ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
6792 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

CORRECTIONAL INDUSTRIES COMMISSION MEETING
January 16, 1992

MOTION: The Commission recommends to the Commissioner of Corrections the finding that the proposed use of inmate labor to clear Alaska Railroad right-of-way minimally impacts the private sector. The Commission further finds that the proposal is in the best interest of the State. This finding and recommendation will be evaluated by the Commission in the fall of 1992.

Motion carried by unanimous consent. Commissioner Hames abstained from voting.

MOTION: The Commission recommends to the Commissioner of Corrections the finding that the proposed telephone information service for State agencies has a minimal impact on the private sector and is in the best interest of the State to operate as a correctional industry.

Motion carried by unanimous consent. Commission Hames abstained from voting.

SEX OFFENDER TREATMENT TASK FORCE
(Final Report and Recommendations)

State of Alaska

Department of Corrections

January 2, 1992

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MISSION STATEMENT

To evaluate and make recommendations on the most effective institutional placement of sex offender programs.

INTRODUCTION

The Department of Corrections has been offering sex offender treatment programing since the early 1980's. Programs presently exist in Lemon Creek, Hiland Mountain and Fairbanks. Technical evaluations of these programs have been done by Rob Freeman-Longo and William Pithers. The Pithers report was not available to the task force. The task force decided that the quality of the programs was beyond the scope of the inquiry and elected to focus on issues of efficiency, institutional ability to provide treatment, and number and type of inmates needing treatment. The passage of HB366 which requires prisoners to participate in sex offender treatment will no doubt impact in ways that are difficult to predict (see March 18, 1991 memo from Mike Taylor).

METHODS OF RESEARCH AND EVALUATION

Documents used by the Task Force are as follows:

* Department's statewide <u>Sex Offender Tracking Report</u> (HCRO170P)
* Sex Offender Statement of Standards 1990
* Rob Freeman-Longo's Report
* 1991 Survey by Trevor Jones
* Memorandum from Sue Ford dated 11-6-91
* Memorandum from Paul Turner dated 10-27-91.
* Memorandum from Mike Taylor dated 3-18-91.

The Task Force initially identified the factual information that would be needed in order to make informed recommendations to the department. It was clear from the outset that there was a dearth of factual data readily available. Various members of the task force were assigned specific subject matters to research. The greatest task was in "pulling" information from the <u>Tracking Report</u>.

DISCUSSION

Statistical Data to be Maintained by Department

The sex offender tracking report contains a good deal of information, but not in usable form. Jim Pagels and other staff at HMCC took several days to hand count and organize tracking information so that the questions below could be answered. Based upon information given to the task force, there is good reason to suspect that the tracking system itself is "breaking down" because staff are not inputting required information. Staff are not doing this because the document is not being circulated consistently and there is the impression that information that is put into the system doesn't stay there. In short, the sex offender tracking document is not maintained accurately.

Listed below is the statistical data that should be maintained in a "user friendly" format:

1. Number and location of sex offenders.
2. Custody of sex offenders.
3. Number of sex offenders with court ordered treatment.
4. Lengths of sentence and bracketed release dates.
5. Number and location of treatment slots.
6. Number of sex offenders who have refused treatment.
7. Number of sex offenders who failed to complete treatment.
8. Number of vacant sex offender beds.
9. Number and location of approved treatment providers.
10. Number and location of sex offenders with less than 18 months.
11. Number of sex offenders being released each year without treatment.
12. Number and location of sex offenders on formal probation.
13. Cost of treatment beds/vendor.
14. Number and location of sex offenders in treatment beds.

Utilization of Treatment Beds

Custody of Sex Offenders

Community	41
Minimum	43
Medium	236
Close	199
Maximum	16
Unclassified	15
Total	550

Existing Sex Offender Treatment Programs

	Beds	Inmates in Treatment
FCC	35	18
HMCC	80 (10 of which are pre-treatment)	70
LCCC	12	9
Total	127	97

Inmates eligible, interested and not receiving:
7 close and 12 other = 19

It appears that the present beds are adequate for the existing populations if they were all filled. However, it also appears that the Cleary cap on Fairbanks makes the continuation of a Sex Offender Treatment Program there unlikely. This question will be addressed more fully under <u>Treatment Programs at Fairbanks Correctional Center</u> and in recommendations six and seven. If the Fairbanks program is closed, HMCC and LCCC could be expanded as follows:

HMCC	LCCC
80 + (10 bed increments up to an additional 40)	26
120	26 = 146

LCCC should be able to take care of all close custody inmates (12 in treatment now and seven more interested), and HMCC could grow according to increased demand as the effects of HB366 are felt. Obviously, no one can predict the long term impact of HB366 but certainly it could be dramatic. Also, as HMCC converts to more SOTP beds it displaces inmates who are not sex offenders and housing must be found for them.

Of the total number of sex offenders in the prison system, 48 have requested treatment, but are not in treatment. Of those 48, only 19 are actually eligible by virtue of the time remaining until the end of their sentence. Twenty-four have too long and four are too short (under 18 months).

The treatment beds at FCC are not being appropriately utilized primarily because of the Cleary population cap which forces the department to keep transferring inmates from FCC to other locations around the state. Of the 35 beds at FCC, 18 were occupied on the date data was gathered. This number is considered representative since the Cleary cap became effective.

It appears that the number of treatment beds is adequate for the existing number of appropriate and interested sex offenders, but as discussed elsewhere in this report, Fairbanks presents a special set of concerns that are addressed in recommendation six and seven.

Close Custody Sex Offender

The task force felt it was important to determine whether or not close custody sex offenders required treatment. The question was whether or not the department should wait for close custody offenders to be reduced in custody before being eligible for treatment. Based upon the large number of close custody offenders and the ability of the department to provide beds with appropriate security, the task force concluded that treatment could and should be provided to these offenders.

Treatment Program at Fairbanks Correctional Center

FCC is not utilizing its 35 beds as noted under "Existing Sex Offender Treatment Programs" above. Unless the department expands the correctional center there is little hope that the treatment program can survive. The priority concern for FCC at this time and for the foreseeable future is maintaining the overall population count. Little if any weight is given to whether or not an inmate is in sex offender treatment when the decision is made to transfer. The task force attempted to get statistical information regarding transfers precipitated by the Cleary cap as compared to other types of transfers, but was unable to do so. The impression of the institution is that transfers have increased dramatically since implementation of the Cleary cap. In any event these beds are not being used even though there are inmates to fill them. It should also be pointed out that the present Cleary Maximum Operating Capacity of 202 will change to 183 on January 1, 1992. It is, frankly, unlikely that the department will be able to meet this cap without exceeding the capacity of other institutions.

Community Corrections

Although the task force was not assigned any community corrections issues, the task force felt that there were institutional issues that were inseparable from community corrections issues. Attached is a report from Sue Ford that identifies the number of sex offenders in community treatment, those not in treatment, those who "successfully" completed treatment, and those who would be in treatment if approved providers were available. P.O. Ford points out that the statistics are conservative due to her limited ability to collect information. Nonetheless, the number of sex offenders in the community who have not completed treatment and who are not presently in treatment is significant and will likely increase in the future. Also, P.O. Ford points out that some appropriate offenders are not being referred for treatment even though it is available, but the largest number of untreated sex offenders reside in areas of the state where there are no providers.

Paul Turner has written a memorandum (attached) recommending the utilization of the Alaska Division of Mental Health and Developmental Disabilities community mental health system to provide outpatient sex offender treatment services. The community mental health system would seem to be a logical resource for providing treatment to offenders in their local community. A major obstacle for providing treatment to sex offenders in the community has been that many of them do not live where services are available. This is especially a problem for Natives. As Dr. Turner points out,

> Good psychological adjustment and better outcome results for mandated sex offender treatment would be expected if offenders lived in their communities with their family (as applicable) and maintained their ties to their culture, extended family, social network, lifestyle and vocational opportunities.

Obviously, the department would need to play a major role in training the staff of the Division of Mental Health for this new and specialized task.

The following tentative release dates for sex offenders are:

Time Period	No. of Released Sex Offenders
10/16/91-12/31/91	64
01/01/92-12/31/92	52
01/01/93-12/31/93	100
01/01/94-12/31/94	50
01/01/95-12/31/95	54
01/01/96-12/31/96	37
01/01/97-2025-	77
Unsentenced	86
Total =	520

The department needs to be prepared for the increase that will occur between 1/93 and 12/93

SUMMARY OF RECOMMENDATIONS

1. Sex offender treatment should be provided to all custody levels, excluding maximum custody. The traditional time frame of between 18 months and six years of the tentative release date or parole eligibility date should be continued. Lemon Creek should serve only close custody sex offenders, and the number of beds should be increased to 24 or 26. (A decrease in custody would not necessarily cause a transfer.)

2. The number of sex offender treatment beds at Hiland Mountain should be increased from the present 80 as needed. This could perhaps be in increments of 10 since that is the number of beds per wing. The beds are for medium/minimum/community custody inmates.

3. The contract for sex offender treatment at Fairbanks Correctional Center should be allowed to expire. If there are any financial savings from closing FCC, those monies should be considered for expanding the training for community mental health workers and field probation officers in sex offender monitoring skills.

4. The department should review the present level of compliance with court ordered sex offender counseling in community corrections.

5. The sex offender tracking report needs substantial revision in the way it organizes and makes information available. One should be able to answer the following questions readily:

    1. Number and location of sex offenders.

    2. Custody of sex offenders.

    3. Number of sex offenders with court ordered treatment.

    4. Lengths of sentence and bracketed release dates.

5. Number and location of treatment slots.

6. Number of sex offenders who have refused treatment.

7. Number of sex offenders who failed to complete treatment.

8. Number of vacant sex offender beds.

9. Number and location of approved treatment providers.

10. Number and location of sex offenders with less than 18 months.

11. Number of sex offenders being released each year without treatment.

12. Number and location of sex offenders on formal probation.

13. Cost of treatment beds/vendor.

14. Number and location of sex offenders in treatment beds.

6. The task force recommends closing the sex offender treatment program in Fairbanks, however, the consequences of such a dramatic change at Fairbanks need to be evaluated immediately. The task force identified the following concerns:

   a) Fairbanks Correctional Center will be left primarily with short-term and pre-trial offenders.

   b) As a result of the above, FCC's programs need to be evaluated for applicability to the new prisoner population profile.

   c) What is FCC's mission?

   d) What will be the impact on the prison industries at FCC?

