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Sex Offender Treatment Programs

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Members
Legislative Audit Commission

In June, 1993, the Legislative Audit Commission directed the Program Evaluation Division to conduct a study of treatment programs for sex offenders. As part of the study, we issued a report in February 1994 on the state's Psychopathic Personality Commitment Law. In this second report, we describe existing sex offender treatment programs and examine state oversight of treatment programs by the Departments of Corrections and Human Services.

We identified 70 programs in Minnesota that treat sex offenders, with three-fourths of them offering treatment on an outpatient basis. Reflecting the trend toward stiffer penalties for sex offenses, the number of beds in community residential programs has declined while treatment beds for sex offenders in state correctional facilities and the state-operated Minnesota Security Hospital have increased. Although a substantial number of sex offenders receive treatment, nearly half of those who begin treatment fail to complete it satisfactorily. We found that the laws that spell out regulatory responsibilities for sex offender treatment may require clarification and we suggest the Departments of Corrections and Human Services need to communicate and coordinate more effectively in overseeing treatment programs.

We received the full cooperation of the Department of Corrections and the Department of Human Services. This report was written by Marlys McPherson (project manager), David Chein, and Nancy VanMaren, with assistance from intern Dean Swenson.

Sincerely yours,

/s/ James Nobles

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Legislative Auditor

/s/ Roger Brooks

Roger Brooks
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Sex Offender Treatment Programs

EXECUTIVE SUMMARY

In response to public concern about sex crimes, the Legislature has toughened penalties for sex offenders, increased funding for programs that treat sex offenders, and taken steps to ensure that more offenders receive treatment. However, basic descriptive information about the number of treatment programs in operation and the number of sex offenders who receive treatment is lacking. Also, legislators have asked whether sex offender treatment programs are effective in reducing the rate at which sex offenders commit additional crimes.

We issued a report on Minnesota's psychopathic personality commitment law in February 1994.¹ In this second report on sex offender treatment programs we address the following questions:

- **How has the number of reported sex crimes changed in recent years? What are the characteristics of these crimes and the offenders who commit them? What sanctions do sex offenders typically receive?**
- **How many sex offender treatment programs are there in Minnesota and what do they consist of? How much treatment do offenders typically receive and how much does it cost?**
- **How do programs assess amenability to treatment? How many sex offenders receive treatment?**
- **To what extent are Minnesota's programs consistent with national treatment standards? Are treatment programs adequately overseen and coordinated by the Departments of Corrections and Human Services?**
- **What data do programs keep to judge whether treatment works? What is known about the effectiveness of sex offender treatment?**

To answer these questions, we analyzed reported crime and conviction data provided by the Department of Public Safety, Minnesota Supreme Court, Sentencing Guidelines Commission, and Office of Strategic and Long Range

¹ Office of the Legislative Auditor, *Psychopathic Personality Commitment Law* (St. Paul, 1994).

Since 1981, convictions for sex offenses involving force have remained constant, but those for intrafamilial and child sexual abuse have increased dramatically.

Planning. We interviewed officials and staff from the Departments of Corrections and Human Services, community corrections administrators, probation officers, and other criminal justice professionals. We also interviewed officials from sex offender treatment programs operating in the fall of 1993 and asked them to complete a short data form about each offender they treated in 1992. Finally, we reviewed Minnesota and national studies of treatment effectiveness.

DESCRIPTION OF SEX OFFENSES AND OFFENDERS

We found that:

- **The number of reported sex offenses in Minnesota increased almost threefold between 1971 and 1984, but has remained relatively constant since then.**

The number of sex offenses reported to the police increased from 2,303 offenses in 1971 to 6,589 offenses in 1984. In 1993, 6,439 sex offenses were reported, of which 49 percent resulted in an arrest.

We think that at least part of the increase in the 1970s and early 1980s was the result of mandatory child abuse reporting laws. As shown in the figure, since 1981, the majority of adult felony convictions have been for child and intrafamilial sexual abuse. We found that:

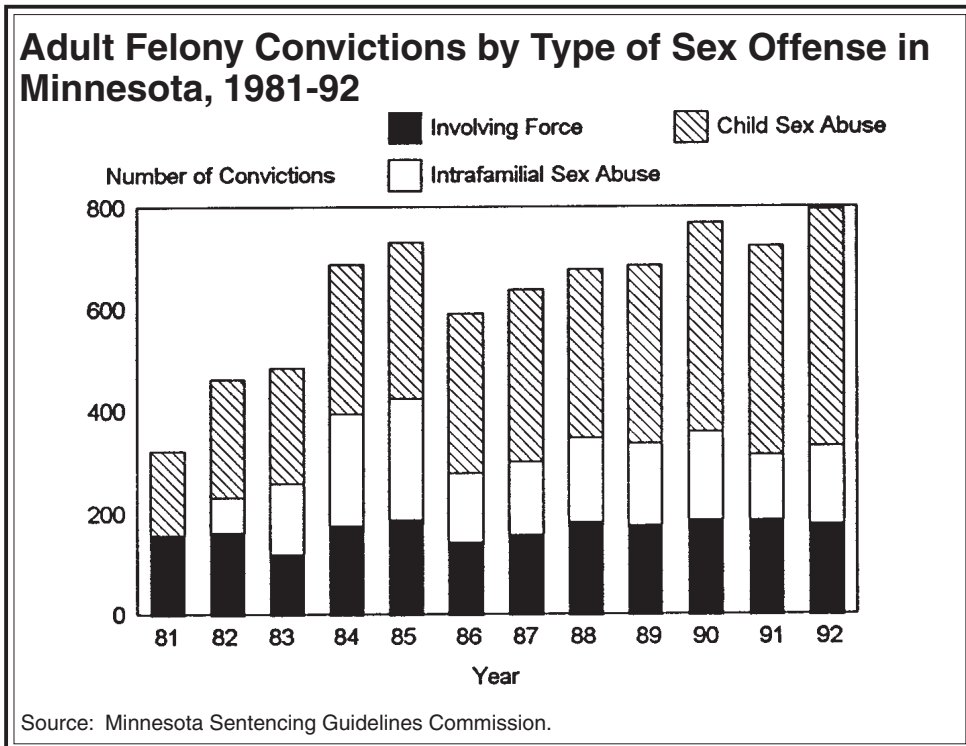
- **Between 1981 and 1992, adult convictions for sex offenses involving force remained at the level of 145 to 190 each year, but convictions for child sexual abuse nearly tripled, rising from 160 to 461, and convictions for intrafamilial sex abuse increasing from 3 to 154.²**

Reflecting these trends, about 90 percent of the victims of convicted sex offenders were children or adolescents. Nearly all of the victims of adjudicated juvenile offenders were under 18 years old, as were 84 percent of the victims of adult offenders (with 46 percent under age 13). Nearly all convicted sex offenders (97 percent) were male and most of their victims were female, although 18 percent of the victims of juvenile offenders and 13 percent of the victims of adult offenders were male.

About 90 percent of the victims of adult and juvenile sex offenders are under 18 years old.

The great majority of convicted sex offenders were related to or acquainted with their victims; only 6 percent of the victims were strangers to the offender. Thirty-nine percent of convicted sex offenders used force or caused fear of bodily harm and 2 percent of adult and 6 percent of juvenile offenders injured their victims.

² The Sentencing Guidelines Commission uses these categories, which are not mutually exclusive, to report convictions. Although many offenses could logically fit in more than one category, each offense has been counted only once.



Nearly all adult sex offenders convicted in 1992 spent some time in a state prison or local jail.

Based on probation officer interviews and data on sentencing, we found that:

- **Thirty percent of adults convicted of felony sex offenses in 1992 received a state prison sentence that averaged 7.4 years. The other 70 percent received probation, plus a local jail sentence of about six months, and were required to complete sex offender treatment as a condition of probation.**

An estimated 80 to 90 percent of adult sex offenders placed on probation were required to complete treatment as a condition of probation, and 90 percent were also sentenced to serve time in a local correctional facility. We also found that:

- **Adult sex offenders convicted of more serious crimes were more likely to receive a prison sentence.**

Between 47 and 61 percent of adult offenders convicted of sexual offenses involving penetration, force, or strangers in 1992 received a prison sentence. Although repeat sex offenders were more likely to be sent to prison, over 70 percent of sex offenders entering prison since July 1990 were first-time felony sex offenders and 73 percent had not previously received any sex offender treatment.

We found that:

- **Most juvenile offenders were placed on probation and required to complete treatment.**

Data on the court's disposition of juvenile cases were inadequate. However, probation officers told us that most adjudicated juveniles—75 to 85 percent—were required to complete sex offender treatment.

DESCRIPTION OF SEX OFFENDER TREATMENT PROVIDERS AND PROGRAMS

In 1993, there were 70 sex offender treatment providers, three-fourths of them offering outpatient treatment.

We attempted to identify all facilities, agencies, and individual providers that accepted court-referred sex offenders or received some public funds to operate programs that treated sex offenders. At the time of our study (fall 1993), we found that:

- **Seventy providers treated sex offenders, about three-fourths of which provided treatment on an outpatient basis.**

Nineteen providers offered sex offender treatment in a residential facility, of which six were funded and operated by the state (five correctional facilities and the Minnesota Security Hospital). The remaining 13 residential providers included three county correctional facilities, three sex offender-specific programs run by nonprofit agencies, five general treatment facilities where sex offender treatment was secondary to other services, and two halfway houses that provided limited treatment to sex offenders upon their release from prison. Ten of the 19 residential providers treated adult offenders and nine treated juveniles. Nineteen of the 51 outpatient providers were community mental health centers or clinics, and the remainder included hospitals, family therapy centers, the University of Minnesota, social service agencies, and private therapists.

We found that:

- **Overall, sex offenders received about two to three times as many hours of treatment in correctional and residential programs as in outpatient programs.**

Adult and juvenile offenders in outpatient programs received an average of 2.9 hours of treatment per week, while those in residential programs received an average of 8.5 hours. Taking into account the number of months that offenders typically remained in treatment, we estimate that offenders in outpatient programs received an average of 241 hours of treatment, compared to an

Offenders treated in outpatient programs received about half as much treatment as those in residential programs.

average of 464 hours for all 19 residential programs. However, offenders in sex offender-specific residential programs received an average of 970 hours of treatment and those treated in state correctional facilities received an average of 549 hours.

We also found that:

- **Treating adult sex offenders in the Minnesota Security Hospital or state correctional facilities was more costly than treating them in local residential facilities, and residential treatment was more costly for juveniles than adults.**

Daily costs at all residential facilities included treatment, plus room and board, supervision, and security costs. At \$210 per day, the Minnesota Security Hospital cost nearly three times more than other residential programs treating adult sex offenders in 1994. The average daily cost at the four adult correctional facilities with sex offender treatment available was \$77, which is slightly more than the cost at four local residential facilities providing sex offender treatment for adults (\$46 to \$69 per day).

The most expensive residential facility that provided treatment for juvenile sex offenders in 1993 was the Hennepin County Home School, at \$230 per day. The state juvenile correctional facility offering sex offender treatment, Sauk Centre, cost \$136 per day. Other juvenile residential facilities ranged from \$91 to \$139 per day. These costs were generally higher than the adult residential facilities that provided some treatment.

We found that it was more costly, overall, to treat sex offenders in residential settings than on an outpatient basis due to the additional costs associated with security and room-and-board. However,

- **Looking only at treatment costs, treatment in most correctional facilities was less expensive than outpatient treatment.**

In 1993, outpatient providers charged an average of \$38 per hour for group therapy and \$86 per hour for individual therapy (used less frequently than group therapy). Based on the number of hours in treatment per year, we calculated that the average annual cost of outpatient treatment was approximately \$7,200 per offender. This compares to annual treatment costs in adult correctional facilities that ranged from \$2,777 (Lino Lakes) per offender to \$6,203 (St. Cloud) and \$24,129 at the juvenile correctional facility (Sauk Centre). Treatment costs comprised between 11 percent and 50 percent of the total annual cost per offender at state correctional facilities.

Offenders pay what they can afford, with the remaining cost of treatment paid from a variety of public sources.

Treatment programs are funded by several sources, including county and state funds, medical assistance, private insurance, and offender contributions. But due to the complexity of funding and reimbursement mechanisms and because sex offender costs are not accounted for separately, we were unable to determine how much state government spends on sex offender treatment.

State funds pay for the treatment programs operated by the Department of Corrections in its correctional facilities and the program at the Minnesota Security Hospital operated by the Department of Human Services. Counties vary in their willingness to pay for residential treatment. Most outpatient programs operated on a sliding fee basis: offenders first contributed what they could afford or their insurance would pay for, and the remainder was paid through county, state, and federal sources, including medical assistance.

DESCRIPTION OF SEX OFFENDERS RECEIVING TREATMENT

We interviewed all 70 treatment providers and 43 probation officers from counties that accounted for approximately 85 percent of felony sex offenses. Probation officers told us that most sex offenders were routinely assessed by treatment program staff to determine whether the individual was amenable to treatment. Even programs within correctional facilities initially screened offenders to determine whether to accept them. Treatment providers told us that:

Most treatment providers are unwilling to accept sex offenders who are low functioning, pose security risks, or deny their crimes.

- **Between half and three-quarters of the sex offenders assessed were accepted into treatment.**

We asked treatment providers how they assessed offenders to determine whether to accept them, and we learned that assessment procedures varied from a file review to multiple tests given while the offender is in residence on a trial basis. Except for the Minnesota Security Hospital, which must accept all individuals who are civilly committed under the state's psychopathic personality commitment law, treatment providers based their acceptance decisions on several key factors. These included the offender's intellectual functioning, risk to others, and level of denial. Based on our interviews, we learned that:

- **Most treatment providers were unwilling to accept offenders who were developmentally disabled or low functioning, posed high security risks, or refused to take some responsibility for their crime.**

Treatment professionals told us that offenders need a minimum level of intellectual ability to succeed in treatment. Community residential and outpatient providers were unwilling to accept offenders who were considered security risks to others in treatment or the community at large, based on their use of violence and past history. Although many providers accepted offenders who denied or minimized their offenses, offenders were usually dropped from treatment if they did not eventually acknowledge responsibility.

In 1992, approximately 2,600 sex offenders received some treatment.

Based on data forms completed by treatment providers for each Minnesota sex offender treated in 1992, plus estimated data from providers unable to complete the forms, we estimate that:

- **Approximately 2,550 to 2,650 Minnesota sex offenders received some treatment in 1992, primarily in outpatient programs.**

Approximately two-thirds of those receiving treatment in 1992 were adults and one-third were juveniles. About 15 percent were treated in state-operated facilities (nearly all in correctional facilities), 19 percent in local residential programs, and the remaining two-thirds in outpatient programs. State correctional facilities and local residential facilities treated more serious offenders than outpatient programs. However, the most serious juvenile offenders tended to be treated in county correctional facilities, while the most serious adult offenders received treatment in state correctional facilities.

We also found that:

- **According to the professional judgment of treatment staff, almost half of the offenders who left treatment during 1992 did not satisfactorily complete it.**

In 1992, almost half of the sex offenders who left treatment failed to complete it satisfactorily.

Nearly half of the offenders treated in 1992 (48 percent) were still in treatment on December 31, 1992. However, of those offenders who left treatment during the year, 53 percent successfully completed treatment while 47 percent left before completing it to the satisfaction of program staff. Forty percent of those who did not complete treatment were asked to leave because they failed to make progress, violated program rules, threatened others, continued to deny their offenses, or otherwise were judged not amenable to treatment by program staff. One-third dropped out or left voluntarily, 13 percent were transferred to other programs, 8 percent left because their sentences or probationary periods expired before treatment was judged successful, and 6 percent violated probation or reoffended.

TREATMENT EFFECTIVENESS STUDIES

We reviewed the national literature on treatment effectiveness, as well as studies that have been done in Minnesota. We found that:

- **Very few evaluations of sufficient quality have been done to permit definitive conclusions about treatment effectiveness.**

Evaluations of sex offender treatment are very difficult to design and conduct. Most suffer from methodological deficiencies, such as lack of a controlled comparison to untreated offenders, inadequate measures of reoffense or recidivism, small samples, or inadequate follow-up periods.

We also found that:

- **Few Minnesota treatment providers tracked their clients to measure the extent to which they commit new offenses.**

With few exceptions, programs were unable to provide data on the rates at which the clients they had treated reoffended (recidivism). We identified eight Minnesota treatment programs for which recidivism data were available. However, only one study by the Department of Corrections compared treated offenders to untreated offenders and to those who dropped out of treatment before completing it, who had the highest recidivism rate of the three groups. Given the differences in populations treated and variation in methods and outcome measures, no comparisons of treatment effectiveness across programs can be made.

We found that:

- **National studies differ in their interpretation of results from the few methodologically sound treatment evaluations, some of which show positive effects from treatment and others which show no or negative effects.**

Researchers and treatment professionals agree that more and better research is needed, but they disagree over how to interpret existing findings. Some conclude from the conflicting evaluation results that, as yet, there is no evidence that treatment reduces reoffense rates of sex offenders. Others believe that the findings from several studies that treated offenders have lower recidivism rates than untreated offenders indicate that *some* kinds of treatment may be effective for *some* offenders.

ADEQUACY AND OVERSIGHT OF TREATMENT PROGRAMS

We compared Minnesota's sex offender treatment programs to descriptions of treatment programs in other states and to recently adopted national standards for adult and juvenile programs. We concluded that:

- **Minnesota's sex offender treatment programs appear consistent with programs described in the national literature with respect to treatment goals, philosophies, and methods.**

The national standards are very general and do not recommend specific treatment approaches. The majority of treatment programs in the U.S. utilized psychological approaches, occasionally accompanied by biomedical (drug) or behavioral techniques. Minnesota's treatment programs were similar in content and approach. They mainly used a variety of psychological

Some evaluations have found positive effects from sex offender treatment and others have found no or negative effects.

Like most programs in the U.S., Minnesota's sex offender treatment programs rely on psychological approaches and group therapy.

approaches in group therapy sessions to help offenders acknowledge their offenses, develop empathy for their victims, and change their behavior. However, we also found that:

- **Few programs provided for continued follow-up, monitoring, and aftercare services.**

Treatment professionals believe that treatment can help some offenders manage and control their sexual behaviors, even if deviant sexual arousal patterns (e.g., attraction to children) cannot be totally eliminated. Hence, the literature recommends that formal treatment should be followed by continued contact with the offender, either through “booster” treatment sessions, supervision over an extended period, or relapse prevention treatment. However, only a third of Minnesota’s treatment programs included a period of aftercare at the end of treatment and few providers monitored their clients long-term.

There are not enough beds in community-based residential programs to meet demand.

Although a substantial number of offenders received treatment, probation officers and others think that there are not enough adult local residential treatment programs to meet demand. Despite the increase in the number of sex offenders convicted of intrafamilial and child sex abuse, the number of residential treatment beds for adult offenders on probation has declined by 112 since 1978. At the time of our study, only two facilities treated adults on probation in a residential setting, and both had long waiting lists. Offenders unable to be placed in a secure residential program were either sent to prison or placed on probation and ordered to complete outpatient treatment where they may not receive enough treatment or supervision.

We also found that:

- **Although the Department of Corrections is currently developing rules for sex offender treatment programs, as mandated by the 1989 Legislature, the rules have not yet been adopted.**

The Departments of Corrections and Human Services share responsibility for licensing residential facilities that provide sex offender treatment as part of their services. However, none of the existing rules specifically covers sex offender treatment. The 1989 Legislature directed the Department of Corrections to adopt rules certifying adult and juvenile sex offender treatment programs in state and local correctional facilities, and the 1992 Legislature directed it to adopt a rule covering outpatient treatment programs.

According to Department of Corrections officials, the department lacked sufficient staff to comply with all of the Legislature’s mandates, which included developing new treatment programs in the prisons and training probation officers in sex offender supervision. The department has since established a Sex Offender Services Unit to coordinate its responsibilities with respect to sex offender treatment. In 1993, the department obtained legislative

State laws governing sex offender treatment regulation may be in conflict.

approval to remove the rulemaking requirement for outpatient treatment programs, and it expects to adopt the required rules for adult and juvenile residential sex offender treatment programs in 1994.

We also found that:

- **State laws are unclear and potentially in conflict about which facilities the sex offender treatment rules being drafted by the Department of Corrections will apply to, and the Departments of Corrections and Human Services have interpreted the laws differently.**

Both departments operate facilities that have sex offender treatment programs. Also, the Department of Human Services licenses facilities that treat individuals with mental illness or emotional problems (including chemical dependency), and the Department of Corrections licenses facilities for criminal offenders. However, largely as a result of court placement decisions over time, facilities licensed by the DHS may house juveniles who are very similar to those in facilities licensed by the DOC. The Department of Corrections has interpreted the laws directing it to adopt rules that would set standards for sex offender treatment programs in adult and juvenile residential facilities to mean that these rules will also apply to treatment programs in facilities operated or licensed by the Department of Human Services. However, there has been insufficient coordination and communication between the Departments of Corrections and Human Services in the rule-development process. Simultaneously the Department of Human Services was granted rulemaking authority by the Legislature to adopt its own rules covering the treatment programs it operates for persons committed as psychopathic personalities. The Department of Human Services has interpreted the laws to mean that it will set standards for programs in DHS-operated facilities, although it is unclear whether DOC's rules may apply to the residential treatment facilities with sex offender treatment programs licensed by DHS.

RECOMMENDATIONS

Given the current state of knowledge, we cannot make specific recommendations about whether or how to expand treatment. In the absence of solid evidence about treatment effectiveness, policymakers have to make decisions about treatment on other grounds, such as public opinion, values and beliefs, potential risks and benefits, or cost considerations. However, since 1989, the Legislature has taken steps to ensure that more sex offenders receive treatment and that more is learned about treatment effectiveness. Hence, we offer the following recommendations for improving the current sex offender treatment system.

State laws governing the regulation of sex offender treatment programs should be clarified.

We recommend that:

- **The Legislature should clarify existing state statutes governing rulemaking authority for the licensing and certification of sex offender treatment programs operated and licensed by the Departments of Corrections and Human Services.**

Given the difference of opinion between the Departments of Corrections and Human Services over who has authority to set standards for sex offender treatment programs and the potential conflict in existing statutes, we think the Legislature should clarify its intentions.

We also recommend that:

- **The Department of Corrections and Human Services should work together to ensure that appropriate treatment services exist and that treatment providers are appropriately regulated.**

Although both departments operate sex offender treatment programs and both regulate facilities that provide treatment, each department operates independently. We think that in order to ensure adequate treatment services and long-term supervision of sex offenders, these two departments need to work together more closely. In our report on the psychopathic personality law, we identified several states in which sex offender treatment was provided jointly by departments of corrections and human services/mental health.³

Specifically, we recommend that:

- **The Departments of Corrections and Human Services should review and clarify their licensing authorities over residential facilities. Also, the Department of Corrections should consult with the Department of Human Services in developing rules for sex offender treatment.**

The Departments of Corrections and Human Services should coordinate more effectively to oversee sex offender treatment programs.

The joint policy spelling out the regulatory relationship between the two departments dates back to 1985. In practice, some residential facilities licensed by the Department of Human Services accept individuals placed there by the court and operate sex offender treatment programs. It is especially important for the Department of Corrections to involve the Department of Human Services directly in the rule development process since the DOC intends to adopt its rules before the 1995 legislative session, which is the first opportunity for the Legislature to clarify agency responsibilities for sex offender treatment program standards.

³ Office of the Legislative Auditor, *Psychopathic Personality Commitment Law*, 34-38.

We also recommend that:

- **The Departments of Corrections and Human Services should review the need for standards covering outpatient treatment programs, and if needed, determine how and by whom regulation should occur.**

Over 60 percent of outpatient providers are not regulated by the state, except through professional licensing boards. Current licensing requirements do not contain specific qualifications for individuals providing sex offender treatment on an outpatient basis, yet two-thirds of the offenders receiving treatment were treated by outpatient providers. According to 30 percent of the probation officers we interviewed, their local outpatient treatment program was inadequate due to poorly trained counselors, narrow program focus, or lack of intensity. Since both the Departments of Corrections and Human Services provide some funding for outpatient programs, they should jointly review the need for outpatient treatment standards or certification.

Finally, we recommend that:

- **The Department of Corrections should monitor all sex offender treatment projects that currently receive state funds and require that grantees regularly submit data on offenders assessed and treated.**

It is reasonable to expect all treatment programs that receive state grant or contract funds to submit data on the clients they serve. The department should develop appropriate data collection forms and ensure that all treatment providers receiving state funds submit them regularly. If possible, these data should be incorporated into the sex offender treatment evaluation project the department is currently implementing.

Introduction

Recent concern about sex crimes has resulted in both a toughening of penalties for sex offenders and a growth of programs for treating sex offenders. Little is known, however, about how many adult and juvenile offenders actually receive and complete treatment or whether the treatment is effective in reducing subsequent sex offenses. We issued the first of two reports on the topic in February 1994.¹ In this second report, we examine sex offender treatment programs in Minnesota, describe their clients and characteristics, and summarize what is known about the effectiveness of treatment. We ask:

- **To what extent has the number of reported sex crimes increased in recent years? What are the characteristics of these crimes and the offenders who commit them? What sanctions do sex offenders typically receive?**
- **How many sex offender treatment programs are there in Minnesota? How much treatment do offenders typically receive and how much does it cost? How many sex offenders enter treatment and how many complete it?**
- **To what extent are Minnesota's programs operated consistent with national treatment standards? Is the current mix of treatment options adequate to meet demand? Are treatment programs adequately overseen and coordinated by the Departments of Corrections and Human Services?**
- **What is known about the effectiveness of sex offender treatment?**

To answer these questions, we analyzed crime and conviction data provided by the Department of Public Safety, the Minnesota Supreme Court, the Office of Strategic and Long Range Planning, and the Minnesota Sentencing Guidelines Commission. We also interviewed officials from the Departments of Corrections and Human Services, community corrections administrators, probation officers, and other criminal justice professionals. We interviewed officials from sex offender treatment programs operating in the fall of 1993

¹ Office of the Legislative Auditor, *Psychopathic Personality Commitment Law* (St. Paul, 1994).

and asked them to complete a short data form about each offender they treated in 1992. We also reviewed Minnesota and national studies of the effectiveness of sex offender treatment.

In general, we found that sex offense rates increased dramatically between 1971 and 1984, but have remained constant since then. Most sex crimes are perpetrated against children under 18 years old, and most offenders are related to or known by their victims. The Legislature has responded to the issue of sex crimes by increasing penalties for convicted sex offenders and enacting requirements and providing funding for sex offender treatment. There were 70 sex offender treatment programs operating in the fall of 1993. Over 2,000 sex offenders received some kind of treatment in 1992, mostly on an outpatient basis, but we estimate that nearly half failed to complete it. Although we found few requirements or rules about the contents of treatment and limited state oversight of programs, Minnesota's sex offender treatment programs were consistent with programs described in the national literature with respect to treatment goals, philosophies, and methods. Most sex offenders are assessed and accorded an opportunity to receive treatment, but we found very little follow-up, monitoring, and aftercare of offenders who complete treatment, and insufficient evidence to permit definitive conclusions about treatment effectiveness.

In the remainder of this report, we explore these issues in greater detail. Chapter 1 reviews trends in reported sex crimes, examines the characteristics of sex offenses, offenders, and victims, and summarizes sentencing patterns for convicted sex offenders. Chapter 1 also summarizes current sex offense statutes and reviews changes in sex offense definitions, sanctions, and treatment requirements. Chapter 2 reviews the national literature on sex offender recidivism and treatment effectiveness. Chapter 3 describes sex offender treatment programs in Minnesota, and Chapter 4 describes the offenders who were treated by those programs. Chapter 5 examines treatment availability and state oversight and administration of existing programs and treatment providers.

Background

CHAPTER 1

In this chapter, we describe sex offenses committed in Minnesota and discuss how the Legislature has dealt with them. We ask:

- **How many sex crimes are committed each year? What are the characteristics of sex offenders and the circumstances of their offenses? Who are the victims of sex crimes? How have the number and type of sex offenses changed over the years?**
- **How are sex offenders handled by the criminal justice system? How many sex offenders go to prison and for how long? How many offenders are ordered to complete sex offender treatment?**
- **How has the Legislature responded to the issue of sex crimes in recent years?**

Our analysis is based on data on reported crimes compiled by the Information and Analysis Division of the Department of Public Safety and data on criminal convictions and sentencing collected by the Supreme Court and compiled by the Sentencing Guidelines Commission (for adult offenders) and the Office of Strategic and Long Range Planning (for juvenile offenders). We reviewed recent legislation aimed at addressing the issue of sex crimes, and we interviewed community corrections administrators, Department of Corrections field supervisors, and 23 adult and 20 juvenile county and state probation officers about sentencing and treatment decisions.

We found that the sex crime rate has more than doubled between 1971 and 1984, but it has remained at about the same level since 1984. Almost half of the 1,379 offenders convicted of sex offenses in 1991 were juveniles under 18 years old. Most offenders knew their victims and the vast majority of victims were juveniles. About one-fifth of the adult convictions and one-third of the juvenile dispositions involved intrafamilial sex offenses. Offenders who used force usually received harsher penalties than intrafamilial offenders or child molesters. In recent years, the Legislature has included more behaviors in the definition of sex crimes, enacted measures to make prosecution of sex offenders easier, increased penalties for serious and repeat sex offenders, and provided additional requirements and funding for sex offender treatment.

CRIMINAL STATUTES AND PENALTIES

Figure 1.1 presents the statutory definitions for the five degrees of criminal sexual conduct.¹ The five degrees differ primarily on three factors: whether or not there was sexual penetration, the amount of force involved, and the relationship of the offender to the victim. First and third degree criminal sexual conduct involve sexual penetration, and second, fourth, and fifth degree

Figure 1.1: Components of Criminal Sexual Conduct Statutes

Criminal Sexual Conduct in the First Degree (Minn. Stat. §609.342):

Requires **sexual penetration** and one of the following conditions:

- victim under 13 and offender more than 3 years older;
- victim 13-15 and offender more than 4 years older and in a position of authority over the victim;
- victim under 16 and offender is parent, stepparent, other adult in the home, or other relative specified in the statute; or
- victim is any age and offender uses force including a weapon, accomplices, injury, or fear of great bodily harm.

Criminal Sexual Conduct in the Second Degree (Minn. Stat. §609.343):

Requires **sexual contact** and any of the conditions specified in criminal sexual conduct in the first degree.

Criminal Sexual Conduct in the Third Degree (Minn. Stat. §609.345):

Requires **sexual penetration** and one of the following conditions:

- victim under 13 and offender less than 3 years older;
- victim 13-15 and offender more than 2 years older;
- victim 16-17 and offender is parent, stepparent, other adult in the home, other relative specified in the statute, or a person in a position of authority over the victim;
- victim is any age and offender uses force or coercion (but less force than first degree criminal sexual conduct);
- victim is mentally impaired or physically helpless;
- offender is psychotherapist and the victim is patient or former patient; or
- offender is health care professional who falsely represents medical purpose for the penetration.

Criminal Sexual Conduct in the Fourth Degree (Minn. Stat. §609.345)

Requires **sexual contact** and any of the conditions specified under criminal sexual conduct in the third degree.

Criminal Sexual Conduct in the Fifth Degree (Minn. Stat. §609.3451)

Any non-consensual **sexual contact**, except touching of the clothing covering the buttocks. Includes removal of clothing if done with sexual or aggressive intent.

¹ Minn. Stat§609.341-609.3451.

Minnesota has five degrees of criminal sexual conduct, depending on the nature of the offense.

involve sexual contact without penetration.² In general, first and second degree criminal sexual conduct involves a greater use of force (such as use of a weapon, use of accomplices, injuring the victim, or causing fear of great bodily harm) than third, fourth, or fifth degree criminal sexual conduct. For crimes against children, first and second degree criminal sexual conduct involve a greater age disparity between the offender and the victim than third or fourth degree criminal sexual conduct.³

Criminal sexual conduct requires some level of sexual contact between an offender and a victim. There are also illegal activities of a sexual nature that do not involve sexual contact, including window peeping, indecent exposure, and obscene phone calls.⁴ All are misdemeanors. In addition, activities related to prostitution (engaging in sexual acts for hire) are felonies with varying degrees of penalties depending upon the offender's role and the involvement of minors.⁵ We do not discuss prostitution in this report.

Minnesota's sentencing guidelines specify the sentences that judges should impose for most felony offenses ("presumptive" sentences). The sentences are based on a ranking of the severity of the offense and a criminal history score determined by prior convictions. Figure 1.2 shows how the Sentencing Guidelines Commission has ranked felony sex offenses and the presumptive sentence for first-time offenders.⁶ The guidelines specify more severe sentences for offenders with one or more prior criminal conviction. Judges may depart from the sentence specified in the guidelines if there are mitigating or aggravating factors, but they must provide a written explanation for the departure.⁷

² "Sexual penetration" is defined broadly to include sexual intercourse, oral and anal sex, and any intrusion into the genital or anal opening of the victim's body by any part of the offender's body or any object used by the offender (*Minn. Stat.* §609.341, subd. 12). "Sexual contact" includes the intentional touching of the victim's intimate body parts including the clothing covering the intimate body parts, or the inducement or coercion of the victim to touch the offender's intimate body parts. (*Minn. Stat.* §609.341, subd. 11).

³ There are other laws intended mainly to regulate sexual contact between consenting adults, but they are rarely enforced. Sodomy (*Minn. Stat.* §609.293) prohibits oral and anal sex; bestiality (*Minn. Stat.* §609.294) prohibits sex with an animal or dead body; fornication (*Minn. Stat.* §609.34) prohibits sexual intercourse between a single woman and a man; adultery (*Minn. Stat.* §609.36) prohibits sexual intercourse between a married woman and a man other than her husband; and incest (*Minn. Stat.* §609.365) prohibits sexual intercourse between a person and a blood relative closer than first cousin. However, incestuous relationships or other sexual crimes against children are almost always prosecuted under the criminal sexual conduct statutes.

⁴ *Minn. Stat.* §609.745, subd. 1; *Minn. Stat.* §617.23; and *Minn. Stat.* §609.79.

⁵ *Minn. Stat.* §§609.321-609.324.

⁶ The statutory maximum sentences for first through fourth degree criminal sexual conduct range from 30 years in prison and a \$40,000 fine for first degree criminal sexual conduct to 10 years in prison and a \$20,000 fine for fourth degree criminal sexual conduct. Minnesota's sentencing guidelines system, however, precludes imposition of maximum sentences except under limited circumstances. Fifth degree criminal sexual conduct is a gross misdemeanor with a maximum sentence of one year in jail and a \$3,000 fine.

⁷ These factors include, among others, the offender's role in the offense, the victim's role in the offense, the victim's vulnerability, the amount of cruelty displayed, and the offender's amenability to treatment. In addition, a specific aggravating factor is a prior conviction for a criminal sexual conduct offense. See *Minnesota Sentencing Guidelines and Commentary*, 22-23.

Sentencing guidelines call for prison sentences for first-time offenders convicted of first degree criminal sexual conduct and second and third degrees with force.

As Figure 1.2 shows, the guidelines specify presumptive prison sentences for first-time offenders convicted of first degree criminal sexual conduct and those sections of second and third degree criminal sexual conduct that involve force. First-time offenders convicted of violating other criminal sexual conduct statutes would receive a “stayed” prison sentence, with the offender placed on probation. The conditions of probation could include a term in a county jail or workhouse for up to one year and completion of sex offender treatment. The judge could then reimpose the prison sentence if the offender failed to satisfy the conditions of probation.

