Subcommittee on Violent Sex Offenders

The Subcommittee met several times during the 1991 Legislative Session. Although not completing work on the bills, they did agree to a number of amendments to SB 18, SB 19 and SB 20. (ATTACHMENTs 1, 2 and 3)

Additional information was received by the Subcommittee from:

° Stuart M. Frager, Ph.D., Psychology Department, Topeka State Hospital, (ATTACHMENT 4);

° Paul Klotz, Executive Director of Association of Community Mental Health Centers of Kansas, Inc. (ATTACHMENT 5); and

° Gregory P. Canova, Senior Assistant Attorney General for the State of Washington. (ATTACHMENT 6)

The Subcommittee recommended to the full Committee that SB 18, SB 19 and SB 20 be suggested for study by an Interim Committee, addressing the cost and funding for the sex offender programs which would result if the amended versions of the bills were to pass.

Session of 1991

SENATE BILL No. 18

By Special Committee on Judiciary

Re Proposal No. 42

12-28

AN ACT concerning persons who commit sexually violent offenses; relating to such persons' civil commitment; alleging sexual motivation in criminal cases; amending K.S.A. 1990 Supp. 21-3110 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. As used in this act:

(a) "Sexually violent predator" means any person who has been convicted of or charged with a sexually violent offense and who suffers from a mental abnormality or personality disorder which makes the person likely to engage in predatory acts of sexual violence.

(b) "Mental abnormality" means a congenital or acquired condition affecting the emotional or volitional capacity which predisposes the person to commit sexually violent offenses in a degree constituting such person a menace to the health and safety of others.

(c) "Predatory" means acts directed towards strangers or individuals with whom a relationship has been established or promoted for the primary purpose of victimization.

(d) "Sexually violent offense" means:

(1) Rape, K.S.A. 21-3502, and amendments thereto;

(2) indecent liberties with a child, K.S.A. 21-3503, and amendments thereto;

(3) aggravated indecent liberties with a child, K.S.A. 21-3504, and amendments thereto;

(4) ~~criminal sodomy, K.S.A. 21-3505, and amendments thereto;~~

(5) aggravated criminal sodomy, K.S.A. 21-3506, and amendments thereto;

(6) enticement of a child, K.S.A. 21-3509, and amendments thereto;

(7) indecent solicitation of a child, K.S.A. 21-3510, and amendments thereto;

(8) aggravated indecent solicitation of a child, K.S.A. 21-3511, and amendments thereto;

(9) sexual exploitation of a child, K.S.A. 21-3516, and amend-

(5)

(6)

(7)

(8)

Proposed Amendments to Senate Bill No. 18

Submitted to Senate Judiciary
Violent Sex Offenders
Attachment 1

ments thereto;

~~(10)~~ sexual battery, K.S.A. 21-3517, and amendments thereto; (9)

~~(11)~~ aggravated sexual battery, K.S.A. 21-3518, and amendments thereto; (10)

~~(12)~~ any conviction for a felony offense in effect at any time prior to the effective date of this act, that is comparable to a sexually violent offense as defined in subparagraphs (1) through (11), or any federal or other state conviction for a felony offense that under the laws of this state would be a sexually violent offense as defined in this subsection; (11)

~~(13)~~ an attempt, conspiracy or criminal solicitation, as defined in article 33 of chapter 21, and amendments thereto, of a sexually violent offense as defined in this subsection; or (12)

~~(14)~~ any act of: (13)

(A) Murder in the first degree, K.S.A. 21-3401, and amendments thereto;

(B) murder in the second degree, K.S.A. 21-3402, and amendments thereto;

(C) assault, K.S.A. 21-3408, and amendments thereto;

(D) aggravated assault, K.S.A. 21-3410, and amendments thereto;

(E) battery, K.S.A. 21-3412, and amendments thereto;

(F) aggravated battery, K.S.A. 21-3414, and amendments thereto;

(G) kidnapping, K.S.A. 21-3420, and amendments thereto;

(H) aggravated kidnapping, K.S.A. 21-3421, and amendments thereto;

(I) unlawful restraint, K.S.A. 21-3424, and amendments thereto;

(J) robbery, K.S.A. 21-3426, and amendments thereto; or

(K) aggravated robbery, K.S.A. 21-3427, and amendments thereto, which act, either at the time of sentencing for the offense or subsequently during civil commitment proceedings pursuant to this act, has been determined beyond a reasonable doubt to have been sexually motivated, as that term is defined in K.S.A. 21-3110, and amendments thereto.

New Sec. 2. When it appears that:

(a) The sentence of a person who has been convicted of a sexually violent offense is about to or has expired ~~at any time in the past~~; within the last three years

(b) the term of confinement of a person found to have committed a sexually violent offense as a juvenile is about to or has expired; or

(c) a person who has been charged with a sexually violent offense and has been determined to be incompetent to stand trial is about to be or has been released pursuant to K.S.A. 22-3305, and amendments thereto; ~~or~~

~~(d) a person who has been found not guilty by reason of insanity~~

~~of a sexually violent offense is about to be released pursuant to K.S.A. 22-3428, and amendments thereto, and it appears that the person may be a sexually violent predator, the county or district attorney of the county where the person was convicted or charged or the attorney general if requested by the county or district attorney may file a petition alleging that the person is a sexually violent predator and stating sufficient facts to support such allegation.~~

New Sec. 3. Upon the filing of a petition under section 2, the judge shall determine whether probable cause exists to believe that the person named in the petition is a sexually violent predator. If such determination is made, the judge shall direct that the person be taken into custody and the person shall be transferred to an appropriate facility for an evaluation as to whether the person is a sexually violent predator. The evaluation shall be conducted by a person deemed to be professionally qualified to conduct such an examination pursuant to rules and regulations developed by the department of social and rehabilitation services. In adopting such rules and regulations, the department of social and rehabilitation services shall consult with the department of health and environment and the department of corrections.

New Sec. 4. Within 45 days after the filing of a petition pursuant to section 2, the court shall conduct a trial to determine whether the person is a sexually violent predator. At all stages of the proceedings under this act, any person subject to this act shall be entitled to the assistance of counsel, and if the person is indigent, the court shall appoint counsel to assist such person. Whenever any person is subjected to an examination under this act, such person may retain experts or professional persons to perform an examination on such person's behalf. When the person wishes to be examined by a qualified expert or professional person of such person's own choice, such examiner shall be permitted to have reasonable access to the person for the purpose of such examination, as well as to all relevant medical and psychological records and reports. In the case of a person who is indigent, the court, upon the person's request, shall assist the person in obtaining an expert or professional person to perform an examination or participate in the trial on the person's behalf. The person, the county or district attorney or attorney general, or the judge shall have the right to demand that the trial be before a jury. If no demand is made, the trial shall be before the court.

New Sec. 5. (a) The court or jury shall determine whether, beyond a reasonable doubt, the person is a sexually violent predator. If the court or jury determines that the person is a sexually violent

hold a hearing to

Such hearing shall be held within 10 days of the filing of the petition under section 2 and the protection requirements contained in K.S.A. 59-2912 regarding probable cause hearings pursuant to such section shall be applicable to such hearing

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predator, the person shall be committed to the custody of the department of social and rehabilitation services in a secure facility for control, care and treatment until such time as the person's mental abnormality or personality disorder has so changed that the person is safe to be at large. Such control, care and treatment shall be provided at a facility operated by the department of social and rehabilitation services. If the court or jury is not satisfied beyond a reasonable doubt that the person is a sexually violent predator, the court shall direct the person's release.

(b) If the person charged with a sexually violent offense has been found incompetent to stand trial, and is about to or has been released pursuant to K.S.A. 22-3305, and amendments thereto, and such person's commitment is sought pursuant to subsection (a), the court shall first hear evidence and determine whether the person did commit the act or acts charged if the court did not enter a finding prior to dismissal under K.S.A. 22-3305, and amendments thereto, that the person committed the act or acts charged. The hearing on this issue must comply with all the procedures specified in this section. In addition, the rules of evidence applicable in criminal cases shall apply, and all constitutional rights available to defendants at criminal trials, other than the right not to be tried while incompetent, shall apply. After hearing evidence on this issue, the court shall make specific findings on whether the person did commit the act or acts charged, the extent to which the person's incompetence or developmental disability affected the outcome of the hearing, including its effect on the person's ability to consult with and assist counsel and to testify on such person's own behalf, the extent to which the evidence could be reconstructed without the assistance of the person, and the strength of the prosecution's case. If, after the conclusion of the hearing on this issue, the court finds, beyond a reasonable doubt, that the person did commit the act or acts charged, the court shall enter a final order, appealable by the person, on that issue, and may proceed to consider whether the person should be committed pursuant to this section.

New Sec. 6. Each person committed under this act shall have a current examination of the person's mental condition made at least once every year. The person may retain, or if the person is indigent and so requests, the court may appoint a qualified expert or a professional person to examine such person, and such expert or professional person shall have access to all records concerning the person. The periodic report shall be provided to the court that committed the person under this act.

New Sec. 7. The involuntary detention or commitment of per-

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sons under this act shall conform to constitutional requirements for care and treatment.

New Sec. 8. (a) If the secretary of the department of social and rehabilitation services determines that the person's mental abnormality or personality disorder has so changed that the person is not likely to commit predatory acts of sexual violence if released, the secretary shall authorize the person to petition the court for release. The petition shall be served upon the court and the county or district attorney. The court, upon receipt of the petition for release, shall order a hearing within 45 days. The county or district attorney or the attorney general, if requested by the county, shall represent the state, and shall have the right to have the petitioner examined by an expert or professional person of such attorney's choice. The hearing shall be before a jury if demanded by either the petitioner or the county or district attorney or attorney general. The burden of proof shall be upon the county or district attorney or attorney general to show beyond a reasonable doubt that the petitioner's mental abnormality or personality disorder remains such that the petitioner is not safe to be at large and that if discharged is likely to commit predatory acts of sexual violence.

(b) Nothing contained in this act shall prohibit the person from otherwise petitioning the court for discharge without the secretary's approval. The secretary shall provide the committed person with an annual written notice of the person's right to petition the court for release over the secretary's objection. The notice shall contain a waiver of rights. The secretary shall forward the notice and waiver form to the court with the annual report. If the person does not affirmatively waive the right to petition, the court shall set a show cause hearing to determine whether facts exist that warrant a hearing on whether the person's condition has so changed that the person is safe to be at large. The committed person shall have a right to have an attorney represent the person at the show cause hearing but the person is not entitled to be present at the show cause hearing. ~~If the court at the show cause hearing determines that probable cause exists to believe that the person's mental abnormality or personality disorder has so changed that the person is safe to be at large and will not engage in acts of sexual violence if discharged,~~ then the court shall set a hearing on the issue. At the hearing, the committed person shall be entitled to be present and to the benefit of all constitutional protections that were afforded to the person at the initial commitment proceeding. The county or district attorney or the attorney general if requested by the county shall represent the state and shall have a right to a jury trial and to have the

Unless the court finds at the show cause hearing that facts do not exist which could warrant a finding that the person's condition has changed that the person is safe to be at large,

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committed person evaluated by experts chosen by the state. The committed person shall also have the right to have experts evaluate the person on the person's behalf and the court shall appoint an expert if the person is indigent and requests an appointment. The burden of proof at the hearing shall be upon the state to prove beyond a reasonable doubt that the committed person's mental abnormality or personality disorder remains such that the person is not safe to be at large and if released will engage in acts of sexual violence.

New Sec. 9. Nothing in this act shall prohibit a person from filing a petition for discharge pursuant to this act. However, if a person has previously filed a petition for discharge without the secretary's approval and the court determined either upon review of the petition or following a hearing, that the petitioner's petition was frivolous or that the petitioner's condition had not so changed that the person was safe to be at large, then the court shall deny the subsequent petition unless the petition contains facts upon which a court could find that the condition of the petitioner had so changed that a hearing was warranted. Upon receipt of a first or subsequent petition from committed persons without the secretary's approval, the court shall endeavor whenever possible to review the petition and determine if the petition is based upon frivolous grounds and if so shall deny the petition without a hearing.

New Sec. 10. The department of social and rehabilitation services shall be responsible for all costs relating to the evaluation and treatment of persons committed to the department's custody under any provision of this act. Reimbursement may be obtained by the department for the cost of care and treatment of persons committed to its custody pursuant to K.S.A. 1990 Supp. 59-2006, and amendments thereto.

New Sec. 11. In addition to any other information required to be released under this act, prior to the release of a person committed under this act, the secretary of the department of social and rehabilitation services shall give written notice of such release to any victim of the person's activities or crime who is alive and whose address is known to the secretary or, if the victim is deceased, to the victim's family if the family's address is known to the secretary. Failure to notify shall not be a reason for postponement of release. Nothing in this section shall create a cause of action against the state or an employee of the state acting within the scope of the employee's employment as a result of the failure to notify pursuant to this section.

New Sec. 12. (a) The county or district attorney shall file a spec-

cial allegation of sexual motivation in every criminal case other than sex offenses as defined in article 35 of chapter 21 of the Kansas Statutes Annotated, and amendments thereto, when sufficient admissible evidence exists, which, when considered with the most plausible, reasonably foreseeable defense that could be raised under the evidence, would justify a finding of sexual motivation by a reasonable and objective fact finder.

(b) In a criminal case wherein there has been a special allegation, the state shall prove beyond a reasonable doubt that the accused committed the crime with a sexual motivation. The court shall make a finding of fact of whether or not a sexual motivation was present at the time of the commission of the crime, or if a jury trial is had, the jury, if it finds the defendant guilty, also shall find a special verdict as to whether or not the defendant committed the crime with a sexual motivation. This finding shall not be applied to sex offenses as defined in article 35 of chapter 21 of the Kansas Statutes Annotated, and amendments thereto.

(c) The county or district attorney shall not withdraw the special allegation of sexual motivation without approval of the court through an order of dismissal of the special allegation. The court shall not dismiss this special allegation unless it finds that such an order is necessary to correct an error in the initial charging decision or unless there are evidentiary problems which make proving the special allegation doubtful.

Sec. 13. K.S.A. 1990 Supp. 21-3110 is hereby amended to read as follows: 21-3110. The following definitions shall apply when the words and phrases defined are used in this code, except when a particular context clearly requires a different meaning.

(1) "Act" includes a failure or omission to take action.

(2) "Another" means a person or persons as defined in this code other than the person whose act is claimed to be criminal.

(3) "Conduct" means an act or a series of acts, and the accompanying mental state.

(4) "Conviction" includes a judgment of guilt entered upon a plea of guilty.

(5) "Deception" means knowingly and willfully making a false statement or representation, express or implied, pertaining to a present or past existing fact.

(6) To "deprive permanently" means to:

(a) Take from the owner the possession, use or benefit of his or her property, without an intent to restore the same; or

(b) Retain property without intent to restore the same or with

leases it back, or pays a reward or other compensation for its return; or

(c) Sell, give, pledge or otherwise dispose of any interest in property or subject it to the claim of a person other than the owner.

(7) "Dwelling" means a building or portion thereof, a tent, a vehicle or other enclosed space which is used or intended for use as a human habitation, home or residence.

(8) "Forcible felony" includes any treason, murder, voluntary manslaughter, rape, robbery, burglary, arson, kidnapping, aggravated battery, aggravated sodomy and any other felony which involves the use or threat of physical force or violence against any person.

(9) "Intent to defraud" means an intention to deceive another person, and to induce such other person, in reliance upon such deception, to assume, create, transfer, alter or terminate a right, obligation or power with reference to property.

(10) "Law enforcement officer" means any person who by virtue of such person's office or public employment is vested by law with a duty to maintain public order or to make arrests for crimes, whether that duty extends to all crimes or is limited to specific crimes or any officer of the Kansas department of corrections or for the purposes of K.S.A. 21-3409, 21-3411 and 21-3415 and subsection (a)(2) of K.S.A. 21-3413 and amendments thereto, any employee of the Kansas department of corrections.

(11) "Obtain" means to bring about a transfer of interest in or possession of property, whether to the offender or to another.

(12) "Obtains or exerts control" over property includes but is not limited to, the taking, carrying away, or the sale, conveyance, or transfer of title to, interest in, or possession of property.

(13) "Owner" means a person who has any interest in property.

(14) "Person" means an individual, public or private corporation, government, partnership, or unincorporated association.

(15) "Personal property" means goods, chattels, effects, evidences of rights in action and all written instruments by which any pecuniary obligation, or any right or title to property real or personal, shall be created, acknowledged, assigned, transferred, increased, defeated, discharged, or dismissed.

(16) "Property" means anything of value, tangible or intangible, real or personal.

(17) "Prosecution" means all legal proceedings by which a person's liability for a crime is determined.

(18) "Public employee" is a person employed by or acting for the state or by or for a county, municipality or other subdivision or [illegible] of the state or the purpose of exer-

cising their respective powers and performing their respective duties, and who is not a "public officer."

(19) "Public officer" includes the following, whether elected or appointed:

(a) An executive or administrative officer of the state, or a county, municipality or other subdivision or governmental instrumentality of or within the state.

(b) A member of the legislature or of a governing board of a county, municipality, or other subdivision of or within the state.

(c) A judicial officer, which shall include a judge of the district court, juror, master or any other person appointed by a judge or court to hear or determine a cause or controversy.

(d) A hearing officer, which shall include any person authorized by law or private agreement, to hear or determine a cause or controversy and who is not a judicial officer.

(e) A law enforcement officer.

(f) Any other person exercising the functions of a public officer under color of right.

(20) "Real property" or "real estate" means every estate, interest, and right in lands, tenements and hereditaments.

(21) "Solicit" or "solicitation" means to command, authorize, urge, incite, request, or advise another to commit a crime.

(22) "State" or "this state" means the state of Kansas and all land and water in respect to which the state of Kansas has either exclusive or concurrent jurisdiction, and the air space above such land and water. "Other state" means any state or territory of the United States, the District of Columbia and the Commonwealth of Puerto Rico.

(23) "Stolen property" means property over which control has been obtained by theft.

(24) "Threat" means a communicated intent to inflict physical or other harm on any person or on property.

(25) "Written instrument" means any paper, document or other instrument containing written or printed matter or the equivalent thereof, used for purposes of reciting, embodying, conveying or recording information, and any money, token, stamp, seal, badge, trademark, or other evidence or symbol of value, right, privilege or identification, which is capable of being used to the advantage or disadvantage of some person.

(26) "Sexual motivation" means that one of the purposes for which the defendant committed the crime was for the purpose of the defendant's sexual gratification.

New Sec. 14. If any provisions of this act or the application thereof to any person or circumstances is held invalid, the invalidity

shall not affect other provisions or applications of the act which can be given effect without the invalid provisions or application and, to this end, the provisions of this act are severable.

Sec. 15. K.S.A. 1990 Supp. 21-3110 is hereby repealed.

Sec. 16. This act shall take effect and be in force from and after its publication in the statute book.

Session of 1991

SENATE BILL No. 19

By Special Committee on Judiciary

Re Proposal No. 42

12-28

AN ACT concerning the treatment act for mentally ill persons; amending K.S.A. 1990 Supp. 59-2902 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 1990 Supp. 59-2902 is hereby amended to read as follows: 59-2902. When used in the treatment act for mentally ill persons:

(a) "Conditional release" means release of a patient who has not been discharged but who is permitted by the head of the treatment facility to live apart from the treatment facility pursuant to K.S.A. 59-2924 and amendments thereto.

(b) "Discharge" means the final and complete release from treatment, by either an order of a court pursuant to K.S.A. 59-2923 and amendments thereto or a treatment facility.

(c) "Head of the treatment facility" means the administrative director of a treatment facility or such person's designee.

(d) "Involuntary patient" means a mentally ill person who is receiving treatment under order of a court of competent jurisdiction.

(e) "Lacks capacity to make an informed decision concerning treatment" means that the person, by reason of the person's mental disorder or condition, is unable, despite conscientious efforts at explanation, to understand basically the nature and effects of hospitalization or treatment or is unable to engage in a rational decision-making process regarding hospitalization or treatment, as evidenced by inability to weigh the possible risks and benefits.

(f) "Law enforcement officer" means any sheriff, regularly employed deputy sheriff, state highway patrol officer, regularly employed city police officer, law enforcement officer of any county law enforcement department or regularly employed police officer of any university, community college or Haskell institute, if such police officer of a university, community college or Haskell institute has completed not less than 320 hours of law enforcement instruction at the law enforcement training center or in a training program ap-

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proved under K.S.A. 74-5604a and amendments thereto.

(g) "Likely to cause harm to self or others" means that the person:

(1) Is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage to another's property, as evidenced by behavior causing, attempting or threatening such injury, abuse or damage; or

(2) is substantially unable, except for reason of indigency, to provide for any of the person's basic needs, such as food, clothing, shelter, health or safety causing a substantial deterioration of the person's ability to function on the person's own.

(h) "Mentally ill person" means any person who:

(1) *(A)* Is suffering from a severe mental disorder to the extent that such person is in need of treatment;

~~(2)~~ *(B)* lacks capacity to make an informed decision concerning treatment; and

~~(3)~~ *(C)* is likely to cause harm to self or others~~,~~; *or*

(2) is suffering from any mental disorder recognized by the American psychiatric association and contained in the diagnostic and statistical manual of mental disorders, third edition, revised (1987), or revisions thereof, which, ~~in the opinion of a qualified mental health professional~~ predisposes the person to commit criminal sexual acts ~~in a degree constituting such a person a menace to the health and safety of others~~ which are likely to cause harm to others

No person who is being treated by prayer in the practice of the religion of any church which teaches reliance on spiritual means alone through prayer for healing shall be determined to be a mentally ill person unless substantial evidence is produced upon which the district court finds that the proposed patient is likely, in the reasonably foreseeable future, to cause substantial physical injury or physical abuse to self or others or substantial damage to another's property, as evidence by behavior causing, attempting or threatening such injury, abuse or damage.

(i) "Patient" means a person who is a voluntary patient, a proposed patient or an involuntary patient.

(j) "Physician" means a person licensed to practice medicine and surgery as provided by the Kansas healing arts act or a person who is employed by a Kansas state hospital or by an agency of the United States and who is authorized by either government to practice medicine and surgery.

(k) "Proposed patient" means a person for whom an application pursuant to K.S.A. 59-2913 and amendments thereto has been filed.

(l) "Psychologist" means a licensed psychologist, as defined by K.S.A. 74-5302 and amendments thereto.

(m) "Restraints" means the application of any devices, other than

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human force alone, to any parts of the body of the patient for the purpose of preventing the patient from causing injury to self or others.

(n) "Seclusion" means the placement of a patient, alone, in a locked room, where the patient's freedom to leave is restricted and where the patient is not under continuous observation.

(o) "Severe mental disorder" means a clinically significant behavioral or psychological syndrome or pattern associated with either a painful symptom or serious impairment in one or more important areas of functioning and involving substantial behavioral, psychologic or biologic dysfunction. "Severe mental disorder" does not include a condition which is caused by the use of chemical substances or for which the primary diagnosis is antisocial personality.

(p) "Treatment" means any service intended to promote the mental health of the patient and rendered by a qualified professional licensed or certified by the state to provide such service as an independent practitioner or under the supervision of such practitioner.

(q) "Treatment facility" means any mental health center or clinic, psychiatric unit of a medical care facility, psychologist, physician or other institution or individual authorized or licensed by law to provide either inpatient or outpatient treatment to any patient.

(r) "Voluntary patient" means a person who is receiving treatment at a treatment facility other than by order of any court.

(s) The terms defined in K.S.A. 59-3002 and amendments thereto shall have the meanings provided by that section.

(t) "Mental health center" means any community mental health center organized pursuant to the provisions of K.S.A. 19-4001 through 19-4015, and amendments thereto, or mental health clinic organized pursuant to the provisions of K.S.A. 65-211 through 65-215, and amendments thereto, and licensed in accordance with the provisions of K.S.A. 75-3307b and amendments thereto.

(u) "Participating mental health center" means a mental health center which has entered into a contract with the secretary of social and rehabilitation services to provide screening, treatment and evaluation, court ordered evaluation and other treatment services pursuant to the treatment act for mentally ill persons, in keeping with the phased concept of the mental health reform act.

(v) "State psychiatric hospital" means Larned state hospital, Osawatomie state hospital, Rainbow mental health facility and Topeka state hospital.

(w) "Qualified mental health professional" means: (1) A physician or psychologist who is employed by a participating mental health

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center or who is providing services as a physician or psychologist, respectively, under a contract with a participating mental health center; or (2) a registered masters level psychologist or a licensed specialist social worker or licensed master social worker or a registered nurse who has a specialty in psychiatric nursing who is employed by a participating mental health center and who is acting under the direction of a physician.

(x) "Registered masters level psychologist" means a person registered as a registered masters level psychologist by the behavioral sciences regulatory board under K.S.A. ~~1989~~ *1990* Supp. 74-5361 through 74-5373 and amendments thereto.

(y) "Licensed specialist social worker" means a person licensed in a social work practice specialty by the behavioral sciences regulatory board under K.S.A. ~~1989~~ *1990* Supp. 65-6301 through 65-6318 and amendments thereto.

(z) "Licensed master social worker" means a person licensed as a master social worker by the behavioral sciences regulatory board under K.S.A. ~~1989~~ *1990* Supp. 65-6301 through 65-6318 and amendments thereto.

(aa) "Secretary" means the secretary of social and rehabilitation services.

(bb) "Osawatomie state hospital catchment area" means the area composed of the following counties: Allen, Anderson, Atchison, Bourbon, Butler, Chautauqua, Cherokee, Cowley, Crawford, Elk, Franklin, Jefferson, Johnson, Labette, Leavenworth, Linn, Miami, Montgomery, Neosho, Wilson, Woodson and Wyandotte.

(cc) "Topeka state hospital catchment area" means the area composed of the following counties: Brown, Chase, Clay, Cloud, Coffey, Dickinson, Doniphan, Douglas, Ellsworth, Geary, Greenwood, Harvey, Jackson, Jewell, Lincoln, Lyon, Marion, Marshall, McPherson, Mitchell, Morris, Nemaha, Osage, Ottawa, Pottawatomie, Republic, Riley, Saline, Sedgwick, Shawnee, Wabaunsee and Washington.

(dd) "Larned state hospital catchment area" means the area composed of the following counties: Barber, Barton, Cheyenne, Clark, Comanche, Decatur, Edwards, Ellis, Finney, Ford, Gove, Graham, Grant, Gray, Greeley, Hamilton, Harper, Haskell, Hodgeman, Kearny, Kingman, Kiowa, Lane, Logan, Meade, Morton, Ness, Norton, Osborne, Pawnee, Phillips, Pratt, Rawlins, Reno, Rice, Rooks, Rush, Russell, Scott, Seward, Sheridan, Sherman, Smith, Stafford, Stanton, Stevens, Sumner, Thomas, Trego, Wallace and Wichita.

(ee) "Catchment area" means the Osawatomie state hospital catchment area, the Topeka state hospital catchment area or the

Larned state hospital catchment area.

(ff) "Direction" means monitoring and oversight including regular, periodic evaluation of services.

Sec. 2. K.S.A. 1990 Supp. 59-2902 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the statute book.

Session of 1991

SENATE BILL No. 20

By Special Committee on Judiciary

Re Proposal No. 42

12-28

AN ACT concerning crimes, punishment and criminal procedure; relating to sex offenders; continuing supervision and treatment after parole, probation, conditional release and completion of term of sentence; amending K.S.A. 21-4501 and 21-4610 and K.S.A. 1990 Supp. 21-4603, 22-3717 and 22-3718 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) In addition to any other sentence authorized by law, the court shall order any person convicted of the commission of any ~~sex offense~~ to receive treatment and supervision by a mental health professional experienced in the care and treatment of sex offenders approved by the court for a period not to exceed 5 years upon the completion of term committed for sentence or as a condition of parole, release on probation, suspension of sentence, assignment to a community correctional services program, conditional release or assignment to a house arrest program.

(b) As used in this act, "~~sex offense~~" means:

(1) Rape, K.S.A. 21-3502, and amendments thereto;

(2) indecent liberties with a child, K.S.A. 21-3503, and amendments thereto;

(3) aggravated indecent liberties with a child, K.S.A. 21-3504, and amendments thereto;

(4) ~~criminal sodomy, K.S.A. 21-3505, and amendments thereto~~;

~~(5)~~ aggravated criminal sodomy, K.S.A. 21-3506, and amendments thereto;

~~(6)~~ enticement of a child, K.S.A. 21-3509, and amendments thereto;

~~(7)~~ indecent solicitation of a child, K.S.A. 21-3510, and amendments thereto;

~~(8)~~ aggravated indecent solicitation of a child, K.S.A. 21-3511, and amendments thereto;

~~(9)~~ sexual exploitation of a child, K.S.A. 21-3516, and amendments thereto;

Proposed amendments to Senate Bill No. 20

sexually violent offense

(5)

(6)

(7)

(8)

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Violent Sex Offenders
Attachment 3

(10) sexual battery, K.S.A. 21-3517, and amendments thereto; (9)

(11) aggravated sexual battery, K.S.A. 21-3518, and amendments thereto; (10)

(12) any conviction for a felony offense in effect at any time prior to the effective date of this act, that is comparable to a sexually violent offense as defined in subparagraphs (1) through (11), or any federal or other state conviction for a felony offense that under the laws of this state would be a sexually violent offense as defined in this subsection; (11)

(13) an attempt, conspiracy or criminal solicitation, as defined in article 33 of chapter 21, and amendments thereto, of a sexually violent offense as defined in this subsection; or (12)

(14) any act of: (13)

(A) Murder in the first degree, K.S.A. 21-3401, and amendments thereto;

(B) murder in the second degree, K.S.A. 21-3402, and amendments thereto;

(C) assault, K.S.A. 21-3408, and amendments thereto;

(D) aggravated assault, K.S.A. 21-3410, and amendments thereto;

(E) battery, K.S.A. 21-3412, and amendments thereto;

(F) aggravated battery, K.S.A. 21-3414, and amendments thereto;

(G) kidnapping, K.S.A. 21-3420, and amendments thereto;

(H) aggravated kidnapping, K.S.A. 21-3421, and amendments thereto;

(I) unlawful restraint, K.S.A. 21-3424, and amendments thereto;

(J) robbery, K.S.A. 21-3426, and amendments thereto; or

(K) aggravated robbery, K.S.A. 21-3427, and amendments thereto, which act, either at the time of sentencing for the offense or subsequently during civil commitment proceedings pursuant to this act, has been determined beyond a reasonable doubt to have been sexually motivated, as that term is defined in K.S.A. 21-3110, and amendments thereto.

Sec. 2. K.S.A. 21-4501 is hereby amended to read as follows: 21-4501. For the purpose of sentencing, the following classes of felonies and terms of imprisonment authorized for each class are established:

(a) Class A, the sentence for which shall be imprisonment for life.

(b) Class B, the sentence for which shall be an indeterminate term of imprisonment, the minimum of which shall be fixed by the court at not less than five years nor more than 15 years and the maximum of which shall be fixed by the court at not less than 20 years nor more than life.

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(c) Class C, the sentence for which shall be an indeterminate term of imprisonment, the minimum of which shall be fixed by the court at not less than three years nor more than five years and the maximum of which shall be fixed by the court at not less than 10 years nor more than 20 years.

(d) Class D, the sentence for which shall be an indeterminate term of imprisonment fixed by the court as follows:

(1) For a crime specified in article 34, 35 or 36 of chapter 21 of the Kansas Statutes Annotated, a minimum of not less than two years nor more than three years and a maximum of not less than five years nor more than 10 years; and

(2) for any other crime, a minimum of not less than one year nor more than three years and a maximum of not less than five years nor more than 10 years.

(e) Class E, the sentence for which shall be an indeterminate term of imprisonment, the minimum of which shall be one year and the maximum of which shall be fixed by the court at not less than two years nor more than five years.

(f) Unclassified felonies, which shall include all crimes declared to be felonies without specification as to class, the sentence for which shall be in accordance with the sentence specified in the statute that defines the crime. If no sentence is provided in the statute, the offender shall be sentenced as for a class E felony.

(g) if a person who is convicted of the commission of a ~~sex offense~~ sexually violent offense *is ordered by the court to receive supervision and treatment by a mental health professional pursuant to section 1, the maximum sentences provided for in this section shall be increased by such period of supervision and treatment ordered by the court.*

Sec. 3. K.S.A. 1990 Supp. 21-4603 is hereby amended to read as follows: 21-4603. (1) Whenever any person has been found guilty of a crime and the court finds that an adequate presentence investigation cannot be conducted by resources available within the judicial district, including mental health centers and mental health clinics, the court may require that a presentence investigation be conducted by the Topeka correctional facility — east or by the state security hospital. If the offender is sent to the Topeka correctional facility — east or the state security hospital for a presentence investigation under this section, the correctional facility or hospital may keep the offender confined for a maximum of 60 days, except that an inmate may be held for a longer period of time on order of the secretary, or until the court calls for the return of the offender. While held at the Topeka correctional facility — east or the state security hospital the defendant may be treated the same as any

person committed to the secretary of corrections or secretary of social and rehabilitation services for purposes of maintaining security and control, discipline, and emergency medical or psychiatric treatment, and general population management except that no such person shall be transferred out of the state or to a federal institution or to any other location unless the transfer is between the correctional facility and the state security hospital. The correctional facility or the state security hospital shall compile a complete mental and physical evaluation of such offender and shall make its findings and recommendations known to the court in the presentence report.

(2) Except as provided in subsection (3), whenever any person has been found guilty of a crime, the court may adjudge any of the following:

(a) Commit the defendant to the custody of the secretary of corrections or, if confinement is for a term less than one year, to jail for the term provided by law;

(b) impose the fine applicable to the offense;

(c) release the defendant on probation subject to such conditions as the court may deem appropriate, including orders requiring full or partial restitution;

(d) suspend the imposition of the sentence subject to such conditions as the court may deem appropriate, including orders requiring full or partial restitution;

(e) assign the defendant to a community correctional services program subject to such conditions as the court may deem appropriate, including orders requiring full or partial restitution;

(f) assign the defendant to a conservation camp for a period not to exceed 180 days;

(g) assign the defendant to a house arrest program pursuant to K.S.A. 21-4603b and amendments thereto;

(h) order the defendant to attend and satisfactorily complete an alcohol or drug education or training program as provided by subsection (3) of K.S.A. 21-4502 and amendments thereto; or

(i) impose any appropriate combination of (a), (b), (c), (d), (e), (f), (g) or (h).

In addition to or in lieu of any of the above, the court shall order the defendant to submit to and complete an alcohol and drug evaluation, and pay a fee therefor, when required by subsection (4) of K.S.A. 21-4502 and amendments thereto.

In addition to any of the above, the court shall order the defendant to receive supervision and treatment by a mental health professional experienced in the care and treatment of sex offenders when required by section 1.

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In imposing a fine the court may authorize the payment thereof in installments. In releasing a defendant on probation, the court shall direct that the defendant be under the supervision of a court services officer. If the court commits the defendant to the custody of the secretary of corrections or to jail, the court may specify in its order the amount of restitution to be paid and the person to whom it shall be paid if restitution is later ordered as a condition of parole or conditional release.

The court in committing a defendant to the custody of the secretary of corrections shall fix a maximum term of confinement within the limits provided by law. In those cases where the law does not fix a maximum term of confinement for the crime for which the defendant was convicted, the court shall fix the maximum term of such confinement. In all cases where the defendant is committed to the custody of the secretary of corrections, the court shall fix the minimum term within the limits provided by law.

(3) Whenever any juvenile felon, as defined in K.S.A. 1990 Supp. 38-16,112, has been found guilty of a class A or B felony, the court shall commit the defendant to the custody of the secretary of corrections and may impose the fine applicable to the offense.

(4) (a) Except when an appeal is taken and determined adversely to the defendant as provided in subsection (4)(b), at any time within 120 days after a sentence is imposed, after probation or assignment to a community correctional services program has been revoked, the court may modify such sentence, revocation of probation or assignment to a community correctional services program by directing that a less severe penalty be imposed in lieu of that originally adjudged within statutory limits and shall modify such sentence if recommended by the Topeka correctional facility — east unless the court finds and sets forth with particularity the reasons for finding that the safety of members of the public will be jeopardized or that the welfare of the inmate will not be served by such modification.

(b) If an appeal is taken and determined adversely to the defendant, such sentence may be modified within 120 days after the receipt by the clerk of the district court of the mandate from the supreme court or court of appeals.

