# TABLE OF CONTENTS

BACKGROUND..................................................................................................................... 1

I. ADULT SEX OFFENDER MANAGEMENT................................................................. 1
   A. Introduction ........................................................................................................... 1
   B. Sex Offender Management in the United States ............................................. 1
   C. Emerging Trends ............................................................................................... 2
   D. Key Elements of Community Supervision ...................................................... 4
   E. Physiological and Monitoring Tools ................................................................. 8
   F. Sex Offender Supervision Legislation ............................................................... 10
   G. Registration and Notification .......................................................................... 11
   H. Risk Assessment ............................................................................................... 20
   I. Treatment of Adult Sex Offenders ................................................................. 25

II. JUVENILE SEX OFFENDER MANAGEMENT.................................................... 33
   A. Introduction ....................................................................................................... 33
   B. Assessment ....................................................................................................... 33
   C. Treatment ......................................................................................................... 34
   D. Aftercare ............................................................................................................ 39
   E. Treatment Limitations ...................................................................................... 40
   F. Major Areas of Need for Sexually Aggressive Youth ...................................... 40
   G. Effectiveness of Treatment ............................................................................ 42

III. STAFF TRAINING................................................................................................. 43

IV. VICTIM ISSUES................................................................................................... 45
   A. Introduction ....................................................................................................... 45
   B. Costs Experienced by Victims ......................................................................... 46
   C. Sexual Assault Nurse Examiners (SANEs) ..................................................... 47

ENDNOTES AND BIBLIOGRAPHY .............................................................................. 51
BACKGROUND

In 2001, Lane Council of Governments (LCOG), on behalf of the Public Safety Coordinating Council (PSCC) and a host of key system players, applied for and was awarded a Sex Offender Management Planning Grant through the US Department of Justice (DOJ). As part of the research for the planning process, LCOG staff completed this national review of the literature on sex offender management.

I. ADULT SEX OFFENDER MANAGEMENT

A. Introduction

The prevalence of sex offenders (SOs) in the criminal justice system has increased over the past several years. In some cases, SOs represent approximately one third of state prison populations. Much of the apparent rise in sex offending, however, is related to increased reporting rather than increased offending, as reporting and recording of sex offenses has increased dramatically in recent years. In addition, enforcement is more aggressive and definitions of sex offenses are more expansive than ever before. Conduct that was once tolerated is now criminally prosecuted. More than eight times more people were incarcerated for lower grades of sexual assault in 1992 than in 1980. This gives the appearance of increased criminal sexual activity when, in fact, much of the variation can be attributed to the official response.

Despite recent legislative changes and sentencing practices that increase the likelihood and length of incarceration for convicted SOs, many of these offenders are supervised in the community. A U.S. Department of Justice study reported that in 1997, approximately 265,000 adult SOs were under the care, custody, or control of correctional agencies in the United States. Of these, almost 60 percent were under some form of community supervision. Most offenders who are convicted of one or more sex crimes will be supervised in the community at some point – either immediately following sentencing or after a period of incarceration in jail or prison. These offenders present unique challenges to probation and parole departments that are primarily responsible for supervising them. Because of the potentially volatile community responses to SOs and the irrefutable harm that re-offenses would cause potential victims, community supervision of SOs is of critical importance to criminal justice agencies and the public.

In Lane County, there are roughly 325 adult SOs under probation/parole supervision at any given time. Given that so many known SOs are “loose” in the community at all times, protection of the community dictates that the behaviors, activities, and lifestyles of these offenders be closely monitored and managed to decrease the likelihood that they will cause further harm.

B. Sex Offender Management in the United States

Throughout the United States, efforts to manage SOs safely in the community go on at many levels of government and within different public and community contexts, including the following:

1. At the most basic level, effective SO management begins at the individual case management stage. It involves a case team of a treatment provider, a probation or parole officer, local law enforcement officers, and perhaps representatives of a victim’s organization. The team operates within a local neighborhood or town where the offenders lives and/or works.
That team needs substantive assistance on management and treatment strategies, on working together as a team, and on involving and working with the community.

The community needs to be educated about SOs and about taking care of their own and their children’s safety.

2. The work of that team happens in the context of the city, town, or county’s criminal justice system, local government, victims’ organizations, and health care and social service delivery systems. Those agencies must work together to determine local policies, practices, and use of resources that permit the case team to do their work and to have the tools that they need.

That local policy group needs basic education on SOs and effective management strategies; they need assistance on working together as a policy group, on creating the interagency agreements and policies needed for effective management, and on educating their citizens.

The county, city, or town’s citizens need education about SOs and about the best use of resources to manage them.

3. Much of what happens on the local level is made possible by the laws, policies, and funding decisions at the state level. Criminal laws, sentencing parameters and options, registration and notification laws, confidentiality laws, parental rights, parole conditions, funding of resources, and many other critical dimensions are determined by state legislators, governors, and state agency directors.

These state-level policymakers need basic education on SOs, their effective management, and the impact of ineffective management and dispositions on the rest of the system. They need opportunities to understand the impact of their laws, policies, and funding priorities on the safety of the community, and on the line staff throughout the criminal justice, social service, and mental health systems.

4. All the actors and agencies, whether state, local, or community-level, whose work impacts these issues are represented by national organizations. The individuals in those positions are heavily influenced by the opinions and activities of their national organizations.

The national associations, coalitions, and organizations need to be educated about SOs and their effective management, and about the role of their constituencies in that management. They need assistance to educate their memberships so that their members will be open to receiving the education and assistance provided at the local and state level.

C. Emerging Trends

The following is an overview and discussion of emerging practices and lessons in communities across the country in the management of SOs under community supervision. A core assumption appears to underlie these emerging practices: the primary goal of managing SOs in the community is the prevention of future victimization. To that end, a comprehensive approach to SO management includes several key elements:

1. **Collaboration.**
Collaboration among those agencies and individuals charged with initiating and implementing effective supervision and treatment practices is essential to managing SOs safely in the community. Given the secrecy, manipulation, and deception that characterizes sex offending behavior, there also must be a clear set of operating norms for all involved to minimize the ability of offenders to circumvent the goals of supervision.

Because of the multifaceted and complex nature of sex offending and its irrefutable impact on victims and society, it is imperative that collaborative efforts to manage SOs venture beyond the traditional, cooperative relationships associated with case management. This requires that the supervision agency work closely with the treatment agency, the victim advocacy community, polygraph examiners, and, if possible, others involved with the management of SOs in the community (e.g., law enforcement officers, defense attorneys, judges, prosecutors, school and social services officials, offenders’ families, and others).

These entities must not only share information about each offender, but should also work together to continually evaluate the offender’s progress and discuss whether modifications should be made in the offender’s treatment and supervision plan based on information they might learn from one another. Supervision of SOs in some ways resembles putting a puzzle together. Small pieces of information taken alone have little significance. However, when the pieces are put together, the picture that emerges often provides important information regarding the offender’s activities. True collaborative relationships foster a new and enhanced sense of awareness among agencies and individuals regarding who the other parties are, what motivates them, and the benefits that they will derive from working together.


Since a primary goal of supervision is the protection of victims and the prevention of future victimization, supervision agencies should work closely with victim advocacy organizations to ensure that their policies do not re-traumatize victims of sexual assault, or inadvertently jeopardize the safety of others. While supervision agencies have traditionally been offender-focused in their work, the most comprehensive and responsible approaches to the community management of SOs are those that focus on the needs and safety of both past and potential victims of sexual assault. In this regard, concern for the protection of the victim and the community guide policy development, program implementation, and the actions and approaches of supervision agents and other practitioners who are either working with victims of sexual assault or supervising perpetrators.

3. Sex Offender Specific Treatment.

Mandated specialized treatment as part of probation or parole conditions is an integral component of effective community supervision. The notion that SOs should be involved in treatment in no way suggests that they be allowed to escape responsibility for their own actions – or that they should be “coddled.” The offense-specific treatment that research has shown to be most effective holds offenders accountable, is victim-centered, and is limited in its confidentiality. It is based on the notion that if an offender can be taught to manage successfully his/her propensity to sexually abuse, he/she becomes less of a risk to past and potential victims.

Clear and consistent polices at all levels (state, local, and agency) are crucial components of community supervision. Clear policy defines how cases will be investigated, prosecuted, and adjudicated. It also defines the method of community supervision, the roles various agencies play in the supervision process, and the response to indications of risk of relapse. Consensus-built policy establishes the goals of the system and helps jurisdictions to identify clearly what role each agency will play in managing these cases.

D. Key Elements of Community Supervision

The experiences of probation and parole agencies across the nation indicate that sole reliance on commonly used supervision practices (e.g., scheduled office visits, periodic phone contact, and community service requirements) does not adequately address the unique challenges and risks that SOs pose to the community. In order to address these challenges, it is imperative that convicted SOs receive, in addition to incarcerative sanctions where appropriate, a period of community supervision. During this period of supervision, the supervising agency is able to assess an offender’s place of residence and employment, restrict contact with minors or other potential victims, select appropriate treatment for the offender, and establish, if necessary, other restrictions that diminish the likelihood of reoffense.

SOs must be monitored intensively during community supervision in order to evaluate their level of commitment to and compliance with all imposed special conditions. This supervision should typically include:

- ensuring that the offender is actively engaged in and consistently attending an approved community-based treatment program;
- verifying the suitability of the offender’s residence and place of employment;
- monitoring the offender’s activities by conducting frequent, unannounced field visits at the offender’s home, at his/her place of employment, and during his/her leisure time (e.g., is he/she engaging in inappropriate, high risk behavior such as collecting items that depict or are attractive to children?); and
- helping the offender to develop a community support system – including friends, family members, and employers who are aware of the offender’s criminal history, are supportive of the community supervision plan, and can recognize the SO’s risk factors.

Probation officers can further enhance their ability to monitor an offender’s compliance with probation conditions by maintaining regular contact with the offender’s family, friends, and other community members. This contact can also provide an opportunity for community members to express concerns they may have about an offender’s behavior.

1. Special Conditions

Special conditions of supervision have been used to add restrictions to the general terms and conditions of supervision. Although many traditional methods of supervision (such as field visits, collateral contacts, surveillance, drug and alcohol testing, and electronic monitoring) are appropriate to utilize when supervising SOs, probation and parole conditions should also address their sex offense histories and individual patterns of offending. Thus, SO specific conditions have emerged as one of the key tools in managing this particular population of offenders.
More intensive community supervision practices ensure that external controls are imposed upon SOs and can, in some instances, interrupt an offender’s sex offense cycle. There are a number of supervision conditions that are generally accepted and widely used with SOs. While these special conditions provide a foundation for the development of a comprehensive case management plan, probation and parole officers should tailor the specific supervision conditions in each SO’s case plan to address individual risks and needs. Specialized conditions for the supervision of SOs usually address:

- **Disclosure:** Signature on a waiver allowing shared communication among treatment, probation/parole, district attorney’s office, and the court; and disclosure to others (e.g., schools and employer) as deemed appropriate.
- **Treatment:** Participation in and payment for evaluation and approved SO specific treatment covered by a signed contract.
- **Victim Contact and Restitution:** No contact of any kind with the victim(s) or their families (including contact through third parties) and payment for victims’ counseling.
- **No Contact with Children:** Restriction from any intentional or prolonged contact with children, regardless of the age and gender of the offender’s prior victims.
- **Driving and Travel:** No unapproved driving after dark or when children are going to and from school except for employment; no connection with hitchhiking; and travel to another jurisdiction only with authorization and a letter signed by local authorities.
- **Daily Living:** Residence only in the supervising jurisdiction; no unapproved visits with family; and maintenance of established curfew hours.
- **Social/Sexual Behavior:** No sexual contact or unchaperoned contact with anyone under the age of 18; full appropriate dress when public view is possible; may not spend time in locations where individuals under the age of 18 are likely to be; no non-therapeutic contact with convicted SOs; and no view, purchase, or possession of adult-oriented materials.
- **Work (paid or volunteer):** No such activity where contact with those under the age of 18 is likely.
- **Alcohol/Drugs:** No purchase, possession, or consumption; testing as requested.
- **Polygraph, Plethysmograph, and Other Tests:** Offender must agree to submit to polygraph, plethysmograph, and other physiological tests as directed by the supervising officer.

In addition, some jurisdictions have imposed additional special conditions of supervision that address:

- **Computer/Internet Restrictions:** Offenders must not use the Internet without permission of their supervising officer and offenders must submit to an examination and search of their computer to verify that it is not utilized in violation of their supervision and/or treatment conditions.
- **Other Technology Restrictions:** Offenders will not possess a camera, camcorder, or videocassette recorder/player without the approval of their supervising officer.
- **Other Employment Restrictions:** Offenders cannot hold a position that allows them to supervise women or children.

Developing a supervision strategy to protect potential victims may also involve random home checks after curfew; review of the offender’s driving log; restriction of the offender’s access to
vehicles; frequent contact with the offender’s family members, roommates, friends, and employer; and the administration of unscheduled polygraph examinations.

Special supervision conditions, when ordered by the court or the supervision agent, are perhaps the most effective method of imposing external controls on SOs. In order to reduce the likelihood of a sexual reoffense, these restrictions must be designed to address the offender’s risk factors, and supervision agents must consistently monitor the offender’s adherence to all of the conditions of probation. Supervision agents should continually assess whether the conditions assigned to SOs appropriately address their current patterns of behavior (including social interactions) and living conditions. For example, a supervision agent may discover during a conversation with a family member that a child molester who has abused strangers is routinely riding a bus to and from work that is also transporting children. The agent might then develop and impose an additional condition that forbids the offender from riding public transportation that is likely to have children as passengers (e.g., during the mornings and in the afternoons and evenings before 9:00 p.m.). This ongoing and intensive evaluation of an offender’s behavior will also reinforce that his/her actions are being constantly scrutinized.

2. Specialized Vs. Non-Specialized Caseloads

A survey of SO supervision practices nationwide concluded that “policies which promote the specialization of job duties for (probation and parole) officers who manage SOs were found to accompany practices associated with the effective management of SOs.” The survey also revealed that specialized caseloads allow supervision staff to:

- gain expertise and training related to SO management;
- ensure that SOs, who might have become “lost” on non-specialized caseloads because of their seemingly compliant nature, are supervised intensively;
- establish rapport with SOs in order to encourage them to talk openly about their thoughts and activities;
- promote feelings of camaraderie and support among officers who maintain these caseloads in order to reduce secondary trauma; and
- increase agency-wide consistency in SO supervision practices.

Specialized officers should have extensive supervision experience; be trained in SO issues such as treatment, assessment and the polygraph; be knowledgeable about victimization; and have interest in and a commitment to working with this population.

Specialized officers must, therefore, be willing to play a different role in supervising SOs than other officers who are responsible for non-specialized caseloads. They must be more involved in the offender’s daily life and habits and be in contact with others knowledgeable about the offender’s current attitudes and behaviors. SO supervision officers have found that the following practices enhance their ability to monitor an offender’s behavior and state of mind:

- open discussions with the offender regarding his/her progress in identifying and avoiding pre-offense planning and behaviors and his/her understanding and use of relapse prevention strategies;
- detailed discussions of any contact the offender may have had with past or potential victims followed by verification of that information with the offender’s family or others in his/her support network;
- close monitoring of the offender’s employment; and
recognition of treatment progress or other positive achievements.

At a minimum, the specialized supervision of SOs requires a probation officer to be able to talk openly about sexuality and sexual deviancy; to be knowledgeable about offender and victim issues; and to work collaboratively with treatment providers and other stakeholders to ensure compliance with community supervision and treatment requirements. “Specialization means that no longer will an SO slip in the door just before 5 p.m., spend five minutes in the probation office talking about his job and last night’s basketball game, pay his fees, and leave.”

The nationwide survey concluded that mixed probation and parole caseloads can also be an effective way to manage SOs, as long as SOs are assigned only to probation officers who receive ongoing, specialized training. Regardless of whether the caseloads are mixed or SO specific, supervision agencies are urged to minimize the number of SOs on an officer’s caseload to the extent possible.

3. *Minimum Standards Of Supervision*¹²

Throughout the course of the offender’s supervision, supervising agents must, at a minimum, be able to:

- check an offender’s residence and place of employment;
- maintain contact with the offender’s therapist, employers, family members, friends, and other community members, including victims;
- establish and maintain contact with an offender’s associates, significant others, employers, Alcoholics Anonymous sponsors, and others to ensure that they are aware of the offender’s history and risk factors; and
- continue to monitor the offender’s adherence to the conditions of supervision – which likely will include ensuring that the offender has no access to potential victims, is not in possession of pornography or using the Internet, drugs, or alcohol, and that he is employed and living at an approved residence. The level of supervision should never be so low as to exclude routine field visits to monitor an offender’s behavior in the community.

4. *Surveillance*¹³

Some jurisdictions also employ surveillance officers who work closely with probation and parole officers to assist with monitoring an offender’s compliance with supervision conditions.

In Maricopa County, Arizona, the Adult Probation Department has teamed probation officers with SO surveillance officers. The surveillance officers work full-time in the community and are assigned flexible and rotating shifts, allowing officers to be in the community seven days a week and 24 hours a day. Surveillance officers monitor SOs’ whereabouts and activities in the community; verify addresses; assure that residences are in compliance with program standards and regulations; and communicate often with probation and parole officers and treatment providers. They have access to considerable technology to maintain close contact with their colleagues and the department’s dispatcher, and to assure their own safety while in the field.