Figure 1.2: Sentencing Guidelines Presumptive Sentences for Sex Offenses

Degree of Sexual Conduct	Severity Level	Presumptive Sentence with No Prior Criminal History ^a
First Degree	VIII	81-91 months in prison
Second Degree With force	VII	44-52 months in prison
Without force	VI	21 months stayed sentence
Third Degree With force ^b	VII	44-52 months in prison
Without force	V	18 months stayed sentence
Fourth Degree With force ^b	VI	21 months stayed sentence
Without force	IV	12 months stayed sentence

Source: Minnesota Sentencing Guidelines Commission, *Minnesota Sentencing Guidelines and Commentary* (St. Paul, 1992), 41-44.

^aJudges may impose up to one year in jail and a monetary fine as a condition of probation. Presumptive sentences for offenders with criminal histories are longer than those listed above.

^bAlso applies to offenses against mentally or physically impaired victims and patients victimized by psychotherapists or health care professionals.

In addition to the sentencing guidelines, the statutes contain other provisions that either permit or require long prison sentences for violent or repeat sex offenders. These provisions, ranging from a minimum of three years to life in prison, are summarized in Figure 1.3.

TRENDS IN SEX CRIMES REPORTED TO LAW ENFORCEMENT

Information on reported crimes is collected by local law enforcement agencies and compiled by the state Department of Public Safety. Summary crime statistics are reported according to categories developed by the Federal Bureau of Investigation. Sex crimes are divided into two categories, “rape” and “other

sex crimes.” The number of reported rapes and other sex crimes from 1971 through 1993 are shown in Figure 1.4.

“Rape,” as defined by the Department of Public Safety, is “the carnal knowledge of a female forcibly and against her will, excluding statutory rape and other sex offenses.”⁸ We learned, however, that in practice the Department of Public Safety does not precisely follow its published definition. It counts all criminal sexual conduct in the first and third degree (the offenses involving

Figure 1.3: Additional Penalties for Sex Offenders

Minimum 3-Year Sentence for Repeat Offenders (*Minn. Stat. §609.346, subd. 2.*):

Offenders convicted of first through fourth degree criminal sexual conduct with a sex offense conviction within the previous 15 years *must* serve *either* a minimum of three years in prison or a jail term followed by long-term inpatient treatment at a program exclusively treating sex offenders and approved by the Commissioner of Corrections.

Doubling of Sentence for Patterned Sex Offenders (*Minn. Stat. §609.1352*):

The court *may* double the presumptive sentence (up to the statutory maximum) if it finds, based on a professional assessment, that an offender is a “*patterned sex offender*” who presents a danger to the public safety and needs long-term treatment or supervision.

Statutory Maximum Sentence for Violent Offenders with History of Violent Offenses (*Minn. Stat. §609.152*):

The court *may* depart from presumptive sentences and impose a prison sentence up to the statutory maximum for offenders convicted of violent crimes (including, among others, murder, manslaughter, assault, and criminal sexual conduct) who have two or more prior convictions for violent crimes and present a danger to public safety.

Doubling of Presumptive Sentence for Violent Offenders (*Minn. Stat. §609.346, subd. 4.*):

The court *must* double the presumptive sentence for offenders convicted of first, second, or third degree criminal sexual conduct involving force if it finds that there are aggravating factors that would merit an upward departure in the sentencing guidelines.

Mandatory 30-Year Sentence (*Minn. Stat. §609.346, subd. 2b.*):

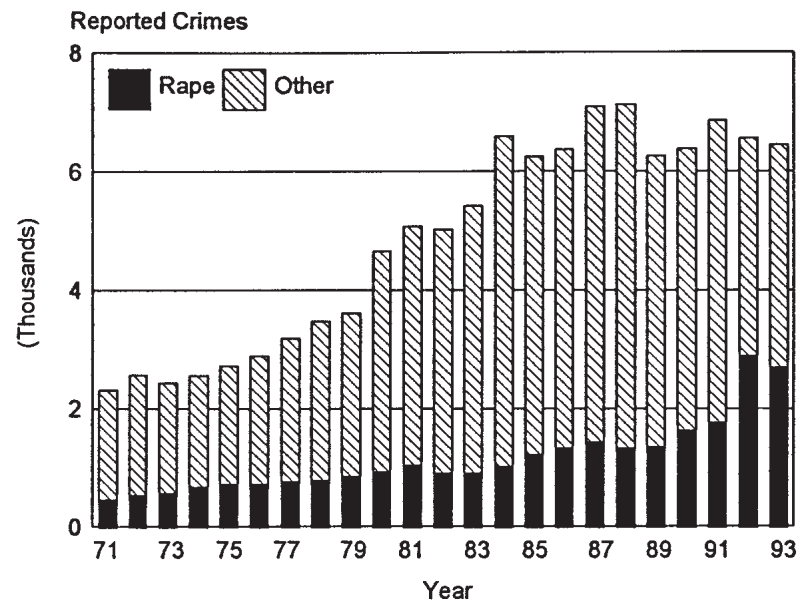
The court *must* impose a 30-year prison sentence for offenders convicted of first or second degree criminal sexual conduct involving force if it finds that there are aggravating factors that would merit an upward departure in the sentencing guidelines and the offender was previously convicted of first, second, or third degree criminal sexual conduct.

Mandatory Life Sentence for Repeat Offenders (*Minn. Stat. §609.346, subd. 2a*):

The court *must* sentence an offender convicted of first degree criminal sexual conduct to life imprisonment if the offender was previously convicted as a patterned sex offender, was previously convicted of first, second, or third degree criminal sexual conduct and received a sentence of at least twice the presumptive sentence, or had two or more previous convictions of first, second, or third degree criminal sexual conduct.

⁸ Department of Public Safety, Office of Information Systems Management, *Minnesota Crime Information, 1992* (St. Paul, 1994), 12.

Figure 1.4: Reported Sex Offenses in Minnesota, 1971-93



Source: Minnesota Department of Public Safety, Minnesota Crime Information.

sexual penetration) in its “rape” category, including offenses against male victims and children. Criminal sexual conduct in the second and fourth degree, crimes that involve sexual contact, are included in the “other sex crimes” category.⁹ In practice, both categories include several types of sex crimes, including child molestation, intrafamilial sexual abuse, and sexual assaults involving physical force, regardless of the age and sex of the victim. Figure 1.4 shows that:

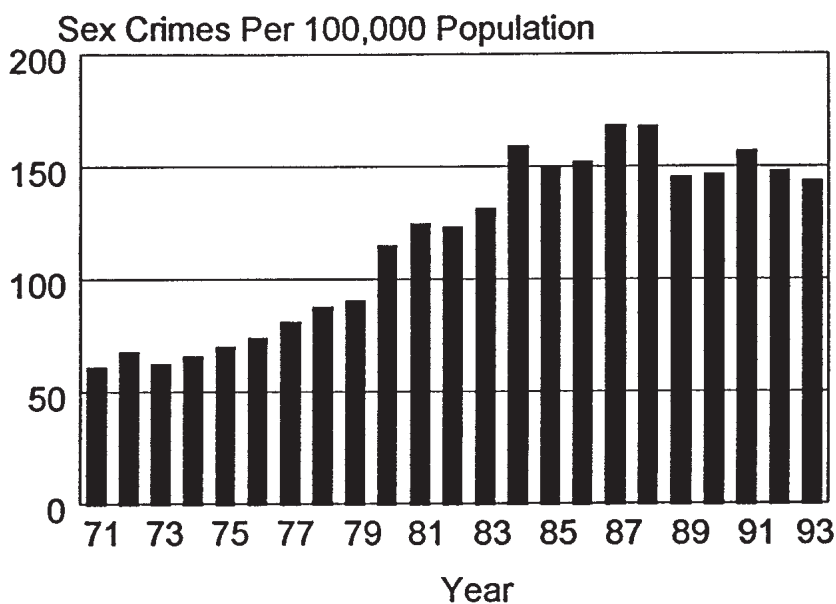
- **The number of sex crimes reported to the police has increased almost threefold, from 2,303 in 1971 to 6,439 in 1993, but the sex crime rate has remained about the same since 1984.¹⁰**

Some of the increase is the result of population growth, but as Figure 1.5 shows, the sex crime rate per 100,000 in 1993 was more than double the 1971 rate. The increase in sex crimes since the early 1970s may have resulted, in part, from increased reporting of sex crimes, especially crimes against children, resulting from efforts of women’s groups and child advocates. For

⁹ The Department of Public Safety has a third category, prostitution and commercialized vice. As noted earlier, we do not discuss prostitution in this report.

¹⁰ Figure 1.4 shows a sharp increase in “rapes” and a corresponding decrease in “other sex crimes” between 1991 and 1992, but the Department of Public Safety says that this resulted from correcting coding errors for prior years and not from a fundamental change in criminal behavior patterns. The Department of Public Safety also reports that, for the years 1985 through 1991, about 45 percent of the rapes (sex crimes involving penetration) and 40 percent of the other sex crimes resulted in an arrest. In 1992 and 1993, the percentage of rapes and other sex offenses resulting in an arrest increased to 53 percent and 46 percent, respectively.

Figure 1.5: Sex Crime Rates in Minnesota, 1971-93



Source: Minnesota Department of Public Safety, Minnesota Crime Information.

After increasing steadily in the 1970s, Minnesota’s sex crime rate has remained constant since 1984.

example, in 1975, the Legislature required health care, child care, social service, and education professionals to report suspected cases of physical or sexual abuse of children to child protection and law enforcement agencies.¹¹ Similarly, changing societal attitudes towards rape may have resulted in an increased willingness among women to come forward and report cases of acquaintance and stranger rape and among law enforcement officials to take action when they receive those reports.¹²

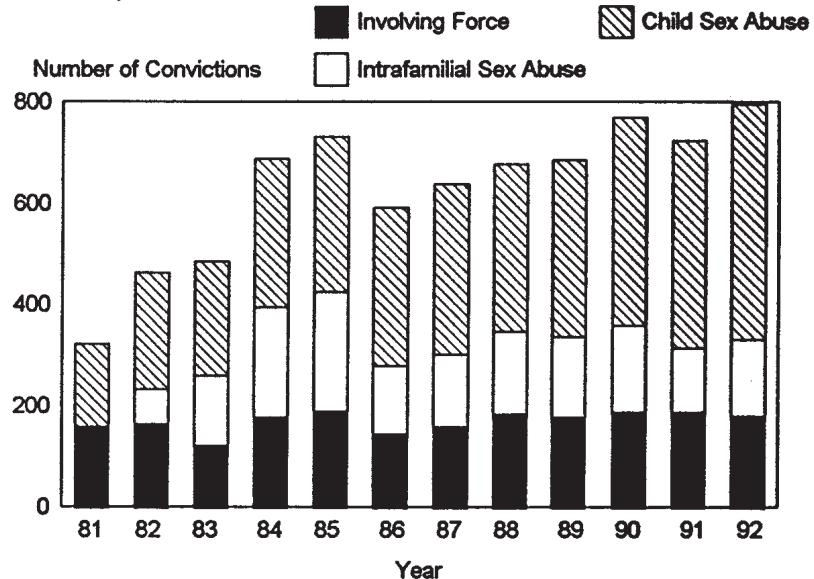
The Sentencing Guidelines Commission reports sex crime convictions based on the offense that determined the sentence. It groups offenses into several categories, including sex crimes involving force, intrafamilial sex abuse, and child sexual abuse. These categories are not mutually exclusive and many offenses could logically fit in more than one category. Also, the governing offense is influenced by prosecutorial discretion and plea bargaining and may not always reflect the total nature of the crime. Nevertheless, this categorization is useful for presenting a picture of the types of sex offenses committed. Using these categories, Figure 1.6 shows that:

¹¹ *Minn. Laws* (1975) Ch. 221; *Minn. Stat.* §626.556. A study of reports of sexual abuse of children in 1978 and 1979 found that most reports did not result in prosecution of alleged offenders. See Chein, David B., *The System's Response to Sexual Abuse of Children* (St. Paul: Crime Control Planning Board, 1981).

¹² National surveys of crime victims indicate that between 40 and 60 percent of sex crimes against persons at least 12 years old are reported to the police, a figure that has remained fairly constant since 1973. These victimization surveys, however, do not include child victims. U.S. Department of Justice, Bureau of Justice Statistics Bulletin, *Criminal Victimization* (Washington, DC, 1991).

- Convictions for both intrafamilial sex abuse and other sex crimes against children have increased greatly since 1981, but convictions for sex crimes involving force have remained about the same.

Figure 1.6: Convictions by Type of Sex Offense in Minnesota, 1981-92



Source: Minnesota Sentencing Guidelines Commission.

Convictions for sex offenses against children have increased greatly since 1981, but the overall number of sex crimes involving force has been stable.

For example, in 1981, there were 160 convictions of adults for sex crimes against children and 158 for sex crimes involving force. In 1992, the number of convictions for sex crimes involving force had risen to 180, a 14 percent increase, but the number of convictions for offenses against children had increased to 461, a 188 percent rise. Intrafamilial sexual abuse was a new crime category in 1981 with only three convictions but, by 1992, there were 154 convictions. It is possible, therefore, that the increase in sex crime rates stems primarily from increased public awareness and reporting of sex crimes against children and increased willingness of criminal justice officials to take action against these offenders.

CHARACTERISTICS OF SEX OFFENSES

Data on criminal convictions come from reports submitted by district courts to the Minnesota Supreme Court. These reports include information on the offender, the victim, the nature of the crime, and the sentence imposed. (Juveniles are not officially convicted and sentenced. They are “adjudicated” delinquents and receive a “disposition.”) A standard Minnesota Uniform Offense Code is used to describe the nature of the offense, the relationship of the offender to the victim, and the age and sex of the victim. Data on adult

offenses are then summarized by the Sentencing Guidelines Commission and data on juvenile offenses are summarized by the Office of Strategic and Long Range Planning.¹³

We found several deficiencies in the data, some of which we could correct. To begin with, the Supreme Court does not routinely audit the data to verify their accuracy. If county clerks do not place a high value on accurate reporting, errors may result. In many cases, the description of the offense, such as whether force was used, was not coded. In the case of juvenile data, counties were not consistent in the way they reported juveniles charged with several crimes at the same hearing. Some counties listed these as one offense and others had multiple entries. To make the data consistent, we eliminated duplicates and included only the most recent offense for juveniles who had a single dispositional hearing for multiple offenses.

Prosecutorial discretion and plea bargaining may influence the actual charge for which adult offenders are convicted and juveniles adjudicated delinquent. Cases where a sex offense was committed, but the offender pleaded guilty to another offense, such as assault or burglary, are not included. Rape-murders were coded as murders, the more serious offense, and are not included in our summary sex offense data.¹⁴ In addition, the adult data represent only felonies while the juvenile data include cases of criminal sexual conduct in the fifth degree, a gross misdemeanor.

Table 1.1 summarizes the characteristics of juvenile sex offenders in 1991 and Table 1.2 provides information about the nature of their offenses.¹⁵ These tables show that:

- **Most juvenile sex offenders were males and most of their victims were female acquaintances or family members under 13 years old.**

Table 1.1 indicates that 96 percent of the juvenile sex offenders in 1991 were males and 57 percent were between 13 and 15 years old. Table 1.2 shows that 82 percent of the victims of juvenile sex offenses were females and 70 percent were under 13 years old. Most offenders knew their victim. Only five percent of the victims were strangers, and 35 percent were members of the offender's family. Table 1.2 also shows that:

- **The majority of sex offenses committed by juveniles did not involve force.**

¹³ The Sentencing Guidelines Commission also uses data from probation officers' sentencing worksheets to prepare annual offense summaries.

¹⁴ The Department of Public Safety reported five homicides committed in conjunction with a rape in 1992. Department of Public Safety, *Minnesota Crime Information* 1992, 25.

¹⁵ As of January 1994 when we completed our data analysis, 1991 data were the most recent available from the Office of Strategic and Long Range Planning on juvenile offenses.

Table 1.1: Characteristics of Juvenile Sex Offenders, 1991

	Number	Percent
Offender's Age		
12 and under	86	13%
13	113	17
14	148	23
15	111	17
16	105	16
17	<u>89</u>	<u>14</u>
Total	652	100%
Offender's Sex		
Male	624	96%
Female	<u>27</u>	<u>4</u>
Total	651	100%
Offender's Residence		
Twin Cities Metropolitan Area	367	56%
Outstate Minnesota	<u>287</u>	<u>44</u>
Total	654	100%

Source: Office of Strategic and Long Range Planning.

Table 1.2: Characteristics of Juvenile Sex Offenses, 1991

	Number	Percent
Use of Force		
No Force	290	57%
Force/Fear of Harm	189	37
Force with Injury	<u>32</u>	<u>6</u>
Total	511	100%
Age of Victim		
Under 13	407	70%
13-15	135	23
16-17	27	5
18 and older	<u>11</u>	<u>2</u>
Total	580	100%
Sex of Victim		
Male	102	18%
Female	<u>478</u>	<u>82</u>
Total	580	100%
Relationship of Offender to Victim		
Acquaintance	304	55%
Family Member	193	35
Position of Authority	29	5
Stranger	<u>28</u>	<u>5</u>
Total	554	100%

Source: Office of Strategic and Long Range Planning.

Just over one-third of the victims of juvenile sex offenders were members of the offender's family.

Tables 1.3 and 1.4 summarize the 798 adult sex offense convictions in 1992. Table 1.3 shows that 98 percent of the sex offenders in 1992 were male. Offenders varied in age, with about three-fifths of the adult offenders between 22 and 42 years old. Table 1.3 also shows that:

- **Most adult sex offenders had no previous felony convictions.**

Over three-fifths of the adult sex offenders convicted in 1992 had no prior felony convictions.¹⁶

We also found that:

- **Most victims of sex offenses committed by adults were females under 18 years old. In addition, only 7 percent of the sex offenses committed by adults involved victims who did not know the offender.**

Over 60 percent of adult sex offenders in 1992 had no prior criminal record.

Table 1.3: Characteristics of Convicted Adult Sex Offenders, 1992

	Number	Percent
Offender's Age		
21 and under ^a	178	22%
22-27	167	21
28-33	154	19
34-42	160	20
43 and older	139	17
Total	798	100%
Offender's Sex		
Male	778	97%
Female	20	3
Total	798	100%
Offender's Race		
White	619	78%
Black	96	12
Hispanic	36	5
Native American	27	3
Asian	15	2
Other	5	1
Total	798	100%
Offender's Residence		
Twin Cities Metropolitan Area	396	50%
Outstate Minnesota	402	50
Total	798	100%
Criminal History Score		
0	496	62%
1	108	14
2	74	9
3	56	7
4 or More	64	8
Total	798	100%

Source: Sentencing Guidelines Commission data.

^aIncludes 18 juveniles sentenced as adults.

¹⁶ Data provided to us by the Department of Corrections on all 887 sex offenders admitted to Minnesota prisons between January 1991 and October 1993 revealed that 73 percent had no prior felony sex offense convictions and 47 percent had no prior felony convictions at all.

Table 1.4: Characteristics of Adult Sex Offenses, 1992

	Number	Percent
Use of Force		
No Force ¹	371	65%
Force/Fear of Harm	186	33
Injury	<u>11</u>	<u>2</u>
Total	568	100%
Age of Victim		
Under 13	331	46%
13-15	232	32
16-17	42	6
18 and Over	<u>116</u>	<u>16</u>
Total	721	100%
Sex of Victim		
Male	91	13%
Female	<u>630</u>	<u>87</u>
Total	721	100%
Relationship of Offender to Victim		
Parent/Stepparent	133	19%
Spouse/Cohabitor	38	5
Other Family	97	14
Position of Authority	51	7
Acquaintance	342	48
Stranger	<u>49</u>	<u>7</u>
Total	710	100%

Source: Sentencing Guidelines Commission data.

¹Includes 87 cases of multiple sex offenses over time.

Table 1.4 shows that most sex offense victims were females, although 13 percent were males. Most victims (84 percent) were under 18 years old. In fact, as Figure 1.7 shows, 46 percent of the victims of adult sex offenders were under 13 years old and another 32 percent were between 13 and 15. Only 16 percent of the offenses involved adult victims. In combination with the data on sex offenses committed by juveniles discussed above, this suggests that:

- **About 90 percent of the victims of sex offenses are children under 18 years old.**

Table 1.4 also shows that 48 percent of the victims of adult sex offenders were acquaintances and an additional 38 percent were members of the offenders' families.

Finally, we found that:

- **Most sex offenses committed by adults did not involve force.**

Five out of six victims of adult sex offenders were under 18 years old.

Figure 1.7: Victims of Adult Sex Offenders by Age, 1992

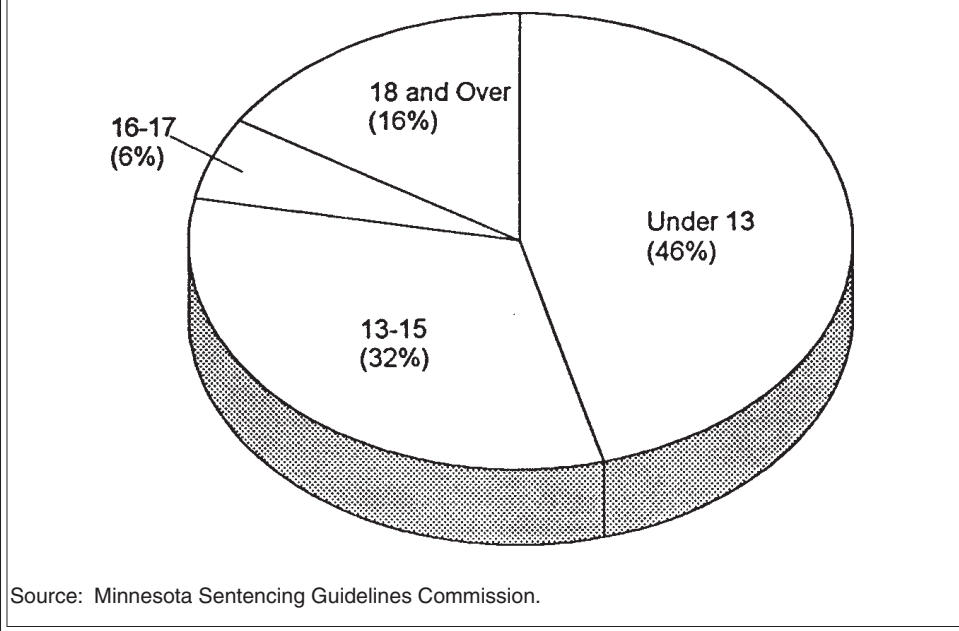


Table 1.4 shows that about one-third of the sex offenses committed by adults in 1992 involved force, and two percent resulted in injury to the victim.¹⁷

SENTENCING OF CONVICTED SEX OFFENDERS

The Supreme Court data base, as summarized by the Sentencing Guidelines Commission and the Office of Strategic and Long Range Planning for adults and juveniles respectively, is the primary source of information on adult sentences and juvenile court dispositions of sex offenders. In addition to the shortcomings noted previously, we found inadequacies in the Supreme Court’s data on sentencing. No data other than the amount of jail time were collected on the conditions of adult probation and only 35 percent of the juvenile cases included information on the outcome or disposition of the offense. Of those juvenile cases that listed dispositions, they were general, such as “counseling” or “group home” and did not specify whether sex offender treatment was offered or required. Accordingly, we supplemented official sentencing data by interviewing community corrections administrators and 23 adult and 20 juvenile probation officers responsible for recommending sentences for sex offenders.

¹⁷ Similarly, 35 percent of the sex offenders admitted to Minnesota prisons between January 1991 and October 1993 were described by prison officials as “rapists.” In contrast, 42 percent were categorized as “child molesters” and 15 percent as “incest” offenders.

Juveniles

Based on the probation officer interviews and the limited disposition data available to us, we found that:

- **In 1991, most juvenile sex offenders received probation and were required to complete sex offender treatment as a condition of probation.**

Information on dispositions was available from the Supreme Court data base for only 227 of the 654 adjudicated juvenile sex offenders in 1991. Of these, 22 percent were committed to a local treatment facility and 9 percent were placed in a community residential treatment facility. Only one offender was committed to the Department of Corrections. Forty percent of the 227 juvenile sex offenders were ordered to undergo counseling or outpatient treatment, but the Supreme Court data base does not provide details on the nature of the treatment. Thus, according to these data, over 70 percent of the juvenile sex offenders in 1991 whose dispositions were known received some type of treatment.

To obtain more information about treatment, we interviewed 20 juvenile probation officers from Community Corrections Act counties and other counties with at least 10 sex crimes in 1991. Eight of the 20 probation officers said all juvenile sex offenders were required to undergo treatment as a condition of probation. Nine respondents said between 75 and 90 percent of juvenile sex offenders were required to complete treatment, and three respondents said between from 50 and 65 percent. Reasons given for not requiring treatment included: the offense was not very serious, some offenders just needed better sex education, the offender was already in private counseling, and the offender did not fit in with existing treatment programs.

We also asked community corrections administrators to provide us with information on the actual number of juvenile sex offenders adjudicated in 1992 and the number required to undergo treatment. Only eight of the regions, comprising 15 counties, were able to provide us with usable data and we did not attempt to independently verify the data that we received.¹⁸ The responses indicated that 82 percent (192 out of 234) of the juveniles adjudicated delinquent for sex offenses in those counties in 1992 were required to complete sex offender treatment.

Adults

As noted earlier, Minnesota's laws and sentencing guidelines provide a range of sanctions for criminal sexual conduct felonies ranging from probation for

¹⁸ The eight regions were Anoka, Aitkin-Crow Wing-Morrison, Dodge-Fillmore-Olmsted, Hennepin, Rice, Todd-Wadena, Norman-Polk-Red Lake, and Washington. Since Hennepin County offenders comprised over half of this sample and non-Community Corrections Act counties were not included, these results may not be representative of the entire state.

Nearly all adult sex offenders convicted in 1992 spent some time in a state prison or local jail.

some first-time offenders to life in prison for certain repeat offenders. We found that:

- **Thirty percent of the adults convicted of first through fourth degree criminal sexual conduct in 1992 were sentenced to prison for an average of 7.4 years. The remainder were placed on probation, although 91 percent of them were sentenced to a term in jail as a condition of probation.¹⁹**

Table 1.5 shows the percent of adult offenders sentenced to prison and the average prison term for several categories of offenders. Consistent with sentencing guidelines, we found that:

- **In 1991, sex offenders who committed more severe offenses and those with two or more prior felony convictions were more likely to receive a prison sentence and when they did go to prison, their average sentences were longer.**

Offenders convicted of criminal sexual conduct in the first degree (severity level VIII) and those parts of second and third degree criminal sexual conduct involving force (level VII) were more likely to go to prison than those convicted of less serious offenses (levels IV through VI), as called for by Minnesota's sentencing guidelines. Among the other variables, sex crimes against strangers and those that involved force were more likely to result in prison sentences and their average sentences were slightly longer than crimes against family members or acquaintances.²⁰

Based on the probation officer interviews and the limited data available to us, we conclude that:

- **The majority of sex offenders sentenced to probation are required to complete sex offender treatment as a condition of probation.**

According to probation officers, most sex offenders on probation are required to complete treatment.

As noted earlier, the Supreme Court data base does not provide information on the conditions of probation (except for jail time). To obtain more information about treatment as a condition of probation, we interviewed 23 adult probation officers from community corrections counties and other counties with at least 10 sex crimes in 1991. We asked them how many of the convicted sex

¹⁹ County jails or workhouses typically hold offenders sentenced to incarceration for one year or less. Jail terms for sex offenders convicted in 1992 ranged from one month to one year. The average jail term was 186 days, just over six months.

²⁰ Table 1.5 also shows that non-white sex offenders are more likely than whites to receive prison sentences (41 vs. 27 percent). We found, however, that most of this difference results from non-whites committing more serious offenses and having more extensive criminal histories. For example, 43 percent of non-whites and 32 percent of whites committed a severity level VII or VIII offense. Similarly, 18 percent of non-whites and 14 percent of whites had a criminal history score greater than two. Controlling for these differences, we found that 17 percent of whites and only 13 percent of non-whites received probation when sentencing guidelines called for an executed prison sentence.

Table 1.5: Sentences of Adult Sex Offenders, 1992

<u>Category of Offender (Number in Parenthesis)</u>	<u>Percent Sentenced to Prison</u>	<u>Average Prison Term (Years)^a</u>
Offender's Sex		
Male (778)	29.8%	7.4
Female (20)	35.0	6.6
Offender's Age		
Under 22 (178)	20.8%	6.7
22 - 33 (321)	31.8	7.1
Over 33 (299)	33.4	8.0
Offender's Race		
White (619)	26.7%	7.7
Non-White (179)	41.3	6.8
Offender's Residence		
Twin Cities Metropolitan Area (396)	31.6%	7.4
Outstate Minnesota (402)	28.3	7.4
Severity Level		
IV (51)	11.8%	4.9
V (139)	9.4	2.7
VI (335)	16.4	4.5
VII (106)	61.3	6.2
VIII (167)	59.9	10.5
Criminal History		
0 (496)	15.1%	5.7
1 (108)	24.1	6.6
2 (74)	51.4	5.7
3 or More (120)	83.3	9.5
Governing Offense		
Child Sexual Abuse (461)	22.1%	7.2
Intrafamilial (154)	34.4	6.7
Forcible Sexual Assault (180)	46.7	8.0
Use of Force		
No Force (371)	24.0%	7.4
Force (197)	42.1	7.7
Relationship to Victim		
Acquaintance (393)	25.2%	7.7
Family Member (268)	27.2	7.1
Stranger (49)	61.2	8.4
Victim's Age		
Under 16 (563)	25.4%	7.5
16 - 17 (42)	31.0	7.6
18 and Over (116)	40.5	7.8
Victim's Sex		
Female (630)	28.6%	7.3
Male (91)	29.7	9.1

Source: Sentencing Guidelines Commission data.

^aBased on 239 offenders sentenced to prison. Actual time served may be reduced by one-third for good behavior.

offenders in their counties were required to complete a sex offender treatment program as a condition of probation. Nineteen of the 23 adult probation officers said between 90 and 100 percent of offenders were required to complete treatment, and the remaining four responses were between 70 and 90 percent.

We also asked community corrections regions to provide us with information on the actual number of adult sex offenders sentenced to probation in 1992 and the number required to undergo treatment. Only eight of the regions (representing 15 counties) were able to provide us with usable data and we did not attempt to independently verify the data that we received.²¹ The responses indicated that 81 percent (233 out of 288) of the adults on probation for sex offenses were required to complete sex offender treatment.²²

We also asked adult probation officers about other conditions of probation in addition to treatment. They told us that typical conditions included a jail term, no unsupervised contact with the victim and in some circumstances with any children, a fine or community service requirement, no drinking or drug use and completion of chemical dependency treatment when applicable, restitution of the victim's counseling costs, and submitting a DNA blood sample.

To determine whether factors other than the offense and offense history related to sentencing in 1992, we looked at "dispositional departures" from the guidelines, cases where the offender received a stayed sentence instead of an imposed sentence and vice versa. Only 15 convicted sex offenders (1.9 percent) received an "aggravated sentence" — an executed prison sentence when the guidelines called for a stayed prison sentence with probation. On the other hand, 129 offenders (16.2 percent) received a "mitigated sentence" — a stayed sentence and probation when the guidelines called for a prison term.

Table 1.6 lists the reasons given by sentencing judges for departing from the guidelines. Up to four reasons were recorded for each departure. Reasons for giving aggravated sentences included: the defendant requested execution of the sentence or agreed to the sentence as part of a plea bargain, the offender was judged unamenable to treatment by professionals or had failed probation before, and the offender was either in a position of authority over the victim or the victim was particularly vulnerable.

Principal reasons for giving mitigated sentences (probation instead of prison) focused either on the offender's amenability to treatment or the agreement of the prosecutor, the victim, and victim's family to probation instead of prison. When we eliminated duplicate responses, we found that:

²¹ See footnote 17 for a list of the eight regions. As was the case with the juvenile data, Hennepin County offenders comprised over half of this sample and non-CCA counties were not included, so these results may not be representative of the entire state.

²² These estimates are slightly higher than the Sentencing Guidelines Commission found in a study of sex offenders sentenced to probation in 1987. That study, based on a sample of 1,794 adult offenders from 37 counties, found that 70 percent of the sex offenders were required to undergo treatment as a condition of probation, usually on an outpatient basis.

Table 1.6: Reasons Cited by Judges for Dispositional Departures from Sentencing Guidelines, 1992

	Number of Responses
REASONS FOR TOUGHER SENTENCES (Aggravating Factors)	
Offender requested execution of sentence or it was part of plea bargain	9
Victim was particularly vulnerable or victim impact was considerable	8
Offender judged unamenable to treatment	6
Offender failed probation before	4
Offender took advantage of position of authority, superiority, or trust	3
Protection of public or vulnerable children	2
Offender sentenced as patterned sex offender	1
Victim's family requested prison sentence	1
REASONS FOR MORE LENIENT SENTENCES (Mitigating Factors)^a	
Offender entered sex offender treatment program	56
Probation acceptable to prosecutor	32
Treatment professional recommended probation	27
Offender had potential for rehabilitation	24
Victim or victim's family requested probation	18
All court functionaries and victim (or victim's family) agreed to probation	16
Court services recommended probation	13
Offender was in need of and amenable to treatment	13
Plea bargaining on sentence	12

Source: Sentencing Guidelines Commission.

Note: Up to four reasons were recorded for each departure.

^aCited in at least ten cases.

The main reason some offenders received more lenient sentences than called for by sentencing guidelines is their perceived amenability to treatment.

- **Seventy-seven percent of the sentences that were more lenient than called for in the sentencing guidelines in 1992 (99 out of 129) listed the offender's participation in or amenability to treatment as a reason for giving probation instead of a prison sentence.**

We also found that 71 percent of those 99 cases were for offenders sentenced in the seven county Twin Cities metropolitan area.²³ Overall, we found that Twin Cities metropolitan area offenders were almost twice as likely as outstate Minnesota offenders (21 versus 11 percent) to receive probation where sentencing guidelines called for a prison sentence.²⁴

These findings suggest that:

- **Greater availability of treatment options in the Twin Cities area may influence prosecutors and judges to make lighter sentences than called for in sentencing guidelines.**

²³ As shown earlier in Table 1.2, Twin Cities metropolitan area cases represented 50 percent of all the 1992 convicted adult sex offenders.

²⁴ Twin Cities metropolitan area offenders were about as likely as outstate Minnesota offenders to receive a prison sentence (32 percent vs. 28 percent) despite the fact that they tended to commit more serious offenses than outstate Minnesota offenders. Forty percent of the Twin Cities offenders and 28 percent of the outstate Minnesota offenders committed a severity level VII or VIII offense that carries a presumptive prison sentence for first-time offenders.

We asked probation officers if there were an adequate number of treatment facilities in their area. Five of seven adult probation officers from the Twin Cities metropolitan area but only one of 16 from outstate Minnesota said there were enough residential facilities in or near their county. Most adult probation officers said there was at least one outpatient sex offender treatment program in their area, but three probation officers from smaller counties said the programs had long waiting lists. Among the juvenile probation officers, 5 of 15 outstate Minnesota respondents said the closest outpatient program was too far away.

