In this chapter, we describe how treatment providers and others determine which offenders to accept into treatment. We also describe the offenders who received treatment during 1992 and where they received it.

We asked:

- **How do treatment programs screen for “amenability” to treatment?** Are there offenders who do not receive treatment and, if so, why not? Do programs also screen for chemical dependency problems?

- **How many sex offenders receive treatment and where do they receive it?** What are the characteristics of offenders who receive treatment? How many begin treatment but fail to complete it and why?

- **Do treatment programs monitor offenders following treatment?** Do they keep recidivism data on their clients?

To answer these questions, we conducted interviews with the correctional and residential programs and outpatient service providers described in Chapter 3. We also obtained data from the Department of Corrections regarding sex offenders entering and leaving prison. Finally, we asked each treatment provider to complete a one-page data form for each offender treated in Minnesota during 1992. A copy of this form is included in Appendix A. Sixty-five percent of the treatment programs (49 of 75) sent us completed forms on the offenders they treated. We received complete information from all state-operated facilities, county correctional facilities, and local residential facilities that treat only sex offenders. However, many of the outpatient programs were either unable or unwilling to comply with our request. As a result, we obtained data forms for 59 percent of the estimated total number of offenders treated, but only 40 percent of the offenders treated by outpatient programs. However, all but two of the programs were able to provide us some data on the number of sex offenders served, types of offenses they committed, and

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1 In some instances, programs were unable to provide data for calendar year 1992 but provided data for an alternate time period that usually contained part of 1992. Seven percent of the data sheets were based on an alternate time period.
and their sex, race, and county of conviction. In this way, we were able to develop an estimate of the total number of offenders who received treatment in 1992.

In summary, we found that all treatment programs screened offenders who were referred to them as potential clients to determine amenability to the treatment they provide. Offenders who were thought to be more difficult to treat were less likely to be accepted into treatment. Overall, many offenders received treatment, although nearly half of those who left treatment failed to complete it to the program’s satisfaction. Approximately two-thirds of the sex offenders treated in 1992 received treatment in outpatient programs. Those who received treatment in correctional facilities tended to have committed more serious offenses than those in residential or outpatient programs. Few programs maintained follow-up data on offenders treated.

**PRE-TREATMENT SCREENING**

We asked treatment providers whether they screened sex offenders for admission into treatment and, if they did, what the screening process entailed. We found that:

- Nearly all treatment providers screened offenders for program admission, but they differed in their screening procedures.

Some treatment providers used standardized psychological tests, such as the Minnesota Multiphasic Personality Inventory and Multiphasic Sex Inventory, to provide basic information about an offender. Others relied primarily on standardized questionnaires developed in-house to determine whether an offender was a good candidate for treatment. Some providers also conducted educational testing to determine the offender’s intellectual ability. Nearly all providers reviewed available court documentation about the offender and his offense and interviewed the offender for information about his personal history of abuse, other offenses he may have committed, and related therapeutic concerns. Treatment officials also used the interview to gauge an offender’s interest in treatment.

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2 We received only estimates of the number treated during 1992 from six agencies: Center for Parents and Children, Elk River Mental Health Center, Genesis II, Phase, Western Human Development, and the University of Minnesota’s Program on Human Sexuality. Two agencies, Central Minnesota Mental Health Center and City Line Associated Psychotherapists, did not provide any data, despite multiple requests and contacts.

3 Some offenders may have received treatment in more than one program during 1992. For example, by matching Department of Corrections’ inmate identification numbers, we identified 23 out of 319 adult offenders (7 percent) who received treatment in more than one correctional facility in 1992. We eliminated these duplicates. Similarly, individuals may have been treated in 1992 by more than one outpatient program or by a combination of outpatient and correctional or residential programs, but we were unable to determine how often this occurred. However, based on information from programs that provided us with data, we estimate that approximately 5 percent of offenders may have been counted in more than one program.
Typically, providers also evaluated the offender’s ties with family and friends. This helped to clarify the complexity of the issues from the offender’s perspective and determine whether long-term support would be available. The nature of an offender’s relationships with family and friends is considered particularly important in cases of incest or when the offender either remains at home during treatment or returns there after completing treatment.

Overall, assessment procedures ranged from a file review to multiple tests done while the offender is in residence on a trial basis. While some providers did not administer any tests and relied only on a review of existing documentation, others incorporated the assessment process into an initial orientation/education period that lasted up to several weeks. During this time, offenders were taught the concepts and terminology necessary for continued treatment. However, if they failed to make progress they were often not allowed to continue with treatment.

The only exception involves the Minnesota Security Hospital’s sex offender treatment program, which must accept all individuals who are civilly committed under the state’s psychopathic personality commitment law. However, individuals who enter the security hospital’s treatment as a condition of probation are assessed for treatment amenability before they are accepted into the program.

We found that:

- While all programs assessed referrals for amenability to treatment, an individual judged “not amenable” to treatment by one program might have been determined “amenable” by another.

Through the assessment process, a provider determined whether an offender was amenable to the treatment provided in its own program, not whether the offender was amenable to any treatment available. In fact, we heard of cases in which professionals from two different treatment agencies testified against each other in court regarding whether the same offender should be treated in the community. As noted in Chapter 2, existing research has not given clear direction to professionals regarding which offenders are most amenable to treatment. In addition, professionals may disagree about the level of risk or danger a given offender poses, and programs differ in their areas of expertise and the resources available to provide treatment. Some programs specialized in certain types of sex offenses (e.g., incest) or certain types of offenders (e.g., low functioning, Spanish speaking).

