

# Explanation of the Need for the "No Known Cure" Language to Remain in Statute

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This is a response to Representative Beth McCann's request for additional information about "no known cure" for the 2010 Colorado House Judiciary Committee.

Written by Greig Veeder with contributions from Stephen Brake, Ph.D., Karen Vigil, Anthony Getzberg and many leading in-state and out-of-state professionals.

March 3, 2010

## How to read this response to Representative Beth McCann's email to Greig Veeder on 2/14/10:

1. Beth McCann's email to Greig Veeder
2. Preamble to the response
3. Responses are divided into two sections:
  - A. Responses to Beth McCann's e-mail questions broken out into their basic parts
  - B. Additional information in the form of additional questions that might reasonably be asked and corresponding answers

### **1. THE 2/14/2010 EMAIL FROM BETH MCCANN**

Thanks Greig. I think what we are asking for is some data to support the no known cure theory. Also, if there is data that shows that the treatment that you and others engage in does help reduce recidivism that would be very helpful. It is very unusual to have one specific theory contained in statutory language and I think that is what we are struggling with. Certainly you can continue to provide treatment without a specific reference in the statute can't you? Anyway, we are seeking to require that the treatment providers demonstrate some data to support the use of the treatments. That seems reasonable to me. Thanks. Beth

### **2. PREAMBLE TO THE RESPONSE**

This preamble addresses the classification of sex offenders who we are, and are not, talking about. In 1992 when the Sex Offender Management Board (SOMB) was created in statute, the focus was on adult sex offenders. It was not the focus of those who created the law that the standards drive the treatment and management of juveniles who sexually offend. Juveniles who sexually offend clearly need a different treatment and management climate than adult sex offenders, and the language "no known cure" does not apply to them. The primary reason juveniles should be treated differently is because they are still developing. We recommend separating the adult sex offender board from the juvenile sex offender board because those who work with juveniles operate with different views of hope than those working with adults. The current mixed juvenile/adult board is disruptive to managing both adults and juveniles.

Since 1992 and the formation of the SOMB, there have been a small fraction of the adult sex offenders who are truly low-risk in nature. At the end of 2008 the SOMB has established a sub-committee to create a protocol for the identification of low-risk sex offenders with the intent of recommending a significantly different criminal justice path. That protocol is currently being tested.

Likewise, developmentally delayed sex offenders present unique challenges both in identifying who they are and how to create more appropriate management and treatment paths for them. Hence, the SOMB has developed standards specifically for this population. Finally, adult females make up less than 10 percent of the convicted adult sex offender population and "no known cure" is not a useful concept for this population.

What follows in this paper is an explanation for the necessity to continue using, in statute, the concept of no known cure for the management and treatment of **adult** sex offenders.

### **3. RESPONSES**

#### **Part A - Beth McCann's Specific Questions**

##### **1. What are the data that supports the "no known cure" theory?**

###### **Recidivism Rates / Re-offense Rates**

Both the collective recidivism research and the key data points about convicted adult sex offenders necessitate concluding that there is no known cure. Further, we must conclude that most convicted adult sex offenders will eventually reoffend, especially after being released from the intensive interventions of probation and parole.

First, the research that drives our basic conclusion about re-offense rates can be found in the supporting appendix titled "Re-offense Rates of Adult Sex Offenders" written by Stephen Brake, Ph. D. and Greig Veeder, M.S.W.

Second, we listed key data points about convicted adult sex offenders that contribute to the logic of the no known cure conclusion.

Key data points:

- A. The real rate of re-offense is technically unknowable because the reporting rate is about 16 percent or less if we are referring to children reporting. ("Factors Related to the Reporting of Childhood Rape", Hanson, Resnick, Saunders, Kilpatrick, and Best [1999])
- B. Recidivism is a small fraction of the real rate of re-offense. This is because recidivism is typically a measure of 're-arrest' for a new sex offense, not a measure of the rate at which sex offenders actually sexually re-offend. This is a definitional difference that points to the fact that all recidivism research is an underestimation of sexual re-offense. This goes to the point that we do not have a reliable cure for convicted adult sex offenders. The profession discusses recidivism because that is what is measureable, but "no known cure" and the citizen cares about the real rate of re-offense. Those studies that show low recidivism numbers are not only offset by the studies that show high recidivism numbers, but the measurable concept "recidivism" significantly under represents the re-offense problem convicted adult sex offenders present to the public.
- C. On average, convicted adult sex offenders have far more victimizations and victims than official records show. ("Self-Report of Crimes Committed by Sex Offenders" by Weinrott and Saylor [1991]; Journal of Interpersonal Violence) & (pages 152 – 165 Colorado Sex Offender Management Board, Standards and Guidelines for the Assessment, Evaluation, Treatment and Behavioral Monitoring of Adult Sex Offenders, revised 2008)
- D. Prevalence studies show 1 in 4 girls and 1 in 6 boys are sexually abused by the age of 18 (Centers for Disease Control and Prevention - <http://www.cdc.gov/nccdphp/ace/prevalence.htm>). This number does not include rape and sexual assault on adults. The sheer size of the problem mandates that we do not lose sight of the most significant aspect of sex offenders; that there is no known cure.