(5) The court shall modify the sentence at any time before the expiration thereof when such modification is recommended by the secretary of corrections unless the court finds and sets forth with particularity the reasons for finding that the safety of members of the public will be jeopardized or that the welfare of the inmate will not be served by such modification. The court shall have the power to impose a less severe penalty upon the inmate, including the power

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to reduce the minimum below the statutory limit on the minimum term prescribed for the crime of which the inmate has been convicted. The recommendation of the secretary of corrections, the hearing on the recommendation and the order of modification shall be made in open court. Notice of the recommendation of modification of sentence and the time and place of the hearing thereon shall be given by the inmate, or by the inmate's legal counsel, at least 21 days prior to the hearing to the county or district attorney of the county where the inmate was convicted. After receipt of such notice and at least 14 days prior to the hearing, the county or district attorney shall give notice of the recommendation of modification of sentence and the time and place of the hearing thereon to any victim of the inmate's crime who is alive and whose address is known to the county or district attorney or, if the victim is deceased, to the victim's next of kin if the next of kin's address is known to the county or district attorney. Proof of service of each notice required to be given by this subsection shall be filed with the court.

(6) After such defendant has been assigned to a conservation camp but prior to the end of 180 days, the chief administrator of such camp shall file a performance report and recommendations with the court. The court shall enter an order based on such report and recommendations modifying the sentence, if appropriate, by sentencing the defendant to any of the authorized dispositions provided in subsection (2), except to reassign such person to a conservation camp as provided in subsection (2)(f).

(7) Dispositions which do not involve commitment to the custody of the secretary of corrections and commitments which are revoked within 120 days shall not entail the loss by the defendant of any civil rights.

(8) This section shall not deprive the court of any authority conferred by any other Kansas statute to decree a forfeiture of property, suspend or cancel a license, remove a person from office, or impose any other civil penalty as a result of conviction of crime.

(9) An application for or acceptance of probation, suspended sentence or assignment to a community correctional services program shall not constitute an acquiescence in the judgment for purpose of appeal, and any convicted person may appeal from such conviction, as provided by law, without regard to whether such person has applied for probation, suspended sentence or assignment to a community correctional services program.

(10) When it is provided by law that a person shall be sentenced pursuant to K.S.A. 1990 Supp. 21-4628, the provisions of this section shall not apply.

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Sec. 4. K.S.A. 21-4610 is hereby amended to read as follows: 21-4610. (1) Except as required by subsection (4), nothing in this section shall be construed to limit the authority of the court to impose or modify any general or specific conditions of probation, suspension of sentence or assignment to a community correctional services program, except that the court shall condition any order granting probation, suspension of sentence or assignment to a community correctional services program on the defendant's obedience of the laws of the United States, the state of Kansas and any other jurisdiction to the laws of which the defendant may be subject.

(2) The court services officer or community correctional services officer may recommend, and the court may order, the imposition of any conditions of probation, suspension of sentence or assignment to a community correctional services program. The court may at any time order the modification of such conditions, after notice to the court services officer or community correctional services officer and an opportunity for such officer to be heard thereon. The court shall cause a copy of any such order to be delivered to the court services officer and the probationer or to the community correctional services officer and the community corrections participant, as the case may be.

(3) The court may impose any conditions of probation, suspension of sentence or assignment to a community correctional services program that the court deems proper, including but not limited to requiring that the defendant:

(a) Avoid such injurious or vicious habits as directed by the court, court services officer or community correctional services officer;

(b) avoid such persons or places of disreputable or harmful character as directed by the court, court services officer or community correctional services officer;

(c) report to the court services officer or community correctional services officer as directed;

(d) permit the court services officer or community correctional services officer to visit the defendant at home or elsewhere;

(e) work faithfully at suitable employment insofar as possible;

(f) remain within the state unless the court grants permission to leave;

(g) pay a fine or costs, applicable to the offense, in one or several sums and in the manner as directed by the court;

(h) support the defendant's dependents;

(i) reside in a residential facility located in the community and participate in educational, counseling, work and other correctional or rehabilitative programs;

(j) perform community or public service work for local governmental agencies, private corporations organized not for profit, or charitable or social service organizations performing services for the community;

(k) perform services under a system of day fines whereby the defendant is required to satisfy fines, costs or reparation or restitution obligations by performing services for a period of days determined by the court on the basis of ability to pay, standard of living, support obligations and other factors; or

(l) participate in a house arrest program pursuant to K.S.A. 21-4603b.

(4) In addition to any other conditions of probation, suspension of sentence or assignment to a community correctional services program, the court shall order the defendant to comply with each of the following conditions:

(a) Make reparation or restitution to the aggrieved party for the damage or loss caused by the defendant's crime, in an amount and manner determined by the court and to the person specified by the court, unless the court finds compelling circumstances which would render a plan of restitution unworkable;

(b) pay the probation or community correctional services fee pursuant to K.S.A. 21-4610a and amendments thereto; ~~and~~

(c) reimburse the state general fund for all or a part of the expenditures by the state board of indigents' defense services to provide counsel and other defense services to the defendant. In determining the amount and method of payment of such sum, the court shall take account of the financial resources of the defendant and the nature of the burden that payment of such sum will impose. A defendant who has been required to pay such sum and who is not willfully in default in the payment thereof may at any time petition the court which sentenced the defendant to waive payment of such sum or of any unpaid portion thereof. If it appears to the satisfaction of the court that payment of the amount due will impose manifest hardship on the defendant or the defendant's immediate family, the court may waive payment of all or part of the amount due or modify the method of payment; *and*

(d) receive supervision and treatment by a mental health professional experienced in the care and treatment of sex offenders as required by section 1.

Sec. 5. K.S.A. 1990 Supp. 22-3717 is hereby amended to read as follows: 22-3717. (a) Except as otherwise provided by this section and K.S.A. 1990 Supp. 21-4628, an inmate, including an inmate sentenced pursuant to K.S.A. 21-4618 and amendments thereto, shall

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be eligible for parole after serving the entire minimum sentence imposed by the court, less good time credits.

(b) An inmate sentenced for a class A felony, including an inmate sentenced pursuant to K.S.A. 21-4618 and amendments thereto but not including an inmate sentenced pursuant to K.S.A. 1990 Supp. 21-4628, shall be eligible for parole after serving 15 years of confinement, without deduction of any good time credits.

(c) Except as provided in subsection (d), if an inmate is sentenced to imprisonment for more than one crime and the sentences run consecutively, the inmate shall be eligible for parole after serving the total of:

(1) The aggregate minimum sentences, as determined pursuant to K.S.A. 21-4608 and amendments thereto, less good time credits for those crimes which are not class A felonies; and

(2) an additional 15 years, without deduction of good time credits, for each crime which is a class A felony.

(d) If an inmate is sentenced to imprisonment for a crime committed while on parole or conditional release, the inmate shall be eligible for parole as provided by subsection (c), except that the Kansas parole board may postpone the inmate's parole eligibility date by assessing a penalty not exceeding the period of time which could have been assessed if the inmate's parole or conditional release had been violated for reasons other than conviction of a crime.

(e) Subject to the provisions of this section, the Kansas parole board may release on parole those persons confined in institutions who are eligible for parole when: (1) The board believes that the inmate should be released for hospitalization, for deportation or to answer the warrant or other process of a court and is of the opinion that there is reasonable probability that the inmate can be released without detriment to the community or to the inmate; or (2) the secretary of corrections has reported to the board in writing that the inmate has satisfactorily completed the programs required by any agreement entered under K.S.A. 75-5210a and amendments thereto, or any revision of such agreement, and the board believes that the inmate is able and willing to fulfill the obligations of a law abiding citizen and is of the opinion that there is reasonable probability that the inmate can be released without detriment to the community or to the inmate. Parole shall not be granted as an award of clemency and shall not be considered a reduction of sentence or a pardon.

(f) The Kansas parole board shall hold a parole hearing during the month prior to the month an inmate will be eligible for parole under subsections (a), (b) and (c). At least the month preceding the

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parole hearing, the county or district attorney of the county where the inmate was convicted shall give written notice of the time and place of the public comment sessions for the inmate to any victim of the inmate's crime who is alive and whose address is known to the county or district attorney or, if the victim is deceased, to the victim's family if the family's address is known to the county or district attorney. Failure to notify pursuant to this section shall not be a reason to postpone a parole hearing. Nothing in this section shall create a cause of action against the state or an employee of the state acting within the scope of the employee's employment as a result of the failure to notify pursuant to this section. If granted parole, the inmate may be released on parole on the date specified by the board, but not earlier than the date the inmate is eligible for parole under subsections (a), (b) and (c). At each parole hearing and, if parole is not granted, at such intervals thereafter as it determines appropriate, the Kansas parole board shall consider: (1) Whether the inmate has satisfactorily completed the programs required by any agreement entered under K.S.A. 75-5210a and amendments thereto, or any revision of such agreement; and (2) all pertinent information regarding such inmate, including, but not limited to, the circumstances of the offense of the inmate; the presentence report; the previous social history and criminal record of the inmate; the conduct, employment, and attitude of the inmate in prison; the reports of such physical and mental examinations as have been made; comments of the victim and the victim's family; comments of the public; official comments; and capacity of state correctional institutions.

(g) Within a reasonable time after an inmate is committed to the custody of the secretary of corrections, a member of the Kansas parole board, or a designee of the board, shall hold an initial informational hearing with such inmate and other inmates.

(h) Before ordering the parole of any inmate, the Kansas parole board shall have the inmate appear before it and shall interview the inmate unless impractical because of the inmate's physical or mental condition or absence from the institution. Every inmate while on parole shall remain in the legal custody of the secretary of corrections and is subject to the orders of the secretary. Whenever the Kansas parole board formally considers placing an inmate on parole and no agreement has been entered into with the inmate under K.S.A. 75-5210a and amendments thereto, the board shall notify the inmate in writing of the specific reasons for not granting parole. If an agreement has been entered under K.S.A. 75-5210a and amendments thereto and the inmate has not satisfactorily completed the programs

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specified in the agreement, or any revision of such agreement, the board shall notify the inmate in writing of the specific programs the inmate must satisfactorily complete before parole will be granted. If parole is not granted only because of a failure to satisfactorily complete such programs, the board shall grant parole upon the secretary's certification that the inmate has successfully completed such programs. If an agreement has been entered under K.S.A. 75-5210a and amendments thereto and the secretary of corrections has reported to the board in writing that the inmate has satisfactorily completed the programs required by such agreement, or any revision thereof, the board shall not require further program participation. However, if the board determines that other pertinent information regarding the inmate warrants the inmate's not being released on parole, the board shall state in detail the specific reasons for not granting the parole. If parole is denied for an inmate sentenced for a crime other than a class A or class B felony, the board shall hold another parole hearing for the inmate not later than one year after the denial. If parole is denied for an inmate sentenced for a class A or class B felony, the board shall hold another parole hearing for the inmate not later than three years after the denial and shall conduct an annual file review for such inmate. Written notice of such annual file review shall be given to the inmate.

(i) Parolees shall be assigned, upon release, to the appropriate level of supervision pursuant to the criteria established by the secretary of corrections.

(j) The Kansas parole board shall adopt rules and regulations in accordance with K.S.A. 77-415 *et seq.*, and amendments thereto, not inconsistent with the law and as it may deem proper or necessary, with respect to the conduct of parole hearings, orders of restitution and other conditions to be imposed upon parolees. Whenever an order for parole is issued it shall recite the conditions thereof.

(k) Whenever the Kansas parole board orders the parole of an inmate, the board:

(1) Unless it finds compelling circumstances which would render a plan of payment unworkable, shall order as a condition of parole that the parolee pay any transportation expenses resulting from returning the parolee to this state to answer criminal charges or a warrant for a violation of a condition of probation, assignment to a community correctional services program, parole or conditional release; and

(2) to the extent practicable, shall order as a condition of parole that the parolee make progress towards or successfully complete the equivalent of a secondary education if the inmate has not previously

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completed such educational equivalent and is capable of doing so.

(l) If the court which sentenced an inmate specified at the time of sentencing the amount and the recipient of any restitution ordered as a condition of parole, the Kansas parole board shall order as a condition of parole that the inmate pay restitution in the amount and manner provided in the journal entry unless the board finds compelling circumstances which would render a plan of restitution unworkable. If the parolee was sentenced before July 1, 1986, and the court did not specify at the time of sentencing the amount and the recipient of any restitution ordered as a condition of parole, the parole board shall order as a condition of parole that the parolee make restitution for the damage or loss caused by the parolee's crime in an amount and manner determined by the board unless the board finds compelling circumstances which would render a plan of restitution unworkable. If the parolee was sentenced on or after July 1, 1986, and the court did not specify at the time of sentencing the amount and the recipient of any restitution ordered as a condition of parole, the parole board shall not order restitution as a condition of parole unless the board finds compelling circumstances which justify such an order.

(m) *If the court which sentenced the inmate ordered at the time of sentencing that the inmate receive supervision and treatment by a mental health professional experienced in the care and treatment of sex offenders as required by section 1, the Kansas parole board shall order as a condition of parole that the inmate receive such supervision and treatment. If ~~the~~ parolee was sentenced before the effective date of this act and the court did not specify at the time of sentencing that the inmate receive such supervision and treatment, the parole board shall order as a condition of parole that the inmate receive such supervision and treatment.*

(n) Whenever the Kansas parole board grants the parole of an inmate, the board, within 10 days of the date of the decision to grant parole, shall give written notice of the decision to the county or district attorney of the county where the inmate was sentenced.

~~(n)~~ *(o)* An inmate shall be eligible for parole on the date provided by statute at the time the inmate committed the crime for which imprisoned unless subsequent amendment of the statute provides an earlier parole eligibility date.

~~(o)~~ *(p)* An inmate who is allocated regular good time credits as provided in K.S.A. 22-3725 and amendments thereto may receive meritorious good time credits in increments of not more than 90 days per meritorious act. These credits may be awarded by the secretary of corrections when an inmate has acted in a heroic or

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who was convicted of a sexually violent offense

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outstanding manner in coming to the assistance of another person in a life threatening situation, preventing injury or death to a person, preventing the destruction of property or taking actions which result in a financial savings to the state.

Sec. 6. K.S.A. 1990 Supp. 22-3718 is hereby amended to read as follows: 22-3718. An inmate who has served the inmate's maximum term or terms, less such work and good behavior credits as have been earned, shall, upon release, be subject to such written rules and conditions as the Kansas parole board may impose, until the expiration of the maximum term or terms for which the inmate was sentenced or until the inmate is otherwise discharged. If the court which sentenced an inmate specified at the time of sentencing the amount and the recipient of any restitution ordered as a condition of release pursuant to this section, the parole board shall order as a condition of release that the inmate pay restitution in the amount and manner provided in the journal entry unless the board finds compelling circumstances which would render a plan of restitution unworkable. If the inmate was sentenced before July 1, 1986, and the court did not specify at the time of sentencing the amount and the recipient of any restitution ordered as a condition of release, the parole board shall order as a condition of release that the inmate make restitution for the damage or loss caused by the inmate's crime in an amount and manner determined by the board unless the board finds compelling circumstances which would render a plan of restitution unworkable. If the inmate was sentenced on or after July 1, 1986, and the court did not specify at the time of sentencing the amount and the recipient of any restitution ordered as a condition of release pursuant to this section, the parole board shall not order restitution as a condition of release unless the board finds compelling circumstances which justify such an order. *If the court which sentenced an inmate specified at the time of sentencing that the inmate receive supervision and treatment by a mental health professional experienced in the care and treatment of sex offenders required by section 1, the parole board shall order as a condition of release that the inmate receive such supervision and treatment. If the inmate was sentenced before the effective date of this act and the court did not specify at the time of sentencing that the inmate receive such supervision and treatment, the parole board shall order as a condition of release that the inmate receive such supervision and treatment.* Prior to the release of any inmate on parole, conditional release or expiration of sentence, if an inmate is released into the community under a program under the supervision of the secretary of corrections, the secretary shall give written notice of such release to any

only who was convicted of a sexually violent offense

victim of the inmate's crime who is alive and whose address is known to the secretary or, if the victim is deceased, to the victim's family if the family's address is known to the secretary. Such notice shall be required to be given to the victim or the victim's family only if the inmate was convicted of any crime in article 34, 35 or 36 of chapter 21 of the Kansas Statutes Annotated. Failure to notify shall not be a reason for postponement of parole, conditional release or other forms of release. Nothing in this section shall create a cause of action against the state or an employee of the state acting within the scope of the employee's employment as a result of the failure to notify pursuant to this section.

Sec. 7. K.S.A. 21-4501 and 21-4610 and K.S.A. 1990 Supp. 21-4603, 22-3717 and 22-3718 are hereby repealed.

Sec. 8. This act shall take effect and be in force from and after its publication in the statute book.

3-14-91

PROPOSAL

SEX OFFENDER TREATMENT PROGRAM

STATE SECURITY HOSPITAL

(Larned, Kansas)

Prepared by:
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Psychology Department
Topeka State Hospital
913-296-4413
February 25, 1991)

Subcommittee - Senate Judiciary
Violent Sex Offenders
Attachment 4

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Preface/Acknowledgments

The treatment of sex offenders is a difficult, intensive and long procedure for which there is some evidence of success (see appendix). The overall goal of such a treatment program is the prevention of continued victimization of the public. Incarceration alone has not proven effective to this end (see appendix). In order for this treatment to be carried out successfully, as determined by my research, the following are **required** characteristics:

1. The treatment program **must** have control over who is admitted to the program for treatment and who stays in the program, (to this end the program should also have both an evaluation and a treatment component);

2. The treatment program **must** have adequate provision for security to protect staff, program residents, other hospital residents and the community at large;

3. The treatment program **must** have adequate staffing in terms of numbers, qualifications and gender representation;

4. The treatment program **must** have adequate funding not only for staff, but for materials and staff training, and for adequate space to carry out its assigned tasks;

5. The treatment program **must** have adequate provisions for aftercare.

The treatment of sex offenders in a mental health setting is a high risk venture. If the treatment program does not have the required characteristics the risks to personnel, patients and potential victims increases leaving the agency liable legally, financially and politically. The author of this proposal would like to state clearly that **if the resources are not available to establish and maintain such a program as indicated above and elsewhere in this proposal that such a program should not be established.** To do otherwise places both individuals and the agency at high risk.

The author of this proposal would like to acknowledge the generous assistance of Richard Seely and his staff at the Intensive Treatment Program for Sexual Aggressives at the Minnesota Security Hospital in St. Peter, Minnesota, Gerald Kaplan and his staff at Alpha Human Services in Minneapolis, Minnesota and many, many others who have given of their time, their material and their ideas. This proposal was drawn heavily from the above programs.

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I. Background/Philosophy

This program proposal is the outgrowth of a response to interest in the Kansas Legislature regarding the effective treatment of sex offenders in Kansas (see appendix). As the result of that initial review it was discovered that the technology for the effective treatment of a selected group of sexual offenders has been developed in the United States and such a program could be set up in Kansas.

In setting up a treatment program for sexual offenders the protection of society is the ultimate goal. One study by a well known researcher reported upwards of over 300 victims and over 500 offenses for each child molester. Even if these figures are inflated (Dr. Abel is one of the foremost researchers in the field in the United States) the potential for victimization is massive. Simply incarcerating offenders has little effect on recidivism. However, with the present technology, only a subgroup of offenders can be treated effectively. Given the high rates of victimization (and the possible major aftereffects of the traumatization) helping even a limited number of these offenders can be of great benefit to society. Then, "rehabilitation of the offender who desires such treatment provides greater protection than simple imprisonment. Control, resocialization, and community reintegration are the three essential elements of rehabilitation of sexual offenders."[1] The treatment program, while humane, imposes strict control on the offenders not simply in terms of the physical constraints which are inherent in the security of the building but in the holding of the offender accountable and responsible for his present and past actions, its consequences and the thoughts, feelings and fantasies underlying such behavior.

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[1]Richard Seely. A Decade of Evaluating and Treating Sex Offenders:Program Development and Outcomes 1975-1985. Minnesota Security Hospital, St. Peter, Minnesota

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II. Goals of Treatment

*GOAL ONE:

Each sex offender will receive a complete, individualized assessment and treatment plan; effective initial and ongoing assessment are prerequisites for successful treatment.

*GOAL TWO:

Each sex offender will (a) accept responsibility for the offense(s) in which he has been involved and (b) gain an understanding of the sequence of thoughts, feelings. events, circumstances, and arousal stimuli that make up the "offense syndrome" that precedes his involvement in sexually aggressive behaviors.

*GOAL THREE:

Each sex offender will learn how to (a) intervene in on or break into his offense pattern at its very first sign and (b) call upon the appropriate methods, tools, or procedures he has learned, in order to suppress, control, manage, and stop the behavior.

*GOAL FOUR:

Each sex offender will engage in a re-education and resocialization process in order to (a) replace antisocial thoughts and behaviors with prosocial ones, (b) acquire a positive self-concept and new attitudes and expectations for himself, and (c) learn new social and sexual skills to help cultivate positive, satisfying, pleasurable, and nonthreatening relationships with others.

*GOAL FIVE:

Each residential sex offender needs a prolonged period during his treatment when he can begin to test safely his newly acquired insights and control mechanisms, in the community, without the potential for affronting or harming members of the wider community.

*GOAL SIX:

Each sex offender needs (a) post-treatment support, peer, or "rap" group and (b) continual postrelease access to therapeutic treatment so he can maintain permanently a safe lifestyle.[2]

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*Used with permission. Fay Knopp,(1984), **Retraining Adult Sex Offenders: Methods & Models**, Safer Society Press

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III. Organizational Chart/Staffing

Staffing for a sex offender is, of necessity, high due to the intensive nature of the evaluation and treatment process. With exception of the Program Director, staffing will be discussed by discipline. Staffing has been determined at two levels: the first year for 25 beds and he second year doubling to 50 beds (see Section X.). It is essential that at least half of the staff be female as so many of the victims are female, and the offenders must learn to relate to females. An example of how this was handled in Minnesota is in the appendix.

Program Director:

This is the key staff member of the program. As the recruitment of other professional staff trained in working with sex offenders will be difficult, if not impossible, the major responsibility for the development and implementation will rest with this individual. He/she will be responsible for setting up the intake procedure, evaluation procedure, the milieu, the group program, and the community interface as well as supervising the work of the plethysmography lab, the chemical dependency subprogram, the recreation program and the education program. The Director will be responsible for chairing all team and treatment planning meetings. This person will be responsible for coordinating all aspects of the program. Direct, broad based, experience in working with this population in a residential setting will be required.

Psychiatry:

The psychiatrist on the unit will be responsible for the admitting psychiatric evaluation, will oversee the Master Treatment Plans and will attend all treatment planning meetings, will be responsible for all medical aspects of care such as referral for medical consultation, prescription and monitoring of medication including the possible use of Depo Provera (which requires careful monitoring for side effects). The psychiatrist will also be responsible for hospital discharge summaries.

Psychology:

One of the psychology positions (Psy. III) will serve as the discipline supervisor on the unit. One of the positions (Psy. II) will be designated as program evaluation, which will be a research, as opposed to a clinical position. Given the nature of the program it is necessary that feedback be available as to the function of various components of the program as well as to assemble meaningful recidivism data. The Psychologist III and other Psychologist II's will perform the psychological assessments on the programs

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III. Organizational Chart/Staffing cont.

patients, perform the plethysmological assessments (these take about 4 hours each), perform plethysmographical assisted behavior therapy for selected patients on referral, serve as a therapy supervisor for assigned patients, and be involved in the group program e.g. Community Group, Small Therapy Group, etc. The psychologists will attend all team and treatment planning meetings and will participate in the treatment planning process.

Social Work:

One of the social work positions (S.W. III) will serve as the discipline supervisor on the unit. The social workers will be responsible for the gathering of the social histories and the sexual histories, will serve as case managers on assigned cases and will perform the community interface on these cases, will be responsible, with the Program Director, for setting up and maintaining the aftercare release program may serve as a therapy supervisor and may do a group.

Nursing:

The R.N.s will be responsible for supervising the LMHTs and the Mental Health Aides, will be responsible for the nursing assessments, the nursing care plans, for ensuring patient hygiene and health care, for the passing of medications and other routine nursing duties. The R.N.s will attend the team and treatment planning meetings and participate in the treatment planning process. The LMHTs will be responsible for the security of the unit, its staff and its patients, and for carrying out aspects of the nursing care plan under the supervision of the R.N.s.

Activity Therapy:

These are seen as recreation therapy positions. These staff will be responsible for the Rehabilitation Evaluation of each patient's social skills, living skills, recreation skills, etc. They will teach how to use recreation activities for social interaction, teach the use of activities to release anger and tension, teach social and living skills in the group process and will assist patients in planning recreation and social activities during their transition when they are planning community reentry. The activity therapists will attend all team and treatment planning meetings and participate in the treatment planning process.

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III. Organizational Chart/Staffing cont.

Education:

The educator on the program will evaluate the educational backgrounds, level of educational achievement and educational needs of the programs patients. If indicated the educator will develop plans for assisting program patients in completing their education and provide remedial education in a classroom setting to this end.

Vocational Rehabilitation:

The VR counselor will perform an evaluation on each program patient to assess their work history and employability. On the basis of these findings the VR counselor will make recommendations to the team as to the level of work on the unit the patient can perform, as well as work off of the unit when the patient has earned the privilege. The counselor will coordinate with work sites in other parts of the hospital to facilitate this process when indicated.

Chemical Dependency:

The Alcoholism Counselor will perform chemical dependency assessments on each of the programs patients. The counselor will recommend to the treatment team what chemical dependency treatment interventions are needed, and will provide a group process to facilitate meeting these needs on referral.

Secretarial:

The secretary will be responsible for answering the unit phone, maintaining the records, typing the reports, etc.

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IV. Intake Procedure/Criteria

All requests for admission to either component of the program, Evaluation or Treatment, would go directly to the designated intake coordinator of the program. The coordinator would request all available material, discuss the case with knowledgeable individuals in the community e.g. probation officer, district attorney, defense attorney, corrections staff, etc. and pass the material on to the treatment team for staffing. The criteria for each component is as follows:

Evaluation Program

1. The proposed patient must have been adjudicated a sex offender by a Kansas court;

2. The proposed patient must have served all but three (3) years of his sentence **or** be given a stay of execution of his sentence by the court with the provision that he successfully complete the residential and aftercare portions of the treatment program (as determined by the program staff);

3. The proposed patient is non-violent in residence (not necessarily criminal offence);

4. The proposed patient is not suffering from mental retardation (i.e. IQ below 70);

5. The proposed patient is not psychotic. Psychotic patients can not tolerate the pressure and confrontation found in the program.

Treatment Program

1. The proposed patient meets the criteria for the Evaluation Program (see above);

2. *[3] The proposed patient admits to being a sexual offender. This usually includes acknowledgement of a history of sexual behavior which has been hurtful to others. (This refers to a pattern of sexually deviant behavior as opposed to a single incident);

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[3]*Used by permission. Richard Seely, A Decade of Evaluating and Treating Sex Offenders: Program Development and Outcomes 1974-1985, Minnesota Security Hospital, St. Peter, Minnesota

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IV. Intake Procedure/Criteria cont

3. *The proposed patient appears motivated to participate in the program with the goal of learning new ways to behave;

4. *The proposed patient demonstrates am ability to understand the concepts of the treatment process. Normal intelligence and at least minimal literacy are seen as necessary to successful participation;

5. *The patient does not require a more (or less) secure setting. Men with a history of extreme physical violence or escaping impose a continuing threat to the peer community of the program;

6. *The court of jurisdiction is willing to consider release to the community within two to three years.

7. The report of the final staffing from the proposed patient's evaluation by the program recommended that the proposed patient be offered treatment within the program. (This reports summarizes the entire evaluative process of the evaluation program and presents the teams judgment as to treatability within the setting).

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V. Evaluation Program*

The evaluation process for adjudicated sex offenders involves a multidisciplinary team assessment assisted by the feedback from other patients in the program. The evaluation period is for 30 days at the end of which a final review is held with the results of this staffing being summarized for the court or corrections department in letter form. These other offenders with similar problems provide the person being evaluated with a basis to compare himself concerning himself and the program. The openness of the small treatment groups helps the offender to get past his initial defensiveness to acknowledge the problems caused to himself and to others by how their sexuality has been expressed. Information is given to the offender concerning how he is to conduct himself, including the unit rules, during the evaluation period. (see appendix)

Multidisciplinary Assessment:

1. Physical Examination - Each patient would receive a standard physical, lab work, X-rays, etc. as performed at L.S.H.

2. Psychiatric Examination - Each patient would receive a standard admission evaluation performed by the attending psychiatrist as performed at L.S.H.

3. Nursing Assessment - Each patient would receive a standard nursing evaluation as performed at L.S.H.

4. Psychological Assessment - Each patient would receive a standard assessment by a psychologist consisting of interview and testing with the additional emphasis on the areas of ego strength, impulse control, defensiveness, maturity and capacity for empathy.

5. Plethysmographical Assessment - Each patient would receive a standard plethysmographical assessment, performed by a psychologist, to assess arousal patterns to normal and deviant stimuli.

6. Social History - Each patient would have an extensive social history taken by a social worker with special emphasis on physical and sexual trauma.

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*The evaluation component of this proposal has been adapted from the Intensive Treatment Program for Sexual Aggressives at the Minnesota Security Hospital, St. Peter, Minnesota

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V. Evaluation Program cont.

7. Sexual History - Each patient would have an extensive sexual history taken by a social worker (see appendix for an example).

8. Educational Evaluation - Each patient would have an evaluation of their educational history and current needs performed by the educational evaluator. This would focus specially on the need for remedial coursework to finish high school or pass the GED examinations.

9. Vocational Evaluation - Each patient would receive a standard vocational evaluation performed by the vocational counselor with the focus being on the individual's ability to achieve self-sufficiency in employment.

10. Rehabilitation Services Evaluation - Each patient would receive a rehabilitation services evaluation performed by an activity therapist focusing on social skills, recreational skills and living skills.

11. Chemical Dependency Evaluation - Each patient would receive a standard chemical dependency evaluation as performed by the alcoholism counselor with emphasis on the need for chemical dependency treatment.

Unit Evaluation:

During the evaluation program the patient is expected to fully participate in on-unit treatment, educational and recreational activities. Each patient is assigned to a small therapy group and to a "big brother" within that group, who along with other group members is expected to orient the new evaluation patient to the unit. Each evaluation patient is expected to complete an extensive autobiography (see appendix) and to participate in the evaluation orientation and support group. Each member of the evaluation patient's small group gives his impressions and recommendations in writing (see appendix) at the end of the evaluation period. The patient completes his own evaluation outcome statement (see appendix).

Team Review:

On the day of admission to the evaluation program team members meet with the patient to acquaint themselves with him and to explain the evaluation process to him. A first review is held 10 days after admission to formulate the Master Treatment Plan and to share preliminary impressions regarding the patient. At the end of

V. Evaluation Program cont.

the 30 day evaluation period a review meeting is held at which all of the findings from all of the evaluations/assessments are given, including the assessments by the patient's peers, reports from the patient's group leaders, and other impressions formed by the staff during the 30 day period. The written statement by the evaluation patient is then read to the assembled team. If a representative from an outside agency, etc. (e.g. district attorney, corrections representative, etc.) is present they are them asked to express their concerns. The team then discusses whether or not this patient is in need of this treatment program and whether the patient has the ability/motivation for the program to be effective for him. In selecting candidates for the program several criteria are used:

1. The patient admits to being a sexual offender, including acknowledgement of a history of sexual behavior which has been harmful to others.

2. The patient has the motivation to participate in the treatment program with the goal of learning alternative behavior patterns.

3. The patient has the ability to understand the treatment process. This normally includes normal intelligence and at least minimal literacy.

4. The court is willing to consider releasing the patient to the community within two to three years. It is assumed that satisfactory movement through the program should lead directly to community re-entry. If the court foresees a long period of incarceration, admission should be deferred until the sex offender is within two to three years of his projected release date.

Contraindications to treatment in the program are as follows:

1. Patients who are actively psychotic, or at risk of decompensating are not capable of insightful change by means of peer pressure and should not be subjected to it.

2. Patients who require a more secure setting due to a history of major physical violence or escape would pose a threat to the less intense security of the program.

A final report is sent back to the court which summarizes the results of all the evaluations and presents the teams decision regarding the patient's suitability for treatment in this setting.

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V. Evaluation Program cont.

If the person is coming directly from the court and treatment in this setting is recommended it is requested that the individual be sentenced, that the sentence be stayed with the individual placed on probation stipulating that he enter and successfully complete both the inpatient and aftercare components of the program. Copies

of the social and psychological assessments accompany this report to the court. If the individual is coming from the correction system as stipulated two to three years prior to expected release then a copy of the above is also sent back to corrections.

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VI. Treatment Program[5]

General:

The programs provides a very intense structured, consistent and unexploitable environment with strong limits of opportunities to interfere with relationships and be exploitive. Simultaneously, attention is paid to the needs of the individual patients as they progress through the stages of treatment. Balancing these two needs for unexploitable structure and responsiveness to individual patient needs is demanding and requires considerable and open communication among staff members and between staff and the patient population. To assist in this process all individual patient requests flow through their small therapy group and then to the interdisciplinary team (and beyond if necessary) for approval.

The treatment itself is multi-modal and multi-disciplinary involving elements of the therapeutic community, behavioral and cognitive approaches, group process, education and recreation.

On admission each patient is assigned to a room with other patients (no patient is allowed to have his own room) so that involvement with other members of the community is constant. Room assignments rotate every four months to interfere with the formation of cliques and to encourage a broader range of interaction. Each new patient is assigned to a "big brother" who is a more experienced member of the program who can assist through the initial, and often stressful, first four weeks. After the fourth week a new "big brother" is assigned by rotation every week so that they patient experiences a relationship with all residents over time. The role of the "big brother" is for support in dealing with the stress of the program. All residents refer to each other as "brother" which recognizes the intense, family role which the patients have with each other. Also on admission each patient is assigned to a case manager, one of the social work staff who will follow his case during his stay and serve as the interface with the outside world including writing reports to the courts, etc. Also each patient is assigned to a therapy supervisor (all disciplines) who meets with the patient weekly to discuss various treatment issues and who works with the case manager to develop ideas for the patient's treatment planning. The therapy supervisor develops the daily schedule for the patient on the basis of the Master Treatment Plan developed by the interdisciplinary team.

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[5]The treatment program described here, with a few exceptions, follows almost exactly that developed by the Intensive Treatment Program for Sexual Aggressives, St. Peter, Minnesota, and is used here with the very kind permission of Richard Seely, Program Director.

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VI. Treatment Program cont.

Phases of Treatment - Basic Sex Offender Program:

This component was taken directly from I.T.P.S.A. material which can be found in more detail in the appendix.

PHASE I - Early Inpatient Treatment: Clarification of Problems and Full Involvement in the Treatment Program

1. Focus on unit-based relationships and issues, i.e. minimize contact with family and friends and avoid establishing new relationships outside the hospital,

2. Demonstrate increasing and caring involvement in group process and life of therapeutic community.

3. Demonstrate understanding of program philosophy.

4. Adopt a help-seeking attitude with minimal evidence of "victim's stance" thinking.

PHASE II - Middle Inpatient Treatment: Initiation of Changes in Sexuality and Interpersonal Relationships

1. Clearly describe the impact of abuse history.

2. Increase and refine responsible and empathetic leadership in group and therapeutic community.

3. Develop plan and begin to change deviant sexuality and dysfunctional relationships.

4. Develop improved problem-solving skills including identification of a number of options available in problem situations.

5. Maintain relationships with peers which are characterized by active, enthusiastic involvement, assertive communication and commitment.

6. Demonstrate continuing growth in:
   a. the ability to consider consequences for behavior before acting;
   b. the ability to consider the rights and feelings of others before acting; and
   c. the ability to delay gratification of wants and needs.

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VI. Treatment Program cont.

PHASE III - Late Inpatient Treatment: Refinement and Generalization of Changes

1. Report effective control of high-risk fantasies.

2. Spontaneously and self-critically bring personal problems to group.

3. Demonstrate effective use of methods for preventing relapse to full abuse pattern as outside relationships are reestablished.

4. Consistently display responsible and empathic involvement in group and therapeutic community while supporting emerging leadership of residents in Phase II.

