FORUM on Corrections Research

The Value of Community Treatment Programs for Released Sex Offenders

Clinicians and researchers working with sex offenders now widely believe that these men require both reassessment and treatment once they are released from institutional settings.[1] *Tentative long-term data from postrelease, community-based programs are now available. The data offer limited but encouraging support for the idea that adding these postrelease components -reassessment and treatment in the community - to the overall treatment approach for incarcerated sex offenders reduces their subsequent rates of recidivism.*[2]

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During the past three years, the Correctional Service of Canada has been expanding its treatment programs for sex offenders in the Ontario region. This will give more sex offenders the opportunity to rehabilitate themselves, lessening the threat they pose to the security of women and children.

The number and capacity of treatment programs in maximum-security institutions (Kingston Penitentiary, Protective Custody and Ontario Regional Treatment Centre) and medium-security institutions (Warkworth Institution) have been increased and, more recently, a program has been established in a minimum-security setting (Bath Institution).

Programs at the maximum- and medium-security institutions are intended for those offenders who have extensive problems requiring comprehensive treatment. The more limited program at Bath Institution (minimum security) is intended for offenders with lesser problems (e.g., incest offenders) and for those who have already been through the more extensive programs.

These positive changes in the Correctional Service of Canada's approach to dealing with sex offenders match corresponding changes under way in the British Prison Service.[3] The changes also address much of the earlier criticism of the failure of Canadian society to treat many incarcerated sex offenders.[4]

In addition to these positive steps, the Correctional Service of Canada has recently begun funding post-release, community-based programs aimed at facilitating the move of sex offenders back into society. Assessment Community-based programs must reassess sex offenders once they are released. Assessments conducted within institutions are essential for determining the benefits an offender has derived from treatment programs and for judging postrelease risk and needs. However, these evaluations take place in an environment (i.e., a prison) where the everyday sights and sounds that sex offenders find provocative are mostly absent. A child molester may, while in prison, see images of children on television or in magazines, but only rarely will actually see a child (perhaps at visiting times). Even then, it is under conditions of maximum supervision and minimal temptation. Rapists certainly see female staff while in prison. Again though, supervision and the careful conduct of staff restrict opportunities for an offence to occur and reduce the likelihood of the rapist experiencing urges to offend.

Institutional assessment of a child molester's attraction to children or a rapist's proclivity to attack a woman sexually is done under the controlled and artificial conditions of a prison. It therefore cannot provide a sound basis for predicting sex offenders' responses in a postrelease world full of women and children.

One must keep in mind that treatment programs for sex offenders cannot "cure" their deviant tendencies. Treatment does not eliminate the urges or desires to offend sexually; it simply reduces them to a controllable level. This means, of course, that if a sex offender is placed in a highly provocative situation, this control will be threatened and the risk of offending will increase.

This rather obvious observation is the basis for the recent development of relapse-prevention components and their addition to treatment programs for sex offenders.[5] Relapse prevention helps the offender avoid risks and cope effectively when some degree of risk is unavoidable.

Once a sex offender is released from prison into an environment where temptations are prevalent, the possibility of encountering risky situations is at its maximum. This sudden change in the number and type of temptations is compounded by the fact that offenders are given much, if not complete, responsibility for their movement in the community. It would be negligent not to consider this radical change in potential risk.

Community-based programs must, therefore, re-evaluate sex offenders within the first month of their release back into society. While the sexual preferences of released offenders must be reassessed, their attitudes, emotional functioning, and current living style and conditions also need re-evaluation.

During the past year, we have evaluated, at our community clinic, a number of sex offenders who were released from penitentiaries in the Ontario region. These men had been assessed in their institutions before release, and most had been recommended for community treatment as part of their release plan. Prerelease assessments showed that most of these offenders were ready for a return to society: that is, their sexual preferences were normal, their anger and hostility were well under control, their attitudes were prosocial and their release plans were sensible.