RECENT LEGISLATION

We reviewed legislation since the criminal sexual conduct statutes were first enacted in 1975 to replace pre-existing rape statutes. We found that:

- **The Legislature has responded to increasing concerns about sex offenses in two primary ways: by increasing penalties for serious and repeat offenders, and by providing new requirements and funding initiatives for sex offender treatment.**

During the 1980s, the Legislature increased penalties for sex crimes, but also expanded treatment requirements.

Figure 1.8 lists the major legislative actions regarding sex offense penalties since 1975. It shows that, during the 1980s, the Legislature included more acts under the definition of criminal sexual conduct, increased penalties for serious sex crimes and repeat sex offenders, and adopted other requirements to aid law enforcement in arresting and convicting repeat sex offenders. For example, sex offenders were required to submit DNA blood samples and to register their address when released from prison. Beginning in 1989, judges were authorized to deviate from sentencing guidelines and increase penalties for repeat sex offenders. Also in 1989, the Sentencing Guidelines Commission significantly increased the presumptive sentence lengths for the most serious crimes. For example, the presumptive prison term for someone convicted of first degree criminal sexual conduct with no prior offenses doubled, from 43 months to 86 months.

Since 1989, the Legislature also focused more attention on providing treatment for sex offenders. Laws required sex offenders to be assessed for amenability to treatment and the Department of Corrections to provide sex offender programming in adult and juvenile correctional institutions. Funding was also provided for community-based treatment programs and the Department of

Human Services was authorized to expand the Minnesota Security Hospital and construct a new treatment facility for psychopathic personalities.²⁵ Figure 1.9 summarizes these efforts and Figure 1.10 shows the increased appropriations associated with them.

²⁵ See Office of the Legislative Auditor, *Psychopathic Personality Commitment Law* (St. Paul, 1994).

Figure 1.8: Major Sex Offense Legislation Since 1975

1975

- Recodified sex crime statutes. Replaced the crime of rape with criminal sexual conduct in the first through fourth degree with maximum penalties ranging from 5 to 20 years.

1981

- Defined “intrafamilial sexual abuse” as a crime within the criminal sexual conduct statutes.

1984

- Included 16 and 17 year-old victims in the definitions of criminal sexual conduct if the offender was in a position of authority over the victim.

1985

- Included sex between psychotherapists and their patients in the definitions of criminal sexual conduct.

1986

- Included sexual penetration and sexual contact by health care professionals who falsely represent a medical purpose in the definitions of criminal sexual conduct.

1988

- Defined fifth degree criminal sexual contact as nonconsensual sexual contact, a gross misdemeanor.

1989

- Defined “patterned sex offenders,” permitted the court to double the presumptive sentence up to the statutory maximum for such offenders, and extended the period of supervision for such offenders upon their release to the community;
- Authorized the court to impose an upward durational departure from presumptive sentences for violent crimes if the offender has two or more prior convictions for violent crimes and is a danger to the public safety;
- Required the court to impose a 37 year prison term on anyone convicted of first or second degree criminal sexual conduct with two prior convictions;
- Required sex offenders to provide biological specimens for DNA analysis;
- Required probation officers to report the address of sex offenders on probation or supervised release to law enforcement authorities; and
- Required the court to make a preliminary determination whether an offender convicted of criminal sexual conduct should be petitioned for civil commitment as a psychopathic personality and to forward findings to the county attorney.

1991

- Strengthened sex offender reporting by requiring convicted sex offenders to register their address along with a photo and fingerprint card with their probation officer at the time of release from prison.

1992

- Lengthened the statutory maximum penalties for first and second degree criminal sexual conduct to 30 and 25 years, respectively;
- Required a doubling of presumptive sentences under certain circumstances;
- Required a mandatory 30-year sentence for offenders convicted of first and second degree criminal sexual conduct involving force with a prior sex offense;
- Lengthened supervised release period for sex offenders released from prison;
- Allowed Commissioner of Corrections to place released sex offenders on “intensive supervised release”; and
- Required the Department of Corrections to make a preliminary assessment of “high risk” sex offenders about to be released as to the applicability of a civil commitment as a psychopathic personality and to refer the matter to the county attorney when a commitment is deemed appropriate.

1993

- Added sexual penetration or contact between a member of the clergy and a person seeking religious or spiritual advice, aid or comfort in private to the definitions of third and fourth degree criminal sexual conduct;
- Clarified sex offender registration and DNA analysis requirements by requiring sex offenders to register and provide specimens at the time of sentencing.

Source: *Minn. Laws* (1975) Ch. 374; (1981) Ch. 273; (1984) Ch. 588; (1985) Ch. 297; (1988) Ch. 529; (1989) Ch. 290, Art. 1, 2, 4; (1991) Ch. 285; (1992) Ch. 571, Art. 1; and (1993) Ch. 326, Art. 4.

Figure 1.9: Recent Legislation Affecting Sex Offender Treatment

1989

- Required the Department of Corrections to offer a range of sex offender treatment programs in its adult and juvenile correctional facilities.
- Required the Department of Corrections to develop a program to train corrections agents in sex offender supervision.
- Required that juvenile sex offenders be assessed for amenability to treatment and required the court to order treatment when the child is assessed as amenable.
- Required the Department of Corrections to adopt rules for the certification of adult and juvenile sex offender treatment programs in state and local correctional facilities and for treatment programs to meet those standards by July 1, 1991 as a condition of operation.
- Required the Departments of Corrections and Human Services to evaluate funding mechanisms for sex offender treatment programs and the use of such programs in Minnesota.
- Required the Department of Corrections to designate and evaluate at least three pilot community sex offender treatment programs.

1992

- Removed the deadline for the Department of Corrections to adopt rules setting standards for sex offender treatment programs in correctional facilities and required the department to set standards for community-based sex offender treatment programs by July 1, 1994.
- Established a sex offender treatment fund to pay counties for community-based treatment for adults and juveniles.
- Required the court to order an independent assessment of sex offender's treatment needs (unless sentencing guidelines provide a presumptive prison sentence).
- Provided funds for special project grants related to treatment.
- Permitted the Department of Corrections to adopt rules to impose disciplinary confinement and delay release of offenders who refuse to participate in treatment.
- Required the Department of Corrections to establish a juvenile sex offender treatment program at the Sauk Centre juvenile correctional facility and a program for young adults at the St. Cloud correctional facility.
- Allowed the Commissioner of Corrections to order sex offender treatment as a condition of supervised release.

1993

- Removed the requirement that the Department of Corrections adopt rules for certifying community-based sex offender treatment programs.
- Repealed the sex offender treatment fund established in 1992 and the requirement, established in 1989, for the Department of Corrections to designate and evaluate at least three pilot community treatment programs.
- Instead required the Department of Corrections to develop a long-term project to provide treatment programs in different parts of the state, to provide follow-up information on sex offender treatment, to assist local governments in establishing treatment programs, and to coordinate a statewide sex offender treatment system.

Source: *Minn. Laws* (1989) Ch. 290, Art. 1, 2, 4; (1992) Ch. 571, Art. 1, 8; and (1993) Ch. 326, Art. 8.

Figure 1.10: Major Funding Initiatives for Sex Offender Treatment

<u>Years</u>	<u>Amount</u>	<u>Purpose</u>
FY 1990-91	\$1,000,000 ^a	Juvenile and adult sex offender treatment pilot programs.
	395,000	Two additional sex offender programs within state correctional facilities.
	300,000	Community residential and outpatient treatment and after care.
FY 1992-93	500,000	Sex offender treatment program at Sauk Centre juvenile correctional facility.
	350,000	Sex offender treatment program at St. Cloud correctional facility.
	150,000	Sex offender treatment fund for local programs. ^b
	500,000	Reimbursement to counties for sex offender assessments.
	8,100,000	50-bed addition to the Minnesota Security Hospital at St. Peter for psychopathic personality commitments.
FY 1994-95	13,400,000	100-bed psychopathic personality facility at Moose Lake. ^c
	2,475,000	Sex offender treatment program development, local assistance and evaluation.
	7,250,000	Additional funding for psychopathic personality facility at Moose Lake.
	400,000	Additional funding for psychopathic personality facility at St. Peter Regional Treatment Center.

Source: *Minn. Laws* (1989) Ch. 290, Art. 1, 2, 4; (1992) Ch. 558; (1992) Ch. 571, Art. 1; and (1993) Ch. 326, Art. 4; and (1993) Ch. 373.

^a Subsequently reduced by \$500,000 due to state budget shortfall.

^b Program repealed in 1993.

^c These funds were originally appropriated to construct or remodel regional treatment centers at the discretion of the Commissioner of Human Services. The 1993 Legislature permitted these funds to be used for the psychopathic personality facility at Moose Lake.

Figure 1.9 indicates that there is some uncertainty about the best way to provide sex offender treatment. For example, in 1992 the Legislature directed the Department of Corrections to set standards for community-based treatment programs, but it rescinded that requirement in 1993. Similarly, the Legislature established a fund in 1992 to pay counties for community-based sex offender treatment and then, after a needs assessment by the Departments of Corrections and Human Services, the Legislature repealed the fund a year later.²⁶ In 1990, the Department of Corrections established the Sex Offender

²⁶ See Minnesota Departments of Corrections and Human Services, Legislative Report: *Sex Offender Treatment Fund* (St. Paul, 1993).

Services Unit to coordinate the department's sex offender programs and administer state funds provided to local treatment programs.

SUMMARY

The number of sex crimes reported to law enforcement grew rapidly between 1971 and 1984, but the sex crime rate has remained relatively stable since then. Most of the sex crime increase resulted from more intrafamilial sexual abuse and other sex crimes against children. Most sex crimes in 1992 were committed against children and most sex offenders victimized family members or other acquaintances. Most convicted sex offenders did not have prior convictions for sex offenses or other felonies. In 1992, 30 percent of adult sex offenders were sent to state prison and the remainder typically spent some time in a local jail, were required to complete treatment, and then placed on probation.

During the 1980s, the Legislature expanded the behaviors defined as sex crimes and increased penalties for serious and repeat offenders. Beginning in 1989, the Legislature shifted some of its focus toward expanding sex offender assessments and treatment. As a result, most offenders convicted of a sex offense are now required to complete a treatment program as a condition of probation and the Department of Corrections must offer sex offender treatment to those offenders sentenced to a prison term.

Literature Review

CHAPTER 2

This chapter summarizes what we learned from our review of the national literature. We address the following questions:

- **What has been learned from previous research about the causes of sexually deviant behavior, sex offender reoffense rates, and the effectiveness of treatment?**
- **How do other states deal with sex offenders?**
- **What are the implications of the research for public policy regarding sex offenders?**

To answer these questions, we examined research on the causes of sexually deviant behavior and reviewed the literature on sex offender treatment and recidivism rates. We also interviewed treatment professionals and others involved in evaluating sex offender treatment programs, and we contacted other states to learn how they deal with sex offenders.

Briefly, the research suggests that sex offenders are very heterogeneous and do not all share the same personal or offense characteristics. Also, mental health professionals disagree about the causes of sexually deviant behavior and have proposed alternative theories to explain why sex offenders commit their crimes. Because sex offender treatment evaluation is a relatively new and complex field, there are no definitive answers about whether treatment is effective. Furthermore, sound evaluations of treatment effectiveness are very difficult to conduct because of inadequate follow-up data, poor measures of effectiveness, and ethical issues that make experimental designs impractical. However, some evaluations have found lower recidivism rates at the end of a three- to-five-year follow-up for treated versus untreated offenders, while other studies have found no evidence of program effectiveness. States have responded to the problem of sex offenses through varying combinations of incarceration and treatment.

BACKGROUND

The practice of singling out certain sex offenders from other criminals as appropriate for treatment dates back to the 1930s.¹ In the late 1930s and 1940s, Minnesota and most other states enacted sexual psychopath or mentally disordered sex offender statutes, which typically provided for indefinite civil commitment of sexually dangerous persons to mental health treatment in lieu of imprisonment. These laws were enacted to protect the public from potentially violent offenders and to provide treatment to those in need. They were based on a belief that sex offenders suffered from a mental disorder that may be treatable.² At the time, the assumptions underlying these laws were accepted uncritically and were not subjected to scientific testing. Also, significantly fewer sexual offenses were reported when these laws were in effect.

States rely on varying combinations of treatment and punishment for sex offenders.

Sex Offender Treatment in Other States

Since the 1960s, the population of convicted sex offenders has grown as the public has become more concerned about sexual assault and child sexual abuse and more crimes have been reported to law enforcement authorities. Simultaneously, most states have repealed their sexual psychopath laws and there has been less use of civil commitment and greater use of incarceration for sex offenders.³ Currently, there is a lack of consensus among the states regarding the appropriate response to the problem of sexual assault. One study noted that as some states were establishing new treatment programs for sex offenders, others were terminating them.⁴

We contacted 19 states reported to have statutes that provided for civil commitment of sex offenders to treatment facilities and learned that most have

¹ For a more complete discussion of this literature, see Office of the Legislative Auditor, *Psychopathic Personality Commitment Law* (St. Paul, 1994).

² Carol Veneziano and Louis Veneziano, "An Analysis of Legal Trends in the Dispositions of Sex Crimes: Implications for Theory, Research, and Policy," *The Journal of Psychiatry and Law*, Summer 1987, 205-225.

³ Mark A. Small, "The Legal Context of Mentally Disordered Sex Offender (MDSO) Treatment Programs," *Criminal Justice and Behavior*, Vol. 19 No. 2 (June 1992), 127-142. Minnesota is one of the few states that retained its sexual psychopath statute, although it was used infrequently until the past several years when its use significantly increased. Minnesota also had a law in effect until 1978 (*Minn. Stat.* §246.43) that required sex offenders to be assessed for amenability to treatment at the Minnesota Security Hospital. This law was repealed in conjunction with the enactment of sentencing guidelines. As described in Chapter 1, more recently (since 1989), the Minnesota Legislature has re-enacted laws that mandate assessments for treatment amenability for offenders not sent to prison.

⁴ Janice K. Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project* (Sacramento: California Department of Mental Health), 5.

either repealed them or no longer actively use them.⁵ However, 17 of the 19 states provided for inpatient treatment of varying numbers of sex offenders either within correctional or mental health facilities. Six of the 19 states had treatment programs for incarcerated sex offenders jointly operated by departments of corrections and mental health/human services.⁶

Washington has developed a comprehensive approach that provides for treatment in alternative settings. It has instituted a "Special Sex Offender Sentencing Alternative" under which judges can suspend prison sentences for adult sex offenders who meet certain conditions and provide outpatient treatment in the community instead. In addition, Washington provides treatment within correctional facilities and has enacted a law under which violent sexual predators may be indefinitely confined to treatment that is jointly provided by corrections and mental health departments.⁷ In contrast, California has restricted inpatient treatment for sex offenders to an experimental program that treats up to 50 offenders at a time, and Florida recently terminated its sex offender treatment program.⁸

The Rationale for Treatment

Nationally, there has been a significant increase in juvenile sex offender treatment programs.

At the present time, there is a large group of mental health professionals, representing a variety of disciplines, including psychology, psychiatry, clinical social work, counseling, and medicine, that continues to believe in the potential efficacy of treating sex offenders. Over the past decade, the sex offender treatment field has grown rapidly, especially programs treating adolescent offenders. The *Safer Society Program*, a national organization that regularly surveys treatment programs, identified 20 programs nationally that treated juvenile sex offenders in 1982; by 1993, the number had increased to over 800 specialized juvenile treatment programs.⁹

The rationale for treating juvenile offenders is based on research that indicates that inappropriate sexual behavior patterns develop early and that a failure to intervene often means that the offender will continue or escalate the

⁵ The states included: California, Colorado, Connecticut, District of Columbia, Florida, Illinois, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, New Jersey, Oregon, Tennessee, Utah, Vermont, Virginia, Washington, and Wisconsin. Only Minnesota and Washington actively used their civil commitment statutes to confine sex offenders to treatment, both following prison sentences. See Office of the Legislative Auditor, *Psychopathic Personality Commitment Law*, 36-37.

⁶ *Ibid.*, 34-38.

⁷ Senator Gary Nelson, *Washington State's 1990 Community Protection Act* (Olympia: Washington State Institute for Public Policy, 1993).

⁸ Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project*, 12.

⁹ Cited in the National Council of Juvenile and Family Court Judges, "The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993 of the National Adolescent Perpetrator Network," *Juvenile and Family Court Journal*, Vol. 44 No. 4 (1993), 5.

inappropriate behavior, thereby representing a continuing danger to society.¹⁰ Similarly, professionals who treat adult sex offenders have argued that even those offenders who are incarcerated for their crimes will eventually return to the community; hence, steps should be taken to reduce the likelihood that they will commit another crime, even though there is uncertainty about whether those steps will be effective. At a recent international meeting of treatment professionals, the following justification for treatment was offered:

Although treatment is costly and unaffordable by some, not to treat can be more costly emotionally and psychologically for the offender, for the victims and future victims, and for society. Today there is more scientific evidence and consensus among professionals that paraphilias are psychosexual disorders. By contrast, the predominant view of the lay public around the world is that sex crimes can be eradicated with punishment and/or death. This predominant view is not supported by scientific evidence, and the scientific community needs to continue to promote awareness that sex crimes can also be manifestations of biomedical/psychiatric/psychological illnesses for which people must be treated, rather than simply punished.¹¹

In making clinical diagnoses, mental health professionals rely on the *Diagnostic and Statistical Manual of Mental Disorders*, a regularly updated document that classifies mental illnesses and disorders and defines their symptoms.¹² Treatment professionals use the diagnostic codes from this manual to obtain reimbursement for their services from insurance companies and agencies administering medical assistance funds.

The American Psychiatric Association's diagnostic manual lists several specific sexual disorders, as well as more general categories of conduct or personality disorders, that are used in diagnosing sex offenders and assessing their amenability to treatment. The specific sexual disorders, referred to as "paraphilias," are characterized by "recurrent, intense, sexual urges and sexually arousing fantasies of at least six months' duration" that are abnormal and interfere with "reciprocal, affectionate sexual activity."¹³ Many sex offenders with abnormal sexual arousal patterns (e.g., an attraction to children) may not meet the criteria to be diagnosed with a specific sexual disorder because their symptoms are not severe enough.¹⁴

¹⁰ *Ibid.* Research shows that 60 to 80 percent of adult offenders reported offending as juveniles; over 50 percent of the molestation of boys and at least 20 to 25 percent of the sexual abuse of girls is perpetrated by juveniles; and many adolescents report they were victimized as children.

¹¹ Eli Coleman, et al., "Standards of Care for the Treatment of Adult Sex Offenders," endorsed by participants of the 3rd International Congress on the Treatment of Sex Offenders, held in Minneapolis, Minnesota, September 20-22, 1993.

¹² American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition Rev. (Washington, DC, 1989).

¹³ In classifying "sexual disorders," the APA distinguishes between "paraphilias," which are not part of normal sexual arousal and activity, and "sexual dysfunctions," which are characterized by inhibitions in sexual desire and response. Paraphilias include pedophilia, exhibitionism, voyeurism, sexual sadism, and sexual masochism, among others. For definitions and a complete listing, see *Ibid.*, 279-290.

¹⁴ W. L. Marshall and A. Eccles, "Issues in Clinical Practice with Sex Offenders," *Journal of Interpersonal Violence*, Vol. 6 No. 1 (1991), 69.

RESEARCH ON SEXUAL DEVIANCY

With the increase in convicted sex offenders and the growth in treatment programs, more research has been done on the causes of sexual deviancy and how to treat it. Results from some of these studies are summarized briefly below.

Types of Sex Offenders

It is important to note that:

- **Sex offenders are not a homogeneous group.**

The term “sex offender” applies to people who have exhibited many different kinds of behavior — some violent, some non-violent, some involving strangers, and some involving acquaintances or family members. In considering what to do about treating sex offenders, the diversity of behaviors, motivations, and victims needs to be kept in mind.

One classification of sex offenders separates them by their victim preferences. The two principal categories are rapists and pedophiles.¹⁵ The term “child molester” is often used as a synonym for “pedophile.” Incest offenders, who are biological parents and stepparents or siblings, are considered a special type of child molester. Child molesters are further classified by whether they prefer victims of the same sex, opposite sex, or both. Another type of sex offender, which includes exhibitionists, voyeurs, and obscene phone callers, does not have physical contact with victims.

Early research assumed that it was possible to develop a profile of the “typical” rapist, which would identify characteristics that distinguished him from a “normal” male. Researchers have developed several typologies of rapists. One common classification identified three categories: “anger rapists” who express their hostility through sex, “power rapists” for whom sex equals conquest, and “sadistic rapists” who are sexually aroused by both power and anger.¹⁶

Recent classification schemes, however, are more complex and further differentiate among types of rapists and multiple categories of pedophiles or child molesters.¹⁷ These schemes incorporate empirical research that has found considerable variation among rapists and significant differences between

Sex offenders commit a variety of different crimes and have varying motivations and victim preferences.

¹⁵ Based on this two-way classification, offenders who commit the offense of “rape of a child” are classified as pedophiles.

¹⁶ See Lana E. Stermac, Zindel V. Segal, and Roy Gillis, “Social and Cultural Factors in Sexual Assault,” *Handbook of Sexual Assault*, 150-152.

¹⁷ For a discussion of various sex offender typologies, see Barbara K. Schwartz, Editor, *A Practitioner’s Guide to Treating the Incarcerated Male Sex Offender* (Washington, D.C.: U.S. Department of Justice, 1988), 19-27.

rapists and child molesters.¹⁸ For example, a study of 200 sex offenders found differences in the attitudes and behaviors exhibited just prior to the victimization act: a greater proportion of rapists than pedophiles displayed anger toward women (77 percent of rapists and 26 percent of pedophiles), acted opportunistically (58 percent versus 19 percent), and used alcohol or drugs prior to offending (56 percent versus 30 percent).¹⁹

These and other findings suggest that sex offenders vary with respect to the amount and nature of aggression, vindictiveness, and opportunism involved, degrees of fixation and impulsiveness, attitudes toward women, and levels of social skills, personal competence, and self-esteem.²⁰ Hence, there appear to be no universal characteristics that distinguish sex offenders from non-offenders.

Theories of Sexually Deviant Behavior

The heterogeneity among sex offenders helps to explain why there are conflicting findings in the research and different theories that purport to explain the causes of sexual assault. Theories to explain why some people commit sex offenses may be grouped into three broad categories: biological, psychological, and environmental. Biological theories include those that emphasize a genetic basis for male aggression, propose biochemical explanations (abnormal sex steroids or endocrine malfunctions), or find neurological impairments.²¹ Psychological theories usually focus on childhood experiences, such as sexual, physical, or emotional abuse, that inhibit the development of self-confidence and appropriate attachments to others or experiences that reward aggressive behavior. Environmental theories focus on the socio-cultural context of sex crimes (availability of pornography, male-dominated culture, and high level of interpersonal violence) and temporary situational factors that contribute to inappropriate responses, such as anger or stress, marital discord, and sexual dysfunction, or that remove normal inhibitions against deviant behavior, such as alcohol and drug abuse.²²

According to a review of the literature, most existing research has focused on three topics: deviant sexual arousal patterns, heterosexual social skills, and

The causes of sexual aggression are complex and not well understood.

¹⁸ Raymond A. Knight and Robert A. Prentky, "Classifying Sexual Offenders," *Handbook of Sexual Assault*, 23-52.

¹⁹ William D. Pithers, et al., "Identification of Risk Factors through Clinical Interviews and Analysis of Records," in D. Richard Laws, Editor, *Relapse Prevention with Sex Offenders* (New York: The Guilford Press, 1989).

²⁰ Stermac, Segal, and Gillis, "Social and Cultural Factors in Sexual Assault," *Handbook of Sexual Assault*, 143-159.

²¹ Clinical research on both animals and humans suggests that in some cases, sexually deviant behavior may result from brain damage or dysfunction. For example, studies have shown that certain types of epilepsy may be associated with changes in sexual behavior. See Ron Langevin, "Sexual Anomalies and the Brain," *Handbook of Sexual Assault*, 103-113.

²² W. L. Marshall and H. E. Barbaree, "An Integrated Theory of the Etiology of Sexual Offending," *Handbook of Sexual Assault*, 257-275.

the sexual and drug history of the offender.²³ While treatment professionals recognize the importance of cognition—an individual's perceptions, mental thought processes, and reasoning—in sexual offending, little systematic research has been done on it.²⁴ There are indications, however, that some sex offenders may develop distorted thought patterns that help them justify their behavior. For example, survey results have found that compared with other respondent groups, child molesters thought that sexual contact was more beneficial to the child and perceived less responsibility for their behavior, greater complicity on the child's part, and less need to punish the adult.²⁵

Use of alcohol and drugs has been frequently linked to sexual offending. Sexual offenders often report that excessive alcohol use was a contributing factor in their offenses, and a study of police and victim reports found that intoxication was involved in 70 percent of all rapes.²⁶ Clinical studies have found that some males respond differently to sexual cues when they are drunk than when they are sober, and alcohol and other drugs can temporarily remove normal inhibitions against committing criminal acts.²⁷ Many treatment professionals consider it to be a relevant factor since it appears to contribute to sexually assaultive behavior for some individuals.²⁸

Types of Sex Offender Treatment

There are several different approaches to treating sex offenders.

The main types of sex offender treatment are described briefly in Figure 2.1 and are associated with the different causal theories discussed above. Behavioral and organic treatments are aimed at changing sexual preferences or arousal patterns through behavioral modification techniques or biomedical methods. Psycho-surgery, which involves destroying the part of the brain associated with sexual arousal, has rarely been used anywhere. Castration has been used in northern Europe with some demonstrated success, although not in the U.S. Both psycho-surgery and castration raise ethical concerns because of their invasive nature.²⁹

A number of studies have reported success in reducing deviant sexual behavior using anti-androgen (hormonal) drugs. However, other researchers have noted that drug therapy has limited applicability for a number of reasons. First, these medications do not eliminate sex offending. They are primarily used in conjunction with psychological therapy as a way of reducing sexual activity to lower levels for those offenders whose sex drives seem excessively high (usually those with diagnosed paraphilias). Second, since this type of sex

23 Zindel V. Segal and Lana E. Stermac, "The Role of Cognition in Sexual Assault," *Handbook of Sexual Assault*, 161.

24 *Ibid.*

25 *Ibid.*, 169.

26 Marshall and Barbaree, "An Integrated Theory of the Etiology of Sexual Offending," *Handbook of Sexual Assault*, 268-269.

27 *Ibid.*

28 Marshall, Laws, and Barbaree, "Issues in Sexual Assault," *Handbook of Sexual Assault*, 4.

29 *Ibid.*, 12-13.

Figure 2.1: Types of Sex Offender Treatment

Behavioral

The goal is to reduce sexual arousal patterns using methods aimed at changing offenders' behavioral responses to sexual stimuli. Typical methods include aversion therapy and satiation therapy. In aversion therapy, a negative stimuli—usually the inhalation of ammonia fumes—is administered while the offender engages in deviant fantasizing. In satiation therapy, offenders masturbate to non-deviant fantasies until satiated, then switch to deviant fantasizing, thereby pairing an inability to become sexually aroused with deviant sexual behavior.

Organic/Biomedical

The goal is to reduce the sexual drive of sexually aggressive men. Organic treatments include surgical castration, neuro- or psycho-surgery, and administration of medications. Psycho-surgery involves destroying the part of the brain associated with sexual arousal. A number of different anti-androgen or hormonal drugs have been tested on sex offenders, with the most common ones being MPA (medroxy-progesterone acetate, commonly called depo-provera) and CPA (cyproterone acetate). Tranquilizers, anti-depressants, and anti-psychotic drugs also have been used.

Psychological/Cognitive

The goal is to reduce sexually deviant behavior by teaching sex offenders how to control their own sexual interest patterns. It is based on the recognition that cognition plays an important role in sexual offending, in addition to sexual arousal patterns. Typical methods include group therapy, role playing, individual counseling, and sex education. Through group interaction and structured educational sessions, sex offenders learn about the cognitive distortions that they use to justify their own deviant behaviors. They are also taught about appropriate sexual behavior. Individual problems, such as lack of self-esteem, alcohol and drug abuse, inadequate anger control, or poor social skills, are also identified and may be dealt with in therapy sessions.

Sources: W. L. Marshall, D. R. Laws, and H. E. Barbaree, Editors, *Handbook of Sexual Assault* (New York: Plenum Press, 1990); and Solicitor General of Canada, *The Management and Treatment of Sex Offenders*, 1990.

offender treatment is voluntary, many offenders have been unwilling to participate and high dropout and noncompliance (failure to take the medications) rates have been reported. Finally, some offenders who have received drug therapy have reported adverse side effects, which contributed to dropout and noncompliance.³⁰

Psychological treatment techniques are based on the role that cognition and social learning plays in sexual offending. Most treatment professionals generally accept the premise that an offender's attitudes about himself and others, sexual beliefs, and thought processes are important in the psychological process that leads to sexual assault, and that attitudes and beliefs may contribute to an inability to refrain from reoffending.³¹ Some treatment

³⁰ For reviews and discussion, see: S. J. Hucker and J. Bain, "Androgenic Hormones and Sexual Assault," *Handbook of Sexual Assault*, 93-102; J. M. Bradford, "The Anti-androgen and Hormonal Treatment of Sex Offenders," *Handbook of Sexual Assault*, 297-310; Marshall, et al., "Treatment Outcome with Sex Offenders," 470-474; and Solicitor General of Canada, *The Management and Treatment of Sex Offenders*, 12-13.

³¹ Marshall, et al., "Issues in Sexual Assault," 4-5.

professionals believe that the deviant sexual preferences (e.g., sexual attraction to children) of some sex offenders cannot be totally eliminated. They believe that a more realistic goal of treatment is managing or controlling deviant behavior, not “curing” it.³² At an Academy of Sciences conference on sexual aggression, Richard Laws, a noted researcher on sex offender treatment, commented:

Most important, perhaps, is the recognition that it is what happens after the delivery of the treatment package that is critical. Consequently, long-term follow-up is now considered essential. Sexual deviation can be managed, but it is unlikely to go away. There is no ‘technofix’ for this problem.³³

For this reason, treatment professionals have developed a specific model within the broad category of psychological treatments referred to as “relapse prevention.”³⁴ It was developed from studies of the relapse process in other addictive behaviors, such as alcoholism and drug abuse. Relapse prevention refers to identifying a sex offender’s high-risk situations—the specific circumstances that threaten the individual’s sense of self-control over illicit sexual behaviors—and developing coping mechanisms to strengthen self-control.

Many treatment professionals think that “curing” sex offenders may not be possible, but teaching them to control their behaviors is a realistic goal.

Individual treatment programs may incorporate a combination of behavioral, organic, and psychological/cognitive approaches into their overall program or treat individuals with a combination of techniques. According to a 1992 national survey of 755 adult and 745 juvenile sex offender treatment providers:

- **Most sex offender treatment programs in the U.S. used psychological techniques. Only a minority of programs also incorporated behavioral techniques or the administration of drugs.**³⁵

The results from this survey suggest that over 80 percent of treatment programs (juvenile and adult) addressed the following psychological elements in their treatment: victim empathy, anger management, sex education, communication, cognitive distortions, assertiveness training, personal victimization/trauma, the relapse cycle, and relapse prevention. Over two-thirds of the programs also incorporated victim apologies, impulse control, values clarification, positive/pro-social sexuality, sex role stereotyping, journal keeping, relaxation techniques, and stress management. Most treatment programs incorporated elements that train offenders to accept responsibility for their illegal behavior and to reduce their exposure to situations where they are at risk to reoffend.

³² Marques, et al., 1991 *Report to the Legislature on the Sex Offender Treatment and Evaluation Project*, 5.

³³ Quoted in Solicitor General of Canada, *The Management and Treatment of Sex Offenders*, 13.

³⁴ See, for example, D. Richard Laws, Editor, *Relapse Prevention with Sex Offenders* (New York: Guilford Press, 1989).

³⁵ Safer Society Program, "Nationwide Survey of Juvenile and Adult Sex Offender Treatment Programs" (Orwell, Vermont, 1992). Seventy-five percent of the 1,500 responding providers ran outpatient programs and 25 percent operated residential programs.

Fewer than 30 percent of the programs surveyed used plethysmography (measuring an individual's responses to different sexual stimuli with a physical device), masturbatory conditioning, or aversive techniques (associating deviant arousal patterns with negative stimuli such as ammonia fumes). Only 17 percent of adult and 11 percent of juvenile programs used hormonal (e.g., depo-provera) medications. Approximately 20 percent of the programs used tranquilizers, antidepressants, or anti-psychotic drugs in conjunction with other treatments. According to the results of this survey, no programs in the U.S. used castration or psycho-surgery as treatment methods.

MEASURING SEX OFFENDER RECIDIVISM AND TREATMENT EFFECTIVENESS

In this section, we discuss the research on sex offender recidivism and the effectiveness of treatment.

Recidivism Studies

The main goal of treatment is to reduce the rates at which sex offenders commit additional crimes. "Reoffense" or "recidivism" rates refer to estimates of the percentages of released prisoners or treated offenders who commit another offense. Recidivism rates are calculated over time and are only meaningful if the length of time since the offender's release from prison or treatment is known and recidivism is clearly defined. Typically, recidivism measures rely on official data sources, such as police arrest reports or conviction data. Since these data include only reported offenses and apprehended offenders, they underestimate the actual number of crimes committed by offenders released from prison or treatment. In the case of sex offenders, recidivism may be defined and measured in several different ways, including rearrest, reconviction, or reincarceration for sex offenses only, for all violent offenses, or for all offenses. Some studies have used self-reported data to measure recidivism, but this relies on offenders to honestly report subsequent criminal behavior.

Regardless of how recidivism has been defined and measured, the cumulative reoffense rate for a given group of offenders is greater if reoffenses are measured over a longer period of time. Research findings also point to the conclusion that:

- **Sex offenders with a criminal history have higher recidivism rates than those convicted for the first time.**

Longitudinal studies of cumulative recidivism rates (irrespective of whether offenders received treatment) in the U.S., Canada, Australia, and northern

First-time sex offenders are less likely to commit another crime than those with criminal records.

European countries have shown similar patterns: the longer an individual's criminal record, the more likely that person will commit another offense. For example, the combined results of studies that followed sex offenders in Great Britain, Denmark, and Norway for 10 to 24 years (a total of 4,347 offenders who had not received systematic therapy) found a 13 percent recidivism rate after one year, with the cumulative proportion reconvicted of another sexual or violent offense gradually increasing over time. However, the reconviction rate for first-time offenders (9 percent) was significantly lower than for those with a prior sexual and/or violent offense (28 percent).³⁶ Another study, which followed sex offenders released from a Canadian prison for 19 to 30 years, found that 42 percent had been reconvicted by the end of the follow-up period, but after 20 years, individuals without prior sexual convictions had been reconvicted at a significantly lower rate (less than 30 percent) than offenders with two or more prior convictions (60 percent).³⁷

A U.S. Department of Justice study of more than half of all offenders released from state prisons in 1983 (108,580 persons) found that after three years, the reincarceration rate was 32 percent for rapists and 24 percent for those imprisoned for other types of sexual assault. These rates were lower than the overall reincarceration rate for all types of offenders (41 percent). Similar to the studies reported above, first-time offenders had lower recidivism rates, measured alternatively as rearrest, reconviction, and reincarceration, than offenders with prior criminal histories.³⁸

The reoffense rates of most sex offenders vary from 5 to 40 percent, irrespective of whether they receive treatment.