5. Expression of feelings is assertive, non-aggressive and non-manipulative.

6. Identify what has changed, what still needs change and how future life will be structured differently in light of these awarenesses.

7. Develop preliminary transition options.

8. Utilize a logical progression of passes to build support system and explore transition options.

PHASE IV - Transition: The Individual Carries Newly Learned Ways of Thinking and Behaving into Life in the Community with the Treatment Program Offering Support and Feedback

1. Report maintenance of effective control of high-risk fantasies.

2. Demonstrate effective use of relapse prevention techniques.

3. Offer responsible and empathetic involvement in group and therapeutic community, especially with residents in Phase III who are preparing for transition.

4. Specify and carry out release plan.

5. Continue involvement in mature, non-exploitive, and growth-producing activities and relationships.

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VI. Treatment Program cont.

6. Ongoing reporting of all sexual activities.

7. Continued abstinence from mood altering chemicals.

Therapeutic Community/Milieu:

The milieu of the therapeutic community is intense and is oriented around mutual concern for each other's progress. The responsibility and accountably of each individual for their behavior **as well as for their thoughts and fantasies** is its major focus. Each "brother" is expected to "support" each other brother by assisting him in dealing with the stress, thoughts, feelings, fantasies and positive behaviors, helping him resist the temptation of engaging in negative behaviors and to bring any of these concerns to the attention of the program. Behavioral infractions are recorded in the unit "issues book" which discussed at the Community Meeting every morning. Entries in this book consist of the infraction and the names of the perpetrator and the witness. Other problem areas are submitted in writing to one of the small therapy group leaders for discussion there. The same procedure is followed for positives observed by each other. Brothers are required at various phases in the treatment program to support other brothers during telephone calls, cigarette breaks, etc.

Group Program:

Small Therapy Group - This group, along with the milieu, represents the heart of the therapy program. This group in the place where everything going on with the patient is processed. It consists of 12-13 group members with 2-3 therapists, at least one of whom is female. One of the leaders, in sequence, rotates to another group every 6 months in order to decrease the members reliance on the leaders and focus more on each other for support. This also presents a framework for dealing with loss and feelings of rejection, which the group members will have to deal with in the future. This group represents a microcosm of everything which is going on in the patient's life, and as such will work on issues arising on the unit, in others groups and aspects of treatment, relationships, the history of offence and other sexual issues, and so on. In this group **everything** is open to discussion. Dealing with responsibility and accountability for oneself in every action and relationship is stressed, no matter how small the issue (e.g. leaving one's coffee cup around for another to pick up) with the material then being tied back to the sexual offense the member committed in terms of errors of thinking and the sequence leading up to reoffense. Both deviant and normal masturbation fantasies

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VI. Treatment Program cont.

are discussed as they apply to the members offense sequence. Group members offer suggestions as to how to cope with these difficulties. Victim empathy is stressed and taught (the author is indebted to the staff of the Alpha Human Services program in Minneapolis, Minnesota for demonstrating how this is accomplished). Assignments given both by the group and others are read here with feedback given. Each group will have an Expectation Board with the assigned expectation each member is to be working on currently written upon it (the author is again indebted to Alpha Human Services for this idea). It is not possible to cover all that this group represents as it is, as stated above, the place where everything going on with the patient is processed.

Sex Education - In this group information is presented dealing with normal and deviant sexuality and sexual development as well as the effects of traumatic experiences on that development. At intervals a Sexual Attitude Reassessment Seminar may be held as an intensive experience to assist members (and staff) in viewing sexuality as a normal experience as well as how other issues become involved leading to deviant behavior.

Human Relations & Communication Skills - This groups deals with various issues of interpersonal relationships, with a strong focus on intimacy, sex role stereotyping and its effects and how to build positive relationships. Included in this is basic communication skills required to relate to others effectively and to be understood.

Chemical Dependency - As many of the offenders in the program have problems with chemical dependency involved in some way with their problems, both with life in general and with their offense, this group which in actuality represents a subprogram, is provided. After an individual has been determined to need this group as part of the chemical dependency assessment he is assigned to this group. There are 15 steps to the program (see appendix) which parallels the steps of the general program. Educational material such as tapes, films and reading materials are presented. Issues dealing with primary chemical dependency are dealt with in this group while issues relating to the offense pattern are referred back to the small therapy group.

Family of Origin Group - This group examines the contributions of family experiences on the offender. There is some evidence that many offenders may have been physically or sexually themselves as children. Each offender completes a family "genogram" and discusses the influence of the members and relationships on him.

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VI. Treatment Program cont.

Anger & Stress Management - This group teaches various concrete procedures for dealing with anger and stress management with the opportunity for practice and feedback.

Recreation & Physical Anger Management - This group teaches and provides the opportunity for normal recreation activities, emphasizing the social aspects and deemphasizing competition. In addition physical outlets for releasing anger are taught with opportunity for practice (e.g. using a punching bag, aerobics, etc.).

Transition Group - This group deals with those patients in Phase IV who are preparing to leave the hospital (as well as those patients on aftercare release who are able to return) and deals with issues involved in making the adjustment to community living.

Individual Program:

Case Management - Each patient meets with his case manager every two weeks for a general review of where he is in treatment. Also issues related to legal status and to the outside world, such as family, financial difficulties, etc. are discussed.

Therapy Supervisor - Each patient meets with his therapy supervisor weekly to review how treatment is progressing. Problems in relating to the treatment program are discussed with the supervisor offering suggestions as to how to deal with these challenges in the program. This meeting is not to be seen as a place to manipulate against the program but rather as a place to problem solve as to how to make the best use of the program.

Behavior Therapy - This modality is available for selected patients who also elect agree to participate with informed consent. This treatment involves the use of plethysmography as a source of psychophysiological feedback (biofeedback) to use in changing arousal patterns to deviant stimuli.

Self Study - This is the procedure by which the patient learns and thinks about his sexual deviancy not initially involving feedback from others, although the expectation is that what is learned from this process is shared with the small therapy group at the least. Each patient is expected to keep and maintain a daily journal of his thoughts, feelings, fantasies and experiences. In this journal he is to record his growing understanding of his

VI. Treatment Program cont.

sequence from the very first component through all the thoughts, emotions, fantasies and behaviors which lead up to the behavioral sex offense.

The patient is given a list of books to read as well as specified written assignments to complete and present to his small therapy group (see appendix). During the course of his treatment he may be asked to write other "concept papers" dealing with some issue which has come up and to then present this paper to his small therapy group.

Medication - Psychiatric medication would be prescribed and monitored by the unit psychiatrist. In addition depo provera would be available for selected patients whose sex drive is so high, and who are not responding to other therapeutic techniques, that they would fail in treatment without this "last ditch" effort. The use of depo provera would be on a voluntary basis and would require obtaining FDA approval for its use with this population.

Education - Following from the results of the educational evaluation the patient may be placed in a course of study on the unit with the objective of attaining a high school education through attaining a diploma or passing the GED examinations.

Vocational Rehabilitation - Each individual will be expected to carry out some work tasks on the unit. As his privileges and progress in the program advances the vocational counselor may meet with the patient for counseling regarding vocational opportunities on the hospital grounds. Towards the end to the patient's treatment, i.e. Transition Phase, the counselor will meet with the patient to discuss vocational and/or vocational educational needs and opportunities in the outside community.

Family Component - Due to the geographic distance of the program from the main population centers the author does not see much opportunity for direct family work. (Also many sex offenders lose their family contacts when their offense comes to light.) However, the case manager will keep in contact with those family members who wish continuing contact. Also, if indicated, further family treatment can be arranged on an individual basis.

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VII. Demission, Aftercare, Discharge

Demission:

It is understood that not all patients accepted into the program will be able to complete the program and will need to be returned to the court and/or the correctional system. This is required to maintain the programs ability to function and without which the entire program for all patients is jeopardized. Any decision to demit a patient will always be a team decision made with the approval of the program director and the unit psychiatrist. The following are reasons for demittance[6]:

1. Assaults
2. Threats
3. Fire-setting
4. Sexual activity with others
5. AWOL attempts
6. Non-prescribed chemical use
7. Violation of release conditions related to sexual behavior
8. Violation of condition of probation
9. Assisting others in these behaviors
10. Major violation of unit rules
11. Failure to attend group therapy, community meetings, full-unit meetings or treatment planning meetings
12. Failure to adhere to conditions of aftercare release
13. Minor violations of program rules
14. Patient requests to leave program

All of the above are to documented in the patient medical record. At team meeting will be held at the earliest possible time to discuss the events and to make a decision regarding demission which is then reviewed by the program director and unit psychiatrist for approval. If the decision to demit is made the patient's probation officer or the appropriate corrections personnel, as well as the court are notified immediately and arrangements for transportation made.

Aftercare:

The aftercare component of the program is the area with the least development as Kansas does not at present have a system in place geared to working with sex offenders leaving

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[6]These reasons for demittance were adopted from the Intensive Treatment Programs for Sexual Aggressives, Minnesota Security Hospital, St. Peter, Minnesota

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VII. Demission, Aftercare, Discharge cont.

residential treatment and following them on an outpatient basis. As the program will not be located near major population centers a program of returning for weekend stays will be difficult to implement. However, both the staff at the Intensive Treatment Program for Sexual Aggressives (St. Peter, Minnesota) and the staff at the Alpha Human Services program (a community based residential treatment program in Minneapolis, Minnesota) stated that the community re-entry phase was the most critical and risky part of the treatment program and required care and careful monitoring. For this component to work in Kansas funds would have to be made available to develop services in the community, possibly on a fee for service in less populated areas and as a grant in areas with more sex offenders. Possibilities would include programs which are already dealing with domestic violence or incest or others who may have specific skills and are already working in this area. The social work staff would be expected to travel to the communities where an offender could return and begin to implement the necessary community interface some time before the patient would actually leave. Program staff would be expected to provide training and ongoing support to any community based treaters working with offenders on aftercare release from the program. At intervals the traveling social work staff would be expected to meet face to face with the offenders in the community to assess the patient's progress, and possible need for return (or incarceration) for him/herself. The availability of an 800 telephone number for the program is strongly recommended so that an offender on aftercare release would be able to call for support at any time.

It is the expectation that after approximately two to three years and the patient has successfully worked his way through the steps of the program that he will be considered for aftercare release. During such period the patient will remain a patient of the hospital on the proper type of leave. When staff believe that a patient has reached this point in treatment a special meeting is set up to make a final evaluation of the patients readiness. All interested parties including the court, district attorney, probation officer, etc. are notified and asked to attend. At this meeting the patient's progress is summarized, written statements from the patient himself and the members of the patient's small therapy group are read and the patient himself is present to present his case. The patient may also invite in the members of his small therapy group to be present if he desires. A decision is then made as to whether the patient is ready for aftercare release with all present. After this meeting a complete aftercare contract is drawn up by the patient and his case manager for presentation to the team for approval. Examples of what such a contract might

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VII. Demission, Aftercare, Discharge cont.

contain are as follows[7]:

1. A full description of living arrangements.

2. Means of financial support.

3. The name, address and phone number of the aftercare case manager, the probation/parole officer, as well as other support persons in the community.

4. The exact nature of community treatment to be followed e.g. individual meetings with therapists, expected attendance at listed support group meetings.

5. A thorough description of the recovering offender's deviant outlet including the age and sex of victims, the pre-assault process, observable behavioral cues, fantasy and thought patterns and actual sexually deviant activities.

6. A complete description of the specific interventions to be used at each stage which have the greatest potential for interrupting the pre-assault pattern.

7. Methods to avoid relapse should be spelled out in detail. This would include behaviors, activities, persons, situations or locations which are likely to sabotage the aftercare plan should be listed and avoided as indicated. Use of chemicals and pornography should be specifically addressed.

8. Plans for education and/or employment.

9. A thorough description of the patient's plan to reintegrate himself socially back into the community, which would include current relationship plans.

This plan is then shared with the court, the probation/parole officer, community case manager, and other involved community treatment staff for approval. After such approval is granted the patient is then moved into the community with the assistance of the staff. As a note such patients should not be allowed to live alone

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[7]Adapted from B.K. Schwartz & H.R. Cellini (Eds) A Practitioner's Guide to Treating the Incarcerated Male Sex Offender. US Department of Jus, Nat. In. ofCorr., 1988, p. 143

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and if possible should be placed with successful graduates of the program.

Discharge:

Approximately 24 months after the patient has been placed on aftercare release status a final staffing is held involving the treatment team and everyone from the community side who can attend. The reports from those who have been following the patient for the 24 months in the community are read and those who have been in contact with the patient report on their assessment of the patient. If it appears that the patient has completed both inpatient and aftercare components of the program successfully and the staff feel that the patient is ready the decision for discharge can be made. At this point a letter is sent to the court outlining the teams assessment of the patient's progress in the aftercare component, with recommendations for any followup monitoring in the community.

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VIII. Staff Training

There are several factors which make staff training a critical component to this proposal. First, the patient population is one which places staff, other patients (both on and off ward), and vulnerable individuals in the community at serious risk. Second, given both the geographic location of Larned State Hospital and the relative scarcity of professionals trained to work with population, it is highly unlikely that trained staff can be recruited for the program. Third, if this patient population is not given state of the art treatment and relapse occurs the agency then comes under serious legal and financial risk.

There are four basic categories of staff training[8].

Procedural and Operational Training:

This covers the basic orientation, education and training given to all employees of Larned State Hospital and the State Security Hospital. This would include CPR and MANDT training.

Program Philosophy, Goals, and Staff Expectations:

Staff should clearly understand the theory involved in the understanding of the sex offender patients and of the approaches to the treatment. This would include the range of sex offenders and specifically the types this program will serve.

Staff should be trained in the guidelines and expectations for staff/client interactions. This is an area of particular concern requiring periodic inservice training. The use of role play and discussion regarding areas of specific concern in interacting with patients is useful for refining and improving relationship skills.

One area of particular concern is that the close interaction with sex offenders may trigger strong reactions which interfere with staff's ability to remain objective. This needs to be attended to regularly in inservice programs and other staff meetings.

Psychological Dynamics of Sex Offenders:

This represents a continuing and ongoing need for which there are many scattered sources. Much of this area would be the

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[8]These training categories are taken from A Practitioner's Guide to Treating the Incarcerated Male Sex Offender: Breaking the Abuse Cycle, US Dept. of Justice, Nat. Inst. of Corr., 1988

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XIII. Staff Training cont.

responsibility of the Program Director and the resource trainers brought in to the program to present workshops. The only "canned" program found by the author was developed by The North Florida Evaluation and Training Center[9] but this author cannot state how good this program is. The key modules in this program are:

-A description of the sex offender program at North Florida Evaluation and Treatment Center.

-Etiological factors in sexual deviance.

-Behavioral manifestations exhibited by offenders.

-How to achieve and demonstrate a neutral stance in client interactions.

-Skills needed for appropriate interactions with clients.

-Crisis prevention and intervention.

-Treatment modalities.

-Documentation of treatment progress.

Specialized Sex Offender Treatment Techniques:

These techniques are primarily performed in groups so an understanding of basic group process is necessary. The small therapy groups are often highly confrontive and geared toward breaking down offender denial or minimization. This requires knowledge of antecedents of sexually deviant behavior, emotional and cognitive problems characteristic of sex offenders, problem-solving, etc. and how these issues are likely to be played out between the members of the group. The group leader will need to understand irrational and criminal thinking patterns which contribute to the offenders sexual deviancy and how to address this in group process. Knowledge of the process and consequences of victimization as well as how to train offenders in empathy (the author gratefully acknowledges the staff of Alpha Human Services, Minneapolis, Minnesota, for their sharing this technique with him).

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[9]Karb, M.P., Wheeler, P.T., Hutchinson, D. & Shaver, C. Specialized Training for Human Services Workers in Sex Offender Treatment. Gainesville, FL:N. Florida Eval. & Treat. Center, 1985

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VIII. Staff Training cont.

Program staff will need to be trained regarding the interface of this program with the community. This is important in all interactions with those outside of the program as sex offenders stir a great deal of concern and especially true when preparing the offender and the community for his upcoming return. Similarly the staff will need to have a very good knowledge of the communities which the program serves and the resources available to patients leaving the program in those communities to best prepare the patient for release.

Psychology staff will need to be trained in behavioral assessment and treatment methods. As this is a rather complex and specialized area the author recommends specialized training using plethysmograph oriented approaches at the Behavioral Medicine Institute. Although this is costly, $3000 for a 10 day residential program plus travel and accommodation expenses, this organization is nationally recognized in this form of treatment of sex offenders and able to give excellent hands on training which could be put to use directly in the program.

From this authors travels, reading and telephone conversations the following resources are recommended for program training. They are all nationally recognized as leaders in the field of treating sexual offenders:

Richard Seely, Director, Intensive Treatment Program for Sexual Aggressives, St. Peter Regional Treatment Center, St. Peter, Minnesota, 507-931-7100

Mr. Seely has over 15 years experience developing and operating a treatment program for sex offenders in a State Security Hospital setting. This program has been recognized by an award from the American Psychiatric Association. Mr. Seely's fee is $400/day plus expenses.

Gerald Kaplan, Director, Alpha Human Services, Minnesota, Minneapolis, 612-872-8218

Mr. Kaplan is the developer and director of what may be the only community based residential treatment program for sex offenders in the United States. Mr. Kaplan, or perhaps his staff, would be particularly useful in understanding the community based aspects of treatment, programmatic issues and are outstanding in the operation of the small therapy group process. The fee for Mr. Kaplan and/or his staff was unavailable.

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VIII. Staff Training cont.

Candy Osborne, Director, Plethysmography Lab, Behavioral Medicine Institute, Atlanta, Georgia, 404-351-0116

Ms. Osborne is very knowledgeable in the use of plethysmographic techniques in the assessment and behavioral treatment of sex offenders in what is probably the leading center for behavioral treatment of sex offenders in the United States. She discussed a 10 day residential program at the institute to give hands on training in cognitive-behavioral techniques with plethysmography in the treatment of sex offenders.

This list of three resources is not meant to be exclusive but does in this author's opinion recommendation represent top people. The National Academy of Corrections within the National Institute of Correction in Boulder. Colorado offers a 36 hour seminar on Treatment Skills for Professionals Working with Sex Offenders, usually on a twice yearly basis. In addition, Dr. Dennis Dailey of the K.U. School of Social Welfare would be a good person to teach human sexuality to the staff.

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IX. Estimated Cost

The cost of this program will depend on two factors. The first being size, whether the program is to be 25 or 50 beds. The second factor concerns whether the existing physical plant is to be remodeled or a new building constructed[10]. The time estimate for either remodeling or new construction, from design to completion is 2 1/2 years. The cost estimates will be presented sequentially using the higher of the two staffing figures which is probably more realistic.

25 Bed Program

Staffing	$1,371,125
Other Expenses	58,288
Dillon Bldg. Remodeled	4,400,000
25 Bed Total with Remodeling	(5,829,413)
New Construction	6,500,000
25 Bed Total with New Const.	(7,929,413)

50 Bed Program

Staffing	$2,534,318
Other Expenses	58,288
Dillon Bldg. Remodeled	5,500,000
50 Bed Total with Remodeling	(8,092,606)
New Construction	9,200,000
50 Bed Total with New Const.	(11,792,606)

[10]The costs for construction/remodeling were submitted by Gary LaShell, architectural consultant to Mental Health and Retardation Services.

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IX. Estimated Costs cont.
Proposed Staffing Costs[11]
First Year - 25 Beds

Classification	FTE	*Mim-Annual	*Max-Annual
Program Director	1	$ 50,000	$ 50,000
Psychiatrist	1	100,000	100,000
Psychologist III	1	30,792	36,540
Psychologist II	3	87,984	104,400
Social Worker III	1	24,438	28,632
Social Worker II	3	69,804	82,864
R.N. III	5	159,408	174,828
LMHT II	1	20,192	23,492
LMHT I	6	117,796	136,552
Mental Health Aide	14	244,060	265,360
Activity Therapist I	2	39,696	47,112
Institutional/Vocational Educator II	1	22,980	32,340
Vocational Rehabilitation Counselor I	.5	10,557	12,366
Alcoholism Counselor	.5	9,123	10,686
Secretary I	1	15,750	18,480
Salaries & Wages	**41**	**1,002,580**	**1,122,652**
+ 13% Fringe Benefits		**130,335**	**145,945**
Health Insurance		**102,528**	**102,528**
Total Staff Cost		**$1,235,443**	**$1,371,125**

*Mim-Annual was computed on the basis of all positions hired at Step A and Max-Annual was computed on the basis of all positions hired at Step H to provide an estimated range of salary cost.

[11]This staffing pattern was developed in consultation with the Larned State Hospital staff.

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IX. Estimated Costs cont.
Proposed Staffing Costs[12]
Second Year - 50 Beds

Classification	(New)	Total FTE	*Mim-Annual	*Max-Annual
Program Director	0	1	$ 50,000	$ 50,000
Psychiatrist	0	1	100,000	100,000
Psychologist III	0	1	30,792	36,540
Psychologist II	3	6	175,968	208,800
Social Worker III	1	2	48,876	57,264
Social Worker II	3	6	139,608	163,728
R.N. III	5	10	318,816	349,656
LMHT II	1	2	40,384	46,984
LMHT I	6	12	235,592	273,552
Mental Health Aide	14	28	488,120	530,720
Activity Therapist II	1	1	22,980	27,288
Activity Therapist I	1	3	59,544	70,668
Institutional/Vocational Educator II	0	1	22,980	32,340
Institutional/Vocational Educator I	1	1	19,848	23,556
Vocational Rehabilitation Counselor I	.5	1	21,114	24,732
Alcoholism Counselor	.5	1	18,246	21,372
Secretary I	0	1	15,750	18,480

[12]This staffing pattern was developed in consultation with the Larned State Hospital staff.

I X. Estimated Costs cont.

Salaries & Wages	37	78	$1,808,618	$2,035,680
+ 13% Fringe Benefits			235,120	264,638
Health Benefits			234,000	234,000
Total Staff Cost		78	$2,277,738	$2,534,318

*Mim-Annual was computed on the basis of all positions hired at Step A and Max-Annual was computed on the basis of all positions hired at Step H to provide an estimated range of estimate.

I X. Estimated Costs cont.

Other Estimated Expenses

Plethysmography Lab

Computerized Plethysmograph (Farrall Instruments - Grand Island, Nebraska)	$12,000
Plethysmography supplies (per year)	1,000
Video Cassette Recorder	400
21" Television	500
13" Television	300
Projection Screen	100
Cassette Audio Tape Player	100
	14,400

Patient Education Materials

25" Television	700
Video Cassette Recorder	400
Slide Projector	400
16 mm Motion Picture Projector 2 @ $800/each	1600
Projection Screens 2 @ $100/each	200
Specialized Materials Multi-Media Resource Center - San Francisco, Calif. Tapes, Films, Slides (14 items) $3695 + 5% S&H	3879.75
Safer Society - Orwell, Vermont Relapse Prevention for Sexual Offenders (tape)	100
Relapse Prevention Workbooks Vs. I, II & III 25 copies each @ $7.65/each = 573.75 + 6% S&H	608.18
(A set of these would be used with each offender so it represents a continuing cost)	
Chemical dependency tapes and films	2000
Patient Library - Books, pamphlets, and other materials on anger, sex offenses, responsibility, chemical dependency, etc.	2000
	11887.93

I X. Estimated Costs cont.

Other Estimated Expenses cont.

Other Patient Equipment

Recreation Equipment, etc. (e.g. weight lifting and other exercise equipment for anger release)	2000

Staff Training

Consultation & Travel - This fund would be used to bring in presenters for staff training and to send staff to be training in plethysmography, therapy techniques and to visit model programs. This expenses would be highest in the first few years of the program.	$20,000
Staff Library - This fund would establish a resource bank of books, articles, etc. dealing with sex offenders and their treatment.	5,000
Other - This fund would provide for expenses not foreseen in this proposal.	5,000
Total Other Estimated Expenses	**$58,287.93**

X. Risk Management

The treatment program would, of course, follow the current risk management procedures of Larned State Hospital. However, due to the high risk posed to others and the agency by sex offenders further precautions are suggested.

Security:

The program should be housed in a secure building with controlled access/exit through several locked doors. Provision should be made to treat the offenders in a self-contained system, including recreation. At some point in treatment individual offenders may acquire more trust and privileges but the option for this self-contained treatment is required for those not at that level.

When patients have earned the privilege to leave the ward without staff accompaniment such passes occur only in groups of three patients, all of which have different offense patterns (i.e. one may have offended with young girls, one a rapist and one with young boys).

Sufficient staff is provided to be aware of where the patients are and what they are doing at all times.

Screening/Demission:

The program has the ability to control who comes into the program and to return patients to the court/corrections. This permits the exclusion of patients who constitute a danger to other patients, the staff and to the treatment program itself.

Plethysmography:

Plethysmography is the only scientific method of assessing an offenders response to deviant sexual stimuli and corresponding patterns of increased arousal to normal sexual stimuli. Should unforseen relapse occur the program would be able to document effectiveness of treatment provided with a nationally accepted standard (see appendix).

Special Consent Forms:

Special consent forms would be used for plethysmograph assessment of sexual arousal patterns, for aversive behavioral treatment and for the administration of Medroxyprogesterone Acetate (depo provera). (see appendix).

X. Risk Management cont.

Documentation:

Very complete recording is required for all assessment findings, all progress or lack of progress, all unusual incidents and how they were dealt with and team discussions of patient response to treatment as well as the team decision making process.

Communication:

Complete and timely communication is maintained with all outside agencies concerned with the outcome of each patient's case especially the court, probation officers, district attorneys and community treatment personnel. Releases would be obtained for all agencies not covered by statute.

Aftercare Contract:

During the aftercare component the patient will remain as a patient of Larned State Hospital on the appropriate status which would allow the patient to be returned to the hospital immediately if the need for this was found. Normally keeping patients on extended leave is thought to increase hospital liability. However, with sex offenders the risk to the agency for premature discharge is of greater concern. The contract itself is very detailed specifying expected behavior and consequences for non-compliance see appendix).

4-38/77

XI. Appendix

1. Response to Senate Bill 19

2. William Marshall - Treatment Outcome with Sex Offenders

3. Evaluation

    a. ITPSA Evaluation Policy
    b. ITPSA Outline of Development Sex History
    c. ITPSA Group Involvement Scale
    d. ITPSA Groups Members Recommendations for Evaluation Patient
    e. ITPSA Evaluation Patient's Statement Concerning Evaluation Outcome

4. Treatment

    a. ITPSA Steps of Progress
    b. ITPSA Daily Management Guide
    c. ITPSA Resident's Annual Statement

5. Chemical Dependency Treatment

    a. ITPSA Chemical Dependency Steps of Progress
    b. ITPSA Chemical History Questionnaire
    c. ITPSA Worksheet on Powerlessness
    d. ITPSA Examples of Chemical Dependency Stepwork

6. Demission/ITPSA Policy & Procedure

7. Fantasy and Relapse Prevention

8. The Need for Female Staff

    a. Marilyn Mason - paper
    b. ITPSA Justification for Hiring Female Staff

9. Plethysmography

    a. Gary Maier, M.D. - letter
    b. Farrall Instruments
    c. Bibliography of Selected References

10. Examples of Consent Forms

    a. Plethysmography Assessment (2)
    b. Behavioral Treatment of Sexual Deviancy
    c. Medroxy Progesterone Acetate (Depo Provera) - guidelines and treatment

Response to Senate Bill 19

This review has been prepared, by request, to provide background understanding of the issues involved in SB19, namely the transfer of sex offenders to the Mental Health system. The findings from this review revealed that this is a very complex area without a simple yes or no response.

In summary, sex offenders are considered to be a high risk group in terms of potential damaging criminal activity whose treatment requires a very specialized program based on cognitive-behavioral principles best augmented by the availability of sex drive reducing medication. Specially trained staff, equipment and security are required. Treatment in a residential setting may require as much as three to five years to be minimally effective. The effectiveness of such programs is very difficult to determine as apparently relapse rates increase as the severity of the disorder increases and/or the quality of the treatment program decreases. If improperly carried out such programs in a mental health facility increases the risk to other patients and the liability of the treaters and the agency. It should also be noted that one model program was transferred from the mental health system to the correctional system after twenty years due to the fact that the state hospital in which it was located could not provide the security required. To have a chance of being effective the experts agreed that any mental health program dealing with sex offenders must have the ability to screen potential offenders for admission to the mental health program with a separate program in corrections for those not amenable to the mental health treatment program. Adequate funding for the program as well as specialized aftercare on an outpatient basis well networked with the residential programs and operated by sexual offender specialists. Current thinking seems to support a joint effort between mental health and corrections departments.

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January 29, 1991

4-40/177

Jon Conte, Ph.D., University of Washington at Seattle, 206-543-1001 - Nationally recognized expert on the treatment of sexual offenders

I spoke with Dr. Conte. He informed me that 50% of adult sex offenders begin as adolescents, that many are persistent and they are skillful at identifying victims. The key diagnostic issue, he stated, lies in the issue of violence, the gratuitous infliction of pain and injury. He recommended a multi-method, multi-theoretical based approach to what is a complex intervention procedure. He stated that the minimum length of treatment is 3 to 5 years to be possibly effective for those that can be safely treated in the community.

Tim Smith, Ph.D., Former Director of Sexual Psychopath Program at Steilacoomb State Hospital, Washington, 206-284-3125 - Nationally recognized consultant in the area of sexual deviancy issues.

I spoke with Dr. Smith. He stated that the language used in SB19 is similar to the sexual psychopath laws in Washington and in California. He stated that the current term is sexual predator. He recommended transfer from the corrections system to the mental health system only if it is a highly specialized program. He related that sexual predators represent the extreme end of the sexual offenders spectrum. He said that such a special program is a "huge undertaking" requiring a special institution of wing within an institution with the minimum length of stay for effective treatment being 3 to 5 years. When asked what would happen if this specialized program was not executed properly (his definition being adequate technology, equipment, staffing, training and security) the consequences would be (1) increased risk to other patients in the institution and (2) "huge liability" when a discharged patient relapses since the program did not follow the national standard for state of the art treatment for this patient group.

Dr. Smith went on to say that in Washington State the Sex Offenders Treatment Program was in the mental health system from 1968 to 1988 when it was transferred to the department of corrections due to the fact that the state hospital could not provide the level of security demanded. He further stated "In the mental health system it is very difficult to ever discharge a sexual predator as free from risk of recidivism."

Lastly, he stated that Washington state will be requiring Sex Offender Treatment Provider Certification to work with sex offenders which will require specialized training, education, continuing education and a passing score on an examination. This certification will set standards for treatment and evaluation. He is currently working on the standards for this certification.

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Gene Abel, M.D., Director, Behavioral Medicine Institute, Atlanta, Georgia, 404-351-0116 - Nationally recognized expert in the treatment of sexual deviance.

I spoke with Dr. Abel. His view is that paraphilias are psychiatric disorders and therefore belong in the mental health system as opposed to the correctional system. His expertise is in behavioral treatment of these disorders. He felt that a locked unit was sufficient but did state that the need for security varies with each particular patient. He felt that it is essential to have qualified staff treating such patients due to the fact that these are serious problems with serious impacts on society.

Dan Ullman, Ph.D., Former Director, Forensic Facility, Lincoln Regional Center, Lincoln, Nebraska, 402-479-5368 - Director of facility treating sex offenders in state hospital setting.

I spoke with Dr. Ullman. After explaining the proposed Kansas statute change his reply was that the issue was not where treatment of the sex offender occurred but how it was done. He felt that it was mistake to define sexual offenses as Mental Illnesses in the statute with the suggestion that the state institute a screening procedure to determine whether an individual should be sent through the correctional system or the mental health system. He sees the mental health component as minimum to moderate security and the correctional component as maximum security.

He further stated that whoever treats these individuals must define the program, who they can treat and when they can be treated, i.e. especially towards the end of the inmates sentence. He stated that without this control the program can be asked to treat sociopaths and aggressive patients which has resulted in 40% of the population in residence at his center being unresponsive to the treatment program. In Nebraska the actual decision to discharge is made by the local Mental Health Board and not the hospital.

He reported that treatment takes about three years and consists of three global steps: (1) admission of guilt (without this the individual is returned to the correctional system), (2) a program leading to an understanding of the crime, human sexuality education, improving social skills deficits and altering fantasies to more appropriate sex objects and (4) relapse prevention and pre-discharge planning. A fairly lengthy probation period is usually requested from the court.

Mark Dekraai, Ph.D., J.D., Planning Office, Department of Public Institutions, Lincoln, Nebraska, 402-471-4444 x5512 - Nebraska Central Office staff dealing with legal/mental health issues

I spoke with Dr. Dekraai and also reviewed documents which he sent to me. The main point which he made was that the gatekeeping mechanism is essential. He felt that only people with specific training in work with sex offenders should be making the determination as to who is treatable. Main points from the documents are as follows:

Mentally Disordered Sex Offender Report - Mentally Disordered Sex Offender Committee, Nebraska Department of Public Institutions, August, 1985

The view of the Committee is that separate and distinct treatment program for mentally ill sexual offenders as an independent and autonomous institution. The autonomous setting is preferable to the mental hospital due to the differences between sex offenders and other patients. These differences include 1) the focus (with offenders) on what happened as opposed to why, 2) sex offenders deny problems using lying and deception and come to treatment because they are forced to as they are in legal trouble, 3) Sex offenders are very defensive with information, are self-serving, are poor predictors of future sexual behavior and are poor managers in their daily life. Their statements have to be viewed with great skepticism. With mental health patients risks are often underestimated as the prediction of dangerousness is difficult. With sex offenders dangerousness is assumed due to demonstrated record of sexual deviance. 5) Mental health professionals rely on patient reports, seek patient input into treatment planning, rely on subjective discomfort as a motivator and tend to trust clients future intention. Working with sex offenders requires confrontation and challenge along with a large degree of skepticism and cynicism.

Another major point is the requirement for outpatient aftercare services. The period after release is considered crucial in controlling reoffence. If specialized outpatient sex offender treatment is available, the offender leaves the controlled environment of the treatment program or prison to the reality of the community without critically needed support to make the real changes long discussed abstractly during treatment.

A third point the committee report stressed is the consequence of sex offenders not being treated. Studies quoted report as average off 533 sex-related crimes and 336 different victims for each offender.

The fourth point regards the status of sex offender legislation. By their report at one time 28 states had some form of mentally disordered sexual offender legislation while only 13 states currently have these type of laws. These laws have come

under attack. The report cited the American Bar Association's recommendation for the "abolition of statutes that provide for the special sentencing and treatment of offenders classified as sexual psychopaths." The alternative suggested by the ABA was adjudication under traditional criminal proceedings and after sentencing possible commitment to a mental health facility for treatment of mentally disordered offenders for during the term of their sentence.

Report of the Department of Public Institution's Task Force on Mentally Disordered Sex Offenders - (Dale B. Johnson, Director, Nebraska Department of Public Institutions), February, 1989

The main message from this report seems to be the difficulty in adequately funding such a program, difficulties with overcrowding, difficulties with inappropriate admissions (the need for gatekeeping) and stressing the need for adequate follow-up and aftercare for patients after release.

LB523 Convicted Sex Offender Act - Bill currently under consideration by the Nebraska Legislature

This bill demonstrates the current thinking of a sister state who has been dealing with sexual offenders in treatment for many years. The main points of the bill define the relationship of the treatment program to the criminal justice system including when, and under what circumstances, an offender is to be treated, requirements for the program's reporting to the court of jurisdiction and the corrections department and how aftercare, when indicated, is to be included as part of an offender's probation.

Howard Halpern, Ph.D., Director, Child Guidance Center and Supervisor, Sexual Abuse Perpetrators Project, Lincoln, Nebraska, 402-475-7666 - Directs program currently treating sexual offenders

I spoke with Dr. Halpern. He felt that for an inpatient mental health program for offenders to work that it was "essential" that the state hospital and the mental health center have control over who is admitted to such a program and that an outpatient program with a half-way house program be available post-discharge. He related that otherwise untreatable offenders would be placed in the program rendering it non-functional.

Richard Seely, Director, Intensive Treatment Program for Sexual Aggressives, St. Peter Regional Treatment Center, Minnesota Security Hospital, St. Peter, Minnesota, 507-931-7100 - Directs nationally recognized program for sexual offenders

4-44/177

I spoke with Mr. Seely. Mr. Seely's program has received the Significant Achievement Award from the American Psychiatric Association. He has served as a consultant for Time Magazine and for Niteline. His program is a 48 bed evaluation and treatment facility for which he claims less than 5% recidivism over the fifteen year existence of the program.