7. For many years Fairbanks Correctional Center has housed long-term and close custody inmates. The prison culture has adapted to this role. If the department is going to allow FCC to evolve into a different kind of prison, a good deal of work needs to be done. The department should be cautious in allowing the Cleary prison cap to be the singular driving force for the future of FCC. In the past, plans had been made for the expansion of Fairbanks. It is a regional center drawing inmates from a substantial geographical portion of the state. It is questionable policy to allow FCC to become a "drive-through" correctional center. If the Cleary cap were excluded, all of the other forces which determine the growth or absence of growth for a correctional center, would likely cause FCC to expand. The department needs to take a very close look at the dynamics of this situation.

8. The department should explore the utilization of the Alaska Division of Mental Health and Developmental Disabilities as a resource for providing sex offender treatment and monitoring in the community. The Department of Corrections would need to provide training to mental health staff in order to ensure that the appropriate treatment model was used.

9. The task force recommends the Department of Corrections look closely at utilizing special needs halfway houses for sex offenders who did not receive or complete in-house sex offender treatment. The utilization of a sex offender halfway house could fulfill the treatment needs and concerns of those sex offenders who fall into the following categories:

   a) Those who received less than 18 months to serve.
   b) Those who refused in-house sex offender treatment.
   c) Those who were terminated or failed to complete sex offender treatment.

   A sex offender halfway house would provide room and board to sex offenders from the bush and other outlying communities while they receive treatment. Further research would need to be undertaken by the Department to determine whether to have these facilities run by state or private organizations/contracts.

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APPENDIX A

Memo from Mike Taylor dated 3-18-91

MEMORANDUM — State of Alaska

Department of Corrections

TO:	Marianne McNabb Criminal Justice Planner Anchorage Central	*DATE:*	March 18, 1991
		TELEPHONE:	465-3376
THRU:		*SUBJECT:*	Legislative Research Agency Request for INFO
FROM:	Mike Taylor Program Coordinator Statewide Programs		

Per your request I am forwarding the following information regarding statistics related to the Sex Offender Treatment Programs administered by the Division of Statewide Programs.

- **An analysis of the cost of running the programs;**

	Anchorage Langdon Clinic	**Fairbanks** Fairbanks Tx. Asso.	Juneau Tongass C.C.C.
Annualized Funding	$ 488,200.00	$ 192,348.00	$ 192,340.00
Treatment Slots			
Prison	80.0	35.0	12.0
Community	60.0	15.0	40.0

(NOTE: Based on allowable levels per contractual obligations);

Current Participants			
Prison	79.0	32.0	11.0
Community	8.0	17.0	10.0

(NOTE: Based on Contractor reported participants per January 1991 monthly billing for services);

Budget Distribution			
Prison	$ 217,760.00 (89.2%)	$ 82,831.50 (81.5%)	$ 77,140.00 (79.8%)
Community	$ 26,340.00 (10.8%)	$ 18,742.50 (18.5%)	$ 19,500.00 (20.0%)

I have also attached a copy of my data base for each program which shows the distribution of hours which have been billed to the Department of Corrections by billing category. Please give me a call if you require any additional information regarding any the Sex Offender Treatment Programs to fulfill the Legislative Research Agency request of February 26, 1991.

MT/mt
cc: Richard Bentson, Director
Statewide Programs

(NOTE: All figures are based on Contractor proposed budget distribution)

Annual personnel costs for corrections officers working on programs	$ 200,000.00	n/a	n/a

(NOTE: This cost was arrived after discussion with superintendent, and correctional officer responsible for programs at Hiland Mountain. The amount represents the personnel costs for four full time correctional officers. Currently there are a total of nine corrections personnel involved in the HMCC Sex Offender Program. The four officers assigned to the sex offender treatment cost was based on the institutional personnel's estimate of allocation of the officer's roles between security and treatment.)

Man/Day cost based on projected participants			
Prison	$ 21.82	$ 13.00	$ 35.32
Community	$ 2.41	$ 6.87	$ 2.68

(NOTE: This is the cost of treatment for full utilization of treatment slots and full expenditure of contractual encumbrances.)

Man/Day cost based on participant level (1/1/91)			
Prison	$ 22.10	$ 14.22	$ 38.53
Community	$ 18.09	$ 6.06	$ 10.71

- **How many hours per day and per week are inmates involved in the programs?**

Following are general distribution numbers indicating proposed allocation of hours in the Contractor submitted budgets for the period January 1 - June 30, 1991.

Service Distribution			
Direct Services	76.11%	89.0%	89.3%
Indirect Services	23.89%	11.0%	10.7%
Individual Treatment			
Prison	50.0	31.0	48.0
Community	8.3	12.0	12.0
Group Treatment			
Prison	62.3	58.0	64.0
Community	30.0	16.0	12.0

(NOTE: All figures are based on Contractor proposed budget distribution)

APPENDIX B

Survey by Trevor Jones dated October 1991

A Survey of Studies and Papers Referring to the Treatment of Sex Offenders

compiled by

Trevor Jones
Fairbanks Treatment Associates employee

October 1991

The goal of this project at its onset was to statistically identify the recidivism benefit of treatment vs. non-treatment of sex offenders. Unfortunately, I have to report that it would be difficult to impossible to identify any general evidence supporting or opposing the efficacy of treatment. It might be more accurate to state that from the pool of research available, one could draw any conclusion one wanted. For example, Sturgeon & Taylor (1980) demonstrated a recidivism rate of 15.4% for a group of 260 treated pedophiles and rapists. Their control group of 122 untreated sex offenders demonstrated a recidivism rate of 25%. Interpretation would suggest that treatment reduced recidivism by 9.6%. In another study, Frisbe (1969), the recidivism rate for 617 treated offenders was reported at 19.4%, and the control group of 365 untreated offenders was 11.5%. If one were to apply the same type of interpretation here as in the fist study, one would have to conclude that treatment increased recidivism by 7.9%. While it is my own personal opinion that treatment is beneficial, the use of recidivism statistics would be a poor measure to base this opinion on. The reasons for recidivism being a poor measure of treatment outcome are multitudinous. It would be impossible to construct an exhaustive narrative on this subject, so I will only suggest a few. Probably the most important factor hampering the assessment of recidivism is the difficulty of discovering that any offense has occurred. It has been suggested that as few as 10% of

sexual offenses are reported. Equally difficult is the burden of proof and maintaining a conviction for the few cases that are reported. The use of recidivism statistics can only be useful when they are applied in some form of comparison, either to an untreated control group or to another treatment program. Unfortunately, in almost all cases reviewed, the treated and control groups differed at the outset in ways other than if they received treatment or not. For example, in Alaska because sex offender treatment program's are not filled to capacity, and nearly all who wish to participate in a treatment program have that opportunity, the only offenders who could be used as a control group would be those who refused treatment, because of the dissimilarity, any statistical comparison to such a control group would be questionable. Similarly, comparing one program's statistics to another's is misleading because of the many differences between various treatment programs. One of the most significant problems in comparing programs lies in the samples that could be developed. For example, if we were to compare Alaska's programs to those in the lower 48, there are no other inmate populations that have a Native American population of 32% (1989). The national average is only 2.8% (1989). Samples also differ based on program admission policy. Some programs accept only the most amiable offenders while others treat the least amiable offenders. Other problems arise with the definition of recidivism. Some studies define rediddivism as being

reconvicted f[illegible] the same sexual offense, others as being convicted of any criminal offense, and still others as such activities as walking to close to a school or playground.

Although recidivism would seem to be such a poor measure, we unfortunately have little else to work with. With the cautionary discourse provided above, we must begin to do what we are cautioned against. The best one can do is control the statistical application to only appropriate cases. Because the variability between treatment programs hampers the ability to generalize between these programs and research projects, a concerted effort must be made to apply only studies to programs that best match one another, and in which careful work has been done to define and accurately identify all research criterion. If we were to make some sort of comparison to the programs in Alaska, the best would be one of three relapse prevention programs in the Lower 48. The Vermont Treatment Program for Sexual Aggressors (VTPSA) has been working with sexual offenders using a relapse prevention model since 1982. Initial treatment outcome statics that they have provided on their program suggests this approach represents an effective method for decreasing recidivism particularly with pedophiles. The VTPSA study's relapse rate was in stark contrast to most sex [illegible]ender recidivism data previously reported for simila[illegible] time periods. In the VTPSA study, relapse prevention appeared to effectively diminish reoffense rates. (Pithers, Cumming 1989)

As policy makers grapple with difficult decisions concerning sex offenders, programs, the community, costs and so on, and if recidivism rates are removed, what measures are available? Potentially, one could employ an assessment of victim impact, fiscal cost to society, what the community at large feels is an appropriate treatment of an offender (such as retribution, restitution, or rehabilitation). Of these, the most measurable is fiscal cost to society.

As the fiscal costs of sexual offenses are considered, one can only ask, "What would it take for a sex offender treatment program to pay for itself?" In an attempt to answer this question, I have taken some figures from the sex offender treatment program in Fairbanks, Alaska. The cost of this program is $~~5,828~~.00 [On 38 Beds] [5343.96] per man, per year (1991). In addition to this, it costs another $~~130,907.00 (1989)~~ [31,156.40 (1990)] per year to incarcerate each offender (based on statewide statistics). Assuming that an individual reconvicted of a sexual offense would receive the presumptive sentence of 8 years, at cost of $~~209,451.00,~~ [249,251.20] we can project that if only 1 individual released each year were deterred from reoffending, this would more than pay for the entire program at a cost of $192,348.00 per year (1991). This estimate only considers the direct cost to the Department of Corrections and ignores the cost of apprehension, trial expenses, and parole supervision. In addition to this, there are other victim related expenses such as costs incurred by services from Department of Social Services,

hospital expenses, victim evaluation, victim witness services, and victim treatment. If these costs were considered they would add an additional $24,898.00, (Prentky and Burgess 1989), to our original estimate of cost for a reoffense.

Since these figures seem somewhat incredible, I would like to stress that they are in no way exaggerated. Because of the incredible cost of incarceration it takes little success for a treatment program to become cost effective. But more important than the potential fiscal gain of treatment, is the immeasurable benefit of any reduction in victimization.

COMMUNITY TREATMENT

In addition to what has been discused above, I was also asked to provide any information concerning community treatment that I became aware of during my study.