In a small but important number of cases, however, release into the community led to new problems or significant reversals of treatment gains. In each of these cases, the return of deviant thoughts was prompted either by the stresses associated with readjustment to society or by the offender's perception of being surrounded by women or children and being allowed relative freedom to watch them in inappropriate ways.

Watching potential victims in this way is one of the behaviours that initiates a return to the whole cycle of deviance. It is typically followed by the reappearance of deviant fantasies, which usually trigger deviant urges. With the consequent distortion of thinking, when the offender convinces himself that offending is not all that bad, the stage is then set for a reoffence.

By retesting offenders, we can detect this negative drift early enough to prevent an offence. We must then decide whether the offender is sufficiently in control to continue treatment in the community, or whether he should be returned to a more secure setting, that is, either to a halfway house or back to a minimum-, medium- or maximum-security prison.

To illustrate what can happen when a previously incarcerated sex offender is exposed to the provocative situations of society, we present the particularly dramatic case of an offender who showed a remarkable loss of treatment gains after only a single month in the community. When this man was assessed at the Regional Treatment Centre (Ontario) after treatment and two months before release, he displayed clear sexual preferences for normal, consenting relations with adult women. He was also found to have significantly more self-confidence as a result of treatment and to have developed a more positive, less hostile attitude toward others, particularly women. It was determined that he had dealt with his propensity to abuse alcohol and that he now assumed responsibility for his behaviour. Finally, he had a release plan that involved placement in a halfway house while he searched for a job and accommodation.

We assessed this offender one month after release (i.e., three months after the institutional evaluation) and found that exposure to society had eroded all the gains of his institutional treatment. He showed strong sexual arousal to depictions of rape, and a level of arousal to young girls that put him at serious risk to reoffend. In our interviews, it was clear that he saw himself as a victim rather than as a responsible person able to direct his own life. He was angry at everyone, particularly the criminal justice system and all associated with it, and he was very hostile toward women. He had made little effort to find a job or a place to live. Perhaps not surprisingly, before we could initiate any treatment, he returned to the halfway house overdue, intoxicated and aggressive, and was immediately sent back to jail.

Although this case represents an unusual degree of reversal upon release, it does illustrate the risk we take if evaluations of sex offenders done in the institution are considered the final word in determining postrelease risk for reoffending.

Furthermore, it is not just the institutional evaluations of risk that may be altered by an offender's exposure to the community; the institutionally prepared relapse-prevention plans may also need to be changed. We saw one offender, for instance, who had been encouraged to follow his interest in fishing in order to fill idle release time with some constructive activity. Idle time is frequently associated with an increased risk of reoffending among sex offenders, so the recommendation to pursue an already-established interest was quite sensible. So that he could enter a treatment program, the man was released to an unfamiliar community, which also provided him with frequent opportunities to fish. The problem was that the available fishing sites were frequented by young boys, and his offence history involved the sexual molestation of boys. We advised him to seek out another, less risky pastime.

Our responsibility clearly does not end with evaluation; we must also involve these offenders in treatment and in informed supervision after release from prison. Treatment The community treatment of sex offenders who have been released from penitentiaries seems such a sensible part of rehabilitation that one wonders why it was not required long ago. Community treatment and supervision are the main components of the essential final stage in an overall plan to reduce recidivism among convicted sex offenders.

We have argued elsewhere[6] that incarceration is a sensible and appropriate part of society's response to a sex offender, and that treatment while the offender is in jail is essential.

Similarly, a graded and selective movement through the jail system is needed to optimize the offender's chance of rehabilitation. Extensive and comprehensive treatment in a medium-or maximum-security institution should be provided for those sex offenders who pose a moderate to high risk.

After completing this treatment, these offenders should be moved to a less intense program in a minimum-security setting. Here, they should be joined in treatment by those sex offenders who are designated as low risk.

From the minimum-security program, these sex offenders should be released into the community, either directly to a halfway house or as part of a gradual release program, depending on their risk to the community.

If unresolvable problems arise at any one of these stages, it should be possible to move the offender quickly back into a more secure setting. Clearly, several countries - most notably Canada, Britain, New Zealand and some states in the United States - are moving rapidly in this direction, although implementation of this comprehensive response has not yet been fully achieved.