Mr. Seely said that to be successful the program must be able to screen potential patients for individuals who are treatable. His own program has screened 1200 offenders in a 30 day evaluation consisting of nine separate assessments on each client. The program then makes recommendations to the court as a presentence evaluation. As treatability is defined as the ability to respond to treatment this in situ evaluation provides a hands on test.

When queried concerning the proposed Kansas statue change he stated that he was not in favor of this change as written feeling that it would cause further problems. The proposed change, which he stated is similar to the Minnesota Criminal Psychopath law, removes all responsibility for treatment from the Department of Corrections and gives the Department of Mental Health/Retardation the responsibility to treat these individuals until they are safe to be at large, which is not really possible. He also stated that simply placing sex offenders in the mental health system without putting in place the necessary programs and resources would then take needed resources away from the vulnerable mentally ill and place sexual predators among the must vulnerable people in society. Thus sexual offenses become the only "crime" receiving an indeterminate sentence.

Bill Marshall, Ph.D., Queen's University, Kingston, Ontario, 613-545-6017 - Review of paper William Marshall et al. Treatment outcome with sex offenders, Clinical Psychology Review (in press)

Summary: This review examined the question "Can sex offenders be effectively treated so as to reduce subsequent recidivism?" The authors believe that the answer to this question is yes but also made it clear that not all programs are successful and not all sex offenders profit from treatment. "Comprehensive cognitive/behavioral programs and those programs which utilize antiandrogens in conjunction with psychological treatments, seem to offer the greatest hope for effectiveness and future development." (An example of an antiantrogen is Provera.) Even these programs vary in effectiveness and tend to do far better with child molesters and exhibitionists than they do with rapists. The present state of the art does not allow prior identification of those who will profit least (except for rapists).

Relevant Points Reviewed:

1) The likelihood of reoffence among released offenders with more than one prior conviction (33-71%) is greater than for first offenders (10-21%).
2) Recidivism rates increase over time:

8.8% reoffend of treated and untreated group in less than 2 years
16.7% reoffend (same group) within 2 to 4 years
40.9% reoffend (same group) after 4 years

(One study reported some untreated child molesters and rapists not reoffending until more than 20 years after release from prison)

3) Antiandrogens (medroxyprogesterone acetate; provera) are useful in reducing sexual activity to controllable levels in offenders with excessively high sex drives to prevents reoffence and to make them more responsive to psychological interventions.

One study using MPA showed 91% relapse for those who did not complete treatment and 30% relapse for those who did.

One study showed that MPA was effective is clearly identifiable paraphiliacs (those who sexually aroused exclusively or persistency by deviant sexual fantasies) but who do not have an antisocial personality disorder, problems with substance abuse, who do not use gratuitous violence in their offenses, and who have a satisfactory consenting sexual relationship with an adult partner.

Other studies show little or no change in a patient with a history of coercive sexual assaults (adults and children) and in a hypersexual pedophile.

4) Studies at a California state hospital treating sexual psychopaths and mentally disordered sexual offenders.

- 1st study 19.4% recidivism after three years increasing to 26.6% in the fifth year after release.

- 2nd study 15.4% reoffended compared with 25% recidivism rate in a comparable group released from California prisons

5) Study from prison treatment center in Massachusetts followed 254 sexually dangerous offenders over 20 years post-release with a reoffence rate (with psychoanalytic treatment) of 29.5%. These were possibly the most dangerous and chronic offenders and probably the most difficult to treat.

6) Cognitive-Behavioral Programs

- Ontario Penitentiary program recidivism rate of 11% for treated offenders and 35% for untreated offenders over 8

years. However, the same program 5 years later shows recidivism of 18% for rapists and 20% for pedophiles, demonstrating deterioration of the program or more difficult patients. (This makes the point that the quality of the program and/or the type of offenders are important variables).

- A comprehensive program at the Saskatchewan federal penitentiary followed 130 treated offenders followed an average of two years post-release showed 10% reconviction. This program targeted a comprehensive range of problems including sexual preferences, distorted cognitions, social competence, stress management and victim empathy and included a relapse prevention component.

TREATMENT OUTCOME WITH SEX OFFENDERS

By

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Clinical Psychology Review (in press)

4-48/177

Abstract

Previous reviews have taken either a severe methodological stance and concluded that treatments have not been demonstrated to be effective with sex offenders or they have ignored methodological considerations and enthused about the value of particular treatment approaches. We have attempted to adopt a position somewhere between these two and have concluded that some treatment programs have been effective with child molesters and exhibitionists but not, apparently with rapists. In examining the value of the different approaches, we concluded that comprehensive cognitive/behavioral programs (at least for child molesters, incest offenders and exhibitionists) are most likely to be effective although there is a clear value for the adjunctive use of antiandrogens with those offenders who engage in excessively high rates of sexual activities.

INTRODUCTION

There have been a number of earlier reviews of treatment effectiveness with sexual offenders (Blair & Lanyon, 1981; Bradford, 1985; 1990; Furby, Weinrott & Blackshaw, 1989, Grossman, in press; Heim & Hursch, 1979; Kelly, 1982; Kilmann, Sabalis, Gearing, Bukstel & Scovern, 1982; Lanyon, 1986; Marshall & Barbaree 1990a; Ortmann, 1980; Quinsey, 1977) with some authors being optimistic about outcome while others came to rather dismal conclusions. Both Blair and Lanyon (1981) and Furby et al (1989), for example, were of the opinion that methodological problems precluded meaningful conclusions regarding the effectiveness of any kind of treatment for these men, while Heim and Hursch (1979) were pessimistic about the value of physical castration. On the other hand Bradford (1985; 1990) and Ortmann (1980) both considered the evidence to show antiandrogens to be very effective in eliminating deviant behavior, and Marshall and Barbaree (1990) were persuaded that comprehensive cognitive/behavioral programs reduced reoffense rates in sexual offenders. These disagreements appear to arise from a number of sources which we must sort out if we are to make sense of the literature and make progress in improving our programs to deal with this very serious social problem.

Methodological Stance

The stance which guides each review is critical to the final evaluation of a body of literature. One crucial aspect of this stance has to do with the reviewer's position on methodological issues. Some reviewers appear to us to set standards for methodological rigor which cannot reasonably be expected to be met in a field so immature as that under consideration here. This is not meant to imply that such ideals should not be persued but rather meant to suggest that we might more profitably review the literature on the treatment of sex offenders guided by an attempt to discern trends encouraging confidence. To demand of the present literature that it demonstrate unequivocally that treatment is effective across all types of offenders, is to court certain disappointment. On the other

hand, to ignore certain criteria in reviewing the literature (e.g., sufficiently large sample size, specification of types of offenders treated, reasonably clear description of treatment procedures used, and objective outcome data collected over at least a 1-year post-treatment period), will not encourage any reader to have confidence in the conclusions drawn from the review. We hope to aim for somewhere between these two extremes. When a variety of treatment reports reveal subsequent reoffense rates which are substantially below that expected of similar but untreated offenders, then it seems reasonable to infer that we are on the right track. However, such a conclusion would not necessarily imply that all approaches to treatment, or even that all applications of any particular approach, are effective.

There are far too many people who are ready to seize on the conclusion of the methodological idealists, that treatment for sex offenders has not been demonstrated to be effective. Unfortunately, this gets readily converted into the declaration that these men cannot (usually this means cannot ever) be treated. At this stage in the development of our understanding of treatment and its effectiveness, we believe that the best approach is to ask not the categorical question "Can sex offenders be treated?" but rather a more modest question such as "Can we discern grounds for optimism in the treatment outcome literature?" If this question can be answered in the affirmative then we might also consider what types of treatment appear to offer the most promise. These will be our goals in this review, but first some brief remarks about how to judge effectiveness.

Judging effectiveness

In determining the value of treating sex offenders we will follow in the tradition of reporting failure rates which are typically derived from official records of rearrest or reconviction, and which report the percentage of men who reoffend (recidivism rates). In their analyses of failures in treating various disorders, Foa and Emmelkamp (1983) also

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took into account those who refused treatment, those who failed to comply with treatment requirements, and those who withdrew after entering treatment. While some treatments may be sufficiently draconian or demanding to discourage entry, compliance or persistence, in many instances these problems result from either the manner in which treatment is presented or the conditions under which patients enter treatment, rather than as a result of the specifics of the procedures employed. Although these issues cannot be dismissed in a complete account of the value of treatment we will focus only on the long-term changes in behavior induced by participation in treatment.

The most common criticism of treatment studies is the failure to provide a controlled comparison with untreated offenders. The ideal is to have at least two groups, one of which receives the supposedly effective treatment while the other receives either no treatment at all or some form of pseudo-treatment. However, this usually means deliberately withholding treatment from a group of these dangerous men which, in our opinion, would be ethically unacceptable.

The only reasonable alternative to a controlled group study, in most circumstances, is to compare treatment outcome against some estimate of the likely untreated reoffense rate although just how this estimate might be derived presents problems of its own. Certainly the population under consideration is pertinent to estimating untreated recidivism. Thus, researchers must indicate the nature of their selection process, what type of offenses their patients committed, and the offense history of the patients. When this is done, the task of identifying appropriate comparison data on untreated offenders is made somewhat easier.

Estimates of recidivism

Furby et al (1989) considered it impossible to infer untreated recidivism estimates from the literature. While Furby et al did try to distinguish among the types of

offenders, they did not attempt to subcategorize the patients in terms of whether they were discharged from prison, hospital or community settings. Since we might expect that offenders in these different settings would vary in terms of their offense histories, it is perhaps not surprising that Furby et al reported excessively broad ranges of recidivism. Numerous studies (Christiansen, Elers-Nielson, LeMaire & Sturup, 1965; Mohr, Turner & Jerry, 1964; Pacht & Roberts, 1968; Radzinowicz, 1957; Soothill & Gibbens, 1978) have shown that the likelihood of reoffense among released offenders who have more than one prior conviction is far greater than among first offenders. For repeat offenders (undifferentiated for offense type) recidivism rates in these studies were 33-71% while for first offenders the rates were 10-21%. This is obviously an important consideration in evaluating the effects of treatment, and selection procedures which tend to exclude chronic offenders from treatment will necessarily result in lower recidivism rates.

In fact selection criteria for entry into treatment is the most problematic feature of many treatment programs (Furby et al, 1989). In some programs, particularly those that are institutionally-based, the offenders judged to be at most risk are selected for treatment. This may, to some extent, account for Furby et al's observation that in some of these institutional programs the outcome for treated patients was worse than for the untreated offenders. In other programs, the selection criteria achieve the opposite goal; that is, the offenders at least risk enter treatment. Unfortunately, selection criteria are not always made clear, but in many cases it is possible to make a reasonable guess at whether the treated group was among the high or low risk offenders.

Recidivism rates have also been shown to steadily increase over the full range of follow-up however long that may have been. Marshall and Barbaree (1988) report increased rates of reoffending in both treated and untreated child molesters over three follow-up periods. Of those offenders (both treated and untreated) who had been at risk for less than two years, 8.8% reoffended, whereas 16.7% of the men at risk for 2-4 years reoffended

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as did 40.9% of those at risk for more than 4 years. Similarly, Soothill and his colleagues (Soothill & Gibbens, 1978; Soothill, Jack & Gibbens, 1976) have provided data to show that some untreated child molesters and rapists do not reoffend until more than 20 years after release from prison.

Perhaps the most important factor affecting the power of treatment has to do with the nature of treatment itself. There is no reason to expect all treatment programs to be equally effective since they appear to differ on a number of quite important features. In their review, Furby et.al did not distinguish among the different types of treatment and so again it is not surprising that outcome rates varied so dramatically.

A neglected factor, which is importantly related to the evaluation of treatment outcome, concerns the benefits to society of even marginal success in treating sex offenders. Since most sex offenders who do reoffend after release from prison or discharge by the courts, do so against more than one victim, then just effectively treating one offender who would otherwise have reoffended, is beneficial in that it saves two or more innocent victims from suffering. However, in addition to the saving in human suffering, treatment for sex offenders can also be cost-effective. Prentky and Burgess (1989), for example, calculated the cost to investigate a reoffense by one of these men, to prosecute and jail the offender, and, finally, to offer minimal assessment and treatment to the victim. The estimates of costs provided by child protection agencies, police, the courts, correctional services and hospitals, amounted to $180,000 for a single offense by a single offender. Similar estimates derived from Canadian sources (Marshall, 1986) produced similar costs. Since it costs far less than this to treat each offender, treatment is not unnecessarily expensive to society.

OUTCOME STUDIES

In this paper we will not pretend to exhaustively review every treatment outcome article; however, we will not exclude any article from consideration just because its data

run contrary to any evident trend. In describing recidivism data we will rely on official police records of offenses and we will only report reoffenses for sex crimes since the primary goal of therapy is not, as yet, to eliminate all criminal tendencies but only sexual offending. We might hope that treatment would reduce antisocial behavior in general, but unless that is a specific target of treatment we cannot reasonably expect non-sexual crimes to constitute one of the dependent variables in evaluating outcome.

Physical treatments

Three different physical interventions have been reported in the treatment of sex offenders: stereotaxic ablation of central nervous system centres; physical castration; and the administration of pharmacologic agents thought to function as sexual antagonists.

Psychosurgery

Brain ablation procedures (typically hypothalamotomies) are of questionable ethical merit (Schmidt & Schorsch, 1981) particularly since the functions of the highly specific aspects of the central nervous system that are targeted, do not appear to be well enough understood to justify such procedures (Valenstein, 1973).

A group of German surgeons have been the leading advocates of stereotaxic operations to reduce deviant sexual tendencies (Roeder, 1966; Roeder & Muller, 1969; Roeder, Orthner & Muller, 1972). Their procedures are meant to destroy the ventromedial nucleus of the hypothalamus which they believe controls sexual behavior. However, the evidence on behalf of this claim does not appear to be convincing. For example, brain lesions occurring after early infancy appear to change the intensity but not the direction of sexual expression (Kolarsky, Freund, Machek & Polak, 1967). Reducing the urges to molest children or rape women is, of course, desirable but a redirection of sexual urges toward more acceptable targets would seem to be the most desirable outcome.

In their summary article, Muller, Roeder and Orthner (1973) describe the use of their procedure with 22 patients, not all of whom were sexual deviates. In fact, this

report reveals an unsettling aspect of their work. A 27 year-old nondeviant man was operated on to deal with his fear of personal contacts because he was thought to be a latent homosexual. A 30 year-old patient had his ventromedial nucleus destroyed to eliminate alcoholism.

Of the patients who had an explicit sexual problem, fourteen had a history of molesting boys, two who had molested girls, three were exhibitionists, and one was described as a hypersexual nondeviant. This hypersexual died as a result of the operation and four of the homosexual pedophiles were said to have made little or no gains. Another homosexual pedophile was described as having achieved a good result despite the fact that he was "still preoccupied with boy love". The unfortunate patient who was thought to be a latent homosexual experienced no relief from his interpersonal anxiety and in fact was made worse by the operation. The alcoholic likewise failed to improve.

By our reckoning this gives an overall failure rate of 36%, with 26% of the sexual offenders failing. This does not appear to be any better than we would expect in the absence of treatment. One of the exhibitionists, who was said to be successfully treated, lost all sexual interest, hardly an optimal outcome.

These results appear less successful than these authors (see also Dieckmann & Hassler, 1975) imply. In addition, there is evidence that hypothalamotomies produce adverse intellectual and emotional side-effects (Schneider, 1977) and that any reduction in deviant behavior is likely due to functional castration thus significantly reducing all sexual perception and expression (Valenstein, 1973). In view of these difficulties it does not appear that psychosurgery should at present, be further explored.

Castration

Physical castration has been widely employed in Europe. At least 102 men have been castrated in Norway (Bremer, 1959), 121 in Switzerland (Cornu, 1973), 900 in Denmark (Sand, Dickmeis & Schwalkbe-Hausen (1964) and 932 in Germany (Langeluddeke, 1963).

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ecidivism data based on official records reveals remarkably low rates of sexual reoffending in the castrates across all these studies (0% - 7.4%). Given the very large number of men treated (n=2055), and the extensive (20 years) follow-up periods, this certainly is impressive. Indeed, as Bradford (1990) notes, these studies provide the most comprehensive data on treatment outcome in the literature.

There are, however, problems with castration studies. In the first place it is clear that many first offenders were castrated although it is typically difficult to determine how many were included in each study. Secondly, the population of castrated offenders is not specified in sufficient detail for us to know the number of each type of offender involved and how each of these types fared after release. For instance, in the early days of the use of castration, homosexual acts between consenting adult partners was an offense and certainly many of these men were castrated. What we need to know is what effects castration had on those offenders whose acts are still considered crimes and particularly on those whose crimes seem to do the most damage to victims (e.g., rape and child molestation).

Heim (1981) reports an appraisal of the effects of castration on 39 offenders including rapists, child molesters and homosexuals. The self-reported frequency of sexual activities and thoughts, and arousability, were all markedly reduced by castration but 46% said they still masturbated or had intercourse. Those who were castrated at a younger age (less than 44 years) were more likely to be sexually active than those castrated at a later age. However, Heim (Heim, 1981; Heim & Hursch, 1979) notes in his reviews that all manner of disabling side-effects seem to result. In addition, while Sturup (1968) reported a zero recidivism rate in terms of sexual offending among the Danish castrates, 33% were subsequently convicted for a non-sex crime while only 20% of a matched group of non-castrated rapists subsequently reoffended in a non-sexual way. Thus, while castration may be effective it seems to achieve this goal at some significant cost. In any case,

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like stereotaxic surgical procedures, it seems unlikely that physical castration will be adopted outside of Europe and most European countries now seem to have abandoned it.

Pharmacologic interventions

A range of pharmacologic agents which reduce sexual drive have been investigated in the treatment of sexual deviancy. Early investigations included clinical trials of estrogens (e.g. Symmers, 1968; Whittaker, 1959). Although reportedly successful in reducing deviant sexual behavior, estrogen treatments were associated with undesirable side effects such as feminization. In a similar manner, neuroleptics appear to have produced reductions in sexual deviancy (e.g. Field, 1973; Sterkmans & Geerts, 1966), but they have dyskinetic side-effects and produce drowsiness and slowed thinking. The dyskinetic effects can be overcome by appropriate medication but the drowsiness and slowed thinking limit the usefulness of neuroleptics in treating sex offenders. More recently, research attention has turned to the utility of medroxyprogesterone acetate (MPA) and cyproterone acetate (CPA). Neurochemically, these hormonal analogues act as androgenic antagonists and compete for particular sites of action, both in the CNS and peripherally, for which androgens have an affinity (Bradford, 1990; Cooper, Ismail, Phanjoo & Love, 1972).

An important point to keep in mind in the appraisal of the benefits to be derived from the administration of antiandrogens, is that therapists who use these procedures do not expect these medications to eliminate sex offending. Rather they are principally used as a way of reducing sexual activity to controllable levels in those offenders who sex drive seems so excessively high as to put them at serious immediate risk to reoffend and to render them unresponsive to psychological interventions. Used in this way, as a temporary control until psychological treatments can begin to build effective self-control, the antiandrogens are to be viewed as adjunctive treatments and need to be evaluated more for their immediate effects on general sexual arousability rather than

either their specific effects on arousal to deviant themes or their long-term effects on deviant sexual behaviour. Unfortunately the reports on the use of antiandrogens do not always make these distinctions so that it appears some researchers are unclear about their goals in employing antiandrogens.

Treatment by MPA: The first assessments of the use of MPA were reported by Money (1968; 1970; 1972). He described reductions in sexual drive and lowered frequency of erections and orgasms among a sample of 9 paraphiliacs, during MPA treatment which was used in conjunction with psychological counselling. Blumer and Migeon (1975) described MPA treatment of 22 cases with similar results and Gagne (1981) combined MPA and milieu therapy in treating 48 sexually deviant men for 12 months. Gagne found substantial improvements in 40 of these men and these benefits were maintained through an unspecified follow-up period. Presuming, then, that at least 8 failed, this reflects a 17% recidivism rate which certainly does not seem remarkable. Less positive results were described by Wiedeking, Money and Walker (1979) in the treatment of 11 sexually deviant XXY males. Behavioral ratings of criminality showed little improvement and only one patient reported reductions in sexual activity and fantasy during MPA treatment. At one year follow-up only two patients reported a cessation of sexually deviant behavior.

A more recent study conducted at Johns Hopkins University by Berlin and Meinecke (1981), treated 20 paraphiliacs with MPA. Eleven discontinued treatment against medical advice, and ten of these eleven subsequently relapsed. Of the nine who continued treatment, three relapsed. Thus, the recidivism rates for those who did not complete treatment was approximately 91%. While it was still quite high (30%) for the treated patients it was clearly better than for those who dropped out. While these data suggest some effect for MPA if the patients remain in treatment, the results also point to a serious problem of attrition and non-compliance.

An attrition problem was also evident in a double-blind comparative study of MPA and

assertiveness training for exhibitionists (Langevin et al, 1979). The dropout rate of 50% in the MPA group was approximately the same as in the Johns Hopkins study and this makes the results difficult to evaluate, although it is clear that the treatments were not remarkably effective. As we noted earlier, however, attrition is not an evaluation of the effectiveness of treatment and may more wisely be responded to by proposing ways in which drop-outs or refusals can be overcome. Maletzky (personal communication), for example, indicates that among sex offenders for whom antiandrogen treatment is mandated, attrition is rarely a problem.

Wincze, Bansal and Malamud (1986) obtained equivocal results in the treatment of three chronic pedophiles using MPA. Reductions in arousal to erotic stimuli in the laboratory setting did not reliably generalize in any of the patients to behavior in other settings. However, Cooper (1987a) demonstrated, in a carefully evaluated study, that MPA produced benefits with three of four elderly, institutionalized, demented males who were sexually acting out. Deviant acts were recorded over a 6-month pre-treatment period, throughout the 1-year treatment program (MPA was administered intramuscularly at 300 mg/week), and for one year post-treatment. Offensive sexual behavior disappeared 10-14 days after the trial began in all four patients and remained absent in three of them, with no apparent side-effects, up to one year after the drug was withdrawn.

Walker and his colleagues at the University of Texas Medical Branch in Galveston have extensive experience in the use of MPA with sex offenders and their work is summarized in two book chapters (Walker & Meyer, 1981; Walker, Meyer, Emory & Rubin, 1984). They distinguish various types of sex offenders and claim (although they offer little in the way of supportive evidence) that MPA is effective only with those men whose sex offenses are related to a clearly identifiable paraphilia (i.e., they are sexually aroused exclusively or persistently by deviant sexual fantasies), who do not have an antisocial personality disorder nor any problems with substance abuse, who do not use

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gratuitous violence in their offenses, and who have a satisfactory consenting sexual relationship with an adult. This certainly excludes a large number of offenders and, worse than that, seems to exclude those most at risk to reoffend during the early stages of psychological treatment. Maletzky (personal communication) is of the opinion that such offenders (i.e., those at risk) are just the ones with whom MPA should be employed.

Nevertheless, Walker et al.'s (1981; 1984) summaries of the literature indicate very few relapses among offenders while they remain on MPA. They point out that there is little data on post-MPA outcome but quite properly note that MPA treatment does appear to protect society during its administration. Whether we can reasonably expect MPA to produce post-treatment benefits seems debatable but if it serves to lower risk while changes induced by psychotherapy gradually take hold, then it will be an effective component in treatment.

An important observation concerning MPA was recently made by Cooper (1987b) in the intensive study of a man who had a history of coercive sexual assaults on both children and adults. Administration of MPA commenced at a dosage of 100mg/day and was increased over 17 weeks to a level of 600 mg/day. Within 14 days of initiating MPA treatment, serum testosterone levels had dropped precipitously by approximately 96% with associated, although not quite so dramatic, decreases in the levels of follicle stimulating hormone and luteinizing hormone; also as expected prolactin markedly increased. These are just the types of changes that were hoped for, but unfortunately they were not matched by reductions in deviant behavior. Frequency of sexual thoughts and erotic dreams remained unaffected, and masturbation rate was unchanged. At laboratory retesting of his sexual preferences, this man showed greater overall arousal (up to 30% greater) than he did at initial testing, and he still showed very strong arousal to children and to violent sexual cues. These observations are consistent with an earlier report by Cordoba and Chapel (1983) who also found no change in erotic preferences in a hypersexual pedophile treated

with MPA. Similarly Gagnè (1981) noted that four sociopathic pedophiles, who showed appropriate reductions in testosterone levels when treated with MPA, displayed no corresponding reduction in sexual arousal. As Cooper notes "in certain individuals, sexual arousal once established, may be independent of testosterone levels which may fall to zero without influencing (some types of) sexual responsiveness" (p 739, Cooper, 1987b).

The data available on MPA, then, are perhaps not as encouraging as some of its advocates might hope. Even when it is effective the excessively high drop-out and refusal rates may discourage some practitioners. However, overall the results suggest that MPA can be a valuable adjunct with some patients.

Treatment by CPA: A range of uncontrolled clinical trials have reported reductions in sexually deviant behaviors after treatment with CPA (e.g. Cooper 1981; Davies 1974; Laschet & Laschet, 1971; Mothes, Lehnert, Samimi & Ufer, 1971). The largest sample (n = 547) of sexually deviant men to be treated with CPA was described by Laschet and Laschet (1975). Of particular interest was a five year follow-up of twenty five of these patients. Not one recidivated, even after CPA was withdrawn. However, a note of caution on the effectiveness of this program was sounded in an earlier report by Laschet (1973) in which she pointed out that CPA proved not to be useful with those chronic deviates whose tendencies to offend had become independent of circulating testosterone levels. Presumably this remark meant that CPA reduced testosterone levels in these men but had no impact on offending. This is consistent with some of the findings we noted on MPA.

A particularly well-designed study by Bancroft, Tennent, Loucas and Cass (1974) compared CPA with estrogen estradiol in a double-blind study of twelve patients. Neither drug produced a significant reduction in erectile responses to erotic stimuli. CPA was, however, associated with positive changes in self-rated arousal during penile tumescence testing, and both drugs were associated with self-reported reductions in sexual activity. Bradford (1990) has taken Bancroft et al's findings to mean that CPA reduces a person's

awareness of arousal to deviant cues and consequently reduces sexually deviant behavior even though the actual degree of arousal remains unchanged. An alternative interpretation might be that these patients deliberately mis-represented their experienced arousal during penile testing; that is, they became aroused (as reflected in their penile responses) but reported lower levels of arousal in order to appear non-deviant. This view would consider the patients' reports of reductions in actual deviant sexual behavior to be similarly suspect and resulting from the same motivation to appear non-deviant.

Bradford and Pawlak (in press) conducted a double-blind placebo crossover study on 37 patients, 12 of whom were habitual sexual offenders. Treatment with CPA resulted in reduced penile tumescence to both erotic visual stimuli and covert sexual fantasy, to levels markedly below those evident at pre-treatment and below the levels produced by a placebo drug. Self-reported sexual activity was also reduced. In addition, Bradford and Pawlak (1987) examined the effects of CPA on high and low testosterone groups of child molesters, in terms of their responses to different types of erotic stimuli. For both groups alike, CPA produced greater inhibition to pedophilic stimuli than to stimuli of consenting adult heterosexual interactions, which is a very positive and quite surprising finding. Of course, as we noted earlier, clinicians who use antiandrogens, use these pharmacologic agents in conjunction with psychological counseling or behavioral treatment, and Bradford's program (Bloom, Bradford & Kofoed, 1988) includes particularly sophisticated cognitive-behavioral components. Since these procedures have been shown (Quinsey & Earls, 1990) to selectively reduce deviant sexual preferences and enhance appropriate arousal, it may be that Bradford and Pawlak's (1987) findings result more from these behavioral techniques than from CPA.

However, there seems to be no doubt of the value of the combination of CPA and psychological treatment. What needs to be done is to partial out the differential effects of the pharmacological and psychological components particularly as they relate to those

patients with high or low levels of serum testosterone. Bradford and his colleagues have clearly begun this important process.

PSYCHOLOGICAL TREATMENTS

Non-behavioral approaches

It is at times difficult to distinguish non-behavioral approaches from cognitive/behavioral ones, particularly nowadays since there has been something of an integration of these two approaches in many settings. We have nevertheless attempted this distinction and it is certainly clear that some programs predate the advent of cognitive/behavioral therapy.

Following their patients for up to 20 years, Pacht, Halleck and Ehrmann (1962) reported that 6.3% of 414 men who were discharged from parole after being treated at the Sex Crime Facility in Wisconsin during 1951-60, reoffended. While still on parole, after treatment, 9.1% of a total population of 475 reoffended. Since offenders were selected for this facility as "deviated" on the basis of an intensive 60-day observation, it seems likely that recidivism rates would have been a good deal higher in the absence of treatment. A similar report by Prendergast (1978), noted a 9.3% recidivism rate among 324 sex offenders who were released from prison after having received "emotional release therapy" over a 10-year period. Again this seems to be a low rate of post-release offending, and suggests that the program reduced recidivism in the men who were treated.

In a series of three reports, Blain (1960), Frisbie (1969), and Frisbie and Dondis (1965), have described outcome data from an early treatment program in a California state hospital which served as a maximum security facility for offenders classified under California Law as sexual psychopaths or mentally disordered sexual offenders. These reports reveal recidivism rates of 19.4% after three years increasing to 26.6% in the fifth year after release. Frisbie (1969) provided comparative data for sex offenders

released from other California prisons or after temporary custody. Their recidivism rate of 11.5% is substantially lower than the treated offenders. However, these prisoners should have been less dangerous (and shoud have had a lower recidism rate) than those in the state hospital if the California law was applied accurately. Nevertheless, the recidivism data up to the late 1960s are certainly not encouraging.

Subsequently, Sturgeon and Taylor (1980) followed-up 260 mentally disordered sexual offenders who were discharged in 1973 after treatment at the same California hospital. Over a 1 - 5 year follow-up, 15.4% reoffended, while a comparable group released from California prisons had a recidivism rate of 25%. Analyzing these groups further revealed little difference between recidivism rates for the treated (19.8%) and untreated (17.9%) men who had molested female children, but quite remarkable advantages for the treated men who molested boys (14.6% for the treated and 37.5% for the untreated offenders) and similar, although not so pronounced, advantages for those who were convicted of rape (19.3% for the treated and 27.9% for the untreated offenders). Thus the later program at the state hospital was apparently more effective, at least for certain types of patients, than was the earlier program.

The Florida Department of Health and Rehabilitative Services (1984) provided a comparison between two groups of men who were released from Florida prisons, all of whom were said to be amenable to treatment. Those who did not receive treatment (n = 31) fared better (6.5% recidivism) than those (n = 59) who did (13.6%). In fact, the 90 prisoners who were described as not being amenable to treatment also did better after release (10.9% recidivism) than did the treated group. Since we do not know in what way these groups differed (if at all), it is hard to know what to make of these data. While it is understandable in the case of this report, and the one from California, that these authors wished to provide some comparative data, we do not believe their choice of offenders housed in regular jails was a wise one. Since these offenders were all in the same system

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it seems reasonable to suppose that the procedures which allocated them to the different institutions, served to make the groups different in ways that are not specified. If we presume that the worst offenders entered treatment then the outcome data seem more encouraging than the provided comparison would suggest. However, we do not know that this true and we cannot, therefore, make any reasonable inferences one way or another.

Two hundred and fifty four sexually dangerous offenders were released from a prison treatment center in Massachusetts between 1959 and 1979, and were followed for up to 20 years after release (Massachusetts Post Audit Bureau, 1979). Their reoffense rate was 29.5% which is quite high and suggests that whatever treatment they were getting (which was decidedly psychoanalytic), was not particularly valuable. In fairness, however, these men confined to the Massachusetts institution were, and continue to be, among the most dangerous and chronic offenders, and they were no doubt among the most difficult to treat.

The programs we have considered to date have been offered within prisons, or at least within maximum security settings. A lower security institution (J.J. Peters Institute, 1980; Peters & Roether, 1971) has operated a treatment program for Philadelphia probationers since 1966. Patients were randomly assigned to either probation alone or to probation plus treatment. In both reports recidivism data consistently revealed higher reoffending rates among the men who received treatment (7.7% and 13.6%) than among those who did not (3.2% and 7.2%).

A guided self-help program has been in operation for some years at a hospital in Washington State. Saylor (1979) reported that 22% of the 409 treated men had reoffended during the 0 - 12 years follow-up which is no better than one would expect in the absence of treatment. Somewhat surprisingly, given the threat they constitute to society, offenders in this program are given responsibility to decide on important issues like release into the community. Nagayama Hall and Proctor (1986) subsequently reported similarly high rates of recidivism (27.5%) for 342 men released from this program, which

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does seem to make the decision to give these offenders autonomy in decision making somewhat unwise.

In one of the most publicly acclaimed treatment programs for incest offenders, Giarretto and his colleagues (Giarretto, 1978; 1982; Giarretto, Giarretto & Sgroi, 1978) have professionals and volunteers lead what are essentially self-help groups. The guiding philosophy is said to be humanistic which is taken to mean that the staff must set aside their revulsion at the acts committed by these men and respond to them in a supportive and caring way. The whole family is involved in both individual and group therapy and meets with various counsellors for an average of 20 hours per week during the initial crisis period and then for at least two sessions each week thereafter for up to two years. Even though an independent evaluation revealed a recidivism rate of 0.6% for Giarretto's ex-patients against an expected rate of 2% (Kroth, 1979), the question at issue concerns not so much the program's effectiveness but rather the value of spending so much time, energy and money on these men when there might have been others in the community (nonfamilial child molesters, for example) who posed a far greater subsequent risk than did these father-daughter incest offenders.

Cognitive/behavioral programs

The earliest behavior therapy programs conceptualized all sexual deviations entirely in terms of sexual motivation. It was believed that changing sexual preferences would eliminate the troublesome behavior (Bond & Evans, 1967; McGuire, Carlisle & Young, 1965). More recent conceptualizations recognize a far broader nature to the motives activating and the problems maintaining deviant sexuality (Finkelhor, 1984; Marshall & Barbaree, 1990b).

Cognitive/behavioral programs derived from these more recent conceptualizations are quite comprehensive including cognitive components (Abel, Becker & Skinner, 1986), a range

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of social and life skill elements (Marshall, Earls, Segal & Darke, 1983), and, more recently, relapse prevention strategies co-opted from the addiction field (Laws, 1989). However, it is important to note that some clinicians who employ behavioral methods target more limited features of sex offenders. Assertiveness training alone has been used (Langevin et al, 1979), as has imaginal desensitization either alone or in conjunction with an antiandrogen (McConaghy, Blaszczynski & Kidson (1988), covert sensitization alone (McConaghy, Armstrong & Blaszczynski, 1985) or either electric aversive therapy alone, biofeedback alone, or the combination of these two procedures (Quinsey, Bergersen & Steinman, 1976; Quinsey, Chaplin & Carrigan, 1980). Indeed, in the most recent report of their treatment program, it is clear that Quinsey and his colleagues continue to select patients as suitable for treatment in terms of their laboratory displayed sexual preferences and that these deviant preferences are the prime targets in treatment (Rice, Harris & Quinsey, 1990).

Institutional-based programs

Inpatient cognitive/behavioral programs have been described within general psychiatric hospital settings (Marshall & McKnight, 1975; Smith, 1984) in jails (Marshall, Johnston, Ward & Jones, 1990; Marshall & Williams, 1975; McCaldon & Marshall 1976; Pichers, 1990), and in maximum security hospitals housing convicted mentally disordered offenders or those found not guilty by reason of insanity (Marques, 1985; 1988; Quinsey, Chaplin, Maguire & Upfold, 1987).

There is very little in the way of satisfactory outcome data from psychiatric hospital settings. Marshall (Marshall, 1973; Marshall & McKnight, 1975) has reported outcome on a limited sample of sexual offenders and while it was encouraging, no comparable data on untreated offenders were provided nor could any be reasonably estimated. Freeman-Longo (1984) indicated that none of the 20 offenders released from the treatment unit in the Oregon State Hospital had reoffended but we do not know how patients

were selected to enter or leave the program.