**Admission Decisions**

The data from correctional programs and interviews with residential and outpatient programs revealed that, ultimately, most providers in Minnesota based acceptance decisions on a few factors, including:
Most providers are unwilling to accept intellectually low-functioning sex offenders or those who pose security risks.

- the client’s level of intellectual functioning (IQ);
- the level of risk an offender posed to the treatment program and the surrounding community; and
- the client’s level of offense denial.

We found that:

- Most treatment programs would not accept developmentally disabled or low-functioning sex offenders.

Three-quarters of outpatient treatment programs would not accept developmentally disabled offenders (those with an IQ less than 70). In addition, half of the outpatient programs would not accept offenders who were intellectually “low functioning,” with IQs above 70 but below 80 or 85. Treatment providers told us that offenders need a minimum level of intellectual ability to succeed in treatment because they must retain certain concepts and sometimes function in the abstract.

Similarly, county and state correctional facilities told us they were not prepared to treat offenders who did not meet the low-functioning criterion. An official from one Department of Corrections’ treatment program told us that the program occasionally accepted low-functioning offenders because they were too vulnerable in the prison’s open population. However, program officials said they considered each case carefully because adapting their programs for lower-functioning offenders uses scarce program resources.

Overall, we estimate that only a few providers treated developmentally disabled offenders and they tended to specialize in that area since this population has distinct needs. For example, as discussed in Chapter 3, we found one residential provider that treated developmentally disabled offenders and two others that added program components in order to treat low-functioning offenders. Under 25 percent of all outpatient programs told us they would accept a developmentally disabled or low-functioning offender if they received a referral, and they would have to adjust their program to accommodate these offenders if accepted. Only two outpatient providers operated a specific program for developmentally disabled offenders during 1992.

We also found that:

- All treatment programs assessed potential participants for the overall level of risk they pose, and they did not accept offenders whom they considered high security risks.4

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4 As noted above, the Minnesota Security Hospital must accept all sex offenders committed under the state’s psychopathic personality commitment law, regardless of their level of functioning, offense denial, or security risk.
Intake professionals in all programs considered a number of factors in determining the level of risk an offender posed to the treatment program and the surrounding community. These factors included an individual’s use of violence in the offense, whether the victim was a stranger, and the offender’s prior history. Local residential and outpatient programs had few security protections, and they carefully considered the overall level of potential risk an offender posed, balancing an offender’s need for treatment with the risk posed to others. Three-quarters of outpatient treatment providers would not accept offenders they considered violent and over half of them would not accept stranger rapists. In addition, some providers indicated that they tried to avoid the negative publicity they would receive if an offender committed a violent sexual assault while in treatment.

However, several outpatient programs told us they rarely received referrals for violent sex offenders for at least two reasons: many of these offenders received prison sentences, and probation officers and judges typically did not consider them appropriate for outpatient treatment. Probation officers told us they often made the initial recommendations regarding where offenders should be treated, based on their judgments of risk and the offender’s particular treatment needs.

Although programs in state correctional facilities did not have the same security concerns as community-based programs, they shared local facility concerns that violent or aggressive offenders could disrupt the program and create an environment less conducive to treatment for others. As a result, they also determined the level of risk an offender posed as part of the admission decision.

We also found that:

- Many programs would accept offenders who denied or minimized their offenses, but often required them to acknowledge some responsibility for their offenses in the course of treatment.

Most treatment professionals said they expected sex offenders to minimize the gravity of their offenses or even deny having done anything wrong. However, just over half of all outpatient providers would not accept offenders who completely denied their offenses. Others were willing to work with offenders for a limited time to break down their denial. Those providers that accepted “deniers” told us they limited the number in treatment at one time to control the treatment atmosphere.

In addition, we found that:

- Sometimes offenders were denied admission into treatment for administrative reasons or because their sentence length was inconsistent with their treatment needs.

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5 As noted in Chapter 1, first-time offenders convicted of criminal sexual conduct in the first degree receive presumptive prison sentences under Minnesota's Sentencing Guidelines.
We learned of several administrative criteria that programs sometimes applied in determining whether an offender was admitted to treatment. First, juvenile treatment programs tended not to admit juveniles who would turn age 18 while in treatment. Programs who treated juveniles told us that they had little time in which to make progress with older juveniles before they had to be released at age 19. Second, we learned that treatment programs within Department of Corrections’ facilities did not accept offenders while their cases were under appeal. Program officials told us that offenders who were appealing the court’s decision typically did not admit their offenses, had little incentive or motivation to change, and could be disruptive to others in treatment. Third, program officials preferred to use treatment slots for those offenders who could complete the entire program and did not accept offenders with insufficient time remaining on their sentences. As we show below, 8 percent of the offenders who failed to complete treatment in 1992 did so because their sentences or probationary periods expired before they could complete treatment to the program’s satisfaction. Finally, we learned of two sex offenders in prison who said they were denied admission to treatment because they were being considered for psychopathic personality commitment proceedings.

### Treatment Acceptance Rates

From information given to us by treatment providers, we estimated the proportion of offenders evaluated for sex offender treatment who were ultimately accepted into treatment. In addition, we examined the reasons why programs did not accept some offenders into treatment.

