TREATMENT AND REENTRY PRACTICES FOR SEX OFFENDERS
An Overview of States

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September 2008

Suggested citation: Reagan Daly. *Treatment and Reentry Practices for Sex Offenders: An Overview of States.* New York: Vera Institute of Justice, 2008.

This report was prepared by the Vera Institute of Justice under grant 2006-MU-BX-K018 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, and the Office for Victims of Crime. Opinions expressed in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice or the Vera Institute of Justice.

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Executive Summary

Over the past 15 years, the response of the criminal justice system to people who have been convicted of a sex offense has become increasingly punitive, relying heavily on incarceration. Yet, a consequent increase in criminal justice costs has led some states to reconsider their response to sex offenders. Concerns about public safety and the protection of victims remain the primary focus, but many states have also invested in treatment and reentry programs as alternatives to incarceration for some people.

Although the content and structure of treatment and reentry programs vary considerably from one jurisdiction to another, few if any resources provide criminal justice officials and policymakers an overview of these programs or a comparative assessment of their effectiveness. This report attempts to address these issues by providing an overview and analysis of existing treatment and reentry practices for sex offenders who are involved with the criminal justice system. It focuses, specifically, on four broad areas of practice: treatment in prison, treatment under community supervision, reentry programming, and community supervision. Interviews with state officials and treatment providers from 37 states that responded to our survey revealed several findings:

- In both prison and community settings, the treatment of sex offenders is generally grounded in evidence-based practices, especially cognitive-behavioral therapy. In general, treatment is much more available in the community than in institutional settings.
- In most of the participating states, community-based treatment for sex offenders is supported, at least in part, by collecting fees from those in treatment—a circumstance that may limit access to these programs.
- Standardized risk assessment tools such as the STATIC-99 are now widely used nationally in both prison- and community-based treatment programs. Needs assessment tools, especially the ACUTE, are becoming more prevalent in community supervision.
- No reentry initiatives were found that specifically target sex offenders. Although eligible for general reentry programming in most states, people convicted of a sexual offense have few, if any, options for reentry programming that addresses their unique needs.
- Correctional institutions and community supervision agencies in most states share information about the case histories and treatment plans of sex offenders who are returning to the community from prison. Research suggests that this type of inter-agency communication can help reduce recidivism.
- In general, community supervision agencies manage risk and provide services. Research suggests that this is an effective approach to reducing recidivism.
- A limited number of states are conducting research on their own treatment, reentry, and supervision initiatives. Almost no studies have examined these programs from a cost-benefit perspective.

Acknowledgments

I would like to thank the following people for their assistance in conducting this study: Robin Campbell, Ashley Cannon, Tina Chiu, Jennifer Fratello, Jordie Hannum, Alisa Klein, Abbi Leman, Scott Matson, Charles Onley, Ruth Parlin, Maggie Peck, Carla Roa, Christine Scott-Hayward, Neil Weiner, Dan Wilhelm, and finally, all interview respondents.

Edited by Patrick Kelly.

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Introduction and Background

The sentencing and management of sex offenders is one of the most difficult and controversial issues facing the criminal justice system today. This is in large part due to the brutal nature of many sex crimes and the fact that many victims are children and other vulnerable people—a combination that elicits highly emotional responses from the public.

Over the past 15 years, the criminal justice system's response to people who have been convicted of a sex offense has become increasingly punitive. In 2004, more than 150,000 people were incarcerated in state prisons for sex offenses, compared with 142,000 in 2002 and 110,000 in 1999.[1] In many states, lengthy prison sentences are now the norm: according to one recent study, people who are incarcerated in connection with a sex offense spend about twice as long in prison as those who serve time for other crimes.[2] Also, an increasing number of local and state laws impose strict registration and residency requirements on people who have been convicted of a sex offense, even after they have served a prison sentence. There are now more than 636,000 registered sex offenders in the United States—one in 500 Americans.[3] This number has doubled in the last decade.[4]

The punitive response of the past 15 years is not limited to sentencing laws and stricter registration requirements: the definition of what constitutes a sex offense has also been greatly expanded. (The beginning of this expansion coincided with the 1993 passage of Megan's Law, a federal regulation that directed states to release information to the public about known convicted sex offenders, and has continued through the passage of Jessica's Law in 2006, which introduced stricter penalties and restrictions for sex offenders.) Today, the term sex offense can include everything from child molestation to public urination.

The increasing reliance on incarceration as a response to sex offenses, together with expanded definitions of what constitutes a sex offense, has driven up criminal justice costs. This has led some states to reconsider their response to sex offenders. While concerns of public safety and the protection of victims remain the primary focus, a number of states—especially those with limited resources—have concluded that incarceration is simply not a viable long-term solution, at least not for all sex offenders.

In fact, most people who are convicted of a sex offense will be placed under community supervision at some point—either on probation immediately following sentencing or on parole after having served a jail or prison term. A 1997 study by the Bureau of Justice Statistics reports that of the approximately 234,000 adult sex offenders who are under the custody or control of correctional agencies on any given day in the United States, almost 60 percent are under some form of community supervision.[5] Although there has been no follow-up study in recent years, this number has likely grown.

To cope with the large number of sex offenders under community supervision, a growing number of states are investing in treatment programs. Increasingly, these programs are also functioning as alternatives to incarceration.

However, the content and structure of treatment and reentry programs vary considerably from one jurisdiction to another, and there are few resources for criminal justice officials and policymakers who would like an overview of these programs nationwide. Both the Center for Sex Offender Management and the Association for the Treatment of Sexual Abusers, an international non-profit

[1] W.J. Sabol, H. Couture, and P.M. Harrison, *Prisoners in 2006* (Washington, DC: Bureau of Justice Statistics, 2006); P. M. Harrison and A. J. Beck, *Prisoners in 2004* (Washington, DC: Bureau of Justice Statistics, 2004); A. J. Beck and P. M. Harrison, *Prisoners in 2000* (Washington, DC: Bureau of Justice Statistics, 2000).
[2] Lawrence A. Greenfield, *Sex Offenses and Offenders: An Analysis of Data on Rape and Sexual Assault* (Washington, DC: Bureau of Justice Statistics, 1997, NCJ 163392).
[3] National Center for Missing & Exploited Children, *Registered Sex Offenders in the United States per 100,000 Population* (map), March 25, 2008.
[4] Devon B. Adams, *Summary of State Sex Offender Registries* (Washington, DC: Bureau of Justice Statistics (Fact Sheet): March 2002, NCJ 192265).
[5] Ibid.

organization, have produced publications on the treatment and management of sex offenders, but policymakers seeking to optimize their use of resources would profit from a survey of the programs that are currently in place across the United States. Similarly, their policy decisions would benefit from a comparative assessment of the effectiveness of current practices.