- E. Essentially 100 percent of convicted sex offenders do not turn themselves into authorities at any time in their criminal sex offending careers. They require being caught, and the modal case of catching a sex offender is a 10-year-old girl summoning the courage to turn in the sex offender to the adult authorities.

Confirming that most sex offenders do not drop their self-centeredness (evidence of no known cure), effectively 100 percent of convicted adult sex offenders quit treatment the moment the court order is lifted. This means the sex offender drops his primary means of reassuring victims and the community of their safety. This in turn means most sex offenders stop having (or never develop) enough remorse and caring to prioritize community safety and reassurance to others.

Fortunately, there are some who sexually offend who do not pose a continuing threat. Usually these are one-time sex offenders and other truly low-risk sex offenders. The SOMB is in the process of developing a protocol for identifying these individuals so we can separate them from the majority of adult sex offenders.

### **Deviant Sexual Arousal – the other aspect of “No Known Cure”**

Unfortunately, there is little scientific understanding of the development of sexual orientations and attractions. For example, we do not know what causes pedophilia.

Children appear to be the most frequent victims of sex offenders. Of those sex offenders who are predominantly sexually interested in children, we do not know why they are sexually aroused by children. However, we do know that sexual arousal to children as measured psycho physiologically, is a strong predictor of reoffense. (Predictors of Sexual Offender Recidivism: A Meta-Analysis, 1996-04 and Predictors of Sexual Offender Recidivism: An Updated Meta-Analysis 2004-02 by R. Karl Hanson and Monique T. Bussiere)

We also know that reducing or eliminating sexual arousal to children is difficult, if not impossible. In fact, the treatment of deviant sexual interests is often enhanced by the use of medication. But as Association of Sexual Abusers says, “As with other treatments discussed in this document, the use of medication may help clients manage their risk for sexually abusive behavior, but medications do not “cure” deviant sexual interests or eliminate the risk for reoffending.” (ATSA Practice Standards and Guidelines for Members of the Association of Sexual Abusers, 2005)

*Note:* Those adult sex offenders who are not sexually aroused to their victims are dangerous because they are using their victims for other dehumanizing purposes.

## **2. What data is there that supports what we do in treatment that reduces recidivism?**

There is as yet no consistent or persuasive evidence that treatment works to reduce recidivism in adult sex offenders once they have left the treatment program. The data appears to suggest, however, that treatment works best when the offenders stay in the program and under supervision. For a full review of effectiveness of treatment please see the supporting appendix titled “The Effectiveness of Treatment for Adult Sex Offenders,” March 2010 by Stephen Brake.

What must be understood while reading treatment effectiveness research is that treatment doesn’t happen without probation or parole because it is court ordered as

a condition of probation or parole. Further, it appears that sex offenders only receive benefits from treatment while the court order is enforced, evidenced by the fact that nearly 100% of sex offender quit treatment as soon as the court order is lifted.

Below is a study that illustrates the same mixed results about treatment effectiveness on recidivism rates as our more comprehensive article located in the supporting appendix.

The table referenced below is from a 2004 review conducted by the Washington State Institute for Public Policy. It summarizes the results from seven studies conducted in various treatment programs. The full report is available by visiting <http://www.wsipp.wa.gov/pub.asp?docid=94-01-1101>.