5. *SO Specific Treatment*¹⁴
SO specific treatment is another critical component of a comprehensive approach to SO management. Appropriate treatment can assist SOs to learn control over their sexually abusive behavior.

The most effective SO treatment programs assist in preventing victimization because they require offenders to acknowledge their crimes and the harm that they have caused their victims, and to participate actively in the treatment process. Successful participation in and completion of sex offense specific treatment is a very common condition of probation and parole supervision.

Effective SO treatment is markedly different from traditional mental health counseling or psychotherapy. Notable differences between traditional psychotherapy and SO specific treatment include:

- the primary focus is the protection of the community;
- considerable attention is directed toward understanding the harm the offender has caused the victim;
- SOs' thinking errors that contribute to their offending patterns are revealed, examined, and challenged;
- offenders participate in professionally facilitated group sessions; these sessions provide an opportunity for offenders to challenge one another regarding their denial, distortions, and manipulation; and
- information discussed in group is shared with supervision agents, polygraph examiners, and other stakeholders as deemed necessary.

SO treatment providers must, therefore, be willing to work beyond the confines of the traditional psychotherapy model, understand the unique treatment needs of SOs, and develop therapy programs accordingly.

In many jurisdictions, supervision agents are encouraged to attend treatment groups periodically to learn more about the offender and to reinforce the close working relationship between supervision staff and SO treatment providers. In some jurisdictions, supervision agents co-facilitate treatment groups with therapists.

E. Physiological and Monitoring Tools

1. *The Polygraph*

The polygraph, a technology that is effective in detecting deception, is being used increasingly as a mechanism to assist in managing SOs. The value of the post-conviction polygraph seems undisputed among those who use it and those jurisdictions that now use it report that they could not get along without it. The polygraph has become an important asset in treatment and supervision, providing independent information about compliance and progress. Where an offender is engaging in non-compliant behavior, the polygraph provides information that informs the case plan and/or the need to take other action to prevent relapse and encourage success. In many jurisdictions, the polygraph examiner is a key part of the case management team.

As is the case with SO treatment providers, polygraph examiners who administer tests to SOs should be specially trained to work with this population. Three types of post-conviction polygraphs are commonly administered to SOs under probation or parole supervision:

a. **Full Disclosure or Sexual History Examination** The primary purpose of this examination is to ensure complete disclosure by the offender of his/her sexual history. This
examination is typically administered after an offender has been in treatment from three to six months.

b. **Specific Issue Examination**: This examination evaluates a specific behavior or allegation during supervision. It is also used when an offender is either in complete denial or maintains that he/she did not commit the crime of conviction (in particular, offenders who were sentenced under an Alford Plea or offenders who continue to minimize their responsibility for the abuse despite their conviction).

c. **Maintenance or Monitoring Examination**: The primary function of this examination is to verify the offender’s compliance with treatment and supervision conditions. Maintenance or monitoring examinations are administered on a periodic basis, usually every six months. In most cases, offenders are not tested more than three times per year. One of the most significant challenges associated with using the polygraph as a SO supervision tool is that not all states have licensing laws or procedures for post-conviction SO testing. When a supervising agent or a treatment provider identifies a polygraph examiner with whom to work, he or she should inquire about the training that the examiner has received and, more specifically, if the training has been endorsed by the American Polygraph Association (APA).

2. **Penile Plethysmograph**

   The penile plethysmograph is a physiological instrument that measures an offender’s erectile response to various stimuli. It is typically used in two ways: to measure the offender’s sexually deviant interests, so that a behavioral program to decrease the deviant arousal can be developed, and as an evaluation tool to measure the success or failure of the treatment interventions.

   The penile plethysmograph is considered to be one of the more invasive techniques used in the field of SO management. Nonetheless, deviant sexual arousal is a significant contributing factor in sex offending (research indicates that deviant sexual arousal is positively correlated with reoffense), and the self-report of offenders regarding their sexual arousal often is not reliable. The Association for the Treatment of Sexual Abusers (ATSA) has developed guidelines for the use of the plethysmograph with SOs.

3. **Drug And Alcohol Testing, And Electronic Monitoring**

   While many jurisdictions use drug/alcohol testing and/or electronic monitoring for their obvious benefits in reducing chemical abuse and providing information about offenders’ whereabouts, neither should substitute for a more specialized approach to SO management that includes interdisciplinary and agency collaboration and SO specific treatment.

   The jurisdictions that have found these technologies to be most helpful use them in a manner that addresses specific SO risk factors. For example, it may not be appropriate to drug and/or alcohol test an offender who, because of a serious medical condition, cannot and does not consume these substances. In addition, it may not be the best use of limited resources to electronically monitor an offender who is surrounded and supervised closely by a group of supportive adults (e.g., an employer, a mother and father, neighbors, or other relatives). In such instances, the resources associated with using these technologies should be applied to offenders who have past histories of substance abuse or have not shown the ability or willingness to abide by court-imposed curfews and other restrictions on movement.
F. Sex Offender Supervision Legislation

1. Lifetime Supervision

Lifetime supervision is another form of SO supervision that has been implemented in a number of states. Lifetime supervision provides for ongoing community supervision of offenders convicted of certain sex crimes throughout the course of their life. The rationale for lifetime supervision is based on several assumptions, including:

- Sex offending can be a life-long, chronic pattern of abusive behavior;
- SOs can often control sex offending behavior, but do not always voluntarily choose to;
- Lengthy probation or parole terms allow supervising officers to respond diligently to offender risks and needs; and
- It is wiser to decrease probation terms as offenders progress than to lack the ability to increase them when more supervision and surveillance is necessary.

Proponents of lifetime supervision assert that sex offending is multi-generational in nature and that future victimization may be avoided through ongoing and extended surveillance and treatment. Such close supervision and surveillance may also improve supervision officers' ability to prevent or detect changes in offenders' behavior patterns, crossover to other types of sex offending, lifestyle changes, or a shift to a new victim group.

2. Community Notification

Community notification legislation enacted around the nation mandates that law enforcement and other officials notify various community members (the scope of community members who are notified typically varies based on SOs' perceived levels of risk to reoffend) when a convicted offender is living in their neighborhood. Community notification can be implemented as a component of a successful approach to community supervision.

While methods vary among jurisdictions, one innovation in community notification involves assigning probation or parole agents – the very individuals who will be responsible for supervising SOs in the community – to conduct community notification. This approach can guarantee that a knowledgeable community corrections agent will be given a forum in which he or she can dispense sound information about offenders, their patterns of sex offending behavior, and how community members can best protect themselves against victimization. It also can empower the supervision agency to intervene in any potential conflicts between the community and the offender, which would likely be detrimental to the offender's successful community reintegration. This approach leaves discretion to the parole or probation officer so a notification plan can be developed according to the offender’s specific offending patterns. Supervision agents can also encourage community members to contact them should any suspicious behavior or other questions or concerns surface.

Some jurisdictions are also using community notification as an opportunity to involve victim advocates in the process of community education about SOs. While probation or law enforcement officers can dispense information to community members about notification laws, known offenders living in their neighborhood, patterns of sex offending behavior, and whom to contact if they notice suspicious behavior, advocates offer the community a wealth of experience in prevention education. They can increase residents’ understanding of this crime; provide them with facts concerning who is at risk for victimization and by whom (since convicted offenders represent only a subgroup of the actual population of SOs); and discuss practical strategies to reduce the risk of being sexually侵害.
assaulted. They can also assist justice system officials in addressing resident concerns, while helping to allay fears and reduce the possibility of vigilantism against offenders.

G. Registration and Notification

1. Introduction

Sexual victimization has become one of the most publicized and researched social problems in society. However, potential linkages between the intended and unintended effects of sex offender management legislation have gone largely unaddressed in social science literature. Sensationalized sex offense cases have understandably shocked and angered our society. In many cases, the public response appears to have been more emotional than logical. During the 1990s, many legislative actions regarding SOs resulted from emotional public response to violent crime rather than from research showing that these laws would make any positive difference in correcting the problem and reducing crime. The laws sound and feel good when they are passed, but they may give citizens a false sense of security.

The emotionally charged nature of the problem of sexual victimization, combined with what is often extreme pressure from interest groups and the general public to “do something,” limits and narrows the discourse on this issue within the legislative process. Unlike legislative issues such as insurance regulation or seat-belt laws, the phenomenon of sexual abuse is intertwined with a strong emotionalism that exacts an almost visceral response in nearly everyone, and some believe that this emotionalism has confounded our lawmakers’ collective abilities to separate legislative proposals that are functionally efficacious from those that are certainly well-intentioned but are nonetheless unsuccessful. In essence, those who do not espouse or who seriously question the dominant values and assumptions that drive popular legislation in this area are faced with the prospect of being labeled “soft” on or sympathetic to SOs, or worse. As such, the first problem associated with how lawmakers think about SOs is inextricably tied to the emotional responses virtually everyone has to offender criminal behavior in particular and to the subject of sexual abuse in general.

Sex offender laws take four forms: sentencing enhancements for certain classes of offenders, sexual predator laws, registration, and community notification.

- **Sentencing Enhancements**
  Some sentencing statutes provide for longer terms of imprisonment for certain classes of dangerous offenders, including predatory SOs and those with previous convictions for sex offenses.

- **Sexual Predator Laws**
  Sexual predator laws authorize the continued detention of SOs beyond the time served for a criminal sentence. Because they are only invoked after the offender has served a criminal sentence, they operate as a last resort to confine offenders who cannot otherwise be detained under criminal or mental health laws. Unlike the earlier sexual psychopath laws, which were justified as an alternative to incarceration and punishment, sexual predator laws are used to confine a group understood to be “the worst of the worst” for an indefinite period of time.

- **Registration**
  Convicted SOs are required to register with the police after release from prison, parole, or probation, and to provide a range of identifying information.
Community Notification

Community notification laws authorize the public disclosure of a SO’s personal information to people and organizations in the local community in which the ex-offender resides. In the United States, these laws are justified as a way to increase public safety (via informing citizens about SOs who live in their area) and to assist law enforcement in the investigation of sex offenses.

In 1994, the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act was enacted, which required all states to establish stringent registration programs for sex offenders by September 1997, including the identification and registration of lifelong sexual predators. This national law was designed to protect children and was named after Jacob Wetterling, an eleven-year old boy who was kidnapped in October 1989. Megan’s Law, the first amendment to the Jacob Wetterling Act, was passed in October 1996. Megan’s Law mandated all states to develop notification protocols that allow public access to information about sex offenders in the community.24

Public notification laws seem logical to their supporters. They give the impression of making people feel safer and of being a workable solution to the child sexual abuse problem. Megan’s Law was developed to alert the public, specifically members of the local community, that they are living in the presence of a dangerous sex offender. The intent was to increase community awareness through these laws so that: (1) parents would be able to inform their children about who is dangerous and whom to avoid; and (2) notification of the public would reduce the likelihood that the SO would reoffend, because everyone would know that he/she is a sex offender, and it would be more difficult for him/her to lure a potential victim.25

2. Positive Aspects

Registration and notification legislation has been the subject of much research since the Jacob Wetterling Act and Megan’s Law were passed. As with most legislation, registration and notification laws have proponents and opponents.

Notification proponents believe that, by informing the public about the presence of an SO in the community, neighbors will be able to take action to protect themselves from SOs by keeping themselves – and their children – out of harm’s way. As a result, notification, according to one commentator, “could prevent some tragedies from happening again.” Notification is also thought to improve public safety because the public will be able identify and report risky behaviors by SOs (e.g. conversing with children, buying sex-oriented magazines) that might escalate into criminal behavior if ignored.26

Among the benefits that have been claimed in the United States for community notification are these:

- It will promote greater interagency collaboration by law enforcement.
- It will develop stronger bonds between law enforcement and members of the general community with greater contact in educating the public about SOs.
- Members of the public are better able to protect themselves and their children, when they know a convicted SO resides in the neighborhood.27

Only one study was found that has examined empirically whether notification protects the public by reducing recidivism. A report prepared for the Washington State Institute for Public Policy compared the number of arrests for new sex offenses among 90 offenders subject to notification
with arrests for sex offenses among 90 offenders not subject to notification. At the end of 54 months, there was no statistically significant difference in the arrest rates for sex offenses between the two groups (19 percent versus 22 percent). However, the study did find that notification had an effect on the time of the next arrest for any type of offense: offenders subject to notification were arrested for new crimes much more quickly than were offenders not subject to notification.\(^\text{28}\)

Based on site visits conducted in thirteen jurisdictions in six states, a co-author of the multi-state community notification study published by the American Probation and Parole Association concluded that:

The threat of community disclosure is the greatest contribution of notification as a tool for managing sex offenders in the community. That is, an immense value of the law is that the threat of notification can act as a catalyst for sex offenders to participate actively in treatment, remain employed, and comply with special conditions of their community placement. Notification becomes one more tool, along with curfews, the polygraph, and special restrictions, to manage sex offenders in community settings.\(^\text{29}\)

Nearly all (agencies consulted) reported that notification is a useful tool for educating the public about the nature of sex offenses.\(^\text{30}\)

3. Negative Aspects

An examination of the literature regarding registration and notification suggests that the majority of the research that has been done in this area has focused on the negative aspects of these practices. The following is an overview of many of the negative consequences of registration and notifications laws, many of which were unforeseen and unintended.

- False Sense of Security
  Public notification is an easy solution to the highly emotional issue of sexual offending. The very nature of the law leads one to believe that by knowing where SOs live, one will feel safer. However, safety is more than knowing. Some people feel more anxious knowing they now live near a convicted SO. Others cannot sell their homes when they want to move and known SOs are residing in nearby housing.\(^\text{31}\) Agencies and commentators suggest that community notification can create a false sense of security in communities by leading residents to conclude that now that they know about the SOs in their midst, they no longer have to worry about the problem.\(^\text{32}\)

- Extension to Other Crimes
  Despite the horrific nature of sexual offenses, many other types of crimes also result in severe damage to innocent victims. One might question why SOs should be singled out for registration and notification. Many other crimes cause severe harm to others, including children. Nonsexual child maltreatment can be just as devastating to a child as sexual abuse.\(^\text{33}\)

- Decrease in Reporting
  There is both growing concern and some preliminary evidence that community notification laws may be affecting the occurrence of and the reporting of domestic child sexual abuse. Researchers have known for years that the vast majority of incest continues to go unreported, and according to Freeman-Longo (1996), recent reports from New Jersey (where notification laws were first enacted) as well as in Colorado suggest a decrease in the reporting of both incest offenses and juvenile sexual
offenses by victims and by family members who do not want to deal with the impact of public notification on their family.  

Sexual abuse within the family is an intensely private and sensitive matter, the exposure of which can shroud the family in feelings of shame, guilt, and embarrassment. Even before the enactment of notification laws, the child victim as well as the non-offending spouse faced the emotionally miserable choice of reporting the abuse or remaining silent.  

It is not unreasonable to consider how the reality of public notification may further discourage a victim or non-offending relative from seeking assistance, as notification affects the entire family unit, not just the offender. Furthermore, a domestic SO may even use the specter of public notification as a tool against the victim and other members of the household to secure their silence. Although the majority of states have tailored the most severe and comprehensive components of their notification procedures to exclude, in most cases, intrafamilial abusers, federal guidelines have now mandated that the names and addresses of all known SOs be posted on the Internet, essentially exposing both domestic abusers and their victims, and states that do not comply with these guidelines will lose valuable criminal-justice and crime-prevention funding.  

An additional reason we should consider the impact of notification laws on family systems is tied to the fact that researchers have found that the vast majority of abuse occurs within the home and that the majority of such abuse continues to go unreported. Unfortunately, such laws are likely to increase the already common public misperception that child sexual abuse is mostly a "stranger" problem. When this occurs, parental attention is focused toward the nonfamilial offender and away from the familial environment where the majority of sexual abuse occurs. For example, although little Mary's mother may repeatedly warn her 11-year-old daughter to avoid the park located near the home of a known offender, she may not be appropriately sensitized to recognize the cues given by Mary when she begs not to be left alone with her stepdad when mom goes shopping.  

Members of an SO's family are often exposed to community reaction in any number of ways. This is particularly true for an offender's children, who often face extremely difficult questions or taunts from their peers when the offender's address is made public. Of course, if the offender's victims were or included a family member, public notification can result in further trauma to the person sexually victimized. As Freeman-Longo suggests, "It is not fair to non-offending persons to impact their lives negatively by advertising that their spouse or relative is a sexual offender. These laws have tremendous potential to victimize non-offending citizens" (p. 93). Additionally, these are not concerns that can be discounted or explained away as reasonable trade-offs when weighing the rights of society against the rights of the offender, as non-offending relatives are both indirect victims of the offender's past behavior as well as citizens with rights.  