However, because individual studies may define "recidivism" differently and follow offenders for varying periods of time, comparisons of recidivism rates across studies are difficult. Studies of treated and untreated sex offenders (excluding exhibitionists) have found recidivism rates that vary from 5 to 40 percent. Although still not conclusive, research on recidivism tentatively suggests that different types of convicted sex offenders may reoffend at different rates (regardless of whether they receive treatment or not). In 1990, Marshall and Barbaree summarized current research as follows:

- Exhibitionists tend to have the highest recidivism rates (ranging from 41 to 71 percent).
- The next highest rates have been found among child molesters who offend against boys (13 to 40 percent).
- Recidivism rates for child molesters against girls (10 to 29 percent) appear to be similar to the recidivism rates for rapists (7 to 35 percent).

³⁶ Cited in Solicitor General of Canada, *The Management and Treatment of Sex Offender*, 15.

³⁷ R. Karl Hanson, Richard A. Steffy, and Rene Gauthier, "Long-Term Recidivism of Child Molesters," *Journal of Consulting and Clinical Psychology*, Vol. 61, No. 4 (1993), 646-652.

³⁸ U.S. Department of Justice, "Recidivism of Prisoners Released in 1983," *Bureau of Justice Statistics Special Report* (Washington, D. C., April 1989).

- Incest offenders tend to have the lowest recidivism rates (4 to 10 percent).³⁹

Studies of Treatment Effectiveness

We reviewed the literature on treatment effectiveness and we found that:

- **Few evaluations of sufficient quality to permit definitive conclusions about treatment effectiveness have been done, mainly because sex offender treatment evaluations are very difficult to do.**

An experimental design in which subjects are randomly assigned to a treatment group or an untreated control group is the best way to evaluate treatment effectiveness. Random assignment permits researchers to control for other factors that may affect recidivism when comparisons of recidivism rates between the two groups are made. However, many treatment professionals consider it unethical to withhold treatment from dangerous men. When random assignment is not possible, a “quasi-experimental” design may be used. For instance, a group of treated offenders can be compared with a group of untreated offenders who have been matched on other characteristics that may affect recidivism, such as type of offense and prior criminal history.

Good evaluations of treatment programs are difficult to do.

Both experimental and quasi-experimental designs are difficult to use in the case of sex offender treatment for the reasons summarized in Figure 2.2. As a result, there have been few studies that have achieved the level of scientific rigor needed to arrive at definitive conclusions about treatment effectiveness. For example, most treatment evaluations have reported the recidivism rates for treated offenders and have not included a controlled comparison with untreated offenders. Others have either failed to adequately describe the treatment received or specify how recidivism was measured, treated small numbers of offenders, or followed offenders for short periods of time. Some sex offenders may reoffend many years after an initial sex offense. Based on longitudinal studies that have followed sex offenders for 20 years or more (discussed above), it has been estimated that a minimum of five years would be needed for about 75 percent of the offenders who reoffend to appear in official records.⁴⁰

While researchers agree that more and better research is needed, they disagree about how to interpret existing findings. There have been several comprehensive reviews of the treatment evaluation literature. One review by Furby and others examined eight studies that directly compared treated and

³⁹ W. L. Marshall and H. E. Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," *Handbook of Sexual Assault*, 371.

⁴⁰ Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project*, 8.

Figure 2.2: Reasons Why Sex Offender Treatment Evaluations are Difficult and Costly

Selection Biases

Offenders are initially assessed for amenability to treatment. Selection procedures that result in the exclusion of more difficult-to-treat offenders will result in lower recidivism rates. Thus, self-selection and program administrator selection biases affect evaluation results unless an evaluation includes adequate controls or random assignment.

Heterogeneity of Sex Offenders

Sex offenses encompass a range of deviant behaviors, including incest, same- and opposite-sex child molesting, and forcible rape (which varies in degrees of seriousness and motivation). Evaluation designs must control for offender and offense characteristics that are known to be associated with differential recidivism rates or include sufficiently large samples to ensure they are representative of the larger population of sex offenders.

Individualization of Treatment

Programs are diverse and treatment is typically geared to the specific needs of the individual offender. Variation in treatment makes evaluating effects across programs, as well as isolating treatment effects from other factors associated with recidivism, more difficult. Ideally, an evaluation would be able to specify why a program was effective or ineffective.

Program Attrition

It is not unusual for large numbers of offenders to withdraw or be terminated from treatment prior to completion. The overall effectiveness of treatment must take into account those who refuse to enter treatment and those who fail to complete it.

Different Measures of "Effectiveness"

There is no consensus in the literature on the best definition of program effectiveness. Most evaluations use "recidivism," although this may be defined in several different ways. Some studies use self-reported data. Other studies rely on intermediate behavioral measures, like polygraph tests, physiological measures, or questionnaire results.

Measurement Error

If official offense data are used exclusively, they are a major source of measurement error. First, those who reoffend must be apprehended by the police. Also, arrest and conviction data are subject to different priorities, definitions, and practices among criminal justice system agencies. For example, jurisdictions vary in their charging, prosecutorial, and plea-bargaining practices.

Sample Sizes and Follow-up Periods

Since only a proportion of sex offenders are likely to reoffend (regardless of whether they receive treatment), large initial samples are required, which add to the costs of evaluation. Also, the research suggests that the probability of sexual offenders committing another offense increases if measured over a longer period. Therefore, a long follow-up period is needed in order to ensure valid results, and evaluations should take into account the differential amount of time each offender is at risk.

Sources: Janice K. Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project* (Sacramento: California Department of Mental Health); Lita Furby, Mark R. Weinrott, and Lyn Blackshaw, "Sex Offender Recidivism: A Review," *Psychological Bulletin*, Vol. 105 (1989), 3-30; and W. L. Marshall and H. E. Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," *Handbook of Sexual Assault* (New York: Plenum Press, 1990), 363-385.

The results of treatment evaluations are inconclusive.

untreated offenders, but only one found a clear positive result. Based on their review, Furby and her colleagues concluded:

Despite the relatively large number of studies on sex offender recidivism, we know very little about it. Because of the many practical difficulties of designing and conducting studies in this area, methodological shortcomings are present in virtually all studies ... There is as yet no evidence that clinical treatment reduces rates of sex offenses in general and no appropriate data for assessing whether it may be differentially effective for different types of offenders.⁴¹

Since the Furby article was published in 1989, the results of additional experimental studies have become available. Other researchers have found reason for encouragement, if the expectations for treatment are realistic and do not require that it be effective across all types of offenders and programs.⁴² In their review of the literature, Marshall and others cited four out of five evaluations that found lower recidivism rates for some types of treated sex offenders compared to untreated offenders. They concluded that:

Evaluations of outpatient cognitive-behavioral programs, then, are definitely encouraging. While there is not an extensive body of outcome literature, what there is suggests that at least child molesters and exhibitionists can be effectively treated by these comprehensive programs ... equally clearly, not all programs are successful and not all sex offenders profit from treatment. Comprehensive cognitive-behavioral programs and those programs that utilize anti-androgens in conjunction with psychological treatments seem to offer the greatest hope for effectiveness and future development. However, even here not all versions of these programs are equally effective and those that are do far better with child molesters and exhibitionists than with rapists.⁴³

The results of several treatment outcome studies that included a comparison to an untreated control group are summarized in Table 2.1. This table illustrates the wide variation in recidivism rates found in studies, with some of the variation due to differing treatments, types of offenders, and follow-up periods. It also shows the conflicting findings in the literature, with some studies showing lower recidivism rates for treated offenders compared to an untreated group and others showing the opposite. However, only two studies, by Romero and Williams, and Marques and others, included random assignment to a control group. The Marques study presents the most recent results from the California Department of Mental Health's Sex Offender Treatment and Evaluation Project, initiated in 1985, which is considered the most sophisticated test of sex offender treatment undertaken to date.

The Minnesota Department of Corrections has also released preliminary results from its study of sex offenders released in 1988. The department has been monitoring recidivism rates for this group of offenders for the past five

⁴¹ Lita Furby, Mark R. Weinrott, and Lyn Blackshaw, "Sex Offender Recidivism: A Review," *Psychological Bulletin*, Vol. 105 (1989), 3-30.

⁴² W. L. Marshall, et al., "Treatment Outcome with Sex Offenders," *Clinical Psychology Review*, Vol. 11 (1991), 465-485. See also Solicitor General of Canada, *The Management and Treatment of Sex Offenders* (1990).

⁴³ Marshall, et al., "Treatment Outcome with Sex Offenders," 480-481.

years. The reconviction rates (sex offenses and other violent crimes) are 9.8 percent for offenders who completed treatment while in prison compared to 14.9 percent for those who did not enter treatment. This study also tracked sex offenders who entered treatment but failed to complete it, and found that this group had the highest reconviction rate at 25.6 percent. The Marques study tracked treatment dropouts and also reported that these offenders appear to have higher recidivism rates than both treated and untreated offenders.⁴⁴ These are the only two studies to report on recidivism for offenders who failed

Table 2.1: Summary of Sex Offender Treatment Outcome Studies

Study/Treatment Program	Offender Population	Follow-Up (Years)	Reported Recidivism Rates		Selection of Untreated Comparison Group
			Treated	Untreated	
Marshall and Barbaree (1988); outpatient, cognitive-behavioral	Child molesters (girls)	4.0	17.9%	42.9%	Patients who expressed an interest in participating but were unable to do so.
	Child molesters (boys)	4.1	13.3%	42.9%	
	Incest offenders	4.0	8.0%	21.7%	
Davidson (1979); inpatient (prison), cognitive-behavioral	Mixed	1-5	11.0%	35.0%	Comparison group selected from untreated offenders in same prison, but from an earlier time period.
Romero and Williams (1983); outpatient, group therapy	Mixed	10	13.5%	7.2%	Random assignment to treatment; comparison group placed on straight probation.
Rice, et al. (1991); inpatient (Psychiatric hospital), behavioral	Child molesters	6.3	37.9%	31.0%	Unknown.
Hanson, et al. (1992); inpatient (prison), individual and group therapy, some aversive conditioning	Child molesters	10-31	44.0%	48.0% 33.0%	Two comparison groups: one group from the same prison but released before treatment was offered; second group in prison at same time as those receiving treatment.
Sturgeon and Taylor (1980); inpatient (state hospital), group therapy	All offenders	1-5	15.4%	25.0%	Comparison group included those not accepted into treatment and those who received some treatment but failed to complete it to program's satisfaction.
	Girl molesters		19.8%	17.9%	
	Boy molesters		14.6%	37.5%	
	Rapists		19.3%	27.9%	
Marques, et al. (1993); inpatient (state hospital), cognitive-behavioral	Child molesters	3.2	7.9% (sex offenses)	10.0% (sex offenses)	Random assignment of matched pairs of offenders (volunteers) to experimental or control (untreated) groups.
			4.0% (other violent offense)	13.9% (other violent offense)	
Kaul, et al. (1994); inpatient (Minnesota prison), group therapy	Mixed	5	9.8%	14.9%	Retrospective study of sex offenders released in 1988. Comparison group includes those who did not receive treatment while in prison.

Sources: Solicitor General of Canada, *The Management and Treatment of Sex Offenders* (1990); Lita Furby, et al., "Sex Offender Recidivism: A Review," *Psychological Bulletin*, Vol. 105 (1989), 3-30; W. L. Marshall and H. E. Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," *Handbook of Sexual Assault* (New York: Plenum Press, 1990), 363-385; R. Karl Hanson, et al., "Long-Term Recidivism of Child Molesters," *Journal of Consulting and Clinical Psychology*, Vol. 61 (1993), 646-652; Janice K. Marques, et al., "The Relationship Between Treatment Goals and Recidivism Among Child Molesters," forthcoming, 1994; and James Kaul, et al., "Sex Offenders Released in 1988" (St. Paul: Minnesota Department of Corrections, 1994).

⁴⁴ Janice Marques, California Department of Mental Health Sex Offender Treatment and Evaluation Project, data presented at ATSA Conference, October 1992, which showed that non-completers had a recidivism rate of 33 percent, compared to 5 percent for treatment completers and between 7 and 8 percent for the control groups. However, these results were based on very small numbers of offenders. For a discussion of the drop-out issue, see Marshall and Barbaree, "Outcome of Cognitive-Behavioral Treatment," 374-375.

Few studies have tracked treatment dropouts, which may be as high as 50 percent.

to complete treatment, although in many programs large numbers of offenders are terminated or withdraw from treatment (up to 30 to 50 percent).⁴⁵ The overall effectiveness of treatment cannot be measured only by those who complete treatment; rather, evaluation of treatment effectiveness must also consider the number who refuse to enter treatment or drop out before completing it.⁴⁶

SUMMARY AND CONCLUSIONS

Based on our review, we conclude that the literature on treatment effectiveness cannot provide policymakers with a clear answer of whether to provide treatment for sex offenders. There is no consistent, solid evidence that clearly proves that treatment reduces sex offender recidivism nor is there solid evidence that it does not. Furthermore, given the length of time needed to conduct treatment outcome studies, it is unlikely that definitive answers will be available in the near future. Hence, policymakers have to make decisions about treatment on other grounds, such as public opinion, values and beliefs, potential risks and benefits, or cost.

Our literature review also suggests that a consensus may be emerging among treatment professionals. Many professionals now believe that it may be unrealistic to expect that treatment can “cure” sex offenders, in the sense that it can totally eliminate the deviant sexual desires of all sex offenders. Rather, a more realistic goal of treatment is training or educating offenders on how to control their deviant behaviors, and it is unlikely to be effective with all offenders. This approach to treatment involves lower expectations and viewing the treatment and supervision of sex offenders as a long-term process.

More and better research and evaluations of treatment are needed.

The literature also 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 receive treatment at all. Second, different types of sex offenders are likely to reoffend at different base rates (irrespective of whether they receive treatment). For example, incest offenders are less likely to reoffend compared with rapists. Third, in view of the wide variation in sex offenders, treatment programs, and research methods and measurements, evaluations of individual programs may not be comparable and must be examined carefully before conclusions are drawn about their relative effectiveness. Some types of programs may be effective with particular types of offenders, but not with others. One implication is that treatment effectiveness studies must be carefully designed or they can result in misleading conclusions.

⁴⁵ Cited in Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project*, 9-10.

⁴⁶ Marshall and Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," 371-376.

Description of Minnesota's Sex Offender Treatment Programs and Services

CHAPTER 3

In this chapter we describe sex offender treatment programs and service providers operating in Minnesota at the end of 1993. We describe where they were located and the types of treatment they provided. We also discuss how much treatment offenders received and how long treatment lasted. Finally, we analyze the costs associated with treatment and the sources of treatment funding. We asked:

- **How many sex offender treatment programs were there in 1993 and who operated them? Where were treatment programs located?**
- **What did sex offender treatment entail and how much treatment did offenders typically receive? How did treatment vary in different treatment settings?**
- **How much did treatment cost and who paid for it?**

To answer these questions, we attempted to identify all treatment programs in Minnesota that treated sex offenders referred by the court or received public funds for some of the costs of providing treatment. We visited programs located in residential settings and those operating in Minnesota correctional facilities to conduct in-depth interviews and examine program documentation. We also conducted detailed telephone interviews with representatives of the outpatient treatment providers we identified and reviewed related documentation. A copy of our outpatient treatment provider interview guide and the data collection form we asked them to complete for each offender they treated in 1992 is included as Appendix A.

We asked treatment providers in Minnesota to describe how they treated sex offenders and, in some cases, we observed group treatment. We also spoke with financial representatives of state, county, and private treatment programs, and interviewed officials from the Departments of Corrections and Human Services regarding sources of treatment funding.

In summary, we identified 70 service providers that treated sex offenders in Minnesota in the fall of 1993. They operated in a variety of settings, including state and county correctional facilities, community residential facilities, a state hospital, and private agencies. We learned that group therapy was the most

common method of sex offender treatment, sometimes supplemented with individual and family counseling. On average, treatment lasted 13 months in state and county correctional programs and 18 months in outpatient programs, although offenders who received outpatient treatment received fewer total hours of treatment. In general, residential sex offender treatment in correctional and community settings was more expensive than outpatient treatment, but in state correctional facilities, program expenses accounted for less than half of the total cost of holding offenders. Treatment programs were funded by several sources, including county and state funds, private insurance, and offender contributions.

IDENTIFYING TREATMENT PROVIDERS

To determine the number of sex offender treatment providers in Minnesota, we began with a list of 65 providers supplied by the Department of Corrections. We contacted these providers and talked with court services administrators and probation officers in Community Corrections Act counties and other counties with more than ten reported sex offense convictions. In the process, we eliminated defunct or inapplicable service providers and added others identified by probation officers and treatment officials. We included only programs that either accepted referrals from court services personnel or received public funds for some or all of the costs associated with treating sex offenders.¹ The service providers we identified are listed in Appendix B.

Minnesota's sex offender treatment programs are changing.

Our efforts to develop a comprehensive, up-to-date list of sex offender treatment providers were hindered by two factors. First, there was no comprehensive list of providers readily available. As we discuss below, no single state agency is responsible for regulating the agencies and therapists that provide sex offender treatment. Second, sex offender treatment programs in Minnesota are undergoing significant change. For example, the Department of Corrections established four new treatment programs in correctional facilities in the last three years and continued to modify them during our study period. In addition, in October 1993, the Department of Human Services instituted a new, comprehensive treatment program at the Minnesota Security Hospital to replace its existing sex offender treatment programs. Some outpatient programs also began or stopped treating sex offenders during our study period. As a result, the number of treatment providers on our list and the type of treatment they offer may have changed since we completed our field work. In this chapter we describe only those programs that were operating in the fall of 1993.

¹ In some cases, we found providers operating separate programs for juveniles and adults. We counted these as a single provider but as two programs.

NUMBER OF TREATMENT PROVIDERS

Table 3.1 summarizes the providers we identified by treatment setting and population treated (juveniles, adults, or both). We found that:

- In 1993, there were 70 providers that treated sex offenders referred by the court or received public funds for some of the costs of providing treatment.

We located 70 sex offender treatment providers, most of which offered treatment on an outpatient basis.

Table 3.1: Sex Offender Treatment Providers by Setting and Population Served, 1993

	Juveniles	Adults	Juveniles and Adults	Total
STATE FACILITIES				
State correctional facilities	1	4	0	5
Department of Human Services facilities	0	1	0	1
Subtotal	1	5	0	6
LOCAL RESIDENTIAL PROVIDERS				
County correctional facilities	2	1	0	3
Sex offender-specific residential facilities	2	1	0	3
Halfway houses	0	2	0	2
General treatment facilities	4	1	0	5
Subtotal	8	5	0	13
OUTPATIENT PROVIDERS				
Sex offender-specific providers ^a	2	4	3	9
Community mental health centers ^b	0	4	15	19
Other agencies and therapists	4	5	14	23
Subtotal	6	13	32	51
TOTAL	15	23	32	70

Source: Program Evaluation Division analysis of data received through November 1993.

^aThese providers serve only sex offenders or offenders with their families.

^bThis includes only Department of Human Services-licensed "Rule 29" facilities.

As shown in Table 3.1, there were six sex offender treatment programs in state facilities, five of which were located in adult correctional facilities. In addition, there were 13 residential programs operated by county correctional facilities or private agencies in the community. This included three residential treatment facilities that specialized in treating sex offenders, three county correctional facilities with sex offender treatment programs, two halfway houses that provided limited treatment and supervision for sex offenders released from prison under contracts from the Department of Corrections, and five general treatment facilities that worked with both sex offenders and others. As Table 3.1 indicates, private agencies, including sex offender-specific and general treatment facilities, operated 6 of the 9 residential programs for juveniles, while state and county correctional facilities operated 6 of the 10 residential programs for adult sex offenders.

Table 3.1 also shows that:

- **Most sex offender treatment service providers in Minnesota were outpatient agencies or therapists.**

Over 70 percent (51 out of 70) of treatment providers we identified provided outpatient services. They included community mental health centers, private agencies, and individual therapists. Most of these providers treated both juveniles and adults.

In addition to the programs listed in Table 3.1, some county probation departments provided limited therapy as part of their overall supervision of sex offenders. At least three probation departments—Dakota and Hennepin Counties and Arrowhead Regional Corrections—held weekly group sessions for sex offenders. These three programs were funded by Department of Corrections’ grants to increase supervision of sex offenders and supplement the treatment they received in other programs.

DESCRIPTION OF TREATMENT PROGRAMS

In this section, we describe the treatment programs operated in state facilities, local residential facilities, and by outpatient service providers.

State-Operated Programs

Table 3.2 shows which Department of Corrections facilities housed sex offenders and operated sex offender treatment programs as of January 3, 1994. As shown, convicted sex offenders comprised 21 percent of the total adult and juvenile correctional facility population, and treatment slots were available for 20 percent of them at a given time. Table 3.2 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.²

Until 1991, the Department of Corrections operated sex offender treatment programs in two adult facilities: Lino Lakes, a transitional facility for offenders scheduled for release; and Oak Park Heights, the state’s most secure facility. During the 1980s, the state correctional facility at Lino Lakes treated the most sex offenders. In late 1992 and early 1993, the number of sex offenders at Lino lakes increased and outgrew the capacity of the existing treatment program and staff. In mid-1993, the department replaced the existing program with a smaller one under new direction and with a slightly different focus. During the last three years, the Department of Corrections also developed two additional treatment programs for adults at Stillwater

Just over 20 percent of state prison inmates are sex offenders.

Recently, treatment for sex offenders in prison has been expanded.

² The department began a psycho-educational group for women sex offenders at Shakopee after our field work was completed.

Table 3.2: Sex Offenders and Treatment Programs in Minnesota Correctional Facilities, as of January 3, 1994

	Total Facility Population	Number of Sex Offenders ^a	Sex Offenders As Percent of Total	Sex Offender Treatment Slots ^b	Treatment Slots As Percent of Sex Offenders
ADULT FACILITIES					
Faribault	583	94	16.1%	—	—
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	—	—
Stillwater	1,443	370	25.6	45	12.2
Other facilities	294	0	—	—	—
Subtotal	4,194	876	20.9%	160	18.3%
JUVENILE FACILITIES^c					
Red Wing	73	4	5.5	—	—
Sauk Centre	91	15	16.5	20	133.3
Subtotal	164	19	11.6%	20	105.3%
TOTALS	4,358	895	20.5%	180	20.1%

Source: Department of Corrections.

^aInmates serving under a governing sex offense.

^bAs of September 1993.

^cAs of February 7, 1994.

(1991) and St. Cloud (1992). The department also plans to operate a new sex offender treatment program at the Moose Lake correctional facility, which is scheduled to open in 1994.

Department officials told us that the new adult programs are designed to serve inmates at different stages of incarceration and with different needs. For example, offenders with long sentences remaining (typically housed at Oak Park Heights) were likely to receive intensive and prolonged treatment, while those in their final year of incarceration (typically housed at Lino Lakes) received treatment that focused on building and maintaining relationships and preventing reoffense after release.³

The program at the St. Cloud facility initially treated 10 sex offenders at one time, but was expanded in the fall of 1993 to serve approximately 30 individuals at once. Unlike other adult sex offender programs, participants in the St. Cloud program are not housed in a separate unit, but are intermingled with other offenders in the prison population.

³ However, the department's need for beds may alter implementation of this plan. Department officials told us in March 1994 that they plan to transfer the intensive sex offender treatment program at Oak Park Heights to another facility in mid-1994. This will allow them to use maximum security beds for offenders who require a higher level of security.

The Department of Corrections also began a 20-bed sex offender treatment program for juveniles at its Sauk Centre facility in March 1993. Since 1987, the department has contracted with an outside consultant to provide counseling at the Red Wing facility for juveniles with a history of sexual offending. The department transferred juvenile sex offenders from the Red Wing facility to Sauk Centre when that treatment program began, and since then, it has placed the majority of its juvenile sex offenders at Sauk Centre.

The Minnesota Security Hospital treats offenders committed as psychopathic personalities and a few other sex offenders.

The Department of Human Services treated adult sex offenders at the Minnesota Security Hospital in St. Peter. Until recently, the Minnesota Security Hospital operated a residential program (Intensive Treatment Program for Sexual Aggressives) for sex offenders on probation who needed more supervision than outpatient programs provided. It also operated a program for less motivated or developmentally slower offenders.

In October 1993, the security hospital began a treatment program for sex offenders committed under Minnesota's psychopathic personality commitment law and incorporated the existing condition-of-probation offenders into the new program.⁴ Treatment officials told us that the increase in the number of psychopathic personality commitments resulted in their reducing by half the number of offenders on probation that they accepted at any one time (from 48 to 24).⁵ As of March 1, 1994 there were 27 offenders on probation, 60 individuals committed under the psychopathic personality law, and 10 mentally ill and dangerous or mentally retarded offenders in the new the sex offender program at the Minnesota Security Hospital.⁶

Local Residential Providers

As shown in Table 3.1, 13 local residential facilities throughout the state provided treatment to sex offenders in the fall of 1993. However, only three of these facilities (one adult and two juvenile) specialized in treating sex offenders. The adult facility, Alpha Human Services, had a capacity of up to 20 sex offenders in residence at one time, most of which were reserved for offenders from Hennepin County. The juvenile facilities, the Leo A. Hoffmann Center and Mille Lacs Academy, each operated more than one program. The Hoffmann Center operated two programs for boys, one of which could treat 36 at one time. The other, which specialized in treating offenders with low IQs, had a capacity of 16. Mille Lacs Academy operated four programs for boys between 10 and 19, divided into groups by age and overall functioning. The two largest groups had a joint capacity of 56 offenders between the ages of 15 and 19, a third could accept 20 offenders between ages 13 and 15, and the newest program had room to treat up to 12 boys between the ages of 10 and 12. Although the Hoffmann Center began

⁴ *Minn. Stat.* §§526.09-.115. See Office of the Legislative Auditor, *Psychopathic Personality Commitment Law* (St. Paul, 1994).

⁵ In addition, the Legislature has appropriated \$8.5 million to improve security and expand program capacity by 50 beds.

⁶ Since most of the clients it treated in 1992 were on probation, we grouped the Security Hospital with "local residential" programs for analysis.

Three private residential facilities specialize in treating sex offenders.

Some sex offender treatment is available in another ten residential facilities, including three local correctional facilities.

with an emphasis on serving juveniles from rural areas, both this facility and Mille Lacs Academy accepted juvenile offenders from counties and states that were willing to pay for their services.

Sex offender treatment was secondary to other services or functions in the remaining ten residential programs. In the three county correctional facilities (one adult and two juvenile), treatment was secondary to the supervision and control of offenders and other functions fulfilled by correctional facilities. The adult facility, Northeast Regional Corrections Center, served approximately 18 sex offenders from the Arrowhead region at one time.⁷ The Hennepin County Home School began its Juvenile Sex Offender Program in 1981 and, in the fall of 1993, could treat up to 48 offenders at one time. The Home School program accepted offenders from other counties and states, as long as they could pay the costs of treatment, but the program director told us that its sex offender treatment program was rarely full.⁸ Anoka County Juvenile Center began a program in 1991 and had room to treat 11 offenders at one time. This program accepted few from outside Anoka County.

Two halfway houses provided limited treatment to sex offenders on supervised release from prison. In addition, five “general treatment facilities” provided limited treatment to offenders who were typically housed at the facility for other reasons. These facilities included:

- three homes for severely emotionally disturbed children;
- an adolescent group home for juveniles who were removed from their homes temporarily; and
- an intermediate care facility for the mentally retarded (ICF-MR).

In all of these facilities, sex offender treatment supplemented the primary functions of the facility. Each program accepted varying numbers of sex offenders over time, based on program resources and the individuals’ other needs. Typically, however, offenders were not placed in these facilities because they were sex offenders, but because of other problems.

A variety of different agencies and individuals treat sex offenders on an outpatient basis.

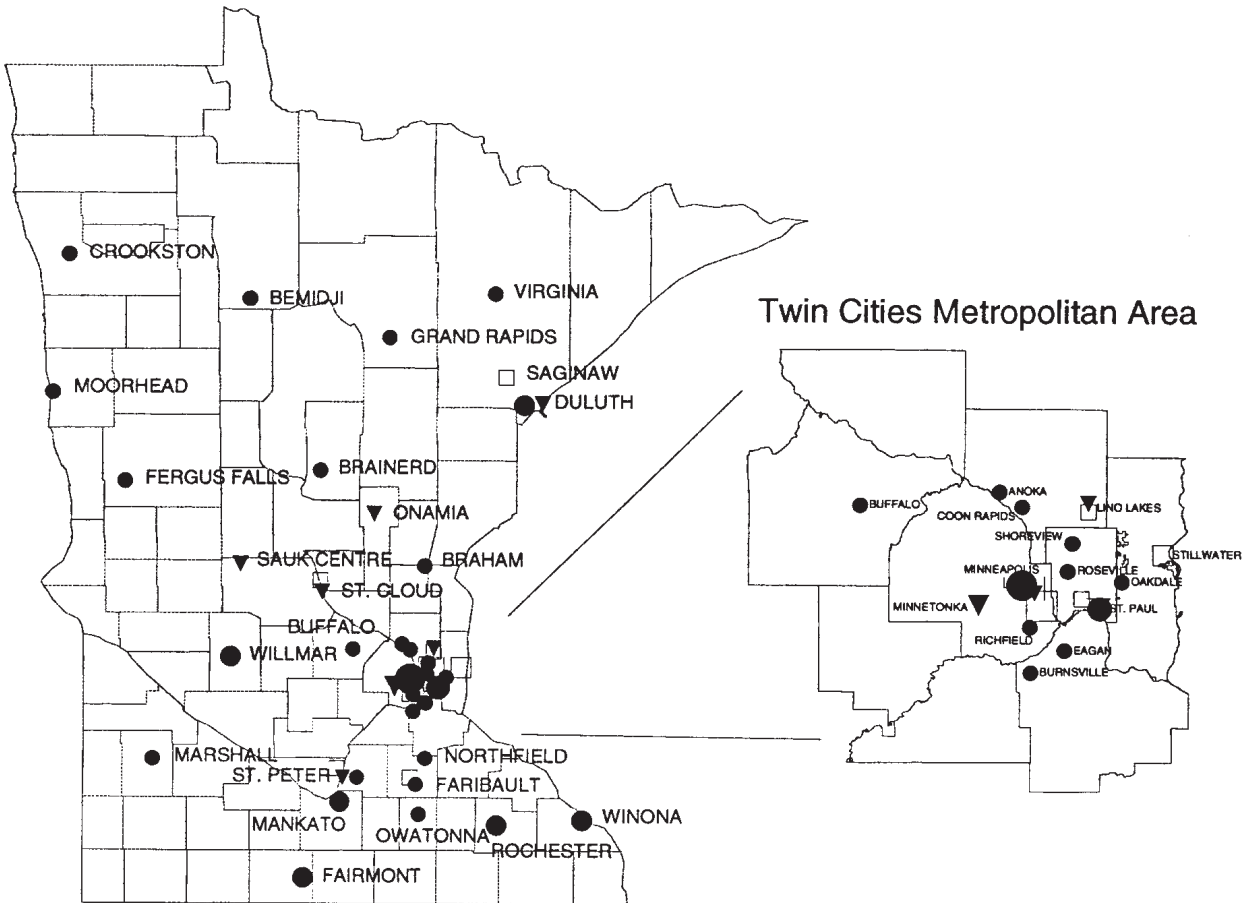
Outpatient Providers

As shown in Table 3.1, 51 agencies or therapists in Minnesota treated sex offenders on an outpatient basis. These providers operated 56 different programs for sex offenders. Nine of the 51 providers treated only sex offenders and 19 were licensed community mental health centers, which served many different clients. All of the others were independent agencies or therapists that treated sex offenders as well as other clients. These included

⁷ The Northeast Regional offenders were only partially separated from other offenders within the facility, so the program's capacity was not limited by its bed space. The Arrowhead region includes Carlton, Cook, Koochiching, Lake, and St. Louis Counties.

⁸ As shown below, the daily cost at the Hennepin County Home School was substantially higher than at other residential juvenile facilities.

Figure 3.1: Location of Sex Offender Treatment Providers



Sex Offender Providers		Number of Providers in a Specific City	
●	Outpatient	● 1	● 3
▼	Juvenile Residential	● 2	● 4+
□	Adult Residential		

Note: State correctional facilities are included in the residential category.

programs at the University of Minnesota, a day program for women involved with the correctional system, several social service agencies, groups of affiliated therapists, and therapists in private practice.

As illustrated in Figure 3.1, approximately half of all local residential and outpatient providers were located in the seven-county Twin Cities metropolitan area (33 of 64). The remainder were dispersed throughout outstate Minnesota. Forty-six percent of outpatient providers in outstate Minnesota were licensed community mental health centers, compared to 28 percent within the seven-county metropolitan area. Conversely, metropolitan area providers were more likely than outstate providers to be specialists in sex offender treatment (20 percent versus 15 percent) or other private therapists (52 percent versus 38 percent).

TREATMENT GOALS AND CONTENT

We asked treatment providers to describe the goals of their sex offender treatment programs, the types of treatment they provided, and the qualifications of staff who provided it.

Treatment and correctional officials told us that the primary goal of sex offender treatment was to stop individuals from repeating deviant sexual behavior. Secondary goals included getting offenders to acknowledge their offenses without minimizing their seriousness or blaming others, and getting them to develop empathy for their victims.

Treatment programs approached these treatment goals somewhat differently. Some programs tried to replace deviant sexual behaviors with more appropriate ones. Some focused on changing offenders' attitudes so that behavioral change would result. Nearly all tried to interrupt the cycles of thought and behavior that led to offenses.⁹ Overall, treatment programs told us they tried to teach offenders about their deviant behaviors and motivations, challenged them to change their patterns of offense, and supported them through the process of change.

Most treatment programs covered the same elements of treatment with each of their clients, but individualized each offender's treatment objectives, required activities, and the time allotted for each element. In many programs, a written treatment plan directed an offender's course of treatment according to specific goals and objectives. According to treatment program staff, treatment plans helped to document offenders' progress through treatment and served as tools for ensuring accountability.

⁹ Minnesota treatment program staff disagreed whether juveniles, like adults, had offense cycles. Some believed juveniles were too young to have already established patterns, but others believed that adult patterns were formed in adolescence.

Minnesota sex offender treatment programs rely primarily on psychological approaches.

We found that:

- **Most sex offender treatment programs in Minnesota relied on a mix of treatment approaches.**

Typically, treatment programs in Minnesota combined learning activities with those that helped to change offender behavior. For example, offenders were often required to attend sexual education lectures, discuss these sessions in groups with other offenders where they could practice social interactions, and then complete homework assignments to further integrate the material into their lives. Programs often had offenders begin treatment by writing their sexual histories, including any abuse they experienced or perpetrated. Many also required offenders to keep written journals of sexual fantasies for review and discussion throughout treatment in order to learn about their motivations and record their progress. Offenders often completed treatment by writing detailed plans for their future behavior.

Some programs in Minnesota incorporated less common activities into treatment. For example, one residential program for juveniles used massage therapy to teach offenders appropriate touch and allow those in treatment supervised physical contact. This program also invited parents to the facility each month for a “family journey,” during which parents and juveniles learned together about healthy communication and sexuality. Another juvenile program sometimes used clinical hypnosis and sex-specific behavior therapies, such as masturbatory reconditioning.¹⁰ At least two residential programs for adults and one for juveniles in Minnesota used plethysmography as part of the assessment or treatment process.¹¹ At least four residential programs occasionally used polygraphs to determine the depth of deviant thoughts and activities.¹²

In addition, the 1992 Legislature directed the Department of Corrections to fund a pilot program to test the effectiveness of pharmacological agents in the treatment of sex offenders.¹³ The department awarded \$203,550 for fiscal years 1993 and 1994 to the University of Minnesota to test the effectiveness of depo-provera and prozac in a controlled experiment with voluntary participants who were simultaneously in outpatient treatment. In addition, staff at the Minnesota Security Hospital said that its new sex offender treatment program, which began operating in October 1993, includes drug therapy.¹⁴ However, we did not identify any other programs in Minnesota that used drug therapy to treat offenders.