This report attempts to address these issues by providing an overview and analysis of existing treatment and reentry practices for sex offenders involved with the criminal justice system (as opposed to those who are civilly committed).[6] Drawing on information that was collected by Vera researchers from policymakers and treatment providers in the 50 states and Washington, DC, it emphasizes the structure, content, and availability of those programs and, when applicable, compares current practices to research findings. Specifically, it focuses on four broad areas of practice: treatment in prison, treatment under community supervision, reentry programming, and community supervision.[7]

Note that this report does not provide an exhaustive catalog of what each state is doing in terms of treatment, reentry, and community supervision, nor does it provide a comprehensive overview of the legal context in which these services are being delivered.[8] Rather, it aims to identify and analyze nationwide *trends* in treatment and reentry practices.

After a brief description of our methodology, we begin with a review of the latest research on treatment, reentry, and community supervision practices for sex offenders. Then, we present and analyze our findings from each of the four broad areas of practice, beginning with prison-based treatment and followed by community-based treatment, reentry programming, and community supervision. We end with a discussion of overarching themes and conclusions.

Methodology

Vera researchers relied on qualitative methods to collect and analyze data for this report. Data was collected over a six-month study period through phone interviews with state officials and other policymakers who manage sex offenders.

For each of the four substantive areas mentioned earlier (prison-based treatment, community-based treatment, reentry, and community supervision), Vera researchers developed detailed interview questionnaires and identified at least one potential respondent from each state (for a minimum total of four contacts per state). Most respondents either worked in the Department of Corrections or another state agency or were treatment providers. Interview questions were open ended.

The overall response rate for all four substantive areas categories across all 51 jurisdictions was 65 percent.[9] For each state, Vera researchers entered information into an answer template that covered all four substantive areas. Once this answer template was completed, it was sent back to the respondents to confirm that it was consistent with the information they had provided. The completed state templates are included as appendices in this report. They provide detailed information on both the treatment and reentry practices themselves as well as the context in which they were developed.

To identify larger patterns, Vera researchers conducted a qualitative data analysis. This qualitative analysis consisted in reviewing each state template and categorizing treatment and reentry practices according to topics of general interest, such as whether statewide standards exist or the number of treatment providers in a given state. These state overviews are also included in

[6] Civil commitment is the court-ordered confinement and treatment of sex offenders who are deemed to represent a significant threat to public safety.

[7] Sex offenders in the community also receive treatment under civil commitment. However, this study focuses exclusively on treatment in the criminal justice context.

[8] To gain a better understanding of state legislation governing sex offender definitions, registration requirements, and sentencing practices, the Vera Institute has also issued a companion report, *The Pursuit of Safety: Sex Offender Policy in the United States*, that gives a national overview of these issues.

[9] In social science research, a response rate above 50 percent is considered adequate for analysis and publishing (see Babbie 2005 for more information).

the appendices. Categorizing treatment and reentry practices in this manner provided researchers with a broad overview of the subjects.

This study has two methodological limitations. First, as is true of any study that relies on interview responses, some of those we contacted chose not to participate, with the result that there are gaps in our data. Our discussion of national trends and patterns here reflects only those states that responded to requests for phone interviews. Second, the trends identified in this report are based on information *reported* by state contacts. While Vera researchers made every effort to ensure that the information is accurate, this is a complex subject, and the open-ended nature of our interview questions left room for interpretation and (possibly) error.

Research on Treatment, Reentry, and Community Supervision Practices

In this section, we present an overview of recent research on treatment (both in prison and in the community), reentry, and community supervision practices for sex offenders. The aim is to provide a context for the assessment of current state practices described in subsequent sections of this report.

Broadly, the research on treatment methods has consistently found that cognitive-behavioral therapy (CBT), a treatment that relies on changing thought processes to help people understand and accept responsibility for their offenses, is the most effective approach to reducing sexual and overall recidivism. (This result applies to programs that provide CBT in prison as well as those that provide it in other settings.) In addition, the research on reentry and supervision practices has uncovered two salient findings: social support is key to making a successful transition back to society, and supervision is most effective when combined with specialized sex offender treatment services. Unfortunately, there has been little cost-benefit analysis of treatment and reentry programming, which makes it difficult to assess the financial impact of these programs.

There are, however, a number of methodological issues associated with research on sex offenders that limit the applicability of these findings. For one, it is often difficult to find a control group with which to compare program participants—a necessary step if one is to know for certain a program's effect. Also, low baseline rates of sexual offense arrests and significant under-reporting of sexual offenses make it difficult for researchers to demonstrate statistically significant reductions in sexual offending as a result of treatment and reentry programs.[10]

In the remainder of this section, we discuss in more detail research as it relates to each of the four broad areas of practice identified earlier: treatment in prison, community-based treatment, reentry programming, and community supervision.

PRISON- AND COMMUNITY-BASED TREATMENT

Treatment programs generally have three aims: First, they aim to help offenders take responsibility for their actions. Second, they aim to prevent relapse. Third, they aim to rehabilitate people who have been convicted of a sex offense.[11] Different programs pursue these goals in a variety of ways, ranging from CBT to chemical castration (the use of a hormonal medication such as Depo-Provera to temporarily reduce testosterone levels) to education. The appropriateness of any particular approach often depends on the nature of a person's offending behavior: a treatment that is geared toward pedophiles, for example, may not be appropriate for an adult rapist who exhibits more general criminal tendencies.

Treatment across settings. A 2002 meta-analysis of 43 studies on the psychological treatment of sex offenders found that the average rate of sexual recidivism for people in treatment (12.3 percent) was statistically

[10] It becomes increasingly difficult to establish statistically significant differences as the number of outcome events decreases.

[11] Kurt Bumby, *Understanding Treatment for Adults and Juveniles Who Have Committed Sex Offenses* (Silver Spring, MD: Center for Sex Offender Management, 2006).

significantly lower than for those who did not receive treatment (16.8 percent).[12] The average rate of overall recidivism for those in treatment was also lower (27.9 percent, compared with 39.2 percent for people who were not in treatment).[13] Finally, the analysis found that CBT, which has become standard practice in almost every state, is much more effective than the treatments that were used before 1980. More recently, a review of 69 controlled outcome evaluations of sex offender treatment confirmed many documented earlier findings. It also found that treatment reduces sexual recidivism by an average of 37 percent and that hormonal therapy and CBT work best—although it was difficult to separate the effect of these treatments from other factors.[14] The report concluded that more rigorous studies were needed to determine the effectiveness of different treatments for different types of offenders.