- Primary Prevention  
The best way to stop sexual abuse is to prevent it before it begins. Public notification laws are tertiary prevention efforts at best, and the antithesis of prevention at their worst. When laws result in a decrease in reporting of a particular crime, increased plea-bargaining, and causing harm to innocent people, they cannot be seen as preventive. The arguments used over and over again in favor of SO registration and notification laws has been that if they save one child, they are worth it. But is any law worth harming others, especially innocent persons, for the sake of one?  
Megan’s law has done little to protect people and prevent crimes. If, in fact, these laws are protecting people and preventing crimes, then this should be documented as states review the impact of Megan’s Law and SO registration. To date, there is little, if any, published evidence that Megan’s Law and/or SO is having any impact on reducing child sexual abuse.
A major limitation of community notification laws is that they focus on a relatively rare form of sexual assault. They target strangers who victimize children, when all available evidence shows that child sexual victims are most likely to be victimized by those they know and that the most frequent victims of sexual violence are young adult women.40

If, for whatever reason, a released offender begins on a path toward reoffending, the next logical question to consider is where a new offense is likely to occur, which, of course, raises an additional concern as to who might be victimized. One of the most persistent criticisms of community notification laws is the contention that offenders who are known in a given neighborhood are more likely (than before such laws were enacted) to victimize in another community where they are not known. That is not to say that from a very narrow perspective the initial legislative premise that released offenders may be inclined to reoffend in their own neighborhoods is not sound.41

A possible relapse in another neighborhood creates two distinct problems above and beyond the relapse itself. First, the vast majority of nonfamilial, child-oriented sex offenders rely on befriending and "grooming" their victims while also having regular access to them. But if an individual finds himself offending in another neighborhood for the reasons described above, it is reasonable to expect that the new offense will manifest itself in a way that appears more stranger-related and perhaps significantly different than the offender's prior behavioral assault pattern.42

In their research examining the potential effectiveness of notification laws on previous cases, Petrosino and Petrosino (1999) agreed that restricting an offender's usual access to children might displace such offenders toward committing predatory acts against children whom they do not know. Of course one has to accept the idea that current law is exacerbating the psychosocial stressors of released offenders, and that many otherwise well-intentioned offenders will be unable to handle the increased ostracism and isolation that in turn may push them toward committing new (and more predatory) offenses. Nonetheless, it is interesting that community notification laws may have the real potential to increase the very offenses most feared by parents, and those most difficult to investigate and solve.43

Finally, the inherent limitations of notification need to be recognized. In particular, notification is unlikely to have much, if any, deterrent effect with offenders who have not yet been arrested or who victimize within homes where other members of the family collude in the behavior.44

- Cost

Public notification requires continuous monitoring by public service agencies (police, courts, and probation and parole agencies) to ensure offender compliance. All states have had to finance the costs of this mandated law (which did not come with funding for implementation). States face losing federal funding if they do not implement the law, but they often do not have the resources necessary to implement it properly. Many states report that the registered addresses are not updated, and in many cases, incorrect addresses have been given. Many states post these on the Internet, listing innocent people’s addresses as those of convicted sex offenders.45

In addition, doing notification is very time consuming and burdensome. One detective in Washington State explained that “At the beginning, no one realized the staffing impact of this legislation; it’s a monster.” Furthermore, probation officers in some States are not given reduced caseloads to compensate for the labor-intensive supervision of SOs. It has been noted that the work is especially burdensome because if an offender moves – sometimes a frequent occurrence – the probation officer has to implement the notification process all over again.46

- Misplaced Responsibility
Public notification places responsibility for community safety and appropriate individual contact on the community instead of the offender. Treatment is most effective when offenders are required to take total responsibility for their behavior.

Several examples illustrate that these laws are having an impact on SO treatment, and in some cases, they are resulting in SOs not getting treatment at all. In the absence of treatment, SOs will never learn to take responsibility for their behavior and stop the abuse. Unfortunately, SO registration and notification laws are impacting quality SO treatment in many states, continuing to put the responsibility for personal safety on potential victims, existing victims, and society – where the responsibility has been all along. These laws have demonstrated their ability to prevent sex crimes or make communities safer, and it is not likely they will if the first five years have not been able to demonstrate such.47

- Undermining Treatment

The majority of SO treatment specialists identify similar problem areas for SO clients, including (but not limited to) poor anger management skills, fear, lack of trust, low self-esteem, feelings of rejection, inadequate social skills, lack of empathy, isolation from others, and poor communication skills. These skills need to be improved, and that happens when SOs have good community support systems and close ties in the community.48

The emergence of community notification legislation as well as the risk-assessment profiling procedures now in place are likely to have a deleterious effect on many offenders with regard to their willingness to participate in the treatment program. According to Winick, sexual predator and community notification laws may be providing a strong disincentive for sex offenders to plead guilty to their crimes and to accept treatment. Long sentences (and the threat of civil commitment in some states) provide a defendant with greater incentives for fighting the charges or at least not providing an admission of guilt, while making the judicial process that much harder on their victims. In many states, current parole and probation policies have already affected treatment participation rates in that parole and probation hearings for most types of SOs rarely result in early release. Because of this, many inmates have said "Why bother signing up for treatment?"49

Unfortunately, risk-assessment profiling and community notification laws may affect an offender's desire to address his/her problem through prison-based treatment. Offenders may feel that no matter what they do, they are still going to face the same postrelease exposure, scrutiny, and ostracism associated with high-risk assessments and community notification measures, whether they attend a treatment program or not.50

According to Winick, community registration and notification laws communicate to society a message that SOs cannot be controlled, which may also inhibit attempts of SOs themselves to control their behavior or seek treatment. What follows is a series of proposals aimed at addressing many of the latent consequences examined in previous sections. A paramount theme to these suggestions is that society in general and legislators in particular must face the fact that recent sex offender management legislation has effectively altered the offender's postrelease environment as well as the offender's perceptions about treatment.51

Increasingly punitive strategies for addressing offender behavior – including lengthier sentences and the now commonplace legislatively mandated parole or early release ineligibility for SOs once imprisoned – have resulted in a nationwide trend in which incarcerated SOs are given little, if any, incentive to face their problems while in prison. Because populist punitiveness has become exceedingly hostile toward the medicalization of sex offending, the "carrots" of potential rehabilitation and redemption have been effectively excised from such offenders' internalized feelings about their own potential for self-transformation and change.52
• Limiting of the Offender’s Ability to Function in the Community

Sex offenders need to learn appropriate skills that assist them in functioning appropriately and safely in the community. In the absence of these skills they do not function well and are at greater risk of reoffending. Threats, harassment, and fear of reprisal by citizens keep the offender in a state of stress and anxiety and, thus, more likely to reoffend. To function in the community, the offender has to feel a part of the community like anyone else. Sex offender registration and public notification laws compromise the SO’s ability to do so in a healthy and safe way.53

Several commentators assert that notification makes it difficult for offenders to find a place to live, find and hold jobs, and reintegrate into society.54 Not only do sex offenders face probable discrimination by employers due to their criminal records, but when notification involves disclosure to the general public, employers are less likely to employ an SO due to a fear of loss of business from an informed public. Indeed, community notification may have the effect of increasing offending.55

Society has adopted two unfortunate practices when faced with sex crime and SO legislation. First, society itself – and by extension, its lawmakers – has gradually adopted a one-dimensional image of what an SO is, and one that is generally limited to his or her deviant behavior. The label of sex offender becomes a master status whereas the variety and diversity of the offender’s other behaviors and identities are summarily obscured. Legislation affecting such offenders tends to focus exclusively on managing our image of such persons while ignoring the crucial areas of day-to-day, basic human functioning that are often negatively affected.56

For example, although laws requiring community notification on an offender’s release from prison may (to various degrees) successfully address deviant propensities, they often do not address or even consider the offender’s ability to successfully reintegrate into society or to obtain even the most basic human needs such as shelter, social contact and assistance, and employment. All of these are, in fact, made much more difficult for released sex offenders under the thumb of such laws. This failure to see SOs as whole persons negatively affects our ability to enact successful legislation to manage the problematic aspects of their complex human experiences, needs, and behaviors.57

To fully understand the impact of notification laws, it is essential that their impact on the released offender’s psychosocial needs be evaluated, because an offender's success at reinteg ration is a necessary component to protecting society at large. It was earlier suggested that we tend to view SOs as one-dimensional creatures, and this perception is crucial to understanding why offenders' psychosocial needs have been ignored in the formation of previous legislation.58

The post-release environment for newly released SOs is highly stigmatized, isolated, and stressful. Although it is vital for the released offender to reintegrate into a given community in a way that allows him or her to find employment and form positive adult supportive relationships, the intense stigma and shame surrounding the offender's prior behavior as well as the ever-present label of “sex offender” make these crucial adjustments extremely difficult and stressful as things stand now.59

SOs do not simply decide to sexually offend, but instead react to one or more emotional triggers that result in a heightened level of anxiety, which in turn can result in a worsening pattern of poor decision making leading to a relapse event. Researchers and therapists have identified stress and isolation as two particularly important emotional triggers in relapse occurrences. Often such feelings, if intense enough, can lead even previously treated and well-intentioned offenders toward a pattern of escape and into a cognitively distorted cycle of decision-making that increases their vulnerability toward reoffending.60
Although it is understandable that few feel sorry for the plight of SOs, it is nonetheless irrational and irresponsible to ignore the kind of postrelease environment such laws have created for newly released offenders. Most individuals take for granted having a roof over their heads and a wide social-supportive structure of family, relatives, and friends on whom they can rely and who rely on them. But the social-supportive postrelease environment for high-risk sex offenders under community notification laws is something quite different. Many released SOs have served long sentences and are emerging from a closed institutional environment in which food, housing, medical care, emotional and social support, and acceptance were both routinized and consistent. Most have little or no familial support system in place on release, and for those who do, such relationships are severely strained under the thumb of such laws because the community's ostracism of the offender now often extends to anyone willing to support or assist him or her. Add to this situational environment an offender who may be predisposed to low self-esteem, inadequate social skills, and/or poor communication skills, and what emerges is a postrelease environment that is replete with anxiety and stress and which very quickly may deteriorate into hopelessness and severe negative emotional states.61

In short, public notification laws make it extremely difficult for the offender to develop new social-supportive contacts or maintain established ones, and those that are developed or maintained are often precarious and dependent on the offender's consistent and unwavering appearance of making successful adjustments, maintaining appropriate behaviors, and having positive attitudinal characteristics. Under such laws, the message to a newly released offender is that "your problems are your own, and you'd better not screw up!"62

Researchers have conducted interviews with SOs to gather their impressions of notification legislation. Only a few of the interviewed offenders thought that the new law on community notification would prevent reoffending by making sex offenders' actions more visible to the public. Most believed that the law would have no deterrent future law violations. The following response (from offenders) was typical:

If you're going to reoffend, it doesn't matter if you're on TV, in the newspaper, whatever, you're going to reoffend. And there's nothing to stop you. It's a choice you make…The only person that can stop it is the sex offender himself. And that's one of the choices he makes. If he chooses not to offend anymore and he chooses to take part in treatment and deal with the situation like a real human being and to have empathy in his life, then we won't reoffend.63

Some interview subjects were of the opinion that notification laws would even have the opposite effect. As one SO explained:

If you have any familiarity with links and patterns of the cycle of sexual offense, much of it revolves around an individual being under pressure and his behavior under pressure. Well, there is no more pressure than being exploited by the media, the people you work with, the people you live with, relatives, and so the pressure is constantly there. And because they’re [sex offenders] miserable, then that would put them in that cycle to recommit an offense.

Another put it even more bluntly:

If these people know that you’re a sex offender and they keep saying—keep pointing at you and everything else, everything breaks under pressure, everything. No matter what. No matter how strong he thinks he is. You taunt a dog long enough, no matter how
calm and cool-calm collected that dog might have been the whole time, it might have been the most loving dog with children and everything else, but you taunt that dog long enough, it’s going to bite. And that’s exactly what this law does. It makes John Q. Public taunt the sex offenders. And sooner or later something is going to snap.

Others drew from their own embittered experience with community notification in suggesting that the tremendous pressure placed on SOs by the public and the media would drive many back to prison. For most offenders in the sample, their overall reaction to the law was negative. The law was regarded as a “public humiliation,” or “another obstacle to overcome.” For others, it was viewed as an “insurmountable obstacle,” preventing their chance to ever succeed in society.

The effects of community notification on SOs who have experienced this disclosure process were most profound in those cases where the news media were involved. More than anything else, SOs were disturbed with media coverage of their post-release circumstances. Publicity about the details of their crimes, including those situations where family members had been victims, greatly disturbed respondents. In such cases, public disclosure of the crime may undermine the therapy of offender and victim alike. While most newspaper and news broadcasts have acted responsibly, many have not.

- Mentally Ill Sex Offenders
  A small percentage of offenders sexually abuse in part because they suffer from a biological anomaly or a mental illness. Despite this handicap, and the need to be sensitive to people with mental illnesses, once a mentally ill sex offender is registered or subject to notification, they are treated with same level of disrespect and disregard as other SOs.

- Misguided
  Portions of the Jacob Wetterling Act, including Megan’s Law, are examples of legislation that was passed quickly, without securing public opinion through polls or community meetings. Necessary, detailed research was not conducted into the cost involved, the resources necessary to implement the laws, and the potential impact on law-abiding citizens. Professionals working with and treating sexual abusers and the national organizations that focus on sexual aggression were not contacted or asked for input into these laws.

  In contrast to other areas of legislation where old ideas are repeatedly questioned and issues constantly reinterpreted, legislative actions regarding SOs have grown out of core assumptions that have yielded a legislative paradigm of punitiveness. Instead of reevaluating these core assumptions when considering a new legislation, public opinion, limited and biased informational resources, and the political environment itself allow new legislation to be supported by a series of fundamental beliefs about the problem of sex offending that often lead to ineffective laws at best or laws that exacerbate the problem at worst.

- Lack of Supporting Data Determining the Efficacy of Public Notification
  At the time this paper was written, states with public notification laws had not yet offered scientific evidence to support the efficacy of such laws in promoting community protection and safety. Washington is the only state that has researched the efficacy of its public notification law. They found no reduction in sex crimes against children; however a benefit was the level of community education regarding sex crimes. At this writing, there are no other published studies that demonstrate the efficacy of Megan’s Law.
Summary

There is no doubt that unexpected problems and blatant abuses of SO registration and notification laws have occurred. Many of these were foreseeable and could have been avoided with more planning, research, and forethought about potential problems. The laws need to be more uniform between states, less punitive and destructive to SOs, less destructive to the lives of innocent persons, and more preventive (even though prevention will only occur in a limited way with these laws). Until we look at them closely and research their potential effectiveness, there is concern that laws designed to protect our citizens may, instead, do more damage than if they did not exist at all.

H. Risk Assessment

i. Introduction

Risk assessment, the process of analyzing a party to a legal action to determine the potential for future harm in order to protect others, occurs routinely in the legal system, despite decades of social scientists’ concerns about the accuracy of the process. Particularly in criminal justice settings, risk assessment permeates many proceedings, ranging from juvenile preventative detention to bail hearings to sentencing. Risk assessment is ubiquitous, occurring at every stage and in every venue of the criminal justice system. Sex offenders, however, present special challenges. The public treats sex offenders differently from other offenders; special treatment programs, indefinite detention (i.e., civil commitment), and warning systems (i.e., community notification) are devised for them. Few offenses arouse more public outrage than sex offenses, especially when combined with extreme physical harm to the victim.

SOs are typically considered to fall into one of the following risk categories:

Category 1: Low risk. Few risk factors are present. No further inquiry into violence risk or special preventative actions are indicated.

Category 2: Moderate risk. Several risk factors are present. Gather additional information, and monitor the individual more closely than usual.

Category 3: High risk. A number of key risk factors are present. Give priority to gathering additional information and monitoring the patient closely. Make preparations for preventative action should the situation deteriorate.

Category 4: Very high risk. Many key risk factors are present. Enough information is available to make a decision. Take preventative action now (e.g., intense case management or treatment, voluntary or involuntary hospitalization, and warning the potential victim).

There are two basic approaches that are used to assess the risk posed by an SO, and in particular, his/her risk of reoffending. The first is “actuarial”; it is the collection of a large amount of static historical data in the belief that knowing enough about an individual’s past will enable one to predict his/her future. The second is often referred to as “clinical” and is based primarily on the anecdotal experience a clinician may have of individuals who are assumed to belong to a certain type.

The argument over which type of approach to use has a long history, stretching back decades. Unfortunately, practice does not always keep up with research. The research literature heavily favors actuarial criteria; nonetheless, much expert violence risk prediction
involves informal, intuitive clinical criteria. Although neither method has proven particularly successful, each has its supporters who typically argue that all that is needed is an improvement in technique. However, given the low base rate of sex offending behavior, the heterogeneity of sexual offenders, and the variety of contexts in which sex offences occur, it is difficult to see how either an actuarial or a clinical approach on its own can, even in theory, provide a reliable means of assessing risk in sexual offenders.

**ii. Actuarial Approach**

In terms of identifying men who are at low risk of reconviction, the actuarial approach appears to be successful. In terms of identifying those at high risk, however, the actuarial data is of less help. Although it may pick out a group who are a higher risk, it tells us little about individual men. Among those who are judged to be of highest risk (i.e., men with a current offense of general violence and who have three or four risk factors for general violence), the most we can typically say is that one out of two of them will go on to reoffend. Thus, when the group is identified, the degree of certainty in prediction within it is no better than flipping a coin.