¹⁰ This treatment method uses an offender's senses to retrain his arousal patterns to respond to appropriate stimuli.

¹¹ A plethysmograph measures responses to sexual stimuli.

¹² There may be other programs that used plethysmographs and polygraphs as part of treatment, but we did not request this information from outpatient providers.

¹³ *Minn. Laws* (1992), Ch. 571, Art. 8.

¹⁴ The security hospital plans to do an independent study of the effectiveness of the drugs it uses in reducing sexual compulsiveness.

We also found that:

- **Few treatment programs regularly included “aftercare” as part of their treatment of sex offenders.**

Few programs include long-term follow up.

In general, aftercare is a period of less intense treatment or support to ensure offender accountability during the transition out of more intense treatment and supervision. Approximately one-third of the treatment programs we identified told us they included a period of aftercare at the end of the treatment period. However, programs differed in what they called aftercare, ranging from verbal check-ins to prolonged therapy. Some programs required offenders to periodically call treatment officials, meet with therapists individually, or attend support groups run by participating offenders. On the other hand, some referred clients to other treatment programs that specialized in aftercare for offenders who had completed primary treatment elsewhere.

TREATMENT METHODS

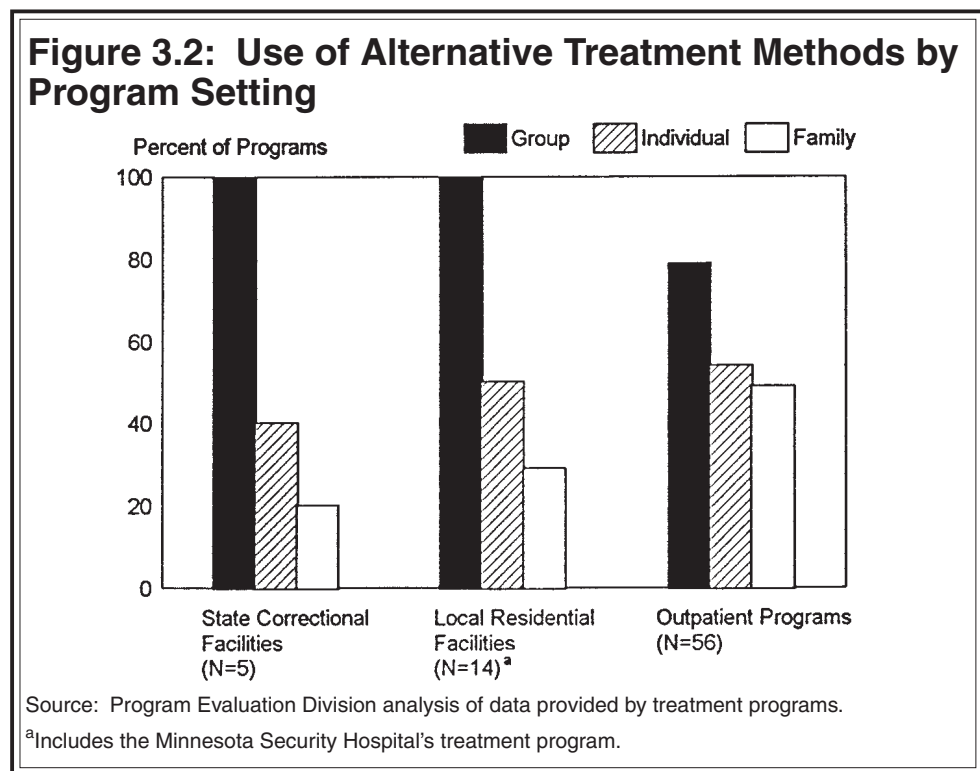
We asked treatment program staff what methods they used to treat sex offenders and how often they used each one. Treatment officials told us they used some treatment methods with all or nearly all of their clients, and other methods only when they seemed to be necessary. We found that:

- **Most programs used group therapy as their primary method of treating sex offenders.**

Over 80 percent of programs use group therapy to treat sex offenders.

As Figure 3.2 shows, all of the treatment programs in state and local residential facilities and 80 percent of outpatient programs regularly used group therapy to treat sex offenders. Fewer programs regularly used individual and family counseling. In addition, offenders received over twice as much group therapy as individual treatment on average. In approximately two-thirds of outpatient programs, two therapists jointly conducted group therapy to balance an individual therapist’s impressions. There were 8 offenders per group on average, although the groups ranged in size from 4 to 12 members. Typically groups focused on one individual’s experience at a time to explore issues common to all.

According to treatment officials, group therapy was most common for at least two reasons. First, sex offenders in treatment with offenders like themselves could not easily deceive each other or their therapists about their offenses. Second, group settings provided role models of similar individuals who were succeeding in the treatment process in some way. According to these treatment officials, peer confrontation and support played an important role in changing deeply rooted patterns of thinking and fulfilling needs.



As Figure 3.2 also shows:

- **Fewer than half of all sex offender treatment programs routinely provided individual or family treatment to their clients.**

Outpatient programs were the most likely to supplement group therapy with the other two forms of treatment. Fifty-four percent of outpatient programs regularly provided individual therapy, compared to 40 percent in state correctional facilities and 50 percent of those in local residential facilities. Forty-eight percent of outpatient programs regularly provided family therapy, compared to 20 percent in state correctional facilities and 29 percent of those in local residential facilities.

Several other programs provided individual counseling “as needed,” and a small number of programs in each treatment setting told us they provided counseling to an offender and his family when possible and necessary to achieve treatment goals. We also learned that some sex offenders in outpatient treatment received individual or family counseling from a different provider at the same time, arranged through an offender’s probation officer or county case manager.

Treatment Staff

We asked treatment providers about the qualifications of the staff who treated sex offenders. We found that:

- **While there were no licensing standards that applied specifically to sex offender treatment providers, most of the people who provided treatment were licensed in mental health fields.**

Most treatment professionals are licensed in mental health fields.

Most sex offender treatment in Minnesota was provided by mental health workers licensed as social workers, psychologists, or, in some cases, psychiatrists. Also, most programs required at least some treatment staff to have a masters-level or more advanced degree in a mental health field. Over 40 percent said they preferred to hire people with previous experience working with offenders or victims or who were interested in working with these client groups. In correctional facilities, staff were often required to also have experience working within a correctional setting. Most providers also told us it was important for staff to stay current with developments in the sex offender treatment field, mainly by attending seminars, workshops, and conferences.

LENGTH OF TREATMENT

We asked treatment programs how much time sex offenders spent in sex-specific treatment activities each week.¹⁵ As Figure 3.3 shows, offenders in state correctional and sex offender-specific residential programs spent the greatest number of hours in treatment each week. These programs, which included the Minnesota Security Hospital, supplemented several hours of group, individual, and family counseling with activities such as educational lectures and videos related to sexual behavior.

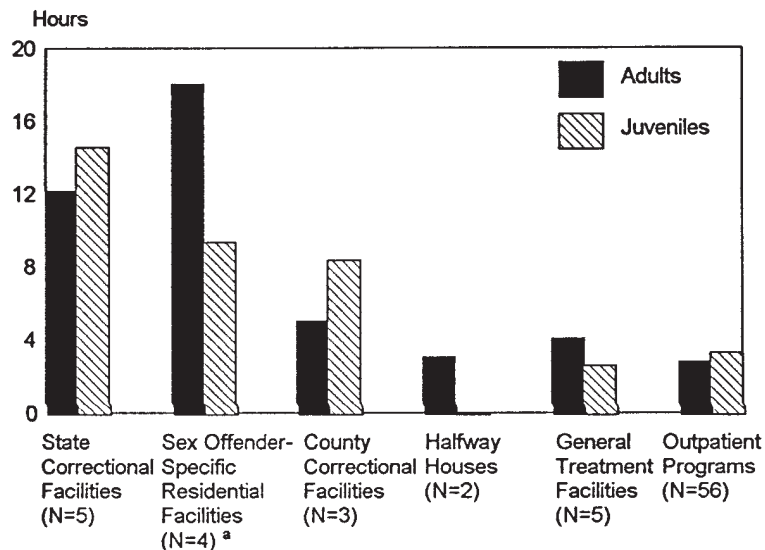
Overall, other residential facilities (which included the halfway houses and general treatment facilities) and outpatient programs provided the fewest hours of treatment each week. They offered between .5 and 15 hours of treatment each week, but on average provided 3 hours of treatment each week. Nearly half of all outpatient programs in Minnesota provided two or fewer total hours of treatment per week.

The amount of treatment juveniles and adults received each week varied in each treatment setting. For example, juveniles in Mille Lacs Academy and the Leo A. Hoffmann Center participated 11 and 8 hours per week, respectively, in sex offender-specific therapy, while adults in the program at Alpha Human Services and the new program at the Minnesota Security Hospital spent

¹⁵ Our hourly figures include the time offenders spent in activities that were specifically and consistently related to an individual's sexually offending behavior. We did not include the hours individuals in residential programs spent each week dealing with issues of personal well-being not specifically related to sexual offending. As a result, our figures may understate the number of hours offenders in state, county, and private residential programs spent in treatment activities overall.

In 1993, sex offenders in outpatient programs received an average of three hours of treatment per week.

Figure 3.3: Average Hours per Week in Sex Offender-Specific Treatment by Program Setting



Source: Program Evaluation Division analysis of data provided by treatment programs.

^aIncludes the Minnesota Security Hospital's treatment program.

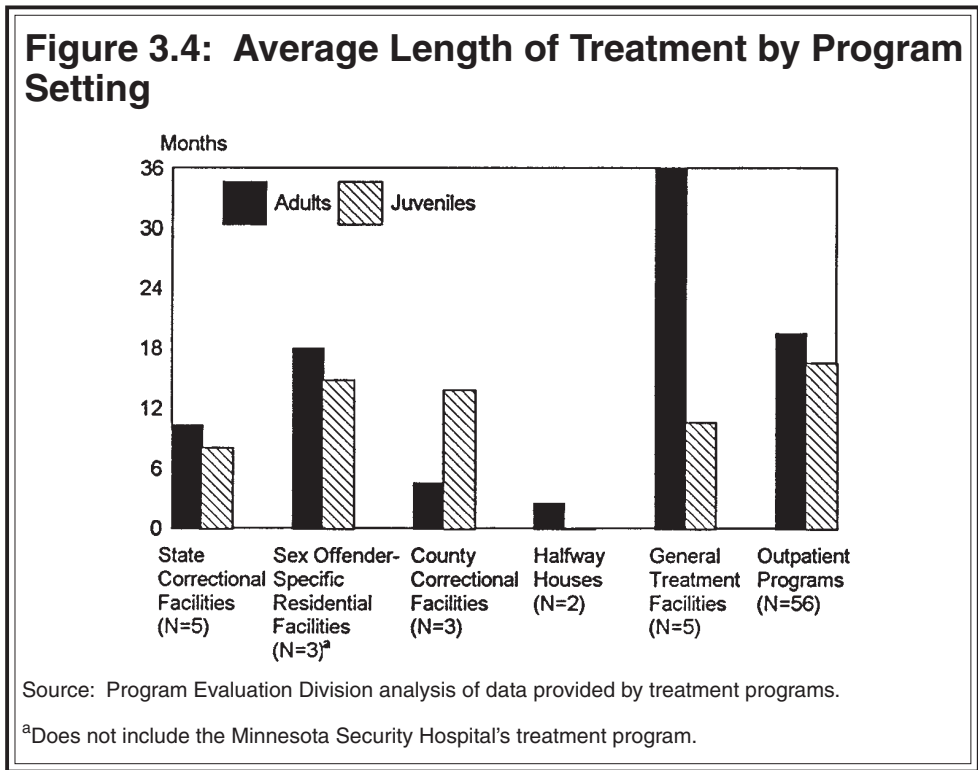
approximately 18 hours each week in sex offender-specific therapy.¹⁶ Juveniles in treatment spend part of each day in school-related activities, which may help account for these differences.

We also asked treatment programs how many months of treatment sex offenders typically received in their programs assuming they successfully completed treatment, and the results are shown in Figure 3.4.¹⁷ With the exception of the one adult general treatment facility—an ICF-MR for the developmentally disabled—outpatient programs lasted the longest on average, followed by sex offender-specific residential programs. Outpatient treatment programs lasted between 2 months and 3.5 years, but most took between 16 and 20 months. In contrast, most residential programs lasted under one year, although Alpha Human Services (sex offender-specific residential program for adults) lasted 18 months plus a period of less intense aftercare. Four of five programs in state correctional facilities took between six and ten months to complete. The intensive treatment program at Oak Park Heights took longer, averaging 17 months for offenders without chemical dependency problems and about 24 months for those who received both chemical dependency and sex offender treatment.

¹⁶ As discussed above, Mille Lacs Academy and the Leo A. Hoffmann Center both operated more than one program. Each of their programs provided a different average number of hours of therapy each week. The numbers listed are typical for most offenders who were in treatment at these facilities.

¹⁷ As we show in Chapter 4, a large number of offenders do not complete treatment to the program's satisfaction. We learned from residential and correctional facility staff and informal contacts with outpatient programs that "successful completion" may be defined differently. We discuss this issue more fully in Chapter 4.

Treatment can last from two months to over three years.



On average, sex offenders in outpatient programs received about half as much treatment in 1992 as those in residential programs.

Table 3.3 shows the average total number of hours of treatment offenders received in each setting.¹⁸ Offenders in the adult sex offender-specific treatment program, Alpha Human Services, received the most treatment by far (an average of 1,638 hours), almost three times the amount of treatment provided by adult correctional facilities and six to seven times the amount of treatment provided by outpatient programs. Juveniles in county correctional facilities received slightly more treatment than those in sex offender-specific treatment facilities, but both settings provided more total treatment than the state program for juveniles at Sauk Centre.¹⁹

We found that:

- **Overall, sex offenders received almost twice as much treatment in correctional and residential settings as in outpatient programs.**

Table 3.3 also shows that there is variation in the average number of hours of treatment offenders received in residential programs, with the fewest hours provided by programs that did not specialize in sex offender treatment (for

¹⁸ We calculated this by multiplying the average length of treatment by the average number of hours of sex offender-specific treatment per week for each program. We then weighted programs by the number of offenders treated in 1992 to calculate an average for each category. We did not include the new treatment program at the Minnesota Security Hospital because most individuals in the program were committed indefinitely under the psychopathic personality commitment law. However, staff estimated that the treatment program would require a minimum of 33-38 months to complete before consideration for transfer to another facility.

¹⁹ The Sauk Centre program was developed for the more difficult-to-treat juvenile, who typically has already spent some time in other treatment programs.

Table 3.3: Estimated Average Total Hours in Treatment by Program Setting

Program Setting	Adult		Juvenile		OVERALL	
	Number of Programs	Average Total Hours	Number of Programs	Average Total Hours	Number of Programs	Average Total Hours
RESIDENTIAL PROGRAMS^a						
State correctional facilities	4	560	1	503	5	549
County correctional facilities	1	98	2	717	3	511
Sex offender-specific residential facilities	1	1,638	2	636	3	970
Halfway houses	2	33	0	n/a	2	33
General treatment facilities	1	624	4	118	5	219
Residential Overall	9	518	9	409	18	464
					<u>Adult and Juvenile</u>	
					Number of Programs	Average Total Hours
OUTPATIENT PROGRAMS					56	241

Source: Program Evaluation Division analysis of data provided by treatment programs.

^aExcludes the Minnesota Security Hospital's treatment program.

example, adult county correctional facilities, halfway houses, and juvenile general treatment facilities.) However, overall offenders received an average of 464 hours of treatment in residential settings compared to 241 hours in outpatient programs.

However, the variation in average total number of hours that offenders spent in treatment does not entirely account for differences in offender treatment experiences. We visited residential treatment programs and observed daily interactions between treatment officials and offenders. We observed that:

- **Offenders in residential treatment became part of a treatment environment that addressed multiple and interrelated issues.**

In residential treatment programs, offenders and treatment officials interacted throughout the day and worked on treatment goals outside of formal treatment activities. In addition, all an offender's activities took place in the treatment environment, which allowed program officials to identify and address related problems with self esteem, anger, and interpersonal relationships. Finally, residential programs immersed offenders in treatment, forcing them to concentrate intensively on one topic for a prolonged period of time.

According to residential treatment officials, an intensive residential experience helped offenders re-learn appropriate responses to daily life situations. However, the isolation which intensified the program's impact by creating a supportive environment was not likely to last beyond the treatment period. At

release from the program, offenders may face the same high-risk situations as before. As a result, some treatment programs included a period of outpatient aftercare following completion of residential treatment.

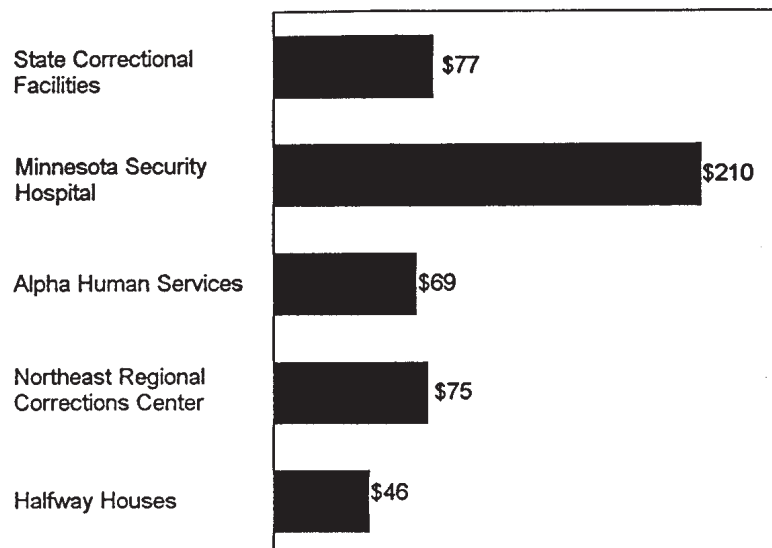
TREATMENT COSTS

We examined the total costs of treatment in each setting. We included the costs of room, board, and security in the expense of correctional and residential programs and calculated the cost of outpatient treatment using hourly charges for group, individual, and family therapy.²⁰

Correctional and Residential Programs

As Figure 3.5 shows, the program at the Minnesota Security Hospital was the most expensive residential treatment option for adults during fiscal year 1994, costing nearly three times more than other residential programs.²¹ Figure 3.5

Figure 3.5: Cost per Day for Adult Residential Facilities, FY 1994



Source: Program Evaluation Division analysis of data provided by treatment programs.

Note: Figures for state correctional facilities and halfway houses are averages weighted by program capacity.

²⁰ Assessment and testing costs were typically absorbed into the total daily cost in correctional and residential programs and in the hourly fees of outpatient programs. In addition, some programs could not tell us what testing fees applied, because they both treated offenders who had undergone assessment elsewhere and assessed offenders who then entered treatment elsewhere. As a result, when programs isolated these costs, we did not include them in our total cost calculations.

²¹ The daily cost figure for the program at the Minnesota Security Hospital, provided by its staff, represented the estimated costs for the new sex offender program that began in October 1993. In addition, we did not include the ICF-MR adult residential facility in these calculations because it works only with developmentally disabled offenders who reside there because of their disabilities rather than their sex offenses.

Residential treatment for juveniles was more expensive than for adults.

also shows that the state and county correctional facilities charged similar daily rates which were only slightly higher than the rate for residential treatment in the community facility, Alpha Human Services. Treatment programs in halfway houses cost the least, although, as mentioned above, they provided only limited treatment to offenders coming out of prison on supervised release. Overall, the most expensive programs—in correctional facilities and the Security Hospital—were those that provided a higher level of security for the public and other treatment participants.

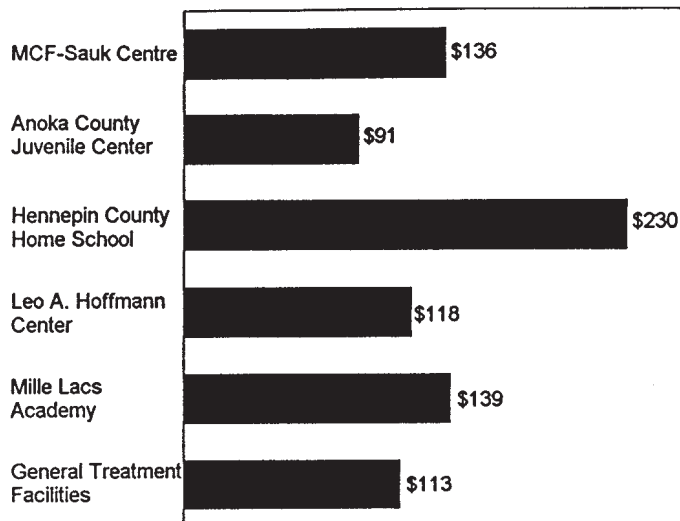
We also calculated the costs of treatment in juvenile residential treatment programs.²² As Figure 3.6 shows, the cost of juvenile programs ranged from a high of \$230 per day at the Hennepin County Home School to a low of \$91 at the Anoka County Juvenile Center.

Comparing these results with those for adult facilities, we found that:

- **Overall, residential treatment in a correctional or community setting was more expensive for juveniles than for adults.**

As shown in Figure 3.5, average daily costs for adults ranged from \$46 to \$210, but costs exceeded \$100 per day at only one facility, the Minnesota Security Hospital. On the other hand, Figure 3.6 shows that five of the six juvenile facilities cost more than \$100 per day and one facility, the Hennepin County Home School, cost \$230 per day. The daily cost at the state

Figure 3.6: Cost per Day for Juvenile Residential Facilities, 1993



Source: Program Evaluation Division analysis of data provided by treatment programs.

Note: Figures for Leo A. Hoffmann Center and Mille Lacs Academy are weighted averages for their several programs. The "General Treatment Facility" category includes Welcome Home, Northwood Children's Home, St. Cloud Children's Home, and St. Joseph's Home for Children.

²² Most of the programs provided us a figure based on calendar year calculations. For consistency, we averaged the costs for fiscal years 1993 and 1994 for those facilities operating on a fiscal year basis.

Treatment accounted for less than 25 percent of the costs of keeping an adult sex offender in prison.

correctional facility at Sauk Centre was \$136. However, counties that participated in the Community Corrections Act paid only about 75 percent of the costs of sending a juvenile to a state correctional facility.²³ The state paid the total cost for juveniles from counties that did not participate in the Community Corrections Act.

However, in all residential programs, the costs of treatment represented only a portion of the total cost of keeping an offender in these facilities. All residential facilities also provided room and board, supervision, and, in some cases, security. We were unable to determine what proportion of the total costs sex offender treatment represented for all of the residential facilities. However, we were able to isolate the costs directly associated with the sex offender treatment programs in state correctional facilities. Using figures for fiscal year 1994, we found that:

- **Treatment program costs accounted for between 10.6 and 24.5 percent of the overall cost of keeping and treating adult sex offenders in prison.**

As Table 3.4 shows, treatment program costs accounted for less than one-fourth of each facility's total costs for an inmate over a year's time. However, sex offender programming accounted for nearly half of the daily cost of keeping a juvenile in the facility at Sauk Centre.

Table 3.4: State Correctional Facilities' Annual Sex Offender Program Costs, FY 1994

	Annual Cost Per Offender	Sex Offender Program Costs Per Treatment Slot	Sex Offender Program Costs as Percent of Total Cost
ADULT FACILITIES			
Lino Lakes	\$26,240	\$ 2,777	10.6%
Oak Park Heights	41,654	5,245	12.6
St. Cloud	25,291	6,203	24.5
Stillwater	20,947	4,620	22.1
JUVENILE FACILITIES			
Sauk Centre	\$48,665	\$24,129	49.6%

Sources: Minnesota 1994-95 Biennial Budget, Department of Corrections Annual Spending Plan, and the Minnesota Correctional Facility-Sauk Centre.

Outpatient Programs

We asked outpatient programs how much they charged to provide different methods of sex offender treatment. We found that:

²³ Counties participating in the Community Corrections Act reimbursed the Department of Corrections for juveniles sent to state correctional facilities at the rate of \$98 per day during fiscal year 1992 and \$108 during fiscal year 1993 (an average of \$103 per day during calendar year 1993).

- **On average, outpatient programs charged \$38 per hour for group therapy and about \$86 per hour for individual therapy.**

Although charges ranged from \$15 to \$90 per hour, approximately three-fourths of all outpatient programs charged under \$45 per hour for group therapy. Out-patient programs specializing in sex offender treatment charged approximately the same hourly fee as those in community mental health facilities and programs operated by other agencies and therapists. However, programs in the seven county metropolitan area charged somewhat more for group therapy (\$41 per hour) than those in outstate Minnesota (\$34 per hour).

Although the hourly charge for individual therapy ranged from \$34 to \$134, half of the outpatient programs that reported their fee charged between \$80 and \$90 per hour. Sex offender-specific providers tended to charge less per hour (\$71) than community mental health centers and other treatment providers, which averaged \$91 per hour. In addition, individual therapy tended to be somewhat less expensive in the metropolitan area (\$81 per hour) than in outstate Minnesota (\$92 per hour).

We found that:

- **It was more costly, overall, to treat sex offenders in residential settings than on an outpatient basis due to the additional costs associated with security and room and board. However, looking only at treatment costs, treatment in most correctional facilities was less expensive than outpatient treatment.**

Based on the number of hours in treatment per year, we calculated the average annual cost of outpatient treatment to be approximately \$7,200 per offender. This compares to annual treatment costs per offender at the state's correctional facilities, shown above in Table 3.4, that ranged from \$2,777 at Lino Lakes to \$6,203 at St. Cloud. Treatment costs at the state's only juvenile facility offering sex offender treatment (Sauk Centre) were \$24,129 per offender.

Outpatient treatment cost about \$7,200 per sex offender per year in 1993.

SOURCES OF FUNDING

We asked treatment programs to tell us who paid for treatment. We also interviewed county and state officials regarding reimbursement for treatment expenses. We found that:

- **Treatment programs were funded by several sources, including county and state funds, private insurance, and offender contributions.**

State funds were used to pay the costs of treating offenders held in state correctional facilities, halfway houses, and the Minnesota Security Hospital (including those in treatment as a condition of probation).

Also, state funds in the form of block grants went to counties that participated in the Community Corrections Act (CCA) to provide alternatives to incarceration. In 1993, state subsidies to CCA counties totaled almost \$21.5 million, which represented approximately 19 percent of CCA counties' total expenditures for community corrections.²⁴ Some portion of these funds eventually paid for treating offenders associated with the correctional system. For example, Arrowhead Regional Corrections, a recipient of state CCA dollars, funded Northeast Regional Corrections Center, where adult offenders from the Arrowhead region received treatment. In addition, Hennepin and Anoka Counties (both CCA counties) operated their own residential treatment programs for juveniles.²⁵ Additional CCA dollars funded outpatient treatment and aftercare in these counties through reimbursements to the service providers. Also, the Department of Human Services administers funds for payment for foster care and group homes where some juvenile offenders received treatment, and administers general assistance funds that pay a portion of residential treatment costs for some offenders.

State funds were also used to pay for some portion of outpatient treatment through a number of direct grants from the Department of Corrections. In addition, some unknown amount of state funds (including medical assistance and state matching funds for federal programs) administered through the Department of Human Services paid for outpatient sex offender treatment. Approximately 60 percent of outpatient programs told us they accepted medical assistance for offenders who qualified for reimbursement.²⁶ Other programs (7 percent) told us they did not accept medical assistance primarily because the reimbursement rates were too low.

We found that:

- **In most cases, the client could not afford the total cost of treatment.**

An offender's resources included personal insurance, medical assistance (if the person qualified), and personal income. When these were inadequate, agencies and counties typically supplemented offender contributions according to the offender's need. We learned that:

- **Most outpatient treatment programs operated on a sliding fee basis. Offenders first contributed what they could afford toward the cost of treatment and the remainder was paid through county or state sources.**

Offenders pay what they can afford, with the remaining cost of treatment paid from a variety of public sources.

²⁴ We were unable to determine what proportion of these funds counties spent for sex offender treatment and services and, consequently, what proportion of the state CCA subsidy went for treatment of sex offenders. These funds were not accounted for separately.

²⁵ Other counties with juveniles in treatment at the Hennepin and Anoka County facilities paid them a daily fee established by the host county.

²⁶ Almost all such programs supplemented medical assistance with funds from other sources because reimbursement rates did not cover the total cost of their services.

In some cases, treatment programs absorbed a portion of the cost of treating offenders. In others, they used discretionary funds to reduce the costs of treatment. For example, treatment officials at some mental health centers told us their centers received block grants from the host counties to treat individuals with inadequate personal resources. Their centers were typically allowed to determine how best to use these block funds, just as with state block grants to counties. As a result, at the center's discretion, some sex offenders benefited from general county treatment funds.

SUMMARY

We located 70 service providers in Minnesota that treated sex offenders in the fall of 1993. They operated programs in state and county correctional facilities, community residential facilities, a state hospital, and private agencies. Approximately half of the service providers were located in the Twin Cities metropolitan area. Sex offenders were most frequently treated in groups, and sometimes received individual and family counseling. On average, correctional and community residential programs provided more than twice as many hours of treatment and a more comprehensive treatment environment than outpatient treatment programs. Correctional and residential programs were also more expensive than outpatient treatment programs, and more expensive for juveniles than for adults. However, in state juvenile and adult correctional facilities, program expenses accounted for only between 11 and 50 percent of the total cost of holding offenders. Overall, treatment programs were funded from several sources, including county and state funds, private insurance, and offender contributions. We were unable to determine how much of total treatment costs was paid with state funds due to the complexity of funding and reimbursement mechanisms and because sex offender costs were not accounted for separately.

Description of Sex Offenders Receiving Treatment

CHAPTER 4

In this chapter, we describe how treatment providers and others determine which offenders to accept into treatment. We also describe the offenders who received treatment during 1992 and where they received it.

We asked:

- **How do treatment programs screen for “amenability” to treatment? Are there offenders who do not receive treatment and, if so, why not? Do programs also screen for chemical dependency problems?**
- **How many sex offenders receive treatment and where do they receive it? What are the characteristics of offenders who receive treatment? How many begin treatment but fail to complete it and why?**
- **Do treatment programs monitor offenders following treatment? Do they keep recidivism data on their clients?**

To answer these questions, we conducted interviews with the correctional and residential programs and outpatient service providers described in Chapter 3. We also obtained data from the Department of Corrections regarding sex offenders entering and leaving prison. Finally, we asked each treatment provider to complete a one-page data form for each offender treated in Minnesota during 1992.¹ A copy of this form is included in Appendix A. Sixty-five percent of the treatment programs (49 of 75) sent us completed forms on the offenders they treated. We received complete information from all state-operated facilities, county correctional facilities, and local residential facilities that treat only sex offenders. However, many of the outpatient programs were either unable or unwilling to comply with our request. As a result, we obtained data forms for 59 percent of the estimated total number of offenders treated, but only 40 percent of the offenders treated by outpatient programs. However, all but two of the programs were able to provide us some data on the number of sex offenders served, types of offenses they committed,

¹ In some instances, programs were unable to provide data for calendar year 1992 but provided data for an alternate time period that usually contained part of 1992. Seven percent of the data sheets were based on an alternate time period.

and their sex, race, and county of conviction.² In this way, we were able to develop an estimate of the total number of offenders who received treatment in 1992.³

In summary, we found that all treatment programs screened offenders who were referred to them as potential clients to determine amenability to the treatment they provide. Offenders who were thought to be more difficult to treat were less likely to be accepted into treatment. Overall, many offenders received treatment, although nearly half of those who left treatment failed to complete it to the program's satisfaction. Approximately two-thirds of the sex offenders treated in 1992 received treatment in outpatient programs. Those who received treatment in correctional facilities tended to have committed more serious offenses than those in residential or outpatient programs. Few programs maintained follow-up data on offenders treated.

PRE-TREATMENT SCREENING

We asked treatment providers whether they screened sex offenders for admission into treatment and, if they did, what the screening process entailed. We found that:

- **Nearly all treatment providers screened offenders for program admission, but they differed in their screening procedures.**

Some treatment providers used standardized psychological tests, such as the Minnesota Multiphasic Personality Inventory and Multiphasic Sex Inventory, to provide basic information about an offender. Others relied primarily on standardized questionnaires developed in-house to determine whether an offender was a good candidate for treatment. Some providers also conducted educational testing to determine the offender's intellectual ability. Nearly all providers reviewed available court documentation about the offender and his offense and interviewed the offender for information about his personal history of abuse, other offenses he may have committed, and related therapeutic concerns. Treatment officials also used the interview to gauge an offender's interest in treatment.

² We received only estimates of the number treated during 1992 from six agencies: Center for Parents and Children, Elk River Mental Health Center, Genesis II, Phase, Western Human Development, and the University of Minnesota's Program on Human Sexuality. Two agencies, Central Minnesota Mental Health Center and City Line Associated Psychotherapists, did not provide any data, despite multiple requests and contacts.

³ Some offenders may have received treatment in more than one program during 1992. For example, by matching Department of Corrections' inmate identification numbers, we identified 23 out of 319 adult offenders (7 percent) who received treatment in more than one correctional facility in 1992. We eliminated these duplicates. Similarly, individuals may have been treated in 1992 by more than one outpatient program or by a combination of outpatient and correctional or residential programs, but we were unable to determine how often this occurred. However, based on information from programs that provided us with data, we estimate that approximately 5 percent of offenders may have been counted in more than one program.

Providers screen sex offenders and decide whether to accept them into their treatment programs.

Procedures to assess sex offenders for treatment amenability vary widely.

Typically, providers also evaluated the offender's ties with family and friends. This helped to clarify the complexity of the issues from the offender's perspective and determine whether long-term support would be available. The nature of an offender's relationships with family and friends is considered particularly important in cases of incest or when the offender either remains at home during treatment or returns there after completing treatment.

Overall, assessment procedures ranged from a file review to multiple tests done while the offender is in residence on a trial basis. While some providers did not administer any tests and relied only on a review of existing documentation, others incorporated the assessment process into an initial orientation/education period that lasted up to several weeks. During this time, offenders were taught the concepts and terminology necessary for continued treatment. However, if they failed to make progress they were often not allowed to continue with treatment.

The only exception involves the Minnesota Security Hospital's sex offender treatment program, which must accept all individuals who are civilly committed under the state's psychopathic personality commitment law. However, individuals who enter the security hospital's treatment as a condition of probation are assessed for treatment amenability before they are accepted into the program.

We found that:

- **While all programs assessed referrals for amenability to treatment, an individual judged "not amenable" to treatment by one program might have been determined "amenable" by another.**

Through the assessment process, a provider determined whether an offender was amenable to the treatment provided in its own program, not whether the offender was amenable to any treatment available. In fact, we heard of cases in which professionals from two different treatment agencies testified against each other in court regarding whether the same offender should be treated in the community. As noted in Chapter 2, existing research has not given clear direction to professionals regarding which offenders are most amenable to treatment. In addition, professionals may disagree about the level of risk or danger a given offender poses, and programs differ in their areas of expertise and the resources available to provide treatment. Some programs specialized in certain types of sex offenses (e.g., incest) or certain types of offenders (e.g., low functioning, Spanish speaking).

