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Alaska Department of Corrections  
Sex Offender Treatment Programs:  
Evaluation and Recommendations

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Goals of the Evaluation

This report evaluates the design and implementation of the Alaska Department of Corrections' sex offender treatment programs within institutions and the community. The following goals were established for this evaluation:

- a. Review of program design with specific emphasis on operating philosophy
- b. Review of treatment modalities currently in use
- c. Review length of treatment, including phases of treatment and intensity of treatment
- d. Review whether appropriate treatment are matched to individual offenders and offense types
- e. Review screening criteria for program referral and admission
- f. Review level and type of staffing
- g. Evaluate the appropriateness of institutional milieu versus community-based treatment
- h. Review continuum of treatment services from high-risk community education groups through intensive aftercare
- i. Evaluate centralized versus regional delivery of institutional treatment services
- j. Evaluate the extent to which sex offender treatment programs are integrated within institutional settings
- k. Review potential for use of Depo-Provera within institutional treatment programs
- l. Evaluate the extent to which developmentally disabled sex offenders are effectively treated
- m. Review role of specialized probation/parole officers
- n. Analyze established program evaluation procedures

The extent to which sex offender treatment programs are integrated within the legal and correctional systems can profoundly enhance or debilitate therapeutic efficacy. Therefore, this report also recommends a number of systemic changes that may improve the functioning of these programs.

Information Considered During Evaluation

The conclusions of this report are based on several sources of information. Between July 15 and 23, 1991, site visits were made to every institutional treatment program. Discussions were held with mental health practitioners involved in both the institutional and community-based programs. Within the institutional programs, meetings were held with treatment providers, offenders engaging in the treatment programs, corrections staff (including those directly (e.g., Wing Counselors at Hiland Mountain) and less directly (e.g., Wardens) involved with the programs). In each setting, at least one probation officer involved with the respective program was contacted. In total, these meetings involved a total of 51 employees or contractors with the Department of Corrections and approximately 40 offenders in treatment (most of whom were at Hiland Mountain). In addition to site visits, a total of 823 pages of written information was reviewed. This information consisted of Robert Freeman-Longo's reviews of program compliance with the "Sex Offender Treatment Programs Statement of Standards", the "Statement of Standards", program descriptions and treatment schedules, intake and screening forms, contracts with treatment providers, criteria used to determine treatment phases, three projects completed by offenders in partial fulfillment of phase criteria, discharge summaries for offenders who had been involved in institutional treatment, and a considerable collection of memoranda.

Thus, information reviewed during this analysis has come from many sources. However, conclusions drawn from this information are the responsibility and work of the author of this report.

This report is organized in the following manner. Information concerning the superstructure of treatment across sites and Departmental operation of programs will be detailed first. The second section of this report provides documentation relevant to the individual treatment programs.

#### Review of Program Design with Emphasis on Operating Philosophy

The basic program design, as delineated in the "Sex Offender Treatment Programs Statement of Standards" and descriptions of the three residential treatment programs, is generally good. The "Statement of Standards" clearly articulates the fundamental assumptions of the treatment design (i.e., multi-modal treatment implemented within a relapse prevention framework), recognizes that a range of therapeutic interventions must be employed to match the variation in sex offenders' assets and deficits, recommends a psychosexual assessment package to differentiate treatment needs, and asserts that these interventions should be delivered with respect for "individual dignity of program participants" (p. 2). The "Statement of Standards" clearly asserts that it intends to "provide minimal standards to insure professionalism" (p. 2).

From a management perspective, the "Statement of Standards" details the expectations of contractors. From a clinical

perspective, the "Statement of Standards" is sometimes vague. This may result from: 1) its attempt to define minimal expectations for both prison-based and outpatient treatment, 2) the difficulties inherent in defining standards for a program involving several sites and teams of providers, or 3) the developmental stage of the program. The clinical expectations of the "Statement of Standards" might be clarified by adding a higher level or "preferred" set of standards. In this manner, the "Statement of Standards" clearly will delineate the minimal expectations practitioners must meet to maintain contractual compliance and also demonstrate the expectation that mental health providers should strive to maintain a higher level of professional service.

Among the standards defined vaguely are those regarding psychological testing and group counseling sessions. Suggested modifications in these standards, which might best be considered recommendations for "preferred" standards, are detailed later in this report (See sections entitled "Review of Treatment Modalities Currently in Use" and "Screening Criteria for Program Referral and Admission").

While the written program design is generally good, and the three program descriptions are very similar, the degree to which the design actually has been implemented varies greatly across sites. This variation is evident in the therapeutic staffs at the three sites. Hiland Mountain uses mental health professionals and correctional officers (referred to as Wing Counselors); Fairbanks

uses mental health professional, a paraprofessional, and a nurse; Lemon Creek employs only mental health professionals. In the case of Hiland Mountain, the largest program, notable variations exist across the mental health professionals within the site. The implementation of the program design at the various sites is detailed in the final section of this report.

The program design would appear to work adequately with Native Alaskans. However, the implementation of the design may need to be altered for these groups and treatment providers who are unfamiliar with Native Alaskan groups may need to take part in training to sensitize them to issues unique to these populations. If such modifications in implementation are made, a special program for Natives would not appear necessary.

The Tongass Community Counseling Center staff employed in the Lemon Creek program have done an exceptionally creative job of adapting the design for implementation with Natives. To assist new residents' involvement in treatment, residents making good progress are assigned the role of "Elder". The importance of the Native Alaskan's community is recognized by this program (and used to therapeutic advantage) by involving them in the "External Supervision Dimension" of Relapse Prevention, referring to this as the "Safety Net Contract". In addition, these providers have identified the importance of providing basic instruction in human development to subcultural groups, recognizing that their culture may endorse beliefs about childhood development that hinder

progress in treatment. Similar creative adaptations in the basic model can be implemented at minimal cost.

Review of Treatment Modalities Currently in Use

The "Statement of Standards" defines the need for:

1) individual counseling, 2) family counseling, 3) group counseling, 4) educational classes, 5) behavioral treatment, and 6) anti-androgen treatment (e.g., Depo-Provera). Thus, the "Standards" call for a comprehensive array of therapeutic services. However, the "Statement of Standards" does not adequately define the specific types of treatment included under each of these broad categories.

Greater specification of treatment modalities may not be necessary for individual, family, or anti-androgenic interventions. However, in order to demonstrate that the program is truly specialized for sex offenders, group and behavioral treatments need to be spelled out in greater detail. (The 1990 Edition of the Statement of Standards I reviewed indicates that a list of Educational Classes would be generated by contractors. I am not aware if this has been accomplished.) The current definition of group counseling in the "Statement of Standards" primarily addresses management concerns (i.e., minimum hours of group counseling per week, need for cotherapists in groups, number of participants per group), rather than specifying clinical concerns (e.g., specifying essential group treatment components).

Neglecting to define group treatment more precisely carries the risk that even highly motivated and professional providers may conduct relatively unspecialized group therapy with sex offenders. Abundant data exists to demonstrate that traditional group (and individual) therapy with sex offenders is ineffective and, in some cases, may make matters worse (See Furby, Weinrott & Blackshaw, 1990). Vague definitions also make it difficult to determine the extent to which treatment providers are addressing issues considered central to effective sex offender treatment (e.g., social competence, emotional management, identification and management of risk factors).

It is important to identify treatment components more precisely. Developing a table of accepted treatment interventions, similar to that shown below, would offer a structure that treatment providers could use to guide the development of highly specialized therapeutic components.

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### Treatment Components

#### I. Group Therapies

- Victim Empathy
- Personal Victimization
- Emotional Recognition
- Situational Anger Management
- Management of Chronic Anger
- Journaling
- Offense Patterns
- Couples Therapy
- Communication Skills
- Sexuality Education

Cognitive Distortions  
Relapse Prevention  
Peer Group  
Transition Group

II. Behavioral Therapies for Arousal Disorders

Covert Sensitization  
Verbal Satiation  
Masturbatory Satiation  
Olfactory Aversion

III. Individual Therapy

IV. Psychohormonal Intervention

V. Adjunctive Therapies

Marital Therapy  
Family Therapy  
Substance Abuse Counseling  
Vocational Education  
Educational Remediation

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Once an accepted group of specific treatment groups has been identified, treatment protocols could be developed that would specify the content and sequence of each treatment group. Treatment protocols would facilitate program evaluation, enhance consistency of treatment across sites, demystify the treatment process, and assist training of new treatment providers.

Development of treatment protocols could be performed by the Central Director of Sex Offender Programs [See the section of this report entitled "Level and Type of Staffing"] in conjunction with selected contractual treatment providers. Funds would need to be provided to reimburse contractors for their participation in this process.

Length of Treatment; Treatment Phases; Treatment Intensity

Length of Treatment. Treatment of sex offenders would be a much easier enterprise if one was able to define, a priori, the proper duration of treatment for all such offenders. The program would be easier to explain to administrators, Judges, attorneys, media representatives, and the offenders themselves. Program management would be facilitated if one could plan on every sex offender deriving benefit from X amount of treatment delivered with Y degree of intensity. While one may operationalize assembly of automobiles in this fashion, it is beyond the realm of reason to anticipate that all sex offenders will benefit equally from treatment, let alone benefitting equally across the same time span.

Length of treatment is a complex issue. The time needed to effectively treat a sex offender is dependent on factors such as the unique personal assets and deficits of each offender, his motivational persistence during the difficult process of change, the intensity and specificity of therapeutic interventions available to the offender, the skills and knowledge of therapists with whom the offender works, and the extent to which the offender is supported by others who are aware of his history of abuse. Since these factors vary across offenders, it is infeasible that they will benefit equally from the same treatment duration.

Time of Admission to Prison-based Programs. The "Statement of Standards" calls for incarcerated sex offenders to enter treatment "within 18 months to six years of projected release/parole

eligibility date. Inmates with the least amount of time left to serve will be given a priority for admission into the program" (p. 8). Some of the people interviewed during site visits expressed concern that the 18 month window and the requirement to give priority to "short-timers" may not be working effectively. This concern was heightened by institutional Probation Officers, many of whom observed a growing tendency for referrals to be made only late in an offender's sentence.