We estimated that:

- **In 1992, outpatient programs accepted approximately three-quarters of the offenders that they screened for treatment.**

Nearly one-third of all outpatient programs told us that they accepted everyone they assessed. This may be overstated, however, as most providers only kept data on those they accepted and, furthermore, only assessed some referrals for treatment. Substantial screening occurred before offenders ever began an agency’s formal screening process. As noted earlier, probation officers made initial recommendations about where an offender should receive treatment and some county courts conducted their own evaluations. A proportion of offenders were also screened out of certain programs during early discussions between referral sources and treatment providers. Probation officers, lawyers,

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6 Although offenses committed by 18 year olds are tried in adult court, programs can keep juvenile offenders until the age of 19. Program officials from Sauk Centre told us that they specifically included provisions in their admission criteria to accept older juveniles, in recognition that these offenders were frequently screened out of treatment elsewhere.

7 See Office of the Legislative Auditor, *Psychopathic Personality Commitment Law* (St. Paul, 1994), 17-18. Since then, the department has changed its policy and will admit offenders into treatment who are being considered for civil commitment.
and other referral sources typically called providers to see if a final placement might be appropriate and if space was available before sending the offender’s file and documentation.

We were unable to calculate an overall acceptance rate for local residential programs for three reasons. First, each program screened offenders differently and kept different data regarding whom they had screened. As a result, data were not comparable or easily aggregated. Second, acceptance into a “general” treatment facility was fundamentally a function of the agency’s primary mission, such as housing adolescents who needed an out-of-home placement, rather than an offender’s need for sex offender programming. Several general treatment providers told us that they would not treat an individual whose predominant need was for sex offender treatment. Third, similar to general treatment facilities, the sex offender treatment available in halfway houses did not determine whether sex offenders were placed there. Offenders on supervised release were placed in one of two halfway houses by the Department of Corrections’ Office of Adult Release because they provided the most secure option for inmates on release from prison.

A number of sources referred offenders to treatment programs within correctional facilities, including program review teams, facility chemical dependency treatment programs, sex offender programs at other facilities, and, less frequently, offenders themselves. Treatment officials met with offenders soon after referral to explain the treatment process and determine whether they met program admission criteria.

We estimated treatment acceptance rates for three of the four adult correctional facilities operating sex offender treatment programs. These data are shown in Figure 4.1. We estimated that:

- **On average, programs in state correctional facilities accepted fewer than half of the offenders referred to them during 1992-93.**

Figure 4.1 shows that the proportion of offenders accepted into treatment ranged from 40 to 61 percent in the three correctional facilities for which data were available. It also shows that some offenders were placed on waiting lists until treatment slots became available.

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8 One of the two juvenile sex offender-specific residential programs accepted only one-quarter of the offenders it assessed for treatment in 1992. The second operated two programs for different populations and did extensive intermediate screening that brought up the acceptance rate. The only local residential treatment program for adults estimated that in 1992, it accepted approximately half of those offenders who may have been appropriate for residential treatment. However, this program also operated an outpatient treatment program for which it did not keep separate statistics. Offenders underwent an assessment process to determine whether residential or outpatient treatment would be appropriate, if any.

9 Officials at both halfway houses told us that they tried to accept all offenders who were referred to them by the Office of Adult Release. However, they retained some discretion in admitting offenders they believed would endanger others in the facility or surrounding community.

10 The program at the Lino Lakes correctional facility was unable to provide this information.
In 1992-93, most of the sex offenders not accepted into prison treatment programs refused to participate or denied they committed a crime.

The reasons that some sex offenders were not accepted into prison treatment are detailed in Table 4.1. We found that:

- Most frequently, incarcerated sex offenders were not accepted into treatment because they lacked interest in treatment or refused to participate.

In addition, approximately one-third were not accepted because they excessively denied their offenses. In a few cases, program personnel

<table>
<thead>
<tr>
<th>Reasons for Rejection</th>
<th>Oak Park Heights (n = 115)</th>
<th>St. Cloud (n = 24)</th>
<th>Stillwater (n = 224)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not interested in treatment/refused to participate</td>
<td>42%</td>
<td>33%</td>
<td>48%</td>
</tr>
<tr>
<td>Denied or excessively minimized offense</td>
<td>32</td>
<td>38</td>
<td>34</td>
</tr>
<tr>
<td>Transferred out of facility/referred to different facility’s program</td>
<td>17</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Judged not amenable to treatment for other reasons&lt;sup&gt;b&lt;/sup&gt;</td>
<td>19</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Segregated from general population/institutional disciplinary problem</td>
<td>13</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

TOTAL                                                                                        123%<sup>c</sup> 100% 100%

Sources: Department of Corrections’ institutional treatment programs.

<sup>a</sup>Data are for varying time periods, as follows: Oak Park Heights, September 1992-September 1993; St. Cloud, June 1992-September 1993; Stillwater, January 1993-August 1993. We were unable to obtain comparable data from the program at Lino Lakes.

<sup>b</sup>Other reasons include: limited intellectual or verbal ability, inability to handle confrontation, psychiatric concerns, refusal to participate in all components of treatment, and sentence length limitations.

<sup>c</sup>Does not total 100 percent because treatment officials at Oak Park Heights may record more than one reason for program rejection.
determined that offenders were not amenable to treatment due to their limited intellectual or verbal abilities, their inability or lack of interest in meeting the requirements of the program, or because their sentences were too long and other offenders took precedence. Prison officials told us that they preferred to treat sex offenders close to the end of their sentences.