Supporters of actuarial approaches are constantly searching for more and better variables to enter into the risk assessment algorithm. The authors of a Canadian study claim that a risk score based on nine variables can produce an estimate of the probability of reoffending by serious sexual offenders that, in the case of those with high scores, approaches unity. Not surprisingly, the most important of these variables are the number of previous sex offense convictions and the number of previous prison sentences. However, also contributing to the risk score are the psychopathy rating derived from the Psychopathy Checklist, the number of past violent convictions, a history of never having been married, having a female victim, having a male child victim, deviance (derived from penile plethysmography evaluation), and having fewer convictions for theft-related offenses.

This study highlights well the fundamental defects inherent in the actuarial approach. First, it is wholly empirically driven, and as a consequence, it gives us no reason to believe that findings from one population can be generalized to another. Second is the implication that human beings are entirely a function of their histories: static historical data does not change, which means that regardless of treatment or maturity, the risk of reoffending remains unaltered. Both these objections, however, are practical ones that can be overcome. A more crucial difficulty arises because actuarial prediction is about groups that, in the context of low frequency behaviors, provides relatively little value in respect to the individuals in those groups.

**iii. Clinical Approach**

Sexual offenders are not simply bundles of variables. Data that is important to actuaries may have little meaning in its own right, but it may become useful when one asks what it indicates about an individual. It makes sense that men who have offended against boys on a number of occasions should be of higher risk of doing so again because this type of behavior suggests a more dedicated type of pedophile – one who is either unable or unwilling to keep his behavior hidden. Similar to this, it is understandable that those with more deviant phallometric profiles might be at greater risk of offending than those without such profiles because in practice these profiles will necessarily involve illegal behavior.
It is explanations of this kind on which those who advocate more clinical approaches to the assessment of risk rely. Their problem is that they tend to come to this explanation in an inductive manner (i.e., based on their experience), that will be based on only a few offenders, particularly those remembered most vividly.81

One of the best known clinical descriptions of serious sex offenders is Brittain's (1970) account of the typical sadistic murderer. Relying explicitly on clinical anecdote and experience rather than on research, he characterized the sadistic murderer as an introverted, timid, over-controlled, and socially isolated man who was over-dependent on a mother with whom he had an ambivalent relationship. He claimed that this type of offender was sexually prudish, reserved, and inexperienced, but sexually deviant, with a rich sadistic fantasy life and an interest in violence. Brittain said these men were obsessive and hypochondriacal and that they had low self-esteem combined with great vanity; he suggested that the sadistic killer usually offended after he had received a blow to his self-esteem.82

If this description really does pick out a well-defined class of individuals, then it provides a wealth of characteristics to look for when assessing individuals who are thought to be at high risk of killing in a sexual context. But does it? The first problem with Brittain's account is that it is unclear just how many of these factors are either necessary or sufficient before one should classify an individual as a potential sadistic killer or if any one factor should be considered more important than any other. For example, if a man does not have an ambivalent relationship with his mother, does this mean it is unlikely that he will become a sadistic killer? Or if he is introverted, sexually prudish, and has a sadistic fantasy life, does this mean that he will?83

It is interesting that Brittain's description has never been tested. This may be because it sounds good; it fits many of our preconceived ideas of what a sadistic killer should be like. However, we do not know whether these characteristics identify sadistic killers any more reliably than they do non-sadistic sexual offenders, murderers in general, thieves, or university students. This is not to say, of course, that Brittain's description should be dismissed out of hand, only that at present, it is perhaps best regarded as literature rather than science. Research from a clinical perspective has been limited, and Brittain's description is often quoted as if it has been validated.84

In the early 1980s, researchers began to focus on one of the factors noted by Brittain: fantasy. An important early study in relation to this looked at a sample of 13 sadistic offenders in an English special hospital (MacCulloch, Snowden, Wood, & Mills, 1983). These authors described a pattern in which sadistic sexual fantasies led to behavioral practices related to these fantasies/practices such as following women in the street or hiding weapons along the route a potential victim might travel. These behavioral practices then fed into the fantasies, each propelling the other so that fantasy and behavior progressed together, leading finally to sadistic sexual offending. It was argued that offending in these men occurred in the absence of external stimuli, contrary to Brittain's claim that offending occurred after a blow to the offender's self-esteem. MacCulloch et al. observed that their subjects sought out or created situations in which they could gain control over their victims in a way that reflected their fantasy lives.85
In some ways, these observations – that fantasy and behavior interact and each is related to risk in sadistic offenders – are obvious, but because research into sex offending had become so preoccupied with attitudes, interpersonal dynamics, and cultural norms, the notion that thoughts could influence behavior must have come as a great revelation to many at the time.  

Fortunately there has been sustained interest in sex offender risk assessment for the past two decades, and this enduring research interest has generated some consistent predictors of SO recidivism. Perhaps the most thoroughly researched area has been personality factors associated with SO recidivism. Two broad areas have emerged from this literature: strength of illegal deviant sexual interest and psychopathy.  

### iv. Consistent Predictors of Sex Offender Recidivism

- **Strength of illegal sexual interest.**  Strength of deviant sexual interest – or extent of fixation on the deviant sexual object or sexual mode (such as use of force) – has uniformly, and not surprisingly, been found to be associated with higher recidivism. Intuitively, one would expect those offenders whose deviant sexual interest pattern is deeply embedded in their lives to be more prone to relapse, and this has been found to be the case. It is possible to assess fixation through a number of methods.

  The first direct assessment method is phallometry, or physiological monitoring of erection response when the individual views or listens to diverse sexual stimuli. Clinically, sex offenders – especially highly compulsive offenders – have been found to ruminate over sexual fantasies involving the offense pattern, and phallometric assessments have been among the most successful at discriminating between groups of sex offenders and non-offenders. Additionally, those sex offenders with the most deviant phallometry patterns – hence having the most deviant sexual arousal patterns – have been found to have the highest recidivism and to be the most unresponsive to treatment.

  Phallometry, however, requires a laboratory and trained staff. Fortunately there are a number of more easily obtained measures of fixation that are well supported in the empirical literature. A variety of studies has found the following to be associated with sex offender relapse: number and chronicity of prior sex offenses (including age of onset), frequency of prior sex offending, choice of victim-related avocation or vocation, use of force, and intercourse during offense. Taken together, such factors point to a high level of sexual fixation. Such factors are readily obtained from archival data, thus circumventing the need for highly trained professional staff in gathering risk assessment information.

  Additionally, a number of studies have found that never having married strongly predicts recidivism. Never having been married is consistent with a strong deviant sexual preference – such as for children or for coercive sex – and as such would be consistent with a finding of high sexual fixation.

- **Psychopathy**

  Psychopathy has been studied for many years, formally since Cleckley’s seminal work in the 1940s. Today the gold standard for assessing psychopathy is Hare’s Psychopathy Checklist-
Revised (PCL-R). The PCL-R is divided into two broad factors, the first being a psychopathic personality style (egocentric, glib, callous, exploitive), and the second being a history of impulsive, antisocial behavior (childhood conduct problems, breadth of criminal history, irresponsibility, revocation of conditional release). Research uniformly indicates that SOs who are more psychopathic recidivate sooner, more frequently, and more violently than less psychopathic SOs. One study found that more psychopathic offenders were the very offenders who also had the most deviant sexual arousal patterns as assessed by phallometry.

Like phallometry, obtaining a PCL-R requires trained staff, and is therefore not easily obtained. Again, fortunately, there are many more easily obtained archival measures associated with either an antisocial personality or a lifestyle that are empirically associated with sex offender recidivism, particularly violent recidivism: prior violent offenses, childhood conduct problems, failure on prior conditional release, prior non-sexual offenses, alcohol abuse history, and general lifestyle impulsivity.

- Involvement in treatment
Although there continues to be disagreement about the effectiveness of sex offender treatment, recent reviews indicate that such treatment is reasonably, although not perfectly, effective. A recent meta-analysis found that treatment reduces the average sex offender recidivism rate from 27% to 17%, and other studies have found similar treatment effects. Additionally, there is evidence that retention in treatment is positively related to lower recidivism, with treatment dropouts having higher recidivism.

Over the past 20 years, sex offender treatment has converged on a common cognitive-behavioral/relapse prevention approach, with 88% of treatment programs in North America espousing some variant of this approach. Common elements of such programs include victim empathy, relapse prevention training, social skills training, sexual assault cycle identification, cognitive distortion modification, and sexual reconditioning. This approach is not only the most common, but also the most empirically tested.

Reactions of offenders to treatment have been found to be related to the likelihood of recidivism. Various studies have found, for instance, that the following are associated with lower recidivism: offenders who endorse treatment goals of reducing attraction to deviant, illegal sexual activity, maintaining or enhancing sexual attraction to adult consensual sex, and increasing communication with adults, and offenders who after treatment are better able to identify risk factors to offending.

However, even here the personality-based risk factors exert power. For example, research has shown that those SOs most likely to reoffend despite involvement in treatment are, not surprisingly, those most psychopathic and those most sexually fixated offenders, who tend to be the least responsive to treatment.

- Supportive environment
Helpful environmental factors include a supportive family and a stable and appropriate job and residence, all of which reduce the likelihood of reoffense. Authorities on risk assessment have recommended for many years that such environmental variables be studied and included in predictive equations.
To a certain extent these environmental variables can be considered results of personality variables such as an antisocial, impulsive lifestyle and lack of social competence. That is, those individuals who are impulsive and antisocial or who lack social competence are more likely to create for themselves environments in which they are unmarried, do not hold a job for long, and have no stable residence.

Some questions in risk assessment involve technical issues, and these can be addressed by experts to increase the predictive accuracy of risk assessment procedures. Such questions might include: What variables best predict recidivism? What variables indicate a likelihood of positive response to treatment? What personality characteristics do these variables point to? What can be done to combine variables to yield better predictions? What offense or offender types occur with such high or low frequency as to make the use of sophisticated risk assessment procedures unnecessary?

Other questions, however, involve values, and these questions cannot be answered by risk assessment experts. This group of questions might include: Given the uncertainty of risk assessment, what level of certainty is required to use such procedures to restrict others’ freedom? Or to publicly stigmatize others as sex offenders? How does one balance the right of the community to protect itself from potential harm against the right of the individual – even a previously convicted SO – to privacy? Such questions are best addressed by legislatures and courts. One can only hope that when writing or interpreting laws that govern risk assessment, legislatures and courts act with reflection rather than haste.

All research studies concerning the determination of sex offender recidivism base rates in previously convicted sex offenders share very significant shortcomings. These shortcomings all serve potentially to under-estimate the true base rates.

I. Treatment of Adult Sex Offenders

1. Introduction

While providing services to victims of sex crimes is of great importance, of greater importance is the prevention of sex crimes and victimization from occurring in the first place. Given that we typically cannot identify SOs until they have offended, the effective prevention of further offending by identified offenders and the development of new sexual offenders is ultimately the only proactive alternative in sexual abuse prevention.

For most of the 20th century, or at least since sex offenders have been identified as a separate category of criminal offenders, incapacitation (in the form of incarceration, community supervision, or civil commitment) was the primary method of controlling sex-offending behavior. Attempts to treat sex offenders have waxed and waned during the past century, but they have done so primarily within the context of incarceration and/or civil commitment.

The first major attempt at controlling sex offenders’ behavior through treatment can be traced back to the 1930s and what has been described as the first generation of civil commitment statutes. For the most part, these state-enacted statutes mandated that individuals convicted of a sex crime who were determined to be “mentally disordered” and unable to control their sexual impulses be committed for psychiatric treatment in lieu of being incarcerated. The specific focus of these early civil commitment laws on sexually disordered individuals reflected the prevailing belief in society at
that time that sex crimes were manifestations of a mental illness that was curable. Sex offenders, therefore, were viewed as individuals who needed to be hospitalized and treated, not just punished.91

Support for psychotherapeutic approaches began to slacken in the 1950s and 1960s as tenets from behaviorism and conditioning began to emerge as dominant concepts in the field of psychological treatment.92

The first generation of civil commitment laws began to fall out of favor in the 1970s, due largely to increasing doubts regarding the efficacy of treatment for sex offenders and the belief that there were no valid or reliable means of identifying sexual psychopaths or predicting their post-release behavior. Indeed, several professional organizations representing psychiatry, mental health, and criminal justice issued calls for the repeal of these laws.93

Although psychotherapy and behavior modification treatments still remained widely used in the treatment of sex offenders, the 1970s and 1980s witnessed the emergence of two newer forms of treatment: cognitive-behavioral and medical treatments. Cognitive-behavioral programs emerged out of the so-called cognitive revolution in the behavioral and social sciences. The primary goal of these programs was the self-control of behavior through increased awareness of high-risk thought processes and improved decision-making and social skills.94

The falling out of favor and ultimate repeal of many of these laws was also reflective of a large shift in society from a rehabilitative to a retributive philosophy for dealing with criminal offenders. Accompanying the shift from rehabilitative to a retributive philosophy of punishment was a shift from indeterminate to determinate sentencing laws, legally prescribed fixed sentences for categories of crimes based on the average length of time served under indeterminate sentencing laws. The demise of the first generation of civil commitment statutes and the shift from indeterminate to determinate sentencing laws resulted in a de-emphasis on treatment, and the earlier release back into society of untreated sex offenders. The combined effect of these events and the occurrence of a number of high-profile sex-related crimes committed by released sex offenders eventually contributed to the reemergence of a second generation of sex offender civil commitment statutes in the 1990s.95

It is generally agreed that the second generation of civil commitment laws began in 1990, with the passage of Washington State’s Community Protection Act. In addition to requiring sex offenders to register with local police, the law allowed for certain sex offenders to be civilly committed after completing their full prison sentence. Throughout the 1990s, other states followed Washington’s lead by enacting similar legislation, which in essence reintroduced the indeterminate component of incapacitation for offenders determined to be sexually violent predators.96

In addition to civil commitment following incarceration, a different form of legal coercion began to appear in the mid-1990s. Sex offender registration and community notification laws required sex offenders to file regularly with state or local agencies, which then, according to the particular state’s law, either actively informed or made this information available to the communities where the sex offenders resided.97

2. Current Methods

Today, sex offender treatment is a common component of sex offender management and typically consists of three principal approaches:

- the cognitive-behavioral approach, which emphasizes changing patterns of thinking that are related to sexual offending and changing deviant patterns of arousal;
- the psycho-educational approach, which stresses increasing the offender’s concern for the victim and recognition of responsibility for their offense; and
the pharmacological approach, which is based upon the use of medication to reduce sexual arousal.

In practice, these approaches are not mutually exclusive and treatment programs are increasingly utilizing a combination of these techniques.98

Treatment providers often work under a set of ethical principles designed to guide their work. The following “Principles of the Standards of Care” have been recommended by SO treatment professionals for use by SO treatment providers.99

**Principle 1.** There is evidence that some kinds of treatment may be effective in managing and reducing recidivism with some types of sexual offenders.

**Principle 2.** Sexual offender treatment is viewed by offenders as an elective process (the choice is theirs), since individuals may not view their sexual offending behavior as psychologically or medically pathological.

**Principle 3.** The evaluation of treatment of sexual offenders requires specialized skills not usually associated with the professional training of clinical therapists or medical professionals.

**Principle 4.** Sexual offender treatment is performed for the purpose of improving quality of life and is considered a humane treatment for people who have committed a sexual offense and to prevent the patient from engaging in further sexual offending behavior.

**Principle 5.** The patient with a documented biomedical abnormality is first treated by procedures commonly accepted as appropriate for any such medical conditions before beginning, or in conjunction with, psychotherapy.

**Principle 6.** The patient having a psychiatric diagnosis (i.e., schizophrenia) is first treated by procedures commonly accepted as appropriate for the psychiatric diagnoses, or if appropriate, for both.

**Principle 7.** Sexual offender treatment may involve a variety of therapeutic approaches. It is important for professionals to keep abreast of this growing and developing field and provide the most efficacious treatments which have been demonstrated through outcome studies.

**Principle 8.** A treatment plan may involve the use of pharmacotherapy which may relieve some sexual arousal and fantasy and some individuals may feel less driven.

**Principle 9.** Professionals who work with sexual offenders should be prepared to work with the criminal justice system in a professional and cooperative manner.

**Principle 10.** Sexual offenders often have a need for follow-up treatment/visits, and this should be encouraged or possibly required.

**Principle 11.** It is unethical to charge patients for services which are essentially for research or which do not directly benefit the patient.

**Principle 12.** In order to effectively persuade the professionals in the legal community as well as society in general about the efficacy of sexual offender treatment, professionals should cooperate with and carry out scientifically sound treatment outcome research.

**Principle 13.** Sexual offenders must often face legal proceedings, and professionals treating these individuals must be prepared to appear in court if necessary.

**Principle 14.** Sexual offenders are given the same rights to medical and psychological privacies as any other patient group, with the exception of where the law requires otherwise, i.e., reporting laws, subpoenaing of records.
Principle 15. Sexual offenders should be not be discriminated against based on age, gender, race, ethnicity, national origin, religious beliefs, socio-economic status, or physical or mental disability.