Davidson (1979; 1984) evaluated the early version of an Ontario penitentiary program by analyzing recidivism data derived from official police records. This program accepted offenders who expressed a desire for treatment and who were close to the end of their sentence. Davidson compared treated patients with a matched group of untreated sexual offenders released in the eight years prior to initiation of the program. The overall recidivism rate for the treated offenders (11%) was better than that revealed for the untreated men (35%) which certainly indicates an effective reduction in expected reoffending. Davidson's (1984) subsequent analyses revealed that the program was more effective in treating child molesters than rapists.

Over the past several years this program has been revised. A multidisciplinary team offers individual and group programs over an 18-week period, targeting sexual education, self-management, victim awareness, social skills, and street skills. The individual therapy is described as cognitive-behavioral but we are not told the orientation of the group process. Leger (1989) has provided official recidivism figures for offenders treated in this revised program and released into the community. The follow-up period for this study was between 3-12 years and the recidivism rates were 18% for the rapists and 20% for the pedophiles. These results suggest that either the quality of this program has deteriorated over the years or it is attempting to treat a more difficult population.

A comprehensive cognitive-behavioral program operating in a Saskatchewan federal penitentiary has released 130 treated offenders, who have been followed for an average of two years (maximum 7 years). A search of official police records revealed that only 10% had been convicted of a further sexual offense (Gordon, 1989). This program targeted a broad range of difficulties (including sexual preferences, distorted cognitions, social competence, stress management and victim empathy) and includes a relapse prevention component. This program targets much the same population of offenders as does the one in

Ontario so the outcome data suggest that it is a more effective version of a penitentiary-based program.

Marques, Day, Nelson and Miner, (1989) have described the program at a California State Hospital housing mentally-disorderd offenders. This program involves a significant relapse prevention component as well as various other components aimed at reducing deviance and enhancing skills. Forty seven of the patients who had successfully completed the hospital part of the program had been released to the community by the end of 1988. Over an average 12.7 months at risk, 8% of the treated group had reoffended compared with 20% of the untreated volunteers (N = 49) and 21% of the nonvolunteers (N = 42). Against this impressive result, however, we must keep in mind that over this follow-up period all of the treated men remained essentially in treatment. They were required to attend at least two sessions each week of individual counseling and to be involved in any other programs deemed necessary (e.g., family interventions, behavior therapy for deviance, etc.). The real test of the value of this program will have to wait until these offenders have been discharged from the aftercare program for at least four to five years.

The program operated by the Vermont State Corrections (Pithers Martin & Cumming, 1989) has also provided an evaluation. In addition to a variety of procedures (all cognitive/behavioral) being employed to attain a variety of treatment goals while the men are still in jail, this project also involves components training the offenders in relapse prevention skills (internal management) and a comprehensive release program based on the relapse prevention model (external management). This external management continues until the end of the offender's parole.

The outcome data from this program (Pithers & Cumming, 1989) are both encouraging and revealing. Of the 147 pedophiles released, only 3% have subsequently committed a sex offense during a six-year follow-up period. Even allowing for the fact that the selection procedures for this program have chosen potentially low rate reoffenders, this is still

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well below expectations for incarcerated child molesters. However, 15% of the 20 treated rapists reoffended during this same period, and this is consistent with Davidson's (1984) finding that the early Ontario program was effective with child molesters but not with rapists.

Our final appraisal concerns a program operated in a maximum security hospital in Ontario (Rice et al, 1990). Quinsey (personal communication) has indicated that the treated group were selected from among more permanent residents (those found not guilty by reason of insanity or those certified as mentally ill), while the untreated controls were men on a brief stay who were remanded for a psychiatric assessment. We might expect quite different recidivism rates from these two groups with more of the permanent residents reoffending if left untreated.

The evaluation report of this program describes treatment as limited to the modification of sexual preferences in all but 42 of the 136 treated patients. Of these 42, 16 also received heterosocial skills training and 26 participated in a sex education course. This is clearly a quite limited approach relative to the comprehensive cognitive/behavioral programs considered in the rest of this section. Even the techniques used to modify deviant sexual preferences seem rather restrictive involving only biofeedback/signalled punishment or classical aversive conditioning; there were apparently no attempts to enhance appropriate responding.

Outcome data from this program revealed no therapeutic benefits. In fact, if anything treatment seemed to have hindered the patients' progress; 37% of the treated patients reoffended over a 7-year follow-up while 31% of the untreated patients reoffended over the same period. Unfortunately, this comparative evaluation involved only 29 subjects from each of the treated and untreated groups since that was all the researchers could appropriately match. According to Rice et al (1990) however, only 18 of these 29 treated subjects were "successfully treated" which presumably means that these were the

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only ones whose deviant preferences were changed. If only 62% reached the goals of treatment, then we could hardly expect much of a difference between treated and untreated patients, particularly since the treated patients appear to have been the more problematic of the two groups and only a very limited intervention was provided.

Despite the failure of both Rice et al's (1990) program, and the more recent version of the Ontario penitentiary program (Leger, 1989), overall it is clear that institutionally based cognitive/behavioral programs can be effective in reducing expected rates of recidivism in sex offenders. The two programs which failed, however, clearly show that an overall positive outcome is no guarantee that all versions of cognitive/behavioral therapy will be equally effective in all settings for all patients.

Outpatient programs

Abel, Mittleman, Becker, Rathner and Rouleau (1988) relied on their patients' self-reported reoffending as the basis on which to determine failures. However, they were able to develop an elaborate procedure to protect the confidentiality of information divulged during assessments and treatment, and certainly some of their published data indicate that patients have disclosed considerably more sensitive information than would have been available in official records. This procedure strengthens our confidence in Abel et al's reoffense data, but does not fully remove our reservations regarding the value of relying on self-reports. In addition, Abel et al have so far only followed their patients for one year.

In a mixed group of non-familial child molesters, Abel et al (1988) reported a 12.2% recidivism rate over this single year. This patient group (n = 98) included men who had molested boys, men who had molested girls and those who had molested children of both genders, making it difficult to compare their outcome to expected rates. Unfortunately, the greatest proportion of their treatment drop-outs came from those patients who seemed to be at greatest risk to reoffend, leaving a greater proportion of the less deviant

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subjects (and therefore lower risk patients) in the final outcome evaluation. If this group of treated patients follows the cumulative progression in recidivism observed in other studies, by the end of the fifth follow-up year these patients might be expected to have failure rates which are similar to those observed by Rice et al (1990).

Long-term follow-up data from the Oregon Clinic (Maletzky, 1987) on the other hand, do seem to convincingly demonstrate effectiveness, at least with child molesters and exhibitionists. Official police records revealed that only 12.7% of 1719 treated heterosexual pedophiles had reoffended over the 1- 14 year follow-up period. Similarly, the reoffense rate (13.6%) for the men (n = 513) who had molested boys over this extensive follow-up, is well ahead of what we would expect if they had not been treated.

Exhibitionists treated at Maletzky's clinic (n = 462) did remarkably well (6.9% recidivism over 1 - 14 years) considering what we (Marshall, Barbaree & Eccles, 1989) found to be the recidivism rate for untreated exposers (23.8% in official police records over 4 years). However, Maletzky (1987) reported rather poor success with rapists. He followed 87 treated rapists for up to 14 years post-treatment and found that 26.5% reoffended. From relevant studies of recidivism it is clear that this rate is no better than we would except for untreated rapists.

At the Kingston Sexual Behaviour Clinic we were able to search the nationwide official police records and we were given access to unofficial files held by police and children's protection agencies. Information derived from these unofficial sources revealed recidivism rates which were more than double the official rates. Marshall and Barbaree (1988) were able to match treated child molesters with untreated men on a number of important variables. All individuals in both groups admitted their crimes and expressed a desire to enter treatment, and all were assessed during the same time period. Those patients who were unable to attend the Kingston Sexual Behaviour Clinic (typically because they lived too far away to attend regularly) were classified as the untreated

group although arrangements were made for them to receive some form of treatment or counselling in their local community. Patients (treated or untreated) were included in the study only if they had been at risk post-treatment or post-assessment for at least 12 complete months with the average follow-up being approximately 4 years.

Recidivism rates for heterosexual pedophiles revealed far better outcome for the treated (17.9% unofficial; 7.5% official) than the untreated men (42.9% unofficial; 17.9% official). For the men who molested boys the corresponding figures were: treated 13.3% (5.5% official); untreated 42.9% (19.2% official). For the incest offenders the rates were: treated 8.0% (2.9%); untreated 21.7% (7.0%).

In a separate report Marshall et al, (1989) have described two outcome studies with exhibitionists treated at the Kingston Clinic. Again unofficial and official records were the basis for estimating recidivism. Patients in the earlier program were treated during the period 1976-1984 when treatment at the clinic was limited to correcting deviant sexuality and enhancing some limited aspects of general social functioning. In this evaluation the recidivism rate for the untreated men was 57.1% (23.8% official) while for the treated men it was 39.1% (17.8% official). Although the treated group did better than the untreated sample, the absolute success rate was not high, and the program was modified.

From 1984 on, Marshall et al increased the focus on relationship issues, particularly the need to accept the responsibilities entailed in relationships and to develop activities which enhance intimacy. The assertiveness component was intensified and decreased emphasis was placed on the strictly sexual aspects of the behavior; a relapse prevention (internal management) component was also added. The subsequent unofficial recidivism rates for this treated group (23.5%) were very encouraging. Although the follow-up period was only three years, earlier data suggests that this figure will not increase remarkably thereafter.

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Evaluations of outpatient cognitive/behavioral programs, then, are definitely encouraging. While there is not an extensive body of outcome literature, what there is suggests that at least child molesters and exhibitionists can be effectively treated by these comprehensive programs. However, as with the institutionally-based programs, outpatient programs are not uniformly effective and none of them as yet have demonstrated effectiveness with rapists.

CONCLUSIONS

In our review of the literature we have attempted to answer the question "Can sex offenders be effectively treated so as to reduce subsequent recidivism?" We believe that the evidence provides an unequivocally positive answer to this question although equally clearly not all programs are successful and not all sex offenders profit from treatment. Comprehensive cognitive/behavioral programs and those programs which utilize antiandrogens in conjunction with psychological treatments, seem to offer the greatest hope for effectiveness and future development. However, even here not all versions of these programs are equally effective and those that are do far better with child molesters and exhibitionists than they do with rapists. At the moment there is insufficient data to identify in advance those patients who will profit least (except of course for rapists), and this topic urgently needs research. However, such research should be directed at identifying what it is current programs are missing rather than identifying who should or should not be treated. Certainly we need to modify our programs for rapists if we are to reduce their subsequent reoffense rates.

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POLICY # 37

Revised June 1987

EVALUATION POLICY

1. The evaluation groups (especially when non-staffed) are not a small therapy group. Its purpose is to join evaluation persons and a few residents together to discuss any personal problems.

2. Evaluation persons must ask residents to escort them to the dining room, as well as to any day-rooms, offices, laundry rooms, team rooms, library, etc. The evaluation person may ask his own therapy group to get the escort restriction lifted.

3. On weekdays between 1 p.m. and 4 p.m., evaluation persons may escort one another (the buddy system) for hall traveling. A resident escort is required, however, if evaluation person is going to offices, unless staff overrides escort for testing.

4. When no other residents are awake on the unit, evaluation persons are not to be up. Weekend breakfasts attendance should be prearranged if evaluation person wants to go.

5. Evaluation persons are able to sleep on the unit between the following hours:

Monday through Thursday	10 p.m. - 7 a.m.
Friday and Saturday	9 p.m. - 9 a.m.
Sunday	10 p.m. - 9 a.m.
Holiday	10 p.m. - 9 a.m.

6. Evaluation persons are not to be alone in their room without a resident escort unless given permission by nurse, staff, or small group.

7. Evaluation persons need a phone escort. The escort may terminate the phone call if he believes it to be abusive. Escort should be from evaluation person's small therapy group.

8. Evaluation persons should get what they need from their rooms and be ready to move to their designated afternoon day-room between 12 noon and 12:30 p.m. Monday through Friday. The North, West, and East Day-Rooms are off limits during these times.

9. Evaluation person will work on his autobiography whenever possible (they are to seek aid whenever possible).

10. Evaluation people may use the Laundry Room between 1 p.m. and 4 p.m. Monday through Friday. Any other time of the day is reserved for residents and permission must be granted before it may be used by an evaluation person.

11. Evaluation persons are encouraged to check the duty roster and the rest of the materials on the daily bulletin board.

(Continued on page 2)

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12. Evaluation persons should be familiar with unit policy for visitors - four hours per week. It is preferred that visits not occur on Monday through Fridays from 1 to 4 p.m. unless the evaluation person pre-arranged for an escort from small group. All lawyer and clergy visits will be private but a hall monitor is still needed.

13. Evaluation persons who wish to use safety type razors need a resident escort for getting and using the razor.

14. Evaluation persons are not to have butane lighters.

15. Typewriter usage - refer to typewriter usage policy.

16. Security: When outside, all evaluation persons will be handcuffed when not in controlled setting.

17. EVALUATION PERSONS BOARD AND GROUP MEETING PROCEDURE:
    a) The chairman, CO chairman, secretary will hold their respective offices for a term of two weeks. The persons holding these offices must be on evaluation status for a minimum of one week. No office is to be held by an evaluation person during his last week.
    b) Offices on the board are not mandatory.
    c) The chairman and secretary will meet with all new evaluation persons and inform them of evaluation policy and procedures.
    d) There shall be at least one evaluation day room monitor for each day room occupied by an evaluation group.
    e) Complaints about evaluation persons will be brought to the attention of the evaluation board and small therapy group. Evaluation persons on restriction will be identified during meetings.
    f) There will be no smoking during evaluation meetings unless the meeting is held in an authorized smoking area.
    g) Introductions will be done during all evaluation small group meetings which are held two times a week. Introductions will follow the same procedures as used in small therapy group.

18. Evaluation persons are not to be alone in day-rooms or dorm rooms, or any other areas at any time. No two evaluation persons are to be alone in an isolated area during afternoons, Monday through Friday, 1 p.m. - 4 p.m. (exception is the laundry room).

19. G-Ratting (horseplay) is not allowed.

20. During afternoons, Monday through Friday, 12:30 - 4 p.m., evaluation persons traveling in two's must inform hall monitor when going from day room to pop machine, library, or washroom.

21. ANY POLICY OR PROCEDURE NOT COVERED HERE OR THAT MIGHT BE CONFUSING SHOULD BE COVERED/DISCUSSED WITH OUR RESPECTIVE BIG BROTHERS OR SMALL THERAPY GROUP.

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UNIVERSITY OF MINNESOTA
MEDICAL SCHOOL
PROGRAM IN HUMAN SEXUALITY

JAMES W. MADDOCK, PH.D.

OUTLINE OF DEVELOPMENTAL SEX HISTORY

I. Overview of Present Situation (including presenting complaint)

II. Childhood
- --sex education--when, how, reactions
- --family attitudes toward sex--how known, expressed
- --perception of parents' marriage, sexual relationship
- --interaction with siblings
- --general interaction with peers
- --patterns of sex play and sex interest
- --awareness of factors shaping sexual attitudes, e.g. religion
- --"special" factors or events shaping sexuality (+ or -)

III. Preadolescence--Puberty
- --pubertal sequence, reactions, feelings, etc.
- --knowledge about sex--when, how, reactions
- --body awareness--masturbation
- --alternate sex contacts
- --same sex contacts (be prepared to trace this into adulthood)

IV. Adolescent Sexual Experience (high school years)
- --dating patterns, duration, initiation, parental controls etc
- --levels and kinds of sexual involvement, factors in decisions
- --general interaction with peers
- --self image
- --special factors or problems

V. Premarital History (college/young adult)
- --steps leading to marriage, factors in decision, etc.
- --level and kinds of sexual involvement during courtship
- --pre-courtship dating patterns, serious relationships, etc.

VI. Marital History (if appropriate)
- --adjustment, history, duration, etc.
- --perception of spouse's adjustment, feelings, attitudes, etc.

VII. Current Sex Profile (return to present focus with more detail)
- --marital patterns
- --extramarital patterns
- --same sex relationships
- --fantasies
- --"special" forms of expression

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THE GROUP INVOLVEMENT SCALE

0 - Absent

1 - Present, occasional sleeping (score as 1 even if makes relevant comments)

2 - Awake, but inattentive

3 - Attentive, but no participation

4 - Exclusively hostile or minimal (example: nodding) participation

5 - Contributes at least one marginally relevant comment

6 - One or two relevant verbal contributions

7 - Three to five relevant verbal contributions, or 1-2 reflecting, same as in 8

8 - Three to five relevant verbal contributions reflecting either:

A) marked sensitivity to another's emotions

or

B) willingness to openly explore personal feelings, thoughts or behaviors

9 - More than five relevant verbal contributions reflecting same as in 8

ITPSA
Revised 7/1/88

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GROUP MEMBER'S IMPRESSIONS AND RECOMMENDATIONS AT END OF EVALUATION AT ITPSA

Name of person being evaluated: _____

Group _____ Date: _____

1. This person's greatest positive characteristics are: _____

2. His greatest problems are: _____

3. In your opinion, is this person ready and able to work at personal change within a treatment program:

   Circle one: Yes No (if "No," go to Question 6)

4. If "Yes" above, is the ITPSA the best placement for this person?

   Circle one: Yes No

5. If you do not recommend placing this person in the ITPSA, what sort of treatment do you recommend?

   More restrictive? Yes No / Less restrictive? Yes No

   Specify what sort of treatment: _____

6. If you answered "No" to question 3, what disposition do you recommend?

Signature: _____

Revised 7/85, NHW

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EVALUATION OUTCOME

Resident's Statement of Wishes
Regarding Outcome of Evaluation by the ITPSA

I. Check one:

_____I Do (want the Team to recommend that the court return me to ITPSA for treatment.)

_____I Do Not

II. If you checked I Do above, write a statement telling why you want treatment in the ITPSA and telling what you have done during evaluation to show your motivation.

III. If you checked I Do Not above, complete the following sentence:

I want the Team to recommend_____

Signature:_____

Date:_____

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ANNUAL REVIEW OUTCOME

Resident's Statement of Wishes Regarding Outcome of Annual Review by the ITPSA

I. Check one:

_____ I do) want the Team to recommend
) that I continue in treatment
_____ I do not) at the ITPSA.

II. If you checked **I Do** above, write a statement telling why you want to continue in treatment at the ITPSA and telling what you have done during the past year to show your motivation.

_____

_____

_____

_____

_____

_____

_____

_____

_____

III. If you checked **I Do Not** above, complete the following sentence:

I want the Team to recommend_____

_____

_____

_____

Signature:_____Date:_____

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ITPSA STEPS OF PROGRESS - Revised 7/89

GOALS AND RESPONSIBILITIES FOR ALL RESIDENTS

1. Abide by unit rules and regulations, especially: no drugs, no abuse of others, no sexual contact with others, and no efforts to escape.
2. Maintain personal cleanliness, pick up after self, accept housekeeping responsibility, rotate through dining room clean up duty.
3. Attend all group therapy sessions when on the unit.
4. Participate in activities therapy, education, work and any other programming indicated in treatment plan.
5. Display increasing openness, honesty, and self-awareness in communication with staff and residents.
6. Minimize dehumanizing language and behavior; use more words and actions which communicate respect of self and others.

EVALUATION	ASSIGNMENTS	RESPONSIBILITIES	PRIVILEGES
	a. Describe offense (and sexual history) in therapy group. Compare this description with victim's description. b. Complete psychological testing. c. Participate in assessment interviews with members of team. d. Complete an autobiography by 10th day after admission and allow group members and supervisors to read it. e. Write statement regarding personal recommendation for outcome of evaluation. f. Collect and read group members' views of you and their recommendations.	a. CQ with big brother.	PRIVILEGES MAY BE REQUESTED AT THE STEP LEVEL INDICATED. STEP LEVEL DOES NOT ENTITLE ONE TO THE PRIVILEGES LISTED. Off-unit activities with two staff and handcuffs during transit.

GOALS OF PHASE I - EARLY INPATIENT TREATMENT - STEPS 1-3

CLARIFICATION OF PROBLEMS AND FULL INVOLVEMENT IN THE TREATMENT PROGRAM

1. Focus on unit-based relationships and issues, i.e. minimize contact with family and friends and avoid establishing new relationships outside the hospital.
2. Demonstrate increasing and caring involvement in group process and life of therapeutic community.
3. Demonstrate understanding of program philosophy.
4. Adopt a help-seeking attitude with minimal evidence of "victim's stance" thinking.

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	ASSIGNMENTS	RESPONSIBILITIES	PRIVILEGES
STEP 1	a. Participate in updating of professional assessments. b. Specify problems to be addressed in treatment and the personal strengths which will be applied toward treatment. c. Develop a treatment plan with therapy supervisor. d. Revise autobiography by adding detail to sexual history and identifying events and personal changes since arrest. Present autobiography to group members and supervisors. e. Write a statement of commitment to personal change and present to group. f. List and describe impact of hurtful, selfish, and irresponsible behavior.	a. Begin daily log. b. CQ with big brother.	May request Security Level 3 Off-unit activities with staff May request assignment to work and/or education within MSH
STEP 2	a. Verbally interpret each section of program philosophy in a manner acceptable to group members and supervisors. b. Write and present to group an interpretation of the program philosophy as it relates to autobiography. c. Write and present to group a description of ideal self--"the kind of person I want to be". d. Describe how you used dential and minimization of blame to allow you to abuse others and specify current use of these defense mechanisms. e. Describe how support and confrontation of group members are both necessary to personal growth. f. Write and present to group "How does Honesty, Effort and Concern relate to my Offense".	a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor.	May request Security Level 4 Begin work and/or education within MSH
STEP 3	a. Read autobiographies of group members, report in group (without notes) on what stands out in each person's history. b. Write and present to group "Relapse Prevention" worksheet. c. Identify in group any continuing difficulties in trusting and accepting group members and plan for building trust. d. Read Boys and Sex and Girls and Sex and report on insight gained from these to group. e. Present a leisure history and how it relates to sexual outlets to small group. f. Describe how projection of blame allowed you to abuse others and specify current use of this defense mechanism.	a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor. d. Silverware duty. e. Visit Hall Monitor.	

GOALS FOR PHASE II - MIDDLE INAPTIENT TREATMENT - STEPS 4-7

INITIATION OF CHANGES IN SEXUALITY AND INTERPERSONAL RELATIONSHIPS

1. Clearly describe the impact of abuse history.
2. Increase and refine responsible and empathetic leadership in group and therapeutic community.
3. Develop plan and begin to change deviant sexuality and dysfunctional relationships.
4. Demonstrate improved problem-solving skills including identification of a number of options available in problem situations.
5. Maintain relationships with peers which are characterized by active, enthusiastic involvement, assertive communication and commitment.
6. Demonstrate continuing growth in:
   a. the ability to consider consequences for behavior before acting;
   b. the ability to consider the rights and feelings of others before acting; and
   c. the ability to delay gratification of wants and needs.

	ASSIGNMENTS	RESPONSIBILITIES	PRIVILEGES
STEP 4	a. In group, tell offense through the victim's eyes. b. Write and present to group examples of continuing deviant sexuality. c. Specify how treatment plan provides for changing the thinking and behavior connected to the pattern of abuse. d. Read and summarize information on reflective/empathic listening skills and answer the question "how might these skills contribute to my growth and well-being? e. Initiate, plan, and carry out an activity for small group and report experience to the group. f. Describe how rationalization and justification allowed you to abuse others and specify current use of these defense mechanisms.	a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor. d. Silverware duty. e. Visit Hall Monitor. f. Serve as big brother.	
STEP 5	a. Read Positive Addiction, present in group how what was learned is going to be applied in current and future choices. b. Identify a second person victimized by offense and tells the offense through that person's eyes. c. Complete role-play of empathic/ reflective listening skills and receive feedback from group. d. Describe current examples of manipulative and productive ways in which you attempt to influence others. e. Ask group members to compare ideal self to real self and present was was learned by this in group. f. Identify significant losses and positive changes experienced since arrest.	a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor. d. Silverware duty. e. Visit Hall Monitor. f. Serve as big brother. g. Security Committee.	

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	ASSIGNMENTS	RESPONSIBILITIES	PRIVILEGES
STEP 6	a. Complete second role-play of empathic/ reflective listening skills and receive feedback from group. b. Identify thoughts which support or reinforce hurtful behavior patterns and report on progress made in changing these thoughts. c. Tell group what is replacing the excitement offered by illegal or hurtful sexual behavior or fantasy. d. Describe a sexual dysfunction personally experienced, feelings about it, and identify what is being done to deal with it.	a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor. d. Silverware duty. e. Visit Hall Monitor. f. Serve as big brother. g. Security Committee.	
STEP 7	a. Resident and group members independently identify problem areas that need further attention with specific attention to sexual thinking and behavior. Present findings in group. b. Ask group members how his leadership has been helpful and how it might be improved. c. Describe healthy sexual outlets being utilized. d. Identify losses experienced by victims of sexual abuse. e. Problem solving skills exercise in group. (See separate instructions).	a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor. d. Silverware duty. e. Visit Hall Monitor. f. Serve as big brother. g. Security Committee.	

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GOALS FOR PHASE III - LATE INPATIENT TREATMENT STEPS 8-11

REFINEMENT AND GENERALIZATION OF CHANGES

1. Report effective control of high-risk fantasies.
2. Spontaneously and self-critically bring personal problems to group.
3. Demonstrate effective use of methods for preventing relapse to full abuse pattern as outside relationships are reestablished.
4. Consistently display responsible and empathetic involvement in group and therapeutic community while supporting emerging leadership of residents in Phase II.
5. Expression of feelings is assertive, non-aggressive and non-manipulative.
6. Identify what has changed, what still needs change and how future life will be structured differently in light of these awarenesses.
7. Develop preliminary transition options.
8. Utilize a logical progression of passes to build support system and explore transition options.

	ASSIGNMENTS	RESPONSIBILITIES	PRIVILEGES
STEP 8	a. Describe what is wrong with his judgement, when and why he cannot trust it, and how he adapts to this awareness. b. Write and present to group Relapse Prevention worksheet. c. Clearly describe to group non-productive style of relating to others and how this is being changed. d. Detail current involvement in interests and activities incompatible with old patterns.	a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor. d. Silverware duty. e. Visit Hall Monitor. f. Serve as big brother. g. Security Committee. h. Escort off-campus passes. i. Serve on Film Committee. j. Manage ward accounts. k. Help lead Evaluation Group.	May request Security Level 5 May request on and off campus passes in St. Peter
STEP 9	a. Present to group a detailed description of methods being used to modify high-risk fantasy and other thoughts. b. Present to group a detailed description of recent examples of both successful and unsuccessful applications of newly learned problem-solving techniques. c. Present to group a detailed description of recent examples of both successful and unsuccessful efforts to practice assertive communication. d. Describe own ideal sexual relationship and strategies needed to accomplish.	a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor. d. Silverware duty. e. Visit Hall Monitor. f. Serve as big brother. g. Security Committee. h. Escort off-campus passes. i. Serve on Film Committee. j. Manage ward accounts. k. Help lead Evaluation Group.	May request day passes out of St. Peter May request on-campus work assignment

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STEP 10	a. Complete "relapse prevention" workbook and present to group. Relate to daily life on the unit. b. Present to group a detailed description of recent examples of both successful and unsuccessful efforts to practice empathic/reflective listening. c. In group, recount offense through the victim's eyes. d. Describe current sexual behavior and level of comfort with own sexuality.	a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor. d. Silverware duty. e. Visit Hall Monitor. f. Serve as big brother. g. Security Committee. h. Escort off-campus passes. i. Serve on Film Committee. j. Manage ward accounts. k. Help lead Evaluation Group.	May request overnight off campus passes
STEP 11	ASSIGNMENTS a. Complete Step 11 Daily Management Guide and use it to structure daily log entries. Report on this weekly in group. b. Role play coping strategies for high risk situations. c. Describe ten options for release placement. d. In group, recount offense through second victim's eyes.	RESPONSIBILITIES a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor. d. Silverware duty. e. Visit Hall Monitor. f. Serve as big brother. g. Security Committee. h. Escort off-campus passes. i. Serve on Film Committee. j. Manage ward accounts. k. Help lead Evaluation Group.	PRIVILEGES May request up to 3-day off campus passes

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GOALS FOR PHASE IV - TRANSITION - STEPS 12-15

THE INDIVIDUAL CARRIES NEWLY LEARNED WAYS OF THINKING AND BEHAVING INTO LIFE IN THE COMMUNITY WITH THE TREATMENT PROGRAM OFFERING SUPPORT AND FEEDBACK

1. Report maintenance of effective control of high-risk fantasies.
2. Demonstrate effective use of relapse prevention techniques.
3. Offer responsible and empathetic involvement in group and therapeutic community, especially with residents in Phase III who are preparing for transition.
4. Specify and carry out release plan.
5. Continue involvement in mature, non-exploitive, and growth-producing activities and relationships.
6. Ongoing reporting of all sexual activities.
7. Continued abstinance from mood altering chemicals.

STEP 12	a. Role play coping strategies for high-risk situations. b. Present autobiography to group. c. Obtain group members' assessments regarding preparedness for leaving inpatient treatment. d. Describe what has been gained from the group and how the group can continue to help. e. Identify and maintain record of warning signs of relapse which occur, review record with group explaining how they were dealt with and what adaptations were made. f. Develop a plan for sexual choices and present it in group. g. Complete plan for community re-entry.	a. Maintain daily log. b. CQ alone. c. Afternoon Hall Monitor. d. Silverware duty. e. Visit hall monitor. f. Serve as big brother. g. Security Committee. h. Escort off-campus passes. i. Serve on Film Committee. j. Manage ward accounts. k. Help lead Evaluation Group	May request up to 4-day off-campus passes May request off-campus work assignment
STEP 13	a. Obtain employment in the community. b. Obtain approval for release. c. Discuss community adjustment each week with therapy group. d. Identify and maintain record of warning signs of relapse which occur, review record with group explaining how they were dealt with and what adaptations were made.	a. Maintain daily log. b. CQ alone. c. Visit escort. d. Silverware duty. e. Security Committee. f. Escort off-campus passes. g. Serve on Film Committee. h. Manage ward accounts. i. Help lead Evaluation Group. j. Schedule of duties to allow for work schedule.	May request move to transition placement with weekly return to unit

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	ASSIGNMENTS	RESPONSIBILITIES	PRIVILEGES
STEP 14	a. Discuss community adjustment once monthly with therapy group. b. Identify and maintain record of warning signs of relapse which occur, review record with group explaining how they were dealt with and what adaptations were made.	a. Maintain daily log. b. Move all belongings out of the hospital. c. Meet with therapy group when on the unit. d. Host visiting ITPSA residents on pass.	
STEP 15	a. Maintain at least monthly contact with transition supervisor. b. Attend quarterly team reviews as scheduled.	a. Maintain daily log. b. Host visiting ITPSA residents on pass.	

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Daily Management Guide

Develop a guide which will assist you in monitoring your personal awareness, experiences, and coping strategies. Use the guide to structure your log entries each day. Following are some suggestions and a daily planner.

A. What will I or did I do today to keep my relationships rewarding; what did I do today to disrupt my relationships ?
B. What are your strategies to cope with stress or other problems ? Schedule those strategies into your day.
C. Plan your life and follow through with plans. Do not rely on "spontaneous" events to fill your day.

DAILY PLANNER

Time	What's planned	What I did
8:00 a.m.		
9:00 a.m.		
10:00 a.m.		
11:00 a.m.		
Noon		
1:00 p.m.		
2:00 p.m.		
3:00 p.m.		
4:00 p.m.		
5:00 p.m.		
6:00 p.m.		
7:00 p.m.		
8:00 p.m.		
9:00 p.m.		
10:00 p.m.		

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ITPSA CD STEPS OF PROGRESS

STEP	TREATMENT GOALS	SPECIFIC ACTIVITIES
I.	a. Have a basic understanding of programmatic beliefs and expectations about chemical dependency/abuse. b. Have an understanding of own chemical use and its consequences.	a.1. Attend all unit CD groups a.2. Attend AA meetings on unit b.1. Write a chemical history. Describe chemical use in terms of time periods, amounts, kinds of chemicals. Include what has happened to feelings, attitudes, and behaviors. b.2. Memorize Serenity prayer.
II.	a. Become aware of and accept chemical dependency as a chronic condition. b. Take first step in AA.	a&b 1.Read chapters 1-5 in ALCOHOLICS ANONYMOUS. a&b 2.Complete written assignment on Powerlessness and Unmanageability, and present to CD group. a&b 3.Attend all unit CD groups and unit AA meetings. a&b 4.Read Steps 1, 2, and 3 in TWELVE STEPS AND TWELVE TRADITIONS.
III.	a. Have a basic understanding of chemical dependency as a Family Systems problem.	a.1. Complete written assignment on families and present to group. a.2. Read chapters 3 & 4 in WHY AM I AFRAID TO TELL YOU WHO I AM? a.3. Attend all unit CD groups and unit AA meetings. a.4. Encourage Alanon for significant others.
IV.	a. Complete Fourth Step in AA. b. Complete Fifth Step in AA (optional).	a.1. Complete Fourth Step Inventory using guide and share with CD group. b.1. Complete Fifth Step with Chaplain or other appropriate person (optional). a&b. Attend all unit CD groups and unit AA meetings. a&b. Read Step 4 & 5 in TWELVE STEPS AND TWELVE TRADITIONS, and write summary.
V.	a. Demonstrate an understanding of defense mechanisms operating in chemical abuse/ dependency.	a.1. Complete written assignments and present to CD group. Readings and outline provided. a.2. Attend all unit CD groups and unit AA meetings.
VI.	a. Identify social constellations associated with chemical use.	a.1. Write "People & Places" history. How friends chosen, identify family members and friends associated with chemical use. a.2. Attend all CD groups and unit AA meetings. a.3. Read Step 6 in TWELVE STEPS AND TWELVE TRADITIONS.

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STEP	TREATMENT GOALS	SPECIFIC ACTIVITIES
VII.	a. Assess and learn about holistic issues in recovery. Begin to plan for alternative highs in life and with family.	a.1. Read "Alternatives to Drugs" and write summary. a.2. Attend all unit CD groups and unit AA meetings. a.3. Read Step 7 in TWELVE STEPS AND TWELVE TRADITIONS.
VIII.	a. Complete AA Steps 8, 9, and 10.	a.1. Read Steps 8, 9, and 10 in TWELVE STEPS AND TWELVE TRADITIONS. a.2. Complete written assignment on amends outline provided). a.3. Read "Living Sober". a.4. Attend all unit CD groups and unit AA meetings.
IX.	a. Work AA Step 12.	a.1. Plan and carry out program for one unit AA meeting. Coordinate with staff. a.2. Attend all unit CD meetings and AA meetings. a.3. Read Steps 11 and 12 in TWELVE STEPS AND TWELVE TRADITIONS.
X. XI. XII.	a. Work AA Step 12.	a.1. Plan and carry out program for one unit AA meeting on each Step (X, XI, and XII), coordinate with staff. a.2. Attend all unit CD groups and unit AA meetings.
XIII.	a. Have plan, including dates for community based CD after-care.	a.1. Seek out community based AA meeting and secure AA sponsor. a.2. Develop a Relapse Prevention Plan. a.3. Attend weekly AA meetings.
XIV. XV.	a. Continue to include CD goals in Release Plan.	a.1. Coordinate this plan with transition supervisor.

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CHEMICAL HISTORY QUESTIONNAIRE

1) Describe your first experience with mood altering chemicals, include your feelings.

2) Describe the first time you became intoxicated or high. Include feelings you remember.

3) Describe the kinds of chemicals you used, the amounts used and how often you used each.

4) When, where, and with whom do you usually use?

5) What rules did you have for yourself about your use? (example: I won't use before noon, I won't use alone, etc.) If you broke these rules discuss why and how you felt.

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6) Describe the effects your chemical use has on your feelings.

7) How have you lied about your chemical use to yourself, family, friends, teachers, employers, etc.?

8) Describe any attempts to control or quit use.

9) How and when have you placed your chemical use before your job, family, friends, responsibility, etc.?

10) How did you hide and protect your chemical supply and use?

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11) Describe preoccupation with use - plans for using.