Prison-based treatment. The research literature on the effectiveness of treatment programs for incarcerated offenders is fairly inconclusive. A 2003 study of 195 sex offenders who took part in a prison-based CBT program in Vermont found that people who completed the program were significantly less likely (5.4 percent) than those who dropped out (30.6 percent) or refused to participate (30.0 percent) to be charged with a sexual offense in a six-year follow-up period.[15] It also found that continuing with treatment after release from prison was significantly associated with lower recidivism of sexual offenses. However, this study did not use randomly assigned treatment or control groups, so despite the fact that researchers found no significant differences in risk assessment scores between those who completed the program and those who did not, it is impossible to know for certain whether factors other than treatment affected the observed outcomes.[16]

In contrast, there are several studies which have examined specific treatment programs and concluded that they do not have a significant effect on recidivism rates.[17] Among these is a study in which prisoners who had volunteered to participate in California's Sex Offender Treatment and Evaluation Project (SOTEP) were randomly assigned to either SOTEP (which employed CBT and relapse prevention, a treatment that uses cognitive and behavioral techniques to help offenders identify and change negative behavioral patterns) or a control group.[18] Likewise, researchers from the Washington State Institute for Public Policy (WSIPP), which is well-known for both its meta-analyses and its research on treatment for sex offenders, found that a sex offender treatment program for inmates had little effect on recidivism rates for sexual and violent offenses—despite the fact that those who participated in the program did so voluntarily and were thus likely to be amenable to treatment.[19]

In spite of these inconclusive results regarding prison-based treatment in general, there is some evidence that CBT in particular is effective for lowering recidivism rates. In addition to the Vermont study

[12] Because meta-analyses incorporate numerous studies that measure recidivism differently, it is not possible to define recidivism more specifically.

[13] R.K. Hanson, A. Gordon, A.J.R. Harris, J.K. Marques, W. Murphy, V.L. Quinsey, and M.C. Seto, "First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders," *Sexual Abuse: A Journal of Research and Treatment*, 14 (2002): 169-194.

[14] F. Lösel and M. Schmucker, "The Effectiveness of Treatment for Sexual Offenders: A Comprehensive Meta-Analysis," *Journal of Experimental Criminology* 1(2005): 117-146.

[15] R.J. McGrath, G. Cumming, J.A. Livingston, and S. Hoke, "Outcome of a Treatment Program for Adult Sex Offenders: From Prison to Community," *Journal of Interpersonal Violence* 18, no 1 (2003): 3-17.

[16] The use of comparison groups allows researchers to assess whether or not changes in outcomes following treatment would have occurred in the absence of treatment as well. Random assignment to treatment or comparison groups provides the strongest evidence of a treatment effect because it creates two groups that are comparable except for the treatment intervention.

[17] A. Mander, M. Atrops, A. Barnes, and R. Munafo, *Sex Offender Treatment Program: Initial Recidivism Study* (Anchorage, AK: Alaska Department of Corrections, 1996); and V.L.E. Quinsey, G.T. Harris, M.E. Rice, and C.A. Cormier, *Violent Offenders: Appraising and Managing Risk* (Washington, DC: APA, 1998).

[18] J.K. Marques, M. Wiederanders, D.M. Day, C. Nelson, and A. Van Ommeren, "Effects of a Relapse Prevention Program on Sexual Recidivism: Final Results from California's Sex Offender Treatment and Evaluation Project (SOTEP). *Sexual Abuse: A Journal of Research and Treatment* 17 (2005): 79-107. Note that because random assignment fully controls for competing influences on recidivism, the absence of a significant difference between the two groups in this study can be interpreted as strong evidence that there was in fact no difference between them.

[19] L. Song, and Roxanne Lieb, *Washington State Sex Offenders: Overview of Recidivism Studies* (Olympia, WA: Washington State Institute for Public Policy, 1995).

mentioned above, a 2000 study of high-risk sex offenders who volunteered for Canada's Clearwater Sex Offender Treatment Program, which used both CBT and a relapse prevention component, found that program participants had significantly lower reconviction rates than those in a comparison group.[20] Moreover, the difference in conviction rates was much larger for sexual reconvictions than for nonsexual reconvictions. Similarly, in a comprehensive meta-analysis, WSIPP researchers found that prison-based CBT reduced recidivism by an average of 14.9 percent.[21]

Therapeutic community programs, which emphasize group support in facilitating behavior change, have also been shown to exert a beneficial effect on sex offender recidivism. In 2003, the Colorado Division of Criminal Justice found that sex offenders who participated in their prison-based therapeutic community program were significantly less likely than sex offenders who did not participate in the program to recidivate across a number of measures.[22] Moreover, the Colorado study found that longer periods of treatment in the therapeutic community led to lower recidivism rates upon release. Again, though, this evaluation did not use randomly assigned treatment and control groups, nor did it match people in the two groups on the basis of characteristics that may have influenced their decision to enroll in treatment. As a result, it is not possible to attribute the observed outcomes to the program with any certainty.

With regard to the cost of prison-based treatment programs, a cost-benefit analysis by the WSIPP found that these programs, when combined with aftercare, actually *increase* costs to taxpayers by an average of $3,258 per participant. In contrast, treatment delivered to juveniles in an institutional setting saved an average of $7,829 per participant.[23] This was the only cost-benefit analysis we uncovered in our review.

Community-based treatment. The research on community-based treatment programs for sex offenders suggests, fairly consistently, that these programs are effective in reducing recidivism. In one study of 1,400 sex offenders who were sentenced to probation in Minnesota, researchers found that re-arrest rates for sexual offenses for those who completed treatment (5 percent) were lower than for those who began but did not complete treatment (11 percent) and those who never entered treatment (11 percent).[24] The Minnesota study also found that offenders who completed treatment were less likely to be re-arrested for any new offense (13 percent versus 45 percent for those who began but did not complete treatment, and 42 percent for those who never entered treatment).

In addition, there is evidence that treatment designed to address deviant feelings and behaviors specifically related to sexual offending has an effect on both sexual and nonsexual recidivism rates above and beyond the effects of general treatment, which addresses more general mental health and behavioral issues. For example, a 1998 study found that probation supervision combined with specialized sex offender treatment, as compared with probation supervision combined with only general mental health treatment, significantly reduced overall re-arrests (for both sexual and nonsexual offenses) among a group of sex offenders in rural Vermont.[25] However, neither the Minnesota nor the Vermont study used random assignment, so it is not possible to conclude with any certainty that the

[20] J. Looman, J. Abracen, and T. Nicholaichuk, "Recidivism among treated sexual offenders and matched controls," *Journal of Interpersonal Violence* 15, no. 3 (2000): 279-290; Polly Phipps, Kim Korinek, Steve Aos, and Roxanne Lieb, *Research Findings on Adult Corrections Programs: A Review* (Olympia, WA: Washington State Institute for Public Policy, 1999). Throughout this section, "significance" means statistical significance.