Principle 16. Professionals who treat sexual offenders must view these individuals with dignity and respect. If they fail to view the offender or their offense with compassion, then the professional should make a proper referral.

3. Effectiveness

- Does Treatment Work?

A popular misconception is that “nothing can cure a sex offender.” This myth can be traced largely to a paper published by Lita Furby in 1989. Furby's paper, however, focused on the lack of sophisticated, reliable data with which to evaluate treatment regimes. It concluded only that evidence of the effectiveness of psychological treatment was inconclusive. Politicians and the mass media picked up this judgment, often converting it to the claim: "Nothing Works!"

That conclusion, however, is against the general weight of the evidence. Most research shows that sex offenders do indeed respond positively to treatment. A comprehensive analysis by Margaret Alexander of the Oshkosh Correctional Institution found far more studies reporting positive results than otherwise.

Despite the efforts of many talented clinicians through the past several decades, the question of whether sex offender treatment works is still hotly debated. Part of the problem is that relatively few well-designed studies of treatment effectiveness have been conducted. Opportunities for controlled experimentation in this field are rare, largely because of the major investment of time and resources that follow-up studies require. Also fueling the debate is the fact that although the question, "Does sex offender treatment work?" is an empirical one, nearly everyone already seems to have an answer. As a result, experts in this field – perhaps more so than in any other – find that answers based on outcome data are not always welcome.

Given these obstacles, progress in the area of determining the effectiveness of sex offender treatment has been slow. Nonetheless, it is clear that continuing efforts to measure and report treatment outcomes is the best way to improve the quality of the debate. Not only is there a need for solid information regarding the overall effect of treatment on sex offenders, but also for answers to more specific (and probably better) questions such as: Which treatments work with which kinds of offenders? What is the optimal combination of inpatient and aftercare services? How do we determine when offenders are ready for less restrictive treatment environments?

- Research Findings

Several attempts have been made to evaluate the effectiveness of treatment programs. Studies on SO recidivism vary widely in the quality and rigor of the research design, the sample of SOs and behaviors included in the study, the length of follow-up, and the criteria for success or failure. Due to these and other differences, there is often a perceived lack of consistency across studies of SO recidivism. For example, there have been varied results regarding whether the age of the offender at the time of institutional release is associated with subsequent criminal sexual behavior. Different studies have reached different conclusions, including:

- there was no relationship between age and criminal sexual behavior;
- that younger offenders were more likely to commit future crimes;
that older sex offenders are more likely to have a more developed fixation and thus are more likely to reoffend;

- that those serving longer periods of incarceration had a lower recidivism rate;
- that those serving shorter periods of incarceration had a lower recidivism rate.\textsuperscript{105}

For the most part, there is little consistency in the conclusions drawn from meta-analyses and literature reviews with regard to the effectiveness of sex offender treatment on reducing recidivism.\textsuperscript{106} The recent reviews and meta-analyses concerning the efficacy of sex offender treatment provide conflicting viewpoints. Some studies found that there was "no convincing evidence that treatment reduced recidivism" rates among sex offenders, while others concluded that treatment does positively affect recidivism among treated sex offenders.\textsuperscript{107}

Just as it is difficult to arrive at definitive conclusions regarding factors that are related to sex offender recidivism, there are similarly no definitive results regarding the effect of interventions with these offenders. Sex offender treatment programs and the results of treatment outcome studies may vary not only due to their therapeutic approach, but also by the location of the treatment (e.g., community, prison, or psychiatric facility), the seriousness of the offender’s criminal and sex offense history, the degree of self-selection (whether they chose to participate in treatment or were placed in a program), and the dropout rate of offenders from treatment.\textsuperscript{108}

To a large degree, the variation across individual studies can be explained by the differences in study populations. Schwartz and Cellini (1997) indicated that the use of a heterogeneous group of sex offenders in the analysis of recidivism might be responsible for this confusion: “Mixing an antisocial rapist with a socially skilled fixated pedophile with a developmentally disabled exhibitionist may indeed produce a hodgepodge of results.”\textsuperscript{109}

There are too few studies focusing on particular types of sex offenders (e.g., exhibitionists, child molesters, adult rapists, and high-risk sex offenders) to enable the authors to draw conclusions about the effectiveness of the programs for different types of sex offenders. This is important to consider when attempting to draw conclusions about what is effective for reducing recidivism among sex offenders. More specifically, sexual offenders vary with regard to the type and number of victims they target. For instance, a study of adult rapists found that, on average, a rapist had attacked 7.5 victims, whereas the average number of attacks among child molesters was found to be at least 10 times that number (i.e., approximately 75 victims per offender). It cannot be assumed, therefore, that programs that are effective with exhibitionists will automatically transfer and be effective with rapists or child molesters.\textsuperscript{110}

Though more research is always helpful and needed, enough is now known to draw some broad conclusions: treated or untreated, few sex offenders reoffend after being caught. Sex offenders actually reoffend less than other types of offenders, and treatment works to lower reoffense rates.\textsuperscript{111} The public trial, shame and humiliation of getting caught appears to deter most sex offenders from further misconduct. Sex offenders who have been identified, convicted and punished probably present less of a threat to society than do most other offenders.\textsuperscript{112}

A number of studies have produced findings that suggest that sex offender treatment does help reduce recidivism. A study was conducted in 1999 that included an analysis of a large group of treatment outcome studies, encompassing nearly 11,000 sex offenders. In this study, data from 79 sex offender treatment studies were combined and reviewed. Results indicated that sex offenders who participated in relapse prevention treatment programs had a combined rearrest rate of 7.2 percent, compared to 17.6 percent for untreated offenders. The overall rearrest rate for treated sex offenders in this analysis was 13.2 percent.\textsuperscript{113}

In 1995, a meta-analysis was conducted consisting of 12 sex offender treatment studies, which compared treated and untreated offenders. The study found that the treated sexual offenders had
fewer sexual rearrests (9 percent) than the sexual offenders in the control group (i.e., the group not receiving treatment) (12 percent).

ATSA has established a Collaborative Data Research Project with the goals of defining standards for research on treatment, summarizing existing research, and promoting high quality evaluations. As part of this project, researchers are conducting a meta-analysis of treatment studies. Included in the meta-analysis are studies that compare treatment groups with some form of a control group. Preliminary findings indicate that the overall effect of treatment shows reductions in both sexual recidivism, 10 percent of the treatment subjects compared to 17 percent of the control group subjects, and general recidivism, 32 percent of the treatment subjects compared to 51 percent of the control group subjects.\footnote{114}

Another study compared the long-term recidivism rates of 296 high-risk sex offenders with a stratified matched sample of 283 incarcerated sex offenders. The follow-up period was, on average, six years. The study measured sexual and nonsexual reconvictions as the outcome variable, and found that sex offenders in the treatment program had a lower proportion of sexual offenses (regardless of the penalties incurred) (14.5 percent) compared to the control group (33.2 percent). Also, the findings indicate that sex offenders in the treatment program had a lower proportion of sexual reconvictions that resulted in a return to federal prison (6.1 percent) than the control group (20.5 percent). Both of the findings regarding sexual reconvictions are statistically significant.\footnote{115}

Yet another study found a substantial difference in the recidivism rates of extra-familial child molesters who participated in a community based cognitive-behavioral treatment program, compared to a group of similar offenders who did not receive treatment. Those who participated in treatment had a recidivism rate of 18 percent over a four-year follow-up period, compared to a 43 percent recidivism rate for the nonparticipating group of offenders.\footnote{116}

The conclusion that treatment reduces recidivism can be refined further by distinguishing between different kinds of sex offenders. Treatment cuts the recidivism rate among exhibitionists and child molesters by more than half, yet cuts recidivism among rapists by just a few percent. Juveniles respond very positively to treatment, indicating that treating sex offenders as soon as they are identified can prevent an escalation of their pathology.\footnote{117}

Another study found that child molesters who participated in a cognitive-behavior treatment program had fewer sexual rearrests than the sex offenders who did not receive any treatment. Both groups of offenders were followed for up to 11 years. The recidivism data was obtained not only through official sources (i.e., police records) but also through unofficial reports (i.e., self-reports). Sex offenders in the cognitive-behavioral treatment program had significantly fewer sexual rearrests than the untreated sex offenders (13.2 percent vs. 34.5 percent, respectively).\footnote{118}

A study comparing the recidivism rates of exhibitionist offenders in a cognitive-behavioral treatment program with sex offenders who did not receive any treatment found that, after a four-year follow-up, treated exhibitionists were reconvicted or charged with a sexual offense less than the untreated exhibitionists (23.6 percent vs. 57.1 percent, respectively).\footnote{119}

Other studies do not produce such positive results. One study examined the long-term recidivism rates of 197 child molesters released from maximum-security prisons between 1958 and 1974. The follow-up period for both treated and untreated child molesters spanned up to 31 years. The study measured sexual and nonsexual offense recidivism as the outcome variable. Recidivism was determined as a reconviction for a sexual offense, violent offense, or both. The study found that offenders in the treatment program had fewer reconvictions (44%) than offenders who were incarcerated prior to the inception of the treatment program (48%) but not compared to offenders who were sentenced to the same institution, at the same time, as the treatment group but did not participate in treatment (33%). These differences are not statistically significant.\footnote{120}
In addition, no positive effect of treatment was found in several other quasiexperiments involving an institutional behavioral program (Rice, Quinsey, and Harris, 1991) or a milieu therapy approach in an institutional setting (Hanson, Steffy, and Gauthier, 1993).121

4. Costs and Benefits

With respect to the costs of sex offender treatment, psychological counseling is expensive, but not as expensive as prison. The average cost of building a new prison cell is about $55,000 and the average cost of operating it for a year is $22,000. A year of intensively supervised probation and treatment may cost between $5,000 and $15,000 per year, depending on the regimen. Thus, a full year of treatment costs far less than an additional year of prison.122

Treated offenders can generally be fully integrated into society as normal productive citizens after completing treatment. Offenders in prison, on the other hand, will continue to cost taxpayers $22,000 a year for as long as they are incarcerated, perhaps even the rest of their lives. Treatment is therefore an essential means of protecting the community at a relatively affordable cost.123

The Washington State Institute for Public Policy (Institute) released a document in May of 2001 that describes the “bottom-line” economics of programs that try to reduce crime. The Institute systematically analyzed evaluations of prevention programs produced in the United States over the last 25 years, independently determining whether program benefits, as measured by the value to taxpayers and crime victims from a program’s expected effect on crime, are likely to outweigh costs.124

What follows is an overview of their findings regarding the costs and benefits of Cognitive-Behavioral Sex Offender Treatment. The principle findings from their review are summarized on Table 1. All monetary figures are expressed in 2002 dollars. The table includes five columns, each describing different results from the analysis.125

- The first column shows the number of studies that was reviewed in determining the crime-related effects for Cognitive-Behavioral Sex Offender Treatment. This is the number of studies that passed the Institute’s minimum research design standards to be included in the analysis.
- The second column contains two numbers: the average “effect size” that they expect for the treatment program and the associated “standard error” of the estimated effect size. The effect size is a summary statistic measuring the degree to which research evidence indicates the program can affect an outcome, in this case, crime. A negative effect size means the program reduces crime.
- The third column shows the estimated net direct cost of the program, per program participant. The cost estimate is a “net” estimate because some programs have an immediate displacement of other program costs. Note, however, that this cost is only up-front – it does not include the present value of any downstream costs stemming from the program’s effect on crime or recidivism rates.
- The fourth and fifth columns provide the main results of the analysis. These are the estimated net economics of the program – that is, the benefits that the program is expected to produce in terms of future crime reduction, less the costs of the program as listed in column (3). The Institute analyzes benefits from the perspective of the taxpayer and the crime victim. For the taxpayer view, the question is whether spending a taxpayer dollar now on a program will save more than a taxpayer dollar in the years ahead. Adding the crime victim view, if the program can reduce rates of future criminal offending, not only will
taxpayers receive benefits but there will also be fewer crime victims. Column (4) shows the taxpayer-only perspective while column (5) provides an estimate that includes taxpayer and crime victim benefits. Thus the information on column (5) provides that broadest public policy implication afforded from the analysis in the report.126

Table 1: Summary of Program Economics127

<table>
<thead>
<tr>
<th>Number of Program Effects in the Statistical Summary</th>
<th>Average Size of the Crime Reduction Effect</th>
<th>Net Direct Cost of the Program, Per Participant</th>
<th>Net Benefits Per Participant (i.e., Benefits minus Costs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower End of Range: Includes Taxpayer Benefits Only</td>
<td>Upper End of Range: Includes Taxpayer and Crime Victim Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Sex-Offender Treatment Programs (compared to no treatment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive-Behavioral Sex Offender Treatment</td>
<td>7</td>
<td>-0.11 (0.05)</td>
<td>$6,504</td>
</tr>
</tbody>
</table>

The Institute studied the sex offender evaluation treatment literature by separately analyzing several different types of sex offender treatment. These categories include:

- Cognitive-behavioral sex offender treatment
- Psychotherapeutic approaches
- Behavioral approaches
- Chemical treatment
- Surgical treatment

For this cost-benefit review, however, they only estimated the effects and the economics of cognitive-behavioral sex offender treatment programs. This treatment modality has emerged as the principal type of sex offender treatment and most recent evaluations of sex-offender treatment have been conducted on this type of program. The cognitive-behavioral approach targets reducing deviant arousal, increasing appropriate sexual desires, improving social skills, and modifying distorted thinking. The treatment occurs both in-prison and in the community.128

The Institute's review of the international research found that relatively few sex offender programs have been evaluated, and fewer still have a strong research design. Using the Institute's weighting scheme to combine the seven studies that met their minimum research design requirements, the evaluations have an average effect size of -.11 (standard error .05) for overall recidivism, and a slightly higher effect size (-.13, standard error .04) for sex crime recidivism. This difference is taken into account when the Institute calculates the costs and benefits.129

They estimate that the typical cognitive-behavioral sex offender treatment program costs about $6,246 per participant. At that price, taxpayers don't break even (-$788 net present value per participant). There is, however, a substantial positive benefit when the crime victim perspective is included. The total estimated net present value is $19,534 per programs participant, producing a benefit to cost ratio of $4.13 of benefits per dollar spent on the typical program. The reason the benefits increase quickly when the crime victim perspective is included is that sex offenders tend to
specialize in sex offenses, which are very costly to crime victims. Thus when sex treatment programs are successful in lowering recidivism rates, especially sex offense recidivism rates, the benefits to society increase significantly.\textsuperscript{130}

Their conclusion is that the average cognitive-behavioral sex offender treatment program is cost-beneficial. That is, compared to not treating sex offenders with this approach, the typical cognitive-behavioral sex offender treatment program saves more than it costs.\textsuperscript{131}

\section*{II. JUVENILE SEX OFFENDER MANAGEMENT}

\subsection*{A. Introduction}

When people hear that an acquaintance treats adolescent sex offenders, they frequently shake their heads and fail to understand why someone would choose such an occupation. To most people outside the field, this work probably seems to be a great challenge filled with many obstacles, and to others, it is work that should be abandoned (in favor of permanent incarceration or even castration).\textsuperscript{132}

However, those in the field recognize that the prevention of sex offenses by adults is often best achieved by addressing and treating sexual offending behavior in juveniles. Research suggests that half of all adult SOs report that their first sexual offense occurred in adolescence, which highlights the importance of addressing deviant sexual behavior as early as possible in order to limit additional victimization.\textsuperscript{133}

\subsection*{B. Assessment}

The process of treating adolescent SOs begins with the process of assessing the offender to determine how best to address their behavior and to meet their needs and that of the community.

Assessment of sexually abusive youth is a complex process. In the initial assessment, the clinician is asked to identify behavior patterns and determine the youth’s potential to reoffend, amenability for treatment, the recommended treatment setting, the type of treatment needed, community safety issues, risk factors, monitoring considerations, and the potential risk if the youth has any contact with the victims or other vulnerable persons. The assessment of the youth also seeks to identify psychiatric, individual, and family treatment needs.\textsuperscript{134}

Assessment for sexually aggressive youth typically consists of a structured or semi-structured interview. Most of the classification systems seek to determine if the adolescent is at a low, moderate, or high risk for future re-offenses. One of the most comprehensive structured interviews was developed by Loss and Ross and consists of questions covering 21 different factors. The factors include cooperation with the assessment process, degree of aggression in offenses, victim selection characteristics, family system functioning, internal motivation for treatment, and response to confrontation.\textsuperscript{135}

There are a number of limitations with respect to the assessment of juvenile SOs, including the following:\textsuperscript{136}

\begin{itemize}
  \item There is currently no empirical validation for any instrument or technique used to assess future risk of re-offending among the youthful sexual offender population. Furthermore, there is no psychometric test or battery of tests that are able to detect who has committed an offense or who is at a risk for re-offending.
\end{itemize}
Structured interviews are commonly used, but none have been shown to be valid or reliable measures of offending behavior or the potential for re-offending. Many of these interviews and risk assessment instruments also include items that are not subject to change, even in response to effective treatment. For example, if “use of a weapon during the offense,” and “any history of chronic substance abuse” are used to determine if an offender is at a “high risk” for re-offense, then he/she shall always be at a high risk to re-offend, even after successful treatment. Such classification systems are not sensitive or responsive to changes in the youth.