Presently, I am aware of an interest in the possibility of shifting an emphasis toward community treatment as opposed to prison based treatment. It seems that in the face of limited resources, a decision must be made as to where these resources can best serve the client and community. Based on my own limited experience, prison based treatment seems more efficient simply because the continuity of the therapy process is maintained much more successfully

than is possible in the community. I believe that it is difficult to maintain the continuity and momentum of treatment in the community because members attend only weekly groups, and monthly individual sessions. This is furthered hampered by any absences which not only affect the individual absent, but also the members of his group who are deprived of a consistent treatment environment and the absent individuals participation in the group process. It is simply easier to maintain progress through daily groups, with full attendance. There is little problem with getting back on track from the previous group meeting when that group met yesterday as opposed to the week before. In Fairbanks, during the summer, it is unfortunately not uncommon for a group's composition change nearly 100% from week to week due to work related, vacation related, and unexcused absences. While most might agree that a residential milieu treatment structure may be of greater benefit to treatment of participants, it is difficult to determine if emphasis on this type of program best serves the community. I make this statement based on information provided by Linda Smith. In a report she wrote in 6/91, she commented:

> "Of interest is that 42 (of 76) offenders, or 55%, were sentenced to straight probation or received sentences of such short duration that they weren't able to participate in the institutional programs. Although it has been the position of DOC that the best treatment

for sex offenders is residential milieu, it's clear the judges aren't buying that completely. DOC may want to reconsider that position and look at perhaps expanding the length of DOC supported community based sex offender treatment" (Smith 1991).

While I am unaware of the exact typeologies of these offenders, I can easily say that unless these two groups (prison sentences and probation sentenced) are very dissimilar, this failure to find prison dispositions should be of great concern. If it is unlikely that longer prison sentences will be given, then longer, much more intense community treatment should be seriously considered.

OTHER ISSUES OF COMMUNITY TREATMENT

Wodarski and Whitaker pointed out many concerns surrounding community treatment. In their article they provided:

1. "If the perpetrator is simply released on condition of completion of a treatment program, victims do not believe their emotional damages have been properly compensated through adequate punishment of the perpetrator." (Wodarski and Whitaker 1989)

2. "If the offense is incest, it is not unusual for the victim to be removed from the home while the perpetrator remains in the home."

3. "If the perpetrator is placed on probation, it is possible for the family unit to reconcile and to remain intact as a family unit. If, on the other hand, he is absent from his family for a long period, the family tends to dissolve." (Giarreto, 1982)

4. The environmental settings of prisons and hospitals are completely different from the community, thus behavior changes which might take place as a result of counseling in these settings have little generalizability to the "real" world.

5. Community treatment is also less costly in the sense that it provides an opportunity for the offender to provide for his or her family care.

6. In terms of human costs, community treatment furthermore is indicated, In the community, incest perpetrators retain the opportunity to modify family relationships and to establish a supportive, as opposed to exploitive, relationship.

Wodarski and Whitaker concluded their article by stating:

> "The treatment of certain sex offenders in the community makes sense in terms of social and monetary costs. Individuals will be less demoralized while more family units will be preserved... The development and provision of appropriate services, however, represent a substantial challenge. The necessary research to accomplish these goals has yet to be undertaken."

Originally, I had hoped to make some comments on the comparability of prison based vs. community treatment. Based on the research literature I reviewed in preparation for this paper (summarized in the first portion of the paper), it seems pointless to attempt such treatment outcome comparisons. What I did find that addressed prison and community treatment suggested that the transition between the two should be made in as many small steps as possible, that a treatment participant should not suddenly graduate from a prison setting into a community program, that the participant should be transitioned gradually into the community program.

THE USE OF PARAPROFESSIONAL STAFF

While this in not a subject much reviewed, I did find some things written about it in program descriptions. Although it seems that nearly all treatment programs employ one form or another of paraprofessional staff, there seems to be no specific ratio. Of what I could find, the number of paraprofessional staff ranged anywhere from 28 down to 2 in each program. Duties of the staff also varied between programs. Some provided direct treatment such as the facilitation of groups, while other programs may have used these staff as research assistants.

CONCLUSION

In conclusion, I again have to regretfully report that there is little consistent empirical evidence to base treatment outcome conclusions on. Presentiy, there are studies that in progress that may be of significance. Based on their projective research design, they look to be more promising than the retrospective research designs of the past. Unfortunately, information from these studies is not fully available. I like to add to all my cautionary notes that the authors who most influenced me in this opinion, (Furby, et al), even in light of finding little statistical support for treatment, believe that outcome data from specialized treatment programs will demonstrate therapeutic efficacy. (Weinrott, 5/88) Initial data from these studies would seem to be very promising, and will be of great interest to the sex offender treatment programs of Alaska, because they are based on relapse prevention which is the treatment model employed by the programs being researched. Lacking these studies, we are left with cost benefit analysis. Although these studies as presented tend to rely heavily on recidivism data, the estimates of costs are very accurate. The understanding of how little it takes for treatment to become cost effective can only prompt us to persevere in providing sex offender treatment.

Ultimately the process leading to decisions regarding efficacy of treatment becomes a "shot from the hip." People who are engaged in making policies regarding the treatment of sex offenders are "gamblers." Knowing the costs of sex offender treatment and the cost of recidivism, one in support of treatment must gamble that the prevention of at least one or two offenses is a possibility. And if that is the case, the gamble will pay off fiscally and in ways that are immeasurable when victimization is considered.

APPENDIX C

Memo from Sue Ford dated 11-6-91

STATE OF ALASKA
Department of Corrections
Adult Probation/Parole
110 Trading Bay, Suite 190
Kenai, AK 99611

MEMORANDUM

TO: Ken Brown
Superintendent
Wildwood Correctional Center

DATE: November 6, 1991

RE: Task Force Data on Sex Offenders

FROM: Susan J. Ford SF
Probation Officer III
Kenai

****

COMMUNITY CORRECTIONS SEX OFFENDER STATISTICS

City	# in SOT	# not in SOT	# successfully completed	# who would be in SOT if approved provider available
Ketchikan	7	8 (3 no treatment order)	0	6
Juneau	26	16	13	4
Sitka	0	9	0	3
Kodiak	12 (all non-approved providers)	3	1	15
Dillingham	0	17	0	17
Kenai	11 (9 non-approved providers)	8	7	13
Palmer	21	0	3	0
Anchorage	150	14 (6 no treatment order)	22	3
Bethel	0	60 (41 no treatment order)	1	[illegible]
Barrow	0	14	0	14
Nome	0	33	4	17
Kotzebue	14 (all non-approved providers)	0	0	0
Fairbanks	20	56 (13 no treatment order)	19	N/A
TOTAL:	261	238	70	152

To better understand the numbers presented above it is important to recognize that Department of Corrections approved sex offender treatment providers are only available in the communities of Ketchikan, Juneau, Kenai, Anchorage and Fairbanks. In Kenai the approved provider has an eight month waiting list. A new sex offender treatment group is just getting underway on a trial basis.

In other areas of the state, as well as communities with DOC approved providers, probation and parole officers are utilizing the services of non-approved DOC mental health providers to provide some level of treatment to their sex offenders. Thus, the category entitled "# of sex offenders in treatment" reflects a mixture of both approved and non-approved treatment providers.

The statistics provided by the Palmer and Anchorage offices are incomplete. Palmer had an employee on extended maternity leave and did not report the sex offender statistics from her caseload. The Anchorage office had only 50% of their probation officers respond to the questionairre. However, Probation Officers Lee Jones and Ron Travis carry a specialized caseload of sex offenders. Lee believes there are only 20 to 30 additional sex offenders who are not included in their statistics.

Another factor which should be taken into account when reviewing the statistics is that a percentage of the sex offenders on probation and parole have no order for sex offender treatment. For instance, in Bethel there are 60 sex offenders on supervision but only 19 have orders to be in treatment. In some areas of the state individual probation officers are not enforcing Court or Parole Board orders for sex offender treatment because of a conflict with their own personal philosophies, i.e., they don't believe sex offender treatment is effective or that sex offenders can be "cured."

The Fairbanks Probation Office completed a study of their sex offenders under community supervision in May, 1991. Of the 56 sex offenders not in treatment, 13 had no Court or Parole Order for treatment, 10 were treatment complete per a DOC approved provider, 7 had not been referred to treatment by the P.O., 6 had received the maximum treatment benefit according to a DOC approved treatment provider, 4 it was unclear why they weren't in treatment, 3 had completed one year of DOC funded community sex offender treatment and did not continue, 2 dropped out of treatment with no revocation action, 2 were on a waiting list for treatment, 2 were pending revocation action for non-compliance, 2 were treatment complete per non-DOC approved treatment providers, 2 were assessed as not in need of treatment per a DOC approved provider, 1 received the maximum benefit per a non-DOC approved provider, 1 was assessed as not in need of treatment per a non-DOC approved provider, and 1 was assessed to be too severely brain damaged to be in treatment.

In summary, it is clear that in those areas where there is no DOC approved sex offender treatment offered, probation officers and judges are not requiring/ordering treatment at the same rate it is being required/ordered in those communities with DOC approved treatment. A large percentage of the sex offenders on probation and parole are residing in those communities where there is no approved sex offender treatment or no treatment at all. It would appear there is a need for more sex offender treatment providers in the village and bush areas where so many of the offenders reside. The utilization of community mental health centers as providers for sex offender treatment would appear to be a recommendation that this task force might want to seriously consider.

cc: Bonnie Majak, FCC
Hubert Nelson, WCC
Susan Jannusch, ACO
Jim Pagels, HMCC
Paul Turner
Dan Carrothers, LCCC
Art Schmidt, PCC
Peggy Brockman, SCCC

APPENDIX D

Memo from Paul Turner dated 10-27-91

PAUL E. TURNER, PH.D.
Clinical Psychologist

Post Office Box 270
Kenai, Alaska 99611
(907)283-7015

October 27, 1991

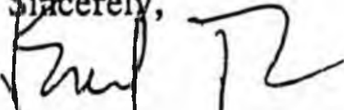
Ken Brown Superintendent
Wildwood Correctional Center
Chugach Avenue
Building 10
Kenai, Ak. 99611

Re: Task Force

Dear Mr. Brown:
I am enclosing my outline of the mental health issues you asked me to address at the task force meeting. Please consider editing these draft liberally and in keeping with the overall draft of the task force.

If you have any questions, please contact me at your convenience.

Sincerely,



PAUL E. TURNER, PH.D.
Clinical Psychologist

Enclosure

W.C.C.
OCT 29 1991
RECEIVED

USE OF MENTAL HEALTH RESOURCES WITH SEX OFFENDERS

This task force recommends the utilization of the resources within the Alaska Division of Mental Health and Developmental Disabilities community mental health system to provide outpatient sex offender treatment services.

The Division of Mental Health and Developmental Disabilities has a system of community mental health providing the state with comprehensive mental health services through over 20 community mental health programs. These services are provided on an itinerant basis in some instances and are available on a sliding fee scale basis. Historically, there has been some reticence to treat sex offenders within the community mental health system.