[21] Steve Aos, Marna Miller, and Elizabeth Drake, *Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates* (Olympia, WA: Washington State Institute for Public Policy, 2006).

[22] Kerry Lowden, Nicole Hetz, Linda Harrison, Diane Patrick, Kim English, and Diane Pasini-Hill, *Evaluation of Colorado's Therapeutic Community for Sex Offenders: A Report of Findings* (Office of Research and Statistics, Division of Criminal Justice, 2003).

[23] Aos, Miller, and Drake, *Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates*, 2006.

[24] *Sex Offender Supervision: 2000 Report to the Legislature* (St. Paul, MN: Minnesota Department of Corrections, 2000).

[25] R.J. McGrath, S.E. Hoke, and J.E. Vojtisek, "Cognitive-Behavioral Treatment of Sex Offenders: A Treatment Comparison and Long-Term Follow-Up Study," *Criminal Justice and Behavior* 25 (1998): 203-225.

reductions in re-arrests were due to treatment rather than other factors.

With regard to specific treatments, there is considerable evidence, grounded in methodologically sound research, that community-based CBT is effective in reducing overall recidivism. However, it remains unclear whether community-based CBT is effective in reducing *sexual* recidivism. In a systematic meta-analysis of sex offender programming that examined only those evaluations that used a well-matched comparison group, WSIPP researchers found that CBT significantly reduces recidivism (by an average of 31.2 percent across studies) among low-risk sex offenders on probation.[26] The WSIPP study did not, however, examine the impact of CBT on sexual recidivism.

It is difficult to assess the impact of medical treatments on sexual offending. This is primarily due to ethical restrictions that prevent researchers from randomly assigning people to procedures or treatments that are either potentially harmful or invasive. Nonetheless, there have been a handful of studies in this area. One of these, a study based on a sample of mostly pedophiles, found that people who volunteered for and were surgically castrated were significantly less likely to engage in recidivism of sexual offenses than volunteers who were not castrated.[27] In addition, a meta-analysis found that hormonal therapy was, on average, more effective in reducing sexual recidivism than psychosocial interventions—although other aspects of these programs may account for this effect.[28]

REENTRY PROGRAMMING

Reentry programming aims to help sex offenders make the transition back into the community after they are released from prison. Although reentry in general is a major topic in the field of corrections, there has been relatively little research that focuses on the specific needs of sex offenders leaving prison. One of the few studies that addresses the subject directly began by examining the general literature on successful reentry strategies for people convicted of a wide range of offenses. Then, arguing that these reentry strategies can be applied to sex offenders so long as one takes the unique needs of sex offenders into account, it identified several key factors in the successful reentry of sex offenders:

1. Institutional and community case managers collaborate to maintain a consistent approach.
2. Manage sex offenders in prison in a way that prepares them for release.
3. Consider the benefits of discretionary release policies.
4. Have case managers actively involved in facilitating the transition.
5. Recognize victims as important stakeholders.
6. Develop a community supervision approach for sex offenders that promotes successful outcomes in addition to risk management.[29]

The Center for Sex Offender Management endorsed these strategies in a 2007 report.

A handful of studies have examined the impact of specific reentry models on sex offenders leaving prison. A 2005 study, for example, examined Circles of Support and Accountability (COSA), a program that originated in Canada and is becoming more prevalent in the United States. COSA encourages high-risk offenders to develop support networks in the community, consisting mostly of volunteers from faith-based organizations who visit them on a regular basis, following their release from prison. The researchers found that sex offenders who participated in COSA recidivated at a rate that was 31.6 percent lower than people in a matched group who did not participate.[30] Another study of COSA, this one from

[26] Steve Aos, Marna Miller, and Elizabeth Drake, *Evidence-Based Adult Corrections Programs: What Works and What Does Not* (Olympia, WA: Washington State Institute for Public Policy, 2006).
[27] Ibid.
[28] Lösel and Schmucker, 2005.
[29] K.M. Bumby, T.B. Talbot, and M.M. Carter, "Sex Offender Reentry: Facilitating Public Safety through Successful Transition and Community Reintegration," *Criminal Justice and Behavior* (in press).
[30] R.J. Wilson and J.E. Picheca, "Circles of Support and Accountability: Engaging the Community in Sexual Offender Management" in B.K. Schwartz (Ed.), *The Sex Offender: Issues in Assessment, Treatment, and Supervision of Adult and Juvenile*

2007, concluded that the program led to a 70 percent reduction in re-arrests for sexual offenses and a 57 percent reduction in re-arrests for violent offenses.[31]

Finally, a number of studies suggest that many sex offenders leaving prison need community support to find a place to live, as strict residency requirements often make it difficult for them to find affordable housing.[32]

COMMUNITY SUPERVISION

Community supervision refers to those forms of correctional supervision that do not involve incarceration, such as probation, parole, and community corrections. (Community corrections involves monitoring offenders independently of probation and parole. In general, community corrections agencies supervise offenders who have been diverted from prison but who represent a higher risk than people on probation.) The research on community supervision is similar to that on reentry in that it stresses the importance of social bonds and community support in reducing recidivism and rehabilitating offenders.

One of the most promising models of community supervision—and perhaps the most widely known in the sex offender management community—is the containment model, an evidence-based model developed by the Colorado Division of Criminal Justice in the 1980s. The containment model is grounded in five key principles, all of which support the notion that sexual re-offending can be minimized through internal and external controls:[33]

1. The primary objectives of sex offender management are to enhance public safety, ensure victim safety, and make reparation to victims.
2. Sex offender management should rely on inter-agency coordination, interdisciplinary partnership, and job specialization to provide a unified approach.
3. Offenders should be held accountable through individualized case management plans that use informal controls (which are learned and reinforced through treatment) as well as external controls (in particular the active involvement of family and law enforcement). Polygraphs should also be used to monitor these internal and external controls.
4. State and local criminal justice agencies and policymakers should work together to develop informed public policies.
5. Criminal justice agencies should develop quality control mechanisms to monitor the implementation of these strategies and to assess their effectiveness over time.