While it appears reasonable to give priority to inmates who have the least amount of time remaining to their release date, attempts to adhere rigidly to this standard may have unintended deleterious effects on treatment. Some offenders who are highly motivated and possess considerable personal assets may accomplish considerable change during 18 months of treatment. However, other offenders (e.g., highly motivated but extremely disordered, marginally motivated with high personal assets) may have difficulty accomplishing sufficient change within 18 months. Thus, entering offenders into treatment solely on the criterion of remaining sentence length neglects the reality that offenders may require different lengths of intensive treatment based on their degree of motivation and the number of issues that must be addressed during their treatment.

I recommend greater flexibility in admissions decisions. If an error is to be made, it is advantageous to enter offenders into treatment somewhat too early, rather than too late. If offenders

enter treatment early and make significant personal change, treatment providers will have the opportunity to assess how effectively the individual works to maintain his change. If not too prolonged, this "maintenance phase" during incarcerative treatment may be advantageous. In contrast, if offenders do not have sufficient time in treatment, they may need to exit the program when their own vulnerability is heightened (e.g., recent disclosure of their own sexual victimization) and, therefore, potentially be at higher risk of relapse than if they had not entered the treatment program.

Treatment Phases. Concern has been expressed about the way in which Phase Criteria currently are used to determine progress in treatment. Some offenders progressing out of treatment are termed "treatment complete". This term apparently refers to offenders who have completed all the Phase Criteria but who remain at high-risk of relapse. The existence of "treatment complete" offenders has raised a question about the adequacy of the criteria associated with completion of Phase Three. The question is: "How can someone have completed all the criteria used to evaluate progress in treatment and still be considered at imminent risk of relapse?"

In order to maintain credibility, the treatment program may need to revise the Phase Criteria to eliminate the potential of offenders completing the criteria only to be considered at high-risk of reoffense. It may be that this revision needs to consider psychosexual assessment data and environmental concerns, rather

than reflecting solely the completion of assignments and demonstrations of prosocial behaviors during treatment sessions and on the treatment unit. It may be possible to address this problem by adding a fourth Phase involving a transitional release sequence or residential treatment in a half-way house. This would allow treatment providers and parole officers to closely monitor an offender's maintenance of change as he begins to encounter risk factors for sexual abuse. It would help to counter the anxiety that treatment professionals experience when facing decisions about graduating offenders from a prison-based treatment program.

Sex offenders who were currently in Phase Three were interviewed during site visits. Many of these individuals suggested that treatment needed to be more individualized at the beginning of each Phase. There was an expressed need for closer interaction with therapists when special assignments are given.

Treatment providers believe that more incentive needs to be created to motivate sex offenders to create personal changes. Several suggested that presumptive sentencing should be eliminated and that opportunity for parole should exist.

Other individuals suggested that the Phase Criteria should place greater emphasis on building self-esteem. The issue of self-esteem in sex offenders has generated a great deal of debate. Many sex offenders experience low self-esteem during the course of their offending, upon their apprehension, and upon entry into treatment. The offenders feel ashamed and embarrassed. It is difficult to

imagine anyone feeling otherwise when their performance of sexual abuse has been unveiled.

Some treatment programs have attempted to deal with offender's low self-esteem by offering interventions specifically intended to enhance one's feelings of self-worth. Some programs have carried this concept to the extreme and offered only interventions designed to enhance self-image. Steve Wormith, from Correctional Services of Canada, has reported data demonstrating that recidivism rates are increased if offenders only receive self-esteem building interventions. Obviously, other answers are needed.

I believe that sex offenders acquire genuine self-esteem as they encounter the personal challenges of specialized treatment and meet those challenges. As these individuals discover that they possess more emotional strength and greater skills than they had believed possible, belief in oneself grows. As one develops the ability to understand others' emotions as never before, belief in oneself grows. As one learns procedures to meet life's stresses with a quiet confidence, belief in oneself grows. By meeting the challenges and conquering them, sex offenders leave treatment with genuine self-esteem. This derivation of self-esteem has far greater longevity than that experienced after a treatment group that artificially instills a momentary sense of self-esteem.

Considerable concern has been expressed about the percentages of offenders who either choose to leave or are removed from treatment. While I did not review specific treatment "casualty"

data, I was informed that estimated casualty rates range from 8% in the Lemon Creek program to 91% in the Hiland Mountain program. Some individuals interviewed during site visits expressed a belief that drop-outs and dismissals tend to occur during the later stages of the Phase Criteria. One person noted that an offender in the Fairbanks program was dismissed after 30 months involvement. Several others pointed to offenders who had dropped out of treatment after 1 to 2 years and returned to the general prison population with a profound sense of hopelessness.

Hypothesized causes of this pattern of drop-outs and dismissals varied. One person asserted that early Phase Criteria are too easy, allowing offenders to believe that they are accomplishing significant change, while Phase Three Criteria are too difficult, discouraging offenders and allowing them to feel deceived about the earlier suggestion that they were making reasonable progress in treatment. Other staff members voiced the opinion that late Phase dismissals reflect treatment providers' anxieties about the effect of recidivism on their reputations. In other words, rather than "graduating" offenders at the end of Phase Three, the providers may be more inclined to dismiss the offender from treatment. When asked to support this hypothesis with facts, one staff member mentioned the case of an offender who entered a treatment team meeting to be considered for advanced status (i.e., Phase Three) but left the team meeting unfavorably dismissed from the program. Still others felt that dismissals late in treatment

might be associated with providers' concerns that new offenders would not be transferred to take the place of dismissed offenders. Therefore, providers hang on to current clients, progress them through the first two Phase Criteria, and only after beginning to consider "graduating" the offender, realize that the offender has not made adequate gains.

Nearly all sex offender treatment programs are plagued by the problem of treatment drop-outs and dismissals. In the Vermont Treatment Program for Sexual Aggressors, 50% of the offenders entering the prison-based program during its first 5 years of existence dropped-out or were dismissed. However, during the last 5 years the drop-out and dismissal rate is closer to 25 - 30%.

A variety of factors affect drop-out rates. Some offenders enter treatment in an effort to serve "easy time" or believe it will increase the possibility of early release, not because they are motivated to change their behaviors. Such offenders often drop out of treatment when their expectations are not met. Programs that do not screen offenders adequately may have higher drop-out and dismissal rates. Changes in therapeutic personnel can be disruptive and lead to a greater rate of drop-outs temporarily. Treatment providers can become frustrated and overly aggressive within the therapeutic relationship.

Drop-out rates might be minimized by providing pre-treatment groups to educate offenders about specialized sex offender treatment, more thoroughly screening offenders prior to admission,

supporting therapists to diminish countertherapeutic behaviors associated with burn-out, and supervising therapists to enhance consistency of approach.

In defense of the treatment programs, one person observed that even many of the offenders dismissed from treatment believe that they derived some benefit from it.

#### Screening Criteria for Program Referral and Admission

The program design calls for matching offenders' treatment needs with highly specialized, focused interventions. In reality, essentially no screening of offenders exists at any point in the system. The program operation could be enhanced greatly by developing a systematic approach to assessment of individual offender' needs and recommending relevant dispositions for treatment and security needs.

The first point at which such assessment might be implemented is at the Presentence Phase of Adjudication. Two components to this assessment are recommended: 1) specialized Presentence Investigations completed by Probation Officers whose training has sensitized them to considerations unique to sex offenders and 2) specialized Psychosexual Evaluations completed by mental health professionals who have experience working with sex offenders. Taken together, these two sources of information provide: 1) a broad and detailed picture of the offender's lifestyle and background and 2) a fine-combed analysis of aspects of the

offender's functioning that may predispose sexual abuse (e.g., beliefs, displacement of responsibility, sexual arousal pattern, emotional management).

When an informed Judiciary is presented with this information, sentences may be tailored to enable the most appropriate disposition for each offender. The need for such information becomes more significant in light of HB-366, which provides Judges the ability to sentence offenders to specific treatment programs. If specialized Presentence Investigations and Psychosexual evaluations are not performed, the only information available to Judges at sentencing that is relevant to sex offender triage will be the offender's record of prior sex offenses. Thus, dispositions will be made in the absence of most information relevant to sex offender treatment. The implications of this process are staggering. While some dangerous offenders might be permitted access to the community through probationary sentences, some offenders who might function safely in outpatient treatment will be sent to prison unnecessarily.

In addition, unless programs have a mechanism for removing unamenable sex offenders from the treatment program, such programs will become overwhelmed with offenders who have no interest in changing their behaviors or values. Offenders motivated to change will progress out of the program, while those who do not desire to change will be left behind. Eventually, the preponderance of unmotivated sex offenders will become so great that even highly

motivated offenders will not be able to withstand the influence of residents resisting change. Even the most effective treatment program will collapse within this framework. Again, the importance of triage is evident.

Specialized assessment of sex offenders is also important to the identification of treatment needs. Therefore, additions are recommended to the assessment battery identified in the "Sex Offender Treatment Programs Statement of Standards". Many of the procedures listed in the table below assess narrow aspects of an offender's attitudes and behaviors which can then be addressed through very specific treatments. In addition, two of these assessment devices (i.e., the Penile Plethysmograph and the Psychopathy Checklist) have been demonstrated a strong relationship to treatment prognosis in recent research.

