase II consists of individual counseling sessions; phase III consists of group therapy and attendance at psychoeducational programs; and phase IV is follow-up treatment with a community treatment program for 16 weeks after the inmate returns to the community.

The program's focus is holistic with the philosophy that sexual abuse is a symptom or end result of dysfunction(s) in the inmate's life. As a result, the inmate will acknowledge sexually abusive behavior, take responsibility for her crime, make amends

where possible, develop understanding of deviant behavior patterns, learn socially acceptable living patterns and provide an understanding of her self-worth so that she can provide for her restoration to society.
Capacity: 16 in phase III
Number participating annually: 12
Staff: two specialized personnel
Information contact: Maureen K. Franz
MCF-Shakopee
1010 West Sixth Avenue
Shakopee, Minnesota 55347-2213
(863) 496-4468

JUVENILE SEX OFFENDER PROGRAM MCF-SAUK CENTRE

This 30-bed residential program for adjudicated juvenile male sex offenders serves offenders who are denied admission to other programs due to age, aggressive behavior(s), previous sex offender-specific program failure, or offense denial. Program admission requires a court commitment to the commissioner of corrections for a sex or sex-related offense. Juveniles from the Red Wing facility who meet admission criteria are transferred to this program.

Programming is based on a group model integrating critical thinking skills training, psychoeducation and individual counseling. Psychoeducation involves elements such as victim awareness, offense prevention, cycle of abuse, grief and loss, social skills development and human sexuality education. Participants maintain a personal journal, completing writing and reading assignments. The program focuses on a continuum of care concept emphasizing aftercare and effective transitioning to community resources.

The program has a research component to evaluate its effectiveness and enhance its methods.

Department juvenile release guidelines establish reference points governing lengths of stay. Each participant has an individualized program plan which must be completed prior to release.
This program will transfer to the Red Wing facility in 1998.
Capacity: 30 juvenile males
Staff: corrections supervisor, three group leaders/case workers, 12 corrections officers
Information contact: James McArdell
MCF-Sauk Centre
Box C
Sauk Centre, Minnesota 56378
(320) 352-1100

PROGRAMMING FOR JUVENILE SEX OFFENDERS MCF-RED WING

Juvenile sex offenders admitted to the Red Wing facility who meet admissions criteria for the sex offender specific program at Sauk Centre are transferred to the Sauk Centre facility.

Juveniles who do not meet transfer criteria are provided services by a consulting sex offender therapist. These services include assessment, individual and group

counseling, and aftercare planning. Residents are referred to these program services most often because they have been sexually abused or because they have previously participated in a sex offender program and have been committed or recommitted for an offense other than sexual misconduct.

Number participating: varies with intake, but averages between eight to ten residents at any given time

Staff: trained staff and consulting therapist for juvenile sex offenders

Information contact: John Handy
MCF-Red Wing
1079 Highway 292
Red Wing, Minnesota 55066
(612) 267-3600

SEX OFFENDER SERVICES UNIT

This unit has department wide responsibility for centralized coordination, planning and implementation of sex offender programs and services. This includes assisting facilities in conducting assessments of sex offenders, making referrals for civil commitment, assisting programs in tracking referrals, monitoring contracts and grants for treatment and supervision of sex offenders on probation or supervised release, conducting large-scale research on sex offenders placed on probation, institutional research, and training. The unit is also responsible for implementation of the 1996 community notification law.

Information contact: Stephen J. Huot, Director
Sex Offender/Chemical Dependency Services Unit
Minnesota Department of Corrections
1450 Energy Park Drive, Suite 200
St. Paul, Minnesota 55108-5219
(651) 642-0279

APPENDIX D

MINNESOTA CORRECTIONAL FACILITY-LINO LAKES
SEX OFFENDER TREATMENT PROGRAM

CONTINUUM OF SERVICES/TRACK DESCRIPTIONS

ASSESSMENT

Clientele: Sex offenders who have been referred, interviewed and accepted by SOTP.
Estimated length of time: four weeks
Focus: The first stage of programming at SOTP. Programming includes a variety of staff-facilitated lectures, videos and discussions on chemical dependency, sexual offending, and group skills. In addition, Assessment participants undergo psychological testing and are screened for potential chemical dependency treatment.

Based on the outcome of the four-week assessment, a determination is made by the clinical staff regarding the individual's treatment needs and recommended program components.