A major problem for the Department has been the lack of approved providers for sex offenders. There is differential enforcement of the requirement that offenders be in treatment with approved providers. Further, many offenders live in remote, bush or rural areas in Alaska and are not afforded the availability of any sex offender treatment. At times, probationers cannot return to their community because of a lack of treatment resources. The requirement of treatment was not intended to sever the ties between a probationer and his family or community. This issue is particularly serious with regard to individuals and Native Alaskans from bush or rural areas. This issue is even more confounded when the victim(s) are not located in the offender's community. Good psychological adjustment and better outcome results for mandated sex offender treatment would be expected if offenders lived in their community with their family (as applicable) and maintained their ties to their culture, extended family, social network, lifestyle and vocational opportunities. This does not mitigate the need for mandated sex offender treatment or the stipulations of limitations on contact with victims.

It would be a straightforward task to sample the community mental health system to determine the problems these agencies have with sex offender treatment including such things as a lack of training, problems with coordination of services with the Department and so forth.

It is recommended that the Department enter into a cooperative agreement with the Division of Mental Health and Developmental Disabilities to provide outpatient services to sex offenders on probation or parole. The cooperative agreement should clearly outline means and methods to provide a continuity of services from incarceration to the community in order to provide outpatient sex offender services to all probationers and parolees of the Department of Correction who are amenable to community sex offender treatment. The cooperative agreement should outline means for coordination of services between local community mental health and probation offices. It is recommended that the Department provide training of community mental health staff for treatment of sex offenders on an outpatient basis. It is recommended that training be provided in association with the annual

Division of Mental Health training conference, regular meetings within the community mental health system or at separate training meetings specifically for sex offender treatment. Training should occur on an annual basis. It is recommended that the Department draft a model outpatient sex offender treatment contract for use within the Division of Mental Health community mental health system.

Sincerely,

PAUL E. TURNER, Ph.D.,
Clinical Psychologist

cc: File

STATE OF ALASKA
DEPARTMENT OF CORRECTIONS
SEX OFFENDER TREATMENT PROGRAMS

CONSULTANT'S REPORT ON PROGRAM EVALUATION

Janice K. Marques, Ph.D.

Purpose of Consultation

The purpose of the consultation was to assist the Alaska Department of Corrections in evaluating its Sex Offender Treatment Programs (SOTP). Assistance was to be provided both in developing an evaluation component for SOTP, and in integrating the evaluation into the existing treatment programs. More specifically, the primary goals of the consultation were to: (1) evaluate the current SOTP to determine evaluation questions to be answered, and measures to be included in the evaluation; and (2) propose a data collection framework that would allow the Department of Corrections (DOC) to integrate this evaluation effort into its ongoing SOTP. The consultant was also asked to provide general background information on recidivism research, including a brief summary of recent findings, an assessment of the current state of the art in treatment outcome research, and a description of the problems facing those trying to conduct or interpret treatment outcome studies.

A number of more specific goals and tasks were also established in the consultation contract, including: (a) determine the Department's primary evaluation issues and priorities regarding the SOTP; (b) provide a conceptual analysis of the treatment programs and their application of the relapse prevention model; (c) formulate evaluation questions, and propose specific measures and data collection procedures for the evaluation; (d) assist DOC in preparing a report addressing the measurement of SOTP effectiveness; (e) determine what current data are relevant to evaluation questions;

(f) propose a framework and guidelines for data management, analysis and interpretation; (g) advise DOC on methods for comparing Alaska statistics with those from other states; and (h) suggest methods for ensuring data reliability and validity.

This report will address each of these goals. For clarity, the background information on recidivism research will be presented first. Information and suggestions relevant to specific goal (d) will be included in this first section, since DOC's report on program effectiveness will need to cover the issues surrounding the conduct of treatment outcome research with sex offenders. The remaining sections of the report will address the rest of the specific goals in the order listed above.

Method

This report is based on information from: (a) the existing literature on sex offender treatment and program evaluation; (b) various written materials provided by DOC, including SOTP treatment manuals, DOC's Statement of Standards, evaluation reports written by Rob Freeman-Longo and William Pithers, contracts with treatment providers, reports prepared for legislators, and samples of current data collection instruments; and (c) interviews with staff in the Anchorage Central Office, Hiland Mountain/Meadow Creek Correctional Center, and the Justice Center of the University of Alaska, Anchorage.

Treatment Outcome Research with Sex Offenders[1]

Background. In recent years, victimization research has consistently documented that American women and children are at significant risk of sexual assault, and that these experiences often have long-term and serious effects on their lives. For example, a recent report from the Los Angeles Epidemiologic Catchment Area Project found that 13.5% of women report being

raped during their adult lives (Sorenson, Stein, Segal, Golding & Burnam, 1987). For children, the risk of sexual abuse is likely to be even higher, with prevalence rates from a recent national survey indicating that 27% of women and 16% of men experienced some form of sexual abuse as children (Finkelhor, Hotaling, Lewis & Smith, 1990). These figures, along with equally disturbing reports of the potential impact of sexual assaults on victims (e.g., Briere, 1988; Burnam et al., 1988), clearly document the enormous cost of sexual aggression.

Greater recognition of the extent and impact of this problem has resulted in increased efforts to determine how sexual aggressors can be stopped. Although the past decade has seen an unprecedented number of special commissions, conferences, and legislation pertaining to sexual aggression, no consensus has been reached concerning the appropriate societal response to the problem. Indeed, at the same time that some states were passing laws to establish new rehabilitative programs, others were rescinding them. The State of Washington, for example, has enacted sweeping law changes within the last year, including a new commitment category for sexual predators, as well as increased availability of treatment for sex offenders in the prison system. The State of Florida, in contrast, has terminated its long-standing treatment program for incarcerated sex offenders. As Furby, Weinrott, and Blackshaw (1989) recently observed, "With respect to the relative appropriateness of simple incarceration versus inpatient treatment, states appear to be passing one another like ships in the night" (p. 3).

<u>Research on the Effects of Treatment on Recidivism</u>. While the controversy surrounding efforts to find appropriate social and legal responses to sexual aggression has a number of determinants, the lack of convincing empirical data on the effectiveness of sex offender treatment has certainly been an important factor. In their extensive review of sex offender recidivism studies, Furby et al. (1989) concluded that past

research has generally not supported treatment. Among the eight studies that directly compared treated and untreated groups of offenders, reoffense rates were higher for the treated than for the untreated subject in five, results were mixed or there were no differences in two, and findings were positive in only one.

The positive study in this review was conducted at Atascadero State Hospital and examined the conviction rates of Mentally Disorder Sex Offenders (MDSOs) for five years following their release from the hospital in 1973 (Sturgeon & Taylor, 1980). One group of MDSOs had been released with a staff recommendation that they were no longer a danger (known as the A Recommendation); a second group were MDSOs who were returned to court with a staff recommendation as still a danger and not amenable to treatment (known as the B Recommendation); and the third group was a cohort of sex offenders who were released from a California prison without receiving treatment. The results indicated that those who had received the A Recommendation were less likely to have committed a new sex offense (12%) than either those who received the B Recommendation (24%) or those in the prison cohort (25%). Unfortunately, these groups were not directly comparable; that is, they differed on a variety of factors such as offense type, race, marital status, and criminal history. Although the results indicated that staff recommendations may have been somewhat predictive of future success in the community, the authors appropriately noted that "none of these data prove that any particular treatment is effective in helping rehabilitate sex offenders" (p. 62) and that such evidence would require a randomized experimental design.

Since the publication of the Furby et al. (1989) review, several other recidivism studies have been completed. Rice, Harris and Quinsey (1990) reported on a 46-month follow-up of 54 rapists released from a maximum security psychiatric hospital. They found that 28% were subsequently arrested for a new sex offense, 43% for a subsequent violent offense, and 59%

for any type of offense. In a similar study (Rice, Quinsey, & Harris, 1991), the same authors reported the recidivism rates of 136 extrafamilial child molesters. During the follow-up period, which averaged 6.3 years, 31% of the subjects were convicted of a new sex offense, 43% committed a new sex offense or other violent crime, and 58% were arrested for some crime that returned them to an institution. They did not find any significant differences between those subjects who had only been evaluated and those who had also received some form of treatment. Again, however, since these groups differed on a number of variables, this finding could not be clearly interpreted.

A review of recent outcome studies that was published by the Solicitor General of Canada (1990) was more encouraging. Four of the five studies that included both treatment and comparison groups found that treatment significantly reduced reoffense rates. In one study of a cognitive-behavioral treatment program, Marshall and Barbaree (1990) found recidivism rates of 17.9% among heterosexual child molesters (men who molested girls) and 13.3% among homosexual molesters (men who molested boys). These offenders had all received treatment, and had been at risk in the community for an average of four years. Untreated child molesters in a comparison group had a reoffense rate of 42.9%. It is unclear, however, if the comparison group differed from the treated group on any important risk factors for recidivism.

The one study in the Canadian review that used random assignment to treatment (Romero & Williams, 1983) failed to find a significant treatment effect. Nevertheless, in contrast to the conclusions of Furby et al. (1989), the Canadian reviewers concluded that there is evidence that current sex offender treatment programs are effective, particularly cognitive-behavioral programs that "address a range of sexual offenders' risk factors/ needs and include relapse prevention components" (p.19).

Despite this trend toward more positive findings regarding sex offender treatment, most outcome studies continue to be plagued by methodological weaknesses. For example, many studies that report low recidivism rates for treated subjects fail to specify their definition of recidivism, the length of time subjects were at risk in the community, or the recidivism rates that were found for similar subjects who did not receive treatment. As a result of these methodological problems, solid conclusions about treatment effectiveness cannot be drawn at this time. In order to make a substantial contribution to answering the question of whether treatment can reduce the likelihood of reoffending among sex offenders, a variety of important methodological issues must be more adequately addressed in future outcome studies. These include:

1. Control group adequacy. A common strategy in the past has been to simply record the percentage of offenders who reoffend after release from a treatment program. This percentage is then compared with the percentage of sex offenders without treatment who have reoffended in a variety of other studies. Unfortunately, such an approach does not take into account the fact that the sex offender population is heterogeneous, with individuals varying in terms of their degrees of risk to reoffend. It is clear that if studies of treatment effectiveness are to make a contribution, they must have adequate control groups. It is commonly recognized that the ideal comparison group would be offenders who were equally interested in treatment but who were randomly assigned to an untreated control condition (Furby et al., 1989; Grossman, 1985; Marshall & Barbaree, 1990; Rice et al., 1991).

2. Sample selection and description. Care must be exercised in the design of the sampling procedures in research on sex offender treatment. The number of subjects selected must be large enough to ensure that adequate statistical power will be available for data analysis and hypothesis tests. Random assignment to treatment and control conditions should be considered if possible. It is also important to assess

background characteristics of subjects thoroughly, in order to determine whether a reasonably representative sample has been selected.