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Psychosexual Assessment Procedures

Attitudes Toward Women (Spence & Helmreich, 1978)  
Autobiography (Long, Wuesthoff & Pithers, 1989)  
Beck Depression Inventory (Beck, 1967)  
Buss-Durkee Hostility Inventory (Buss & Durkee, 1957)  
Clarke Sexual History Questionnaire (Langevin, 1983)  
Cognitive Distortions Scale (Abel, Becker, Cunningham-Rathner, Rouleau, Kaplan & Reich, 1984)  
Fear of Negative Evaluation Scale (Watson & Friend, 1969)  
Interpersonal Reactivity Index (Davis, 1980)  
Millon Clinical Multiaxial Inventory (Millon, 1977)  
Minnesota Multiphasic Personality Inventory  
Multidimensional Self-Esteem Inventory (O'Brien & Epstein, 1983)  
Multiphasic Sex Inventory (Nichols & Molinder, 1984)  
Multiscore Depression Inventory (Berndt, 1986; Western Psychological Services)  
Novaco Anger Scale (Novaco, 1975)

Penile Plethysmograph  
Psychopathy Checklist (Hare, 1980)  
Rape Myth Acceptance Scale (Burt, 1980)  
Relapse Fantasies (Marlatt & Gordon, 1985)  
Rotter Locus of Control Scale (Rotter, 1966)  
Self-monitoring (MacDonald & Pithers, 1989)  
Sex Fantasy Questionnaire (Wilson, 1978)  
Situational Competency Test (Chaney, O'Leary & Marlatt, 1978)  
Social Avoidance and Distress Scale (Watson & Friend, 1969)  
Social Support Scales (Russell & Cutrona, 1984)  
State-Trait Anger Expression Inventory (Spielberger, Jacobs,  
Russel & Crane, 1983; Psychological Assessment Resources)  
State-Trait Anxiety Scale (Spielberger, Gorsuch & Lushene,  
1970)  
Wechsler Adult Intelligent Scale-Revised (Wechsler, 1981)

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In addition to identifying more specifically offenders' behavioral excesses and deficits for the focus of treatment, many of these measures may be used as process measurements of therapeutic progress and as information for release considerations. Also, by establishing a record of assessments of an offender's behavioral change, maintenance of change can be evaluated after the offender is out of formal treatment. "Maintenance evaluations" could be performed at regular intervals or upon the request of a probation/parole officer who believes the offender may be resuming the relapse process. In this fashion, decisions about admission, release, and supervision may be made in a rational, data-based, manner rather than on the basis of clinical intuition alone.

Is the Match of Individual Offenders and Treatments Appropriate?

A reasonable range of therapeutic interventions is listed in the "Sex Offender Treatment Programs Statement of Standards". However, as mentioned previously, the assessment process does not identify the behavioral excesses and deficits of offenders as precisely as possible. Therefore, it is likely that the match between an offender's needs and the treatment program is not as close as possible. Despite this, since the treatment program applies the available interventions broadly across all offenders, the program should be able to meet the needs of most offenders.

It may be important to consider that broadly applying therapeutic interventions across a group of clients may not be the most efficient or effective treatment process. Treatment resources are expended inefficiently when therapeutic interventions are applied to clients who may not need them. Applying interventions to offenders who do not need them may also compromise therapeutic outcome. For example, socially skilled offenders who are required to take part in social skills training may conclude that they are being asked to engage in treatment that has no relevance to their actual problems.

The absence of readily identifiable process measurements of change also makes it difficult to determine whether the existing treatment components reasonably match offenders' needs. Process measurements would allow one to evaluate the extent to which each individual in therapy had benefitted from each treatment group in which they had participated.

Thus, the absence of a thorough assessment process logically suggests that the match between treatment and individual offenders is less than ideal. Use of a wide-range of interventions with offenders likely addresses most of their needs. However, this style of service delivery may compromise therapeutic efficiency and efficacy.

#### Level and Type of Staffing

The level and type of staffing within each program site appears generally adequate and, in some instances, excellent. Exceptions to this general pattern are noted below:

1. The Hiland Mountain program receives more funding than other programs and treats more offenders. This program has the highest public and political visibility. Therefore, this program should have the strongest direction.

The Program Director at Hiland Mountain is the only person in such a position who does not hold a terminal degree (i.e., Ph.D., M.D., D.S.W., etc.). Her professional training as a social worker (M.S.W.) does not permit her (in most states) to administer or interpret many psychological assessment techniques.

The Highland Mountain Program Director is a highly controversial person. Some of the staff with whom she works appreciate her strong convictions and willingness to "take on the management". However, most of the individuals contacted during this site visit did not regard her as an appropriate person for the

position of Program Director. The reasons for this claim ranged from her "overly confrontational, borderline abusive" therapeutic style, to her "blowing up" at institutional administration which some viewed as "making matters worse", to her inflexibility.

It may be advisable to have a terminally degreed individual whose professional training has prepared him/her to administer and interpret psychometric procedures, and to supervise others using such techniques. In addition, the person in this position needs to be able to respond assertively, not aggressively, to differences of opinion with supervisees and administrators. Since this individual may also be the leader in remediating a poor relationship between the Langdon Clinic and the Department of Corrections, the ability to tolerate ambiguity during conflict resolution will be essential. The person in this position also provides spiritual leadership to others working in the program. Their ability to manifest strength, confidence, and patience in times of distress is essential to effective program management.

2. The Fairbanks program contractually employs the facility nurse to conduct plethysmographic assessments. The nurse works every other week in the prison. This individual's work schedule makes it difficult to schedule evaluations and sometimes leads to cancellation of evaluations. As a result, offenders apparently have been released from the program without ever engaging in a plethysmographic evaluation. In addition, the dual roles of health care provider and plethysmographic technician may be conflictual

and disadvantageous.

3. If specialized Presentence Psychosexual Evaluations were to be used more frequently by the Court, additional mental health providers and funds may be needed to respond to the demand. Due to potential conflicts of interest, it would be advantageous that funds supporting these evaluations not come from the Department of Corrections. Funds for these evaluations should come from: 1) offender payments, 2) third-party payments, or 3) funds appropriated specifically for this use to the Judiciary, Prosecuting Attorneys, and Public Defenders.

4. A strong recommendation is made that a Central Director of Sex Offender Treatment should be employed to oversee and supervise all residential and outpatient sex offender treatment programs affiliated with the Department. Among the functions of this position could be: 1) Review and approve assessment and treatment procedures, 2) mediate and make recommendations for concerns of the Department and its contractual treatment providers, 3) chair the committee that approves outpatient providers, 4) respond to media inquiries about the treatment program (since responses made by treatment experts are generally more informative than those of administrators), 5) have direct input into Departmental policies that may affect treatment, 6) increase coherence of the residential and outpatient treatment programs, 7) enhance liaison with outside agencies whose support of the program is important (e.g., victims' groups) and/or whose function affects the ability to treat sex

offender effectively (e.g., the Judiciary), 8) provide the program with "an identity", and 9) provide emotional leadership to treatment providers. Given these functions, the individual in this position should possess a terminal degree in a mental health profession, experience in sex offender treatment, a demonstrated ability to manage treatment programs, and supervision skills.

5. Requests for proposals for outpatient and follow-up treatment programs should be separated from those used to solicit contractors for the institutional programs. In addition, it may be advantageous to develop smaller contracts with several vendors for outpatient/follow-up treatment services. This may allow more mental health practitioners to seek contracts to provide sex offender services, diminish the potential development of "group think" within a single group of professionals, and result in reduced contract costs.

6. Sex offender treatment programs can be run effectively with contractual mental health providers (as is the case in the Vermont's program). Alternately, the Department could seek to employ mental health providers to conduct the program.

In my experience, programs run by employees generally are less expensive than those run by contractors. Over time, programs tend to become dependent on a small group of providers. If programs become dependent on contractors, the potential exists that demands for sizable increases in compensation can occur. In the short-term, the Department may see little option but to yield to these

demands. In contrast, if the treatment program becomes dependent on services provided by employees, Cost-of-Living-Allowances often are regulated by the State at relatively low percentages. Within this scenario, the relative cost-savings of employee-run programs will increase over time. In addition, the hourly compensation of professional employees typically is less than that of contractors. However, the apparent savings are eroded since contractors are paid only for the number of hours of service provided while employees receive compensation for hours during which direct services are not offered (e.g., "down time").

Appropriateness of Institutional Milieu Versus Community-Based Treatment

Institutional and community-based treatment are two components of a comprehensive approach to sex offender therapy. Each component is essential to the creation of an effective treatment program.

Institutional programs need to exist to serve offenders who are at such risk of relapse (e.g., an excessive number of high-risk factors, inability to proscribe access to high-risk factors through probation conditions) that their treatment cannot reasonably be initiated in the community. Community-based programs need to exist to serve offenders who have been released from institutional programs or who have relatively few risk factors and whose access to risk factors can be minimized through special conditions of probation.

Few therapists, who have experience working with sex offenders, regard the sexual aggressor as "curable". No existing therapeutic intervention eradicates, across time and situations, the offender's sexually deviant fantasies.

However, many sex offenders enter treatment believing that therapy will affect a "cure". When suffering from physical maladies in the past, a quick trip to the physician and ensuing medication usually led to elimination of the disorder. Treatment has been something done to him, rather than an activity requiring his active involvement. Thus, the sex offender may enter treatment for sexual deviance with similar expectations about a quick fix that makes few personal demands.

Unfortunately, many treatment programs effectively promote the offender's belief in the possibility of "cure" by failing to prepare clients for the likelihood of lapses (i.e., a return to the moods, fantasies, and thoughts associated with the relapse process).

Similarly, institutionally-based treatment programs, functioning without associated outpatient follow-up groups, promote the deceptive assurance that treatment ends upon discharge. Clients who leave therapy with such misconceptions are primed for relapse. (Pithers, Cumming, Beal, Young, & Turner, 1989).

To avoid this problem, a comprehensive program must offer institutional, transitional, and community-based treatment programs for sex offenders. Maintaining this continuum of clinical services offers the greatest potential of assisting sex offenders to maintain enduring personal change and, therefore, provides the greatest measure of protection to society. All of the programs within this continuum must share the same theoretical orientation in order to maximize effectiveness.

Continuum of Treatment Services from High-Risk Community Education Groups through Intensive Aftercare

A continuum of treatment services for sex offenders is essential. A comprehensive array of treatment options allows offenders to receive the most appropriate treatment in the most appropriate setting. This permits optimal treatment outcomes without exposing the community to undue risk. In addition, prolonged involvement in outpatient treatment enhances maintenance of behavioral change, regardless of the initial setting in which treatment occurred.

Sentence Criterion for Residential Treatment. As was mentioned previously in this report, the "Statement of Standards" calls for incarcerated sex offenders to enter one of the three treatment programs "within 18 months to six years of projected release/parole eligibility date. Inmates with the least amount of time left to serve will be given a priority for admission into the

program" (p. 8). The potential flaws in this procedure were detailed in an earlier section of this report (See "Length of Treatment; Treatment Phases; Treatment Intensity").