12) Describe effects of your use:

a) legal -

b) school, grades, attitudes, behavior -

c) financial -

d) accidents and destructive behavior against self or others -

e) insane or strange behavior, memory loss, blackouts, etc. -

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f) effects on attitude, honesty, respect for self or others -

g) effects on responsibility at work and at home -

h) effects on belief in a higher power

i) effects on relationship with <u>each</u> member of your family (include also boyfriend/girlfriend) -

13) Did your sexual activities violate your personal values? If so, how?

14) Describe significant experiences you have had with any family members that abused chemicals. Describe how you <u>felt</u>.

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POWERLESSNESS

1.) HOW HAVE CHEMICALS PLACED YOUR LIFE OR LIVES OF OTHERS IN JEOPARDY?

1.

2.

3.

2.) HOW HAVE YOU LOST SELF-RESPECT DUE TO YOUR CHEMICAL USAGE?

1.

2.

3.

3.) WHAT IS IT ABOUT YOUR BEHAVIOR THAT YOUR SPOUSE - FAMILY - FRIENDS OBJECT TO MOST?

1.

2.

3.

4.) HOW HAVE YOU TRIED TO CONTROL YOUR CONSUMPTION OF CHEMICALS OR ALCOHOL?

1.

2.

3.

5.) GIVE 5 EXAMPLES OF HOW POWERLESSNESS (LOSS OF CONTROL) HAS REVEALED ITSELF IN YOUR PERSONAL EXPERIENCE.

1.

2.

3.

4.

5.

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6.) WHAT TYPE OF PHYSICAL ABUSE HAS HAPPENED TO YOU OR OTHERS AS A RESULT OF YOUR CHEMICAL USAGE?

1.

2.

3.

7.) WHAT IS YOUR CURRENT PHYSICAL CONDITION? (HEART - LIVER - ETC.)

8.) WHAT IS THE DIFFERENCE BETWEEN ADMITTANCE AND ACCEPTANCE?

ARE YOU ADMITTING OR ACCEPTING?

DEFINE HOW YOUR ARE ADMITTING OR ACCEPTING THROUGH YOUR BEHAVIOR.

9.) WHAT CONVINCES YOU THAT YOU NO LONGER CAN USE ALCOHOL OR DRUGS SAFELY?

10.) ARE YOU AN ALCOHOLIC OR CHEMICALLY DEPENDENT PERSON?

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YOUR CHEMICALLY DEPENDENT FAMILY MEMBERS

1. Who in your family do you suspect has a problem with alcohol or other drugs?

2. Keeping in mind the family members listed above, complete the following pages.

Before evaluating the effects of another person's chemical dependency on you and your family, it helps to complete some preliminary steps. Complete an in-depth review of this person's pattern of alcohol and other drug use and the effects on his or her own life. This will help you clarify the extent of the problem and the ways this person has been victimized by chemical dependency.

Following is a list of symptoms and behaviors associated with chemical dependency. Review the list and circle the number of each statement that applies to the chemically dependent person in your life.

Pattern of alcohol or drug use

P1 Uses drugs or alcohol to excess (gets drunk or "high") almost daily.

P2 Goes on alcohol or other drug-use "binges."

P3 Can't seem to cut down or stop alcohol or drug use once it starts.

P4 Continues to use alcohol or drugs despite their causing problems.

P5 Mixes alcohol and other drugs to "boost" the effects.

P6 Often uses more alcohol or drugs, or for a longer time, than intended.

P7 Has had a problem with alcohol or drugs for several years.

P8 Continues to use despite a health professional's advice to stop using and seek help.

P9 Injects drugs into veins or muscles.

Medical or physical effects

M1 Is able to consume large amounts of alcohol or other drugs.

M2 Gets drunk or "high" much quicker now than in the past.

M3 Often uses to relieve or avoid withdrawal symptoms (e.g. drinks in the morning to relieve the "shakes").

M4 Has experienced withdrawal symptoms when stopping or cutting down on alcohol or drugs.

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M5 Has had physical problems from alcohol or other drug use.

M6 Has said or done things while under the influence that could not be remembered later.

Behavioral or psychological effects

B1 Doesn't think he/she has a problem with alcohol or other drugs.

B2 Doesn't want to stop using alcohol or other drugs.

B3 When using, often becomes unpredictable in his/her behavior.

B4 Feels guilty or shameful because of using alcohol or other drugs.

B5 Becomes moody or depressed when using alcohol or other drugs.

B6 Gets mean or aggressive when using.

B7 Has become too self-centered.

B8 Has done things under the influence that others find difficult to forget.

B9 Lies about alcohol or other drug use.

B10 Gets physically violent when using.

Family and social effects

F1 Neglects or avoids family responsibilities.

F2 Has caused financial hardships for our family.

F3 Doesn't provide adequately for our family.

F4 Doesn't take an interest in our family.

F5 Seldom participates in family activities.

F6 Spends much time in bars, clubs, parties, or with others getting "high."

F7 Often gets drunk or "high" when expected to fulfill family or social obligations.

F8 Socializes mainly with others who use alcohol or other drugs to excess.

F9 Has given up social or recreational activities because of alcohol or other drug use.

F10 Manipulates others to get alcohol or other drugs.

F11 Has had a negative impact on our children or grandchildren.

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Other effects of alcohol or drug use

O1 Has job or school-related problems from alcohol or other drug use.

O2 Has legal problems from alcohol or other drug use.

O3 Has been in treatment before, but relapsed.

O4 Has given up religious beliefs or practices as a result of the alcohol or drug problem.

Think of other things that have happened with your chemically dependent family member as a result of alcohol or other drug use. Describe them here:

How long has this person had problems with alcohol or other drugs?

In reviewing the items you have checked, what would you conclude about this person's chemical dependency? How severe do you think it is?

Have you ever shared your concerns about this person's alcohol or other drug use with him or her? If yes, what happened? If no, why not?

USING THE INVENTORY TO HELP YOUR CHEMICALLY DEPENDENT FAMILY MEMBER

Now that you have reviewed the inventory on chemical dependency and answered questions, you should discuss this with either your counselor, your "sponsor" if you are in a self-help program such as Al-Anon, or with another person whom you trust. The purpose of the discussion is to help you clarify, with an "objective" person, the degree to which chemical dependency is a problem. The more items you circled in the inventory, the more serious the chemical dependency is likely to be.

If your chemically dependent family member is currently in a treatment or self-help program, you can also discuss this with him or her to share your experiences related to the chemical dependency. If this seems difficult now, you may wish to postpone such a discussion. Or, you can seek the assistance and advice of a professional counselor.

If your chemically dependent family member is not in treatment and is still using alcohol or other drugs, you can contact a local alcoholism or drug treatment clinic and ask for help with an "intervention." As mentioned before, an intervention is a process by which families and concerned others work together to convince the chemically dependent person that help is needed.

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YOUR FAMILY UNIT

Evaluating the Effects of Chemical Dependency

Chemical dependency is a family disease, meaning that children of chemically dependent parents are more predisposed to the disease than those in families with no chemical dependency. The chemically dependent person affects the family members several ways, many of which are harmful. The family often adapts to this person and makes him the focus of family life, whether he's using alcohol or other drugs or not. Family members also affect the chemically dependent person in many ways. Some are harmful, contributing indirectly to further chemical dependency.

Family members of the chemically dependent often structure their lives around this person. Chemical dependency influences the thoughts, feelings, behaviors, and personal relationships of other family members. These effects often remain, even when you no longer live with the dependent person. The specific effects will depend on your unique relationship with the chemically dependent person, how you're treated, the severity of the chemical dependency, where and when the alcohol or drug use occurs, whether this person is now sober, and your relationships with others in or outside your immediate family. For children, two other important considerations are (1) which parent is chemically dependent (mother or father), and (2) how the non-addicted parent acts towards the child.

To progress in recovery it is important to honestly evaluate how your family unit and each member have been affected by the chemical dependency. If you are in a primary relationship (spouse, lover, or live-in-mate) with a chemically dependent person, you should also evaluate your relationship. Although painful at first, thinking about the effects on you and your family will help you in the long run.

Review the following list and circle the number of each statement that applies to your family or its members, and which you believe describe the effects of the chemical dependency.

The mood or atmosphere in your family

M1 Is often tense and anxiety provoking

M2 Is depressing

M3 Is hopeless

M4 Is often disappointing, especially during holidays or special events like birthdays or graduations

M5 Often leads members to prefer being other places than at home

M6 Is often filled with anger

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Communication in your family

C1 We do not share feelings or problems freely.

C2 The chemical dependency problem is not openly discussed.

C3 Members don't keep each other informed about what is happening in their lives.

C4 Family members don't show much interest in each other's lives.

C5 There is too much yelling or arguing.

C6 Love and affection are seldom expressed.

Interaction among family members

i1 Meals are seldom eaten together at home.

i2 There is physical violence in my family.

i3 Our family seldom shares fun recreational activities.

i4 There is too much fighting in our family.

i5 Our family hasn't taken a vacation in a very long time.

Relationship to outside world (community, friends, etc.)

R1 Relatives avoid us because of the chemical dependency problem.

R2 Friends of family members avoid us because of the problem.

R3 Our family keeps to itself because of the problem.

R4 Some family members are seldom home because of the problem.

R5 Members are too afraid or embarrassed to bring people into our home.

Family enabling

E1 We have denied the chemical dependency problem for a long time.

E2 Our family has "covered up" this problem.

E3 The chemically dependent member has been bailed out of trouble by our family.

E4 Members often are preoccupied with this problem.

E5 Members assume the responsibilities of the chemically dependent one.

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Describe any other effects on your family unit that the chemical dependency problem has caused. Also include any *positive effects* you can think of:

In reviewing the effects of chemical dependency on your family, what conclusions would you draw?

USING THE RESULTS OF THE INVENTORY TO HELP YOUR FAMILY

Once you have completed the inventory and answered the questions, you should have a clearer idea of how your family unit has been affected by chemical dependency. Again, you are advised to discuss this inventory with a professional counselor, Al-Anon or Nar-Anon "sponsor," or someone you trust who understands chemical dependency problems.

There are four things you can do to help your family get out of the chemical dependency trap.

1. Encourage your family to learn about chemical dependency and codependency.
2. Encourage them to learn about *family recovery.* They can learn through reading, and personal counseling, and by attending educational programs or self-help programs such as Al-Anon, Nar-Anon, Alateen and Alatots (for the kids), and POTADA (for parents).
3. Openly discuss your feelings and concerns within the family and honestly face the real issues. Get others to also share their feelings and concerns.
4. Accept responsibility for making things better with the family and with yourself. Don't sit back passively—take positive action.

Once the decision is made and family recovery begins, you and your family are likely to experience benefits. You will probably find many others suffering with similar problems who will volunteer their help. Although this may feel awkward at first, try to accept help with an open mind. Others are simply trying to tell you "I understand. I've been there. Let me support your efforts to change."

Source: Dennis C. Daley (1987), Family Recovery Workbook: For Families affected by chemical dependency. Bradenton, FL: Human Services Institute, Inc.

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C.D. STEP V.

1) Chapters 1 - 4 in "I'll Quit Tomorrow", Vernon E. Johnson. (Book in Library).

2) "Chemical Dependency - The Disease" and "The Delusional System" in Alcoholism, a Treatable Disease, The Johnson Institute. (copies available).

Write a summary of each of the readings. Present to group your understanding of the defense mechanisms you use/have used, in relation to your chemical abuse.

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STEP IV READINGS

FOREWORD

Alcoholism and harmful dependence upon other mood-changing chemicals are treatable illnesses. The Johnson Institute programs of education and information are designed to inform you of the nature of the disease with two basic goals in mind - - - prevention where possible; intervention when needed.

1. If you are thoroughly acquainted with the early symptoms of harmful dependence, you may be able to alter your use pattern before loss of control occurs and treatment becomes necessary.

2. If prevention fails, or the disease has progressed to a point where outside help is required, appropriate forms of intervention must have a climate of understanding within the company in order to be effective. With this climate of understanding, the denial systems which always accompany the disease and which typically reject "help", can be breached more effectively, and the individual can more easily understand the need for treatment.

The use of mood-changing chemicals is a matter of personal choice. The Johnson Institute's only concern is to help those who may become harmfully dependent.

Chemical Dependency-

The Disease

Dependence on alcohol or other drugs used to be thought of as a moral problem. The alcoholic was looked upon as a weak-willed individual. He was thought not to care about other people, or even himself. A common attitude was, "All he (or she) has to do is control his drinking or, better yet, quit altogether!"

Today, of course, medical doctors, clergymen and other professionals have come to realize that alcoholism is a disease, and that it responds to properly designed treatment. Some of the old misconceptions remain, however, and they plague effective recognition of the disease. They have been with us a long time and remain firmly entrenched in our minds.

The chemically dependent person himself is often the last to accept the disease concept. But spouses and other persons close to the victim also continue to be very slow in identifying the disorder as an illness. This is because they are simply too involved, emotionally, with the sick person.

The American Medical Association has given formal recognition to the disease concept since 1956. Recognizing alcoholism and other drug abuse as an illness implies several things:

1. The illness can be described.

2. The course of the illness is predictable and progressive.

3. The disease is primary – that is, it is not just a symptom of some other underlying disorder.

4. It is permanent.

5. It is terminal – if left untreated, it inevitably results in premature death.

Let's take a closer look at these statements.

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THE ILLNESS CAN BE DESCRIBED. The alcoholic's compulsion to drink is manifested in drinking habits that are inappropriate, unpredictable, excessive and constant. His behavior oscillates to extremes, so that people around him are confused and bewildered. He might be good at hiding the compulsion, but it is always there. He might say, "Compulsion means that you just have to have a drink. I'm obviously not like that. I always decide whether or not I'm going to drink, so I can't possibly be an alcoholic." To an objective outside observer, however, it becomes obvious that sooner or later, the "decision" is always the same – to drink.

THE COURSE OF THE ILLNESS IS PREDICTABLE AND PROGRESSIVE. It will get worse, it's as simple as that. Sometimes there are plateaus where the drinking behavior seems to remain constant for months or even years. Occasionally some event will trigger what seems to be spontaneous improvement. But, over a period of time, the course of the disease is inevitably towards greater and more serious deterioration. This deterioration can be physical, mental and spiritual.

THE DISEASE IS PRIMARY. For a long time, most medical and psychiatric professionals started from a false premise – they treated alcoholism as though it were only a symptom of emotional or psychological disorders. The method of treatment was "Let's find out what's really wrong with you and then you will no longer have the need to drink." It didn't work. Now these people have come to realize that alcoholism is a primary disease. It causes mental, emotional and physical problems. Other problems which the victim might have cannot be treated effectively until the alcoholism is treated first.

THE DISEASE IS PERMANENT. Once you have it, you have it. Trying to learn to "drink like a gentleman (or lady)", just won't work. The only solution is to seek help to permanently arrest the disease – the earlier the better. It used to be thought that alcoholism could not be treated effectively until the victim had "hit bottom". Now we know that this is not so. The chances for successful treatment are much better in the earlier stages of the disease.

THE DISEASE IS TERMINAL. If you have this disease, and you do not successfully arrest it, you will die from it. Death certificates use a lot of euphemisms for alcoholism, but the result is the same – the victim is dead. Whether the chemical complicated a heart condition, high blood pressure, liver problem, bleeding ulcer or precipitated a suicide, it is still the agent that caused the death.

There are many definitions of chemical dependency. One of the most useful ones is this:

> If the use of alcohol or other chemicals is causing any continuing disruption in an individual's personal, social, spiritual or economic life and the individual does not terminate use of the chemical, that constitutes harmful dependence.

The non-alcoholic might have one brush with the law. He might have one reprimand from his employer. He might have family problems over one drinking episode. But one such event would be enough to make him say to himself, "Wow, if I'm going to have that kind of trouble, I'm going to cut this stuff out!" And he will.

The alcoholic, on the other hand, will continue to use the chemical even though it causes continuing problems in any or all of the relationships that are important to him. He is saying, by his actions, "Family, friends and job are important to me, but my dependence on this chemical is so great that I must continue using it even though it
feres with these relationships."
is attaching an emotional importance to an inert substance, a chemical. It is obviously abnormal. This pathological importance is one of the surest symptoms of harmful dependency.

In addition to this pathological importance, there are other signs which usually indicate that harmful dependency is developing. Hopefully this booklet will help some to recognize dangerous patterns and arrest the disease before it really has a chance to develop.

Usually, however, the highly developed defense system of the dependent person results in a lack of insight, that is, an inability to recognize the truth about his emotional, mental and spiritual disorders. This kind of mental mismanagement remains even though the person may be temporarily "dry". He remains tense, nervous, easily frustrated and anxious because, either consciously or unconsciously he remains preoccupied with thoughts of drinking or not drinking.

He begins to adapt his life style to the use of the chemical, rather than change his use of the chemical so as not to interfere with the demands of his life style. Because of this mental mismanagement, the obser-

vations of persons close to the victim are usually more reliable than any personal insight into his dependency problem.

Another symptom which indicates developing dependence is a growing tolerance to the chemical. Now it takes three drinks to effect the mood change where once it took only two. The "relaxing" cocktail after work becomes two, three or four. It seems to be needed every night instead of just on Fridays. It is paradoxical that many alcoholics recall that they could "drink everyone else under the table." They thought that their ability to "handle their liquor" better than others was evidence that they could not have a drinking problem. In reality, this indicates a growing tolerance not usually found in non-alcoholic persons.

One rationalization often used by the alcoholic is, in reality, another symptom. This is the one called "I don't have to drink. Look how easy it is for me to quit!" Eventually the alcoholic must face the truth about sporadic attempts at withdrawal. They are not, as he believes them to be, "proof of my ability to stop any time I want to." They are, rather, proof of the opposite – that inevitably, a resumption of drinking follows, often at more severe or harmful levels.

As you can see, a lot of rationalizations that the dependent person uses to try to convince others, and himself, that he does not have the disease are actually symptoms of the disease itself. His defense system draws him farther and farther away from reality. Those closest to him are ready to cry out in frustration, "How can you look at your bizarre behavior and continue to ignore what is perfectly obvious to everyone around you?"

The answer of course, is that his defense system has become so highly developed that he cannot see that which seems so obvious to everyone else. He cannot recognize that his behavior, and the defenses which he uses to explain it away, are bizarre. In order to understand how this defense system can become so impenetrable, it is necessary to examine it further.

The Delusional System

The self-delusion of the alcoholic is the result of a uniquely developed psychological defense system. Rationalization, projection and denial become ways of life which put the sufferer out of touch with reality.

There is an even more bewildering cause of self-delusion; one which is typical and almost universally present with the disease. It is the faulty memory system. The alcoholic protects his consciousness from the pain of accurate recall by three methods:

First, there is the chemically induced blackout. This should not be confused with passing out – a total loss of consciousness. A blackout is complete loss of memory for a period of time, while functioning in an otherwise normal fashion. Persons around the alcoholic during one of these blackouts perceive him to be normal, and usually assume that he is in complete control of his faculties. But later, the victim is unable to recall anything about the blackout period and never will. The quantity of alcohol consumed seems to have no direct relationship to the frequency of blackouts. A small amount of alcohol might cause a blackout and, to the contrary, large amounts may not. A blackout is one of the more definite signs of alcoholism. The recovered alcoholic, in retrospect, usually says "No one ever told me that. I thought everyone drew a blank once in a while, when he had drunk too much." But it turns out that everyone doesn't. This is a phenomenon that usually occurs only with alcoholism.

As these memory losses occur, the victim becomes more and more fearful, bewildered and depressed. With the progression of the disease they become more frequent and more unpredictable. Anxieties begin to mount as the alcoholic begins to wonder about such things as:

"What did I do last night after 10 o'clock?"

"Where did I leave my car?"

"Who was I with?"

"Where did I hide that bottle?"

Since the alcoholic cannot remember these episodes and never will be able to, he is denied specific feeling reactions to the bizarre, anti-social behavior which often occurs during blackouts. In some instances, even blackouts are "blacked out!" The victim doesn't realize that he had a blackout and so there are large periods of time which are totally unaccountable in his memory system. Guilt, shame and remorse are vague and nameless. They are of no help in self recognition, the way accurate recall of drinking behavior would be.

A recovering alcoholic explained the sick thinking that follows a blackout by saying, "I thought I was going crazy. So, every time this happened to me, I'd force myself to forget it. I got so good at it that I actually had myself believing that things just 'slipped my mind' from time to time."

Since the alcoholic's anxiety resulting from a blackout is so great, he will tend to minimize or discredit any first-hand account of his behavior during the blackout. "My wife, (or husband) is always exaggerating these things," he will say to himself. And he'll begin to believe it! This conflict between what others say about his behavior, and what he will allow himself to believe contributes to a growing paranoid feeling that others are trying to persecute him about his drinking.

Second, there is the psycholcgically induced blackout. The suffering alcoholic develops the ability to repress unwanted, shameful memory material. He literally shuts it out of his mind. He rationalizes much of his behavior, but also becomes very adept at repressing, or suppressing, memory materiai which he cannot rationalize. This is done on an unconscious or instinctive level rather than through a premeditated effort.

This is done as a natural effort towards self-preservation. Recovered alcoholics describe, in retrospect, periods of time following drinking episodes as being filled with such bitter remorse and guilt that they were simply intolerable. They felt, "I've just got to forget!" And they would!

One woman described this phenomenon by saying "I had my own 'built-in' blackout system, and it worked!" There was no chemical blackout, but whole areas of her life were quite literally forgotten as the illness progressed. The more bizarre the behavior pattern, the stronger the instinct becomes to suppress the shameful memory material. Outward manifestations of this can be seen in intensified nervousness, resentment, hostility and self-pity.

Third, there is euphoric recall, or feeling memory. This is another source of a great deal of self-delusion. In this condition, the alcoholic remembers only how he felt, and not how he behaved. He doesn't remember slurred words, exaggerated gestures or a weaving gait. He remembers that he felt like he was expressing himself brilliantly, and was the life of the party.

One man describes his disbelief when actually hearing a tape recording of one of his drinking episodes. Before playing back the recording, his wife pointedly asked him if he could remember how he said what he had said on the previous night. His reply was, "Of course I can! I had a few drinks, but I was perfectly alright!" He believed that statement until, with dismay, belief and shock, he heard his o voice stuttering, stammering and slurring through virtually nonsensical statements he had uttered the night before. He revealed, "The really terrible feeling came when I realized how many times I had remembered feeling good, but must have behaved the same way!"

Memories of such periods of time in the alcoholic's life are so distorted that self-evaluation is very difficult, or impossible. One woman put it this way: "When I used to tell people that 'I just wasn't myself' last week, I thought I was using a figure of speech. I did not see that I had become so self-deluded that it had become an entirely accurate description."

POLICY/PROCEDURE: ITPSA DEMISSION CRITERIA
February 13, 1991

ITPSA residents may be demitted from the program and returned to court with specific recommendations for disposition for the following reasons, and with the understanding that any demission is subject to review and approval by the ITPSA Director in consultation with the Medical Director.

I. Assaults, threats, fire-setting, sexual activity with others, AWOL attempts, non-prescribed chemical use, violation of release conditions related to sexual behavior, condition of probation, assisting others in these behaviors, and other major violation of unit rules.

Procedure: Immediate transfer to a more secure environment if indicated. Resident and peer group write assessments and recommendations. Probation officier notified. Full treatment team review, assessment and decision as soon as possible.

II. Refusal to attend group therapy, community meetings, full-unit activities, treatment planning, failure to abide by conditions of release, and minor violations of program rules.

Procedure: Placed on Thursday's team agenda immediately, document in medical record daily. Treatment team review, strategies discussed. Team may request assessment updates, resident and peer group written assessments and recommendations, and/or follow-up team review. Probation officier invited to any scheduled team meeting.

III. Resident requests to leave program.

Procedure: Request documented in medical record. Resident and peer group write assessments and recommendations. Scheduled for Thursday team meeting by group supervisor. Supervisors write assessment and recommendations, assessment updates completed by all disciplines. Probation officier invited to team meeting at which request is considered.

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IV. Lack of progress in treatment (less than one step progression in bimonthly/quarterly review period) or unwillingness to cooperate with individualized treatment expectations or follow clinical advice during transition.

Procedure:

A. Bimonthly/quarterly team review identifies problems, develops strategies, documents specific directions to resident and group to achieve two step progressions before following bimonthly/quarterly review. Weekly discussion in group therapy specific to the progress toward the goals established. Peer group, group supervisors, and resident enter a cooperative effort to establish a process of active participation in the development of new short-term objectives designed to enhance involvement and personal change toward treatment goals. Weekly documentation by case manager and monthly mini-team review regarding progress or lack of same toward meeting short term objectives.

B. Bimonthly/quarterly review by mini-team to review progress. If less than two step progressions in past two bimonthly/quarterly periods, placed on full team agenda for the following Thursday. Full team review and participation in revising treatment plan, assessing individual's specific needs, assessing appropriateness of group placement, short term objectives, etc. to develop goals and objectives to be met by the following bimonthly/quarterly. Weekly documentation and discussion in treatment group regarding progress, lack of progress, directions for individual and group. Work/education problems/opportunities limited or remitted until objectives met.

C. Bimonthly/quarterly team review to assess status. If less than two step progressions in past three bimonthly/quarterly review periods, group and resident directed to submit written assessments and recommendations to full team. Resident to be scheduled for clinical assessment updates.

D. Full team review held as scheduled by case manager following completion of required assessments. Demission considered.

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FANTASY

What is a fantasy?	A fantasy is a wish for reality.
Why fantasize?	Individuals fantasize to get immediate self gratification. (short term good feelings)
What is a process?	A process is a way of thinking which either intervenes prior to the reinforcing of a deviant fantasy or may be utilized should the individual choose to reinforce the deviant fantasy.
Why process?	Individual's process to prevent themselves from engaging in destructive behaviors and thereby victimizing others.
How to process	The individual will carry the fantasy to it's logical conclusion. The individual will take into account the real affects on the victim, the victim's family, the individual, the individual's family, and the community.

TYPES OF FANTASY:

1. Sexual
2. Violent
3. Suicidal
4. Running
5. Chemical

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SEXUAL FANTASY

CATEGORIES OF SEXUAL FANTASY

APPROPRIATE

Examine:

1. Target
2. Motive
3. Type of sexual behavior
4. Situation/environment

Definition of an appropriate sexual fantasy: A consenting rationally minded adult engaging in a mutually acceptable sexual act at an appropriate place and time. The behavior engaged in is appropriate.

COUNTER-PRODUCTIVE

Examine:

1. Target
2. Motive
3. Type of sexual behavior
4. Situation/environment

Definition of a counter-productive fantasy: A consenting rationally minded adult engaging in a mutually acceptable sexual act but in an inappropriate place or time under the influence of mind altering chemicals or in a committed relationship with another person. This is not illegal but is not healthy.

DEVIANT

Examine:

1. Target
2. Motive
3. Type of sexual behavior
4. Situation/environment

Definition of a deviant fantasy: A minor, non-consenting assault or mentally incapacitated person, non-mutually acceptable sexual act, in public, in front of the children or

with animals. This behavior is illegal and/or immoral.

Questions to ask self:

Target: Is this person of an appropriate age?
Is this person able to give informed consent?

Motive: What is my real motive for desiring sexual interaction with this person? Love, fun, procreation.

Type of sexual behavior: What type of sexual behavior do I want to engage in with this person?
Is this acceptable to them?
Is this acceptable to me?

Situation/Environment: Is this an appropriate time\place to be having sexual interaction?

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RELAPSE PREVENTION WORKSHEET

1) Define "apparently irrelevant decisions" (AIDS).
Reference: "Relapse Prevention with Sexual Aggressives: A Self-control Model of Treatment and Maintenance of Change" (available in resident file cabinet)

2) List AIDS that led to your offense.

3) What early warning signals (emotional, interpersonal, sexual) preceded AIDS and might precede AIDS in the future?

4) Describe how you might justify an AIDS in the future or convince yourself that an AIDS is harmless, nothing to be concerned about.

5) Describe what happened to your relationships while you were offending.

6) What needs did you meet through deviant sexual fantasy?

7) Describe how you will respond to lapses into fantasy of sexual aggression or high risk sexual fantasy after such lapses occur.

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8) Describe the role that anger played in your offense.

9) How do you deal with anger now?

10) Describe situations you need to avoid.

11) What were the unmet needs in your life prior to your offense?

12) What are they now?

13) What have you learned about dealing with unmet needs?

14) Identify and describe what is productive and non-productive about the way you currently relate to others.

15) What is the relationship between your style of relating to others and your deviant sexual fantasy?

16) What is the most important thing you need to remember?

17) What do you have to lose if you re-offend?

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Tyn Mason, Program in Human Sexuality, U of Minnesota
(International Congress of Sexology-Rome, 10/25-28/78)

ABSTRACT

The predominant mode of treatment for male sex offenders is either a behavioristic approach or group psychotherapy -- both with male therapists. This paper describes the role of the female co-therapist in working with an ongoing all male sex offenders group at the Program in Human Sexuality, Department of Family Practice at the University of Minnesota Medical School.

The paper consists of four parts. The first component describes the history, goals and theoretical underpinning of the co-therapy approach used in the Sex Offenders Group at the University of Minnesota. The second section presents a brief sketch of the composition of this group and the psychological and behavioral characteristics of group members, including the incest father, the pedophile and the flasher. Typologies of particular sex offenses will include the interaction patterns of the male offenders in their relationships with women -- in their families of origin, in stages of psycho-social development and manifestation of these relationships in adult behaviors.

The major concern of the next section is the role of the female co-therapist as she focuses on cognitive restructuring with clients moving through their stages of self identity (intrapsychic) into development of interpersonal relationships. Here emphasis is on presentation of the female co-therapist as a screen onto which clients' projections are cast. The role of the male therapist in processing these dynamics is salient here. Also, special attention is placed on the use of the female therapist in this specific therapeutic environment through use of roleplay, use of transference, family of origin issues and cross-sex interpersonal dynamics.

The concluding section of this paper outlines parameters required of a group using a female co-therapist in an all-male sex offenders group and the importance of the asocial response therapeutic mode used in this particular kind of group. The section also includes special concerns, advantages and cautions in using the female co-therapist in a male sex offenders group.

1. New trends exist in the treatment of male sex offenders including behavior modification programs and long term psychotherapy. It is the latter this paper will address. For the past year and a half, the Program in Human Sexuality at the University of Minnesota Medical School has sponsored an ongoing group for sex offenders who have been referred by the courts for the most part. This psychotherapeutic approach was developed in an attempt to provide alternatives for offenders who were sentenced to prison, the workhouse or perhaps were living in the community. This group has approximately 12 members and meets weekly for three hour sessions. The male therapist uses a social work approach in his work with the offenders, working closely with probation officers and court services personnel. This groups differs from other traditional groups for male sex offenders in the inclusion of psychosexual developmental issues -- an indepth approach focusing on the intrapsychic and interpersonal dimensions of sexual behavior. In order to pursue the psychosexual issues in depth, the primary therapist included a female co-therapist to help explore the multi-faceted dimensions of the males' relationships with women, early developmental experiences and current attitudes and behaviors.

The goals of the therapist are: a) to examine the function of current sexual behaviors; b) to determine what family or origin issues contributed to current behavior; c) to increase clients' levels of awareness of themselves as well as to others; d) to assist clients in understanding their behaviors and fantasies and changing those

behaviors; e) to help clients understand the effects of their behaviors on others and take responsibility for their sexuality; f) to work with the clients in a rehabilitation program that can result in their returning to the community. The theoretical underpinnings of the program include systems theory, behavior modification and psychoanalytic theory. It is the interrelatedness of these theories that allows the therapists to do symptom removal (behavior therapy) but at the same time treat the individual's internal conflict resulting from childhood experiences (psychoanalytic). Currently those men who are actively involved with partners are also receiving "systems" treatment, wherever possible. For example, a group for the Significant Others of Sex Offenders has been established. This group meets weekly at the Program and group members are either wives or ex-wives of the offenders. The female co-therapists in this group work cooperatively with the therapists in the male offenders' group to bridge the gap from individual to whole family treatment. Conjoint relationship counseling is yet another component in this total family systems treatment approach (systems theory). (Whole family treatment, including all family members, has only been possible in a few cases.)

The purpose of this paper is to focus on the one dimension of this family systems approach -- the ongoing male sex offenders group.

II. Group Composition

The group is composed of approximately 12 men with varying offenses: offenders v. children (pedophiles), incest offenders v. children, homosexual offenders v. children, homosexual offenders v. minors and exhibitionists. The men, married, divorced and single, are between the ages of 22 and 55 and come from varying occupations: newspaperman, tennis coach, truck driver, mechanic and photographer are a few. They fit the "typical" description of the sex offender community -- that is, they are conservative and moralistic in their attitudes.

General characteristics of the group members include strong denial systems and compliant behavior. Initially a strong group norm is the "no squeal" rule. In its simplest form this translates to - "I won't confront you (squeal) if you don't squeal on me." Another characteristic is that most group members are shame based and also have difficulty in distinguishing fantasy from reality. One last common characteristic that all offenders share is that they were all deprived of touch in early years. The group is a group of victims who have little or no family supportiveness and have been living in isolation.

The categories of offenses listed above can be generalized to the following typologies:

Offenders v. children. This subgroup of pedophiles has been charged with sex offenses toward children. Often they come from an "older" population, behave compulsively and fear they have no control over behavior. The children involved are between the ages of 8 and 10-

usually female. One group member had learned only to get reinforced for negative behaviors. In addition, he did not recall any support from his father during early years. Another person in the group discovered as an adult that his sister was his mother and the family still did not know that he knew the family secret. Passivity and lack of initiation result from these early childhood experiences, both with the single as well as the married males in the group. Both males disclose their feelings of "safety" with very young girls -- where they feel secure to initiate play. When asked to recall the feelings associated with early sexual experiences, they share the warm feelings that each as an individual has experienced when a child touched his penis.

Incest Offencers v. children Incest offenders v. children are adult males who have had sexual contact with their daughters or stepdaughters under twelve years of age. The incest fathers are males who have been sexually abused as children, are compulsive and have strong denial patterns. The males in this group could be described as passive-aggressive in their behaviors -- that is, they move from a position of extreme passivity to aggressive (physically and sexually) behaviors. They are shame-based and want to blame others for their activities and refuse to accept any responsibility for their behaviors. These offenders have strong resistance patterns and will attempt to talk to others and about others rather than themselves; rather The fantasy-reality lines are blurred for these men as are their other boundaries. Their own personal boundaries have not been established; therefore they are able to readily violate children's boundaries. They are dependent on women in a hostile dependent relationship

and some often display gregarious behaviors to cover passivity. The offenders in this typology express rageful feelings toward women and want to blame women for their victimization. They feel the world is to blame for what has happened to them and feel helpless to control their lives.

Homosexual offenders v. minors. This category includes adult males who have made homosexual advances to, or had sexual contact, with, boys under 12. This carries the double taboo -- the taboo against sexual contact with children as well as homosexuality.

Three of the males in the group have identified themselves as homosexuals (only one identified himself as homosexual upon entering the group). However, these males have stated their genuine affectionate feelings toward young males. The homosexual offenders do not want to admit their homosexuality and have attempted to deny their homosexual feelings -- one through withdrawal socially -- another through marriage and children. As adults they have fears of interacting with any children in fear that they might commit some offense with young boys as they did earlier when working with youth groups. The males in this subgroup lack interest in women in general despite comfortable interpersonal communication styles with women. It is interesting to observe that these males are the men in the group who move most quickly to the development of a conscience -- there is a desire to make amends for their behaviors and an understanding of possible consequences for the young people with whom they have been involved. These males have never felt included in their families of origin and have been living in isolation for the most part (except for the married male with two children).

Exhibitionists. Exhibitionists are adult males who have deliberately exposed their genitalia to females in situations where exposure was inappropriate. Often exhibitionists will masturbate while exposing themselves.

This area of sexual behavior is one that legally favors females, i.e., if a female is seen undressing in front of a window the male is called a voyeur and faced charges. If, on the other hand, the male is seen undressed and exposed before a window, it is still he who faces charges; he is called an exhibitionist. American culture has long supported female exhibitionism, via legalized exhibitionism (strip-tease shows) and sauna parlors. These exhibitionists often perform for the sake of "flashing" itself. The behavior is seen as an expression of the personality -- that is, the exhibitionist "flashes" in a variety of ways -- to get attention. A few exhibitionists flash to seek female arousal. One exhibitionist in the group related the story of trying to get attention of some women at work. While telling the story in the group, he included a description of how his body had wires taped on him for an experiment. At that moment in his storytelling, he tore open his shirt and simultaneously "flashed" the group. So while the flasher may stop the exhibiting of genitals, he does not cease the flashing attention-getting behavior.