For sex offenders, such factors as age, employment, marital status, criminal history, victim preference and types of offenses committed appear to affect the likelihood of reoffending (Abel et al., 1987; Amir, 1971; Chappell, Geis, Schafer, & Siegel, 1971; Finkelhor, 1984; Fitch, 1962). The use of highly selective samples, or the failure to provide a sufficiently thorough description of the subjects, will limit the utility of the findings. In addition, the ability to partition the sample on the basis of such characteristics as offense type or previous criminal history may provide useful information regarding the differential responsiveness to or effectiveness of treatment. A comprehensive sample, however, requires more detailed subject descriptions and more complex data analyses (Furby et al., 1989).

3. <u>Treatment interventions</u>. Although there is an emerging consensus regarding the important components of sex offender treatment, there is wide variability in how the recommended treatment strategies are implemented. Treatment structures and components vary across settings and even within a single setting across extended periods of time. It is necessary to thoroughly document the content and delivery of all treatment components if the results are to be replicable. The specific activities, their sequence, and the degree to which staff may deviate from protocols could affect recidivism rates. As a result, it is important to deliver the treatment in as consistent a manner as possible (Furby et al., 1989).

4. <u>Measuring treatment effects</u>. It is insufficient to simply demonstrate that a given treatment program, with its wide variety of treatment activities, may reduce recidivism. Why a program worked or failed to work is also a critical issue. Therefore, specific intermediate therapeutic objectives and the extent to which they are reached must also be examined. Without the ability to relate specific in-treatment changes to

outcome, little practical knowledge is gained from an evaluation effort. Ideally, an outcome study is designed so that each treatment intervention has its respective measure that can be associated with future effects in long-term adjustment and success (Furby et al., 1989).

5. Attrition. In many treatment programs, large numbers of offenders are terminated or withdraw from treatment prior to completion. It is not unusual for this level to be as high as 30-50% (Knopp, 1984). It has been observed that the value of a program is not only indicated by the success of those who complete treatment, but also by the number who refuse to enter it or drop out once they have started therapy (Foa & Emmelkamp, 1983). Successful programs, therefore, must manage attrition in order to maximize treatment delivery to the widest range of offenders. Those who do withdraw or are terminated after some degree of exposure to therapy must also be taken into account when examining total treatment effectiveness.

6. Definition of recidivism. When designing an evaluation of treatment, careful consideration must be given to the ultimate criteria for effectiveness. There is currently no consensus on the best definition of recidivism for sex offender outcome studies. Should a child molester, for example, be considered to have reoffended if he exposed himself to an adult, or was found with a collection of child pornography? Should a rapist be classified as a recidivist if he commits a non-sexual assault on a woman, or on a man? The answers to such questions will greatly affect the results that will be derived from any study (Furby et al., 1989).

In addition, the criminal justice system serves as a major source of error in the measurement process (Repucci & Clingempeel, 1978). Whether a defendant is charged with a sex offense, or some other violent offense without a sexual connotation may often have less to do with the act committed than the propensities of the local police department, prosecutor's office, or court. An act that may be filed and vigorously prosecuted as a sex crime in one county may be

brought to trial and disposed in a very different manner in another county. Defendants and their legal counsel may plea-bargain sex offense charges to avoid the stigma of sexual perversion. Clearly, these sources of error can seriously undermine the objectivity of the ultimate measure of treatment effectiveness. As a result, studies that rely exclusively on official records of charges and convictions will yield incomplete, and low, estimates of recidivism (Grossman, 1985). Recidivism figures that are based on information from a variety of different measures should provide a more complete picture of treatment effectiveness.

7. Follow-up periods. Even with the incorporation of a control group into the study design, care must be taken to assure that characteristics of their postrelease supervision do not bias comparisons. Furby et al. (1989) note that because subjects receiving experimental treatments are likely to receive more intensive supervision, they are at greater risk for discovery than are controls, thus leading to possibly higher arrest rates for them and the erroneous rejection of potentially valuable treatment interventions.

In addition, the length of follow-up is important. The longer a group of sex offenders is followed in the community, the greater is their time at risk, and therefore the greater will be the expected rates of reoffending (Furby et al., 1989). California researchers have completed a re-analysis of one of the cohorts studied by Sturgeon and Taylor (1980), prisoners who received no treatment, for the purposes of estimating the sample size required for adequate statistical power in a follow-up study (Marques, Day, Nelson & Miner, 1989). The amount of time at risk for the cohort at the time of the re-analysis was 15 years. The results indicated that a minimum of five years at risk would be required for approximately 75% of the offenders who reoffend to be reported via official records.

8. Correlates of reoffending. A well-conceived evaluation study looks not only for treatment effectiveness, but also attempts to uncover correlates of reoffending. Rice and her

associates (Rice et al., 1990; Rice et al., 1991) have found such variables as criminal history, psychopathy and deviant sexual arousal to be significantly predictive of future recidivism. Investigation of the characteristics of those who reoffend allows for a determination of not only what treatment may be effective, but for whom it may be effective as well. Such information is critical in guiding the design and implementation of future treatment strategies.

9. Data analysis. A final consideration is the way in which the data are to be summarized and analyzed. Often, recidivism data have been presented as simple percentages of individuals who reoffend. This approach assumes that the time at risk for all subjects in the sample is uniform. More sophisticated analyses allow for incorporating varying times at risk by employing survival analytic strategies developed for actuarial or "life tables" that calculate the likelihood of subjects reoffending during a certain period of time. This method presents the percentage of offenders who reoffend during the first year at risk in the community, then removes them from the calculation for the second year and so on. It takes into account varying periods of risk for offenders and also permits an examination of not only how treatment affects the number who relapse but also how it affects the length of time until a reoffense occurs. A thorough evaluation should also include, in addition to the percentage of offenders who recidivate and length of time to reoffense, the number of offenses (and victims) involved, and some measure of the seriousness of the crimes (Furby et al., 1989).

In summary, the evaluation of the effectiveness of sex offender treatment requires the use of the most rigorous and comprehensive designs possible. The question is no longer viewed as simply: Does treatment work? Instead, it has become: What treatment works, for what kind of offender, in what type of setting, and with what definition of success?

Department of Corrections' Evaluation Issues and Priorities

Three major evaluation issues were described by DOC administrators. The first concerned the quality of the treatment provided by SOTP: Are the programs in the mainstream? Can the treatments provided be considered state of the art? Is the program adequate in terms of intensity, duration, and continuity (institution to community)? Is the program in compliance with DOC's Statement of Standards? Is treatment provided consistently across various sites and providers? Are treatment regimens determined by individual assessment data? Are the treatments provided the same as those described in treatment manuals?

The second evaluation issue described was the effectiveness of the SOTP. The questions here, of course, concern whether treatment works: Does treatment reduce the reoffense rate among sex offenders? What kinds of offenders are most effectively treated? Are the participants reaching the in-treatment goals established by the programs and the Statement of Standards? Is the SOTP a cost-effective alternative to incarceration alone?

The third evaluation issue concerned how SOTP should be evaluated. What are the best methods for determining the adequacy and effectiveness of SOTP? Are the established program evaluation procedures sufficient? What specific process and outcome measures are needed to address the evaluation questions listed above? How can program evaluation become an integral part of the ongoing SOTP? Can a reasonably valid treatment outcome study be conducted within the DOC system?

In terms of evaluation priorities, the question of effectiveness comes first. A well-documented, highly structured and intense program that has no effect on reoffending cannot be considered successful. On the other hand, good treatment outcome studies take a great deal of time and effort to complete. It is important, therefore, to

implement process measures early in any program evaluation in order to ensure treatment fidelity and monitor treatment progress. In the following sections of this report, specific outcome and process measures for the SOTP evaluation will be proposed.

Conceptual Analysis of SOTP's Relapse Prevention Program

The SOTP Statement of Standards and individual program descriptions from the three treatment facilities were reviewed in order to begin to address DOC's evaluation questions concerning the quality of treatment. It should be noted that this analysis will provide only a very general evaluation of treatment quality, since: (a) the consultant only visited one of the three programs for a few hours, and did not observe any treatment activities; and (b) comprehensive evaluations of the quality of treatment have recently been performed by both Mr. Freeman-Longo and Dr. Pithers. The focus of the following analysis of the program will be on whether SOTP is in the mainstream of sex offender treatment, and whether it is articulated clearly enough to be evaluated, especially with regard to treatment fidelity and the measurement of specific in-treatment changes relevant to the SOTP treatment model.

A general assessment of the quality of treatment can be made by comparing SOTP with the current trends in sex offender treatment. At this time, although the public policy controversy regarding sex offender rehabilitation continues, there appears to be an emerging consensus among treatment providers regarding the essential components of "state of the art" treatment for this population. First, it is generally accepted that the overall goal of treatment is one of management or control, not cure. This rejects the notion that sex offending is an illness from which one will recover and that successful treatment will result in the elimination of the disorder. Instead, it suggests that successful interventions are those that train offenders to reduce exposure to situations

that place them at risk for reoffense, and accept responsibility for their own illicit sexual behavior (Knopp, 1984; Marques & Nelson, 1989; Marshall, Laws, & Barbaree, 1990; Nelson, Miner, Marques, Russell, & Achterkirchen, 1988).

Second, sex offender treatment is viewed as a sophisticated clinical specialty dominated by multimodal assessment and treatment packages designed to measure and modify specific determinants of sexual offending. The three most common targets of treatment are: (a) deviant sexual interests or preferences; (b) cognitive distortions about illicit sexual behavior; and (c) a broad range of skill deficits such as social incompetence, lack of empathy, and impaired anger or affect management (Abel, Becker, & Skinner, 1985; Annis, 1982; Knopp, 1984; Marshall & Barbaree, 1990).

Another recent and promising development is that programs are focusing more on teaching offenders specific skills in the area of relapse prevention; that is, training the offender how to recognize the chain of events and specific risk factors that have led up to his sex crimes, and how to interrupt that chain of events in order to avoid reoffense (Marques, 1984).

Finally, there is an increased emphasis on a continuum of care for offenders that includes a strong community supervision component. Community aftercare services for sex offenders being released from institutional programs are essential to facilitate community readjustment, deliver booster sessions to prolong treatment effects, and provide direct supervision over an extended posttreatment period (Maletzky, 1991; Marshall et al., 1990).

The treatment philosophy described in the Statement of Standards and the individual program descriptions clearly represents a mainstream approach. Sex offending is seen as a complex, multidetermined behavior; treatment is geared toward control, not cure; personal responsibility is emphasized; and offenders are taught to recognize and interrupt their offense patterns. Two factors are listed as necessary for the commission of sex offenses: (a) deviant sexual interests and

(b) a personality disorder/thought process that allows the person to act on those interests. While at first this analysis seems a bit oversimplified, further review of the program descriptions reveals that the second factor (the enabling personality disorder/thought process) encompasses a number of the internal and interpersonal risk factors that are considered important in sex offender treatment.