TRACK 1

Treatment Preparation:
Clientele: Sex Offenders who maintain denial of their offenses or motives and offenders who need additional time to become group-ready.
Estimated length of time: four to six months
Focus: Develop ownership and accountability for offending behaviors and motives. Demonstrate comprehension of materials and information presented in the core psycheducational classes. Core classes include Cognitive Restructuring, Sexual Assault Dynamics, Anger Management/Assertiveness, and Morals and Values. The use of a polygraph may be used at times to assist in addressing denial.

TRACK 2

Long-Term, Intensive Chemical Dependency Treatment:
Clientele: Sex Offenders who have been assessed chemically dependent and in need of long-term, intensive chemical dependency treatment.
Estimated length of time: 9 to 12 months
Focus: Address chemical dependency issues as they relate to offending behavior including consequences of chemical use on themselves and others. Address criminal thinking and criminal history. Develop and implement a plan to maintain sobriety from alcohol/drugs.

Short-Term, Intensive Chemical Dependency Treatment:

Clientele: Sex Offenders who have been assessed as chemically dependent and in need of intervention. Inmates who have limited time remaining until release, or inmates who have had previous treatment and are in need of relapse prevention programming.
Estimated length of time: three to six months
Focus: Address chemical dependency issues as they relate to offending behavior including consequences of chemical use on themselves and others. Develop and implement a plan to maintain sobriety from alcohol/drugs.

TRACK 3

Long-term, Intensive Sex Offender Treatment:
Clientele: Inmates who are in need of long-term sexual offender treatment.
Estimated length of time: 9 to 12 months
Focus: Identify patterns of behavior, thoughts/beliefs/actions that lead to and maintain the offense behaviors and develop interventions for these issues. Develop empathy and an understanding of the consequences of their behavior.

Short-Term, Intensive Sex Offender Treatment:
Clientele: Inmates who have been determined by SOTP treatment staff to be appropriate based on a minimal offense history, prior long-term treatment without reoffending behavior, forthrightness about offense behaviors and motives, and/or limited time remaining until release.
Estimated length of time: four to six months
Focus: Identify thoughts/beliefs/actions that are involved in sexual offending behavior and develop interventions for offense-related behavior. Recognize boundary violations involved in their offending and develop appropriate interpersonal boundaries. Develop empathy and an understanding of the consequences of their behavior.

TRACK 4

Intensive Transitional Treatment:
Clientele: Inmates who have completed the other recommended program tracks and are close to their Supervised Release Dates (SRD) or are in need of full day programming due to other circumstances.
Estimated length of time: four to six months
Focus: Completion of a reoffense prevention plan, family therapy and release planning. Integration of learning into everyday behavior.

TRACK 5

Transitional Treatment:
Clientele: Inmates who have completed the other recommended program tracks, work full-time in the institution, and will be returning to the community or remaining in the prison system after program completion.
Estimated length of time: six to nine months

Focus: completion and implementation of a Reoffense Prevention Plan, family sessions and reintegration into society.

TRACK 6
POST-RELEASE PROGRAMMING

Institution-based (MCF-LL):
Clientele: Inmates that have completed a DOC sex offender treatment program and remain incarcerated.
Estimated length of time: Inmates may attend until release or transfer from MCF-LL. Biweekly voluntary meetings.
Focus: Support system for maintaining healthy behavior within the prison system. Continued integration of knowledge obtained in treatment.

Community-based:
Inmates that have completed treatment or are successfully participating in treatment up to their release date are referred to treatment providers in the community for follow-up services.

PSYCHOEDUCATIONAL CLASSES

A variety of psychoeducational classes are offered to the inmates in conjunction with the various program tracks. They are not offered to inmates outside of the program or as a separate treatment option. The classes offered include Cognitive Restructuring, Sexual Assault Dynamics, Anger Management/Assertiveness, Morals and Values, Relaxation and Energy, Victim Empathy, Personal Victimization (Class 1 and Class 2), Sexuality Education/HIV/STD, Forgiveness, Grief and Loss, Relationships, Social Skills, Sexual Behaviors, Criminal Thinking and Reoffense Prevention.

In addition, when appropriate to the individual's treatment plan, inmates are referred for parenting education classes, vocational training, and basic education, provided at this institution.