There are two components to treating released sex offenders in the community: correction of those problems identified at community reassessment, and implementation and supervision of the offender's relapse-prevention program.

As we noted earlier, the responses some offenders display once back on the street are very different from those evident at the time of the institutional prerelease evaluation. In the case of the rapist illustrated in the section on community assessment, we would have had to implement a rather comprehensive program had the offender not been returned to jail. Returning him to the institution was a much more sensible response than leaving this dangerous man in the care of a community program.

Community programs are not meant to correct serious flaws in dangerous offenders. This is why it is so essential that movement backwards in the system be a ready option.

As we have described, we have seen sex offenders whose deviant urges, fantasies and distorted thinking patterns, successfully corrected in an institutional program, returned once they were on the street for a few weeks. For these men, many of the elements of their institutional treatment programs must be repeated.

For instance, if an offender shows a return to deviant sexual arousal patterns at assessment or reports strong deviant sexual urges or fantasies, then he should undergo some combination of masturbatory reconditioning[7] and covert sensitization or olfactory aversion[8] (where unpleasant images and odours are used to create an aversion to a particular sexual deviation). In those cases where urges are frequent and intense, then perhaps anti-androgen treatment[9] or a course of serotonergic medication (both drug treatments) will be required to reduce the strength of these urges.[10]

If the offender's distorted and self-serving thinking patterns have returned (e.g., negative views of women, acceptance of rape myths or beliefs that justify sex with children), then cognitive-restructuring techniques should be implemented.[11]

Anger management, victim empathy, substance abuse treatment, social skills training, relationship therapy and other components of comprehensive cognitive-behavioural programs[12] may be needed, depending upon the nature of the returning or emerging problem.

Emotional distress or cognitive disturbances brought on by the stress of return to society, and all the responsibilities and disappointments that go with it, may require referral to a psychiatric clinic if the community program does not have its own psychiatrist.

In most cases, treatment for released offenders can be limited and need involve only one or two components to address problems that were treated in the institution. For most released offenders, relapse-prevention training is the most critical feature of treatment. It has recently been added to most comprehensive programs for sex offenders.

The first step in relapse prevention is to have offenders recognize the factors that led to their offences and that might put them at risk in the future. Some of the more common factors identified in this stage of relapse-prevention training are: stress, interpersonal or relationship problems, use of intoxicants, distressing emotional states, deviant or distorted thinking, an idle or aimless lifestyle, or situations in which one is alone with children or in a place where one may encounter a lone woman. Each individual is assisted in developing a personal list of risk factors. In addition, help is given on how to avoid these risks or to deal with them when they are unavoidable.

Most of relapse-prevention training is best done in the institution, where the list of risk factors and strategies for dealing with them can be prepared as part of the offender's postrelease plan. The relapse-prevention plan can then be shared with those who will treat and supervise the offender on the street.

The community treatment program can then help the offender effectively to implement and, if necessary, modify the relapse-prevention plan when confronting the reality of life back on the street. Parole officers can also effectively help the offender by using the relapse-prevention plan to identify particular issues that need to be watched.

Lack of compliance in treatment is a common problem in community programs. All too often, offenders believe that once they are released from jail, they only have to go through the motions without properly participating in treatment. Offenders may object to the manner in which treatment is conducted and ask to be referred elsewhere. The most common complaint we hear from offenders is that they do not like group therapy or that we are too confrontational when dealing with their denials, minimizations and distortions of the offence.

When offenders fail to participate or request to be referred elsewhere, our response must be carefully considered. If it is "soft," offenders will see no reason to make an effort to deal with their problems. Offering an alternative treatment is likely to encourage offenders to believe that they can simply run away to another therapist whenever they feel uncomfortable in treatment. If there are no significant consequences for failure to co-operate with treatment, offenders will not be encouraged to participate meaningfully.