I suggest the following changes in procedure for consideration. Sex offenders sentenced to prison should be housed initially in an institution containing a treatment program. While at this facility, the resident should be required to take part in a brief orientation to the correctional system and its sex offender treatment programs. This process would counter the disinformation about the program arising out of the prison culture and the resulting anxieties that inhibit some offenders from entering treatment. At the end of this phase, offenders should be asked to sign a form indicating their interest or disinterest in being evaluated for the program. Offenders who indicate their disinterest should be required to sign the form again at regular time intervals. This process would avoid the pitfall of offering offenders only one opportunity to gain entry to treatment or placing total responsibility on the offender for initiating a second approach.

It may be useful to identify different treatment tracks, one of which would offer prolonged intensive treatment and the other providing shorter educational interventions. Offenders whose assessment data and sentence length make them appropriate for prolonged intensive treatment would be sent to programs similar to those currently in existence. Rather than attempting to fit

"short-timers" into the intensive programs, a more educational approach, focused on victim empathy and life skills (e.g., relapse prevention, emotional management, sex education) may be employed. The program intended for "short-timers" could also be used as a "pre-treatment" program for offenders from other cultures, easing their entry into the intensive treatment program.

Outpatient/Follow-up Treatment. Follow-up services for sex offenders released from institutional treatment programs are essential. Currently, the Department provides funding for one-year of follow-up treatment. After that time, the offender assumes responsibility for payment.

One-year of follow-up service is better than no service during an important transitional phase. However, if the intent is to maximize community safety, two shortcomings to this plan are evident. First, while research suggests that rapists may be at the highest risk of relapse during the first year after release from incarceration, child abusers are at the highest risk of relapse only two to three years after release. Thus, the one year follow-up does not cover the period of highest risk for pedophiles and incest offenders. Second, the one-year follow-up period begins when the offender is placed on furlough, not when the offender is released from the correctional facility. The potential exists that the year of Departmentally-supported treatment could expire shortly after the offender is released from the correctional facility.

Regardless of the Department's willingness to pay for sex

offender's follow-up treatment, the recommended duration of follow-up services should be prolonged. The percentage of offenders who reoffend increases with greater time-at-risk. However, one researcher (Nelson, personal communication) has asserted that the greatest percentage of reoffenses occur within the first five years after treatment termination. Thus, given the improbability of funding or legislation that would permit life-long probation/parole supervision of sex offenders, mandating a five-year period of follow-up treatment and probation/parole supervision would represent a reasonable compromise.

Different problems arise once offenders are required to assume financial responsibility for their own treatment. Many offenders work seasonally and may neglect to budget finances. This problem potentially could be dealt with by enhancing offenders' life management skills or through a parole condition requiring seasonally employed offenders to make regular payments in a "treatment escrow account". In addition, some seasonal work requires offenders to be away from their home community for months at a time, making impossible regular attendance at treatment groups. This problem could be resolved by prohibiting offenders from seasonal employment that takes them away from home, requiring them to complete regular homework assignments in workbooks during their absence, or using collateral contacts who have been informed about the offender's relapse process as sources of information about the offender's maintenance. As an example, collateral

contacts could be requested to routinely complete a form, listing an offender's high-risk factors, by checking off any risk factors that have been observed.

Data from a Fairbanks Probation Officer suggests that offenders in treatment commit fewer violations than those not in treatment. Therefore, in addition to protecting community safety, follow-up treatment could potentially represent a cost-savings relative to probation/parole violations which result in incarceration. Therefore, if the Department intends to shift allocations for sex offender treatment, consideration should be given to enhancing (e.g., more frequent assessments, offering couples' therapy) and prolonging the period of follow-up treatment in the community.

Another way of shifting available treatment funds would be for the Department to fund group therapy only and/or to fund this treatment only for indigent offenders. Offenders who require individual therapy could be required to pay for some portion of their treatment. Alternately, individual therapy could be funded for a specific offender if treatment providers can demonstrate the need. Offenders who have the capacity to pay for services should be required to pay. Failure to impose this burden on offenders who possess financial resources shifts the burden to the taxpayers of Alaska. Clearly, the burden should be placed in the hands of the individual whose behaviors are responsible for the existence of the need, not the public victimized by those behaviors.

Requirement that Released Sex Offenders Live in Anchorage. To facilitate group follow-up treatment, sex offenders released from Hiland Mountain are required to reside in the greater Anchorage area regardless of whether this was their original community. In part, this decision appears motivated by a dearth of specialized treatment providers and a desire to keep offenders in an area of Alaska readily accessible to Parole Officers. At the same time, these individuals are not permitted to associate with other former inmates who also were in the prison-based treatment program.

Particularly in the case of Native Alaskans to whom community is meaningful, and to offenders from very isolated regions, the need to reside in Anchorage and avoid contact with other former program participants may be countertherapeutic. One concern is that these circumstances could predispose offenders to experience precursors to sexual abuse (i.e., profound loneliness, anger resulting in "victim-stancing", seeking relief from boredom and difficult emotions through substance use/abuse). Parole Officers reported that such offenders are more likely to seek companionship in self-defeating ways (e.g., bars).

High-Risk Educational Groups. High-Risk Educational Groups are a very recent innovation in the overall program structure. They are intended to help prepare offenders who have not been in the prison-based programs to take part in the outpatient groups. Early opinions about the High-Risk Groups range from "they may be useful, but its too early to tell" to "they don't seem to be

working".

My experience suggests that the success or failure of such an effort depends largely on the criteria used for entry to such groups. The groups tend to work effectively when used to treat offenders who are motivated for treatment, but who have been unable to enter treatment as a result of factors beyond their control (e.g., lack of available bedspace in an intensive program, a sentence structure that prohibits entry, etc.). The current criteria for inclusion in these groups are: 1) program drop-outs, 2) offenders terminated from treatment, and 3) offenders who have refused treatment. Given these criteria, my belief is that these groups may represent a poor investment of treatment resources.

These groups tend to be a relatively poor investment when they represent a "last ditch" effort to reach offenders who deny responsibility for offenses or who have expressed ongoing disinterest in changing their behaviors. Generally, few of these individuals will be motivated by a time-limited intervention to pursue more intensive treatment. Rather than using precious treatment funds in an effort to persuade the unconvinced, the funds may be put to better use by prolonging the outpatient follow-up treatment of more motivated offenders.

Evaluate Centralized Versus Regional Delivery of Institutional Treatment Services

Whether to centralize or regionalize services is a complex issue. Given the current state of the individual sex offender treatment programs in Alaska, and the relationship between contractual treatment providers and the Department, this consideration becomes still more complicated.

If a centralized program was the favored option, the obvious choice would be to place the program at Hiland Mountain. Hiland Mountain and Anchorage vicinity offer: 1) the most "treatment-friendly" physical plant; 2) the greatest opportunity to have flexibility of choice in contracting with treatment providers; 3) proximity to the state's population center (offering the greatest opportunity for offender employment); 4) nearby universities which would offer the potential of interns from graduate training programs and enhanced resource development through library and research resources. However, the working relationship between the Department and the contractual treatment providers at the Langdon Clinic currently is strained. If the Department opted for a centralized program, the potential exists that the Department might need to contract with other mental health professionals in the Anchorage area to provide services.

Several structures for service delivery are apparent:

- 1) multiple, equivalent programs (i.e., the current service delivery structure);
- 2) a single, intense, centralized program; and
- 3) an intense centralized program that receives offenders from regionalized, pre-treatment programs. This list ignores another

yet another option of having different treatment programs for distinct populations (e.g., Native Alaskans) since I do not believe this is necessary if treatment providers exercise creativity in adapting the current treatment model.

The most expensive model is the current one, involving several distinct and intensive treatment programs conducted at different sites. Assets of this model are that it: 1) allows treatment of the greatest number of offenders; 2) permits creation of highly specialized programs (e.g., intellectually low functioning, female offenders); 3) fosters treatment of offenders closer to their home, facilitating family treatment and release planning; and 4) spreads ownership of the program more widely. Potential liabilities of this model include: 1) the administrative costs affiliated with each site; 2) the potential for destructive lack of integration of, or rivalry between, sites (in the absence of an Central Director of Sex Offender Programs).

A single intense treatment program would: 1) minimize ongoing management problems. However, the liabilities associated with this model in a state of Alaska's geographic enormity are immense. These include: 1) the lack of geographic proximity to the program minimizes the involvement of critical resources (e.g., supervising Parole Officer, outpatient mental health providers, offenders' families); 2) large, centralized programs often result in less individualized attention to the unique characteristics of each offender; and 3) documentation of assessment and treatment

sometimes is less adequate in immense programs than smaller ones.

My recommendation would be to consider working toward a centralized program that receives offenders from one or more regional pretreatment programs. Regionalized, pre-treatment programs could be implemented at the higher-security facilities typically used to house offenders when they first enter the Department's custody. At these pre-treatment sites, offenders sentenced for sex crimes (and who meet minimal criteria (e.g., not a career criminal) could participate in a mandatory inmate orientation that includes basic information about the sex offender program. After this orientation is concluded, offenders could then be required to sign a "treatment interest" form indicating whether they wish to take part in a pre-treatment program or to be removed from the "treatment track" altogether. Some offenders who initially deny interest in treatment later change their mind. Therefore, offenders who choose not to participate in treatment should be requested periodically to sign the "treatment interest" form.

I believe that the Department and the Parole Board should be encouraged to adopt separate policies that would not reward sex offenders who decide not to participate in treatment. If one believes that treatment is essential to enhance community safety, sex offenders who do not take part in treatment should not be released prior to offenders who have the courage to choose the more difficult path of taking part in treatment that requires personal

change. To fully invoke a system that does not reward offenders who avoid treatment, and which protects society from such offenders for a longer period of time, presumptive sentencing may need to be eliminated.

Pretreatment groups could be used to prepare offenders for the intensive, centralized treatment program. The pretreatment phase could be used to familiarize some offenders with the fundamentals of group treatment (e.g., the need to make personal disclosures, the need to listen actively to other group members). Some literature suggests that pretreatment exposure to group therapy can enhance treatment outcomes for individuals from lower socio-economic levels. Some of the topics covered in pretreatment groups could include: 1) recidivism rates for treated and untreated offenders, 2) child/human development, 3) effects of sexual/physical/emotional abuse on children and adults, 4) types of denial of responsibility for sexual abuse and their impact on the treatment process, and 5) dealing with family and friends who have supported denial, including the possibility of couples' and family therapy. Within this structure, pretreatment could be a method for addressing issues pertinent to subcultural groups which might otherwise interfere with their ability to participate meaningfully in intensive treatment.