As was pointed out by Dr. Pithers, the weakest part of the Statement of Standards is the description of assessment and treatment components. The assessment of sex offenders is crucial to effective treatment and to sound program evaluation. As was concluded by the Solicitor General of Canada (1990): "While there is no standard assessment procedure for sexual offenders, experts generally agree on broad areas that need to be assessed. These areas include sexual history, sexual preference, hormonal (testosterone) levels, sexual attitudes, substance abuse, cognitive abilities, interpersonal skills, and potential for violence. Detailed, corroborated information on the offence(s) is essential. Phallometric assessment (e.g., a physiological measurement of sexual arousal), although not immune to deliberate faking, is essential for identifying deviant sexual arousal and useful for planning and monitoring treatment" (p.27).

Assessment procedures should identify factors that contribute to sexual offending for each individual offender. With this type of assessment, treatments can be provided that directly address the risk factors that are identified. If the treatment is theory-based (e.g., SOTP's relapse prevention model), assessment procedures should include measures that directly reflect the variables of interest to the program (e.g., factors "a" and "b" above). In the SOTP, while the physiological assessment directly addresses the deviant interests factor, a number of measures related to the broader personality disorder/thought process factor are not included. Also, many of the specific variables included in descriptions of the treatment sequence (e.g., motivation, anger management

skills, locus of control, victim empathy, problem solving skills, relapse prevention skills) are not assessed.

In terms of treatment modalities, the descriptions in the Statement of Standards also fall somewhat short. As Dr. Pithers noted, state of the art sex offender treatment is now based on highly specialized therapeutic components. Although SOTP's behavioral treatments are clearly designed to modify deviant sexual interests, the specific targets for the other components are not described. It is not clear, for example, how individual, group, and educational modalities are used to address the issues considered central to the SOTP theoretical framework. Similarly, while the importance of aftercare is clearly reflected in the SOTP Standards for Community Treatment of Sex Offenders, the content and in-program goals of the community services are not specified.

In contrast, the treatment sequence sections of the Statement of Standards and the individual program descriptions include clear statements regarding the specific factors that are of interest in SOTP. While not systematically assessed pre-post, the factors that define treatment progress are listed in each phase's goals, requirements, and evaluation forms. One can assume that these factors are in fact the focus of treatment interventions; what is needed is a description of how the various individual, group, educational, and milieu activities are supposed to work. Again, as was recommended by Dr. Pithers, specific treatment protocols that specify the content, sequence, and goals of each group are needed. It should be emphasized that this does not necessarily mean that the staff must develop all of this material; many treatment manuals for the components of a relapse prevention program are currently available (e.g., those from the Sex Offender Treatment and Evaluation Project in California).[2]

At this time, the SOTP has a treatment philosophy and a framework that are definitely in the mainstream of sex offender treatment. Until the content and goals of the programs' assessment and treatment components more clearly articulated,

however, evaluation of treatment fidelity and relevant pre-post changes in program participants will be difficult.

One final thought on the quality of treatment. As Dr. Pithers noted, DOC's current level system for determining aftercare intensity has some problems. In addition to those noted by previous evaluators, there is another issue that deserves attention: the fact that offenders who have completed or are still in institutional programs when they are released are given the most intense aftercare service, while those who drop out or are expelled from treatment get the least. Although this system may indeed treat those who are the most "amenable", it also fails to offer the most intense treatment available to the highest-risk offenders (e.g., those who refused or failed institutional treatment). Recent research findings suggest that treatment may have its greatest impact on higher-risk offenders (Gordon, Holden & Leis, 1991). In the interest of public safety, then, DOC should consider trying to include institutional failures as well as successes in its most intensive community programs. One possibility is that treatment staff could refer more participants to aftercare, albeit with different treatment "grades", instead of dismissing so many participants late in the institutional program.

Proposed Evaluation Questions, Measures, and Data Collection Procedures; Current Data That Are Relevant to the Evaluation

This section of the report will formulate questions that can be addressed by specific evaluation measures, and will recommend evaluation strategies to be used in the SOTP. First, questions and strategies for the measurement of treatment outcome will be described; second, additional approaches that may be useful for evaluating the treatment process will be suggested. Since different evaluation strategies require different types of data collection procedures, this section will also discuss specific data sources that should be used, including those that are currently available in DOC.

The treatment outcome question of most interest, of course, concerns recidivism: "Does treatment significantly reduce rates of reoffending?" Related outcome questions include "What types of offenders are most effectively treated in SOTP?", "What are the best predictors of reoffense/successful adjustment?", and "Is treatment cost-effective?".

As was described earlier, treatment outcome studies are very difficult to conduct; as a result, few of the existing studies are free of major methodological problems. Only rarely (e.g., Marques et al., 1991) is treatment outcome research conducted within a valid experimental design (i.e., random assignment to treatment or control conditions). For DOC, in fact, a "pure" outcome study that involved assigning some treatment volunteers to a no-treatment control group would be in conflict with the program's mission, that of "providing a comprehensive system of sex offender assessment, treatment, aftercare, and community supervision for convicted sexual offenders committed to DOC."

This is not to say that agencies with a clear treatment mission should avoid outcome evaluation. Indeed, there is increasing public and political emphasis on accountability, and on spending only on programs that can show that they work. As a result, DOC is encouraged to start a program of outcome evaluation by: (a) analyzing existing data on how treated and untreated offenders have performed in the community after their release (a retrospective study); and (b) incorporating an outcome evaluation component into its ongoing SOTP program (for prospective studies).

While the most valuable information on treatment effectiveness will come from (b), the most immediate information will come from (a). That is, if a system is started in 1992 to collect data on sex offenders from their admission to DOC, through treatment (or no treatment) in SOTP, and then through five years postrelease, significant results will not be available for years. Despite this obvious problem, it is recommended that DOC construct a sex offender data base

that will allow for the conduct of prospective evaluation studies. Ideas for this system will be presented later in this section.

In the meantime, in order to respond more immediately to questions about the effectiveness of SOTP, DOC should conduct a modest retrospective study of SOTP's effectiveness. Rather than attempting to measure the impact of all the programs since their inception, a follow-up study involving a sample of treated offenders and a sample of untreated offenders is recommended.

It should be noted that a waiver of informed consent would be needed for this type of study, since subjects would not be contacted directly. The research protocol should be reviewed by an Institutional Review Board in order to ensure that the subjects of the research are adequately protected.

For simplicity, the study could focus on only one of the programs, preferably the largest one. During the consultation visit, DOC staff at Hiland Mountain/Meadow Creek indicated that they were, in fact, already attempting a follow-up study of 840 treatment participants from 1983 to the present time. Data available included entry status and date, dates of advancement within the program, total treatment days, exit status and date, and type of reoffense (rule violation/misdemeanor/felony, sex/non-sex crime).

The easiest way to do a modest outcome evaluation at this time would be to do a retrospective analysis of this existing information, supplemented by data on a number of demographic and historical variables and a more thorough search for evidence of recidivism. A Research Analyst, working under the (proposed) Director of SOTP, with the assistance of the DOC Planning and Research Unit, SOTP treatment staff and possibly interns or student assistants, could probably complete such a study within a year.

As is the case in all retrospective studies, the researcher will need to make some compromises regarding the quality and quantity of data to be used in the study. Also, since the

Hiland SOTP has evolved significantly since it began in 1982, the study should not include individuals treated before the current "assault cycle" cognitive treatment was introduced in 1984. After a power analysis is done to determine necessary sample size, decisions can be made about the number of subjects to include and the length of the follow-up period. A compromise will be needed to balance sample size and time at risk. That is, as more subjects (later graduates) are included, the average follow-up time will be shorter. It is not necessary, however, to have the same follow-up time for all subjects, as long as most have been at risk for at least five years. For example, if the sample is all offenders released between 1985-1988, time at risk will be 4-7 years as of 1992.

First, since the data are available, the evaluation should describe all the sex offenders at Hiland during the study period. DOC's OBSCIS data can provide demographic and history data on all the offenders, and data from DOC's sex offender tracking system or Hiland's internal system can be used to identify those who were ineligible for treatment. After the pool is described, further analyses should focus on those who were eligible.

Because of the high rate of attrition in the Hiland program, the study should include all eligible subjects in some of the analyses, with the sample stratified on some measure of exposure to treatment. Again, in the interest of simplicity, a combination of time in treatment and progress in treatment (e.g., phases completed) is recommended. In this regard, refusers would have "0" scores for treatment, early dropouts might range between "1" and "3", half-completers/medium stays "4" to "6", nearly complete/long stays "7" to "9", and treatment completers "10". Additional information on treatment progress from SOTP case files (e.g., discharge summaries) may also be used to refine the scores. Note that if these subgroups differ significantly on measures related to recidivism (especially type of offense and extent of criminal history), appropriate statistical controls will need to be applied in the outcome analyses.

Another measure of treatment exposure will be required to reflect the DOC system of providing aftercare service (community treatment for released offenders). That is, those who have progressed furthest in institutional treatment ("maximum/partial benefit") get more intense treatment after their release. As a result, some measure of the intensity of aftercare/supervision will also need to be included as a "treatment dose" variable in this study.

In terms of recidivism data, all possible sources of information on subjects' postrelease activities should be considered. Although Hiland staff are working hard to get information on all returns to custody, additional resources are needed to make sure that all events are included. OBSCIS movement files and rapsheets from the Department of Public Safety should be major sources of data. If staff are available, data from current and archived case files should be obtained in order to get more accurate descriptions of the time and type of offense committed. Getting information "closer to the crime" will allow evaluators to identify charges that were omitted on rapsheets or plea-bargained, and to rate the severity of the crimes.

For data analysis, the use of survival analysis, discussed in the background section of this report, is strongly recommended. The question "Does treatment work?" will be best addressed by comparing the reoffense rates and survival curves of the various study subgroups. Obviously, the most important independent variable is treatment exposure/progress. Rates of reoffending for subjects with various levels of treatment (e.g., none, some, most, all) should be reported, along with analyses of the effects of treatment on time to reoffense, number of offenses and victims, and severity of the crimes. In addition, other factors that may interact with the treatment effect should be investigated, particularly offender type (rapist, heterosexual molester, homosexual molester, bisexual molester), and criminal history (sex and non-sex priors).

The second outcome evaluation task, incorporating a program evaluation component into the ongoing SOTP, is a bit more complex. This system should allow evaluators to accurately report on overall treatment effects, and to describe varying effects on different types of offenders, predictors of reoffense, and the cost-effectiveness of treatment.

At a minimum, data elements for a basic outcome evaluation component include information on: (a) pretreatment offender characteristics (demographics, criminal history, type of instant offense, assessment data on various risk factors); (b) treatment variables (time in treatment, components/phases completed or other measures of progress); (c) prerelease assessments (scores on various risk factors at the end of the inmate's prison stay); (d) community treatment (type provided, compliance, progress); (e) community adjustment (housing, work, social supports, activities); and (f) all incidents resulting in contacts with law enforcement (parole violations, new charges for sex and non-sex crimes).