Each of these principles is grounded in the clinical treatment literature, and research on the containment model provides support for its effectiveness in reducing recidivism. Some of this research overlaps with the treatment literature discussed earlier—for example, the Colorado therapeutic community program that was found to reduce recidivism was grounded in the containment approach. In addition, a 2001 Oregon study found that people on probation and parole who took part in a program that combined treatment, polygraph monitoring, and specialized supervision were 40 percent less likely to be convicted of a new felony than people on probation and parole in a neighboring county who did not receive the same combination of services.[34] Other state-specific analyses have found that sex offenders who are supervised under the containment model have low

Populations (pp 13.1-13.21) (Kingston, NJ: Civic Research Institute, 2005).

[31] R.J. Wilson, J.E. Picheca, and M. Prinzo, "Evaluating the Effectiveness of Professionally Facilitated Volunteerism in the Community-Based Management of High-Risk Sexual Offenders: Part Two—A Comparison of Recidivism Rates, *The Howard Journal*, 46, no. 4 (2007): 327-337.

[32] Joan Petersilia, *When Prisoners Come Home: Parole and Prisoner Reentry* (New York, NY: New York Open Society Institute, 2003).

[33] K. English, S. Pullen, and L. Jones, *Managing Adult Sex Offenders in the Community: A Containment Approach* (Washington, DC: National Institute of Justice, Research in Brief, 1997).

[34] K.A. England, S. Olsen, T. Zakrajsek, P. Murray, and R. Ireson, "Cognitive/Behavioral Treatment for Sexual Offenders: An Examination of Recidivism," *Sexual Abuse: A Journal of Treatment and Practice* 13, no. 4 (2001): 223-231.

felony re-arrest rates (6 percent in one study). However, none of these state-specific studies used comparison groups, so it is difficult to attribute this outcome with any certainty to the containment model.[35]

Other research suggests that strong social support can play a crucial role in preventing recidivism. For example, a 2004 study of sex offenders sentenced to probation for child molestation found that people who had strong support from family and friends were less likely to have their probation status revoked for either a technical violation or a new arrest and that people with strong support whose status was revoked generally lasted longer on probation than people without such support.[36] The study also found that people who were employed were less likely to violate the terms of probation.[37] These findings are consistent with a body of research that highlights the shortcomings associated with a straight risk management approach (that is, an approach that emphasizes monitoring offenders without attempting to address their needs). According to some studies, risk management strategies have a negligible impact on recidivism rates among the *general* offender population when they are used in isolation; additional research suggests that this is true of sex offenders as well.[38]

On a different note, a recent study in Vermont examined the impact of polygraph techniques on recidivism rates among 208 adult male sex offenders who were both receiving treatment and under community supervision. Half of the people in this sample group were subject to polygraph monitoring. Researchers found that although significantly fewer people in the group that was subject to polygraph monitoring were charged with non-sexual violent offenses, there were no significant differences between the two groups with respect to the number of people charged with sexual offenses; the number of people charged with sexual or violent offenses; or the number of people charged with criminal offenses in general.[39]

Recent Trends in Treatment, Reentry, and Community Supervision Practices

This section summarizes recent trends in each of the four substantive areas outlined earlier—prison-based treatment, community-based treatment, reentry, and community supervision—as revealed by our survey. When applicable, we assess these trends in light of extant research. A detailed, state-by-state overview of current practices for each substantive area can be found in the appendices.

PRISON-BASED TREATMENT

Our analysis of prison-based treatment indicates that while few states are able to provide treatment to all imprisoned sex offenders who are eligible, the treatment services that are currently in place are grounded in evidence-based approaches such as CBT and relapse prevention. There is less emphasis on drug therapy and polygraph monitoring, which have not yet been adequately evaluated by researchers. Our qualitative analysis of survey data identified four trends: the limited availability of prison-based treatment; the widespread use of evidence-based treatment; the growing use of treatment standards; and the widespread use of risk (but not needs) assessments.

Limited availability. Prison-based treatment for sex offenders is available in most states. In general, though, the treatment capacity of prisons and jails is quite

[35] Division of Probation Services, *Special Analysis* (Denver, CO: State Court Administrators Office, Judicial Branch, 2007); M. Walsh, "Overview of the IPSO Program—Intensive Parole for Sex Offenders – in Framingham Massachusetts, Presentation by the parole board chair to the National Governors Association policy meeting on sexual offenders. November 15, 2005. San Francisco, CA.

[36] This includes revocations for technical violations and new arrests.

[37] John R. Hepburn, and Marie L. Griffin, "The Effect of Social Bonds on Successful Adjustment to Probation: An Event History Analysis," *Criminal Justice Review*, 29, no. 1 (2004).

[38] Kurt Bumy, Tom Talbot, and Madeline Carter, *Managing the Challenges of Sex Offender Reentry* (Silver Spring, MD: Center for Sex Offender Management, 2007).

[39] R.J. McGrath, G.E. Cumming, S.E. Hoke, and M.O. Bonn-Miller, "Outcomes in a Community Sex Offender Treatment Program: A Comparison Between Polygraphed and Matched Non-polygraphed Offenders," *Sex Abuse* 19 (2007): 381-393.

limited, especially when compared with community-based programs. Across the 37 states that responded to our survey of prison-based treatment, we found that the percentage of imprisoned sex offenders in treatment at any given time ranged from 1 to 33 percent. Interviews with policymakers and treatment providers suggest that limited institutional capacity was the primary reason these figures were so low. Only one state (Pennsylvania) reported that treatment is available in all facilities; in contrast, 13 states reported that treatment was either unavailable altogether or available in only one facility. Our findings also suggest that it is especially difficult for female sex offenders to access treatment. Fewer than half of the participating states reported that treatment is available in at least one women's prison. (We did not, however, directly ask about the availability of treatment in women's prisons, so the actual number may be higher.)

In light of the limited availability of prison-based treatment programs, it is not surprising that very few states require all incarcerated sex offenders to undergo treatment. Indiana, Iowa, Missouri, and New Jersey were the only states that reported mandatory treatment in prison without any qualifiers. (In other words, all incarcerated sex offenders in those states are presumably required to undergo treatment.) Other states provide treatment to select groups of sex offenders, or offer education that does not technically qualify as treatment. Montana, for example, requires all people convicted of a sex offense to participate in a 15-week group educational program with a sex therapist prior to being screened for further treatment; Ohio mandates treatment for all medium- and high-risk sex offenders, as defined by scores on the STATIC-99 risk instrument.[40]

Evidence-based treatment methods. Our survey indicates that most prison-based treatment programs rely heavily on CBT, a treatment that, as noted earlier, is supported by research.