Once an offender has completed the pretreatment phase (as reflected in assignments and process assessments), he could be transferred to the centralized, intensive residential program.

This program could be conducted at a less secure facility since sex offenders' custody levels usually drop rapidly soon after incarceration. It would involve more mental health professionals, and more frequent and more specialized treatment groups, than the pre-treatment program. Among the topical groups at the centralized program could be: 1) victim empathy, 2) personal victimization, 3) behavior therapy for arousal disorders, 4) emotional management, 5) relapse prevention, and 6) release planning. Again, completion of the intensive program would be defined by phase criteria including completion of assignments, behavior in the prison and in treatment groups, and signs of constructive change on process assessments.

As suggested previously, community reintegration is more complicated when offenders are treated in a centralized program that is far away from their home communities. To enhance maintenance of therapeutic change and community safety, a structured release program should be established. The following paragraphs describe the transitional release process employed in the Vermont Treatment Program for Sexual Aggressors. These paragraphs are included in this report only as an example of one type of a progressive release sequence.

At an appropriate stage of treatment and under adequate supervision, each offender practices his newly-acquired behaviors in the community on time-limited passes. When an individual demonstrates continued progress in residential therapy and appropriate behavior

during furloughs, he is placed on work release. This enables the offender to obtain employment in the community, but requires him to return to the correctional facility during non-work hours. After a period of successful work release, the offender receives extended furloughs. During this phase of treatment, the client resides in a halfway house or in the community, but his freedom of movement is restricted to approved locations at designated hours. During the work release and extended furlough phases of treatment, the client continues to participate in treatment at the facility. He also begins to attend outpatient therapy groups which will be the sole source of treatment once he is released on parole. If the offender demonstrates highly appropriate behaviors throughout the extended furlough treatment phase, he is recommended for parole. Upon receiving parole, the client is mandated to attend outpatient therapy groups facilitated by specially-trained treatment providers.

In this manner, the transition from residential to outpatient treatment is accomplished in a carefully controlled, progressive manner. Since family members and probation and parole officers represent important resources in monitoring the behaviors of sex offenders, clients are required to sign confidentiality waivers and

to inform these individuals about their risk factors and offense patterns. By following this structured and collaborative approach to treatment and maintenance of change, the probability of therapeutic success and community safety may be enhanced. (Pithers, Martin, and Cumming, 1989).

Obviously, only those sex offenders who appear to have benefitted from treatment should be considered for this transitional process. In addition, the process must be monitored carefully. The situations to which the offender has access must be selected with care to avoid exposing an offender to extremely high-risk factors. The offender should be supervised by someone who is trained in the relapse prevention model.

Departments of Corrections have become increasingly nervous about establishing pre-release programs for offenders. For offenders who have participated in treatment and demonstrated behavioral change, a structured, supervised, progressive release process enhances community safety. Clearly, this process will be associated with lower recidivism rates than releasing offenders from correctional facilities directly to the community without the opportunity to establish a support network that is informed about the precursors to his offenses.

#### Extent to Which Sex Offender Programs Are Integrated within Institutional Settings

The extent to which sex offender treatment is integrated

within the institutional setting varies across settings. The Hiland administration appears ambivalent about the program, possibly as a result of conflicts with the Program Director and the Langdon Clinic. The Lemon Creek administration values the program and has made accommodations in the physical plant and work schedules to support it. The Fairbanks administration strongly wants to preserve its program.

Before discussing integration with institutional management, it is important to address integration with Department-wide administration. One of the most frequently voiced frustrations heard during site visits concerned the Classification Director's refusal to give priority to the needs of treatment programs and sex offenders seeking treatment. As a result, treatment programs have had empty beds for as long as 6 months while offenders accepted into treatment have awaited transfer. In another case, the Classification Director transferred sex offenders out of a treatment program even though these offenders were actively involved in treatment and the treatment team had requested that program residents not be transferred.

A number of potential problems may be caused by the failure to assign priority to transfers of sex offender into existing openings in treatment programs. One of the most salient concerns is the possibility of litigation arising from the failure to treat willing sex offenders when bedspace in the treatment program has been available. In addition, contractual funds are expended less

efficiently when vacancies exist. Therapists are paid the same amount whether they treat 8 offenders or 5 offenders; paying them to treat 8 offenders obviously is the better deal. Vacancies in treatment programs also affect the treatment process and offender motivation. When treatment teams are aware that transfers into the program occur slowly, they may permit resistant and disruptive offenders to remain in the program longer than advisable. In fact, this already has happened in one of the programs. Some of the offenders with whom I met expressed frustration that some disruptive and belligerent offenders had not been removed from their treatment program even though they had initiated a request that these offenders be removed. Treatment staff also are less consistent in enforcing rules. They may become more reluctant to remove offenders from the program on a temporary basis (30-60 days) for disciplinary purposes.

Clearly, the Classification Director should be encouraged to prioritize transfers for treatment programs. The Department's sex offender treatment programs are specialized and should not be treated as if it were any other correctional program. Sex offender treatment resources are expensive. The Department cannot afford to waste resources that are sorely needed by offenders for even one month, let alone six. The Commissioner's support may be needed to develop policies or a supervision mechanism that will ensure that the Classification process facilitates immediate transfers of sex offenders for treatment purposes.

Hiland Mountain. At Hiland Mountain, the program received unequivocal support during its early days. If any error in program management took place, it was supporting the program with such enthusiasm that sufficient oversight did not occur. In more recent days, the Department has exercised much greater control oversight of the contracts for services.

It is not possible for me to determine whether the program has ever been integrated within the institution. However, it is evident that the program is not currently integrated with the institutional management. One individual summarized the situation, "Power and control are at the heart of the matter. Its a turf issue. Whose jail is this? Whose program is this? The program was designed to be shared but it isn't." Yet another individual commented, "There is a real problem with contractors being willing to work with the Department. Most contractors try to dictate terms to the Department." Many of the upper-level professionals interviewed and the documents reviewed during the site visits reflected the sense of struggle for control of the program.

In the struggle to determine who will control the program, at least some of the integrity of the program has been sacrificed. The reality is that this is a treatment program that exists within a correctional setting. Contractual mental health professionals can not be permitted to control Departmental and institutional policies and procedures. However, they reasonably may expect to be consulted for input when the Department or institution are

considering policies and procedures that could affect the program. Similarly, Departmental and institutional personnel should not assume the expertise to make unilateral decisions that affect the treatment program. However, since the Department funds the program and the program is housed in an institution, the Departmental and institutional administrators should have the opportunity to approve changes in the treatment program that affect Departmental policies and procedures.

Lemon Creek. The Lemon Creek program has suffered historically due to frequent changes in therapeutic staff supplied by the Tongass Community Counseling Center. Reportedly, these changes were the result of the dissatisfaction of treatment providers at Tongass with their own administration. As a result, the providers left the Counseling Center. These administrative problems apparently have been resolved and the Tongass staff currently involved in the Lemon Creek program appear highly motivated, creative, and have developed an excellent relationship with the institutional administration.

Approximately one year ago, Lemon Creek modified and dedicated one unit of the prison for sex offenders in the treatment program. Additional modifications in the physical plant were underway at the time of the site visit to complete a professional space for plethysmographic evaluations. The administration has agreed to allow offenders to be freed from work assignments to attend treatment groups. Since treatment groups occur almost daily, this

represents a significant gesture on the part of the institutional management. It is also exactly the type of support needed to allow treatment programs to blossom.

The management team at Lemon Creek regards the Tongass staff as doing "a good job" and "exceeding state standards". The only comments approaching criticism involved a belief that the anger management treatment component could be shored up and the desire that treatment providers would be willing to run treatment groups during evening hours.

Decisions about offenders are made by a treatment team composed of treatment professionals and institutional staff. Disagreements emerge, but the team usually processes decisions to consensus. Authority issues have not emerged.

Fairbanks. Fairbanks also houses program residents together on a special unit. The institutional administration regards the treatment program as offering an operational resource to the facility since they are able to go outside the building to work. Since 40 to 60% of the population in Fairbanks are pre-trial detainees who cannot go outside to work, the 28 sex offenders in the treatment unit perform most of the maintenance work around the institution.

Institutional management expressed concern as to whether a long-term treatment program can continue to be housed in a booking facility, especially as overcrowding becomes more problematic. The population cap at Fairbanks will be 183 in January 1982. The

institutional management believes that meeting this cap would necessitate transferring all sex offenders elsewhere, with the population at Fairbanks becoming a mixture of detainees, offenders with short sentences, and individuals awaiting release. It should be noted that in December 1990 approximately 8 to 10 prisoners were transferred to meet a population cap of 202. Some of the transferred prisoners were involved in the treatment program. The Departmental Classification Officer ignored input from the treatment teams request to refrain from transferring sex offenders actively involved in treatment. The Classification Officer is viewed as having made a "clear, clean decision that ignored treatment needs."

There may be other grounds for concern that the Fairbanks administration may fail to keep sufficient boundaries between the treatment program and institutional management. The Chairperson of the treatment team is also the Chairperson of the classification committee. While this individual may be able to keep separate her roles in the two committees, her dual role is open to being perceived as a conflict. In the management of treatment programs it is important not only to avoid improper conduct, it is important to avoid even the appearance of questionable conduct. Integration of treatment programs within institutions is important, but blurred boundaries should not be mistaken for integration.

Fairbanks has enjoyed contracting with the same treatment providers since September 1985. The institutional administration

and contractual treatment providers enjoy a close relationship.

Use of Depo-Provera within Institutional Treatment Programs

Provera, the trade name under which Upjohn markets Medroxyprogesterone Acetate, is a synthetic female hormone that, when used with males, lowers the level of male hormones (androgens) circulating in the blood stream. Depo-Provera is the name given to the form of Provera that is administered through muscular injection. Androgens are believed to be associated with both sexual and, to some extent, aggressive behaviors in males.