In terms of data collection procedures, the following recommendations are made. A research file should be created that includes all sex offenders entering DOC, beginning with the basic structure of the current sex offender tracking system (including reasons for ineligibility). Demographic, criminal history, and offense information should be entered for all offenders. Most of this information is currently available in the Department's OBSCIS files. Care should be taken to include historical risk factors in sexual offending (prior sex and non-sex offenses, multiple sexual deviancies and types of victims, use of force, etc.) Presentence investigations may be needed in addition to OBSCIS to complete the risk factor profile. Treatment candidates should be identified through the current system, and offered treatment when they are eligible.

Pretreatment assessment data should be collected by institution staff on all subjects who volunteer for treatment, and if possible, on those who refuse treatment as well. Again, the measures used should address major risk factors for sex

offending (e.g., deviant sexual interests, cognitive distortions, poor personal and social controls), as well as other factors that are important to the theoretical framework of the program (e.g., lack of knowledge about one's offense cycle and high-risk elements). A long list of standard assessment measures was provided by Dr. Pithers in his evaluation report; examples of additional theory-based measures are included below in the discussion of process evaluation.

Although detailed information on treatment is not necessary for basic outcome evaluation, some measures of exposure to treatment and treatment progress (see above description of "treatment dose") should be included. If Dr. Pithers' suggestion of providing more highly structured treatment components is implemented, the subject's file should include a list of components completed as well as other measures of progress. Reasons for voluntary or involuntary termination from the program should also be entered. Again, it is important that subjects who decline, drop out or are expelled from institutional treatment be tracked in the system. This will allow evaluators to analyze treatment effectiveness much more thoroughly.

Prerelease assessment data should be collected by institution staff on all subjects currently in treatment and, when possible, on all eligibles, especially those who at least started the treatment program. (Any studies of the predictors of reoffense will be much stronger if prerelease data are available for all subjects, not just those who are "treatment complete"). This would essentially involve readministering the pretreatment battery of standard tests, along with some mastery measures for the treated subjects. As always, assessment should focus on factors known or predicted to be related to recidivism, including those of interest to the relapse prevention model.

After the subject's release, aftercare providers should be required to submit information on treatment contacts, progress, and community adjustment. These data do not need to be extensive; a simple checklist would probably do.

For recidivism, the system should include multiple indicators of criminal activity. Again, current data sources include the OBSCIS movement files, rapsheets from the Department of Public Safety, and case files in Probation/Parole Offices. In the ongoing California outcome study (Marques et al., 1991) the use of actual incident descriptions from parole files has yielded significantly higher estimates of reoffense rates than the use of rapsheets alone. Incidents from files should also be used to get more accurate ratings of the time of offense, number of offenses, number of victims, and severity of crimes. If the population is especially mobile, FBI rapsheets may also be worth obtaining on some periodic basis. (There should be information on mobility from the retrospective study described above; otherwise, Permanent Fund files could be checked to find out how many are leaving the state).

As was suggested above, data analysis should employ survival analytic strategies that allow the researcher to calculate the likelihood of subjects reoffending during a certain period of time. In terms of what constitutes a reoffense, multiple definitions are suggested. That is, a complete outcome picture would require analyses of rates of reoffense and time to reoffense, with "reoffense" variously defined as "any offense", "any crime against a person", and "any sex offense". Sex offenses may be further distinguished as "hands-on" or "hands-off" crimes.

Once this system is in place, it can be used to generate outcome evaluation reports on a periodic or special request basis. Obviously, since collecting some of the information (e.g., case file data) will be labor-intensive, a schedule for updating this will be required. Whether this is done on a quarterly or annual basis will depend on available resources. In this regard, DOC may want to explore the use of interns from the Justice Center of the University of Alaska Anchorage to collect and/or analyze case file material.

It should be emphasized that the system proposed above is not an experiment, but rather an ongoing monitoring and

evaluation component. As was noted earlier, it is not feasible for DOC to conduct an experimental (e.g., random assignment) study of treatment, particularly in light of the Department's treatment mission. This does not mean that it would be impossible to conduct some methodologically stronger outcome research within SOTP. If there is interest, a design such as randomly assigning subjects to various levels or models of aftercare could produce some important findings. DOC's Research Analyst Steve Schwartz suggested this idea, and would certainly be qualified to collaborate on such a study.

Although it does not need to be part of the ongoing system, information necessary for the conduct of cost-benefit analyses should also be compiled by SOTP. In addition to information on the time, number, type and severity of reoffenses, this would require data on the cost of treatment services (above standard institutional and parole/probation costs), and the cost of reoffenses (law enforcement, courts, incarceration, supervision, victim services, etc.). A methodology for such studies has been developed by Prentky and Burgess (1990). A cost-benefit analysis might be another activity of interest to interns or collaborators from the UAA program.

Finally, the issue of process evaluation. This is an area that requires a clear conceptualization of the treatment model and components. First, some attention must be given to treatment fidelity: Is the program providing the treatment it describes? Unless treatment is thoroughly described and documented (in treatment manuals), and consistently delivered to participants, evaluation findings will be difficult to interpret. The thorough program reviews conducted by Mr. Freeman-Longo address the question of treatment fidelity, but only on an annual basis. Additional methods should include: (a) observation of treatment sessions by the (proposed) Director of SOTP, and (b) use of mastery tests to see if treatment participants are really learning the relapse prevention model and techniques. This can be done by simple pass/fail assignments.

The most important process questions concern why a treatment worked or did not. If a study includes a clear statement of in-program goals and corresponding measures for those goals, the relation between those measures and recidivism can be explored. As was noted previously, while the description of SOTP components is still somewhat vague, the requirements for advancement in treatment are stated quite clearly in the program descriptions. What is needed is for the SOTP clinicians to define, in a measurable sense, the most important of these in-program goals. What changes do they want to see in an offender to consider him successfully treated in the SOTP relapse prevention program? What measures in the SOTP pre-post assessment battery best address these changes?

For illustration purposes, examples of in-program goals and measures from the Sex Offender Treatment and Evaluation Project are provided in Table 1. It is recommended that SOTP develop a similar system of assessing the impact of treatment, and that the system focus on a small number of key attitudes, behaviors and skills. This will require some work by the treatment staff, especially on the task of selecting measures for the more personal items, e.g., "complete understanding of offense cycle and patterns". Again, however, a number of standard measures for factors such as locus of control, cognitive distortions, deviant sexual interests, and coping skills are currently available, many of which were included on Dr. Pithers' list of assessment procedures. For treatment goals that are highly idiosyncratic and not easily addressed by standard measures, the use of Goal Attainment Scaling (Kiresuk & Sherman, 1968; Quinsey & Harris, 1976) is recommended.

Finally, another group of process measures will be needed if SOTP goes to the more structured program of specialized treatment components recommended by Dr. Pithers. In that case, some measure of mastery or change should be included for each component. Again, for purposes of illustration, a list of the measures used for the Sex Offender Treatment and Evaluation Project is provided (see Table 2).

Table 1

SEX OFFENDER TREATMENT AND EVALUATION PROJECT
TREATMENT PHASE GOALS

If SOTEP's Relapse Prevention (RP) model is being successfully applied, subjects completing the program should demonstrate the following:

1. AN INCREASED SENSE OF PERSONAL RESPONSIBILITY AND DECREASED USE OF JUSTIFICATIONS FOR SEXUAL DEVIANCE

   Measures: Locus of Control (intake-prerelease)
   Multiphasic Sex Inventory (CDI and J Scales) (intake-prerelease)

2. A DECREASE IN DEVIANT SEXUAL INTERESTS

   Measures: Physiological assessment (intake-prerelease)
   Multiphasic Sex Inventory (intake-prerelease)

3. AN UNDERSTANDING OF, AND ABILITY TO APPLY, THE BASIC CONCEPTS AND TECHNIQUES OF RP

   Measures: Tests of RP concepts (Core RP Group)
   Clinician ratings of Cognitive-Behavioral Chain and Decision Matrix (prerelease)

4. AN IMPROVED ABILITY TO IDENTIFY THEIR HIGH-RISK SITUATIONS (internal and environmental factors that can facilitate relapse)

   Measures: Clinician ratings of Cognitive-Behavioral Chain
   High-Risk Situations Test (treated and untreated subjects at prerelease)

5. BETTER SKILLS IN THE AREAS OF AVOIDING AND COPING WITH HIGH RISK SITUATIONS

   Measures: Sex Offender Situational Competency Test (intake-prerelease)

Table 2

SEX OFFENDER TREATMENT AND EVALUATION PROJECT
TREATMENT COMPONENT EVALUATIONS

1. CORE RELAPSE PREVENTION (RP) GROUP
   - Cognitive-Behavioral Model of Relapse
   - Test of RP Concepts

2. SEX EDUCATION GROUP
   - Standard measures of sexual knowledge (anatomy/function)

3. HUMAN SEXUALITY GROUP
   - Attitudes Toward Women Scale
   - Thorne Sex Inventory

4. RELAXATION GROUP
   - Digital skin temperature after relaxation exercises
   - Subject ratings of effectiveness of various techniques

5. STRESS/ANGER MANAGEMENT GROUP
   - Daily Hassles Inventory

6. SOCIAL SKILLS GROUP
   - Social Reactions Inventory
   - Social Interaction Role Play

7. SUBSTANCE ABUSE GROUP
   - Situational Competency Test
   - Self-Efficacy Card Sort

8. BEHAVIOR THERAPY
   - Physiological assessment

Framework and Guidelines for Data Management, Analysis and Interpretation

A number of issues concerning data management, analysis and interpretation have already been addressed. In this section, additional suggestions for organizing and analyzing the SOTP evaluation data will be offered. Since these activities will be determined by the type and level of evaluation effort ultimately pursued by DOC, these suggestions will be general in nature.

After developing some of the basic data collection instruments for the retrospective study, the investigator should work with DOC Planning and Research Unit staff on setting up the project's data management system. Due to the fact that a variety of computer systems will be involved, consultation from the faculty of UAA's Justice Center, and the cooperation of other agencies (e.g., Department of Public Safety) will also be required. While the study proposed in this report would not require repeated analyses over time, it is recommended that all of the study data be coded and entered into an electronic data base, to allow various analyses to be done without going back to raw data. Building this kind of data base will also aid in the later development of the ongoing program evaluation system recommended in the previous section.

Because the information in the system will include sensitive historical and clinical data, care must be taken to protect the identities of subjects and to limit access to the files. Review of the data protection procedures by an Institutional Review Board should ensure adequate safeguards in this area.