Admission Decisions

The data from correctional programs and interviews with residential and outpatient programs revealed that, ultimately, most providers in Minnesota based acceptance decisions on a few factors, including:

- the client’s level of intellectual functioning (IQ);
- the level of risk an offender posed to the treatment program and the surrounding community; and
- the client’s level of offense denial.

We found that:

- **Most treatment programs would not accept developmentally disabled or low-functioning sex offenders.**

Most providers are unwilling to accept intellectually low-functioning sex offenders or those who pose security risks.

Three-quarters of outpatient treatment programs would not accept developmentally disabled offenders (those with an IQ less than 70). In addition, half of the outpatient programs would not accept offenders who were intellectually “low functioning,” with IQs above 70 but below 80 or 85. Treatment providers told us that offenders need a minimum level of intellectual ability to succeed in treatment because they must retain certain concepts and sometimes function in the abstract.

Similarly, county and state correctional facilities told us they were not prepared to treat offenders who did not meet the low-functioning criterion. An official from one Department of Corrections’ treatment program told us that the program occasionally accepted low-functioning offenders because they were too vulnerable in the prison’s open population. However, program officials said they considered each case carefully because adapting their programs for lower-functioning offenders uses scarce program resources.

Overall, we estimate that only a few providers treated developmentally disabled offenders and they tended to specialize in that area since this population has distinct needs. For example, as discussed in Chapter 3, we found one residential provider that treated developmentally disabled offenders and two others that added program components in order to treat low-functioning offenders. Under 25 percent of all outpatient programs told us they would accept a developmentally disabled or low-functioning offender if they received a referral, and they would have to adjust their program to accommodate these offenders if accepted. Only two outpatient providers operated a specific program for developmentally disabled offenders during 1992.

We also found that:

- **All treatment programs assessed potential participants for the overall level of risk they pose, and they did not accept offenders whom they considered high security risks.⁴**

⁴ As noted above, the Minnesota Security Hospital must accept all sex offenders committed under the state’s psychopathic personality commitment law, regardless of their level of functioning, offense denial, or security risk.

Intake professionals in all programs considered a number of factors in determining the level of risk an offender posed to the treatment program and the surrounding community. These factors included an individual's use of violence in the offense, whether the victim was a stranger, and the offender's prior history. Local residential and outpatient programs had few security protections, and they carefully considered the overall level of potential risk an offender posed, balancing an offender's need for treatment with the risk posed to others. Three-quarters of outpatient treatment providers would not accept offenders they considered violent and over half of them would not accept stranger rapists. In addition, some providers indicated that they tried to avoid the negative publicity they would receive if an offender committed a violent sexual assault while in treatment.

Typically, sex offenders must acknowledge responsibility for their crimes or they are not accepted into or allowed to remain in treatment.

However, several outpatient programs told us they rarely received referrals for violent sex offenders for at least two reasons: many of these offenders received prison sentences, and probation officers and judges typically did not consider them appropriate for outpatient treatment.⁵ Probation officers told us they often made the initial recommendations regarding where offenders should be treated, based on their judgments of risk and the offender's particular treatment needs.

Although programs in state correctional facilities did not have the same security concerns as community-based programs, they shared local facility concerns that violent or aggressive offenders could disrupt the program and create an environment less conducive to treatment for others. As a result, they also determined the level of risk an offender posed as part of the admission decision.

We also found that:

- **Many programs would accept offenders who denied or minimized their offenses, but often required them to acknowledge some responsibility for their offenses in the course of treatment.**

Most treatment professionals said they expected sex offenders to minimize the gravity of their offenses or even deny having done anything wrong. However, just over half of all outpatient providers would not accept offenders who completely denied their offenses. Others were willing to work with offenders for a limited time to break down their denial. Those providers that accepted "deniers" told us they limited the number in treatment at one time to control the treatment atmosphere.

In addition, we found that:

- **Sometimes offenders were denied admission into treatment for administrative reasons or because their sentence length was inconsistent with their treatment needs.**

⁵ As noted in Chapter 1, first-time offenders convicted of criminal sexual conduct in the first degree receive presumptive prison sentences under Minnesota's Sentencing Guidelines.

We learned of several administrative criteria that programs sometimes applied in determining whether an offender was admitted to treatment. First, juvenile treatment programs tended not to admit juveniles who would turn age 18 while in treatment. Programs who treated juveniles told us that they had little time in which to make progress with older juveniles before they had to be released at age 19.⁶ Second, we learned that treatment programs within Department of Corrections' facilities did not accept offenders while their cases were under appeal. Program officials told us that offenders who were appealing the court's decision typically did not admit their offenses, had little incentive or motivation to change, and could be disruptive to others in treatment. Third, program officials preferred to use treatment slots for those offenders who could complete the entire program and did not accept offenders with insufficient time remaining on their sentences. As we show below, 8 percent of the offenders who failed to complete treatment in 1992 did so because their sentences or probationary periods expired before they could complete treatment to the program's satisfaction. Finally, we learned of two sex offenders in prison who said they were denied admission to treatment because they were being considered for psychopathic personality commitment proceedings.⁷

Treatment Acceptance Rates

From information given to us by treatment providers, we estimated the proportion of offenders evaluated for sex offender treatment who were ultimately accepted into treatment. In addition, we examined the reasons why programs did not accept some offenders into treatment.

We estimated that:

- **In 1992, outpatient programs accepted approximately three-quarters of the offenders that they screened for treatment.**

Probation officers and judges decide whether and where sex offenders should receive treatment.

Nearly one-third of all outpatient programs told us that they accepted everyone they assessed. This may be overstated, however, as most providers only kept data on those they accepted and, furthermore, only assessed some referrals for treatment. Substantial screening occurred before offenders ever began an agency's formal screening process. As noted earlier, probation officers made initial recommendations about where an offender should receive treatment and some county courts conducted their own evaluations. A proportion of offenders were also screened out of certain programs during early discussions between referral sources and treatment providers. Probation officers, lawyers,

⁶ Although offenses committed by 18 year olds are tried in adult court, programs can keep juvenile offenders until the age of 19. Program officials from Sauk Centre told us that they specifically included provisions in their admission criteria to accept older juveniles, in recognition that these offenders were frequently screened out of treatment elsewhere.

⁷ See Office of the Legislative Auditor, *Psychopathic Personality Commitment Law* (St. Paul, 1994), 17-18. Since then, the department has changed its policy and will admit offenders into treatment who are being considered for civil commitment.

and other referral sources typically called providers to see if a final placement might be appropriate and if space was available before sending the offender's file and documentation.

We were unable to calculate an overall acceptance rate for local residential programs for three reasons. First, each program screened offenders differently and kept different data regarding whom they had screened. As a result, data were not comparable or easily aggregated. Second, acceptance into a "general" treatment facility was fundamentally a function of the agency's primary mission, such as housing adolescents who needed an out-of-home placement, rather than an offender's need for sex offender programming. Several general treatment providers told us that they would not treat an individual whose predominant need was for sex offender treatment.⁸ Third, similar to general treatment facilities, the sex offender treatment available in halfway houses did not determine whether sex offenders were placed there. Offenders on supervised release were placed in one of two halfway houses by the Department of Corrections' Office of Adult Release because they provided the most secure option for inmates on release from prison.⁹

A number of sources referred offenders to treatment programs within correctional facilities, including program review teams, facility chemical dependency treatment programs, sex offender programs at other facilities, and, less frequently, offenders themselves. Treatment officials met with offenders soon after referral to explain the treatment process and determine whether they met program admission criteria.

We estimated treatment acceptance rates for three of the four adult correctional facilities operating sex offender treatment programs.¹⁰ These data are shown in Figure 4.1. We estimated that:

- **On average, programs in state correctional facilities accepted fewer than half of the offenders referred to them during 1992-93.**

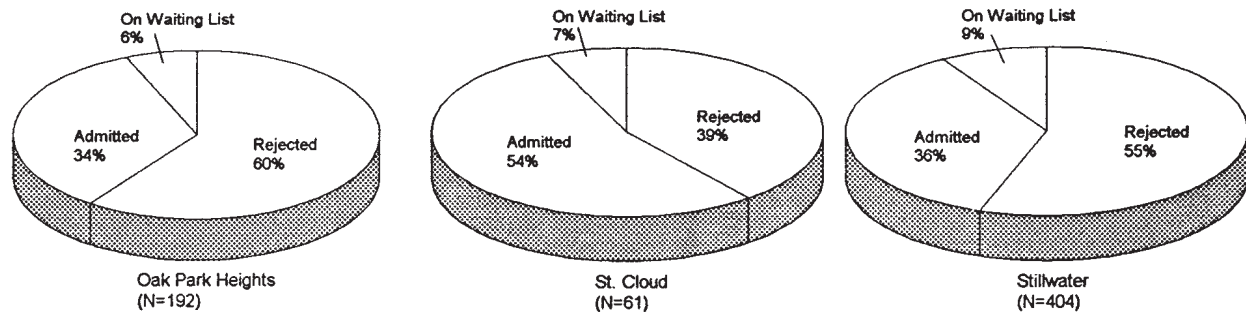
Figure 4.1 shows that the proportion of offenders accepted into treatment ranged from 40 to 61 percent in the three correctional facilities for which data were available. It also shows that some offenders were placed on waiting lists until treatment slots became available.

⁸ One of the two juvenile sex offender-specific residential programs accepted only one-quarter of the offenders it assessed for treatment in 1992. The second operated two programs for different populations and did extensive intermediate screening that brought up the acceptance rate. The only local residential treatment program for adults estimated that in 1992, it accepted approximately half of those offenders who may have been appropriate for residential treatment. However, this program also operated an outpatient treatment program for which it did not keep separate statistics. Offenders underwent an assessment process to determine whether residential or outpatient treatment would be appropriate, if any.

⁹ Officials at both halfway houses told us that they tried to accept all offenders who were referred to them by the Office of Adult Release. However, they retained some discretion in admitting offenders they believed would endanger others in the facility or surrounding community.

¹⁰ The program at the Lino Lakes correctional facility was unable to provide this information.

Figure 4.1: Sex Offender Program Acceptance Rates, Minnesota Correctional Facilities, 1992-93



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

The reasons that some sex offenders were not accepted into prison treatment are detailed in Table 4.1. We found that:

- **Most frequently, incarcerated sex offenders were not accepted into treatment because they lacked interest in treatment or refused to participate.**

In addition, approximately one-third were not accepted because they excessively denied their offenses. In a few cases, program personnel

In 1992-93, most of the sex offenders not accepted into prison treatment programs refused to participate or denied they committed a crime.

Table 4.1: Reasons for Program Rejection at State Adult Correctional Facilities, 1992-93

Reasons for Rejection ^a	Oak Park Heights (n = 115)	St. Cloud (n = 24)	Stillwater (n = 224)
Not interested in treatment/refused to participate	42%	33%	48%
Denied or excessively minimized offense	32	38	34
Transferred out of facility/referred to different facility's program	17	8	13
Judged not amenable to treatment for other reasons ^b	19	13	4
Segregated from general population/institutional disciplinary problem	13	8	0
TOTAL	123% ^c	100%	100%

Sources: Department of Corrections' institutional treatment programs.

^aData are for varying time periods, as follows: Oak Park Heights, September 1992-September 1993; St. Cloud, June 1992-September 1993; Stillwater, January 1993-August 1993. We were unable to obtain comparable data from the program at Lino Lakes.

^bOther reasons include: limited intellectual or verbal ability, inability to handle confrontation, psychiatric concerns, refusal to participate in all components of treatment, and sentence length limitations.

^cDoes not total 100 percent because treatment officials at Oak Park Heights may record more than one reason for program rejection.

determined that offenders were not amenable to treatment due to their limited intellectual or verbal abilities, their inability or lack of interest in meeting the requirements of the program, or because their sentences were too long and other offenders took precedence. Prison officials told us that they preferred to treat sex offenders close to the end of their sentences.

We also found that:

- **Almost three-fourths of sex offenders entering prison between July 1990 and October 1993 had not received any sex offender treatment before being sent to prison.**

Three out of four sex offenders who entered prison in 1990-93 had not received treatment before their imprisonment.

According to data collected by the Department of Corrections on all 887 sex offenders who entered prison between July 1990 and October 1993, 73 percent had not participated in previous sex offender treatment. Another 24 percent had one prior treatment experience, and 3 percent had two or more treatment experiences before being sentenced to prison. However, we do not know if individuals with prior treatment experience actually completed it.

A higher proportion of rapists (82 percent) than incest perpetrators (64 percent) and child molesters (67 percent) had not received treatment before entering prison. This is consistent with current sentencing policy and the pre-screening that is done by probation officers and treatment professionals, which results in a higher proportion of violent offenders being sent to prison.

We also found that:

- **Many sex offenders were released from prison without having received treatment there.**

The Department of Corrections had no summary data on how many of the adult sex offenders released from prison had received treatment, but using a list of sex offenders who were released from state correctional facilities between January 1991 and June 1993, treatment officials within each adult facility identified those individuals who had participated in their programs. According to our analysis:

- **Thirty-three percent of the 587 adult sex offenders released between January 1991 and June 1993 began sex offender treatment in an institutional program, but only 24 percent completed treatment in prison.**

As discussed above, many offenders refuse to participate in treatment while in prison or are not accepted into treatment for other reasons, including their limited intellectual abilities or excessive denial of their offense.

These results suggest that more sex offenders have been treated in prison in the past few years compared to five or six years ago. In a study of 223 sex offenders released from correctional institutions in 1988, Department of Corrections' researchers found that 27 percent had entered sex offender treatment in prison and 13 percent had completed it.¹¹

Chemical Dependency Screening

As discussed in Chapter 2, some researchers have found a relationship between the use of alcohol or drugs and deviant sexual behavior for some sex offenders. Accordingly, we also asked treatment providers whether they screened sex offenders for chemical dependency problems and whether they provided treatment for these problems as well. We found that:

- **Almost all sex offenders were screened to some extent for chemical dependency.**

All state correctional facilities screened offenders for chemical dependency upon intake into the correctional system, as did the treatment program in the Minnesota Security Hospital. County correctional facilities and sex offender-specific residential treatment programs also routinely screened for chemical dependency. In fact, only one of the 13 local residential programs we interviewed did not screen offenders for chemical use problems to some degree.

In addition, we estimated that 85 percent of outpatient treatment programs screened offenders for chemical use problems, either informally or formally. Over three-quarters of outpatient programs "informally" determined whether an offender was chemically dependent or in need of treatment, based on information collected about the offender from court documentation, the referring agency, and their personal assessment. Approximately one-fifth of all outpatient treatment programs in Minnesota pursued more in-depth chemical dependency screening when they suspected chemical problems. These programs either screened offenders in-house according to Department of Human Services rules, or referred offenders for screening elsewhere.¹²

Approximately two-thirds of all outpatient programs gave us an estimate of the proportion of sex offenders they treated whom they believed were either chemical abusers or chemically dependent. The proportion ranged from zero in two programs to 80 percent in two programs which together served 15 clients. In over half of the programs that provided estimates, fewer than one-quarter of offenders were thought to be chemical abusers or chemically dependent. The average across these outpatient programs was between 30 and 35 percent. The average estimate was higher in programs that only worked with adults than in programs that worked exclusively with juveniles.

¹¹ Jim Kaul, Stephen Huot, and Doug Epperson, *Sex Offenders Released in 1988 from Department of Corrections Institutions* (St. Paul: Department of Corrections, March 1993).

¹² *Minn. Rules* §§9530.6600-9530.6660, also known as Department of Human Services Rule 25, establish standards for chemical dependency assessments.

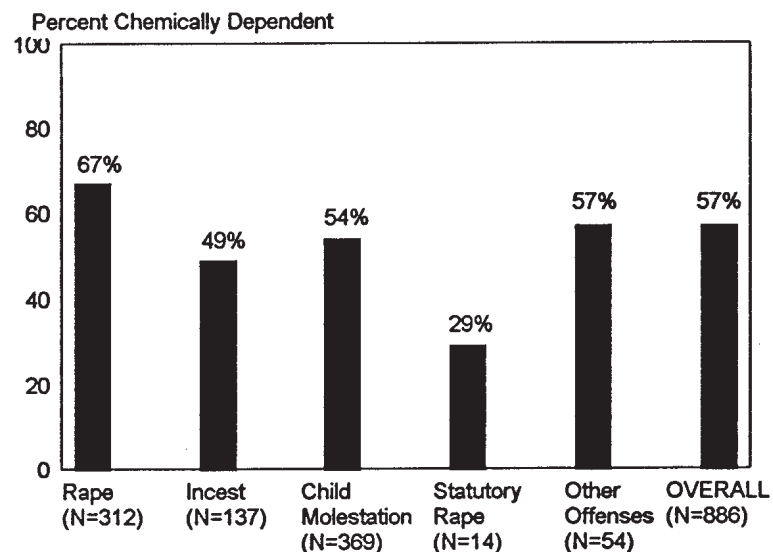
Most treatment providers also screen for chemical dependency problems, although screening procedures vary.

This estimate of chemically dependent sex offenders in outpatient treatment programs is noticeably lower than the percent of chemically dependent sex offenders within the state correctional system. As shown in Figure 4.2:

- **An average of 57 percent of all sex offenders who entered prison between July 1990 and October 1993 were assessed by chemical health professionals at intake as being chemically dependent.**

As Figure 4.2 shows, the proportion of sex offenders with chemical dependency problems varied by type of offense, with a higher proportion of chemically dependent rapists (67 percent) than child molesters (54 percent) and incest offenders (49 percent). The types of offenders treated in prison

Figure 4.2: Chemically Dependent Sex Offenders Entering State Correctional Facilities by Type of Offense, July 1990 - October 1993



Note: Based on intake assessments and categorization of offenders entering prison between July 1990 and October 1993.

Source: Department of Corrections.

versus residential and outpatient programs may account, in part, for this difference. As shown in Chapter 1, proportionately more rapists were sent to prison, while incest offenders tended to be placed on probation where they served a jail sentence and were required to complete treatment in either residential or outpatient programs.

We found that:

- **Most outpatient treatment providers in Minnesota did not simultaneously treat sex offenders for chemical dependency.**

We asked outpatient programs if they would provide sex offender treatment to a chemically-dependent offender referred to their agency. Forty-three percent of them said they would treat chemically dependent sex offenders only after they had completed some portion or all of chemical dependency treatment. The remaining outpatient programs said they would treat a chemically-dependent sex offender who was enrolled in a chemical dependency treatment program at the same time. Some outpatient treatment programs, such as community mental health centers, referred appropriate offenders to the chemical dependency treatment unit of their center for evaluation or treatment.

Most providers prefer that chemical dependency problems be addressed before sex offender treatment begins.

Local residential treatment programs varied in how they addressed chemical dependency issues in treatment. All three sex offender-specific residential programs told us they would accept offenders with chemical dependency problems, but provided only minimal treatment for this. For example, Alpha Human Services included a chemical abuse group in its overall treatment program, but preferred that chemically-dependent offenders go through chemical dependency treatment prior to entering its intensive sex offender program. The two juvenile residential programs provided educational units on chemical health for all residents, and both juvenile correctional facilities tried to arrange chemical dependency treatment following offenders' release from the facilities.

We conclude that:

- **Local residential and outpatient treatment providers were aware of offenders' chemical use issues, and often preferred that chemical dependency be treated prior to or concurrent with sex offender treatment.**

On the other hand, state-operated facilities for adults did treat offenders for chemical dependency. All four adult correctional facilities in Minnesota operated chemical dependency treatment programs for inmates within the facility. Typically, sex offenders completed treatment for chemical dependency before entering sex offender programming or received it simultaneously.

Finally, the last phase of the Minnesota Security Hospital's new treatment program included a unit on chemical dependency. Program officials told us they encouraged chemically-dependent offenders to attend Alcoholics Anonymous meetings within the institution and would incorporate a plan for abstinence into each offender's treatment discharge plan.

In 1992, approximately 2,600 sex offenders received some treatment.

DESCRIPTION OF OFFENDERS WHO RECEIVED TREATMENT IN 1992

In this section, we present the results of analyses of the data forms we asked all treatment providers to complete for offenders treated during 1992.¹³

Characteristics of Offenders Treated

Table 4.2 shows the number and percent of sex offenders treated in the various treatment settings identified in Chapter 3. We included a range to account for those offenders who may have been treated in more than one program.¹⁴ The table excludes offenders from other states treated in Minnesota programs and Minnesotans treated out of state. We estimated that:

- **In 1992, Minnesota treatment programs and service providers treated approximately 2,600 sex offenders, primarily in outpatient programs.**

About two-thirds of the offenders treated in 1992 were treated in outpatient programs. About 15 percent of the offenders receiving treatment in 1992

Table 4.2: Estimated Number of Minnesota Sex Offenders Treated by Program Type and Population Served, 1992

Type of Program	Juveniles		Adults		TOTAL	
	Number	Percent	Number	Percent	Number	Percent
STATE FACILITIES						
Department of Corrections	29	3%	319	18%	348	13%
Department of Human Services	0	0	43-44	3	43-44	2
Subtotal	29	3%	360-363	21%	389-392	15%
LOCAL RESIDENTIAL PROGRAMS						
County Correctional	57-59	7%	34-35	2%	91-94	4%
Sex Offender-Specific	162-166	19	53-54	3	215-220	8
General Treatment	59-61	7	119-122	7	178-183	7
Subtotal	278-286	33%	206-211	12%	484-497	19%
OUTPATIENT PROGRAMS						
Sex Offender-Specific	249-261	30%	581-609	34%	830-870	32%
Mental Health Centers	134-140	16	363-381	21	497-521	20
Other Therapists	140-147	17	209-219	12	349-366	14
Subtotal	523-548	63%	1,153-1,209	67%	1,676-1,757	66%
TOTAL	830-863	100%	1,719-1,783	100%	2,549-2,646	100%

Source: Program Evaluation Division analysis of data from treatment programs.

Note: Information on 1,369 clients (52 percent) is based on individual client information on forms we asked providers to complete for clients served in 1992. An additional 189 information forms (7 percent) are based on clients served during a different recent twelve month period, and information on 1,088 clients (41 percent) is based on summary data or estimates provided to us by treatment programs.

¹³ As described above, we received completed data forms for 59 percent of the estimated total number of sex offenders treated, but only 40 percent of the information on outpatient clients. However, we received summary data or estimates from most providers who did not complete the forms.

¹⁴ We estimated the number who received treatment in more than one program from completed data forms on offenders who were transferred to a more appropriate program or facility.

were treated in state-operated facilities, and nearly all of those were treated within correctional facilities. The remaining sex offenders treated in 1992 were treated in county correctional or local residential facilities. Approximately two-thirds of those receiving treatment were adults and one-third were juveniles.

Table 4.3 shows the types of offenders treated in different treatment settings. In general, we found that:

- **State prisons and local residential facilities treated more serious offenders than outpatient programs.**

Table 4.3: Types of Sex Offenders Treated by Program Type and Population Served, 1992

	Percent Rapists	Percent Convicted of Criminal Sexual Conduct in First Degree	Percent With Prior Sex Offense
ADULTS			
State correctional facilities (n=319)	41%	52%	39%
County correctional facilities (n=35)	14	6	14
Residential programs (n=218) ^a	23	35	35
Outpatient programs (n=453) ^b	12	13	13
Adults Overall (n=1,025)	23%	30%	26%
JUVENILES			
State correctional facilities (n=29)	52%	21%	10%
County correctional facilities (n=58)	26	38	14
Residential programs (n=198) ^a	8	17	27
Outpatient programs (n=223) ^b	6	13	3
Juveniles Overall (n=508)	11%	18%	18%

Source: Program Evaluation Division analysis of completed data forms from treatment programs.

^aIncludes sex offender-specific, general treatment programs, and the Minnesota Security Hospital.

^bCompleted data forms were received for only 40 percent of the estimated total number of offenders treated in outpatient programs.

More serious adult sex offenders tended to receive treatment in a state prison.

For example, Table 4.3 shows that 41 percent of the adults and 52 percent of the juveniles treated in prison programs committed stranger or acquaintance rape. In contrast, in the outpatient programs that provided data, 12 percent of the adults and 6 percent of the juveniles committed stranger or acquaintance rape. Most of the other offenders were treated for incest or child molestation, and a few were treated for other deviant sexual behaviors such as exhibitionism or voyeurism. In all, treatment providers reported that 82 percent of the juveniles and 73 percent of the adults receiving treatment had victimized children.

We also found that:

- **More serious adult offenders tended to receive treatment in prison or, to a lesser extent, in local residential programs. However, more serious juvenile offenders tended to be treated in county correctional facilities and local residential programs.**

As shown in Table 4.3, higher proportions of repeat adult sex offenders and those convicted of criminal sexual conduct in the first degree (CSC-1) were treated in state correctional facilities. This is consistent with current sentencing and correctional policies and how various facilities are used. For example, we identified only one program operating for adult sex offenders in a county jail, at the Northeast Regional Corrections Center. Most serious adult sex offenders were likely to receive treatment in prison or, to a lesser extent, in one of the two residential treatment programs for adults on probation, the Minnesota Security Hospital or Alpha Human Services.

In contrast, higher proportions of repeat juvenile offenders and those convicted of CSC-1 were treated in county correctional or local residential programs than in state correctional facilities. State policy regarding juvenile offenders has favored treating them at the local level in community facilities. Possibly as a result, juvenile county and local residential facilities tended to have more serious offenders than the state juvenile sex offender programs. For example, the Hennepin County and Anoka County facilities housed and treated most of the serious offenders from these counties as well as some from other counties. According to Hennepin County corrections officials, some serious repeat sex offenders who have failed at the Hennepin County Home School have been sent to a treatment facility in Colorado. However, the treatment program at Sauk Centre was designed for hard-to-treat offenders, and some juveniles who have failed the Home School's program have been sent there since March 1993 when the Sauk Centre program began.

In contrast, more serious juvenile sex offenders tended to receive treatment in a county correctional facility or local residential program.

We also examined the demographic characteristics of those sex offenders receiving treatment.¹⁵ Over 98 percent of those offenders for whom we received complete information were male, which is consistent with information presented in Chapter 1 about sex offenders in general.

We also learned that:

- **The average juvenile offender who received treatment in Minnesota during 1992 was 15 years old and the average adult offender was 34.**

Juveniles who received sex offender-specific treatment ranged in age from six to 17. Almost one-third of all juveniles who received some sex offender treatment during 1992, and for whom we received data, were under the age of 15.

Adult offenders ranged in age from 18 to 91. Ninety percent were below the age of 50, and two-thirds were between the ages of 25 and 45. Those who received treatment in the county-operated correctional facility were slightly younger than average (29 years old). Outpatient programs treated offenders who were slightly older on average (approximately 36 years old).

¹⁵ Note that the data presented in this and the following section are based on the number of offenders for whom we received completed data forms, which represents all those treated in state and local residential programs but only 40 percent of the offenders treated in outpatient programs.

Finally, as Table 4.4 shows, 84 percent of the adult and 80 percent of juvenile offenders for whom we received data were white. Although few juveniles (87) were treated in state or county correctional facilities, they were disproportionately non-white, relative to the overall average for juveniles. In addition, the forms we received indicated that there was a slightly higher than average proportion of white adult offenders in outpatient treatment programs.

Table 4.4: Race of Sex Offenders in Treatment, 1992

	Adults (n = 1,021)			Juveniles (n = 505)		
	Percent White	Percent Black	Percent Other	Percent White	Percent Black	Percent Other
State correctional facilities	78%	15%	7%	48%	31%	21%
County correctional facilities	83	6	11	53	33	14
Residential programs ^a	76	18	6	89	4	7
Outpatient programs	92	1	7	83	8	9
OVERALL	84%	9%	7%	80%	11%	9%

Source: Program Evaluation Division analysis of completed data forms from treatment programs.

^aIncludes sex offender-specific, general treatment programs, and the Minnesota Security Hospital.

Treatment Completion

For each offender treated during 1992, we asked whether, on December 31, 1992, that offender was still in treatment, had successfully completed treatment, or had left treatment before completing it. For those who left before finishing treatment, we asked program staff to tell us the reason the offender left. Of the 1,551 offenders for whom we received forms (59 percent of the estimated number treated), 48 percent (744) were still in treatment at the end of the period. Excluding those still in treatment, we found that:

- **Fifty-three percent of those sex offenders who left treatment by the end of 1992 had completed it to the program's satisfaction.**

Of the 807 sex offenders who left treatment during 1992 for whom we had data forms, 424 of them completed treatment to the satisfaction of program staff. The remaining 383 offenders (47 percent) left treatment before successfully completing it. A slightly higher proportion of juveniles completed treatment (61 percent) than adults (48 percent). These numbers are comparable to program completion rates reported in the literature.¹⁶ Applying these proportions to the estimated total number of sex offenders treated in 1992 as shown in Table 4.2, we estimate that approximately 710 of the sex offenders who received treatment in 1992 completed it to the program's satisfaction, and 630 offenders left treatment before completing it, with about 1,240 offenders in treatment at year-end.

¹⁶ As noted in Chapter 2, surveys of treatment programs have found that between 30 to 50 percent of all offenders who begin treatment fail to complete it. See Janice K. Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project* (Sacramento: California Department of Mental Health), 9-10, and W. L. Marshall and H. E. Barbaree, "Outcome of Comprehensive Cognitive-Behavioral Treatment Programs," in *Handbook of Sexual Assault* (New York: Plenum Press, 1990), 374-375.

In 1992, almost half of the sex offenders who left treatment failed to complete it satisfactorily.

We also found that:

- **Programs used different criteria to determine “successful” program completion.**

We did not systematically ask outpatient treatment providers how they determined successful program completion. However, we learned from our interviews with residential treatment providers and informal contacts with several outpatient providers that programs do not apply the same criteria when deciding if an offender has successfully completed treatment. For example, programs with specific goals or treatment requirements expected offenders to complete the goals or requirements to the satisfaction of treatment staff. Other programs used staff observations and interviews with the offender to determine when sufficient behavioral change had occurred. A few treatment providers used results from post-tests to assist in determining when treatment had been successful. Ultimately, determining successful program completion relied heavily on the professional judgments of treatment staff. And, as shown below, in a couple of programs within correctional facilities, some offenders did not complete treatment to the satisfaction of program staff because their sentence lengths were shorter than the treatment programs.

Table 4.5 shows the reasons why sex offenders left treatment in 1992 before completing it.¹⁷ We found that:

- **Most offenders who left treatment were asked to leave by program staff because they did not comply with program requirements or were otherwise considered not amenable to treatment.**

Table 4.5: Reasons for Treatment Non-Completion by Type of Program, 1992

Reason for Non-Completion	State Correctional Facilities		Residential Programs ^a		Outpatient Programs		TOTAL	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Non-compliant/non-amenable ^b	60	69.0%	62	41.6%	30	20.7%	152	39.9%
Voluntarily left or absconded	19	21.8	35	23.5	71	49.0	125	32.8
Transferred to another treatment program or more appropriate setting	2	2.3	14	9.4	32	22.1	48	12.6
Probation or sentence expired	6	6.9	21	14.1	4	2.8	31	8.1
Violated probation	0	0.0	12	8.1	3	2.1	15	3.9
Reoffended	0	0.0	4	2.7	5	3.4	9	2.4
Developmentally disabled	0	0.0	1	0.7	0	0.0	1	0.3
TOTAL	87	100.0%	149	100.0%	145	100.0%	381	100.0%

Source: Program Evaluation Division analysis of completed data forms from treatment programs.

^aIncludes county correctional facilities, sex offender-specific residential programs, general treatment programs, halfway houses, and the program for sex offenders on probation at the Minnesota Security Hospital operating in 1992.

^bIncludes those who failed to make progress in treatment, continued to deny their offense, violated program rules, exhibited violent behavior, threatened others, or failed to attend treatment.

¹⁷ Based on data forms for offenders who did not complete treatment and where a reason was given for non-completion.

Forty percent of the individuals who did not complete sex offender treatment were asked to leave because they failed to make progress, violated program rules, threatened others or exhibited violent behavior, or continued to deny their offenses. Another third of the individuals who did not complete treatment chose to leave or absconded from the program, and 13 percent were transferred to another program or to a more appropriate setting. As Table 4.5 also shows, however, 8 percent failed to complete treatment because their sentences or probationary periods expired before treatment was judged to be successful by staff.¹⁸ Approximately 6 percent of the offenders who failed to complete treatment reoffended during treatment or violated the terms of their probation.

Most sex offenders who left treatment in 1992 before completing it did not comply with requirements, failed to make progress, or left voluntarily.

As Table 4.5 also shows:

- **A higher proportion of offenders in state correctional facility programs than residential and outpatient programs failed to comply with treatment requirements or were otherwise judged not amenable. In contrast, higher proportions of offenders in residential and outpatient programs voluntarily left treatment or were transferred to more appropriate treatment programs.**

In outpatient programs, nearly half of those who failed to complete treatment voluntarily left the program or absconded, and another 22 percent were transferred to other programs, including placements in more secure settings or in psychiatric treatment. In prison and local residential programs, fewer of the offenders voluntarily dropped out of treatment or were transferred to other programs. In prison programs, 69 percent of those who did not complete treatment failed to comply with treatment requirements or were otherwise considered not amenable to treatment. This may indicate that treatment officials in more secure settings have fewer options available for transferring offenders who do not do well in their programs.

We do not know what happened to those individuals who voluntarily left or were asked to leave treatment before completing it in outpatient and local residential settings (in correctional facility programs, they were transferred to the general prison population). However, we asked the 43 probation officers we interviewed to tell us what happens to offenders who drop out of treatment or are asked to leave it. All 43 probation officers said they filed violation-of-probation reports when offenders failed to complete assigned treatment programs. Just under 40 percent of the adult probation officers (9 out of 23) said they also recommended that these individuals be sent to prison, while 17 percent (4 out of 23) said they explored other treatment options before recommending a prison sentence. The remaining 10 respondents (43 percent) said it depended on the circumstances, such as the

¹⁸ Approximately two-thirds of these offenders were located at the only adult county correctional program, Northeast Regional Corrections Center (NERCC). Offenders were released from NERCC when their sentences (under one year in length) expired, rather than as a function of treatment completion. Program officials at NERCC told us that nearly all offenders who left their program needed further treatment and were referred to an outpatient provider in the region to continue for a number of months.

type of program and why the offender dropped out, or that the court determined what happened next.

In contrast, 55 percent of the juvenile probation officers (11 out of 20) said they tried other treatment alternatives, possibly in combination with some detention time. Several respondents said that if a juvenile offender did not cooperate with an outpatient program, they considered placement in a residential program, and if one residential program did not work, they would try another one. Only 15 percent (3 out of 20) said they would commit to the Department of Corrections a juvenile offender who failed to complete treatment. As discussed in Chapter 3, there were more residential treatment programs for juveniles than for adults, so there were more treatment options to try when an individual fails in one program or needs a more secure setting.

Treatment Follow-Up

We asked treatment providers whether they tracked any of their clients after they left their program. We found that:

- **Most sex offender treatment programs did not follow their clients after they left treatment.**

Very few sex offender treatment programs in Minnesota monitored offenders who went through treatment to determine whether they reoffended. Treatment programs that tracked clients after treatment tended to keep informal records and typically learned about reoffenses by word of mouth. Few treatment programs had the means available to evaluate their long-term effectiveness.