Very few states employ drug therapy as part of prison-based treatment on anything other than a case-by-case basis. Among those states that do administer drugs, most use anti-depressants such as selective serotonin reuptake inhibitors (SSRIs), as opposed to chemical castration or other types of hormonal therapy—the types of drug therapy that are generally associated with medical treatment of sex offenders in the research literature. Because very few studies have examined the role of anti-depressants in prison-based treatment for sex offenders, it is difficult to draw conclusions about the impact of current drug therapy practices.

While polygraphs are more prevalent than drug therapy in the context of prison-based treatment, they are hardly widespread. Fewer than half of the states that responded to our survey reported using polygraphs in some capacity in prison-based treatment programs. Unfortunately, as noted earlier, there is very little research (as of spring 2008 we were unable to find a single study) that examines the impact of polygraph monitoring on sexual recidivism.

A few states reported assigning people to different treatment programs based on their level of risk. This practice is consistent with criminological research, which shows that, in the general population of offenders, those who are higher risk achieve better outcomes when they receive more intensive programming, and those who are lower risk do better in less intensive programming.[41]

Finally, a number of states have treatment programs that employ either multiple treatment components or a progressive series of phases (or both). Most multi-phase programs begin with an educational component. The content and purpose of this educational component varies from program to program: In Colorado and Montana, for example, the first phase of treatment involves providing an overview of the program so that participants know what to expect before they begin. In Ohio, on the other hand, the first phase consists of a "psychoeducation" program that explains to participants

[40] The STATIC-99 is an actuarial risk assessment instrument that predicts risk for sexual recidivism among adult males based on 10 factors that are stable over time.

[41] D.A. Andrews and J. Bonta, *The Psychology of Criminal Conduct*. 3rd edition (Cincinnati, OH: Anderson, 2003).

the nature of their mental illness to help them prevent relapse.

Standards for treatment. Most states have standards that define the parameters of treatment programming, although only 15 of the 37 states that responded to our survey reported that their standards had been developed by independent bodies outside of the department of corrections. The existence of treatment standards is significant because it creates a system of accountability among criminal justice agencies and providers and encourages them to use evidence-based techniques. Independent standards provide an additional level of oversight and, thus, encourage criminal justice agencies and treatment providers to adopt responsible and effective approaches to treatment. Moreover, the fact that independent standards are usually drafted by mental health professionals and other authorities suggests that such standards are more likely to be effective than standards created by correctional officials. Among the states with standards that were created by independent, legislatively created bodies are Colorado, Connecticut, Kentucky, and Texas.[42] Several other states—among them Washington, Vermont, and Montana—have standards that were created by independent bodies that were not legislatively created.

Risk and needs assessments. A great majority of participating states use at least one actuarial risk assessment instrument for predicting sexual recidivism among people incarcerated for sex offenses. Such tools have the advantage of determining risk through statistical relationships, rather than through subjective clinical judgments. The most widely used risk assessment instrument is a standardized instrument known as the STATIC-99. In general, standardized instruments are more common than customized instruments, though it remains unclear to what extent such standardized instruments have been validated for the particular uses individual states put them to.

Only five states (Colorado, Illinois, Utah, Vermont, and Wisconsin) reported having developed customized risk assessment tools based on statistical data drawn from local sex offender populations.[43] Two of the most widely recognized customized state tools are the Minnesota Sex Offender Screening Tool (MnSOST-R) and the Vermont Assessment of Sex Offender Risk (VASOR), both of which are being used in a number of other states.

Although the use of risk assessment tools is fairly widespread, only a few states use actuarial *needs* assessments in prison. (The two types of instruments serve very different purposes in the context of prison-based treatment: risk assessments are primarily used to predict the likelihood that a sex offender will recidivate; needs assessments provide information about "dynamic" factors—such as alcoholism and negative moods—that change over time. Information about dynamic factors can then be used to craft individual treatment plans with targeted interventions that can be re-evaluated over time.) Only about one-quarter of states reported using a standardized needs assessment instrument in prison settings; Vermont is the only state that has developed its own needs assessment instrument.[44] The Vermont instrument is distinct from other needs assessment instruments in that it can be used not only to identify possible interventions, but also to assess progress in treatment.

[42] Both Delaware and New Mexico recently passed legislation to create sex offender management boards (SOMB) for the purpose of drafting treatment standards. In addition, California and West Virginia are currently developing standards tied to legislative initiatives: California has a SOMB and recently created a treatment committee, which submitted a report to the state legislature in early 2008. In West Virginia, the Department of Health and Human Resources is developing standards to meet requirements of the 2006 Child Protective Act.

[43] Minnesota has one as well—the MnSOST-R—but did not participate in the study.

[44] The MnSOST-R includes some dynamic factors, but in this report, needs assessment instruments have been defined as those that contain ACUTE dynamic factors. Among those that are commonly recognized are the ACUTE, Vermont Treatment Needs and Progress Scale, Multiphasic Sex Inventory (MSI), Psychological Inventory of Criminal Thinking Styles (PICS), Sex Offender Need Assessment Rating (SONAR), and COMPAS.

COMMUNITY-BASED TREATMENT

In most states, the treatment that is provided for sex offenders under community supervision is, like that which is available for incarcerated sex offenders, grounded in evidence-based approaches such as CBT. Most states also reported efforts to ensure that consistent treatment is available for people returning home from prison. In general, sex offenders in the community have greater access to treatment than those in prison, although in many states access to treatment is at least partially paid for by offender fees.

There are many different community-based treatment programs for sex offenders. At the county level, where most probation is administered, there can be considerable variation in the content and structure of these programs. To simplify the process of gathering information on community-based treatment, we focused exclusively on programs at the state level, most of which target people on parole.

Evidence-based treatment. As was the case for prison-based treatment programs, almost all community-based treatment programs use CBT to some extent; many also use relapse prevention, arousal control (a technique for reducing deviant sexual urges), and victim empathy (a technique that helps sex offenders become aware of the impact of their actions on victims.) Again, the prevalence of CBT is consistent with research that shows this method is effective in reducing recidivism.

Community-based treatment programs are also similar to prison-based treatment programs in their reluctance to use drug therapy on anything other than a case-by-case basis. Although officials in about half of the states that responded to our survey reported that drug therapy is sometimes used for sex offenders under community supervision, most also noted that it is not a standard component of treatment. A number of states reported using hormonal drug therapy in addition to chemical drug therapy—almost always only rarely or on a case-by-case basis.

On the other hand, the use of polygraph tests appears to be much more prevalent in community-based programs than in prison-based programs. Thirty-two out of 36 states that responded reported using polygraphs in some capacity for sex offenders on community supervision. A few states reported using them for multiple purposes, including assessing the offender's ability to admit the full extent of his or her crime; assessing the offender's criminal history; obtaining information about victims; and assessing the extent to which an offender is complying with treatment and supervision requirements (the most common use). As noted earlier, there is little evidence that polygraphs are effective in reducing recidivism rates, so it is unclear whether or not these practices should be expanded.