Once again, care should be taken to include all available data sources in the analysis of outcome. First, reoffense information from the most available source (e.g., rapsheets) should be analyzed, in order to report information quickly on as many subjects as possible. Then, data from the case files of all study subjects should be added to the analysis to

provide a more complete reoffense picture. Information from sources that are available for only part of the study sample (e.g., aftercare therapist reports) should be analyzed separately to avoid bias in the group comparisons. Analyses should also be conducted using various definitions of reoffense; for example, both sex crimes and other crimes against persons may be of interest, especially when dealing with official records that may reflect plea-bargained convictions.

As was discussed before, the large number of dropouts presents a problem in data analysis. If all subjects are included, and are grouped by "treatment dose" levels (categories from "none" to "treatment complete"), a number of approaches can be used. One could, for example, conduct an analysis of variance using all levels of exposure/progress, as well as an analysis involving only the extreme (untreated vs. complete) subgroups.

Since the evaluator will have no control over group assignment (treated vs. untreated), the study should also include methods such as analysis of covariance to at least partially separate the effect of treatment differences from that of selection differences. For example, if offenders with one incest charge predominate in the "treatment complete" group, while most rapists and predatory molesters with long criminal histories are in the untreated group, such selection differences must be taken into account in the analyses.

Finally, as there will be differential periods at risk, the life-table method used in survival analyses is recommended for calculating the likelihood of men in the sample recidivating during a specified follow-up period. A number of other summary statistics for recidivism research are discussed by Furby et al. (1989).

For the ongoing evaluation system, many of the same guidelines are proposed. A project manager needs to be assigned to begin to build the necessary evaluation data base from the OBSCIS base, and to design the elements to be included

in the system. Treatment staff should be included early in the planning process, especially since they will be needed to select appropriate process measures, and to report on the progress of treatment participants.

The analysis of treatment effects, even within an ongoing evaluation effort, is complicated and time-consuming. "Treatment", as discussed in this report, is not an all-or-none experience. In addition to varying on important pretreatment characteristics, subjects will bring different levels of skill and motivation into the program, and will have different exposures to treatment (in terms of length of treatment, number of treatment components completed, etc.). As above, analysis of covariance can be used to take these differences into account. Another approach, described by Furby et al. (1989), is to "place the treatment and potential biases in competition with one another as alternative explanations for the results. Typically, this will require multiple analyses, each of which estimates the effects of a different pattern of potential biases. If, after all plausible biases have been accommodated, a group difference still emerges, then one might feel reasonably comfortable about interpreting it. Of course, such a conclusion is solidified if the result converges with those of other studies"(p. 10).

Regardless of the analytic approach used, evaluation reports should include descriptions of the various study groups (including dropouts), descriptions of the treatment components provided in the program, pre-post comparisons on relevant assessment measures, analyses of the overall effects of treatment on various measures of recidivism, and specific analyses for various subgroups (e.g., offender types). In addition, reports should clearly identify variables that interact with treatment or predict reoffense. It is especially important to determine if the achievement of in-program goals or completion of any particular treatment component is significantly related to recidivism. These analyses are critical in designing data-based program improvements.

Due to the complexity of the analyses, it is recommended that a schedule be established early in the program for producing periodic reports for administrators and other interested parties, rather than attempting to provide results on a request basis. Unless there are special circumstances or undeniable requests, an annual report on the overall program evaluation should suffice.

The interpretation of outcome evaluation data must take into account all of the factors discussed in the background section of this report, as well as those in the discussion of validity below. Given the multitude of sources of error and bias, most applied studies do not yield clear-cut, easily replicable results. Interpretations must be limited to the subjects, treatments, and measures employed in the study. If the results are presented in the context of a detailed description of the treatment and research methods, however, they can definitely help answer the question of whether treatment works.

Methods for Ensuring Reliability and Validity, and for Comparing Alaskan Statistics with Those from Other States

In order to have confidence in the results of the SOTP evaluation, DOC administrators must be assured of the reliability and validity of the data included in the analyses. Also, since correctional treatment programs for sex offenders have been and are currently being evaluated in other states, DOC staff need to know whether Alaska's findings are comparable with those from similar studies elsewhere. This final section of the report will address these two issues.

All evaluation studies should include procedures designed to maximize the reliability of the measures that are used. Reliability is an index of the consistency of a measuring instrument in repeatedly providing the same score for a given subject. In some cases, such as coded criminal history data from OBSCIS files, reliability is a small issue. In others,

such as scores on measures of treatment progress (e.g., how thoroughly an individual understands his offense cycle), methods are required to ensure that reliability is at an acceptable level.

Most of the independent variables that have been recommended for study in this report can be measured in fairly reliable ways. Data on type of offense, stable offender characteristics (such as history and demographic characteristics), and time in treatment are likely to be very reliable. So are other treatment data such as number of components and phases completed, and scores on standardized pretreatment assessment measures. The major independent measures needing a close reliability check will be those that assess progress in treatment, especially if clinician ratings are more heavily weighted than data from standardized measures in the computation of scores. For data from ratings, care should be taken to have two trained raters independently score the same individuals. If interrater agreement is acceptably high, evaluators can have confidence that the measures are reliable enough to use in a treatment progress assessment. Since developing rating scales, training raters, and doing reliability checks are time-consuming activities, the use of standardized measures that are linked to specific in-program goals is recommended.

Ensuring the reliability of the major dependent measures is also crucial. It was suggested above that multiple measures be used in order to get as much information as possible on reoffense activities. Again, in some cases, such as rapsheets, measures are likely to be very reliable. As one gets away from official documents and into sources such as case files, however, reliability becomes an issue. For example, if research staff retrieve case files and collect information on all incidents described by Parole/Probation Officers, methods for coding and quantifying the data must be developed and tested for reliability. Often the description of an event is not easily categorized in terms of sex/non-sex and severity.

At times, the evidence presented is compelling, at times very weak. So, coding systems must be tested to ensure that interrater reliability is high and that conflicting scores can be resolved. Again, this does not necessarily require the development of a new procedure; such a coding system is being used by California's Sex Offender Treatment and Evaluation Project, and is available from the author.

Validity is a broader and more complex issue than reliability. In a general sense, validity refers to the methodological or conceptual soundness of the research. For example, the question "Does this study really test what it is supposed to test?" is about validity. There are many specific types of validity and methods of testing it, but for this report, only the general question stated above will be addressed.

In order to be assured that an outcome study with sex offenders is a valid test of treatment, all of the methodological issues described in pages 6-10 of this report must be addressed. The term "addressed" is used, rather than "resolved", because applied studies of ongoing programs are never methodologically perfect. What is needed for DOC's purposes is a clear statement of the goals of the evaluation and the type of treatment being tested, a description of how the study methods will attempt to achieve the goals, and a list of possible sources of bias/error with methods that are being used to minimize error. In some cases, limitations on the study's validity are inherent in the design. For example, excluding certain target groups limits the study's findings to offenders who meet the criteria for inclusion; offering a treatment program with a restrictive philosophy and a single treatment modality limits the test to that kind of treatment.

In other cases, attempts to reduce threats to validity must be a high priority for the investigator. Again, the most important variable in treatment outcome research with offenders is the criterion variable, reoffense. As was described earlier, it is very difficult to determine with any precision

the occurrence of a new crime, the type of offense, and the time that an offender remained crime-free. If a majority of crimes are undetected, the test of treatment will not be valid. This is especially true if more crimes in one study group (e.g., untreated subjects) go undetected than in another group (e.g., treated subjects).

The previous section on data collection procedures includes a number of recommendations for maximizing the validity of the STOP evaluation. Most of these involve using multiple measures of the study's most important variables, treatment and reoffense. A valid test of treatment requires a detailed description of the interventions that were used, and the subject's progress in/exposure to treatment. For reoffense, the most detailed, closest-to-the-event descriptions of postrelease problems must be used in conjunction with more easily accessible rapsheet information.

Another approach to the validity question is to compare the methods and findings of DOC's evaluation with those of other studies. If, for example, a number of outcome studies that treat child molesters with an intensive cognitive-behavioral program found four-year recidivism rates of around 15%, the validity of a similar study in Alaska that found a rate of 0% would be questioned. Such a divergence would at least suggest a look at how recidivism was defined and measured in the Alaska study.

Unfortunately, given all of the variables that are included in applied outcome research, it is rare to find studies that are directly comparable. Although a number of states are currently conducting evaluation research in their sex offender treatment programs, there is significant variety in the types of offenders involved, the type and length of treatment, intensity of aftercare and supervision, and the definition and measurement of "treatment failure". Despite these differences, it is important to determine where one state's effort fits into the big picture of sex offender treatment.

It is strongly recommended that DOC's new Director of SOTP monitor the program developments and evaluation findings from other states and Canada. For example, as the reviews cited in the background section of this report indicate, a number of researchers have conducted retrospective studies of treatment similar to the one suggested here. In addition, many states with institutional programs are currently setting up evaluation components for ongoing monitoring of treatment outcomes. Of particular interest to Alaska would be the new evaluations planned for the treatment programs at Oregon State Hospital and the Washington State Program at Twin Rivers. The Washington program in particular seems quite similar to the Alaska program in regard to screening criteria, treatment setting and duration, cognitive-behavioral methods, and community aftercare. If a careful review of the treatment and research methods used elsewhere indicates a high degree of similarity, the results from their evaluations can be used to bolster the credibility of DOC's findings.

It should be noted that it is also important to compare findings with programs that include different treatment approaches from those in SOTP. For example, if another program has identified a highly effective treatment or supervision strategy, SOTP may want to include a similar component in the future. Comprehensive evaluation efforts such as the author's Sex Offender Treatment and Evaluation Project will likely produce this kind of component-level results.

At this time, some the strongest evaluation efforts are taking place in the federal and provincial treatment programs in Canada. The Correctional Service of Canada has been very active in developing new programs, assessing risk factors in sex offenders, and testing the effectiveness of its treatments. A recent issue of the Forum on Corrections Research describes this work, and is available from Frank Porporino, Ph.D., Director General, Research and Statistics Branch, Correctional Service of Canada, 340 Laurier Avenue West, Ottawa, Ontario, Canada K1A 0P9.

Author's Notes

1 Some of the material in this section was adapted from Marques, J. K., Day, D. M., Nelson, C., Miner, M. H., and West, M. A. (1991). The Sex Offender Treatment and Evaluation Project: Fourth Report to the Legislature in Response to PC 1365. Sacramento: California State Department of Mental Health.

2. Treatment manuals are available from Craig Nelson, Ph.D., Sex Offender Treatment and Evaluation Project, Atascadero State Hospital, P.O. Box 7001, Atascadero, CA 93423-7001.

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EVALUATION AND RECOMMENDATIONS

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