We found that information on reoffense rates was available for eight of the 70 treatment providers we identified. The following agencies collected and analyzed data on reoffense rates for treated sex offenders: Hennepin County Community Corrections (on Alpha Human Services' residential treatment program); Hennepin County Home School (juvenile sex offender treatment program); University of Minnesota's Program on Human Sexuality (outpatient sex offender treatment program); University of Minnesota, Duluth (on the Northeast Regional Correctional Center sex offender treatment program); 180 Degrees (halfway house sex offender transition program); Minnesota Security Hospital (on its now defunct Intensive Treatment Program for Sexual Aggressives); and the Department of Corrections (on its treatment programs at Lino Lakes and Oak Park Heights).¹⁹

Data from these programs exhibited many of the same problems as the national literature on sex offender treatment effectiveness. With the exception of the Department of Corrections and Hennepin County Community Corrections data, the other studies tracked only offenders who successfully completed treatment. Only the Department of Corrections study included a

¹⁹ In addition, Project Pathfinder staff told us they have contracted with a private agency to establish a database on their clients and collect follow-up data. However, no data were available at the time of our study.

Few providers monitor or follow up on their clients after they leave treatment.

comparison to untreated offenders and to offenders who failed to complete treatment. The length of follow-up varied from six months to ten years. As with other treatment effectiveness studies, reoffense rates were not defined consistently across studies. A couple of the studies used self-reported information obtained through interviews to determine reoffense rates. One study compared pre- and post-test scores on the MMPI and California Psychological Inventory, in addition to analyzing official reconviction data.

Given the differences in populations treated in these programs and variation in the methods used to measure treatment outcomes, no comparisons of treatment effectiveness across programs can be made. However, the reported reoffense rates for sex offenders treated in Minnesota programs were comparable to those found in the treatment effectiveness literature.

SUMMARY

Except for the Minnesota Security Hospital, which must accept all individuals civilly committed for treatment, all treatment providers screened referrals to determine whether an offender might benefit from the treatment they offer. Some offenders were more difficult to treat and were less likely to be accepted into treatment. These included offenders who posed risks to the community, excessively denied their offenses, had lower intellectual abilities, or were not motivated for treatment. Treatment programs accepted between half to three-quarters of those they assessed. More serious sex offenders tended to receive treatment in state (adult) or county (juvenile) correctional facilities or local residential programs. In addition, most treatment programs screened offenders for chemical use problems.

Overall, many offenders received treatment. We estimate that over 2,600 individuals received some treatment in 1992, two-thirds of them adults. Almost half of them were still in treatment at the end of 1992. However, approximately 45 to 50 percent of those who left treatment during the year failed to complete it to the program's satisfaction, most often because they failed to make progress, continued to deny their offenses, or violated program rules. Few treatment programs monitored their clients after treatment to assess reoffense rates or determine treatment effectiveness.

Adequacy and Oversight of Treatment Programs

CHAPTER 5

In this chapter, we draw upon the findings of earlier chapters and assess the adequacy of Minnesota's sex offender treatment system. We also assess how well the Departments of Corrections and Human Services have coordinated to provide sex offender treatment services and regulate treatment providers. We ask:

- **To what extent are Minnesota's treatment programs operated consistently with national standards for sex offender treatment?**
- **Is the current mix of treatment alternatives adequate to ensure that all individuals who need treatment receive it?**
- **How well does the Department of Corrections oversee and administer sex offender treatment programs? Do the Departments of Corrections and Human Services coordinate to ensure that programs are licensed and inspected regularly? Do current standards ensure that treatment providers are qualified?**

To answer these questions, we interviewed officials and licensing and treatment program staff from the Departments of Corrections and Human Services. As described in Chapter 3, we systematically interviewed all residential (in person) and outpatient (by phone) treatment providers and asked them to complete a one-page data collection form on each offender treated in 1992. In addition, we interviewed 23 adult and 20 juvenile probation officers from counties that accounted for about 85 percent of the felony sex offense convictions in 1991. We also interviewed community corrections administrators, public defenders, county attorneys, and others knowledgeable about the criminal justice system in Minnesota. Finally, we reviewed the national literature on sex offender treatment.

We found that Minnesota's sex offender treatment programs are similar in content and method to most other treatment programs operating in the United States. National standards endorsed by treatment professionals recommend that treatment staff be qualified. The Department of Corrections is currently developing rules that would specify staff qualifications and treatment standards, as mandated by the 1989 Legislature.¹ Consistent with the trend toward stiffer penalties for sex offenses, we found that the number of

¹ *Minn. Laws* (1989), Ch. 290, Art. 4.

community-based residential beds for adult sex offenders has declined over the past 15 years, while the number of treatment beds in prison and the Minnesota Security Hospital, the more expensive treatment settings, has increased. Finally, we found that the laws that spell out regulatory responsibilities for sex offender treatment may require clarification and that the Departments of Corrections and Human Services need to communicate and coordinate better in overseeing sex offender treatment programs.

ADEQUACY OF SEX OFFENDER TREATMENT SERVICES

Due to uncertainty about what works, national standards do not specify preferred treatment approaches.

Ideally, a program's adequacy should be measured by how effective it is in reducing recidivism. However, follow-up data to determine treatment effectiveness do not exist. As a result, we assessed adequacy by reviewing the level and range of treatment services provided and by comparing Minnesota's treatment programs with those operating in other states and to national program standards that have been developed by associations of treatment professionals.

Minnesota's Treatment Programs in the National Context

We compared what we learned about Minnesota's sex offender treatment programs, as described in Chapters 3 and 4, with descriptions of treatment programs located in other states. We found that:

- **Minnesota's sex offender treatment programs appear consistent with programs described in the national literature with respect to treatment goals, philosophies, and methods.**

The national standards, discussed below, do not specify preferred treatment approaches. As described in Chapter 2, the majority of treatment programs in the U.S. utilized psychological approaches, occasionally accompanied by biomedical (drug) or behavioral techniques (aversive conditioning or masturbation reconditioning). Most Minnesota treatment programs also rely on psychological approaches, usually group therapy, accompanied by individual assignments aimed at understanding the individual's motivations and learning how to direct those motivations in socially acceptable ways. One program, operated by the University of Minnesota's Program on Human Sexuality, is experimenting with drug (anti-androgen) therapy, but it has experienced difficulty in recruiting willing volunteers.² The new sex offender treatment program at the Minnesota Security Hospital also includes drug therapy. A few programs in Minnesota incorporate behavioral techniques along with psychological approaches.

² The initial grant application envisioned 24 subjects, which was subsequently increased to 90. In November 1993, there were seven subjects enrolled.

Figure 5.1 summarizes the national standards or “principles of good practice” that have been endorsed by treatment professionals. Treatment program standards for adult sex offenders were first drafted in 1989 with input from 60 professionals.³ Subsequent drafts were discussed at international meetings and the most recent draft (summarized in Figure 5.1) was unanimously endorsed in 1993 at the Third International Congress on the Treatment of Sex Offenders.⁴ These standards, which are very general, focus on the professional competence

Figure 5.1: Summary of National Standards or “Principles of Practice” for Sex Offender Treatment Programs

	Adult Programs	Juvenile Programs
Professional Competence	<ul style="list-style-type: none"> • Minimum of a master’s degree or equivalent medical degree in a clinical field by accredited educational institution. • Demonstrated competence in therapy, as indicated by license to practice medicine, psychology, clinical social work, or marriage and family counseling. • Demonstrated competence in counseling and diagnosis of sexual disorders, as documented by training or supervised clinical experience, along with continuing education. 	<ul style="list-style-type: none"> • Primary treatment providers should have knowledge and skills in counseling theory and techniques, psychological disorders, and developmental deficits, as well as assessment and treatment theory and methods specific to sexual offenders. • Specialists treating sexually abusive youth must be accountable to the community and their profession.
Assessments	<ul style="list-style-type: none"> • Prospective patients should receive an extensive evaluation that includes appropriateness and amenability for treatment, psychological diagnoses, and evaluation of safety for the community. • A thorough physical examination is recommended. • Prospective patients should receive a psychological or psychiatric examination to rule out other disorders (which if found should be treated prior to sex offender treatment). • If medications are prescribed, patient must be given information regarding benefits and potential side effects. 	<ul style="list-style-type: none"> • Assessment of sexually abusive youth requires consideration of many factors. A combination of clinical and actuarial indicators must be considered on a case-by-case basis. • A comprehensive clinical assessment, prior to a final decision on placement, is essential. • Evaluations of sexually abusive clients may result in multiple diagnoses which must be considered in treatment planning. • Plethysmography is a potentially useful technique in the evaluation of some sexually abusive youth. When it is used, data should be interpreted cautiously. Practitioners using it should adhere to standardized procedures. New guidelines suggest that only auditory stimuli should be used.

³ Eli Coleman and Margretta Dwyer, "Proposed Standards of Care for the Treatment of Adult Sex Offenders," *Journal of Offender Rehabilitation*, Vol. 16 (1990), 93-106.

⁴ Eli Coleman, et al., "Standards of Care for the Treatment of Adult Sex Offenders," endorsed by participants at the Third International Congress on the Treatment of Sex Offenders, Minneapolis, Minnesota, September 20-22, 1993.

Figure 5.1: Summary of National Standards or “Principles of Practice” for Sex Offender Treatment Programs, *continued*

	Adult Programs	Juvenile Programs
Principles Governing Treatment	<ul style="list-style-type: none"> • Treatment is elective; patients have a right to refuse treatment. • Treatment professionals should work with the criminal justice system in a cooperative manner. • Purpose of treatment is to improve quality of life. Treatment is considered humane and is intended to prevent people who have committed a sex offense from engaging in further sex offending behavior. • Evaluation of sex offender treatment requires specialized skills not usually associated with professional training of clinical therapists or medical professionals. • Any medical abnormalities or psychiatric diagnoses should be treated before or in conjunction with psychotherapy. • A treatment plan may involve the use of drug therapy. • Sex offender treatment may involve a variety of therapeutic approaches. Professionals should keep abreast of changes in the field and provide the most efficacious treatment as demonstrated through outcome studies. • Follow-up treatment should be encouraged or possibly required. • Patients should not be charged for services that are essentially for research. • Treatment professionals must be prepared to appear in court if necessary. • Sex offenders should be given the same rights to medical and psychological privacies as any other patient group, except where the law requires otherwise (e.g., reporting laws, subpoenaing of records). 	<ul style="list-style-type: none"> • Community protection must be the highest priority. • Treatment requires an inter-agency approach (treatment and criminal justice systems working together). • The purpose of treatment is to help the juvenile gain control over abusive sexual behavior and to facilitate social interactions. • Treatment goals can be accomplished through a diverse range of strategies. Practitioners are encouraged to remain flexible, creative, and open, as well as knowledgeable of current consensus regarding practice. • A range of interventions is required in order to meet the needs of different youth. Specialized treatment should be available at all levels of supervision/security. • Current treatment interventions draw on a combination of theories. The application of theory must be individualized and is based on clinical experience. Research is needed to validate clinical impressions.

Sources: Eli Coleman, et. al., “Standards of Care for the Treatment of Adult Sex Offenders,” endorsed by participants of the Third International Congress on the Treatment of Sex Offenders held in Minneapolis, Minnesota, September 20-22, 1993; and National Adolescent Perpetrator Network, “The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993,” *Juvenile and Family Court Journal*, Vol. 44, No. 4 (1993).

National sex offender treatment standards emphasize that staff should be experienced and competent.

of treatment staff, the process by which sex offenders are assessed to determine the appropriateness of treatment, and the principles that govern the treatment professional-patient relationship.

In the case of juvenile sex offenders, individuals from more than 800 programs organized a group called the National Adolescent Perpetrator Network. In 1986, it established a national task force to suggest standards for the assessment and treatment of juvenile offenders. Since 1986, the task force has solicited input from professionals that deal with juvenile sex offenders and has concluded that the creation of “standards” is premature, given the current state of knowledge. However, the task force has summarized a “definition of current thinking” among treatment professionals, based on clinical experience, which it refers to as “principles” or “assumptions” of current treatment practice. The most recent draft was published in 1993.⁵

Both sets of standards or principles emphasize that staff who treat sex offenders should possess demonstrated competence, as indicated by their knowledge, professional licensing, skills, and experience. The standards for adults suggest that a master’s degree or its medical equivalent should be required of everyone who treats offenders, while juvenile guidelines are less specific. Both standards recommend that an initial comprehensive assessment be done, with standards for adult offenders specifically suggesting that a medical examination be included to rule out any medical causes of the sexually aberrant behavior. In the case of juveniles, treatment principles suggest establishing standardized procedures to cover the more controversial aspects of assessment and treatment.

Both emphasize the importance of treatment professionals working in close cooperation with criminal justice system personnel and remaining flexible and open to new approaches. Finally, the standards for adult offenders spell out in greater detail than those for juveniles the procedures that should govern the treatment professional-client relationship. The adult standards specify that patients should have the right to refuse treatment and that their privacy rights should be respected.

We reviewed the draft rules, which the Department of Corrections has been working on since 1989, that will apply to all state and local residential facilities providing sex offender treatment. We found that:

- **In general, the standards contained in the Department of Corrections draft rules are consistent with national standards, with the exception of the department’s proposed treatment staff qualifications, which are lower.**

⁵ National Adolescent Perpetrator Network, "The Revised Report from the National Task Force on Juvenile Sexual Offending, 1993," *Juvenile and Family Court Journal*, Vol. 44, No. 4 (1993). This document is more extensive than the standards for adult offenders. It includes a lengthy discussion of the working assumptions underlying treatment and issues of disagreement among professionals. We have necessarily abbreviated the document to highlight the major points of comparison between the standards for juveniles and adults.

Although the treatment literature recommends long-term monitoring of sex offenders, few programs in Minnesota provide it.

The department's draft rules require that each sex offender be thoroughly assessed prior to treatment, consistent with national standards. Also, the department's draft rules are consistent with national standards for juveniles in requiring procedures covering potentially controversial treatment approaches. The proposed rules spell out policies governing client medical and treatment records, although they do not specify whether client assignments completed as part of treatment should be excluded from the official records.⁶

However, as shown in Figure 5.1, the standards endorsed in 1993 by the international congress recommend that all staff who assess or treat sex offenders should have a master's degree, a professional license in medicine, psychology, clinical social work, or marriage and family counseling, plus demonstrated competence in counseling and diagnosis of social disorders. The most recent draft of Department of Corrections' rules would require similar qualifications of clinical supervisors and therapists, but counselors who assist in the treatment of sex offenders would not be required to have more than a high school diploma, plus one year of supervised work experience with correctional or treatment clients. The Department of Corrections' standards are more specific with respect to continuing education and experience requirements than national standards.⁷

We also found that:

- **There are few programs in Minnesota that provide for continued follow-up, monitoring, and aftercare services for sex offenders.**

Treatment professionals believe that treatment can help offenders to manage and control their inappropriate sexual behavior. But some professionals believe that it may not be possible to "cure" sex offenders, in the sense of totally eliminating their deviant sexual arousal patterns (e.g., attraction to children). Consequently, it is recommended in the literature that formal treatment be followed by continued contact with offenders, whether in the form of "booster" treatment sessions, direct supervision over an extended period, or relapse prevention treatment.⁸ However, we learned that only about a third of Minnesota's treatment programs included a period of aftercare at the end of treatment. In addition, we identified three probation departments that provided regular group sessions for sex offenders following treatment completion.

⁶ As part of treatment, clients are encouraged to be completely honest. Hence, they should be informed of how the information divulged during treatment may be used. In an earlier report, we recommended that the Department of Corrections should develop clear policies covering client records and information divulged during treatment. See Office of the Legislative Auditor, *Psychopathic Personality Commitment Law* (St. Paul, 1994).

⁷ Department of Corrections, "Proposed Permanent Rules Relating to Residential Treatment of Juvenile Sex Offenders," dated 12/30/93. According to department staff, the proposed rules for juveniles and adults will be very similar. They would require 40 hours per year of continuing education for treatment professionals.

⁸ See, for example, W. L. Marshall, D. R. Laws, and H. E. Barbaree, "Present Status and Future Directions," *Handbook of Sexual Assault* (New York: Plenum Press, 1990), 390-392; Solicitor General of Canada, *The Management and Treatment of Sex Offenders*, 1990; and D. Richard Laws, Editor, *Relapse Prevention with Sex Offenders* (New York: Guilford Press, 1989).

Availability of Treatment Services

Based on the number of treatment programs in operation at the time of our study and the number of offenders who received treatment, we can reasonably conclude that:

Most sex offenders who want treatment can get it either in an outpatient program or in prison.

- **Most sex offenders in Minnesota who are willing to participate in treatment are able to get it, either in a correctional facility or in a community program.**

We identified 70 agencies, facilities, and therapists that provided treatment for sex offenders and found that approximately 2,600 offenders received some treatment in 1992, which is almost twice the number of felony sex offenders convicted in the same year. Since treatment often extends beyond one year, it is reasonable that the total number receiving treatment in a given year would exceed the number convicted.⁹ The probation officers we interviewed told us that most convicted sex offenders who were not sent to prison were required to complete sex offender treatment as a condition of probation. But we also learned that considerable screening occurs by probation officers, the courts, and treatment providers to determine which offenders are likely to benefit from treatment and where an offender should receive treatment, if amenable, to ensure that the public is protected.

Residential Treatment for Adult Sex Offenders

We also found that:

- **The number of community-based residential treatment beds for adult sex offenders has declined by 112 since 1978 while the number of treatment beds in state prisons and the Minnesota Security Hospital, which are more expensive, has increased.**

A 1978 study identified 13 community residential treatment programs serving a total of 120 sex offenders.¹⁰ In addition, 36 sex offenders on probation were being treated at the Minnesota Security Hospital's Intensive Treatment Program for Sexual Aggressives, for a total of 156 residential treatment beds for sex offenders on probation.¹¹ Since then, all but one of the community residential facilities have closed and the Minnesota Security Hospital reduced the number of beds for condition-of-probation sex offenders in order to accommodate a significant increase in offenders committed as psychopathic personalities. Today, the 20-bed Alpha Human Services in Minneapolis is the only remaining community residential facility specifically for adult sex

⁹ We also found that nearly half the offenders who entered a given treatment program did not complete it.

¹⁰ Peggy Specktor and Sharon Sayles, *The Judiciary and Sexual Assault* (St. Paul: Minnesota Program for Victims of Sexual Assault, 1978).

¹¹ Minnesota Department of Public Welfare and Minnesota Department of Corrections, *Sex Offender Treatment Program: Location Alternatives* (St. Paul, 1979).

The number of beds for sex offenders in community facilities has declined despite growing demand, while the number in state facilities has increased.

offenders. Added to the 24 beds reserved for condition-of-probation offenders at the security hospital, there were 44 adult residential treatment beds (outside of state prisons) in 1993.

There were no treatment programs in the state correctional facilities until 1978 when the program at Lino Lakes began.¹² By 1993, there were sex offender treatment programs operating in four adult correctional facilities, serving up to 160 sex offenders at a time. Also, as of March 1994, an additional 60 offenders who had been indefinitely committed as psychopathic personalities upon their release from prison were in treatment at the Minnesota Security Hospital. This represents a total of 220 incarcerated and indefinitely committed adult sex offenders in treatment in state facilities. As described in Chapter 3, it costs more to treat sex offenders in state-operated facilities, especially the Minnesota Security Hospital, than in community-based residential or outpatient programs.

The growth in the number of treatment beds within state-operated facilities is consistent with the trend toward stiffer penalties for sex offenses, which is reflected in the increased number of sex offenders sentenced to prison and committed as psychopathic personalities. But we also found that:

- **There may not be enough adult community-based sex offender residential treatment programs to meet demand.**

The decline in the number of community residential beds for adult sex offenders is reflected in long waiting lists at Alpha Human Services and the Minnesota Security Hospital's treatment beds for condition-of-probation sex offenders. Alpha officials told us in September 1993 that offenders had to wait from six to eight months to get into their residential program. Officials at the Minnesota Security Hospital told us in March 1994 that they were not accepting any more condition-of-probation offenders in their treatment program because the current waiting period was more than one year. Furthermore, as competition for available bed space has increased, program staff have become less willing to keep offenders in the program who do not quickly adapt and show progress. The security hospital is considering phasing out its condition-of-probation treatment beds because it may need the beds for persons committed as psychopathic personalities.

The majority of probation officers we interviewed expressed the view that there were not enough residential treatment facilities for adults. Only 6 of 23 adult probation officers (26 percent) said there were enough residential facilities in or near their county, and 5 of them were from the Twin Cities area. Thirteen of the 23 adult probation officers (57 percent) said that long waiting lists made it difficult for them to place offenders at residential treatment facilities. Nine of the 23 (39 percent) said they were unable or reluctant to place sex offenders in a residential facility due to the high cost. Counties vary

¹² There were rehabilitative programs and psychological services available within the prisons, but none that focused specifically on sex offenders. See Spektor and Sayles, *The Judiciary and Sexual Assault*, 5.

in their willingness to pay for residential treatment for sex offenders, so this was more of a problem in counties unwilling to pay for treatment or with a limited treatment budget.

When probation officers are unable to place an offender in a residential treatment program, the offender is either sent to a state prison or may be required to complete outpatient treatment, typically following or concurrent with a local jail sentence. In the latter case, offenders may receive less treatment or supervision than they need. Some probation officers expressed concern that some sex offenders on their caseloads needed a secure setting after their release from jail but their county does not have one. Several county attorneys and public defenders we spoke with expressed the opinion that some offenders needed more treatment than the two or three hours per week they typically received in an outpatient program, but their offenses or circumstances did not warrant a prison sentence or the county was unwilling to pay for residential treatment. Adult offenders receive six to seven times more treatment at Alpha Human Services, the only sex offender-specific community facility for adults, as those treated on an outpatient basis.

Correctional staff who treat offenders in prison said that some sex offenders do not require the high level of security provided by a prison setting and could receive treatment in a community residential setting. But convicted sex offenders are sentenced under the sentencing guidelines system, based on the severity of the offense and their prior criminal history, not their need for treatment. As shown in Chapter 1, a relatively small number of sex offenders were sentenced to prison when the guidelines called for probation. However, it is also the case that the growth in sex offense convictions since 1980 is primarily accounted for by increases in the number of incest perpetrators and child molesters. In the opinion of treatment professionals, these types of offenders may be more amenable to treatment.

It may be difficult to expand local residential treatment for sex offenders because of community resistance.

However, it may be difficult to expand the availability of local residential treatment programs for sex offenders because of community resistance. Some of the community-based treatment facilities that closed in the past decade were forced to do so because citizens complained about the presence of the facility in their community.

Residential Treatment for Juvenile Sex Offenders

In contrast to adults, we found that:

- **There were more local residential programs and treatment beds for juvenile sex offenders but relatively few of these beds were in secure facilities.**

The four local residential treatment programs for juvenile sex offenders had a combined capacity to treat 200 offenders at a time. In addition, the Department of Corrections juvenile sex offender program at Sauk Centre could treat 20 offenders at a time. Both county correctional facilities that operated

There are approximately 220 residential beds for juvenile sex offenders, but few are in secure facilities.

treatment programs (Hennepin and Anoka Counties) indicated a willingness to accept juveniles from other counties willing to pay their fees, provided space was available. The other two programs, run by privately operated sex offender-specific facilities, accepted juveniles from any county willing to pay their fees.

We asked juvenile treatment providers to estimate the waiting lists for their programs. Anoka Juvenile Center did not have a formal waiting list, but they told us in October 1993 that about five juvenile sex offenders were waiting to enter their treatment program. Hennepin County Home School staff said there were vacant beds in its sex offender program, possibly due to the program's high cost (\$230 per day). They also told us they used to have a long waiting list when they were one of the few programs in the country. The remaining two sex-specific residential treatment programs (Leo A. Hoffmann Center and Mille Lacs Academy) reported a two-month wait for some of their programs, but no wait for others.

Although there were more residential beds for juvenile sex offenders and programs claimed to have shorter waiting lists than adult programs, 11 of the 20 juvenile probation officers we surveyed (55 percent) said that long waiting lists made it difficult to place juveniles at a residential treatment facility. When security is an issue (either the juvenile offender's or a victim's), an immediate out-of-home placement may be needed. Some juvenile sex offenders may be placed in residential facilities that do not specialize in sex offender treatment. Also, five probation officers (25 percent) said that the existing programs were too far away, making it difficult for families to be involved in the treatment process.

Probation officers in Hennepin County cited the need for a secure treatment facility for more serious juvenile sex offenders who have failed in community residential programs. Of the residential facilities for juvenile offenders, only the Anoka County Juvenile Detention Center was licensed by the Department of Corrections as a secure facility. All other treatment programs, including the treatment programs at the Hennepin County Home School and Minnesota Correctional Facility for juveniles at Sauk Centre, were licensed as non-secure juvenile facilities. Both Hennepin and Ramsey Counties told us they send some of their juvenile sex offenders to programs outside of Minnesota.

Outpatient Treatment

Based on our interviews with treatment providers and probation officers, we learned that:

- **Most outpatient providers were able to incorporate referrals into an existing program without significant delay.**

In contrast to residential facilities, most probation officers said there was at least one outpatient sex offender treatment program in their area. Also, a number of outpatient providers told us that they were able to adjust their workloads to meet demand for treatment services, for example, by adding another therapy group.

However, 3 of the 43 probation officers we interviewed said there were waiting lists for the outpatient programs in their area, and 7 of them (16 percent) said they wished there was a greater variety of programs to choose from. Another five probation officers said the closest outpatient program was too far away, but they were from smaller counties that typically had few sex offense convictions per year so it may not be feasible for each to have their own outpatient program. Thirteen of the 43 probation officers (30 percent) thought that their local program, usually at the regional mental health center, was inadequate. Reasons cited were the lack of counselors adequately trained in sex offender therapy, the narrow focus of the program (e.g., only treated intrafamilial abuse), or the lack of intensity (many programs meet only two hours per week).

In addition, just over one-quarter of the outpatient providers we interviewed said they knew of an instance when an offender considered amenable to treatment was denied it because of a lack of funds. Overall, however, they said that this occurred infrequently. Several outpatient providers said they refused to treat offenders on medical assistance, and a number of them mentioned that current diagnostic codes, which determine eligibility for medical assistance reimbursement, are not well suited for sex offenders.¹³

STATE ADMINISTRATION AND OVERSIGHT OF TREATMENT

In this section, we discuss state regulation of sex offender treatment programs and the Department of Correction's administration of state funds to support local sex offender treatment programs.

At the present time, there are no state regulations designed specifically for sex offender treatment programs.

State Regulation of Sex Offender Treatment Programs

Most of the facilities and agencies that operated sex offender treatment programs, whether on a residential or outpatient basis, existed for purposes other than to treat sex offenders and have developed treatment programs due to the growing number of sex offenders among their clients. The Departments of Corrections and Human Services share responsibility for licensing

¹³ As described in Chapter 3, outpatient treatment was typically funded with a combination of funding mechanisms, including client insurance, county social service or correctional funds, medical assistance, and general assistance.

residential facilities that provide sex offender treatment as part of their services. However, none of the existing rules were specifically designed for sex offender treatment programs and, therefore, do not contain any specific requirements regarding treatment.¹⁴

Nineteen of the 51 outpatient providers were community mental health centers and clinics, which offered a wide range of mental health services and were licensed by the Department of Human Services. Other outpatient providers and private practitioners were not licensed as sex offender treatment providers, but many of their counselors and therapists were licensed by the state boards covering their professions. However, existing licensure provisions do not include special requirements for professionals operating in specialized fields, such as sex offender treatment.

In recognition of this, the 1989 Legislature directed the Department of Corrections to adopt rules under the Administrative Procedure Act by July 1, 1991 for the certification of adult and juvenile sex offender treatment programs in state and local correctional facilities.¹⁵ In 1992, the Legislature directed the department to adopt a rule covering outpatient (community-based) treatment programs by July 1, 1994.¹⁶ We found that:

- **The Department of Corrections has yet to adopt rules covering sex offender treatment programs, as mandated by the Legislature.**

According to Department of Corrections officials, the department lacked sufficient staff to comply with these rulemaking requirements. In 1992, at the Department of Corrections' request, the Legislature removed the deadline for adopting rules covering treatment programs in residential facilities. As of March 1994, the sex offender services unit was still drafting the two rules that would establish standards for adult and juvenile residential sex offender treatment programs. Corrections staff told us that the development of these rules has been difficult due to the complexity of the sex offender delivery system and the lack of detailed national standards to use as a guide.

After meeting with a task force established to help the department draft standards for outpatient treatment providers, the department obtained legislative approval in 1993 to remove the rulemaking requirement for outpatient programs. The department believed it did not have sufficient staff to adopt three sets of rules at the same time and questioned whether it was the

¹⁴ In general, the Department of Human Services' and Department of Corrections' rules for residential facilities cover the same topics, including general organizational requirements, staffing qualifications, and requirements designed to protect clients and to ensure appropriate care (e.g., room size, nutrition, code compliance, disciplinary procedures, client rights and grievance procedures, and record keeping). Rules contain few specific requirements regarding treatment. For example, there are no requirements involving minimum hours per week of treatment, types of treatment to be offered, content of treatment programs, or treatment staff qualifications. The few treatment requirements either mandate organizational program plans or individual treatment plans.

¹⁵ *Minn. Laws*, Ch. 290, Art. 4. According to this law, no correctional facility was to operate a sex offender program after July 1, 1991 unless it met the standards adopted by the Commissioner of Corrections.

¹⁶ *Minn. Laws* (1992), Ch. 571, Art. 8.

**The 1989
Legislature
directed the
Department of
Corrections to
adopt standards
for residential
sex offender
treatment
programs.**

appropriate agency to regulate outpatient programs since most funding for these programs comes through county social services or indirectly from funds administered by the Department of Human Services.¹⁷

Figure 5.2 describes the nine different state rules under which facilities providing some sex offender treatment were licensed.¹⁸ The specific type of facility and clientele it serves determines which agency should be responsible for licensing. In general, the Department of Human Services licenses facilities that treat individuals with mental illness or emotional problems (including

Figure 5.2: State Rules Covering Licensing of Facilities that Provide Some Sex Offender Treatment

DEPARTMENT OF CORRECTIONS RULES:

<u>Facility Type</u>	<u>Minn. Rules Reference</u>	<u>Description</u>	<u>Number Providing Some Treatment</u>
Adult Halfway Houses	Ch. 2920	Community-based residential facilities that provide services to adults charged with or convicted of a crime.	3
Adult Detention Facilities	Ch. 2910	Secure facilities used to confine adult prisoners for up to one year (mostly county jails).	1
Juvenile Detention Facilities	Ch. 2930	Secure facilities used to confine juvenile delinquents.	1
Juvenile Residential Facilities	Ch. 2935	Non-secure private or government-run facilities for the treatment of juvenile delinquents.	3

DEPARTMENT OF HUMAN SERVICES RULES:

<u>Facility Type</u>	<u>Minn. Rules Reference</u>	<u>Description</u>	<u>Number Providing Some Treatment</u>
Residential Facilities for Adult Mentally Ill Persons	Ch. 9520.0500 to 9520.0690 ("Rule 36")	Facilities providing residential care and program services to 5 or more adult mentally ill persons.	1
Residential Programs for Persons with Mental Retardation	Ch. 9525.0210 to 9525.0430 ("Rule 34")	Facilities providing residential programs and services for 5 or more persons with mental retardation or related conditions.	1
Child-Caring Institutions	Ch. 9545.0900 to 9545.1090 ("Rule 5")	Private agencies and state-operated institutions that provide 24-hour care and treatment for more than 10 children away from their families.	4
Group Homes	Ch. 9545.1400 to 9545.1500 ("Rule 8")	Group homes that provide 24-hour care and treatment for up to 10 children away from their families.	1
Mental Health Centers and Clinics	Ch. 9520.0750 to 9520.0870 ("Rule 29")	Standards for approval of community mental health centers and clinics for insurance reimbursement (outpatient treatment).	19

¹⁷ As noted, community mental health centers, which operated 19 sex offender treatment programs, were regulated by the Department of Human Services.

¹⁸ Although there were no state rules covering the operation of the four state adult correctional facilities, they met national (American Correctional Association) accreditation standards.

chemical dependency) and the Department of Corrections licenses facilities for criminal offenders. Under a joint policy statement formalized in 1985, the Departments of Corrections and Human Services agreed to honor each other's regulatory authority and that facilities would be licensed by either DOC or DHS but not by both.¹⁹ According to this policy, the source of funding does not dictate the licensing authority, and changes in licensing authority may be made in response to requests from licensees.

Based on interviews with state licensing officials and representatives from licensed facilities, we found that:

- **DHS- and DOC-licensed facilities serve similar broad ranges of juveniles, rather than each serving a specialized group of juveniles.**

Our interviews with probation officers and others suggest that sometimes placement decisions have been made based on which facility had a bed available or was willing to accept a particular child, rather than whether the child was delinquent or in need of treatment. Sometimes a juvenile may be both a sex offender and a victim of sexual assault in need of treatment. Consequently, according to state inspectors, some facilities licensed by DHS may house juveniles that are very similar to individuals housed in facilities licensed by the DOC. The 1985 agreement stipulates that the two departments accept the status quo, even if facilities or clientele change over time. As a result, although both the Leo A. Hoffmann Center and the Mille Lacs Academy are residential facilities that specialize in treating juvenile sex offenders, the former is licensed by the Department of Human Services as a "Rule 5" facility, while the latter is licensed by the Department of Corrections as a "juvenile residential facility." In practice, both accept court-ordered juvenile placements.

We also found that:

- **State laws are unclear and potentially in conflict about which facilities the sex offender treatment rules being drafted by the Department of Corrections will apply to, and the Departments of Corrections and Human Services have interpreted the laws differently.**

The 1989 law directing the Department of Corrections to adopt rules for the certification of adult and juvenile sex offender treatment programs states that the rules will apply to programs in state and local correctional facilities.²⁰ The term "correctional facility" is defined as "any facility, including a group home, having a residential component, the primary purpose of which is to serve

Both the Departments of Corrections and Human Services operate sex offender treatment programs and license facilities that offer treatment.

¹⁹ Department of Corrections policy manual, Part IV (Community Services), "Licensing Issues between Department of Corrections and Department of Human Services," dated June 1985. As a result of this agreement, the Department of Human Services continued to license and inspect some facilities that primarily served juveniles adjudicated as delinquent.

²⁰ *Minn. Laws* (1989), Ch. 290, Art. 4.

State laws covering sex offender treatment regulation may be in conflict.

persons placed therein by a court, court services department, parole authority, or other correctional agency having dispositional power over persons charged with, convicted, or adjudicated to be guilty or delinquent.”²¹ As discussed previously, there are a few juvenile residential facilities licensed by the Department of Human Services to which this definition could apply. In 1993, the Legislature extended the Department of Corrections’ rulemaking authority to apply to programs in state-operated adult and juvenile sex offender treatment programs not operated in state or local correctional facilities.²² The Department of Corrections has interpreted these laws to mean that, in addition to the facilities operated and licensed by the DOC, the two rules it has been drafting will also apply to adult and juvenile facilities with sex offender treatment programs that the Department of Human Services either operates directly or licenses.

The Departments of Corrections and Human Services have different interpretations of the laws.