Consistency between prison-based and community-based treatment programs. In most states, correctional institutions and community supervision agencies share information about the case histories and treatment plans of sex offenders who are returning to the community from prison. By communicating in this manner, these states aim to ensure that treatment is provided consistently during the transition period—a goal that is consistent with the unified approach to sex offender management emphasized in the containment model. The majority of states that took part in our survey reported that even in cases where a person begins treatment in prison but does not continue treatment under community supervision, prison officials and community supervision officials communicate about the person's prison-based treatment. In Montana, for example, community treatment providers generally call prison case managers to learn more about a person's treatment while in prison, while in Colorado prison-based treatment providers send treatment records on to community-based providers as a part of the standard discharge procedure.

Greater availability but limited state funding. Our data also suggest that treatment is more readily available under community supervision than in institutional settings. This is to be expected, given the higher risk of recidivism among offenders who re-integrate into society. All of the states that participated in our

community treatment interview reported that treatment is available in some capacity for sex offenders under community supervision; about two-thirds described the distribution of treatment providers as "statewide."

The number of treatment providers varied greatly from one state to another, ranging from three (in both Arkansas and Washington, DC) to 427 (in Texas). There was also a great deal of variation in treatment settings. Most states contract with private providers in some capacity; some states contract with a single provider, others work with an assortment of different providers. An example of the former is Connecticut, which contracts with the Connection Inc.'s Center for the Treatment of Problem Sexual Behavior (CTPSB) to provide all treatment to people on probation and parole. (CTPSB employs a staff of 30). Examples of the latter include Washington and Ohio. In Washington, treatment is provided by both the Department of Corrections and private contractors. In Ohio, there are two types of residential programming for sex offenders in the community: halfway houses that provide sex offender-specific programming (in addition to other types of programming) for offenders on probation and parole, and community-based correctional facilities, which provide diversionary programs for low-risk sex offenders on probation.

For many community-based treatment programs, funding appears to be a significant concern. Most states reported that at least some funding comes directly from offenders; around one-quarter of states reported that offender fees are the only source of funding for community-based treatment. In these states, access to community-based treatment is at least partially dependent on the sex offender's ability to pay for it.

REENTRY PROGRAMMING

Given that most sex offenders who are sentenced to prison are eventually released into the community, reentry programming has recently become a topic of significant interest in the field of sex offender management. Yet, our review has revealed that reentry programming for sex offenders in the United States is limited. Although sex offenders in most states are eligible for general reentry programs, only about a third of participating states reported that they have reentry programming that targets the specific needs of this population. In addition, the role of faith-based organizations in providing reentry programs for sex offenders is not especially prominent. On the other hand, case managers—people assigned to help sex offenders plan and carry out reentry plans—are becoming more common in prisons.

Lack of sex-offender specific initiatives. Especially striking was the finding that many states do not have reentry initiatives for sex offenders.[45] Most states reported that they provide at least some services for offenders (including sex offenders) during reentry, but only around half reported having specific reentry initiatives to coordinate the delivery of those services. None reported having a reentry initiative specifically for sex offenders. Both Colorado and Ohio reported that they use the COSA model (discussed earlier in the section on reentry programming), but because COSA focuses on post-release support, it is not, technically speaking, a reentry initiative. Finally, we found that in most states that provide services to sex offenders at some point during reentry, those services are available in all prisons throughout the state.

Case managers in prison and community settings. Our review also indicates that case managers—people assigned to help sex offenders plan and carry out individual reentry plans—are almost as widely available in prisons as they are in the community. This is a very positive development; as mentioned earlier, collaboration between institutional and community case managers has been identified as one of the key components of successful reentry. About half of the states we interviewed reported that some sort of case

[45] For the purposes of this report, a reentry initiative is distinct from reentry programming in that it represents a comprehensive effort to provide well-coordinated services to people who are making the transition home from prison. In general, reentry initiatives regulate the provision of services both before and after release.

manager is assigned to offenders while they are still in prison. Our survey also indicates that this practice is not limited to states with a particular reentry initiative in place. Montana, for example, does not have a reentry initiative; nonetheless, probation officers begin working with offenders to prepare them for reentry about 90 days prior to release. In many states, the role of post-release case manager is filled by probation and/or parole officers, although some states (such as Pennsylvania and Utah) employ specialized case managers for that purpose.[46] In Washington State, some service providers begin working with offenders six to twelve months before release and continue working with them in the community.

Role of faith-based organizations. Our data suggest that in most jurisdictions, faith-based organizations do not play a central role in the provision of post-release reentry services for the general population of offenders. While a number of states have adopted the COSA model, which, as discussed earlier, makes extensive use of volunteers from faith-based organizations to support and monitor sex offenders returning to the community, very few states cited COSA as a reentry initiative. Indeed, the role of faith-based organizations in reentry appears difficult to measure. Most interview respondents could only estimate the involvement of faith-based organizations in very general terms (e.g., some, limited), and Vera researchers were unable to obtain precise data about the proportion of service providers that are faith-based. That said, respondents from a few states did report that faith-based organizations either play or are expected to begin to play a significant role in the provision of reentry services. In Ohio, for example, a law (HB 113) was recently passed that requires the Department of Rehabilitation and Corrections to work with faith-based organizations to develop prison-based mentorship reentry programs. Respondents from Washington reported that at least half of all nonprofit reentry service providers are faith-based, and in Michigan, faith-based organizations play a role in the development of reentry policy through county-level reentry steering committees. In Delaware, nonprofit organizations generally do not provide services to sex offenders; however, the few that do are faith-based.

COMMUNITY SUPERVISION

The last of the four substantive areas on which we surveyed policymakers and treatment providers was the supervision of sex offenders in the community. As in previous sections, our discussion here is limited to supervision at the state level. In some states, that means both probation and parole. In other states (such as Kansas), it also means community corrections agencies separate from probation and parole. In still other states, where probation is administered at the county-level, it means parole alone. And in a few states (Pennsylvania is an example), probation and parole are administered at both the state and county level. In order to simplify our discussion, we do not distinguish here between parole-based practices and probation-based practices on the state level. For more information on these issues, please refer to the individual state appendices.

Our review indicates that needs assessments are increasingly being administered to sex offenders under community supervision. In addition, we found that in most states, community supervision agencies pursue two goals: managing risk and providing services. Research suggests that this is an effective approach to reducing recidivism.