A very small percentage sex offenders experience obsessive fantasies about sexual abuse. In some cases, despite the offender's best intentions, these fantasies seem to intrude into the individual's consciousness.

Their situation is somewhat analogous to that of an individual who hears a song over the radio early in the morning. Occasionally, people will find themselves hearing the song inside their head without conscious intent. Sometimes, throughout the course of an entire day, the song will continue to intrude into their thoughts to the point where it becomes quite annoying. The song may continue to be heard until the individual retires for the evening. However, upon arising the following day, the song typically is no longer heard.

For some sex offenders, fantasies of sexual abuse are similar to that intrusive song. Only the song of sexual abuse may be

present every morning when the offender awakens and throughout every day of his life. There is not the promise that the song will end with a good night's sleep. Some offenders experience such powerfully intrusive sexual fantasies that they have difficulty attending to the content of treatment groups without being distracted by their fantasies. Obviously, for such individuals, additional forms of treatment are warranted. Rather than feeling like some sort of medicinal thought control, access to the relief offered by Depo-Provera may feel like a wonderful gift to some offenders.

It must be noted that Depo-Provera does not change the offender's sexual preferences. If, prior to administration of Depo-Provera, an offender experienced greater sexual arousal to fantasies of young boys than adult females, he will still experience greater arousal to young boys after he is placed on the medication. It simply will take the offender longer to become aroused under Depo-Provera. The increased latency of arousal provides the offender with a greater opportunity to remove himself from situations in which sexual abuse is possible.

Depo-Provera appears to effectively disrupt the frequency and strength of internally-generated, obsessive fantasies in some sex offenders. That is, the medication reduces the incidence of fantasies occurring in the absence of external stimulation (e.g., presence of a child, photographs of children). However, external stimuli associated with child abuse often continue to evoke sexual

arousal, although it takes the individual longer to become aroused. Thus, even with Depo-Provera, offenders cannot be permitted to have contact with stimuli that may predispose sexual abuse.

Depo-Provera also is not effective with all sex offenders. Few sex offenders have androgen levels that are higher than average. Therefore, it is crucial that this medication not be regarded as a magical, "silver-bullet". It is simply one of a number of therapeutic interventions that may be useful, but whose use needs to be determined on the basis of each offender's unique constellation of personal assets and deficits.

It must be mentioned that while Depo-Provera is approved by the Food and Drug Administration (FDA), it is not approved specifically for use with sex offenders. However, physicians have the ability to use an FDA-approved medication for unapproved uses as long as their use of the medication is sound and defensible. Given this situation, I would suggest that Depo-Provera only be employed after provision of informed consent. Since incarcerated offenders represent a special group whose ability to provide true informed consent may be compromised, I recommend that the explanation and signature of the informed consent document should be monitored by an outside party (e.g., the offender's attorney). The person monitoring the consent process also should sign the document as a witness. Provisions for discontinuation of psychohormonal treatment must be stated explicitly in the consent document.

As mentioned previously, some sex offenders experience such intrusive fantasies that they are unable to pay attention during treatment groups. Obviously, program residents who cannot attend to the content of treatment groups are not going to benefit from them. Therefore, it is important to provide such individuals with access to a psychohormonal treatment that may enable them to derive greater benefits from group interventions. Depo-Provera is one such form of treatment.

All medications can have undesirable side-effects (e.g., aspirin can cause bleeding from stomach lining). Depo-Provera also is associated with a range of negative side-effects, most notably weight gain and increased blood pressure. Therefore, I suggest that this medication only be considered for use after other forms of treatment (i.e., behavioral therapies to change sexual arousal patterns) have been employed and found ineffective.

#### Extent to Which Developmentally Disabled Sex Offenders Are Treated Effectively

I am unable to comment on the extent to which developmentally disabled sex offenders are treated effectively. Unfortunately, the site visits did not afford an opportunity to acquire information that would allow a response to this issue.

#### Role of Specialized Probation and Parole Officers

It is important to avoid endorsing the myth that specialized treatment alone is sufficient to reduce the recidivism rates of sex

offenders. Sex offenses generally are not the result of psychiatric or medical disorders, but rather the manifestation of a choice to engage in a violent, criminal act. Since sex offenses are the result of choice, not the manifestation of a "disease", no existing form of treatment that can "cure" sex offenders. No form of treatment has the power to remove the offender's ability to make decisions. Since sex offenses are the result of choice, sex offenders can learn to control their abusive patterns.

Since even successfully treated sex offenders occasionally will choose to indulge in abusive fantasies and or precursors to abusive behaviors, it is essential that Probation and Parole Officers become involved in supervising the offender's behaviors. Specialized supervision enables detection of offense precursors at the earliest possible moment.

Criteria used to assess risk of general criminal offenders have little relevance to sentencing considerations with sex offenders. Very few Probation/Parole Officers in Alaska appear to possess specialized skills in preparation of Presentence Investigations or in supervising sex offenders. Specialized Probation/Parole Officers are a critical missing link in the development of a comprehensive approach to the treatment and management of sex offenders.

The three specialized Probation Officers with whom I met (two in Anchorage and one in Fairbanks) appeared highly motivated, wondrously skilled, and largely have pursued training opportunities

and readings on their own. They firmly believe there is great need for more specialized officers in Alaska. I concur.

Clearly, there is a pressing need to identify more Probation/Parole Officers to work with sex offenders and their treatment providers. Specialized Probation Officers are needed to support triage of sex offenders at the Presentence Phase. At the supervision stage, specialized Probation/Parole Officers are able to identify and monitor for precursors that are unique to each sex offender. By monitoring for precursors specific to each sex offender rather than the entire constellation of risk factors for general criminal offenses, the efficiency and efficacy of supervision is increased. In addition, specialized Probation/Parole Officers can work to create a collateral network that is fully informed about the sex offender's risk factors for sexual abuse. Thus, community members who have more frequent contact with the sex offender than the Probation/Parole Officer are able to identify the offender's risk factors and inform the offender and supervising officer of their observations. Thus, providing interested Probation/Parole Officers with routine, periodic, specialized training on sex offender supervision represents a crucial step toward creating a comprehensive, integrated program of treatment and supervision.

Large caseloads are a major inhibitor to Probation/Parole Officers who are interested in working with sex offenders. Supervising sex offenders effectively requires more work than

supervising other offenders. While generalizations are generally unfair, sex offenders often are more skilled manipulators than other offenders. Therefore, closer attention needs to be paid to their behaviors and statements. It takes time to develop the collateral supervision network that is critically important in monitoring the offender's risk factors for sexual abuse. It takes time to meet with treatment providers and discuss the significance of nuances of the offender's recent behaviors. Sex offenders are at high risk of relapse and their reoffenses can create horrible damage to another person. Thus, the emotional demands of supervising sex offenders are greater than with other offenders. Probation/Parole Officers working with sex offenders clearly need to be given smaller caseloads. By having other Parole Officers supervise high caseloads of low risk offenders, it may be possible to manage the creation of specialized sex offender Parole Officers.

Another inhibitor to Probation/Parole Officer specialization is the lack of routine, periodic training in this field. Trained Probation/Parole Officers can make a major difference in the effort to develop a systemic approach to sex offender treatment and management. Trained Probation/Parole Officers can indirectly educate other components of a comprehensive system (e.g., prosecutors, defense attorneys, Judges) by preparing reports that describe the reasoning underlying their recommendations. Through their work, treatment programs become empowered and understood by others whose work directly affects the treatment process. Training

on preparation of specialized Presentence Investigations and supervision strategies for sex offenders should occur regularly at periodic intervals.

Probation/Parole Officers working with sex offenders also should be supported through the creation of a regional or statewide network. Providing the resources for specialized Probation/Parole Officers to meet quarterly (at a minimum) would allow them to share newly acquired skills or information, enhance consistency of approach, and provide emotional support.

It should be noted that some treatment providers expressed concern that Probation/Parole Officers were not sufficiently supportive of treatment. Among the occurrences leading to this concern were: 1) a Probation Officer's statement to an offender that the educational group for high-risk offenders was equivalent to a treatment group, 2) new Probation Officers who were not aware that a supervision manual exists and was used as the basis of a training session 6 months earlier, 3) a Probation Officer's neglect to take action for 2 weeks after being informed that a high-risk sex offender was drinking alcohol, and 4) Probation Officers permitting sex offenders to meet the requirement to engage in treatment by seeing unspecialized therapists in individual treatment. These countertherapeutic episodes may be a sign of lack of specialized training, rather than an indication of lack of concern or malfeasance.

Existing Program Evaluation Procedures

Currently, the only evidence of program evaluation is the site visits performed by Robert Freeman-Longo. These reviews have provided useful information about the extent to which treatment providers and programs have adhered to the "Sex Offender Treatment Programs Statement of Standards" and deserve to be continued.

In addition to these reviews, it is essential that the program implement process and outcome evaluations. Process evaluations are essential to validate the effectiveness of the various treatment modalities called for in the "Statement of Standards". This type of evaluation will facilitate revisions in treatment components to enhance their efficacy. Process measurements of offenders also may be crucial to defend the program when it is publicly scrutinized for releasing an offender who later relapses. A major reason for the collapse of some sex offender treatment programs was their inability to demonstrate a rational and defensible basis for the decision to graduate or release an offender who then committed an egregious relapse.

Prior to making irreversible decisions about the nature of the treatment program, an outcome evaluation should be performed. The outcome data from each treatment site should be analyzed separately. Since an outcome study is to be conducted under the consultative supervision of Dr. Janice Marques, recommendations for outcome evaluations are not included in this report.

Outcome evaluations based on recidivism data should be

interpreted with extreme caution. The maximum percentage of recidivistic offenders that one can reasonably expect to identify is constrained by the percentage of offenses that are reported to authorities. Thus, if one assumes that only 10% of all rapes are reported to authorities and that the perpetrator of each reported rape is apprehended, the highest recidivism rate that one can reasonably hope to identify is 10%. Therefore, one must be exceedingly cautious about basing decisions solely on recidivism data. At the same time, recidivism research needs to be conducted if only because it is often the first, and sometimes the only, item of information requested by groups providing oversight of the program.