The use of penile plethysmography as a risk assessment instrument still lacks empirical reliability and validity for use with adolescents. Furthermore, the ethics of placing a device around the penis of a juvenile and exposing him to erotic images have not been vigorously debated. These issues should make practitioners proceed with caution in their use of the plethysmograph as an assessment technique.

The Able Assessment of Interest in Paraphilias (i.e. a method of assessing sexual attraction and interest by exposing the individual to various pictures and measuring the amount of sustained interest they have toward various types of stimuli) was found to have problems with temporal stability, sensitivity, and specificity. The need for further refinements has been suggested.

Overall, the technology used in the assessment of sexually aggressive youth is still underdeveloped. Structured interviews and checklists may serve as rough guidelines in practice, particularly in determining whether a child needs secure treatment, but their utility has not yet been empirically supported. Psychological tests can provide useful information but they cannot tell us with certainty if an offense occurred or if an individual is at a high risk to re-offend. Some of the newer attempts at psychometric tests to assess offender-specific issues provide additional information, but still have not established their reliability and validity. The use of penile plethysmography also lacks reliability and validity for use with adolescent offenders and presents some ethical dilemmas for both researchers and practitioners.

C. Treatment

Approximately 20% of all people charged with a sexual offense in North America are juveniles. In response to the obvious need to reduce the risk of adolescent sexual reoffending, the number of treatment programs has increased significantly in North America during the past 20 years. In the U.S., for example, although there was only one specialized treatment program for adolescent SOs in 1975, there were over 600 by 1995.137

The National Adolescent Perpetrator Network has taken the position that the safety of the community should be the primary objective in the treatment of sexually aggressive youth. Such position statements as this have led to the development of highly structured, often secure, residential treatment programs. Research suggests that 82% of all juvenile SO treatment programs were originated around one of three treatment models: cognitive-behavioral, psycho-educational, and relapse prevention.138

Early approaches to treating juvenile SOs focused primarily on addressing the offender’s deviant sexual behavior, often ignoring potential contributing factors. Today, the general consensus is that such so-called “uni-modal” approaches may be less than optimal, especially with adolescents who
have a variety of developmental needs that must be addressed concurrently with, and as a part of, their sex offense-specific treatment. A program treating adolescents who sexually abuse must develop a wide approach to address the many areas that must be targeted for effective treatment to take place. Clients must be treated in their entirety, beyond simply targeting “the problem.”

In contrast to the uni-modal approach is the multi-modal methodology, which involves the use of several different sex offense-specific treatment interventions at the same time. Examples are a youth in a residential program who participates in a sex offense-specific group, individual therapy with a trained specialist, and family therapy, and an adult in a day program at a clinic who attends sex offense-specific group and individual therapy, and who participates in a social skills training groups and sexuality education. In the multi-component model, the various modes of treatment are linked and use a common treatment staff, common theoretical models, and common jargon. The multi-component model is an effort to maximize the range of services provided to the client, while allowing for the highest possible level of continuity and coordination among these various services.

There is notable consensus regarding the issues to be addressed in the specialized treatment of adolescent SOs. Treatment goals include increasing offender accountability; assisting offenders to understand and interrupt the thoughts, feelings, and behaviors that maintain sexual offending; reducing deviant sexual arousal, if present; improving family relationships; enhancing victim empathy; improving social skills; developing healthy attitudes towards sex and relationships; and reducing the offenders’ personal trauma, if present.

The more recent literature clamors for comprehensive, empirically supported treatment programming for young offenders, based on the four foundational elements:

- **Treat the Whole Child**
  Rather than seeing the youth and his/her problems in narrow terms, there is a need to treat the whole child. For severely disturbed children with pervasive deficits, attending only to the sexual offenses does little to increase the child’s overall level of functioning in the community. His/her academic and skill deficits, along with poor anger and impulse control, topped off by substance abuse problems, trauma history, dysfunctional family, and intense depression all need to be treated.

- **Change Treatment as the Child Develops**
  Effective treatment needs to be developmentally sensitive treatment. As each child grows, new developmental tasks and challenges unfold. Often youth with developmental delays begin making gains in response to good treatment. A strong program needs to be sensitive to all of these changes and stages. Treatment becomes a fluid, constantly evolving process, rather than a rigid, lock-step program. Changes in the child’s treatment plan are not only tolerated, but become expected and celebrated.

- **Understand and Build on Strengths and Skills**
  Effective treatment not only understands deficits and limitations, but also incorporates strengths and skills into the treatment process. As much effort as there is in determining correct diagnoses and risk factors is also put into assessing individual strengths and existing skills. The development of these skills should be plotted over time as a measure of treatment progress. The program is skill-based and oriented around individual strengths.

- **Expand the Treatment Team**
Traditional concepts of a treatment team have been limited to treatment professionals within each program. However, understanding that each child needs a comprehensive treatment program also logically leads to an understanding that the “treatment team” is much broader than a few professionals. It includes family members, community supports, agency representatives, and advocates. This concept is often hard for traditionalists to embrace, but it is vitally important to the success of these youth. For many, this model represents a major shift in thinking. For others, this is simply common sense.

Table 3.2 presents a scheme that lists the goals of a comprehensive program for adolescents who commit sexual offenses.

<table>
<thead>
<tr>
<th>Table 3.2. Casella’s Goals of a Comprehensive Program\textsuperscript{143}</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The program should include a complete, individualized assessment and treatment plan.</td>
</tr>
<tr>
<td>• The treatment should assist the offender to</td>
</tr>
<tr>
<td>— accept responsibility for his/her offenses; and</td>
</tr>
<tr>
<td>— understand and be aware of his/her patterns of reoffending (e.g., sequence of thoughts, feelings, events, circumstances, and arousal stimuli).</td>
</tr>
<tr>
<td>• The treatment should assist the offender to</td>
</tr>
<tr>
<td>— learn to intervene in or break into his/her offense pattern; and</td>
</tr>
<tr>
<td>— call upon tools, methods, and procedures to suppress, control, manage, or stop the behavior.</td>
</tr>
<tr>
<td>• The treatment should provide reeducation and resocialization to</td>
</tr>
<tr>
<td>— replace antisocial thoughts and behaviors with prosocial ones;</td>
</tr>
<tr>
<td>— acquire a positive self-concept and new attitudes and expectations of him/her self; and</td>
</tr>
<tr>
<td>— learn new social and sexual skills to help cultivate healthy relationships.</td>
</tr>
<tr>
<td>• In residential treatment, an offender needs a prolonged period to safely test his/her newly acquired insights and control mechanisms in the community.</td>
</tr>
<tr>
<td>• Each offender needs a posttreatment support group and continued postrelease access to therapeutic treatment.</td>
</tr>
</tbody>
</table>

The most widely used components (in a multi-component treatment program) are the following:\textsuperscript{144}

- **Sex-offense specific group**: a standard in the treatment of this population.
- **Family therapy education**: very important for adolescents in treatment.
- **Individual therapy**: has many important functions when used in conjunction with group therapy.
- **Adjunct/therapy treatment**: addresses wide issues and treats the whole person.
- **Milieu treatment**: an essential component for group care programs dealing with a treatment environment.
- **Assessment and treatment planning**: a component ensuring quality treatment.

Two additional components encapsulate treatment and represent “book-ends” to the client’s involvement with a given program:

- **Pretreatment**: prepares clients to engage in treatment (usually only needed in the first intervention setting with clients who are not yet ready to enter full-scale treatment).
Two final components support the work of others:

- **Staff training**: gives the staff needed tools to work with the adolescents.
- **General resident education**: assists group care programs with a mixed population to create a healthy, tolerant, safe milieu.

The following are two sample “stage” systems that were developed for implementation at long-term residential programs.

*Stage 1 – Orientation and Assessment.* Tasks include the following (possible time frame of two months):

- Meet with SO therapist prior to entering group.
- Disclose offenses to therapist; begin individual therapy.
- Begin SO group and disclose offenses to group.
- Complete the “orientation packet.”

*Stage 2 – Exploring, Changing, and Relearning.* Tasks include the following (possible time frame of nine to twelve months):

- Continue in weekly SO group.
- Continue in weekly individual therapy.
- Be able to genuinely take responsibility for offenses.
- Deepen understanding of self and sexual abuse cycle and dynamics.
- Explore family dynamics and role in family.
- Come to grips with own victimization.
- Explore own sexuality, normal sexual behavior, as well as male and female roles.
- Develop a degree of empathy for victims.
- Increase quality of social skills and interactions.
- Learn to recognize, identify, and express feelings.
- Explore the role and function of fantasy, and work to modify deviant fantasy.
- Learn about grooming, maintenance, coercion/force, and pre-offense patterns; apply this understanding to self.
- Develop a background for relapse prevention planning.
- Work on all issues through sessions with counselor, daily group therapy, multiple family therapy (MFT), and milieu treatment in the program.

*Stage 3 – Relapse Prevention Planning.* Tasks include the following (possible time frame of three months):

- Continue with SO group and all other treatment.
- Complete “relapse prevention packet.”
Managing Sex Offenders in the Community: A National Overview

Stage 4 – After Graduation. Tasks include the following (possible time frame of three months for active program involvement, at the discretion of the provider):

- Follow up with program by participation in aftercare follow-up component.
- Continue in aftercare treatment with next provider.
- Review and follow relapse prevention plan.

These next stages were originally designed and implemented at the Tom Ray Treatment Center in Charlotte, North Carolina.

Stage I: Preadmission

The goals of this stage are:

1. Achieve a clear understanding with all those who have a stake in the client’s treatment to allow them to work cooperatively with the program to meet the client’s needs.
2. Obtain sufficient information to assure that the client meets the admission criteria.

Stage II: Assessment

The goals of this stage are:

1. Achieve a comprehensive understanding of the client’s particular needs as they relate to the risk of sexual and nonsexual assault.
2. Design an intervention strategy, drawing on an array of available interventions, to meet the client’s particular needs.
3. Establish a “treatment ally team” as a functional group with clear commitments and goals.
4. Define a “target discharge environment.”

Stage III: Treatment

The goals of this phase are:

1. Decrease the youth’s risk for sexual and nonsexual assaultive behavior by increasing specific abilities that will allow for effective nonviolent community functioning.
2. Increase the treatment ally team member’s abilities to support and monitor the youth in the target discharge environment.

Stage IV: Transition
The goal of this phase is:

1. The youth and the treatment ally team implement an effective plan for functioning in a less restrictive environment.

D. Aftercare

The ultimate test of treatment is the sexually abusive youth’s ability to control abuse behavior in the community after treatment. He or she must use the multiple behavioral, emotional, attitudinal, interactional, cognitive, and physiological changes effected to maintain control of his or her behaviors. Aftercare planning, relapse-prevention techniques, and follow-up services were increased or developed to support the growing awareness that a gradual decline (not a sudden termination) of contact, support, and treatment intervention encourages the offender to continue applying new techniques and concepts to manage his/her behaviors in a new environment.147

Aftercare is that portion of comprehensive adolescent sexual perpetrator treatment intervention that takes place in the community after the youth is released from the institution. It is the area of the rehabilitative intervention process that involves supervision and continued treatment of the client after release from secure custody, residential treatment, or inpatient care. Aftercare philosophies recognize that the offender is not cured in the traditional sense, and acknowledge the compulsive nature of the sexually abusive behaviors. Aftercare is the part of the treatment plan that most directly connects with the client’s future and thus deserves to be as integral a part of treatment planning and the rehabilitative process as other components.148

Aftercare is a significant conjunct to offense-specific treatment for three primary reasons. First, an aftercare program assists the offender with acknowledging that he/she continues to be at risk of offending, and that his/her behavior problem is still part of him/her and has not magically vanished on release or discharge. Aftercare encourages the youth to continue to use the tools acquired to prevent reoffense and focuses on strengthening behavior management. Clients experience more difficulty with maintaining these abilities while reentering the community than in an institutional program. The world they return to after leaving a residential program lacks the controls, structure, treatment intervention, and type of support that they have become accustomed to. Aftercare supervision provides a therapeutic link of continued accountability for offense behavior management.149

Second, aftercare provides a clear-cut method for monitoring the youth’s behavior after release. The aftercare supervisor can observe clients for any resumption of behaviors or thinking errors that could become dangerous to others or themselves and can often intervene before the behaviors progress or the client can reoffend. In order to monitor the client’s behavior adequately, the aftercare provider must maintain close contact with the youth, his/her family, and close friends or any significant others in the offender’s life.

The third benefit of an aftercare program is that of helping the youth establish a community-based locus pairing, or association of the therapeutic messages received by the offender with the locus of the community. Prior to release, the youth’s locus is the residential or closed-custody facility. When the youth is released, the change of locus and custody status may precipitate a new level of denial. The youth may begin to believe, “The problem doesn’t exist for me anymore. I’m cured. I’ve dealt with it so there will be no more problems.” The youth is more likely to be of higher risk subsequent to release and may exhibit some regression while coping with change and transition issues.”150
E. Treatment Limitations

The field of juvenile sex offender treatment is clearly advancing in its efficacy and innovation. Practitioners are becoming increasingly aware of the need to develop comprehensive treatment models. Currently, there are at least two major limitations of the field, however. The first is the tendency to pattern programs for youth after adult models, resulting in an overly narrow focus in many treatment programs for highly disturbed youth with a wide range of problems. A second limitation is the failure of some practitioners to view the sexually aggressive youth as their client. Many of the treatment programs employ modalities and techniques that were developed for adult offenders. Most adult offenders are usually pedophiles or rapists who have issues with regard to deviant arousal. Thus, programs have been developed to identify the deviant thoughts and satiate or extinguish them. The most recent view of sexually aggressive youth is that their offenses are multi-determined and the sexual aggression is usually only one way in which they victimize others. A review of a sample of youth admitting or adjudicated for a sexual offense suggests that less than half show any evidence of “deviant arousal.” However, many programs for sexually aggressive youth insist that they journal their deviant sexual fantasies.

In adults, the sexual offending behavior is usually the sole focus of treatment. Most sexually aggressive youth have co-morbid psychiatric diagnoses, possible substance abuse issues, severe family dysfunction, and skill deficits in many areas. They are often highly disturbed individuals, and their deficits are usually pervasive and require individualized and comprehensive treatment programming.

Practitioners have correctly recognized that they have a tremendous responsibility when working with sexually aggressive youth. In undertaking such treatment, they have accountability for helping to ensure the safety of the community. This has led some to adopt the position that their only “client” is the community. This is a wrong-headed conclusion that may have negative implications.

When treating sexually aggressive youth, it is wise to consider the community to be a “client.” But it is entirely unethical not to regard the individual in treatment as one’s client, as well. It is impossible to provide treatment services to someone who is not your client.

Such attitudes make it possible for treatment providers to act outside of the best interest of the individual in treatment. Sexual offending produces a sense of outrage like few other behaviors, and the political and community pressure is clearly communicated to the treatment providers. Wary of being accused of being too soft on offenders, practitioners may adopt rigid and punitive approaches to treatment.

F. Major Areas of Need for Sexually Aggressive Youth

- Sexual Socialization
  Sexuality as a social phenomenon is often confusing and complex to the adolescent. Although it is clear that sexuality, social confidence, and self-concept are important and connected issues for many adolescents, sexually aggressive youth are often undersocialized and have difficulty establishing either sexual or nonsexual peer relationships. The importance of healthy sexual development, as well as the connection between socialization and sexual beliefs and attitudes, combine to mark this as a serious area of need for the sexually aggressive youth. Treatment programs must be prepared to help individual clients develop healthy sexual norms, obtain accurate sexual information, develop non-intrusive social skills, and resist sexually deviant cultural influences.
• Resolution of Past Trauma
  Many sexually aggressive youth have been sexually and/or physically abused. There is extensive
evidence that physical and sexual abuse of children raises the level of aggression observed in their
subsequent behavior. For many sexual offenders, their own victimization needs to be an important
focus of treatment. It is important that practitioners do not allow treatment strategies to lose focus
on the youth’s own responsibility for his/her aggressive behavior. However, to do this by failing to
address other important (and possibly central) treatment issues is ill-advised.

• Deviant Arousal Management Skills
  There is clearly a significant segment of sexually aggressive youth who have reoccurring deviant
sexual fantasies. When these individuals also exhibit high degrees of impulsive decision making,
they may be at very high risk to perpetrate sexual assaults. These individuals clearly need to develop
sophisticated skills in managing both the occurrence of the sexual fantasies and the potentially self-
deceptive behavioral process that can lead to acting on these impulses. Learning to self-monitor and
to specifically intervene with these “seemingly unimportant decisions” is a very important need for
these clients.

• Rage Control
  Anger and rage appear to play a significant role in the commission of many acts of sexual
aggression. In fact, there has been considerable debate in the literature over the years about the
extent to which sexual assault is primarily a sexually motivated, or anger/aggression motivated
phenomenon. In general, older publications emphasize the sexual motive for sexual offending.
More recent publications tend to emphasize the role of aggression. Whether seen as primary or
secondary, however, there seems little doubt that anger and rage play a role in many assaults.