It is very important that it be possible to reverse an offender's progress through the stages of release and reintegration. Unco-operative offenders should be told that their stay in a halfway house or on their own in the community depends on full and proper participation in the treatment program to which they have been referred. Offenders who still do not comply should be returned to the next stage back in their release program (i.e., to the halfway house if they are on their own, or to the institution if they are in the halfway house). Once offenders demonstrate a determination to comply, they can be released again into the community. Summary The rehabilitation of sex offenders should be seen as a staged process, each step of which is vital to reducing the risk sex offenders pose when they are returned to the community.

An essential link in this process is postrelease assessment and treatment, both of which should be incorporated in the release plan prepared in the institution. Assessments done in the community may reveal a loss of institutionally based treatment gains and may indicate a need both to treat these problems and to modify relapse-prevention plans. Community treatment can continue and elaborate upon the processes initiated by institutional treatment, can correct community-induced reversals or new problems and can begin implementing the offender's relapse-prevention plan.

The ability to move the offender readily and quickly back to more secure settings will help resolve problems arising in community treatment.

Finally, our hope is that the Correctional Service of Canada will continue to expand current efforts to fund community-based treatment of released sex offenders. Such efforts will go a long way to reduce the risk these men pose to innocent women and children in our society.

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(1) J.K. Marques, *"The Sex Offender Treatment and Evaluation Project: California's New Outcome Study,"* Annals of the New York Academy of Sciences, *538 (1989): 235-243. See also W.L. Marshall, S.M. Hudson and T. Ward, "Sexual Deviance," in P.H. Wilson (Ed.),* Principles and Practice of Relapse Prevention. *(New York: Guilford Press, at press). And see W.D. Pithers, G.R. Martin and G.F. Cumming,* "Vermont Treatment Program for Sexual Aggressors, *in D.R. Laws (Ed.),* Relapse Prevention with Sex Offenders. *(New York: Guilford Press, 1989).*

(2) J.K. Marques, D.M. Day, C. Nelson and M.H. Miner, *"The Sex Offender Treatment and Evaluation Project." Third Report to the California Legislative, July 1989. See also W.D. Pithers and G.F. Cumming, "Can Relapses Be Prevented? Initial Outcome Data from the Vermont Treatment Program for Sexual Aggressors," in* Laws, Relapse Prevention with Sex Offenders.

(3) W.L. Marshall, *"The Design of Institutional Programs for Sex Offenders in Britain." Paper presented at the British Prison Psychologists Annual Conference. (Scarborough, England, October 1991).*

(4) W.L. Marshall and S. Barrett, Criminal Neglect: Why Sex Offenders Go Free. *(Toronto: Doubleday Publishing, 1990).*

(5) Laws, *Relapse Prevention with Sex Offenders.*

(6) Marshall and Barrett, *Criminal Neglect:* Why Sex Offenders Go Free.

(7) D.R. Laws and W.L. Marshall, *"Masturbatory Reconditioning with Sexual Deviates: An Evaluative Review," Advances in Behaviour Research and Therapy, 13 (1991): 13-25.*

(8) W.L. Marshall and A. Eccles, *"Issues in Clinical Practice with Sex Offenders,"* Journal of Interpersonal Violence, *6 (1991): 68-93.*

(9) J.M.W. Bradford, *"The Antiandrogen and Hormonal Treatment of Sex Offenders," in W.L. Marshall, D.R. Laws and H.E. Barbaree (Eds.),* Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender, *(New York: Plenum Press, 1990).*

(10) *Pearson, "Paraphilias, Impulse Control and Serotonin,"* Journal of Clinical Pharmacology, *10 (1990): 123-124.*

(11) *W.E. Barbaree and W.L. Marshall, "Treatment of the Sexual Offender," in R.M. Wettstein (Ed.),* Treatment of the Mentally Disordered Offender. *(New York: Guilford Press, at press).*

(12) *W.L. Marshall and H.E. Barbaree, "Outcome of Cognitive-Behavioral Treatment," in Marshall, Laws and Barbaree (Eds.),* Handbook of Sexual Assault: Issues, Theories and Treatment of the Offender.