We also found that:

- **Almost three-fourths of sex offenders entering prison between July 1990 and October 1993 had not received any sex offender treatment before being sent to prison.**

According to data collected by the Department of Corrections on all 887 sex offenders who entered prison between July 1990 and October 1993, 73 percent had not participated in previous sex offender treatment. Another 24 percent had one prior treatment experience, and 3 percent had two or more treatment experiences before being sentenced to prison. However, we do not know if individuals with prior treatment experience actually completed it.

A higher proportion of rapists (82 percent) than incest perpetrators (64 percent) and child molesters (67 percent) had not received treatment before entering prison. This is consistent with current sentencing policy and the pre-screening that is done by probation officers and treatment professionals, which results in a higher proportion of violent offenders being sent to prison.

We also found that:

- **Many sex offenders were released from prison without having received treatment there.**

The Department of Corrections had no summary data on how many of the adult sex offenders released from prison had received treatment, but using a list of sex offenders who were released from state correctional facilities between January 1991 and June 1993, treatment officials within each adult facility identified those individuals who had participated in their programs. According to our analysis:

- **Thirty-three percent of the 587 adult sex offenders released between January 1991 and June 1993 began sex offender treatment in an institutional program, but only 24 percent completed treatment in prison.**

As discussed above, many offenders refuse to participate in treatment while in prison or are not accepted into treatment for other reasons, including their limited intellectual abilities or excessive denial of their offense.
These results suggest that more sex offenders have been treated in prison in the past few years compared to five or six years ago. In a study of 223 sex offenders released from correctional institutions in 1988, Department of Corrections’ researchers found that 27 percent had entered sex offender treatment in prison and 13 percent had completed it.11

### Chemical Dependency Screening

As discussed in Chapter 2, some researchers have found a relationship between the use of alcohol or drugs and deviant sexual behavior for some sex offenders. Accordingly, we also asked treatment providers whether they screened sex offenders for chemical dependency problems and whether they provided treatment for these problems as well. We found that:

- **Almost all sex offenders were screened to some extent for chemical dependency.**

All state correctional facilities screened offenders for chemical dependency upon intake into the correctional system, as did the treatment program in the Minnesota Security Hospital. County correctional facilities and sex offender-specific residential treatment programs also routinely screened for chemical dependency. In fact, only one of the 13 local residential programs we interviewed did not screen offenders for chemical use problems to some degree.

In addition, we estimated that 85 percent of outpatient treatment programs screened offenders for chemical use problems, either informally or formally. Over three-quarters of outpatient programs “informally” determined whether an offender was chemically dependent or in need of treatment, based on information collected about the offender from court documentation, the referring agency, and their personal assessment. Approximately one-fifth of all outpatient treatment programs in Minnesota pursued more in-depth chemical dependency screening when they suspected chemical problems. These programs either screened offenders in-house according to Department of Human Services rules, or referred offenders for screening elsewhere.12

Approximately two-thirds of all outpatient programs gave us an estimate of the proportion of sex offenders they treated whom they believed were either chemical abusers or chemically dependent. The proportion ranged from zero in two programs to 80 percent in two programs which together served 15 clients. In over half of the programs that provided estimates, fewer than one-quarter of offenders were thought to be chemical abusers or chemically dependent. The average across these outpatient programs was between 30 and 35 percent. The average estimate was higher in programs that only worked with adults than in programs that worked exclusively with juveniles.

11 Jim Kaul, Stephen Huot, and Doug Epperson, *Sex Offenders Released in 1988 from Department of Corrections Institutions* (St. Paul: Department of Corrections, March 1993).

12 Minn. Rules §§9530.6600-9530.6660, also known as Department of Human Services Rule 25, establish standards for chemical dependency assessments.
This estimate of chemically dependent sex offenders in outpatient treatment programs is noticeably lower than the percent of chemically dependent sex offenders within the state correctional system. As shown in Figure 4.2:

- An average of 57 percent of all sex offenders who entered prison between July 1990 and October 1993 were assessed by chemical health professionals at intake as being chemically dependent.

As Figure 4.2 shows, the proportion of sex offenders with chemical dependency problems varied by type of offense, with a higher proportion of chemically dependent rapists (67 percent) than child molesters (54 percent) and incest offenders (49 percent). The types of offenders treated in prison versus residential and outpatient programs may account, in part, for this difference. As shown in Chapter 1, proportionately more rapists were sent to prison, while incest offenders tended to be placed on probation where they served a jail sentence and were required to complete treatment in either residential or outpatient programs.

We found that:

- Most outpatient treatment providers in Minnesota did not simultaneously treat sex offenders for chemical dependency.
We asked outpatient programs if they would provide sex offender treatment to a chemically-dependent offender referred to their agency. Forty-three percent of them said they would treat chemically dependent sex offenders only after they had completed some portion or all of chemical dependency treatment. The remaining outpatient programs said they would treat a chemically-dependent sex offender who was enrolled in a chemical dependency treatment program at the same time. Some outpatient treatment programs, such as community mental health centers, referred appropriate offenders to the chemical dependency treatment unit of their center for evaluation or treatment.

Local residential treatment programs varied in how they addressed chemical dependency issues in treatment. All three sex offender-specific residential programs told us they would accept offenders with chemical dependency problems, but provided only minimal treatment for this. For example, Alpha Human Services included a chemical abuse group in its overall treatment program, but preferred that chemically-dependent offenders go through chemical dependency treatment prior to entering its intensive sex offender program. The two juvenile residential programs provided educational units on chemical health for all residents, and both juvenile correctional facilities tried to arrange chemical dependency treatment following offenders’ release from the facilities.