• Sobriety
  Alcohol and other intoxicating substances have been long established as having powerful dis-
inhibiting effects on behavior. When the sexually aggressive youth has substance abuse problems or
is at high risk for developing substance abuse, this becomes a significantly important treatment need.
Some clinicians who treat sexually aggressive youth may be reluctant to fully explore this area for
fear that they will inadvertently provide the offender with a means of reducing or avoiding direct
responsibility. Clinicians can promote and communicate the legal and moral absolute that, any
person who knowingly makes decisions to become intoxicated, bears full responsibility for his or her
subsequent actions. The need for a sexually aggressive youth, then, is to learn skills to remain sober
so that good judgment and impulse control will be maintained.

• Non-abusive Personal Power
  The skills in the arena of sexual development include a complex array of social and interpersonal
abilities that allow the person to gain peer acceptance, as well as attract and maintain intimate
relationships. The person who does not have this array of social competencies is less likely to
develop and maintain close interpersonal relationships. The link between poorly developed social
ability and sexual offending seems clear. Teaching these skills as a part of the concept of nonabusive
personal power helps that youth discover ways to feel good about him/her self, and feel less lonely and
more socially accepted, but never at the expense of another individual.

• Trust Skills
Severe deficits in numbers of close friendships have been found in populations of sexually aggressive youth. Numerous studies have reported that populations of sexually aggressive youth have difficulties relating to peers. Given the complex development of trust skills, there appear to be several different ways this process may be disrupted for the sexually aggressive youth. Many sexually aggressive youth have been sexually abused, and one common cluster of symptoms related to such victimization involves subsequent impairment in the person’s ability to judge the trustworthiness of others. These considerations support the assertion that comprehensive treatment of sexually aggressive youths should include attention to the development of the abilities required for stable, intimate, non-abusive relating. These trust skills are a fundamental part of human relating that emerge from a complex developmental process. This developmental process is often disrupted for juvenile offenders.

- Empathy and Respect for the Rights of Others
  Many juvenile offenders have an overall disregard for the rights of others that is not limited to sexual arenas. The more empathetic one is toward others, the more distressing it becomes to behave in ways that hurt them. It has been recommended that reducing the offender’s tendency to deny the offense and/or to blame the victim while building victim empathy become a basis for treatment of sexually aggressive youth. Youthful sexual offenders appear to need a broad sweep approach to learn about and internalize moral concepts such as fairness, consideration of others, sensitivity to the feelings of others, and a clear code of “rights” that govern socially responsible behavior.

- Functional Family Relationships
  The families of sexually aggressive youth are often unstable, have high rates of violence, and are frequently disorganized. Because family relationships provide an early template on which children base their relationships with others, the dysfunction in the youth’s family seems to be an important causal link to the youth’s sexual and nonsexual aggression. A treatment process for the family of the sexually aggressive youth can alter the family’s structure and function in ways that support the youthful offender’s treatment. Most youth will continue to have lifelong relationships with family members. If family systems can be altered to become more functional, then the long-term influence of the individual youth is more likely to be positive. It may be extremely important to the goal of preventing relapse to engage family members in supporting these therapeutic changes.

- Allies to Monitor and Support Treatment
  A major frustration to practitioners who put their time and energy into facilitating change in residential treatment environments occurs when treatment successes appear to fade on discharge. Therefore, any comprehensive treatment approach should include enlisting the support of individuals who will help plan for and support the treatment changes after the youth is discharged. The basic components of treatment that need most to be extended into the community are support and supervision.
  To avoid youth becoming lost in a systemic approach that treats everyone the same, program design for sexually aggressive youth must include a wide range of possible interventions that address issues both directly and indirectly related to the sexual aggression. This concept is termed treating the whole child. To treat the whole child, a program must include a process for discovering and defining the unique and often complex array of sexual and nonsexual issues that need to be addressed.

G. Effectiveness of Treatment
Despite the high level of agreement in the field regarding treatment goals and the recent proliferation of treatment programs, little is known about the success of specialized treatment. Since the development of the first comprehensive treatment program for adolescent sexual offenders in 1975, there had been only 10 published reports of criminal recidivism following specialized treatment, as of the year 2000.

Noting a number of shortcomings present in these earlier studies, a recent study focused on the Sexual Abuse, Family Education and Treatment (SAFE-T) Program, a specialized, community-based program that provides sexual abuse specific assessment, treatment, consultation, and long-term support to juvenile SOs. The purpose of the study was to examine the success of specialized adolescent sexual offender treatment by comparing subsequent recidivism rates between treated offenders and a comparison group. A secondary goal of this study was to examine the predictive utility of the variables assessed with respect to both sexual and nonsexual recidivism.

The SAFE-T program involved comprehensive clinical and psychometric assessments, followed by treatment plans individually tailored for each offender and family, and treatment goals that were reviewed approximately every four to six months. SOs were typically involved in concurrent group, individual, and family therapy. The program addressed issues related to denial and accountability, deviant sexual arousal, sexual attitudes, and victim empathy. Related treatment goals included the enhancement of social skills, self-esteem, body image, appropriate anger expression, trust, intimacy, etc.

The results of the study support the efficacy of specialized community-based treatment at the SAFE-T program for reducing the risk of adolescent sexual recidivism. Relative to the Comparison group, there was a 72% reduction in sexual recidivism for adolescents completing at least 12 months of assessment and treatment. Furthermore, although previous research has found that many treated SOs are likely to be charged with subsequent nonsexual offenses, participation in specialized treatment was associated with a 41% reduction in violent nonsexual recidivism and a 59% reduction in nonviolent reoffending.

Given the notable absence of published outcome data regarding specialized treatment for adolescent sexual offenders, some authors have questioned not only the efficacy of specialized treatment, but also the notion that sexual offenders are different from nonsexual offending adolescents. The results of the present study suggest that not only does specialized treatment reduce the risk of subsequent sexual and nonsexual offending for adolescent sexual offenders, but that the risk of further sexual aggression is related to factors that are unrelated to nonsexual offending. Of course, additional studies will be necessary to isolate the specific treatment mechanisms that are responsible for positive outcomes and to identify reliable predictors of sexual and nonsexual recidivism. To date, it appears that comprehensive treatment that combines a strong family-relationship component along with certain offense specific interventions may be most successful for adolescent SOs.

III. STAFF TRAINING

Staff training is a crucially important component in a comprehensive sex offense-specific treatment program. Programs survive or fail based on the strength of their staff, and all the good therapy and treatment planning evaporates when staff will not or cannot do their jobs well.

Some topics commonly addressed in staff training programs are placed here under three categories. First are the training topics that may be considered mandatory for staff. This category has two levels: (1) those which should be done prior to beginning work or very soon afterward, and
(2) those which might be required but can be picked up in time. Examples of training programs falling under this first category follow.162

First level:

- Agency orientation (personnel policies, program procedures)
- Explanation of agency/program treatment model
- CPR/First Aid
- Medical issues/medication management
- Crisis intervention/restraint
- Shadowing a member of staff (i.e., spending some number of shifts working hand in hand with an experienced staff member for on-the-job training)

Second level:

- Fire/water safety
- Behavior management
- Depression/suicide
- Staff as a member of the treatment team
- Case study scenarios for discussion
- Ongoing supervision

The second category includes clinically oriented training programs that are highly beneficial to staff. As many staff as possible should attend these. The more staff trained in these areas, the greater the effectiveness of the treatment team. The following are some examples:

- Treatment planning
- Group dynamics/conducting groups
- Working with families
- Milieu treatment techniques
- Interviewing skills
- Ongoing supervision

The third category includes training offered for staff development. Staff should be encouraged to attend such programs to satisfy their interests or to gain insight into areas particularly pertinent to their jobs or needs. Some examples include the following:

- Communication skills
- Child abuse/neglect
- Substance abuse issues
- Cultural diversity
- Sexuality issues
- Anger management/relaxation techniques
- Designing educational programs for clients
• Skills building through milieu and recreation
• Advanced topics in conducting groups and interviewing
• Other training opportunities available in the community

The following minimal standards for a professional should be adhered to:

  o A minimum of a master’s degree or its equivalent or medical degree in a clinical field
    granted by an institution of education accredited by a national/regional accrediting board
    or institution.
  
  o Demonstrated competence in therapy as indicated by a license (or its equivalent from a
certifying body) to practice medicine, psychology, clinical social work, professional
  counseling, or marriage and family counseling.
  
  o Demonstrated specialized competence in counseling and diagnosis of sexual disorders
    and sexual offending behaviors as documentable by training or supervised clinical
    experience, along with continuing education.
  
  o Demonstrated training and competence in providing psychotherapy.

IV. VICTIM ISSUES

A. Introduction

The most comprehensive and responsible approaches to community management of sex
offenders are those that place paramount importance on addressing the needs and safety of past and
potential victims of sexual assault. With this in mind, justice system agencies and sex offender
treatment providers in several jurisdictions have begun to join with victim advocacy programs and
other victim service organizations to ensure that victim safety and support are the primary goals of
their interventions with sex offenders.163

The sheer brutality of a sexual assault is completely contrary to the sexual union’s intended
intimacy. Because of the nature of this violation, many victims suffer extensive psychological
trauma. This trauma does not necessarily dissipate with time, but may resurface later in life. In
addition, many victims display physical effects, including eating disorders and depression. Similarly,
sexual assault victims often develop a greater tendency to abuse drugs or alcohol later in life.164

Victims of sexual crimes have often been made to feel responsible for or guilty about their own
victimization; rape victims have feared the publicity and accompanying trauma of testimony. For
centuries, the incest taboo prevented disclosure more effectively than it prevented occurrence, and
males who have been sexually victimized during childhood or adolescence have always been
socialized to deny or minimize the nature of such experiences in order to preserve the image of male
invulnerability.165

While any offender’s subsequent reoffending is of public concern, the prevention of sexual
abuse is particularly important, given the irrefutable harm that these offenses cause victims and the
fear they generate in the community.166
B. Costs Experienced by Victims

Identifying and quantifying costs and consequences of sexual victimization may be helpful both in characterizing the crime problem and in examining ways to address it. Ignoring the non-monetary benefits of crime reduction can lead to a misallocation of resources. To victims, the costs are mainly (1) out-of-pocket expenses such as medical bills and property losses, (2) reduced productivity at work, home, and school, and (3) non-monetary losses – such as fear, pain, suffering, and lost quality of life. Although some of these losses are tangible and easily quantified, even the intangible losses (such as lost quality of life) may be valued in dollar terms.

The National Institute of Justice published a study in 1996 that provides dollar estimates for the impacts on victims of specified crimes. Table 1 below displays these costs (converted to 2003 dollars), which are averages and include attempted crimes that result in minimal consequences as well as extremely violent crimes that result in long hospital stays and devastate victims’ quality of life for years to come. Thus, the fact that the average rape costs about $620 in medical expenses reflects the fact that only about 25 percent of all rape victims in the National Crime Victimization Study (the government’s main source of information about criminal victimization) reported receiving any medical treatment; only about 2 percent of rape victims stayed overnight in a hospital.

Table 1: Losses per Criminal Victimization (Including Attempts)

<table>
<thead>
<tr>
<th>Crime Type</th>
<th>Productivity</th>
<th>Medical Care/Ambulance</th>
<th>Mental Health Care</th>
<th>Police/Fire Services</th>
<th>Social/Victim Services</th>
<th>Property Loss/Damage</th>
<th>Subtotal: Tangible Losses</th>
<th>Quality of Life</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatal Crime</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape, Assault, etc.</td>
<td>$1,269,109</td>
<td>$20,687</td>
<td>$60,921</td>
<td>$1,650</td>
<td>$0</td>
<td>$152</td>
<td>$1,307,182</td>
<td>$2,423,998</td>
<td>$3,731,180</td>
</tr>
<tr>
<td>Arson Deaths</td>
<td>918,835</td>
<td>22,337</td>
<td>6,092</td>
<td>2,412</td>
<td>0</td>
<td>27,413</td>
<td>977,214</td>
<td>2,500,145</td>
<td>3,477,359</td>
</tr>
<tr>
<td>DWI</td>
<td>1,459,476</td>
<td>23,225</td>
<td>6,092</td>
<td>939</td>
<td>0</td>
<td>12,310</td>
<td>1,497,548</td>
<td>2,531,873</td>
<td>4,029,421</td>
</tr>
<tr>
<td>Child Abuse</td>
<td>2,792</td>
<td>546</td>
<td>3,173</td>
<td>37</td>
<td>2,284</td>
<td>12</td>
<td>10,065</td>
<td>66,465</td>
<td>76,530</td>
</tr>
<tr>
<td>Sexual Abuse (incl. Rape)</td>
<td>2,665</td>
<td>622</td>
<td>6,092</td>
<td>71</td>
<td>1,396</td>
<td>0</td>
<td>12,057</td>
<td>113,967</td>
<td>126,024</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>4,315</td>
<td>1,002</td>
<td>3,426</td>
<td>26</td>
<td>2,665</td>
<td>32</td>
<td>11,422</td>
<td>72,974</td>
<td>84,396</td>
</tr>
<tr>
<td>Emotional Abuse</td>
<td>1,143</td>
<td>0</td>
<td>3,426</td>
<td>26</td>
<td>2,665</td>
<td>0</td>
<td>7,234</td>
<td>26,779</td>
<td>34,013</td>
</tr>
<tr>
<td>Rape &amp; Sexual Assault (excluding Child Abuse)</td>
<td>2,792</td>
<td>634</td>
<td>2,792</td>
<td>47</td>
<td>35</td>
<td>127</td>
<td>6,472</td>
<td>103,306</td>
<td>109,778</td>
</tr>
<tr>
<td>Other Assault or Attempt</td>
<td>1,206</td>
<td>539</td>
<td>96</td>
<td>76</td>
<td>21</td>
<td>33</td>
<td>1,967</td>
<td>9,899</td>
<td>11,866</td>
</tr>
<tr>
<td>NCVS with Injury</td>
<td>3,935</td>
<td>1,866</td>
<td>132</td>
<td>106</td>
<td>58</td>
<td>49</td>
<td>6,092</td>
<td>24,494</td>
<td>30,586</td>
</tr>
<tr>
<td>Age 0-11 with Injury</td>
<td>3,553</td>
<td>1,866</td>
<td>127</td>
<td>106</td>
<td>58</td>
<td>49</td>
<td>5,838</td>
<td>35,662</td>
<td>41,500</td>
</tr>
<tr>
<td>Non-NCVS Domestic</td>
<td>965</td>
<td>394</td>
<td>103</td>
<td>0</td>
<td>0</td>
<td>49</td>
<td>1,523</td>
<td>12,691</td>
<td>14,214</td>
</tr>
<tr>
<td>No Injury</td>
<td>89</td>
<td>0</td>
<td>83</td>
<td>88</td>
<td>11</td>
<td>19</td>
<td>254</td>
<td>2,157</td>
<td>2,411</td>
</tr>
<tr>
<td>Robbery or Attempt</td>
<td>1,206</td>
<td>470</td>
<td>84</td>
<td>165</td>
<td>32</td>
<td>952</td>
<td>2,919</td>
<td>7,234</td>
<td>10,153</td>
</tr>
<tr>
<td>With Injury</td>
<td>3,173</td>
<td>1,269</td>
<td>83</td>
<td>204</td>
<td>56</td>
<td>1,777</td>
<td>6,399</td>
<td>17,513</td>
<td>24,112</td>
</tr>
<tr>
<td>No Injury</td>
<td>95</td>
<td>0</td>
<td>84</td>
<td>139</td>
<td>19</td>
<td>507</td>
<td>889</td>
<td>1,650</td>
<td>2,539</td>
</tr>
<tr>
<td>Drunk Driving</td>
<td>3,553</td>
<td>1,777</td>
<td>104</td>
<td>51</td>
<td>?</td>
<td>2,030</td>
<td>7,615</td>
<td>15,103</td>
<td>22,718</td>
</tr>
<tr>
<td>With Injury</td>
<td>15,356</td>
<td>8,122</td>
<td>104</td>
<td>152</td>
<td>?</td>
<td>4,560</td>
<td>28,302</td>
<td>61,425</td>
<td>89,727</td>
</tr>
<tr>
<td>No Injury</td>
<td>216</td>
<td>0</td>
<td>23</td>
<td>22</td>
<td>0</td>
<td>1,269</td>
<td>1,650</td>
<td>1,777</td>
<td>3,427</td>
</tr>
<tr>
<td>Arson</td>
<td>2,221</td>
<td>1,396</td>
<td>31</td>
<td>1,269</td>
<td>?</td>
<td>19,671</td>
<td>24,747</td>
<td>22,844</td>
<td>47,591</td>
</tr>
<tr>
<td>With Injury</td>
<td>19,545</td>
<td>12,691</td>
<td>7</td>
<td>1,269</td>
<td>?</td>
<td>28,429</td>
<td>62,187</td>
<td>194,174</td>
<td>256,361</td>
</tr>
<tr>
<td>No Injury</td>
<td>10</td>
<td>0</td>
<td>6</td>
<td>1,269</td>
<td>0</td>
<td>18,529</td>
<td>20,306</td>
<td>634</td>
<td>20,940</td>
</tr>
<tr>
<td>Larceny or Attempt</td>
<td>10</td>
<td>0</td>
<td>6</td>
<td>101</td>
<td>1</td>
<td>342</td>
<td>470</td>
<td>0</td>
<td>470</td>
</tr>
<tr>
<td>Burglary or Attempt</td>
<td>15</td>
<td>0</td>
<td>1,155</td>
<td>165</td>
<td>6</td>
<td>1,231</td>
<td>1,396</td>
<td>381</td>
<td>1,777</td>
</tr>
</tbody>
</table>
These estimates help demonstrate the devastating impacts of sex crimes on victims. Among non-fatal crimes, “Child Abuse: Sexual Abuse (incl. Rape)” and “Rape & Sexual Assault (excluding Child Abuse)” are the second and third most costly to victims (as defined by the average total cost per crime). The bulk of these costs are categorized as “Quality of Life” costs, which are intangible and sometimes difficult to measure, but are nevertheless very real. While tangible costs such as medical expenses to treat injuries are paid once and can be forgotten, memories of the trauma experienced by victims can last a lifetime and cause ongoing damage to victims. This is especially true for victims of sex crimes, for whom it can be difficult to ever enjoy a “normal”, consensual sex-life, thus being deprived of what can be for many a critical aspect of a happy, healthy existence.