Increasing use of needs assessments. There is a growing use of needs assessment instruments for sex offenders under community supervision. One prominent example is the ACUTE, which was adapted from the Sex Offender Need Assessment Rating (another needs assessment tool) and includes seven scales of *acute*

[46] In both Pennsylvania and Utah, sex offenders are assigned to a "transitional coordinator," a parole agent charged with helping the newly released person re-integrate into the community immediately upon release from state prison. After 90 days, the person's case is then transferred to a general parole agent.

dynamic factors, which change rapidly.[47] As mentioned earlier, the use of such tools is a positive development, as they can track changes in dynamic risk factors over time and modify supervision practices according to changes in risk levels. More than half of the states that responded to our survey reported that they use actuarial needs assessment tools to manage sex offenders under community supervision—a figure that is much higher than the proportion of states that use these tools in prison settings.[48] As previously mentioned, Vermont has developed a customized instrument that assesses both needs and treatment progress, and this instrument has recently been adopted in West Virginia as well.

In addition to needs assessments, almost all of the states we surveyed administer at least one type of actuarial *risk* assessment to sex offenders under community supervision. The STATIC-99 is the most prevalent risk assessment tool: 24 out of the 29 states we interviewed reported using it in some capacity. Only three states reported having developed customized risk assessment tools for sex offenders under community supervision, although customized tools are used more frequently in the community than in prison. The customized risk assessment tools that were developed in Colorado and Vermont, as discussed earlier, are administered both in prison and to those under community supervision. Additionally, the Iowa Department of Corrections is in the process of developing a customized tool called the ISORA 8 for sex offenders on both probation and parole.[49]

Focus on treatment and monitoring. Our review also revealed that most states have specialized provisions for sex offenders under community supervision. Specialized provisions are supervision conditions—such as restrictions on an offender's contact with minors—that apply specifically to sex offenders. In general, they aim to enhance community supervision and reduce exposure to cues that are likely to trigger deviant behavior. In many states, specialized provisions are reserved for specialized caseloads that include only sex offenders.[50] (Probation and parole officers who administer these caseloads have generally undergone specialized training.)

In addition, more than half of the states that reported back have lifetime supervision (mandatory supervision for the rest of a person's life). In most cases, this sanction is only used for high-risk or violent sex offenders: In Iowa, for example, only people who are convicted of a Class C felony sex offense or higher are eligible for lifetime supervision.

Our review does not indicate that specialized provisions, specialized caseloads, and lifetime supervision have displaced efforts to provide services, however. As noted earlier, most of the states that responded to our survey reported that treatment has become an important part of community supervision. This finding is consistent with research showing that community supervision that combines surveillance and intensive supervision with treatment and rehabilitation services is more effective at reducing recidivism than surveillance alone, both among the general offending population and among sex offenders.[51]

[47] ACUTE dynamic factors are distinct from stable dynamic factors, which change over longer periods of time.

[48] Again, needs assessment instruments are defined as those that contain ACUTE dynamic factors. These include the ACUTE, Vermont Treatment Needs and Progress Scale, Multiphasic Sex Inventory (MSI), Psychological Inventory of Criminal Thinking Styles (PICS), Sex Offender Need Assessment Rating (SONAR), and COMPAS.

[49] Alabama; Kansas; Montana; Washington, DC; and Wyoming also reported having customized risk assessment tools under community supervision, but they described them as general risk assessment instruments, rather than sex offender-specific.

[50] Some states do not have specialized caseloads for *all* sex offenders under community supervision, but this is usually because not all jurisdictions have enough sex offenders to warrant specialized caseloads. Additionally, some states require only those sex offenders who meet certain risk or offense criteria to be supervised on specialized caseloads. For example, in Indiana, if an offender on parole is originally convicted of or has a history of at least one of a specific subset of offenses, including, rape, criminal deviant conduct, molestation, or failure to register, he or she is required to be supervised under the Sex Offender Management and Monitoring Program.

[51] S. Aos, P. Phipps, R. Barnoski, and R. Lieb, *Evidence-Based Adult Corrections Programs: What Works and What Does Not. Document number 06-01-1201.* (Olympia, WA: Washington State Institute for Public Policy, 2006); R.J. McGrath, G.F. Cumming, J.A. Livingston, and S.E. Hoke, "Outcome of a Treatment Program for Adult Sex Offenders: From Prison to Community," *Journal of Interpersonal Violence, 18* (2003): 3-17.

Conclusions

Our findings can be summarized as follows:

- In both institutional (prison-based) and community settings, the treatment of sex offenders is generally grounded in evidence-based practices, especially cognitive-behavioral therapy (CBT). In general, treatment is much more available in the community than in institutional settings.
- In a majority of participating states, community-based treatment for sex offenders is supported, at least in part, by collecting fees from those in treatment—a circumstance that may limit access to these programs.
- Standardized risk assessment tools such as the STATIC-99 are now widely used in both prison-based and community-based treatment programs across the nation. However, a lack of data prevented us from determining the number of states that have validated these tools for their local populations.
- Needs assessment tools, especially the ACUTE, are becoming more prevalent in community supervision.
- We found no reentry initiatives that specifically target sex offenders. Although sex offenders in most states are eligible for general reentry programming, there are few reentry programs that address the unique needs of this population. One exception is Circles of Support and Accountability (COSA), a program that encourages high-risk offenders to develop support networks in the community. COSA has been piloted in several states.
- In most states, correctional institutions and community supervision agencies share information about the case histories and treatment plans of sex offenders who are returning to the community from prison. Research suggests that this type of inter-agency communication can help reduce recidivism.
- In general, community supervision agencies both manage risk and provide services. Research suggests that this is an effective approach to reducing recidivism.
- A limited number of states are conducting research on their own treatment, reentry, and supervision initiatives. There have been almost no studies that examine these programs from a cost-benefit perspective.

The variety in treatment and reentry practices across different states (and even from one jurisdiction to another) makes it impractical to devise blanket recommendations from these findings. However, the need for more rigorous research on treatment and reentry practices for sex offenders is clear. Although the current body of research indicates that cognitive-behavioral therapy and the containment model of supervision are both effective in reducing recidivism, many questions remain unanswered: Many of the practices described in this report, for example, consist of multiple components, but it is unclear how each of the individual components affects recidivism or improves offender outcomes such as reintegration. Furthermore, there is very little research that provides a clear picture of what works for whom. Finally, it bears repeating that there is a noticeable lack of research on the cost-savings associated with treatment and reentry programs. Finding answers to these questions will help policymakers create more informed and more effective policies for the treatment and management of sex offenders.

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