We conclude that:

- **Local residential and outpatient treatment providers were aware of offenders’ chemical use issues, and often preferred that chemical dependency be treated prior to or concurrent with sex offender treatment.**

On the other hand, state-operated facilities for adults did treat offenders for chemical dependency. All four adult correctional facilities in Minnesota operated chemical dependency treatment programs for inmates within the facility. Typically, sex offenders completed treatment for chemical dependency before entering sex offender programming or received it simultaneously.

Finally, the last phase of the Minnesota Security Hospital’s new treatment program included a unit on chemical dependency. Program officials told us they encouraged chemically-dependent offenders to attend Alcoholics Anonymous meetings within the institution and would incorporate a plan for abstinence into each offender’s treatment discharge plan.
DESCRIPTION OF OFFENDERS WHO RECEIVED TREATMENT IN 1992

In this section, we present the results of analyses of the data forms we asked all treatment providers to complete for offenders treated during 1992.13

Characteristics of Offenders Treated

Table 4.2 shows the number and percent of sex offenders treated in the various treatment settings identified in Chapter 3. We included a range to account for those offenders who may have been treated in more than one program.14 The table excludes offenders from other states treated in Minnesota programs and Minnesotans treated out of state. We estimated that:

- In 1992, Minnesota treatment programs and service providers treated approximately 2,600 sex offenders, primarily in outpatient programs.

About two-thirds of the offenders treated in 1992 were treated in outpatient programs. About 15 percent of the offenders receiving treatment in 1992

Table 4.2: Estimated Number of Minnesota Sex Offenders Treated by Program Type and Population Served, 1992

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Juveniles</th>
<th>Adults</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td><strong>STATE FACILITIES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Corrections</td>
<td>29</td>
<td>3%</td>
<td>319</td>
</tr>
<tr>
<td>Department of Human Services</td>
<td>0</td>
<td>0</td>
<td>43-44</td>
</tr>
<tr>
<td>Subtotal</td>
<td>29</td>
<td>3%</td>
<td>360-363</td>
</tr>
<tr>
<td><strong>LOCAL RESIDENTIAL PROGRAMS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County Correction</td>
<td>57-59</td>
<td>7%</td>
<td>34-35</td>
</tr>
<tr>
<td>Sex Offender-Specific</td>
<td>162-166</td>
<td>19</td>
<td>53-54</td>
</tr>
<tr>
<td>General Treatment</td>
<td>59-61</td>
<td>7</td>
<td>119-122</td>
</tr>
<tr>
<td>Subtotal</td>
<td>278-286</td>
<td>33%</td>
<td>206-211</td>
</tr>
<tr>
<td><strong>OUTPATIENT PROGRAMS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex Offender-Specific</td>
<td>249-261</td>
<td>30%</td>
<td>581-609</td>
</tr>
<tr>
<td>Mental Health Centers</td>
<td>134-140</td>
<td>16</td>
<td>363-381</td>
</tr>
<tr>
<td>Other Therapists</td>
<td>140-147</td>
<td>17</td>
<td>209-219</td>
</tr>
<tr>
<td>Subtotal</td>
<td>523-548</td>
<td>63%</td>
<td>1,153-1,209</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>830-863</td>
<td>100%</td>
<td>1,719-1,783</td>
</tr>
</tbody>
</table>

Source: Program Evaluation Division analysis of data from treatment programs.

Note: Information on 1,369 clients (52 percent) is based on individual client information on forms we asked providers to complete for clients served in 1992. An additional 189 information forms (7 percent) are based on clients served during a different recent twelve month period, and information on 1,088 clients (41 percent) is based on summary data or estimates provided to us by treatment programs.

13 As described above, we received completed data forms for 59 percent of the estimated total number of sex offenders treated, but only 40 percent of the information on outpatient clients. However, we received summary data or estimates from most providers who did not complete the forms.

14 We estimated the number who received treatment in more than one program from completed data forms on offenders who were transferred to a more appropriate program or facility.
were treated in state-operated facilities, and nearly all of those were treated within correctional facilities. The remaining sex offenders treated in 1992 were treated in county correctional or local residential facilities. Approximately two-thirds of those receiving treatment were adults and one-third were juveniles.

Table 4.3 shows the types of offenders treated in different treatment settings. In general, we found that:

- State prisons and local residential facilities treated more serious offenders than outpatient programs.

Table 4.3: Types of Sex Offenders Treated by Program Type and Population Served, 1992

<table>
<thead>
<tr>
<th>Type and Population Served</th>
<th>Percent Convicted of Criminal Sexual Conduct in First Degree</th>
<th>Percent With Prior Sex Offense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent Rapists</td>
<td></td>
</tr>
<tr>
<td>ADULTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State correctional facilities (n=319)</td>
<td>41%</td>
<td>52%</td>
</tr>
<tr>
<td>County correctional facilities (n=35)</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Residential programs (n=218)*</td>
<td>23</td>
<td>35</td>
</tr>
<tr>
<td>Outpatient programs (n=453)**</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Adults Overall (n=1,025)</td>
<td>23%</td>
<td>30%</td>
</tr>
<tr>
<td>JUVENTILES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State correctional facilities (n=29)</td>
<td>52%</td>
<td>21%</td>
</tr>
<tr>
<td>County correctional facilities (n=58)</td>
<td>26</td>
<td>38</td>
</tr>
<tr>
<td>Residential programs (n=198)*</td>
<td>8</td>
<td>17</td>
</tr>
<tr>
<td>Outpatient programs (n=223)**</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Juveniles Overall (n=508)</td>
<td>11%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Source: Program Evaluation Division analysis of completed data forms from treatment programs.
*Includes sex offender-specific, general treatment programs, and the Minnesota Security Hospital.
**Completed data forms were received for only 40 percent of the estimated total number of offenders treated in outpatient programs.