The males in this group did have relations with women -- one young male had an attraction toward very young boys -- ages seven through 10 -- and the others had sexual relations with women.

III. The Role of the Female Co-Therapist.

The role of the female co-therapist is multi-faceted. First a description of the role is necesary; then a discussion of the various techniques used by the co-therapist will follow.

The female is to focus on cognitive restructuring with group members, moving through their stages of self identity (intrapsychic) into development of interpersonal relationships. She uses a variety of techniques while moving through these stages. The role is unique because the female who is using herself as a screen onto which all projections may be thrust becomes the mother, sister, aunt, wife or child of all the males in the group. She is able therefore to provide the necessary projected female identity with whom the client has difficulty so that the male co-therapist could process the interaction and delve back into the past to seek origins of the behavior, and see how that behavior functioned in those early years. For example, the incest father who has rageful feelings toward his ex-wife and mother as well as daughters, attempts to project all those hostile feelings onto the female therapist. She uses an "oberver approach" in responding. This approach is termed the "curious" approach -- using questions and reflections so the client can then work with the male therapist to better understand who the client is angry with from the family of origin that has led to inappropriate expressions of anger. The therapist's role leans toward the psychoanalytic approach. Since the therapist cannot be the metaphor for all women, she would have difficulty in using herself personally in the group. This also could result in a high risk situation therapeutically. The projection screen approach allows for distance

and also respect for gender differences.

This therapeutic movement from the intrapsychic to interpersonal can be juxtaposed to Erikson's Psychosocial stages. David Elkind in his book, Children and Adolescents, describes Erikson's three major contributions to the study of the human ego:

a) He posited that, side by side with the stages of psychosexual development described by Freud (the oral, anal, phallic genital, Oedipal and pubertal), were psychosocial stages of ego development, in which the individual had to establish new basic orientations to himself and his social world;

b) that personality development continued throughout the whole life cycle;

c) and that each stage had a positive as well as a negative component.

Erikson describes eight stages in the human life cycle, in each of which a new dimension of "social interaction" becomes possible -- that is, a new dimension in a person's interaction with himself, and with his social environment. The female co-therapist worked with men at specific "stages". These stages are briefly described below and examples given.

Stage One - Trust vs. Mistrust -- is the stage corresponding to the oral stage in classical psychoanalytic theory and usally extends through the first year of life. The infant whose needs are met and is played with and talked to, develops a sense of the world as a safe place. When this care is rejecting and inconsistent, basic mistrust is fostered and an attitude of fear and suspicion on the part of the infant results. It is important to realize that both trust and mistrust will be reactivated at different times during the life cycle. Most group members come into the group with low trust levels. Some members,

especially incest fathers, take longer periods of time to work through this trust period. For instance, when a female joined the group, it was rumored that she was really the court psychiatrist and not to be trusted. They had not learned to develop a trusting relationship with the first woman with whom they had a relationship -- their mothers -- and had been suspicious of all women since that time.

The second stage of development is Autonomy vs. Doubt, spanning the second and third years of life (Freud's anal stage). At this stage a child's motor and mental abilities are built upon. Children in this group have not been allowed to take pride in their new accomplishments, whether unwrapping candy or flushing a toilet -- and the sense of autonomy has been thwarted. He has not developed a sense of controlling his own environment. When parents have done for the child what he or she can do for themselves, they reinforce a sense of shame and doubt. The helplessness that the incest fathers bring to the group is real; they do not know that they are able to accomplish anything and have learned to deny their reality. They carry with them an air of innocence as revealed through such statements as "Why, I always bathed my daughters and suddenly she had developed breasts!" (The daughter in this case was a blossoming thirteen year old.)

The third stage in Erikson's developmental theory is Initiative vs. Guilt (the genital stage of classical psychoanalysis) when the child is between ages four to five. In this stage Erikson

describes the need the reinforcement for the child in motor play as well as in fantasy and intellectual initiative. When this is lacking, the child can develop a sense of guilt over self-initiated activities in general that persist through later life stages. For example, in doing family of origin work with one very angry 30 year old male, he went back to the age of four and recalled banging his head for his mother's attention. Mother had over-protected him; he attempted to please the female co-therapist in the same way to be taken care of. He had not learned that he could get attention in other ways; he had learned that only young children were "safe". An example is seen in offenders with young children who have learned to take risks only with young children.

The fourth stage is the Industry vs. Inferiority stage -- ages six to eleven, (the latency phase) -- the time during which the child's love for the parent of the opposite sex and rivalry with the same sexed parent are quiescent. Here is where children learn to play by the rules, and the school begins to play a role in the development of the child. Other adults come into the child's life. An example is seen in the eye contact of the males and one male in particular teasingly calling the female co-therapist "mom". Perhaps the degree to which the group members protect their mothers in the therapy sessions are indication to how "stuck" they are in their families of origin. Several men in the group have not yet "divorced" their mothers; they are reluctant to talk about their mothers and feel deeply loyal to them and want to blame their fathers for what their [illegible] crises they have experienced.

The last stage to be discussed here, the fifth stage, is the Identity vs. Role Confusion stage -- roughly ages 12 to 18 -- where the child reawakens and seeks to find a romantic partner of his own generation. At this stage, the adolescent cares about the perceptions of others and can conceive of ideal families and religions, etc. This is the stage where the adolescent integrates all he has learned about himself. Examples in group therapy are seen in two of the homosexual vs. minors offenders. One of the males was deeply concerned about the young boys with whom he had sexual relations and decided to write a letter to the parents and to the young boy as well to ask forgiveness. Another example was seen in a 30 year old gay male who wanted to clarify his sexual lifestyle and have a respected place in his religious community and sought his minister out for consultations. After experiencing rejection there, he was then able to find other religious institutions that would not reject him. Yet another male in the group discovered that his sister was his mother and was deeply confused about his role. He then sought out family members and broke the implicit family rule not to talk about this and began to learn about his own identity. Perhaps what stands out most clearly in working with group members who are at this stage is the sense of a conscience. At this point in therapy the members want to reach outside themselves and as in the examples given, make amends and consequently change the negative identity to a more positive one.identity to a more positive one.

The last Eriksonian stage, Intimacy vs. Isolation, will not be discussed here -- the young adulthood phase of the life cycle. It is at this stage where members are leaving the group and entering an aftercare group. At this time the men are establishing intimate relationships with others and make a transition into the aftercare group. This does not necessarily mean sexual intimacy; it means the establishing of intimacy in friendships. For most of the men the group becomes a family -- the outside resources are few because of their isolation and they form a support system for one another while moving through their therapy.

The last stages, Generativity vs. Self Absorption of middle age and the Integrity vs. Despair of later years are not pertinent here.

It must be made clear here that these stage identifications are only identifiable retrospectively. Had any categories been used in working with the group members, it could have hindered the therapist's freedom to learn about the specific issues involved. At best the categories can only serve as support for some generalizations from one group experience. There are specific assumptions both therapists had in working with the men:

1) Each person is a unique individual with his own idiosyncracies.

2) Human sexual behavior can be viewed on a continuum -- that is, there is a little voyeur in each of us, a bit of the flasher in each of us. (And how many parents are unwilling to talk about their own sexual attraction to their children?)

3) Sexual fantasies may never leave a person. While sexual behavior can be changed and a symptom removed, the fantasy life might well continue and therapists can give support to individuals to own these fantasizing parts of themselves. Through the use of an aftercare group modeled after Alcoholics Anonymous -- living with a problem a day at a time -- the members can get support so they do not repeat the behavior. Many programs for sex offenders had led to behavioral changes; yet the "offender" still has a fantasy life he feels guilt-ridden with.

This section examines some specific techniques used in the therapeutic process.

1) Roleplay - An example of using roleplay is when group members are working on interpersonal issues, such as a relationship with a wife. One particular group member is very shy and afraid to be assertive with his wife. Through roleplay with the female co-therapist, he was able to practice new behaviors and practice the roleplay until he could feel stronger in his interaction with his partner. This cognitive restructuring allowed him to develop some new interpersonal skills cognitively and through roleplay he was able to experience the affect accompanying the behavior. He was rewarded with praise from the group when he was able to assert himself. His physical posture also changed dramatically when he was exercising new behaviors. Another example of roleplay was with an individual who was seeking to establish a relationship with a woman at work and thought he could not say anything to her. He felt angry about being

a passive receptacle for whatever had come to him and decided he wanted to change that behavior and ask the woman to accompany him for a cup of coffee. His concern was that he would not be able to hold her attention. Through a series of attempts, he found that he could indeed assert himself yet was also able to talk about the accompanying fears. Through this roleplay he was also in the process of discovering how he interacted with all the group members -- that the presentation of himself was typically the passive receptacle. The group member expressed mixed feelings toward the female co-therapist from anger to hurt to acceptance when he found that he could be in charge of himself. Following the roleplay the group and male therapist gave him feedback.

Transference. The use of transference is always present in the female co-therapist's repertoire because of so many projections are coming so rapidly. Early in the group experience, transference was used to help discern where a group member's affective responses were rooted. One hostile incest father had learned to control women through the use of his anger. He would use his anger like a magical wand and when he waved this wand, it was similar to a golden eagle swooping down over some baby ducks. He knew that this technique worked and through the use of processing the transference and not reacting to the anger but by taking a "curious" approach and questioning the group member, the male therapist was able to work with the offender to see that it was someone else (his projection) with whom he was really angry and not the female co-therapist. He learned that he did this with many people and yet did not understand why people were afraid of him. Through processing his anger, he began to explore his private logic

that "all women are bad" and to begin unraveling that meaning system. The empathy that can be extended by the female co-therapist often comes as a surprise to that group member; he usually gets anger in return. It was interesting to discover that his daughters stated in family therapy that they no longer feared him sexually, but did fear his physical abuse which resulted from years of his beating them in rageful outbursts.

An example of transference and perhaps the most powerful, was seen in the group when one of the group members proposed to gang rape the female therapist. One of the group members expresses himself from one of two positions -- complete passivity or total rage. This particular group member, after suggesting the rape, sought agreement from group members and his eyes searched the group for agreement, and he did get some. He then asked the therapist what she was feeling: A long pause followed and a hush fell over the group. Finally the female co-therapist responded by curiously questioning the member about his wanting to rape her and stating how surprised she was and what that meant. The male therapist joined her to help process what had happened and helped the males see how many of them had no alternative behaviors but passivity and aggressiveness and talked about what alternatives are available. The following week when the female co-therapist was absent, the male therapist raised the issue again and talked at length about the fantasy/reality confusion. Case notes from the female co-therapist revealed her internal response to the situation:

> "I felt a lightning bolt hit me; I felt like I was going to totally disintegrate. For the first time in my life I felt terrorized. I felt like I had been raped; I wanted to escape. My professional screen seemed to be completely stuck; it was like a home movie screen with a rusty handle that would not release itself so the screen could be rolled up. I

> somehow mustered enough strength to force that handle to crank up the screen and was thus able to feel the screen slowly turning up to face the man who had a tightly drawn steady grin on his face. It seemed to take an hour. I was grateful for the screen at that time and as soon as the group ended, I felt grateful to allow myself to allow the victim in me to fall apart and cry and talk about my feelings with Bill. Bill was most supportive and caring; I realized at a new level that there was more than perceived danger in some of his work (Bill is the male therapist.)"

When the female co-therapist re-entered the group two weeks later, some group members apologized and therapeutic work followed with the member who said he could apologize but did not understand why he should. This was another example of the confusion between fantasy and reality for the group members. After showing a film on rape one evening, group members stated: "Why, she wanted that, didn't she? She did not say no." Their ability to understand abstractly led us to believe that whenever films are shown to this group, it is imperative to discuss them to determine what meaning they are making. The therapists learned what films not to use in this case, or if used, how to process it to show the difference in reality and fantasy.

Reflection is often used in the group. Group members are asked to relive their experiences and identify the feelings accompanying the behaviors. For example, when a new member disclosed that he was a man who liked to dress in women's clothing and had been arrested at a shopping center for his transvestism, the female co-therapist was able to question him from the female perspective, focusing on particular details of the dress to get ~~a full description of his perception of how~~ he would look as a woman and how he set himself up to be caught. (He had a five o'clock shadow, blonde wig, no lipstick and wore nothing for breasts).

Family of origin issues are linked to current sexual behaviors. For example, several male offenders are in the group for incest. Most incest is multi-generational and by going back to family of origin issues, the member could learn more about himself. In going back to family interaction with mother, he found that mother often had different men in bed with them (he too slept with mom), but often his older brother had forced him to come and view his mother having intercourse with another male. The female co-therapist is allowed to ask questions of the offenders so they can begin to have cognitive restructuring of who and what they are today in relation to who they were in their families of origin.

Cross-Sex Interpersonal dynamics are always at play in this group. The pleasing behavior of the offenders whan a new female co-therapist enters the group is seen as "gift-giving" -- the disclosing of information to reveal themselves to the new therapist. They all are asked by their male therapist to state how they happen to be in the group -- for what offense and who ordered them here and what they are doing about it. Typically, the male offenders give a gift -- that is, they go more in depth concerning their past sexual behaviors and reveal more about themselves. For example, the man who had been placed in the group for his touching a woman on the thigh disclosed that he also likes to cross dress. Each member went to a deeper level of disclosure and revealed more sexual information about himself -- sometimes sexual "offenses."

Other cross-sex interpersonal dynamics are processed in helping group members examine their seductive behaviors and their indirect communication styles.

The female co-therapist also can provide some supportive, empathic responses to individuals who are working on specific issues with daughter, wives or mothers. She is able to break the no-talk rule about women and discuss how it is different to have a woman in the group and how the gender differentness affects behaviors. At a time when adrogny is a prominent theme, the men in this group seem to need a clarification of the gender difference -- not sameness. The issue of boundaries is important -- the separateness of male and females. By constant awareness of the process of the group, the therapists have rich data for helping group participants see themselves in relation to someone of the opposite sex.

Sex Education is an important role of the female co-therapist. Most men as well as women are victimized through lack of information about human sexual behavior. For these men, there is a dire need for information about female sexuality as well as male sexuality. The pairing of the therapists allows the group members to receive a sex education they were denied. This information can then be integrated with their personalities, leading to a recovering lifestyle.

IV. Advantages and Cautions in Using a Female Co-Therapist.

Obviously there would be many parameters required when using a female co-therapist in a group. The therapist needs to be made aware of some of the dangers inherent in this process. For instance, she may be the receiver of obscene phone calls! While it cannot be known whether the caller is from the group, she needs to be made aware that it might be helpful to have an unlisted telephone number for the duration of her work with this particular group.

Police protection is helpful. The female co-therapist needs to meet with the family violence police in her area and then very subtly let the group know that she does know these men and use the protection they symbolize. This is not a surprise to the men because they have all been assigned court workers and have police probation officers with whom they meet. This backup system provides support for the female therapist; should they cross any boundaries the consequences would be immediate return to the workhouse or even to the prison.

The female co-therapist needs to be aware of her own seduction and to her responses to different seductive behaviors. Many pulls come to the female co-therapist to become "one of the group" and while she can become involved in the group intimately, it is her responsibility to acknowledge that she is different from them and her boundaries must be made clear. The female co-therapist needs an awareness of any counter-transference that might be occurring during the group. A consultation group is often helpful for processing the specific interaction.

The learning of the female co-therapist are too numberable to mention. It is important to have knowledge of her own therapeutic issues and understand how and where they might get in the way. She

also needs to have an understanding of her own values and biases concerning male sex offenses. The depth of understanding that comes from this experience is rich. The female co-therapist who is able to have this experience is open to valuable learning about male sex offenders. The mode of therapy used in this particular group allows the offenders to explore their sexual identities in depth and give a broader perspective to sexual therapy for offenders. When the participants learn they do not have to deny to comply with the group, they offer more information about themselves and can see more alternatives available to them.

Conclusion. While it is too early to determine what effects the role of the female co-therapist can have on the group, a gathering of cases, notes and recordings of particular instances can provide information for a descriptive date base if nothing else. Pre and post testing through MMPI, Tennessee Self Concept and Minnesota Sexual Attitudes Scale are a few of the instruments presently used. What would be challenging would be comparison studies between other modes of therapy with this particular mode from the Program in Human Sexuality at the U. of M.

DEPARTMENT : MINNESOTA SECURITY HOSPITAL - ITPSA

STATE OF MINNESOTA

Office Memorandum

DATE : December 18, 1989

TO : Ms. Mary Jean Anderson
Affirmative Action Director
Department of Human Services

FROM : Richard K. Seely, Director
Intensive Treatment Program for Sexual Aggressives
Minnesota Security Hospital

PHONE : 150

SUBJECT : BONA FIDE OCCUPATIONAL QUALIFICATIONS REQUEST

Please consider the following request for the establishment of a 50 percent male/50 percent female goal for group therapy supervisors at the Intensive Treatment Program for Sexual Aggressives (ITPSA).

The ITPSA is responsible for the evaluation and treatment of adjudicated sexual offenders referred to the Minnesota Security Hospital from district courts throughout Minnesota. The offenses of these persons include rape, incest, child molestation, and other forms of sexual assault. Each resident is assigned to a small group composed of 12 offenders and two group therapists, one male and one female. These groups meet five times weekly to deal with therapeutic issues of individuals within the group. Theoretically, we have implemented the strategy of male/female co-therapy in our groups, drawing on Masters and Johnsons' model to deal with the significant sexual dysfunction of the men here. More specifically, ITPSA has developed a role definition of both therapists. The female therapist's role is to bring power to the issues of victimization, along with the female perspective of sexual assault. The male's role is to support the legitimacy of those issues in the therapy groups.

ITPSA's staff consists presently of five social workers, four psychologists, three recreation therapists, and two security counselors. The staffing for the 48-bed unit is complimented with RN's, psychiatric consultations, vocational/educational services, etc. Throughout its history, ITPSA has been successful in maintaining the male/female pairing in group supervision, drawing from the pool of assigned employees.

The ITPSA presently has a vacancy in the psychology department and a vacancy in the female group therapist role. Please consider our request that we be allowed to recruit a female psychologist at this time. Our recent vacancy was complicated by a mobility assignment of our research psychologist, reducing the pool of available clinicians for the group therapy role, making this request necessary.

4-152/177

Attached please find:

1) A copy of the Brief Description of ITPSA
2) The most recent organizational chart of ITPSA staff
3) Letters of understanding from:
   A. William Erickson, M.D., Medical Director
   B. Darel J. Hulsing, Consulting Psychiatrist
   C. Gerald Ylinen, Personnel Director
   D. Glenda Bode, Client Advocate, Office of Ombudsman
   E. Nancy Lundin, Affirmative Action Committee Chair, SPRT
4) Position description of Psychologist II.

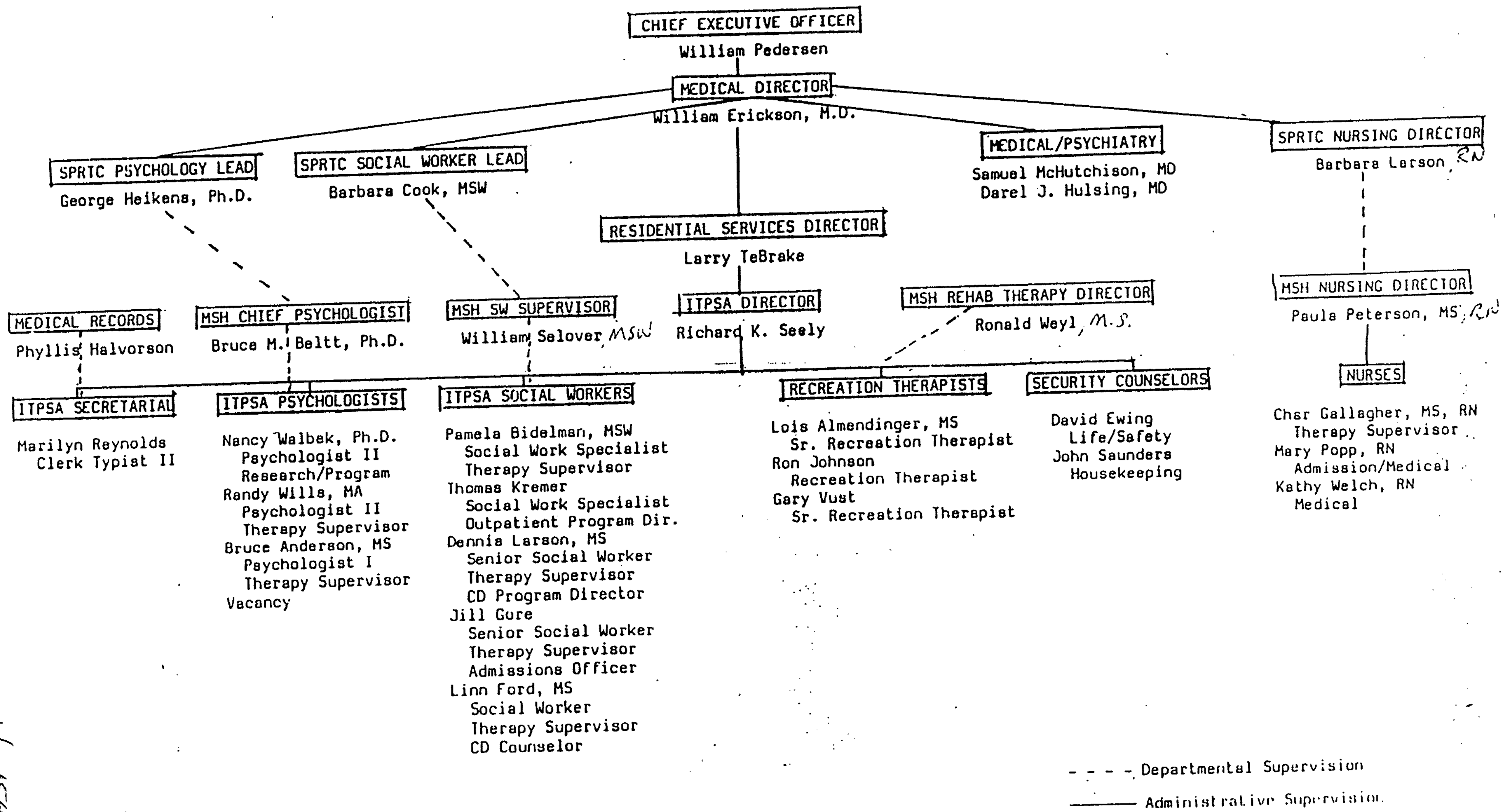
Thank you for your consideration of this request. If you should desire any further information, please call me at 507-931-7150.

RKS/mr

INTENSIVE TREATMENT PROGRAM FOR SEXUAL AGGRESSIVES
Minnesota Security Hospital

Staffing Profile

November 1, 1989



St. Peter Regional Treatment Center

100 FREEMAN DRIVE - ST. PETER, MN 56082
507/931-7100

January 4, 1990

Ms. Mary Jean Anderson
Affirmative Action Director
Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155

Dear Ms. Anderson:

The Intensive Treatment Program for Sexual Aggressives (ITPSA) is a specialized program operating at the Minnesota Security Hospital (MSH) to treat patients referred to us by the district courts of Minnesota subsequent the disposition of those patients as patterned sexual offenders. I have served as a consulting psychiatrist to the program for the past 13 years and currently as the Medical Director of MSH, directly supervising the treatment of the patients in ITPSA. Richard Seely, ITPSA Director, has asked me to review his request for bona fide occupational qualifications, specifically asking that he be allowed to hire a female psychologist to serve as a group therapist in the program. I have reviewed his request to you and concur wholeheartedly with his position, and with the clinical necessity for both genders to be represented in group therapy supervision. This model has served ITPSA well as it continues to treat the significant sexual dysfunctions of the patients.

I have provided process supervision to all of the ITPSA's treatment groups and strongly recommend that the gender balance be continued. Recent staff turnover, the reassignment of staff, and the disciplined specific needs of ITPSA make this request necessary.

Very Sincerely,

William D. Erickson, M.D.
Medical Director
Minnesota Security Hospital

mr

St. Peter Regional Treatment Center

100 FREEMAN DRIVE - ST. PETER, MN 56082
507/931-7100

January 4, 1990

Ms. Mary Jean Anderson
Affirmative Action Director
Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155

Re: BONA FIDE OCCUPATIONAL QUALIFICATIONS REQUEST BY ITPSA

Dear Mary Jean Anderson:

Richard Seely, Director of the Intensive Treatment Program for Sexual Aggressives (ITPSA) has asked me to review his bona fide occupational qualifications request to you and to provide your office with criticism and/or support of the request. I have served as a psychiatric consultant to the program for the last year, subsequent to Dr. William Erickson's appointment as Medical Director of the Minnesota Security Hospital (MSH). I have had the opportunity to psychiatrically evaluate all admissions to the program and the treatment of clients on that unit since my appointment. I have participated in all group therapy offered by the program, and have been impressed with the theoretical design of the program, specifically the roles of the male and female therapists in each group. My judgment is that this design is the most effective way in which to deal with the sensitive issues around sexuality, and specifically those of victimization and sexual assault. I have had experience in dealing with offenders of this type in one-to-one sessions and in group therapy, and am most satisfied with the outcome of those groups where male and female staff are in constant contact with the patients and the design of their individualized treatment plan.

Please consider this memo as my endorsement of the request for a BFOQ. Thank you.

Sincerely,

Darel J. Hulsing, M.D.
Consulting Psychiatrist
St. Peter Regional Treatment Center

mr

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT : ST. PETER REGIONAL TREATMENT CENTER

DATE : January 4, 1990

TO : Ms. Mary Jean Anderson
Affirmative Action Director
Department of Human Services

FROM : Gerald Ylinen, Personal Director
St. Peter Regional Treatment Center

PHONE : 119

SUBJECT : ITPSA'S BONA FIDE OCCUPATIONAL QUALIFICATIONS REQUEST

I have reviewed Mr. Seely's memo to you of December 18, 1989 requesting that he be allowed to specifically recruit for a female psychologist to serve the Intensive Treatment Program for Sexual Aggressives (ITPSA). I have worked with the program since its inception in 1975, and have been aware that the program has consistently used a male and female clinician to supervise the therapy groups there. I understand the clinical issues of the program and concur with the necessity for those groups to be supervised by both members of each gender. It would be my opinion that the ITPSA patients are best served by allowing a continuation of this program design.

I am aware that early in the development of the program, the ITPSA needed to rely on non-clinical staff to represent both genders, but subsequent to clinical privileging, they have consistently been able to draw from only staff members trained and determined competent to provide therapy to the groups of offenders in that program.

Thank you for your consideration of this request.

GY/mr

DEPARTMENT : ST. PETER REGIONAL TREATMENT CENTER

STATE OF MINNESOTA

Office Memorandum

DATE : January 4, 1990

TO : Ms. Mary Jean Anderson
Affirmative Action Director
Department of Human Services

FROM : Glenda Bode, Client Advocate Glenda Bode
Office of Ombudsman for Mental Health & Mental Retardation

PHONE : 105

SUBJECT : ITPSA'S BONA FIDE OCCUPATIONAL QUALIFICATIONS REQUEST

The staff of the Intensive Treatment Program for Sexual Aggressives (ITPSA) has shared with me their memo to you asking that you consider a bona fide occupational qualifications request so that they may hire a female to provide group therapy at ITPSA. I have served as the Advocate at SPRTC, and have reviewed the care provided at ITPSA since 1981. I have been impressed with the professionalism of the staff and the design of the program which holds the men responsible for their behavior, yet treats them with respect and results in the lowest number of complaints of any unit in this hospital. It is fairly easy for me to assume that the professionalism of the staff and the balance of the male/female ratio of staff plays a vital role in the treatment of these most difficult clients. I wholeheartedly concur with their request to you, with the judgment that it is clinically sound, and with the client's needs clearly driving the request.

Thank you for considering their request to you.

GB/mr

STATE OF MINNESOTA

DEPARTMENT : ST. PETER REGIONAL TREATMENT CENTER

Office Memorandum

DATE : January 4, 1990

TO : Ms. Mary Jean Anderson
Affirmative Action Director
Department of Human Services

FROM : Nancy Lundin, Affirmative Action Chair
St. Peter Regional Treatment Center

PHONE : 724

SUBJECT : BFOQ FOR ITPSA

I have reviewed the Intensive Treatment Program for Sexual Aggressives' (ITPSA) request for your approval so that they may hire a female psychologist at this time. I am confident that the Affirmative Action Committee of this campus would have no problems endorsing their request. The ITPSA is well known to each of us, and their programmatic design appears to have integrity, and I am aware that they have consistently held to that design since the program was developed in 1975.

NL/mr

4-159/177

MENDOTA MENTAL HEALTH INSTITUTE

MEMO

February 12, 1991

TO: Dr. Stewart Frager

FROM: Gary J. Maier, M.D.

RE: Assessment and Treatment of Sex Offenders

I apologize for the quality of these memos. While they are dated, they still represent the basic elements in the treatment of rapists and pedophiles. Let me summarize the elements that must be considered in the implementation of any corrections oriented program.

1. The Legislation should provide for assessment at the pre sentence or post sentence level, that would direct only patients amenable to treatment into treatment. The potential patient must agree to accept the treatment. The treating authority must have power to reject volunteers who exhibit only political motivation for treatment.

2. The treatment facility can be free standing or part of a bigger facility. Sex offenders are still stigmatized and for that reason the system needs to respect their need for confidentiality.

3. Psychophysiological techniques are the only scientific, i.e. measurable, way to assess sexual deviation, that positively correlates with decreased recidivism following treatment. Abel's work is the most definitive in this area.

4. The basis elements of an assessment/treatment are described in our proposal. They are:

    1. Behavioral
    2. Psychoeducational
    3. Psychodynamic
    4. Biological

5. Maintaining control, legal control over treatment candidates, is one of the keys to successful inpatient treatment. Unmotivated patients can destroy the therapeutic milieu. Further, sociopaths will not "bond" to the treatment without external control to keep them focused on the difficult problem of change.

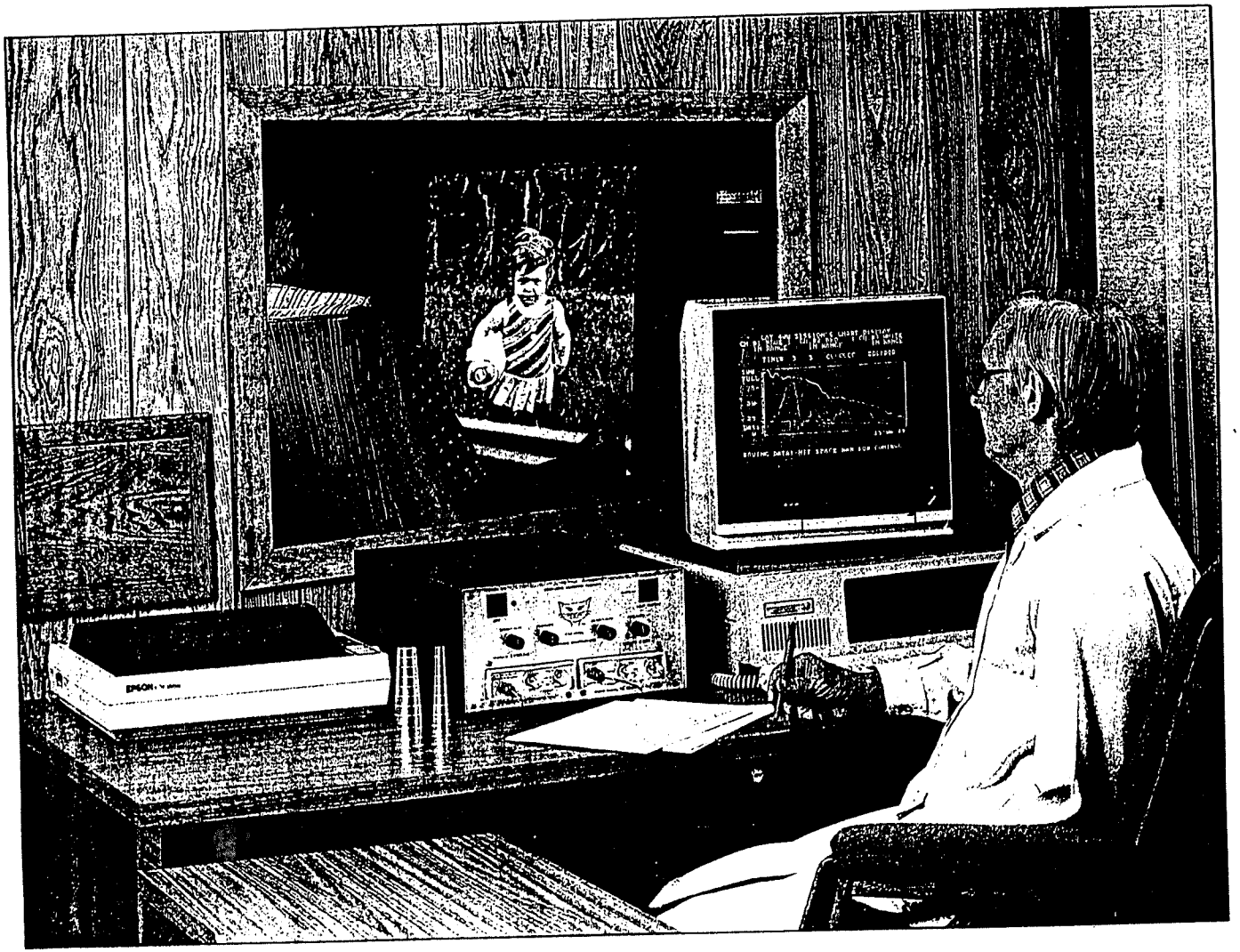
I hope this helps. Call me if I can be of further assistance.

GJM:js

GJ Maier

4-160/177

CAT-400 Sex Offender Assessment System



To treat a sexual offender, one must understand the process through which he arrived at the level of sexual arousal that motivated the act. This includes not only varieties of stimuli but levels of responding penile tumescence as well. There is a growing body of experimental literature revolving around measuring the sexual components of erectile responses to arousal. Such measurement techniques not only have been found to be reliable indices of early stages of such sexual arousal, important in considering treatment approaches, but also permit differentiation between appropriate and deviant arousal.

C.M. Earls, Ph.D.
W.L. Marshall, Ph.D.

FARRALL INSTRUMENTS

4-19-77

After decades of incarcerating sex offenders, society has become concerned with the possibility of changing deviant sexual behavior. The financial cost of lifetime incarceration is unacceptable, as is the cost of further victimization because the offender is released without effective treatment. The change in public attitude toward rehabilitation is making possible great achievements in correcting this undesirable behavior. Numerous effective programs throughout the U.S. and Canada, both in and out of prisons, are in operation.

Traditionally, techniques of assessment and treatment of those accused of sex crimes or sexual deviancy have come from psychoanalysis, psychological testing and insight based therapy. While these methods are still important, the scientific assessment of offenders by state-of-the-art psychophysiological instrumentation greatly facilitates a more fair and equitable disposition of the offender and reduces the victimization.

During the past few years the concurrent development of behavioral analysis and physiological monitoring has come of age. A rapidly growing body of literature supports the importance of measuring penile response to target and standardized stimulus material during assessments. It validates other methods and gives information useful in treatment design. Determining sexual preference throughout the therapy helps to evaluate the progress of treatment. Accurate penile response information is needed to assist in the determination of when to return the offender to society. Periodic assessments after release can be of use in predicting possible relapse.

Erectile assessments of sexual preferences are the crucial data in evaluating treatment procedures since they constitute the most satisfactory measurements for describing deviant sexual interests.

Vernon L. Quinsey, Ph.D.
W.L. Marshall, Ph.D.