#### Additional Information Regarding Specific Programs

##### Hiland Mountain Sex Offender Treatment Program

The majority of the documents reviewed during this consultation concerned the program at the Hiland Mountain Correctional Center. These documents either raised concerns about this treatment program or contained responses to expressed concerns. Some of these documents conveyed strong emotions about the nature of the Hiland Mountain program. Given this debate, and the central role that this site plays in the Department's planning, the Hiland Mountain Sex Offender Treatment Program received closer scrutiny than the other programs.

Operation of the Hiland Mountain Program. Historically, the Hiland Mountain program operated with considerable autonomy from the central office and institutional staff of the Department of Corrections. From a contractor's perspective, autonomy offers the ability to create effective treatment programs by flexibly responding to the changing demands of the clients and the setting.

From the Departmental perspective, offering autonomy to contractors is an act of trust based on assumptions that the contractor: 1) offers highly professional services, 2) offers these services in a manner that is beyond reproach, 3) will inform the Department when conditions arise that require Departmental action (e.g., changes in contractual terms, recommendations for changes in facility operation to enhance treatment), and 4) is sensitive to the security needs and procedures of the correctional system. When any of these conditions are open to question, adequate management of a program requires that some measure of oversight be instituted by the Department, at least until sufficient trust is regained to permit resumption of more autonomous functioning.

Issues leading to need for greater oversight. Some actions of the current contractor for the Hiland Mountain program, the Langdon Clinic, have resulted in the Department electing to institute greater oversight of the contractor. Some of these actions (e.g., billing for work not done, failure to keep appointments reliably) apparently were performed by individuals no longer associated with

the Langdon Clinic. Some of the actions are more difficult to defend (e.g., billing for several months services to a deceased person). Increased Departmental oversight is manifested in closer monitoring of invoices for payment of services, shorter contract durations, and a greater role in program management by institutional administration.

Many of the Departmental staff at Hiland Mountain endorsed the therapeutic model that serves as the basis for the sex offender program, but expressed great concern about how some of the Langdon Clinic staff have implemented the model. Among the more pointed comments were: "The program is essentially dishonest. It says it is voluntary but it isn't." "Stereotyping of offenders is abundant." "The program is too secret. It doesn't share information with others." "Everything is black-and-white, wrong-and-right. There is no gray." "Some of the therapists are arbitrary, abusive, and use a double-standard." "There is no modeling of constructive behaviors." "Groups appear too assaultive." "There is no reward for involvement in treatment. They fail to recognize progress." "Some of the providers are here for the power and the money." "Hiland staff are afraid to say what they think because they see Langdon as having the power. They're afraid to disagree because they are afraid of being ridiculed or regarded as a fool." "Langdon is too powerful." "Compassion is lacking, ridicule has taken its place." "Samenow's work has been taken to an extreme and abused." "Some of the therapists don't

care about a therapeutic relationship. Its more of a power relationship." "When there was a waiting list [for the treatment program], they were ruthless." "[The Program Director] sets the wrong tone for the program. She's very controlling. She's a nice person in many ways, but very volatile." "I no longer feel able to tell offenders to be honest and everything will work out okay. This gets offenders to the medium level [Phase Two], but not to the high stage of treatment [Phase Three]." "The treatment model seems appropriate if the practitioners implement it well. I see some problems with personalities that affect implementation." "Failure to tailor goals to special populations may make treatment self-defeating." "There needs to be greater clinical oversight of the contractor and the current contractor may not respond favorably."

Greater oversight appears warranted at the moment. However, after years of autonomous functioning, closer supervision doubtlessly feels intrusive. From the contractor's perspective, increased oversight is perceived correctly as a sign of damaged trust. The contractors perceive the closer supervision to have been imposed without discussion. The contractors believe that the behaviors of a former colleague have caused, in large part, the closer oversight. Concern exists about how long they will be held responsible for that individual's behaviors. Thus, considerable frustration exists about the current level of oversight and the way in which this oversight has been implemented.

The Langdon staff understandably is concerned about the way in

which they are viewed by the Department. Unfortunately, the situation has been compounded by the manner in which a few of the Langdon staff have demonstrated their frustration. The Program Director appears embroiled in the current atmosphere of distrust and appears to perceive the conflicts as personal attacks and as a struggle for control. Her strong emotional response makes more difficult efforts at resolution and restoration of trust.

As the Department has managed contracts more actively, some decisions have been made without notifying the contractors. While oversight appears necessary at the moment, some Departmental responses may interfere with program operation and treatment. The local administration of Hiland Mountain has asserted the right to veto decisions made by the treatment team. Regardless of its intent, within the prevailing climate between the Department and contractor, the administrator's ability to veto treatment team decisions carries a powerful message of distrust of the contractor's clinical judgment. While the administrator should have the authority to veto treatment team decisions as a result of concerns for facility security, this individual should not be permitted to override clinical decisions made by the treatment team.

Concerns of the Contractor. The Langdon Clinic expresses concern that both the Department and some of their own staff might be "digging a deeper hole" for themselves. They experience the relationship with the Department as being so frustrating that they

have considered not renewing the contract. The Langdon staff regard the current Departmental approach to their work with sex offenders as micromanagement without macromanagement: the details are being scrutinized while more global issues are neglected.

Among the issues concerning the Langdon staff are: 1) six month contracts, which make treatment planning and recruitment of staff difficult; 2) close review of invoices and refusals to pay for disputed services; 3) the addition of clauses to contracts for Fiscal Year '91 after the contract was signed; 4) modification of the treatment standards without input from the contractors; 5) appointment of Wing Counselors to the treatment program without input from their staff; 6) failure to provide contractual funds to support administrative or indirect costs and research; and 7) the sense that security appears to have taken precedence over treatment concerns.

Potential Steps to Resolution. A clear potential exists that the trust between the Department and the Langdon Clinic has been breached beyond repair. Restoring this trust will require work and a willingness to take some risks. One of the necessary risks is open discussion of the current level of distrust, the basis for this distrust, and concrete changes that may permit development of greater trust. Currently, both the Department and contractor appear to be failing to share information openly. Each perceives the other as keeping secrets, generating suspicion about motives bordering on paranoia.

If the Department and the contractor want to resolve the current distress, a number of steps may be helpful over time. An initial mediated meeting may help to clear the air. Additional steps might include: 1) delineation of who is responsible for making decisions regarding overall program management, individual treatment decisions concerning clients, and decisions regarding the way in which the treatment program relates to the institutional environment (e.g., assignment to and supervision of Departmental personnel in the treatment units); 2) discussion of the implications of the last report prepared by Robert Freeman-Longo; 3) resolution of the personal disaffiliation between the Program Director and Warden at Hiland Mountain; 4) negotiations to clarify ownership of information generated from the program; and 5) discussion about the extent to which the current level of program oversight will be maintained or modified.

It is recommended that the following steps be considered:

- 1) Overall program management should be the primary responsibility of a new Departmental position mentioned previously, Director of Sex Offender Treatment Programs. This person should make decisions about program management with input from clinical contractors and, as necessary, institutional and central office management. Treatment decisions regarding clients should be made by the treatment team alone, without the involvement of the Director of Sex Offender Programs.

Since the treatment program exists within a prison, security

concerns occasionally may need to take precedence over therapeutic judgments. Thus, the institutional management team should have the authority to override treatment team decisions, but solely for security concerns. I would suggest that whenever an administrative override of a clinical decision is made, the appropriateness of the override should be reviewed automatically by the a Central Office team involving (at a minimum) the Director of Security, the Director of Statewide Programs, the Director of Sex Offender Treatment Programs (or their designees).

2) To minimize the number of occasions when institutional concerns are not available to the treatment team while it is contemplating decisions about program residents, it is recommended that the Warden appoint someone (e.g., Program Coordinator, institutional probation officer) to represent the institution's perspective.

3) I reluctantly recommend that consideration be given to changing the role of the current Program Director. It is my opinion that the current director does not possess the professional background and skill that is essential for someone in this role. The Program Director needs to set the standard and serve as a model for other professionals and paraprofessionals involved in the treatment effort.

During this site visit, the current Program Director received her strongest support from the Wing Counselors. The Wing Counselors, many of whom are frustrated with the Department's

inability or unwillingness to provide them with desired changes in their positions, see the current director as someone who is willing to challenge institutional management.

Far more people expressed the belief that the Program Director's responses to difficult situations often have made them worse. In my experience, when a person in her position conducts herself in such a manner, the program becomes distressed and fractionated. It is the responsibility of the Program Director to exercise judgment, even during moments of great dispute, that enhance harmony. Otherwise, program staff, participants, and others are affected negatively by the disharmony. Such has been the case at Hiland Mountain.

4) The role of institutional Program Director should be articulated clearly. The relationship of this position to that of the Program Director from the Langdon Clinic should be delineated. It is suggested that the institutional Program Director be considered the representative of the Department during treatment team meetings.

If a high degree of trust between parties can be restored, the Department is encouraged to resume a more autonomous management style. If trust is restored, ongoing meetings should be held to permit regular discussion about small disputes rather than waiting until meetings are motivated by crises.

The Role of Wing Counselors. Much discussion has centered on the use of correctional officers as Wing Counselors. The

discussion generally has concerned the disparities between the roles and compensation of Wing Counselors versus Correctional Officers working in traditional roles.

According to the Wing Counselors, they lose approximately \$300/month plus overtime opportunities relative to other Correctional Officers. Wing Counselors also asserted that they are less likely to be promoted than others. They observed that Wing Counselor positions are unpopular among most Correctional Officers and that such positions typically remain unfilled for several months.

Relative to traditional Correctional Officers, Wing Counselors believe they have more specialized skills and greater responsibilities (e.g., running treatment groups, writing summaries). They indicated that it takes 7 to 10 months before a new Wing Counselor develops treatment skills. They also noted that their intensive work with sex offenders is more stressful than supervising behaviors of other inmates. I believe this to be true.

Several attempts reportedly have been made to resolve this dilemma. Efforts have been made to develop a unique job classification for Wing Counselors, to offer them 10 hour shifts, and to reward them with college credits for coursework. None of these efforts has reached fruition. As a result, Wing Counselors have lost faith that anyone takes their position seriously and their sense of hopelessness was evidenced during our group meeting. Some of the Wing Counselors feel uncommitted to the treatment

program because they do not know if it will continue to exist, further compounding their sense of hopelessness.