For example, Table 4.3 shows that 41 percent of the adults and 52 percent of the juveniles treated in prison programs committed stranger or acquaintance rape. In contrast, in the outpatient programs that provided data, 12 percent of the adults and 6 percent of the juveniles committed stranger or acquaintance rape. Most of the other offenders were treated for incest or child molestation, and a few were treated for other deviant sexual behaviors such as exhibitionism or voyeurism. In all, treatment providers reported that 82 percent of the juveniles and 73 percent of the adults receiving treatment had victimized children.

We also found that:

- More serious adult offenders tended to receive treatment in prison or, to a lesser extent, in local residential programs. However, more serious juvenile offenders tended to be treated in county correctional facilities and local residential programs.
As shown in Table 4.3, higher proportions of repeat adult sex offenders and those convicted of criminal sexual conduct in the first degree (CSC-1) were treated in state correctional facilities. This is consistent with current sentencing and correctional policies and how various facilities are used. For example, we identified only one program operating for adult sex offenders in a county jail, at the Northeast Regional Corrections Center. Most serious adult sex offenders were likely to receive treatment in prison or, to a lesser extent, in one of the two residential treatment programs for adults on probation, the Minnesota Security Hospital or Alpha Human Services.

In contrast, higher proportions of repeat juvenile offenders and those convicted of CSC-1 were treated in county correctional or local residential programs than in state correctional facilities. State policy regarding juvenile offenders has favored treating them at the local level in community facilities. Possibly as a result, juvenile county and local residential facilities tended to have more serious offenders than the state juvenile sex offender programs. For example, the Hennepin County and Anoka County facilities housed and treated most of the serious offenders from these counties as well as some from other counties. According to Hennepin County corrections officials, some serious repeat sex offenders who have failed at the Hennepin County Home School have been sent to a treatment facility in Colorado. However, the treatment program at Sauk Centre was designed for hard-to-treat offenders, and some juveniles who have failed the Home School’s program have been sent there since March 1993 when the Sauk Centre program began.

We also examined the demographic characteristics of those sex offenders receiving treatment. Over 98 percent of those offenders for whom we received complete information were male, which is consistent with information presented in Chapter 1 about sex offenders in general.

We also learned that:

- The average juvenile offender who received treatment in Minnesota during 1992 was 15 years old and the average adult offender was 34.

Juveniles who received sex offender-specific treatment ranged in age from six to 17. Almost one-third of all juveniles who received some sex offender treatment during 1992, and for whom we received data, were under the age of 15.

Adult offenders ranged in age from 18 to 91. Ninety percent were below the age of 50, and two-thirds were between the ages of 25 and 45. Those who received treatment in the county-operated correctional facility were slightly younger than average (29 years old). Outpatient programs treated offenders who were slightly older on average (approximately 36 years old).

15 Note that the data presented in this and the following section are based on the number of offenders for whom we received completed data forms, which represents all those treated in state and local residential programs but only 40 percent of the offenders treated in outpatient programs.
Finally, as Table 4.4 shows, 84 percent of the adult and 80 percent of juvenile offenders for whom we received data were white. Although few juveniles (87) were treated in state or county correctional facilities, they were disproportionately non-white, relative to the overall average for juveniles. In addition, the forms we received indicated that there was a slightly higher than average proportion of white adult offenders in outpatient treatment programs.

### Table 4.4: Race of Sex Offenders in Treatment, 1992

<table>
<thead>
<tr>
<th></th>
<th>Adults (n = 1,021)</th>
<th></th>
<th></th>
<th>Juveniles (n = 505)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent White</td>
<td>Percent Black</td>
<td>Percent Other</td>
<td>Percent White</td>
<td>Percent Black</td>
<td>Percent Other</td>
</tr>
<tr>
<td>State correctional facilities</td>
<td>78%</td>
<td>15%</td>
<td>7%</td>
<td>48%</td>
<td>31%</td>
<td>21%</td>
</tr>
<tr>
<td>County correctional facilities</td>
<td>83</td>
<td>6</td>
<td>11</td>
<td>53</td>
<td>33</td>
<td>14</td>
</tr>
<tr>
<td>Residential programs*</td>
<td>76</td>
<td>18</td>
<td>6</td>
<td>89</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Outpatient programs</td>
<td>92</td>
<td>1</td>
<td>7</td>
<td>83</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>OVERALL</td>
<td>84%</td>
<td>9%</td>
<td>7%</td>
<td>80%</td>
<td>11%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Source: Program Evaluation Division analysis of completed data forms from treatment programs.

*Includes sex offender-specific, general treatment programs, and the Minnesota Security Hospital.

