Sex Offender Treatment Programs

EXECUTIVE SUMMARY

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

We issued a report on Minnesota’s psychopathic personality commitment law in February 1994. In this second report on sex offender treatment programs we address the following questions:

- How has the number of reported sex crimes changed in recent years? What are the characteristics of these crimes and the offenders who commit them? What sanctions do sex offenders typically receive?

- How many sex offender treatment programs are there in Minnesota and what do they consist of? How much treatment do offenders typically receive and how much does it cost?

- How do programs assess amenability to treatment? How many sex offenders receive treatment?

- To what extent are Minnesota’s programs consistent with national treatment standards? Are treatment programs adequately overseen and coordinated by the Departments of Corrections and Human Services?

- What data do programs keep to judge whether treatment works? What is known about the effectiveness of sex offender treatment?

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

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1 Office of the Legislative Auditor, Psychopathic Personality Commitment Law (St. Paul, 1994).
Planning. We interviewed officials and staff from the Departments of Corrections and Human Services, community corrections administrators, probation officers, and other criminal justice professionals. We also interviewed officials from sex offender treatment programs operating in the fall of 1993 and asked them to complete a short data form about each offender they treated in 1992. Finally, we reviewed Minnesota and national studies of treatment effectiveness.

DESCRIPTION OF SEX OFFENSES AND OFFENDERS

We found that:

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

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

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

- Between 1981 and 1992, adult convictions for sex offenses involving force remained at the level of 145 to 190 each year, but convictions for child sexual abuse nearly tripled, rising from 160 to 461, and convictions for intrafamilial sex abuse increasing from 3 to 154.

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

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

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2 The Sentencing Guidelines Commission uses these categories, which are not mutually exclusive, to report convictions. Although many offenses could logically fit in more than one category, each offense has been counted only once.
Nearly all adult sex offenders convicted in 1992 spent some time in a state prison or local jail.

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

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

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

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

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

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

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

**DESCRIPTION OF SEX OFFENDER TREATMENT PROVIDERS AND PROGRAMS**

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

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

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

We found that:

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

Adult and juvenile offenders in outpatient programs received an average of 2.9 hours of treatment per week, while those in residential programs received an average of 8.5 hours. Taking into account the number of months that offenders typically remained in treatment, we estimate that offenders in outpatient programs received an average of 241 hours of treatment, compared to an
Offenders treated in outpatient programs received about half as much treatment as those in residential programs. Offenders pay what they can afford, with the remaining cost of treatment paid from a variety of public sources.

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

We also found that:

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

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

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

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

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

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

Treatment programs are funded by several sources, including county and state funds, medical assistance, private insurance, and offender contributions. But due to the complexity of funding and reimbursement mechanisms and because sex offender costs are not accounted for separately, we were unable to determine how much state government spends on sex offender treatment.
Most treatment providers are unwilling to accept sex offenders who are low functioning, pose security risks, or deny their crimes.

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

**DESCRIPTION OF SEX OFFENDERS RECEIVING TREATMENT**

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

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

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

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

Treatment professionals told us that offenders need a minimum level of intellectual ability to succeed in treatment. Community residential and outpatient providers were unwilling to accept offenders who were considered security risks to others in treatment or the community at large, based on their use of violence and past history. Although many providers accepted offenders who denied or minimized their offenses, offenders were usually dropped from treatment if they did not eventually acknowledge responsibility.
Based on data forms completed by treatment providers for each Minnesota sex offender treated in 1992, plus estimated data from providers unable to complete the forms, we estimate that:

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

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

We also found that:

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

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

**TREATMENT EFFECTIVENESS STUDIES**

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

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

Evaluations of sex offender treatment are very difficult to design and conduct. Most suffer from methodological deficiencies, such as lack of a controlled comparison to untreated offenders, inadequate measures of reoffense or recidivism, small samples, or inadequate follow-up periods.
Some evaluations have found positive effects from sex offender treatment and others have found no or negative effects.

We also found that:

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

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

We found that:

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

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

Adequacy and Oversight of Treatment Programs

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

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

The national standards are very general and do not recommend specific treatment approaches. The majority of treatment programs in the U.S. utilized psychological approaches, occasionally accompanied by biomedical (drug) or behavioral techniques. Minnesota’s treatment programs were similar in content and approach. They mainly used a variety of psychological
approaches in group therapy sessions to help offenders acknowledge their offenses, develop empathy for their victims, and change their behavior. However, we also found that:

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

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

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

We also found that:

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

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

According to Department of Corrections officials, the department lacked sufficient staff to comply with all of the Legislature’s mandates, which included developing new treatment programs in the prisons and training probation officers in sex offender supervision. The department has since established a Sex Offender Services Unit to coordinate its responsibilities with respect to sex offender treatment. In 1993, the department obtained legislative
approval to remove the rulemaking requirement for outpatient treatment programs, and it expects to adopt the required rules for adult and juvenile residential sex offender treatment programs in 1994.

We also found that:

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

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

RECOMMENDATIONS

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

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

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

We also recommend that:

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

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

Specifically, we recommend that:

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

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

3 Office of the Legislative Auditor, Psychopathic Personality Commitment Law, 34-38.
We also recommend that:

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

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

Finally, we recommend that:

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

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