The Wing Counselors see treatment becoming more diluted and receiving less Departmental support. They view the involuntary transfer of Jim Pagels to a Shift Supervisor position as one manifestation of the erosion of Departmental support. At one point, Mr. Pagels was prohibited (by institutional administration) from discussing the program with community groups and the media. The Wing Counselors believe he was transferred because he was gaining influence and was removed by the institutional administration for that reason. His replacement was assigned to the position and is viewed by staff as disinterested in the program.

Wing Counselors view the Langdon staff, particularly Dr. Marty Atrops, as being very supportive of their work. They have held 3 potlucks with them in the last 3 years at which the Wing Counselors were given certificates by the Langdon staff. Differences of opinion exist but the Wing Counselors do not perceive any power struggles occurring.

The Wing Counselor model is obviously at a crossroads. If the Department intends to preserve this model, some change must be made to demonstrate a recognition that their work is different and more specialized than that of the traditional Correctional Officer. In the absence of such recognition, Wing Counselors will either quit or, even worse, remain in their positions but perform poorly and

interfere with the treatment process. Additional training opportunities should be afforded Wing Counselors. Topics for training might include methods for confronting offenders without being abusive and adaptations in counseling approaches for Native Alaskans.

While the Wing Counselors take their responsibilities very seriously and some have developed quite superb skills, I am not convinced that this model is essential to the program's functioning. The consistent presence of the same Correctional Officer on a treatment unit facilitates the development of a therapeutic milieu. However, these Correctional Officers do not need to be, and, perhaps, should not be the individuals conducting treatment groups.

An alternate model would call for graduate-level Psychological Interns to participate in the treatment process. Half-time interns can be employed in many areas of the country for approximately \$7,500 - 8,500 for 11 months.

Several benefits might offset the additional cost of an intern for each of the treatment units. By bringing graduate students into the program, the Department would expand the network of professionals who have been trained to assess and treat sex offenders. This would increase the availability of services to offenders and would also enable the Department to have more options for contracts for such services. Since graduate students often are required to complete Masters and Doctoral research projects, their

employment could facilitate the development of process measurements to evaluate progress in treatment and outcome evaluations. Publications resulting from this research could be used to gain increased support for the program from legislators and the academic community, as well as offering the Department greater note nationally. Supervising interns often is regarded by treatment professionals a way of remaining intellectually stimulated. Finally, interns would not face the conflicts of the dual role of therapist and supervisor which are inherent in the Wing Counselor positions.

Discharge summaries. Discharge planning reportedly has improved within the past year. However, discharge summaries from Hiland Mountain could provide a more detailed analysis of the offender's high-risk factors. These summaries could differentiate the high-risk factors that are early precursors to relapse (i.e., suggesting the offender is not managing life effectively, but not that he is at imminent risk to reoffend) and those that are immediate precursors to relapse (i.e., indicating that the offender is at imminent risk of reoffense). In addition, more discussion of the offender's strengths could assist outpatient treatment planning and offer a balance to a reporting of the offender's deficits.

Comments of Participants in the Hiland Mountain Program. The individuals currently in treatment at Hiland Mountain vividly described what amounts to two distinct treatment programs. One group of offenders expressed gratitude for the skill of their

therapists and the personal changes that they were able to accomplish. The second group felt denigrated and angry. It is critical to note that, almost without exception, membership in these two groups was defined by residential unit. Clients who felt that they had benefited from treatment had worked with one group of therapists (led by Marty Atrops, Ph.D.); those who felt discouraged and angry had worked with a different group of therapists (led by Jackie Joday, M.S.W.).

I am predisposed to view offenders' complaints about therapists and therapy with circumspection. The need to confront offenders often provokes a degree of resentment and anger. However, in the case of Hiland Mountain, most of the offenders working with Dr. Atrops and his colleagues felt positively about their experience while those working with Ms. Joday and her colleagues felt abused. It was the consistency of this view that impressed me. This dichotomy was expressed most poignantly by one offender (whose words are paraphrased): "I feel very good about myself and the changes I have made in my life. I would like to be able to talk with men from the other unit about my changes. I don't feel able to do that because those guys don't feel the same way I do about their treatment. If I were to tell them about how good my treatment has been, I'd depress them more."

The consistency of this view among most staff and offenders suggests that some restructuring of contractors appears warranted.

Lemon Creek Sex Offender Treatment Program

The Lemon Creek Sex Offender Program contracts with a non-profit agency, the Tongass Counseling Center, for its treatment staff. The program uses mental health professionals exclusively as treatment providers.

Treatment staff. Only two mental health providers currently work in the program. As a result of reported instability of administration in the Tongass Counseling Center (which has been corrected), there have been excessive changes in the therapeutic staff in past years. However, the two individuals providing services in the program appear excellent and their supervisors appear very supportive of their work in the sex offender program. They are described by program residents, a probation officer, and institutional administration as having a confrontational, but respectful, approach to sex offenders. The probation officer meets with the treatment providers on the last Tuesday of each month. He depicts the treatment program as being "exactly what we needed."

As mentioned previously in this report, the treatment staff have made a number of very creative modifications of the basic treatment model which assist its implementation with Native Alaskans. These adaptations may be essential to the success of the Lemon Creek program since approximately 75% of the program participants are Native Alaskans. The treatment providers suggested that the existence of numerous subcultures within Alaska could impede any effort to develop a single, centralized, treatment

program. Among the changes they would recommend in the program operating philosophy are more attention to the need for Native Alaskans to deal with grief and family or clan issues.

Number of outpatient program participants. While this program has a contract that will reimburse it for services to 40 outpatient clients, only 22 were in outpatient treatment at the time of the site visit (8 in a high-risk educational group; 14 in regular treatment groups). Lack of enforcement of the requirement that sex offenders take part in specialized sex offender treatment may be one of the causes of this low rate of service utilization.

Comments of Participants in the Lemon Creek Program. The program residents interviewed at Lemon Creek were at an earlier phase of treatment than those interviewed from other programs. The Lemon Creek residents strongly wanted the program to remain and felt they were beginning to make constructive changes.

Discharge summaries. One person interviewed during the site visit suggested that discharge summaries have seldom been provided from Lemon Creek. Although I had not learned of this concern prior meeting with the treatment providers, it may be that part of this difficulty was caused by the rapid turnover of treatment providers in the past.

#### Fairbanks Sex Offender Treatment Program

The Fairbanks sex offender treatment program appears to be the least expensive of the three sites. It is highly supported by

institutional administration. The treatment providers expressed concerns about the future of the program, stating that it is "as disturbed" as it has ever been. This disturbance is seen as resulting from the offenders' perception that the Department is not committed to the Fairbanks treatment program.

Program residents. According to institutional administrators, the Fairbanks program takes offenders who have a very short time remaining in their sentence (i.e., 6 months remaining to release date). It is estimated that, within the last 6 years, this program may have accepted 6 such short-term offenders. The rationale for such acceptances is that these offenders will be introduced to treatment in the prison and continued in outpatient treatment.

Fairbanks does not appear to screen offenders. One individual contacted during this site visit stated that Fairbanks accepts "some high risk offenders, some real high risks." The credibility of the Fairbanks program has been impugned by their apparent recommendation for parole of some offenders who have had "3 or 4" prior convictions for sex offenses. While some of these repeat offenders reportedly have completed the treatment program, the parole board has declined to grant parole. Sex offenders dropped from other programs can enter the Fairbanks program. This can create a systemic problem, becoming what amounts to "program shopping". The Department should create a policy defining whether treatment drop-outs and dismissals will be eligible for entry into other programs.

Need for staff training. Treatment providers expressed concern that, while the program receives administrative support, line officers convey attitudes that diminish the offenders' interest in treatment. Apparently, some correctional officers have informed sex offenders that "treatment is a waste." While it may not be necessary (or appropriate) to have correctional officers serving as therapists (Wing Counselors), it is important to have a consistent, supportive, correctional officer in the treatment unit.

Need for contractual flexibility. The contractors believe the program would function more efficiently if they were permitted to shift hours designated for specific activities within their contract.

Probation officer. The primary probation officer for sex offenders expressed some dissatisfaction with the current treatment program. Concern was voiced about the perception that the offenders do not seem to have a primary therapist, but are shifted between contractors without apparent reason. In a similar fashion, the probation officer asserted that leadership of groups is inconsistent; the therapist leading a treatment group may change from week to week.

The probation officer believes that case management meetings with the treatment providers are ineffective and inefficient. The therapists do not seem prepared to discuss cases in detail. In addition, both providers attend treatment team meetings,

representing a greater fiscal expenditure than if only one attended. However, since the primary therapists do not co-lead all groups, both therapists may need to attend treatment team meetings.

Comments of Participants in the Fairbanks Program. Phase Three program participants believe that the program's positives outweigh its negatives. Their three major concerns were: 1) the lack of new residents entering the treatment program, 2) the need to create a division of power between the program and the prison, and 3) the need for one of the institutional administrators to spend more time in the program.

Phase Three participants were frustrated that new members of the treatment unit "are getting away with too much." Since program vacancies are filled only after extended delays (reportedly as long as 6 months), program participants believe treatment staff have become lax about enforcing rules that could lead to temporary or permanent removal of program residents. The Classification Officer should be encouraged, or Departmental policies developed, to give priority to inmate transfers for treatment purposes. Offenders also believe that long-termers should be permitted to enter the program rather than permit beds to remain empty. They also recommended allowing offenders to enter treatment earlier in their sentence while they may be most amenable.

The offenders recommended that adjunctive treatments, such as Alcoholics' Anonymous, should be offered within the sex offender treatment program. Currently, program residents need to take part

in adjunctive treatments with the general prison population. [In my experience, the general prison population tends to be less seriously engaged in adjunctive treatments than sex offenders who are taking part in a specialized program.] They would also like more opportunity for individual treatment.

Program residents believe that Phase levels should not be considered in making decisions about custody level. Their concern is magnified by the fact that one institutional administrator serves as the Chairperson of both the treatment team and classification board. The program residents are worried that treatment providers may be reluctant to disagree with this administrator since she also contracts with the treatment providers.

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