## Treatment Completion

For each offender treated during 1992, we asked whether, on December 31, 1992, that offender was still in treatment, had successfully completed treatment, or had left treatment before completing it. For those who left before finishing treatment, we asked program staff to tell us the reason the offender left. Of the 1,551 offenders for whom we received forms (59 percent of the estimated number treated), 48 percent (744) were still in treatment at the end of the period. Excluding those still in treatment, we found that:

- Fifty-three percent of those sex offenders who left treatment by the end of 1992 had completed it to the program’s satisfaction.

Of the 807 sex offenders who left treatment during 1992 for whom we had data forms, 424 of them completed treatment to the satisfaction of program staff. The remaining 383 offenders (47 percent) left treatment before successfully completing it. A slightly higher proportion of juveniles completed treatment (61 percent) than adults (48 percent). These numbers are comparable to program completion rates reported in the literature. Applying these proportions to the estimated total number of sex offenders treated in 1992 as shown in Table 4.2, we estimate that approximately 710 of the sex offenders who received treatment in 1992 completed it to the program’s satisfaction, and 630 offenders left treatment before completing it, with about 1,240 offenders in treatment at year-end.

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16 As noted in Chapter 2, surveys of treatment programs have found that between 30 to 50 percent of all offenders who begin treatment fail to complete it. See Janice K. Marques, et al., *1991 Report to the Legislature on the Sex Offender Treatment and Evaluation Project* (Sacramento: California Department of Mental Health), 9-10, and W. L. Marshall and H. E. Barbaree, “Outcome of Comprehensive Cognitive-Behavioral Treatment Programs,” in *Handbook of Sexual Assault* (New York: Plenum Press, 1990), 374-375.
We also found that:

- Programs used different criteria to determine “successful” program completion.

We did not systematically ask outpatient treatment providers how they determined successful program completion. However, we learned from our interviews with residential treatment providers and informal contacts with several outpatient providers that programs do not apply the same criteria when deciding if an offender has successfully completed treatment. For example, programs with specific goals or treatment requirements expected offenders to complete the goals or requirements to the satisfaction of treatment staff. Other programs used staff observations and interviews with the offender to determine when sufficient behavioral change had occurred. A few treatment providers used results from post-tests to assist in determining when treatment had been successful. Ultimately, determining successful program completion relied heavily on the professional judgments of treatment staff. And, as shown below, in a couple of programs within correctional facilities, some offenders did not complete treatment to the satisfaction of program staff because their sentence lengths were shorter than the treatment programs.

Table 4.5 shows the reasons why sex offenders left treatment in 1992 before completing it. We found that:

- Most offenders who left treatment were asked to leave by program staff because they did not comply with program requirements or were otherwise considered not amenable to treatment.

### Table 4.5: Reasons for Treatment Non-Completion by Type of Program, 1992

<table>
<thead>
<tr>
<th>Reason for Non-Completion</th>
<th>State Correctional Facilities</th>
<th>Residential Programs</th>
<th>Outpatient Programs</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Non-compliant/non-amenable</td>
<td>60</td>
<td>69.0%</td>
<td>62</td>
<td>41.6%</td>
</tr>
<tr>
<td>Voluntarily left or absconded</td>
<td>19</td>
<td>21.8%</td>
<td>35</td>
<td>23.5%</td>
</tr>
<tr>
<td>Transferred to another treatment program or more appropriate setting</td>
<td>2</td>
<td>2.3%</td>
<td>14</td>
<td>9.4%</td>
</tr>
<tr>
<td>Probation or sentence expired</td>
<td>6</td>
<td>6.9%</td>
<td>21</td>
<td>14.1%</td>
</tr>
<tr>
<td>Violated probation</td>
<td>0</td>
<td>0.0%</td>
<td>12</td>
<td>8.1%</td>
</tr>
<tr>
<td>Reoffended</td>
<td>0</td>
<td>0.0%</td>
<td>4</td>
<td>2.7%</td>
</tr>
<tr>
<td>Developmentally disabled</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
<td>0.7%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>87</td>
<td>100.0%</td>
<td>149</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Program Evaluation Division analysis of completed data forms from treatment programs.

\[a\] Includes county correctional facilities, sex offender-specific residential programs, general treatment programs, halfway houses, and the program for sex offenders on probation at the Minnesota Security Hospital operating in 1992.

\[b\] Includes those who failed to make progress in treatment, continued to deny their offense, violated program rules, exhibited violent behavior, threatened others, or failed to attend treatment.

17 Based on data forms for offenders who did not complete treatment and where a reason was given for non-completion.
Most sex offenders who left treatment in 1992 before completing it did not comply with requirements, failed to make progress, or left voluntarily.

Forty percent of the individuals who did not complete sex offender treatment were asked to leave because they failed to make progress, violated program rules, threatened others or exhibited violent behavior, or continued to deny their offenses. Another third of the individuals who did not complete treatment chose to leave or absconded from the program, and 13 percent were transferred to another program or to a more appropriate setting. As Table 4.5 also shows, however, 8 percent failed to complete treatment because their sentences or probationary periods expired before treatment was judged to be successful by staff.\textsuperscript{18} Approximately 6 percent of the offenders who failed to complete treatment reoffended during treatment or violated the terms of their probation.

As Table 4.5 also shows:

- A higher proportion of offenders in state correctional facility programs than residential and outpatient programs failed to comply with treatment requirements or were otherwise judged not amenable. In contrast, higher proportions of offenders in residential and outpatient programs voluntarily left treatment or were transferred to more appropriate treatment programs.