However, there has been insufficient communication and coordination between the Departments of Corrections and Human Services in the rule-development process, especially given that the application of DOC rules to DHS-operated and DHS-licensed facilities would represent a major change in the regulatory relationship between the two departments. Simultaneously the Department of Human Services was granted rulemaking authority by the Legislature to adopt its own rule governing the operation, maintenance, and licensure of the program established at the psychopathic personality commitment center being built in Moose Lake.²³ In 1994, the Legislature extended DHS’s rulemaking authority to any other programs operated by DHS for persons committed as psychopathic personalities.²⁴ Presently, this would include the sex offender treatment program operated at the Minnesota Security Hospital, which treats individuals committed as psychopathic personalities as well as sex offenders on probation ordered by the court to complete treatment. The Department of Human Services interprets the laws to mean that it will set standards for DHS-operated facilities, although it is unclear whether DOC’s rules may apply to the residential treatment facilities with sex offender treatment programs licensed by DHS.

Administration of State Funds for Sex Offender Treatment

Since 1989, the Legislature has moved to expand the availability of sex offender treatment and ensure that more offenders receive it. The Legislature directed the Department of Corrections to establish a “sex offender treatment system” that would finance a range of treatment programs within the limits

²¹ *Minn. Stat.*, subd. 1 (5).

²² *Minn. Laws* (1993), Ch. 326, Art. 8.

²³ *Minn. Laws* (1 Sp. 1993), Ch. 1, Art. 7.

²⁴ *Minn. Laws* (1994), Ch. 529. The Department of Human Services believes that these laws supersede the prior laws that granted the Department of Corrections rulemaking authority over state-operated sex offender treatment programs not operated in correctional facilities.

of available funding.²⁵ In this section, we examine how well the Department of Corrections has carried out its legislative mandates.

Coordination, Program Development, and Training

The department established a “sex offender services unit” within central administration to implement the Legislature’s directives regarding sex offender programming and treatment program regulation. Since 1990, the unit has expanded to include eight staff members (six professional and two clerical) and has also assumed responsibility for coordinating the department’s chemical dependency treatment programs. The unit has developed four new sex offender treatment programs in state correctional facilities and has implemented a training program for probation officers, as directed by the Legislature.²⁶ Since 1990, the unit has trained approximately 325 probation officers in the supervision of sex offenders.

Grants and Contracts for Local Treatment Programs

In 1989, the Legislature appropriated \$1 million (reduced to \$500,000 in 1990) for “pilot sex offender treatment programs” designed to “increase sex offender treatment.”²⁷ In 1992 and 1993, the Legislature appropriated additional funds to expand the availability of community-based juvenile treatment programs, provide treatment and enhanced community supervision for sex offenders released from prison, and test the effectiveness of biomedical therapy. A total of \$1,364,000 in state funds was allocated for these services for fiscal year 1994.

We found that:

- **Initially, the Department of Corrections interpreted legislative intent narrowly in awarding funds for “pilot” sex offender treatment programs.**

The first grants for pilot sex offender treatment programs were awarded for fiscal year 1991 and were monitored by the department’s community services unit, which also administered the Community Corrections Act. According to staff, the department initially interpreted legislative intent as the development of “new” programs that would not supplant existing funding sources or expand existing services.²⁸ In addition, legislative criteria also limited funding to social service agencies or community corrections agencies, thereby eliminating most direct providers of sex offender services. In the department’s opinion, many of the initial submissions failed to meet the criteria so applicants were invited to reapply with a different program focus. This was

²⁵ *Minn. Stat.* §241.67.

²⁶ Since our field work, the department has established a therapy group for female sex offenders at the Shakopee correctional facility.

²⁷ *Minn. Laws* (1989), Ch. 290, Art. 4.

²⁸ Department of Corrections staff told us they subsequently received clarification from legislators that the intent was to expand treatment services.

The Department of Corrections administers grants for local sex offender treatment programs.

the reason that among the six grants awarded, one went to Hennepin County to subcontract with an agency to provide outpatient treatment for female sex offenders and a second to the University of Minnesota's Program on Human Sexuality to develop and run an outpatient treatment program for elderly men (over age 60). With the exception of a one-time grant to develop a treatment program for low-functioning juveniles, the initial "pilot" grants awarded in 1990 have been renewed each subsequent year.²⁹ However, it is not clear how these grants meet the goal of establishing an adequate treatment system.

We examined the documentation contained in the grant files for the five pilot projects and found that:

- **The Department of Corrections has done a minimal amount of grant monitoring.**

Although the department developed a one-page data collection form, which was supposed to be submitted on a quarterly basis, the department has not required that agencies submit it. Staff told us that they did not have enough time to compile it. Our review of the grant files substantiated that submission of the forms was sporadic. In addition, department staff were unable to tell us how many offenders have been treated under these grants and the information was not contained in the files. Grant-monitoring responsibilities for the pilot projects were transferred to the sex offender services unit in July 1993. Staff in this unit told us that they intend to improve the department's monitoring of grants and contracts and make regular phone calls or personal visits to grantees.³⁰

In addition to the five pilot grants, the department has awarded three contracts to provide aftercare programming for sex offenders released from state correctional facilities, seven grants to provide treatment for juvenile sex offenders, and the grant to the University of Minnesota to test biomedical (drug) therapy for fiscal years 1994-95.

Sex Offender Assessment Reimbursements

In 1989, the Legislature mandated that all juvenile sex offenders be assessed for amenability to treatment by a qualified treatment professional.³¹ In 1992, the Legislature extended this requirement to adult sex offenders not sentenced to prison and appropriated \$500,000 to reimburse counties for these mandated assessments.³² An additional \$385,000 was allocated for this purpose in fiscal year 1994. The legislation also provided that reimbursements should be made on a sliding fee basis, with each offender paying a portion of assessment costs.

²⁹ Thus, the University of Minnesota's outpatient elderly program has received over \$250,000 and has been approved for its fourth and fifth years of funding, although the need or appropriateness of this level of state funding for elderly sex offenders may not be justified.

³⁰ The department reports that it instituted regular grant-monitoring procedures in January 1994.

³¹ *Minn. Laws* (1989), Ch. 290, Art. 4.

³² *Minn. Laws* (1992), Ch. 571, Art. 8.

The department notified probation and county court services departments of the availability of these funds in November 1992.

We found that:

- **From January 1, 1993 through March 31, 1994, a total of \$117,159 had been spent to reimburse counties for sex offender assessments, with \$63,000 of it (54 percent) going to Hennepin County.**

As of March 31, 1994, only 36 counties have applied for reimbursement funds, with over half of the funds going to Hennepin County. Several large counties, including Ramsey, Dakota, and Stearns, have not applied for assessment reimbursements. Department of Corrections staff told us the reimbursement funds not spent in fiscal year 1993 (approximately \$497,000) were used for other sex offender treatment services.

Counties have applied for less than 15 percent of the \$800,000 in assessment reimbursement funds that the Legislature has appropriated.

Based on our interviews with probation officers and treatment providers, we think that most sex offenders were routinely assessed for treatment amenability prior to the Legislature mandating it and providing reimbursement funds. All but one of the 43 adult and juvenile probation officers we interviewed said that 75 percent or more of the sex offenders in their counties were assessed for treatment amenability, usually as part of the pre-sentence investigation. The main reason given for not ordering an assessment was that the offense was minor, such as window peeping or consensual sex between teenagers.

Three adult and two juvenile probation officers said their counties had full-time, in-house psychologists doing assessments (including Hennepin County) even before they were mandated. Most outstate counties used regional mental health centers. Some counties contracted with individual psychologists or treatment programs. For offenders accepted into treatment, the cost of assessment may be included in the overall treatment costs, which was typically paid from a variety of sources, including client's insurance, medical assistance, and county social service funds. Most adult probation officers, but fewer juvenile officers, were aware that the Department of Corrections now reimburses counties for assessments. However, one said that his county did not apply for reimbursement because it was "too much of a hassle to collect." Another officer said the county had already been doing its own assessments so it did not apply for reimbursement.

Sex Offender Treatment Evaluation

In 1992, the Legislature directed the Departments of Corrections and Human Services to establish a fund to pay counties for community-based sex offender treatment. Based on the results of a needs assessment conducted by the two departments, the Legislature repealed this fund in 1993 and replaced it with an evaluation project, under the direction of the Department of Corrections, that would fund a limited number of community-based programs accompanied by a study of treatment outcomes. The Legislature appropriated \$2,475,000 for

fiscal years 1994-95 for this purpose.³³ The department established an evaluation task force in October 1993 to help design and oversee the evaluation. Current plans call for establishing a uniform data gathering system, conducting retrospective outcome studies (e.g., analyzing recidivism data on offenders already released), setting up and evaluating pilot community-based programs, and possibly conducting an intensive research project. The department has been in contact with the National Institutes for Mental Health about the possibility of federal funding to augment state funds. It is too soon to make any judgments about the adequacy of the department's evaluation efforts.

CONCLUSIONS AND RECOMMENDATIONS

In general, we conclude that the Department of Corrections has taken some steps to establish a sex offender treatment system. It has established an administrative structure to handle its new responsibilities and has developed and implemented new treatment programs to provide a "continuum of care" in the state's correctional facilities. But the department has been slow in developing treatment standards as mandated by the Legislature, and the Departments of Corrections and Human Services have not sufficiently coordinated their efforts in developing standards covering sex offender treatment programs. Also, the Department of Corrections has not adequately monitored the grants it has awarded to local treatment providers.

Given the absence of methodologically sound studies of treatment effectiveness, our report does not permit definitive conclusions nor specific recommendations about whether or how to expand sex offender treatment services. However, the Legislature has taken steps since 1989 to ensure that sex offenders receive treatment, whether on probation in the community, in state correctional facilities, or at the Minnesota Security Hospital. The Legislature has also enacted longer sentences for sex offenders. In 1993, the Legislature funded an evaluation project that would help establish better information about treatment effectiveness, which might be used to guide future decisions.

State statutes governing the regulation of sex offender treatment programs should be clarified.

Specific Recommendations

Keeping these legislative actions in mind, we offer the following recommendations to improve the current sex offender treatment system. We recommend that:

- **The Legislature should clarify existing state statutes governing rulemaking authority for the licensing and certification of sex offender treatment programs operated and licensed by the Departments of Corrections and Human Services.**

³³ *Minn. Laws* (1993), Ch. 326, Art. 14.

The Departments of Corrections and Human Services should improve communication and coordination to ensure state oversight of sex offender treatment programs.

Given the difference of opinion between the Departments of Corrections and Human Services over who has authority to set standards for sex offender treatment programs and the potential conflict in existing statutes, we think the Legislature should clarify its intentions. First, clarification is needed concerning whether the rules the Department of Corrections is drafting to certify adult and juvenile sex offender treatment programs will also apply to facilities with sex offender treatment programs either operated or licensed by the Department of Human Services. If the Legislature decides that the Department of Corrections' rules should apply only to programs in facilities it operates or licenses, the Legislature should consider directing the Department of Human Services to develop standards for sex offender treatment programs in residential facilities it licenses. Existing statutes direct DHS to establish treatment program standards for facilities it operates. Alternatively, the Legislature may want to consider directing the two departments to develop a single set of rules establishing sex offender treatment standards for programs in residential facilities licensed by either the Departments of Corrections or Human Services.

Regardless of any subsequent legislative action, we also recommend that:

- **The Departments of Corrections and Human Services should work together to ensure that appropriate sex offender treatment services exist and that treatment providers are appropriately regulated.**

Both the Departments of Corrections and Human Services operate sex offender treatment programs, as well as fund and regulate local treatment providers. However, we found that the two departments operate relatively independently and have not sufficiently coordinated their efforts.³⁴ We think that to avoid unnecessary duplication, as well as to ensure that an adequate range of treatment services exists throughout the state, the two departments need a more formal way of cooperating and coordinating their treatment programs and regulatory responsibilities.

In particular, we recommend that:

- **The Department of Corrections should consult with the Department of Human Services in developing rules for sex offender treatment programs.**

The lack of coordination is most noticeable in the area of residential treatment facilities for juveniles and outpatient treatment programs. Of immediate concern is that the Department of Human Services, which licenses many residential facilities providing treatment, be consulted in the development of rules for sex offender treatment programs. This is especially important since the Department of Corrections intends to adopt its rules before the 1995 legislative session, which is the first opportunity for the Legislature to clarify

³⁴ The two departments communicate regularly for the purpose of monitoring psychopathic personality commitments that originate with the Department of Corrections.

which agency is responsible for establishing sex offender treatment program standards.

We also recommend that:

- **The Departments of Corrections and Human Services should review the current licensing authority of residential facilities that treat juvenile sex offenders and modify such authority where needed.**

There is overlap between the departments in the regulation of treatment providers. We found that the policy governing the regulatory relationship between the two departments dates back to 1985, and the distinctions governing their responsibilities have become blurred.

We also recommend that:

- **The two departments should jointly review the need for standards covering outpatient sex offender treatment programs, and if such regulation is deemed necessary, determine how it should occur.**

The Legislature directed the Department of Corrections to adopt standards covering outpatient sex offender treatment programs, and later removed this requirement at the department's request. According to 30 percent of the probation officers we interviewed, their local outpatient treatment program was inadequate due to poorly trained counselors, narrow program focus, or lack of intensity. Since both the DOC and DHS currently provide some funding for outpatient treatment programs, we think they should jointly review the adequacy of existing programs and seek legislative authority, if necessary, to correct any problems that exist. The two departments should review all available options for ensuring that outpatient treatment staff are qualified, including the development of standards through rulemaking, certifying sex offender treatment providers or individuals who treat sex offenders, or specialized licensing through existing professional licensing boards. The two departments should also work with existing educational institutions to ensure that specialized courses and continuing education in the area of sex offender treatment are available.

The Department of Corrections should monitor the treatment programs it funds and require that uniform data be submitted.

Finally, we recommend that:

- **The Department of Corrections should monitor the sex offender treatment programs it funds and require that grantees submit data on assessed and treated offenders.**

It is reasonable to expect all treatment programs that receive state grant or contract funds to submit data on their clients. The department should develop appropriate data collection forms and ensure that all treatment providers receiving state funds regularly submit data on clients they assess and treat, including those offenders who drop out of treatment before completing it. If

possible, these data should be incorporated into the evaluation project the department is currently implementing.

The Need for Evaluation

Despite the difficulty of conducting empirically sound evaluation studies, we believe that existing treatment programs should be encouraged to evaluate their outcomes. The Legislature has recognized this need by providing funds and directing the Department of Corrections to evaluate treatment effectiveness. Our review suggests the following areas need additional research and evaluation, and we suggest that the Department of Corrections consider them in implementing its treatment evaluation project:

- Identifying whether different methods of treating and supervising sex offenders can reduce the likelihood of recidivism among sex offenders;
- Developing and testing treatment approaches for different types of offenders, including child molesters, incest offenders, and those who are more resistant to treatment, such as rapists, repeat offenders, those who deny their offenses or do not want to enter treatment, and those who drop out of treatment before completing it;
- Developing and testing alternative methods of assessment and identifying variables associated with sexual offending that may be appropriate for treatment intervention; and
- Determining how different incentives and disincentives affect sex offenders' motivations to enter treatment and complete it.

Given the length of time required for controlled experimental evaluations of treatment effectiveness, the Department of Corrections should also consider interim evaluation strategies in its evaluation project. These might include: greater use of pre- and post-measurements on standardized tests; comparisons with expected base rates of recidivism for different types of offenders; and retrospective studies of treated and untreated offenders using matching techniques to control for other variables associated with recidivism.

Sex Offender Outpatient Treatment Programs Interview Guide

APPENDIX A

PROGRAM DESCRIPTION

1. When did your treatment program for sex offenders begin operation?
2. Which of the following does your program treat?
 - Adult males
 - Adult females
 - Juvenile males
 - Juvenile females
 - Developmentally disabled or low functioning adults
 - Developmentally disabled or low functioning juveniles
3. What types of sexual deviancy does your program treat?
 - Stranger rape
 - Acquaintance rape
 - Same-sex child molestation
 - Opposite-sex child molestation
 - Incest
 - Exhibitionism
 - Voyeurism
 - Multiple sexual deviancy
 - Bestiality
 - Obscene phone calls
 - Other (please specify) _____
4. Do you currently have a waiting list? If so, how many people are on it and how long is the wait likely to be?
5. How would you describe your program's philosophy or approach to treatment?
6. What are the goals of your treatment program?
7. What are the main components of your treatment program (e.g., group therapy, individual therapy, family counseling, education, etc.)?
8. Is treatment tailored to an offender's specific needs or problems? If so, how?

9. How many months of treatment do sex offenders typically receive in your outpatient program (assuming they successfully complete treatment)?
Range:
Average:
10. What is the average number of hours per week that a client spends in treatment? How is that time typically spent?

COSTS OF TREATMENT

11. How much do you charge the client for your treatment? Is this the same rate for everyone? If not, what are the different rates?
Cost per hour:
Cost per month:
12. Does your program have any contracts with units of government to provide treatment services? If yes, with whom do you contract? County? DOC?
13. Who pays the cost of treatment? [If possible, we want to get data on the percent of treatment costs paid by the following: state, community corrections agency, county social services, client medical assistance, client insurance, client personal resources, and other sources.]

CLIENT REFERRAL AND PROGRAM PARTICIPATION

14. From where do you get program referrals?
15. Do you assess a client for “amenability” to treatment prior to accepting him or her? If so, do you use a standard assessment procedure? If so, what is it?
16. Are there any sex offenders that you will not accept? If so, who are they? Why won’t you accept them? (eg. violent offenders, those who used a weapon, deniers, low functioning individuals—what is the IQ cutoff for this category?)
17. Have you ever had to refuse treatment for a client who was determined to be amenable to treatment because there were no funds to pay for it? If so, when? Why? What county involved? How often has this happened?
18. How many sex offenders did your program screen for treatment during calendar year 1992? [If not open in 1992, start from whenever you first opened.] Of those, how many were accepted? Why did you not accept the others?

***If you have already completed the data forms we have sent you, or plan to do so, we can skip Questions 19 and 20.

19. Of those who were accepted into treatment during calendar year 1992, how many successfully completed treatment, how many failed to complete treatment, and why?
20. Can we get a breakdown of individuals treated during 1992 by county of residence, and numbers of juveniles versus adults (if applicable)?
21. Do you assess clients for chemical abuse problems? If yes, do they receive treatment for their chemical abuse problems as part of therapy? What proportion of clients are chemically dependent?
22. Do you track any clients after they have left your program? If so, how? Whom do you track?

PROGRAM STAFFING

23. How many treatment staff do you employ to treat **sex offenders**?
24. What qualifications do you require of your treatment staff? What kind of training have they had in treating sexual deviance?
25. What is the current ratio of treatment staff to average size of the client population? What is each therapist's caseload? If you have group therapy, how many clients and how many therapists are in each group?

Sex Offender Treatment Program Data on Clients Served

Please complete **one** form for each client served between January 1, 1992 and December 31, 1992.

1. Client's Sex:
 Male
 Female
2. Client's Age (at time of entry or on 1/1/92 if already in program): _____
3. Client's Race:
 White
 Black
 Other
4. Type of Sexual Deviancy (check all that apply):
 stranger rape
 acquaintance rape
 same-sex child molestation
 opposite-sex child molestation
 incest
 exhibitionism
 voyeurism
 other sexual deviancy (specify) _____
5. County of conviction or disposition: _____
6. Offense of conviction or disposition:
 Criminal sexual conduct in 1st degree
 Criminal sexual conduct in 2nd degree
 Criminal sexual conduct in 3rd degree
 Criminal sexual conduct in 4th degree
 Criminal sexual conduct in 5th degree
 Other (please specify) _____
7. Number of prior convictions or dispositions for sex offenses: _____
8. Client status as of 12/31/92:
 Still in treatment
 Successfully completed treatment
 Client voluntarily left or absconded from treatment before completion
 Client asked to leave treatment before completion (specify reason)

Minnesota Sex Offender Treatment Providers

APPENDIX B

<u>Treatment Provider</u>	<u>Program Type</u>	<u>Program Treats</u>	<u>Program Orientation</u>	<u>Average Length of Treatment (Months)</u>	<u>Number Served in 1992</u>
180 Degrees 236 Clifton Avenue South Minneapolis, MN 55403 (612) 870-7227	Residential	Adults	Adult halfway house	2.5	85
Affiliated Medical Centers 101 Willmar Avenue Willmar, MN 56201 (612) 231-5000	Outpatient	Adults & Juveniles	Sex offender treatment	24	4
Alpha Human Services 2712 Fremont Avenue South Minneapolis, MN 55408 (612) 872-8218	Residential	Adults	Sex offender treatment	18	48
Alpha Service Industries 1516 West Lake Street, Suite 101 Minneapolis, MN 55408 (612) 872-8218	Outpatient	Adults	Sex offender treatment	30	241 (est.)
Anoka County Juvenile Center 7555 4th Avenue Lino Lakes, MN 55014 (612) 786-7350	Residential	Juveniles	Supervision and control	11.5	14
Bonnie-Lyn Center 430 Patterson Avenue Mankato, MN 56001 (507) 388-5801	Outpatient	Adults & Juveniles	Sex offender treatment	18	12
Center for Parents and Children 810 4th Avenue South Moorhead, MN 56560 (218) 233-6158	Outpatient	Juveniles	Sex offender treatment	18	8
Central Minnesota Mental Health Center 1321 13th Street North St. Cloud, MN 56303 (612) 252-5010	Outpatient	Juveniles	Sex offender treatment	6	25
City Line Associated Psychotherapists 2469 University Avenue West St. Paul, MN 55114 (612) 642-1709	Outpatient	Adults & Juveniles	Sex offender treatment	Unknown	35

Treatment Provider	Program Type	Program Treats	Program Orientation	Average Length of Treatment (Months)	Number Served in 1992
Community Based Services, Inc. 277 Coon Rapids Blvd., Suite 108 Coon Rapids, MN 58716 (612) 780-8871	Outpatient	Adults & Juveniles	Sex offender treatment	12	2 ^a
Counseling Associates of Winona 157 Johnson, Suite 100 Winona, MN 55987 (507) 454-1599	Outpatient	Adults	Sex offender treatment	12	5 ^a
Peter Dimock 401 Groveland Avenue Minneapolis, MN 55403 (612) 879-0154	Outpatient	Adults & Juveniles	Unknown	12	5
Elk River Mental Health Center 730 Dodge Avenue, #101 Elk River, MN 55330 (612) 441-3770	Outpatient	Adults	Sex offender treatment	13	37
Family Life Mental Health Center 1428 5th Avenue South Anoka, MN 55303 (612) 427-7964	Outpatient	Adults	Sex offender treatment	24	35
Five County Sexual Abuse Program P.O. Box 287 Braham, MN 55006 (612) 396-3333	Outpatient	Adults	Sex offender treatment	36	35
Genesis II 3036 University Avenue South Minneapolis, MN 55414 (612) 348-2762	Outpatient	Adults & Juveniles	General treatment for women	12	5 (est.)
Harley Family Counseling Center 2780 North Snelling Ave., Suite 304 Roseville, MN 55113 (612) 636-9242	Outpatient	Adults & Juveniles	General treatment, with some emphasis on sex offenses	6	10
Hennepin County Home School Juvenile Sex Offender Program 14300 County Highway 62 Minnetonka, MN 55343 (612) 949-4500	Residential	Juveniles	Sex offender treatment	16	60
Human Services, Inc. 7066 Stillwater Blvd. Oakdale, MN 55128 (612) 777-5222	Outpatient	Adults & Juveniles	Sex offender treatment	18	25
Institute for Psychological Therapies 13200 Cannon City Blvd. Northfield, MN 55057 (507) 645-8881	Outpatient, with a quasi-residential component	Adults & Juveniles	Sex offender treatment	6	3
Itasca County Human Services 123 4th Street Northeast Grand Rapids, MN 55744 (218) 327-2981	Outpatient	Adults	Sex offender treatment	27	10

Treatment Provider	Program Type	Program Treats	Program Orientation	Average Length of Treatment (Months)	Number Served in 1992
LaOportunidad 1821 University Ave. W., Suite 182 St. Paul, MN 55104 (612) 646-6115	Outpatient	Adults	Sex offender treatment	2	11 ^a
Lakeland Mental Health Center 126 East Alcott Fergus Falls, MN 56537 (218) 736-6987	Outpatient	Adults & Juveniles	Sex offender treatment	6	35
Leo A. Hoffmann Center 105 3rd Street South St. Peter, MN 56082 (507) 931-6122	Outpatient Residential	Juveniles Juveniles	Sex offender treatment	9 11.5	22 98
Linden Center for Psychological Health 3549 Washington Drive Eagan, MN 55122 (612) 686-7521	Outpatient	Adults	Sex offender treatment	24	24
Lutheran Social Services 2414 Park Avenue South Minneapolis, MN 55404 (612) 879-5340	Outpatient	Juveniles	Sex offender treatment	15	36
MCF-Lino Lakes Transitions 7525 4th Avenue Lino Lakes, MN 55014 (612) 780-6100	State correctional facility	Adults	Supervision and control	Unknown	121
MCF-Oak Park Heights Sex Offender Treatment Unit Box 10 Stillwater, MN 55082 (612) 779-1400	State correctional facility	Adults	Supervision and control	17	80
MCF-St. Cloud Sex Offender Risk Reduction Program St. Cloud, MN 56301 (612) 255-5030	State correctional facility	Adults	Supervision and control	7	16 ^a
MCF-Sauk Centre Sauk Centre, MN 56378 (612) 352-2296	State correctional facility	Juveniles	Supervision and control	8	21 ^a
MCF-Stillwater Sexual Education and Evaluation Center Box 55 Stillwater, MN 55082 (612) 779-5731	State correctional facility	Adults	Supervision and control	7	116
Mayo Clinic 200 1st Street South Rochester, MN 55905 (507) 284-2511	Outpatient	Juveniles	Sex offender treatment	12	9
Meta Resources 970 Oak Ridge Avenue Shoreview, MN 55126 (612) 642-9317	Outpatient	Adults & Juveniles	Sex offender treatment	30	26

Treatment Provider	Program Type	Program Treats	Program Orientation	Average Length of Treatment (Months)	Number Served in 1992
Metropolitan Community Mental Health Center 2201 Blaisdell Avenue South Minneapolis, MN 55404 (612) 871-2273	Outpatient	Adults & Juveniles	Sex offender treatment	30	32 (est.)
McGuire Family Therapy Center 51 4th Street East Winona, MN 55987 (507) 452-3120	Outpatient	Adults & Juveniles	Sex offender treatment	15.5	186 (est.)
Mille Lacs Academy P.O. Box F Crosier Center Onamia, MN 56359 (612) 532-4005	Residential	Juveniles	Sex offender treatment	18	116
Minnesota Security Hospital 100 Freeman Drive St. Peter, MN 56082 (507) 931-7668	Residential	Adults	Sex offender treatment with comprehensive services for other mental disorders	36	44 ^a
Northeast Regional Corrections Center 6102 Abrahamson Road Saginaw, MN 55779 (218) 729-8673	Residential	Adults	Supervision and control	4.5	33
Northern Pines Mental Health Center 520 5th Street Northwest Brainerd, MN 56401 (218) 829-3235	Outpatient	Adults & Juveniles	Sex offender treatment	30	10
Northwestern Mental Health Center 100 College Avenue Crookston, MN 58716 (218) 281-3940	Outpatient	Adults & Juveniles	Sex offender treatment	19	30
Northwood Children's Home Society, Inc. 714 West College Street Duluth, MN 55811 (218) 724-8815	Residential	Juveniles	General treatment, with some emphasis on sex offenses	15	16
Park Nicollet Medical Center 14000 Fairview Drive Burnsville, MN 55337 (612) 892-8608	Outpatient	Adults & Juveniles	Sex offender treatment	12	8
PHASE 1600 University Ave. W., Suite 305 St. Paul, MN 55104 (612) 641-1485	Outpatient	Juveniles	Sex offender treatment	37	12
Program in Human Sexuality University of Minnesota 1300 2nd Street South, Suite 180 Minneapolis, MN 55454 (612) 625-1500	Outpatient	Adults	Sex offender treatment	36	60 (est.)
Project Pathfinder 1821 University Ave. W., Suite 1377 St. Paul, Minnesota 55104 (612) 644-8515	Outpatient	Adults	Sex offender treatment	37	90 (est.)

Treatment Provider	Program Type	Program Treats	Program Orientation	Average Length of Treatment (Months)	Number Served in 1992
Psychological Health Services 8 North 2nd Avenue East Duluth, MN 55806 (218) 722-1254	Outpatient	Adults & Juveniles	Sex offender treatment	36	24
Ramsey County Mental Health Clinic 529 Jackson Street St. Paul, MN 55101 (612) 298-4737	Outpatient	Adults	Sex offender treatment	26	15
Range Mental Health Center 624 13th Street South, P.O. Box 1188 Virginia, MN 55792 (218) 749-2881	Outpatient	Adults & Juveniles	Sex offender treatment	18	32
Re-Entry, Ashland 532 Ashland Avenue St. Paul, MN 55102 (612) 659-9420	Residential	Adults	Adult halfway house	2.5	23 ^a
REM-Lyndale 2210 Lyndale Avenue North Minneapolis, MN 55411 (612) 922-6776	Residential	Adults	Intermediate Care Facility for the Mentally Retarded (ICF-MR)	36	14
St. Cloud Children's Home 1726 7th Avenue South St. Cloud, MN 56301 (612) 251-8811	Residential	Juveniles	General treatment, with some emphasis on sex offenses	16.5	20
St. Joseph's Home for Children 1121 46th Street East Minneapolis, MN 55407 (612) 827-6241	Residential	Juveniles	General treatment, with some emphasis on sex offenses	9	11 (est.)
Seals and Associates, Inc. 1111 3rd Avenue South, Suite 141 Minneapolis, MN 55404 (612) 673-9628	Outpatient	Adults	Sex offender treatment	18	106 (est.)
South Central Human Relations Center 215 South Oak Avenue Owatonna, MN 55060 (507) 451-2630	Outpatient	Adults & Juveniles	Sex offender treatment	24	10
Spectra 206 4th Street West Duluth, MN 55806 (218) 720-3031	Outpatient	Adults & Juveniles	Sex offender treatment	22.4	71 ^a
Storefront Youth Action 7145 Harriet Avenue Richfield, MN 55423 (612) 830-1331	Outpatient	Juveniles	Sex offender treatment	15	25
Joe Switras 208 2nd Street West Fairmont, MN 56031 (507) 235-5651	Outpatient	Adults & Juveniles	Sex offender treatment	5	20 (est.)

Treatment Provider	Program Type	Program Treats	Program Orientation	Average Length of Treatment (Months)	Number Served in 1992
Robert V. Thureson 2445 Park Avenue Minneapolis, MN 55404 (612) 872-0045	Outpatient	Adults	Sex offender treatment	12	20
Transition Place 23 4th Street Southeast, #202 Minneapolis, MN 55414 (612) 379-8050	Outpatient	Adults	Sex offender treatment	18	60
Upper Mississippi Mental Health Center P.O. Box 640 Bemidji, MN 56601 (218) 751-3280	Outpatient	Adults & Juveniles	Sex offender treatment	12	57
Uptown Mental Health Center 2344 Nicollet Ave. S., Suite 120 Minneapolis, MN 55404 (612) 871-1111	Outpatient	Adults	Sex offender treatment	24	14
	Outpatient	Juveniles		24	8
Welcome Home 4250 Stone Bridge Minnetrista, MN 55364 (612) 474-7052	Residential	Juveniles	General treatment, with (est.) some emphasis on sex offenses	2	15
West Central Community Services Center P.O. Box 787 Willmar, MN 56201 (612) 235-4613	Outpatient	Adults & Juveniles	Sex offender treatment	42	50
Western Human Development P.O. Box 450 Marshall, MN 56258 (507) 532-3236	Outpatient	Adults & Juveniles	Sex offender treatment	Unknown	17
Wilder Child Guidance Center 919 Lafond Avenue St. Paul, MN 55104 (612) 642-4001	Outpatient	Adults	Sex offender treatment	18	10
Wilson Center Faribo Town Square 201 Lyndale Avenue South, Suite U Faribault, MN 55021 (507) 332-2253	Outpatient	Adults & Juveniles	General treatment, with some emphasis on sex offenses	6	4 (est.)
James Wright 1020 146th Street East, Suite 115 Burnsville, MN 55337 (612) 431-2191	Outpatient	Juveniles	Sex offender treatment	14	16
Zumbro Valley Mental Health Center 2116 Campus Drive S.E., Suite 105 Rochester, MN 55904 (507) 281-6240	Outpatient	Adults & Juveniles	Sex offender treatment	28	24 (est.)

Note: Two treatment providers were omitted from this list by request.

^aData from period other than 1992.

**Minnesota
Department of
Corrections**

Office of the Commissioner

July 11, 1994

James R. Nobles
Office of the Legislative Auditor
Centennial Building
St. Paul, Minnesota 55155

Dear Mr. Nobles:

Thank you for the opportunity to review the final draft report on sex offender treatment programs. We appreciate the fact that many of our suggestions were incorporated into the final report. It is an impressive compilation of information in an area where information-gathering is a complex and difficult task. It will serve as a very valuable tool in future discussions and planning for sex offender treatment programming in Minnesota.

We support your finding that legislative clarification of existing state statutes is necessary to determine the most appropriate agency to certify or license sex offender treatment programs operated or licensed by the state Department of Human Services. Our department will continue to work with the Department of Human Services to reach a consensus on this issue and present a unified recommendation to the 1995 Minnesota Legislature.

The Departments of Corrections and Human Services have worked closely together on rule promulgation and in other areas to ensure that appropriate sex offender treatment services exist. This strong cooperative and collaborative relationship will continue.

We appreciate the report's recognition that the Sex Offender Programming Evaluation Project mandated by the 1993 Legislature and administered by our department is designed to address many of the issues identified in the audit report.

In response to your review of the department's rule promulgation activity, it should be noted that rules covering sex offender treatment programs in residential facilities are scheduled to be promulgated by September 1, 1994. Rule development in this complex area is very difficult, particularly since there are no existing national standards for sex offender programming. The rules to be promulgated are unique and will set a far-reaching precedent. As noted in the report, the fact that our department initially was not provided staff resources to develop these rules was a factor that slowed the development process. This issue has since been addressed by the legislature. It is also important to

James R. Nobles
July 11, 1994
Page Two

note that the legislature, recognizing the need for adequate time for rule development, removed any deadlines for adopting rules covering treatment programs in residential facilities.

We totally support the recommendation regarding improved monitoring of projects receiving state funds. The responsibility for grant monitoring has been placed with the department's sex offender services unit which provides comprehensive oversight including requirements for quarterly progress reports, completion of data collection forms, and quarterly site visits.

In conclusion, we would like to thank Marlys McPherson for her work as project manager on this extensive report. The report provides excellent information which will be extremely useful to the legislature and sex offender treatment professionals.

Sincerely,

/s/ Frank W. Wood

Frank W. Wood
Commissioner

FWW:sb



State of Minnesota
Department of Human Services

Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155

July 11, 1994

Mr. James R. Nobles
Legislative Auditor
Centennial Office Building
648 Cedar Street
Saint Paul, Minnesota 55155

Dear Mr. Nobles:

Thank you for the opportunity to review the Legislative Auditor's draft report on Minnesota "sex offender treatment programs." In general, the report provides a comprehensive description of available treatment services and client characteristics.

Minnesota, like other states, is striving to ensure availability of appropriate treatment services and determine the efficacy of treatment outcomes. Your report assists this effort by providing a factual framework for the Legislature and others striving to come to grips with the pertinent issues.

I look forward to working with you and the Legislature as these important issues are discussed.

Sincerely,

/s/ Maria R. Gomez

MARIA R. GOMEZ
Commissioner