4-162/177

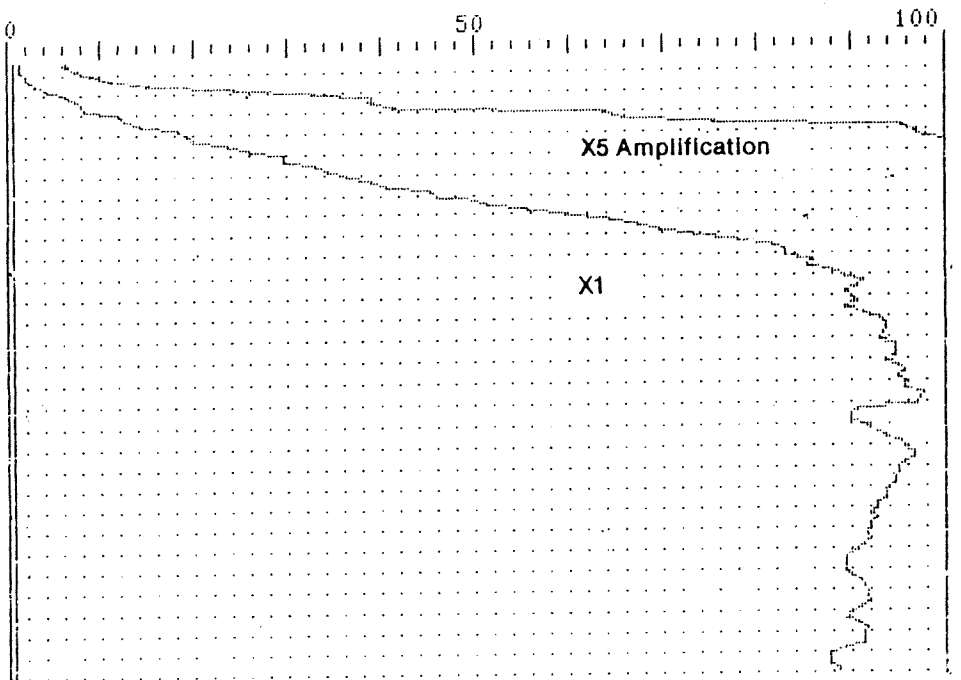
In a recent monogram, Murphy and Barbaree stated, "The decision to target deviant sexual arousal for treatment in our judgement is strongly supported by the evidence. As reviewed, no other variable besides deviant sexual arousal has consistently separated offenders from nonoffenders. Even though the evidence is not clear that reduction of deviant arousal is clearly related to recidivism, it is our opinion that the cost of treatment is quite low compared to the cost of revictimization." (Murphy & Barbaree, 1987)

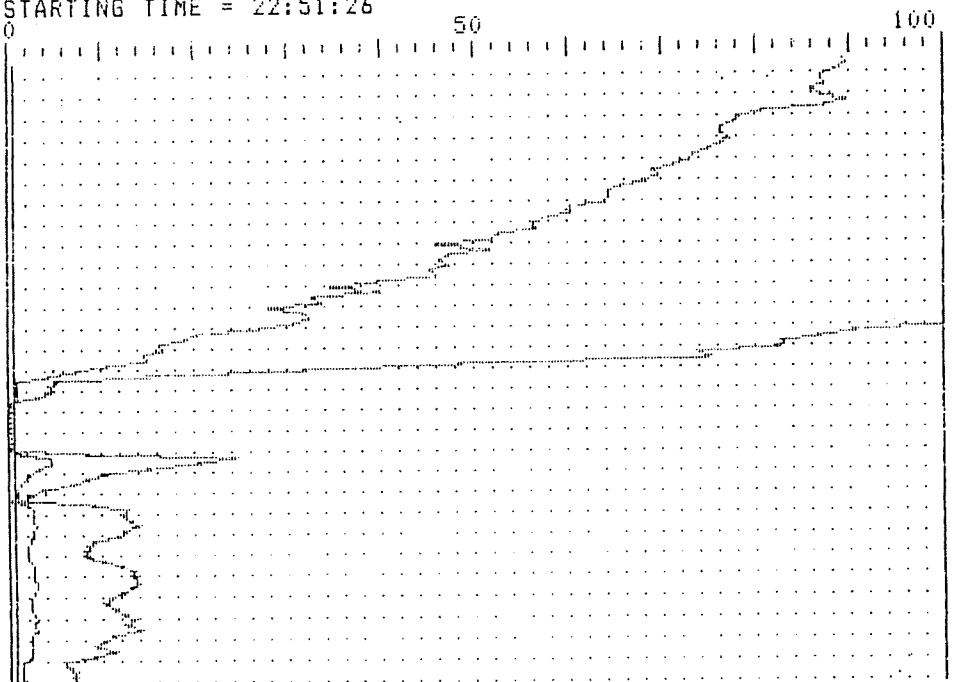
These scientific techniques provide accurate answers to the question of sexual preference, making it possible to safely treat many offenders on an out-patient basis, thereby reducing the cost of behavior change. There are, of course, some risks in treating sex offenders on an out-patient basis; but behavior change methods, when followed with physiological assessment, have proven to be very successful in reducing this risk. Many treatment groups are reporting 85% "cure" rates on long term follow-up.

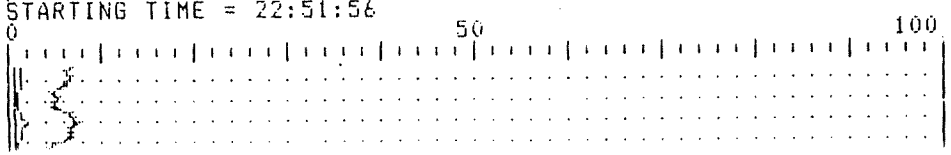
The penile plethysmograph is not a sexual lie detector and should not be used to prove innocence or guilt. It does show sexual preference. During evaluations a discriminant response is the major goal; in treatment a differential response to a particular class of stimulus across time is the goal (Farrall & Card, 1988).

THE ASSESSMENT PROCEDURE

The client sits in a comfortable chair in a small room and is presented audio or visual stimuli. A strain gage on his penis measures his erection with such high sensitivity that the recording can show arousal before the client can sense it. This sensitivity allows the therapist to determine both the subconscious and conscious arousal patterns. A GSR channel helps identify attempts to fake. Novelty and other factors are ruled out with repeated stimuli and the use of both audio and visual stimuli. Diagnosis is made by comparing responses of the clients to various classes of stimuli. Thus, a high arousal to a child's picture with a low arousal to the picture of an adult indicates a preference to the child.







F09N2
B-34
CAT-3

F Females 09 9-year-old

N nude 2 Tanner Scale

B-34 Individual Slide Catalog Number

CAT-3 Category 3

TIME = 0:30.00

D

Category	Age Range	SEX
1	Infant	F
2	4-8	F
3	9-12	F
4	13-15	F
5	16-19	F
6	Adult	F
7	Infant	M
8	4-8	M
9	9-12	M
10	13-15	M
11	16-19	M
12	Adult	M

TIME = 0:30.25

The chart is shown full size. Every stimulus and detumescence is printed this way. Green text is explanation only and does not appear on the chart.

4/83/77

A Computer Plethysmograph

The greatest challenge of the therapist is to gain maximum information about a client in a minimum amount of time. Using the power of computer controlled assessments with statistical data reduction, total assessment time can be accomplished under two hours. This computer system will give accurate data of gender and age preference, will provide some answers to questions of choice of activity, and will indicate arousal to the victim's consenting or non-consenting behavior, and determine if the motivation behind the deviant behavior was sexual or aggressive.

Years of work in the field of sex research and therapy have helped us to develop a remarkable computer controlled system to run assessments and process the data. Your ability to assess and treat sex offenders will be greatly enhanced with the accurate penile plethysmograph recordings and data reduction made possible with this system. The CAT- 400UL offers a significant improvement in efficiency, accuracy of measurement and analysis of sexual arousal patterns.

After the session, the therapist can get a print-out of the statistical analysis including minimum, maximum, and average erection of every stimulus period, the detumescence time, the standard deviation, and the area under the curve analysis of each individual stimulus. This statistical analysis is based upon each individual stimulus. The same analysis is performed on groups of slides in a given stimulus category. These averages are printed numerically and also in the form of bar graphs. The statistical data is prevented from being affected by movement artifact by an automatic "noise" removal feature in the software.

COMPUTER ASSISTED THERAPY

Farrall Instruments

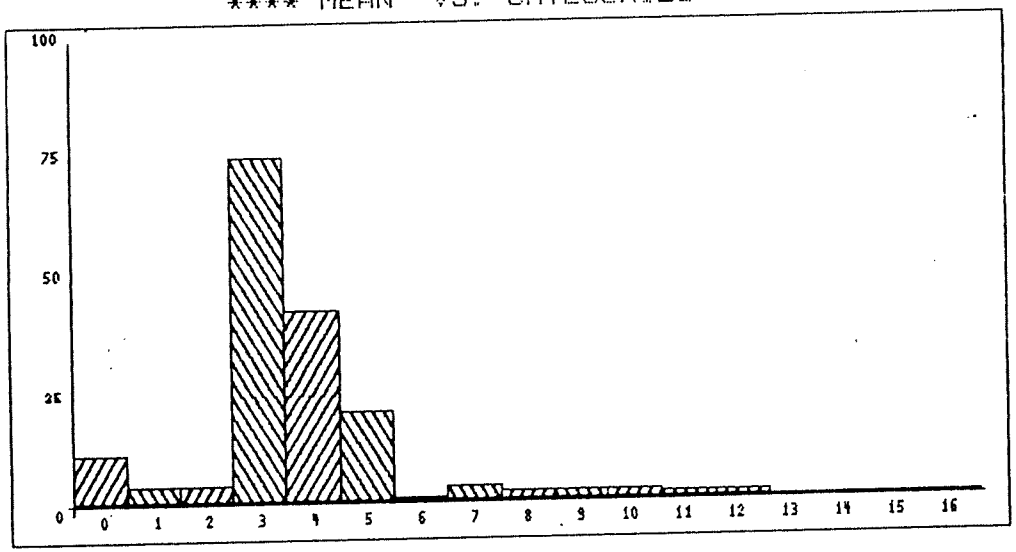
The CAT- 400UL is a data collection system which processes physiological signals from the time proven Farrall Instruments modules. A wide range of modules provides a choice of physiological measurements including male and female sexual arousal, GSR, respiration, EMG and client arousal self-report. The system can measure both penile arousal and one other physiological parameter simultaneously. One parameter can be amplified five times which is useful when assessing "non-responders". The standard package includes modules for male arousal, self-report of arousal and GSR. Modules for other parameters can be substituted at no extra charge, or purchased in addition to the standard package. Modules are designed as convenient plug-in cases and can easily be changed at any time. Not all modules carry UL approval.

Nearly all known assessment paradigms described in the literature can be selected by the CAT- 400UL System using Version 4.0 software. The system can use audio, visual, video or a combination audio-visual package for stimuli. The entire session, with presentation of visual or auditory stimulus, is controlled by the computer. The operator has great flexibility in choosing the parameters of assessment; i.e., stimulus duration, detumescence time, number and order of stimulus. The data collected for the three parameters chosen is displayed in real time on the CRT monitor, is continuously printed in strip chart form one stimulus period after it is collected, and is stored on floppy disks for additional data processing.

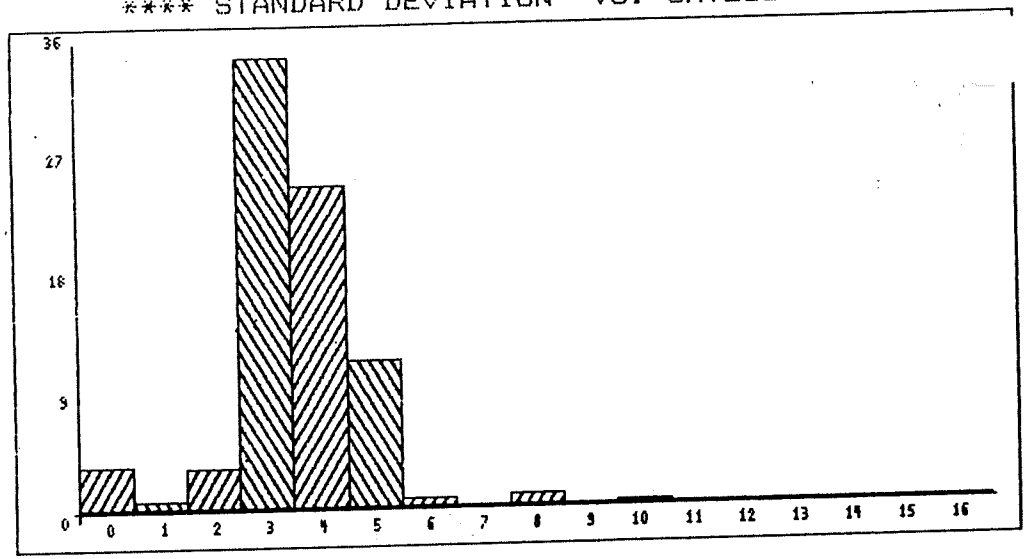
This data reduction greatly reduces the therapist's time for analysis and reduces the error of human judgement. In succeeding treatment sessions, the computer program plots the statistics over time and displays the arousal pattern of the offender to any selected stimulus, even if the stimulus appears in several assessment sessions on a random basis.

The new computer system greatly simplifies linearization of the transducer. Prior to the assessment, the system is calibrated using a set of standard circumference cones. The transducer is placed on a cone step and the space bar on the computer is pressed. The transducer is then moved through the range of steps which represent the circumference of the expected erection. The space bar on the computer is pushed for each step. The computer then uses this calibration to automatically linearize the data.

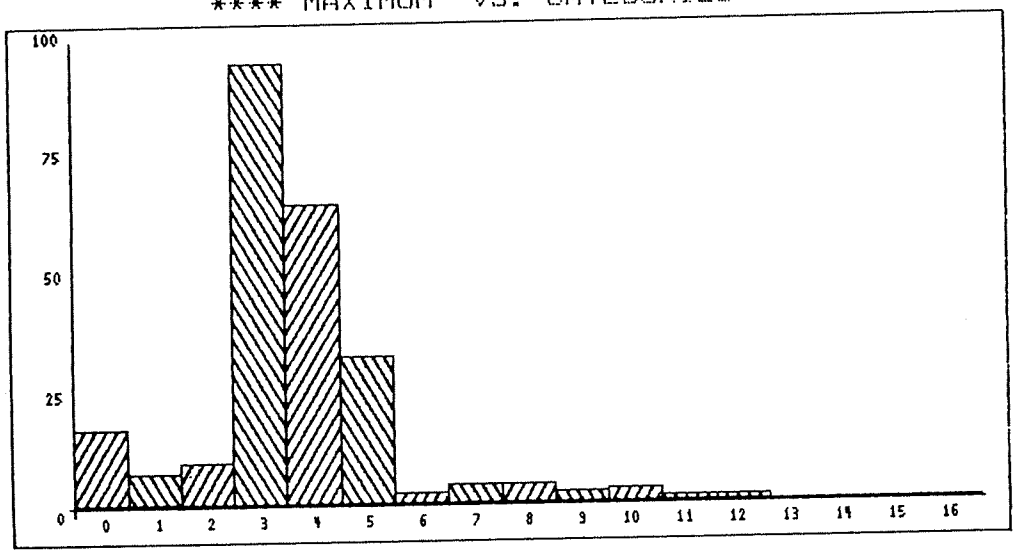
**** MEAN VS. CATEGORIES ****



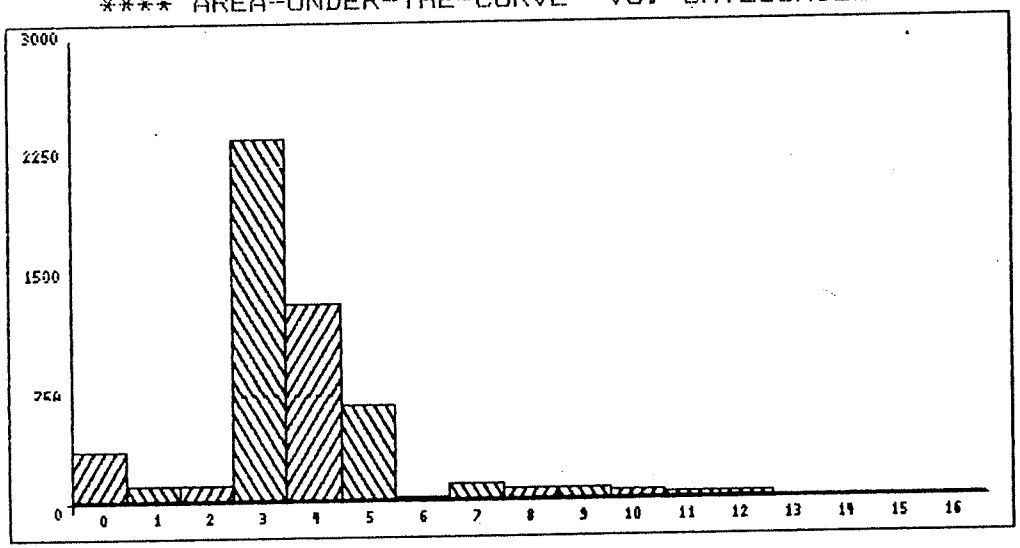
**** STANDARD DEVIATION VS. CATEGORIES ****



**** MAXIMUM VS. CATEGORIES ****



**** AREA-UNDER-THE-CURVE VS. CATEGORIES ****



Actual charts from printer demonstrate the ease with which the data can be understood. Categories represent different ages and gender. Since maximum arousal measures often do not tell the story, latency and area under the curve are very helpful in these instances. There, also, is a digital print-out of the data which is used to construct the bar graphs.

Farrall Instruments

4-185/77

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SPECIFICATIONS

CAT- 400UL Computer Assisted Therapy System a penile plethysmograph, includes Main Instrument (7'' x 13'' x 17'', 18 pounds), with SIB-50UL Module for erection monitoring, SGM-40UL Module for GSR monitoring, SER-40UL Module for self-report recording, tape player, 10 SHG-20 Indium-Gallium strain gages, all Underwriters Laboratories Listed under UL544 and registered with the FDA. Also includes Version 4.0 Assessment Software, SA-10 Standardized Slide Set Version 4.0 and CAL-100A Calibration Set. Not included, but available from Farrall Instruments: Kodak slide projector, computer, printer.

COMPUTER REQUIREMENTS

The CAT- 400UL hardware and software is designed to run on the MARK-12 or -14 computers supplied by Farrall Instruments. Other computers can be used if configured with the same components. Generally, an IBM® PC or PC compatible capable of running MS-DOS can be used if it has the correct hardware features. The minimum requirements are two floppy disk drives, one serial port, one parallel port, a real time clock, and a color monitor with 640 x 200 high resolution color card. The system can be used with the new IBM System 2 and can be used with hard drive systems.

TRAINING OPPORTUNITIES

A comprehensive two-day course in the use of the penile tumescence recording equipment for the assessment of sex offenders and sex research is available 3 or 4 times a year at the Institute for Advanced Study of Human Sexuality in San Francisco; and, on an irregular basis, at the factory in Grand Island. Taught by Professor Farrall and the faculty of the Institute, the student will learn how to do an accurate assessment, from operating the equipment to interpreting the results. A certificate and continuing education credits are available. Write for a brochure describing this opportunity.

FARRALL INSTRUMENTS, INC.

P.O. Box 1037, Grand Island, Nebraska 68802 U.S.A.
PHONE: 308 384-1530 FAX: 308 384-2667

LISTED 74U6

Photo by LIGHT-WORKS STUDIO
Lincoln, Nebraska

CAT-8/88

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PHONE (808) 545-2646

JACK S. ANNON, PH.D.
DIPLOMATE IN FORENSIC PSYCHOLOGY
LICENSED CLINICAL PSYCHOLOGIST
LICENSED PRIVATE INVESTIGATOR

CLINICAL AND FORENSIC PSYCHOLOGY
PRIVATE INVESTIGATION — CRIMINOLOGY
FORENSIC HYPNOSIS — CRIME LABORATORY
POLYGRAPH—VSA—EVIDENCE PHOTOGRAPHY

SOME SELECTED REFERENCES ON THE PSYCHOPHYSIOLOGICAL MEASUREMENT OF THE SEXUAL AROUSAL RESPONSE IN HUMANS

I. GENERAL THEORY, RESEARCH, AND PRACTICE

Abel, G. (1976). Assessment of sexual deviation in the male. In M. Hersen & S. Bellack (Eds.), Behavioral Assessment, A Practical Handbook. Elmsford, N.Y.: Pergamon Press, 437-457.

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STATEMENT OF INFORMED CONSENT (EVALUATION)

Introduction. I have been referred/am referring myself to (Co-investigator & institution) for evaluation of a sex-related problem. I understand that I will be asked to participate in an procedure that will measure how much sexual arousal I show when I look at sexually explicit pictures. The purpose of this evaluation is to find out what my sexual preferences are in order to help me with the kind of sex problems I may have. I recognize that procedures like the one in which I will particpate have been around for 25 years and are no longer considered experimental. If I participate in this evaluation I can expect to be involved from 2-4 hours.

Alternative evaluations. The evaluation being offered to me is not the only one available to investigate sex problems such as I may have. There are other types of psychological and behavioral evaluation procedures, any or all of which might obtain the same information as this one.

Benefits. The major benefit I can reasonably expect to gain from participating in this evaluation is a better understanding of myself as a sexual person. The evaluation might also indicate some areas where I might need to get help for any sex problems I might have.

Risks. There will be risks and discomforts to me if I participate in this evaluation.

1. The information I receive about my sexual arousal patterns may be undesirable or upsetting to me. My sexual responses

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may be different from those I would like to have or different from those other people think I should have. I recognize and accept that to this extent my right to privacy and my right to conceal the nature of my sexual interests will be invaded.

2. I may feel anxious, ashamed, depressed or guilty as a result of participating in this evaluation. Because these things may happen to me I am also aware that I may, at any time, seek help from the professional staff for any discomfort that I may be having as a result of the procedures.

3. There is a very slight risk that I could contract a sexually transmitted disease from the sensing device that I will place around my penis. After each use these units are soaked in a powerful germicide called Cidex-Plus, then thoroughly washed in clear water. In the course of evaluating hundreds of men, these researchers have never seen a single case of a sexually transmitted disease from use of this device.

Sexual arousal measurement. My penile erection response to sexually explicit slides will be measured by means of an electronic device. This device looks like a small rubber band and in complete privacy I will place it around the shaft of my penis. It is connected to another piece of equipment which can tell if my penis gets bigger when I get sexually excited. I understand that this is not a sexual lie detector and the staff cannot make me get a penile erection. Only I can produce a penile erection so any information obtained from me by this method is being given voluntarily by me. This measurement system is safe for use with humans and I will not receive an electrical shock by using it.

Sexual stimulus materials. I understand that my sexual response will be measured while I look at sexually explicit pictures. I affirm that I have seen, heard, read about, or thought about sexually explicit things or situations and I agree to being exposed to these materials.

I believe that I have been fully informed about this evaluation in language that is understandable to me. I have expressed any questions that I have about the nature of the evaluation and its possible influence on me, and these questions have been answered to my satisfaction by the professional staff.

Date: _____, 19__

_____
Signature of Participant

_____
(Co-investigator & institution)

I have witnessed the reading and explanation of the above statement to the participant. I verify that he was given ample opportunity to ask any questions about the evaluation and that these questions seemed to have been answered to his satisfaction. I witness his signature

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indicating that he fully understands and accepts the terms of this agreement.

Signature of Witness

DRL/CAO:11/30/87

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APPENDIX O

OSH Correctional Treatment Programs

Behavioral Treatment of Sexual Deviancy

I, _____ understand that I am asked to participate in treatment specifically designed to reduce my sexual arousal to deviant themes and/or increase my sexual arousal to non-deviant themes.

During treatment I may be shown explicit sexual slides, asked to listen to explicit sexual tapes or asked to verbalize or imagine explicit sexual behavior. This sexual material will depict deviant sexual behavior as well as non-deviant sexual behavior relating to my problems. While I observe, listen to, or verbalize these sexual materials my erection responses will be measured by a penile transducer.

I understand treatment could include aversive conditioning which is a procedure that pairs deviant sexual material with aversive elements. Aversive elements include noxious scenes (scenes creating fear of repulsion) and noxious odors (ammonia, etc.). Noxious odors are administered by means of a squeeze bulb which passes the odor through a plastic tube to a cannula attached to the nostrils of the nose. I am aware that use of the aversive elements may result in increased anxiety and/or nausea. This anxiety may carry over to outside the laboratory and cause me to have fears about my sexual performance, and I may develop difficulty getting an erection. Also, because my therapists will know my erection responses I may feel anxious, uncomfortable, depressed, or angry.

The benefits of treatment are that it will decrease deviant sexual arousal and assist in overcoming my habitual pattern of sexual deviancy.

Alternate means of treatment include group therapy and individual therapy without aversive conditioning. I may wish to choose this means of treatment if I have excessive concerns about measurement of my erection response or the aversive conditioning process.

At any stage of my treatment I may withdraw my consent to this treatment.

By signing this I give my voluntary consent to participate in all of the above which I have read and understood.

_____

Subject Signature Date

_____

Behavioral Therapist Date

_____

Witness Date

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APPENDIX P

OSH Correctional Treatment Programs

Procedures for Administering MPA
(Medroxy Progesterone Acetate)

A C.T.P. resident's Treatment Team may suggest that he be administered MPA for reduction of deviant sexual arousal if:

a) Resident has participated in multiple treatment sessions using less intrusive aversive counterconditioning methods, yet deviant sexual arousal remains significantly high as measured by plethysmograph assessments.

and

b) Resident submits a written request for MPA and signs consent form after having had its medical use and potential positive and negative side effects explained to him.

Resident will be administered MPA on a weekly basis. Prior to use resident's serum testosterone level will be taken and a plethysmograph assessment done.

Stage 1

Reduce resident's testosterone level to ½ his normal level. 400 mg of MPA will be administered first and second week. In the third week a testosterone level will be taken prior to administering MPA. MPA dosage will be increased or decreased accordingly to achieve a testosterone level of ½ normal. Another testosterone level will be taken in the fifth week again prior to administration of the drug. Again the MPA dosage may be changed until the desired testosterone level is achieved. (If this reduction later proves insufficient resident's testosterone level may be reduced to a pre-pubescent level.)

Once the desired testosterone level is achieved the subject is assessed by the plethysmograph and is ready for Stage 2.

Stage 2

Resident participates in behavioral therapy in the form of aversive counterconditioning while receiving weekly doses of MPA. Monthly plethysmograph assessments and testosterone levels will be conducted. When resident's deviant sexual arousal is reduced to an insignificant level and remains so for at least two consecutive months, he should proceed to Stage 3.

Stage 3

While resident continues to participate in behavioral therapy MPA doses will be reduced by 50-100 mg per month. Monthly plethysmograph assessments and testosterone levels will continue to be conducted. Deviant sexual arousal should remain at an insignificant level. If at any time deviant sexual arousal becomes significant MPA will be increased to the previous month's dosage. The following month the process will begin again and continue until the resident is eventually no longer on MPA and his deviant sexual arousal remains insignificant.

Stage 4

Bi-monthly testosterone levels will be taken for the next six months while monthly plethysmograph assessments will continue indefinitely.

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APPENDIX Q

OSH Correctional Treatment Programs

RESIDENT REQUEST FOR MPA TREATMENT

(Medroxy Progesterone Acetate)

I _____, understand that I am requesting MPA to be administered to me to assist in reducing my sexual arousal to and interest in deviant themes. I also understand that I may have already participated in methods of treatment designed to reduce my deviant sexual arousal, but that those methods have not sufficiently done so. It is because I still have significant deviant arousal that I request use of MPA.

I understand MPA is administered on a weekly basis by injection and that serum testosterone levels will be conducted before and periodically during use, as will plethysmograph assessments.

I understand that the dosage of MPA will be sufficient to reduce my testosterone level to my pre-pubertal level. During which time I will be participating in behavioral therapies including aversive counterconditioning. Once my deviant sexual arousal is reduced to an insignificant level my weekly dosages of MPA will be reduced monthly until I am no longer taking it.

The benefits of treatment are that it may reduce my deviant sexual arousal and assist in overcoming my habitual pattern of sexual deviancy.

I understand potential side effects resulting from use of MPA include: weight gain, increased need for sleep, cold sweats, hot flashes, testicles may decrease in size, hyperglycemia, hypertension, nightmares, elevated blood glucose, muscular pain, labored or difficult breathing, decreased sperm count, abnormal sperm, nervousness, and upset stomach. I also understand that with use of MPA I may have difficulties obtaining erections and the overall desire to sexualize or fantasize may decrease. These side effects are temporary while receiving MPA treatment and are reversible.

At any stage of treatment I may withdraw my consent for MPA by submitting my withdrawal in writing to my Treatment Team.

In signing this I indicate I have read and do understand the above.

_____

Resident Signature Date

_____

Behavioral Therapist Date

_____

Witness Date

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Association of Community
Mental Health Centers of Kansas, Inc.
835 SW Topeka Avenue, Suite B, Topeka, KS 66612
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April 15, 1991

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Kermit George
Past President
Hays

Paul M. Klotz
Executive Director
Topeka

Honorable Paul "Bud" Burke
Chair, Legislative Coordinating Council
Kansas Senate
Statehouse, Room 359-E
Topeka, KS 66612

Dear President Burke:

This is to strongly support a request from the Senate Judiciary Committee to appoint a special interim committee to study the issue of providing a plan of action for the sexual offender and other hard to serve populations. The Association of Community Mental Health Centers of Kansas, Inc., stands ready to work with such an interim study group in any way that proves useful and appropriate. In fact, this Association initiated, beginning last fall, a group to study this issue on an ongoing basis. The group includes representation from the Department of Corrections, Department of SRS and the centers. A number of centers, if not all, are already serving sexual offenders across the state.

As you probably know, there are many issues that need to be addressed carefully before statutes are developed and passed. We feel the following issues need consideration:

- Which types of offenders need to receive treatment under incarceration?
- Which types of offenders respond positively to treatment and what type/form of treatment?
- Which offenders are "good risks" for diversion (treatment) programs?
- How can DOC offender programs applied during incarceration be more effectively tied to programs available in community MHC's?
- What statutes or statute modifications need to be made to effectively address the what, how, who on this issue?
- What are the conditions for entering and completing treatment programs?

Subcommittee - Senate Judiciary
Violent Sex Offenders
Attachment 5

- What are the barriers to more offenders being treated at the community level?
- What are the funding requirements and potential funding mechanisms for addressing this general population?
- What has/hasn't worked effectively and efficiently in other states?

Many other issues, no doubt will be addressed by the interim, but these would be a good start.

Senator Burke, I would be happy to respond to any question you or the LCC might have on this important issue.

Thank you for your consideration.

With every best wish, I remain,

Sincerely,

Paul M. Klotz
Executive Director

cc: Wint Winter, Jr., Senator
David Kerr, Senator
George Vega, SRS
Roger K. Werholtz, DOC
June Teasley, DOC
John G. Randolph, Emporia MHC
E.W. "Dub" Rakestraw, Topeka MCH

Shirley [illegible]n
Williar [illegible]
Grego [illegible]a
Thomas [illegible]apman
Owen F. Clarke, Jr.
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ATTORNEY GENERAL
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DEPUTIES, DIVISION CHIEFS
AND SENIOR COUNSEL

March 22, 1991

Mr. Gordon Self
Office of Reviser of Statutes
State House, 3rd Floor
Topeka, Kansas 66612

Re: Civil Commitment of Sexually Violent Predators, Senate Bill No. 18

Dear Mr. Self:

I have reviewed Senate Bill 18 (hereinafter S.B. 18), with the proposed amendments, which you recently sent me. As you requested, I have outlined below my comments and, in some cases, questions relating to this most recent version of the bill.

As is clear from both the brief I forwarded to you and from our earlier conversations, for a statute such as this to be constitutionally valid it must be civil, not criminal, in its focus, i.e., the focus of the statute must be treatment rather than punishment. While the substantive portions of S.B. 18 make 1 it clear that the statute is a civil statute, it would be helpful to add a legislative intent preamble, similar to that found in the Washington statute. The concepts set out in the preamble to the Washington statute are not unique to Washington cases and are supported by current expert opinion and by the literature in the field.

Related to this comment is the question of whether the statute which is being amended, K.S.A. 1990 Supp. 21-3110, is a criminal statute or a civil statute. As is noted in our brief, 2 the Washington statute is part of a civil portion, not a criminal portion of our statutes. The placement of the statute obviously reflects the intent of the legislature on this civil/criminal definition.

My next comment relates to § 2 of S.B. 18 and the proposed amendment which, in effect, establishes a three year statute of 3

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Violent Sex Offenders
Attachment 6

limitations regarding prior sexually violent offenses which may be considered as a basis for the filing of a civil commitment petition. Superficially, the limitation appears to be a reasonable one; if an individual has not offended within the past three years, how could any expert predict that he would be likely to reoffend in the future?

The real problem with this limitation is that it removes from consideration any individual whose most recent conviction was not for a sexually violent offense but who may have an extensive prior record of sexually violent offenses. For example, an individual is about to be released from prison having served five years on a conviction for an assault which was plea bargained down from a rape because of proof problems or because of the wishes of the victim. If this individual had two or three prior rape convictions he would not be, under this proposed amendment, subject to the civil commitment statute when, in fact, he would appear to be a perfect candidate. The district attorneys should be trusted to exercise their discretion in this civil area as they are, I assume in Kansas, trusted to exercise their professional discretion in criminal charging decisions.

The next problem I see is presented in § 2 by the deletion of both paragraph (d) and the remaining portion of § 2 which follows it. These deletions cause two problems: 1) the deletion of § 2(d) eliminates the ability to file civil commitment proceedings against individuals previously found to be not guilty by reason of insanity. As a policy matter, there appears to be no reason for distinguishing between these individuals and individuals found to be incompetent to stand trial, under § 2(c). Individuals in these categories of offenders may well be the most dangerous sexually violent predators of all and those most in need of confinement for treatment purposes; and 2) the deletion of the last portion of § 2 completely eliminates the implementation language from the statute. I assume this deletion was inadvertent since, without this language, there is no authority for anyone to file a sexually violent predator petition under the statute.

4

The next problem I see is in § 3, regarding the proposed amendment requiring a contested probable cause hearing, rather than simply allowing the court to determine, ex parte, that probable cause exists. I do not know if this amendment is necessary to make this portion of the statute consistent with K.S.A. 59-2912, which is referenced in the amendment, but such a probable cause hearing is not required under Washington law.

5

6-24

The major practical problem created is that the probable cause determination and the issuance of the detention order need to immediately follow the filing of the Petition. Otherwise, at least if the media access in Kansas is similar to that here, the offender will learn of the filing and be able to flee the jurisdiction prior to such a hearing. This is not an unlikely scenario, given the potential lifetime commitment for treatment and the reality that some offenders will have been released prior to the district attorney's being able to file a Petition.

This situation becomes even more dangerous when you realize that, at least in Washington: 1) there is no ability to extradite a person from another state for such a civil proceeding and, 2) the parole board has no criminal jurisdiction over a person who would be released and subject to a civil commitment petition, so they would not be able to seek extradition either.

There is no reason to require a contested probable cause hearing as long as a judge has had an opportunity to review a certification or an affidavit setting forth facts which support a finding of probable cause. In Washington, such an affidavit is the basis for the issuance of arrest warrants upon the filing of criminal charges and no probable cause hearing is ever required. The defendant may then be held in custody prior to trial, usually for 60 days (longer if a speedy trial waiver is obtained).

At the end of § 4, I would suggest adding language which reflects that, as in other civil cases, only ten of twelve jurors must agree for the verdict to be entered. Inclusion of this provision will avoid some of the unnecessary confusion which its omission has caused in our cases.

The proposed amendment to § 8(b) inappropriately shifts the focus of the show cause hearing and, in essence, provides the committed person with a presumption that the subsequent, full hearing should be held. There is no valid basis for such a presumption to be included in this statute, and it is inconsistent with the clear intent of the section, which requires a showing by the committed person that the "change" has occurred.

I suggest an amendment to § 8(b), changing language in the last sentence of that subsection from "will engage in acts of sexual violence" to "is likely to commit predatory acts of sexual violence." This change makes the element which must be proven consistent with both the initial definition of sexually violent predator, found in § 1(a), and that found in the last sentence of § 8(a). This inconsistent language is also found, unfortunately, in the Washington statute. We will be seeking to amend our

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statute to cure this inconsistency, which is solely the result of inartful drafting and not reflective of any intent to change the elements.

I hope the above comments will be of assistance to the Committee in reviewing S.B. 18. Please contact me if any other information is needed or if you or the Committee members desire any specific update on any of the information I have provided you previously. As I advised you in my February 8, 1991 letter, I will keep you apprised of the appellate court developments in our cases.

Very truly yours,

Gregory P. Canova

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