In outpatient programs, nearly half of those who failed to complete treatment voluntarily left the program or absconded, and another 22 percent were transferred to other programs, including placements in more secure settings or in psychiatric treatment. In prison and local residential programs, fewer of the offenders voluntarily dropped out of treatment or were transferred to other programs. In prison programs, 69 percent of those who did not complete treatment failed to comply with treatment requirements or were otherwise considered not amenable to treatment. This may indicate that treatment officials in more secure settings have fewer options available for transferring offenders who do not do well in their programs.

We do not know what happened to those individuals who voluntarily left or were asked to leave treatment before completing it in outpatient and local residential settings (in correctional facility programs, they were transferred to the general prison population). However, we asked the 43 probation officers we interviewed to tell us what happens to offenders who drop out of treatment or are asked to leave it. All 43 probation officers said they filed violation-of-probation reports when offenders failed to complete assigned treatment programs. Just under 40 percent of the adult probation officers (9 out of 23) said they also recommended that these individuals be sent to prison, while 17 percent (4 out of 23) said they explored other treatment options before recommending a prison sentence. The remaining 10 respondents (43 percent) said it depended on the circumstances, such as the.

\textsuperscript{18} Approximately two-thirds of these offenders were located at the only adult county correctional program, Northeast Regional Corrections Center (NERCC). Offenders were released from NERCC when their sentences (under one year in length) expired, rather than as a function of treatment completion. Program officials at NERCC told us that nearly all offenders who left their program needed further treatment and were referred to an outpatient provider in the region to continue for a number of months.
type of program and why the offender dropped out, or that the court determined what happened next.

In contrast, 55 percent of the juvenile probation officers (11 out of 20) said they tried other treatment alternatives, possibly in combination with some detention time. Several respondents said that if a juvenile offender did not cooperate with an outpatient program, they considered placement in a residential program, and if one residential program did not work, they would try another one. Only 15 percent (3 out of 20) said they would commit to the Department of Corrections a juvenile offender who failed to complete treatment. As discussed in Chapter 3, there were more residential treatment programs for juveniles than for adults, so there were more treatment options to try when an individual fails in one program or needs a more secure setting.

**Treatment Follow-Up**

We asked treatment providers whether they tracked any of their clients after they left their program. We found that:

- Most sex offender treatment programs did not follow their clients after they left treatment.

Very few sex offender treatment programs in Minnesota monitored offenders who went through treatment to determine whether they reoffended. Treatment programs that tracked clients after treatment tended to keep informal records and typically learned about reoffenses by word of mouth. Few treatment programs had the means available to evaluate their long-term effectiveness.

We found that information on reoffense rates was available for eight of the 70 treatment providers we identified. The following agencies collected and analyzed data on reoffense rates for treated sex offenders: Hennepin County Community Corrections (on Alpha Human Services’ residential treatment program); Hennepin County Home School (juvenile sex offender treatment program); University of Minnesota’s Program on Human Sexuality (outpatient sex offender treatment program); University of Minnesota, Duluth (on the Northeast Regional Correctional Center sex offender treatment program); 180 Degrees (halfway house sex offender transition program); Minnesota Security Hospital (on its now defunct Intensive Treatment Program for Sexual Aggressives); and the Department of Corrections (on its treatment programs at Lino Lakes and Oak Park Heights).\(^\text{19}\)

Data from these programs exhibited many of the same problems as the national literature on sex offender treatment effectiveness. With the exception of the Department of Corrections and Hennepin County Community Corrections data, the other studies tracked only offenders who successfully completed treatment. Only the Department of Corrections study included a

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\(^{19}\) In addition, Project Pathfinder staff told us they have contracted with a private agency to establish a database on their clients and collect follow-up data. However, no data were available at the time of our study.
comparison to untreated offenders and to offenders who failed to complete treatment. The length of follow-up varied from six months to ten years. As with other treatment effectiveness studies, reoffense rates were not defined consistently across studies. A couple of the studies used self-reported information obtained through interviews to determine reoffense rates. One study compared pre- and post-test scores on the MMPI and California Psychological Inventory, in addition to analyzing official reconviction data.

Given the differences in populations treated in these programs and variation in the methods used to measure treatment outcomes, no comparisons of treatment effectiveness across programs can be made. However, the reported reoffense rates for sex offenders treated in Minnesota programs were comparable to those found in the treatment effectiveness literature.

SUMMARY

Except for the Minnesota Security Hospital, which must accept all individuals civilly committed for treatment, all treatment providers screened referrals to determine whether an offender might benefit from the treatment they offer. Some offenders were more difficult to treat and were less likely to be accepted into treatment. These included offenders who posed risks to the community, excessively denied their offenses, had lower intellectual abilities, or were not motivated for treatment. Treatment programs accepted between half to three-quarters of those they assessed. More serious sex offenders tended to receive treatment in state (adult) or county (juvenile) correctional facilities or local residential programs. In addition, most treatment programs screened offenders for chemical use problems.

Overall, many offenders received treatment. We estimate that over 2,600 individuals received some treatment in 1992, two-thirds of them adults. Almost half of them were still in treatment at the end of 1992. However, approximately 45 to 50 percent of those who left treatment during the year failed to complete it to the program’s satisfaction, most often because they failed to make progress, continued to deny their offenses, or violated program rules. Few treatment programs monitored their clients after treatment to assess reoffense rates or determine treatment effectiveness.