C. Sexual Assault Nurse Examiners (SANEs)

1. Introduction

One of the most promising innovations with respect to serving victims of sex crimes has been the advent of the “sexual assault nurse examiner” (SANE). A SANE is a registered nurse who has advanced education and clinical preparation in forensic examination of sexual assault victims. In the 1990s, SANE programs sprang up in hundreds of communities across the country to address the inadequacy of the traditional model for sexual assault medical evidentiary exams. Those who work with sexual assault victims have long recognized that victims are often re-traumatized when they come to hospital emergency departments for medical care and forensic evidence collection. Where they exist, SANE programs have made a profound difference in the quality of care provided to sexual assault victims. SANEs offer victims prompt, compassionate care and comprehensive forensic evidence collection. In addition to helping preserve the victim’s dignity and reduce psychological trauma, SANE programs are enhancing evidence collection for more effective investigations and better prosecutions.

SANE programs address several problems in the medical-legal response to sexual assault victims in hospital emergency departments, including the following:

- Emergency department staff frequently regard the needs of sexual assault victims as less urgent than other patients because the majority of these victims do not sustain severe physical injuries.
- Sexual assault victims often endure long waits in busy public areas (four to ten hour waits are not uncommon).
- Sexual assault victims often are not allowed to eat, drink, or urinate while they wait for a physician or nurse to conduct the evidentiary exam, to avoid destroying evidence.
- Physicians or nurses that perform evidentiary exams often have not been trained in forensic evidence collection procedures or do not perform these procedures frequently enough to maintain proficiency.
- Some physicians are reluctant to perform evidentiary exams because they know that they might be called from the hospital to testify in court and that their qualifications to conduct the exam might be questioned due to a lack of training and experience.
Emergency department staff may not understand sexual assault victimization (e.g., they may blame victims for their assaults or may not believe a “real rape” occurred), and may overlook the need to treat victims with sensitivity and respect.

Emergency department staff may fail to gather and/or document all available forensic evidence, particularly in non-stranger cases.172

With the advent of SANE programs, it has become possible for sexual assault victims to consistently receive prompt and compassionate emergency care from medical professionals who understand victimization issues. A SANE can speed up the evidentiary examination process by reducing the time victims have to wait in a hospital’s emergency department and the time it takes to complete the examination. The quality of the examination is usually improved because an experienced SANE is adept at identifying physical trauma and psychological needs, ensuring that victims receive appropriate medical care, knowing what evidence to look for and how to document injuries and other forensic evidence, and providing necessary referrals.173

Most SANE programs use a pool of SANEs who are on call 24 hours a day. The on-call SANE is paged whenever a sexual assault victim enters the community’s response system.174

In many jurisdictions, community-based sexual assault victim advocates are involved in the initial medical-legal response to sexual assault victims. SANEs often collaborate with these advocates during examinations to ensure victims receive crisis intervention, help with safety planning prior to discharge, and referrals for other types of assistance and ongoing support.175

Successful SANE programs do not operate in isolation. They work closely with other members of the community sexual assault response system (e.g., advocates from sexual assault crisis centers, law enforcement officers, prosecutors, judges, other court personnel, forensic lab staff, victim/witness specialists based in justice system offices, and child protective services workers) to meet the multiple needs of victims and to hold offenders accountable for their crimes.176

Over time, strong alliances between advocates and SANEs have the potential to facilitate a comprehensive and timely community response to sexual assault that is truly victim centered.177

2. Impact on Law Enforcement

SANE programs “have taken response to sexual assault victims at the emergency department out of the dark ages,” according to a detective with the Sex Crimes Unit of the Alexandria, Virginia, Police Department. The detective noted that SANEs present victims with a positive first impression of the community response system, increasing the likelihood that they will cooperate with law enforcement and prosecution. Officers know that victims are in good hands with SANEs because victims will be treated with kindness and respect. Officers also recognize the increased efficiency that SANEs bring to the evidentiary exam process, and as a result, the time they spend waiting for evidence and waiting to interview victims can often be greatly reduced.178

With the growth of SANE programs throughout the country, court systems are processing greater numbers of cases of sexual assault in which the victim has undergone a forensic exam. As more of these cases go to trial and result in increased numbers of convictions, state and federal appellate courts are reviewing constitutional and evidentiary challenges by defendants. As of 2001, these courts had rejected all defense challenges to convictions based on SANE testimony.179

3. Training and Certification.

SANEs require specialized training. Basic training programs typically consist of at least 40 hours of classroom instruction, with topics including the definition of the SANE role, collection of
Managing Sex Offenders in the Community: A National Overview

Evidence, testing and treatment of STDs, evaluation of other care needed, victim responses and crisis intervention, assessment of injuries documentation, courtroom testimony, corroborating with community agencies, competent completion of an exam, and forensic photography. Some programs also specify a designated number of clinical hours to build SANE experience. Continuing education and competency requirements should be routinely met to maintain active SANE status.180

Rather than base location decisions on what is convenient for service providers, SANE program planners should develop sites that meet the needs of the victims in their community. Addressing victim needs also requires that, regardless of the location of the program site, SANEs communicate and coordinate their efforts with others involved in the community response system (e.g., through active participation in sexual assault response teams).181

The majority of SANE exam sites are located in hospital emergency departments. The emergency department offers a secure site, is open 24 hours a day, and provides access to a wide array of medical and support services. Physicians are available to treat victim injuries, and SANEs can conduct evidentiary exams and treat victims for STDs at the same location. Emergency department overhead and physicians fees, however, can represent a sizable sum charged to victims, their insurance, SANE programs, or state compensation programs. To control these costs, some SANE programs have negotiated reasonable fees for use of the emergency department and the department’s staff time.182

Community-based programs typically offer victims more privacy than hospital exam sites and are not mandated to report felony crimes as hospitals are required to do in some states. Victims are usually not billed for medical care and services. A community-based program may be more committed to coordinating service provision with other members of the response team. For example, some SANE programs may be one component of a comprehensive response center for sexual assault victims.183

4. **Funding Issues**

SANE program startup costs include community and institutional needs assessments, facilities and utilities, office and exam supplies and equipment, staff advertising and selection, staff training, media promotion, and staff salaries for the first year. Planning teams should be careful in estimating how many trained SANEs are needed to ensure that the program has the capacity to consistently and promptly respond to incoming calls on a 24-hour basis. Otherwise, the program will fail to significantly reduce medical-legal response time to sexual assaults.184

5. **Conclusion**

SANE programs are emerging in small and large localities across the nation to improve the quality of sexual assault evidentiary exams. All adults and children who are sexually assaulted deserve to receive the prompt and compassionate emergency medical-forensic care that SANEs offer. Thorough evidence collection in each case opens the door to the possibility of offender conviction. Where SANE programs do not exist, agencies involved in coordinated response to sexual assault victims should not delay in considering implementing such a promising model in their community.185
ENDNOTES

AND

BIBLIOGRAPHY
ENDNOTES

1 Oregon Department of Corrections
2 http://www.igc.org/ncia/sexo.html
3 Ibid.
4 Bureau of Justice Statistics, 1997
5 Community Supervision of the SO: An Overview of Current and Promising Practices, p. 1
6 Lane County Parole & Probation
7 Strategies to Promote Public Safety Through the Effective Management of SOs in the Community: Recommendations to the Office of Justice Programs from the National Summit Working Groups, p. 2
10 Community Supervision of the SO: An Overview of Current and Promising Practices, pp. 7-9
11 Community Supervision of the SO: An Overview of Current and Promising Practices, p. 9
12 Community Supervision of the SO: An Overview of Current and Promising Practices, p. 10
13 Ibid.
14 Community Supervision of the SO: An Overview of Current and Promising Practices, p. 11
15 Community Supervision of the SO: An Overview of Current and Promising Practices, pp. 11-12
18 Community Supervision of the SO: An Overview of Current and Promising Practices, pp. 13-14
21 Revisiting Megan's Law and Sex Offender Registration: Prevention of Problem, p. 1
22 Contextualizing Sex Offender Management Legislation and Policy: Evaluating the Problem of Latent Consequences in Community Notification Laws, p. 84
23 The War on Sex Offenders: Community Notification in Perspective, pp. 261-265
24 Revisiting Megan's Law and Sex Offender Registration: Prevention of Problem, p. 1
25 Revisiting Megan's Law and Sex Offender Registration: Prevention of Problem, p. 2
26 Sex Offender Community Notification, p. 2
27 The War on Sex Offenders: Community Notification in Perspective, p. 267
28 Sex Offender Community Notification, p. 11
29 Sex Offender Community Notification, p. 12
30 Ibid.
31 Revisiting Megan’s Law and Sex Offender Registration: Prevention of Problem, p. 8
32 Sex Offender Community Notification, p. 13
33 Revisiting Megan’s Law and Sex Offender Registration: Prevention of Problem, p. 6
34 Contextualizing Sex Offender Management Legislation and Policy: Evaluating the Problem of Latent Consequences in Community Notification Laws, p. 91
35 Ibid.
37 Ibid.
31 Revisiting Megan’s Law and Sex Offender Registration: Prevention of Problem, pp. 7-8
32 The War on Sex Offenders: Community Notification in Perspective, pp. 266-267
35 Ibid.
36 Sex Offender Community Notification, p. 16
37 Revisiting Megan’s Law and Sex Offender Registration: Prevention of Problem, p. 4
38 Sex Offender Community Notification, p. 10
39 Revisiting Megan’s Law and Sex Offender Registration: Prevention of Problem, p. 11
40 Ibid.
41 Contextualizing Sex Offender Management Legislation and Policy: Evaluating the Problem of Latent Consequences in Community Notification Laws, p. 95
44 Ibid.
45 Revisiting Megan’s Law and Sex Offender Registration: Prevention of Problem, pp. 11-12
46 Sex Offender Community Notification, pp. 13-14
47 The War on Sex Offenders: Community Notification in Perspective, pp. 266-267
49 Ibid.
52 Ibid.
54 Ibid.
55 Sex Offender Community Notification: Managing High Risk Criminals or Exacting Further Vengeance?, p. 387
56 Sex Offender Community Notification: Managing High Risk Criminals or Exacting Further Vengeance?, p. 388
57 Sex Offender Community Notification: Managing High Risk Criminals or Exacting Further Vengeance?, pp. 389-390
58 Revisiting Megan’s Law and Sex Offender Registration: Prevention of Problem, p. 14
59 Revisiting Megan’s Law and Sex Offender Registration: Prevention of Problem, p. 2
61 Revisiting Megan’s Law and Sex Offender Registration: Prevention of Problem, p. 4
70 Revisiting Megan’s Law and Sex Offender Registration: Prevention of Problem, pp. 16-17
71 Sex Offender Risk Assessment and the Law, p. 347
72 Sex Offender Risk Assessment and the Law, pp. 367-368
73 Sex Offender Risk Assessment and the Law, pp. 354-355
74 Actuarial and Clinical Assessment of Risk In Sex-Offenders, p. 331
75 Sex Offender Risk Assessment and the Law, p. 352
76 Actuarial and Clinical Assessment of Risk In Sex-Offenders, p. 331
77 Actuarial and Clinical Assessment of Risk In Sex-Offenders, p. 333
78 Ibid.
79 Actuarial and Clinical Assessment of Risk In Sex-Offenders, p. 334
80 Actuarial and Clinical Assessment of Risk In Sex-Offenders, p. 335
81 Ibid.
82 Ibid.
83 Ibid.
84 Ibid.
85 Ibid.
87 Recidivism Base Rates, Predictions of Sex Offender Recidivism, and the “Sexual Predator” Commitment Laws, p. 99
88 Juvenile Sexual Offending: Causes, Consequences, and Correction, p. xii.
90 Coercion and Sex Offenders: Controlling Sex-Offending Behavior Through Incapacitation and Treatment, pp. 91-95
91 Ibid.
92 Ibid.
93 Ibid.
94 Ibid.
95 Ibid.
96 Ibid.
97 Ibid.
98 Recidivism of Sex Offenders pp. 12-13
99 Sexual Offender Treatment: Biopsychosocial Perspectives, pp. 16-17
100 http://www.igc.org/ncia/sexo.html
101 Ibid.
102 How to answer the question: "Does sex offender treatment work?", p.1
103 Ibid.
104 What Works in Adult Sex Offender Treatment? A Review of Prison- and Non-prison-based Treatment Programs, p. 357
105 Recidivism of Sex Offenders, p. 7
106 What Works in Adult Sex Offender Treatment? A Review of Prison- and Non-prison-based Treatment Programs, p. 358
107 Ibid.
108 Recidivism of Sex Offenders, p. 14
109 Recidivism of Sex Offenders, p. 7
110 What Works in Adult Sex Offender Treatment? A Review of Prison- and Non-prison-based Treatment Programs, p. 374
Sexually Aggressive Youth: A Guide to Comprehensive Residential Treatment, p. 39
Adolescent Sexual Offender Recidivism: Success of Specialized Treatment and Implications for Risk Prediction, p. 966.
Adolescent Sexual Offender Recidivism: Success of Specialized Treatment and Implications for Risk Prediction, p. 968
Adolescent Sexual Offender Recidivism: Success of Specialized Treatment and Implications for Risk Prediction, p. 967
Adolescent Sexual Offender Recidivism: Success of Specialized Treatment and Implications for Risk Prediction, p. 968
Adolescent Sexual Offender Recidivism: Success of Specialized Treatment and Implications for Risk Prediction, p. 976
Adolescent Sexual Offender Recidivism: Success of Specialized Treatment and Implications for Risk Prediction, p. 979
Treating Youth Who Sexually Abuse: An Integrated Multi-Component Approach, p. 231
Sexually Aggressive Youth: A Guide to Comprehensive Residential Treatment, p. 135
Treating Youth Who Sexually Abuse: An Integrated Multi-Component Approach, p. 236-238
Engaging Advocates and Other Victim Service Providers in the Community Management of Sex Offenders, p. 1
A Message to Sex Offenders: Sex Registration and Notification Laws Do Not Infringe Upon Your Pursuit of Happiness, p. 294
Juvenile Sexual Offending: Causes, Consequences, and Correction, p. 10
Reidivism of Sex Offenders, p. 1
Victim Costs and Consequences: A New Look, p. 1
Victim Costs and Consequences: A New Look, p. 9
Victim Costs and Consequences: A New Look, pp. 9-10
Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, p. 1
Ibid.
Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, p. 2
Ibid.
Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, p. 3
Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, pp. 3-4
Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, p. 5
Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, pp. 5-6
Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, p. 7
Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, p. 8
Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, p. 9
181 Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, p. 10
182 Ibid.
183 Ibid.
184 Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, p. 11
185 Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims, p. 14
BIBLIOGRAPHY


CENTER FOR EFFECTIVE PUBLIC POLICY, Strategies to Promote Public Safety Through the Effective Management of Sex Offenders in the Community: Recommendations to the Office of Justice Programs from the National Summit Working Groups, December 1996


CENTER FOR SEX OFFENDER MANAGEMENT, Community Supervision of the Sex Offender: An Overview of Current and Promising Practices, January 2000

CENTER FOR SEX OFFENDER MANAGEMENT, Engaging Advocates and Other Victim Services Providers in the Community Management of Sex Offenders, March 2000

CENTER FOR SEX OFFENDER MANAGEMENT, “Recidivism of Sex Offenders,” May 2001


GREER, WILLIAM C., in Gail Ryan, and Sandy Lane (eds.), Juvenile Sexual Offending: Causes, Consequences, and Correction,” (San Francisco: Jossey-Bass Publishers, 1997), pp. 417-430


HINDS, LYN, and KATHLEEN DALY, “The War on Sex Offenders: Community Notification in Perspective,” The Australian and New Zealand Journal of Criminology, Vol. 34, No. 3, pp. 256-276


Managing Sex Offenders in the Community: A National Overview


Ryan, Gail, and Sandy Lane, “Introduction,” in Gail Ryan, and Sandy Lane (eds.), Juvenile Sexual Offending: Causes, Consequences, and Correction,” (San Francisco: Jossey-Bass Publishers, 1997), pp. xi-xiii