### TREATMENT OUTCOME STUDIES FOR SEX OFFENDERS

STUDY & TREATMENT	OFFENDER TYPE	FOLLOW-UP (years)	RECIDIVISM RATES	
			Treatment	Non-Treatment
Davidson (1979), <i>Inpatient Cognitive/Behavioral</i>	Sex offenders released from an Ontario prison	5 +	11.0%	35.0%
Sturgeon and Taylor (1980), <i>Inpatient</i>	All offenders Girl molesters Boy molesters Rapists	1 - 5	15.4% 19.8% 14.6% 19.3%	25.0% 17.9% 37.5% 27.9%
Marshall and Barabee (1988), <i>Cognitive/Behavioral</i>	Child molesters Incest offenders	1 - 11	13.2% 8.0%	34.5% 21.7%
Rice et al. (1991), <i>Behavioral treatment</i>	Child molesters admitted to a maximum security psychiatric institution	6.3 (average)	37.9%	31.0%
Hanson et al. (1992)	Child molesters	10 - 31	44.0%	48.0% 33.0%
State of Vermont (1992), <i>Outpatient</i>	All sex offenders Rapists Child molesters Incest offenders Exhibitionists, etc.	8	6.3% 19.0% 7.0% 3.0% 3.0%	
Marques et al. (1992), <i>Inpatient Cognitive/Behavioral</i>	Rapists and child molesters	2	5.7% - 8.0%	

Also there is a 1996 study conducted by the Alaska Department of Corrections, in conjunction with the University of Alaska at Anchorage that found, "A treatment effect was clearly demonstrated." Treated sex offender lasted longer in the community before they re-offended than offenders in any of the comparison groups. Even under varied definitions of re-offense, the treatment group lasted longer without re-offense regardless of the definition applied." The full report is available by visiting <http://justice.uaa.alaska.edu/research/1990/9419sotp/9602sotp.html>.

Further support of the use of treatment with the probation/parole combination is found in the much used Schwartz and Cellini book series titled, *The Sex Offender*:

- "One of the advantages of lifetime probation, even in "incest only" cases, is that the offender can be assessed during different phases of his life. Case files on sex offenders are filled with examples of the multi-generational offender who might have molested his siblings as a teenager, his children as a parent and his grandchildren 20 years later (The Sex Offender – Volume II, Schwartz and Cellini, 1997, pg 16-10)."

- “Certainly total safety can never be guaranteed. An interesting and unfortunate fact is that in the three years that the specialized unit has been keeping statistics, half the re-offenses occurred because family members allowed their children to be in contact with the offenders, even though they had been appropriately informed (The Sex Offender – Volume II, Schwartz and Cellini, 1997, pg 16-10).”
- “Lifetime probation gives the probation officer (*and the therapist- our addition to this quote*) the time to work with difficult cases without being rushed to monitor reunification or to see the terms of probation expire (The Sex Offender – Volume II, Schwartz and Cellini, 1997, pg 16-10).”

**Our conclusion** is “some treatment and supervision approaches show promise. Some research suggests that recidivism rates may be lower for particular groups of offenders and for offenders who remain in treatment and supervision programs longer.” See supporting appendix.

**3. It is very unusual to have one specific theory contained in statutory language and I think that is what we are struggling with. Certainly you can continue to provide treatment without a specific reference in the statute can't you?**

**The Basic Answer**

The more precise question is: “Why is it necessary to have the statute direct the specific orientation of treatment?” It is the specific statutory language of “no known cure” that assures citizens that the legislators and all who follow the directives of the legislation understand the continuing nature of the management and treatment that is needed. There is nothing more germane to the direction of sex offender management than the “no known cure” language. The citizens have a real stake in the policies, guiding principles and standards of the Sex Offender Management Board, and their only substantive means to express their will is through the statute. The SOMB is a professional board despite the fact that it is open to the public. Additionally, the citizenry cannot be expected to be generally present for ongoing SOMB business and process, and thus must rely on the statute to be sufficiently specific as to meet the citizens’ primary needs from the professionals.

**Example Of Theory Being In Statute In Service Of Directing Legislative Intent**

There are other examples of having one specific theory contained in Colorado statutory language, including Title 19 Children’s Code, Article 1 General Provisions which states, “The general assembly recognizes the numerous studies establishing that children undergo a critical bonding and attachment process prior to the time they reach six years of age.” This language is making an assumption, based on research, that all children are bonded and attached to someone by the age six and that this assumption must be carried throughout the Children’s Code statute.

**Additional History and Explanations for Question #3**

**Brief History**

By 1992, specialized sex offender teams had formed within local probation and district attorney offices. Also, the leading treatment programs working with sex offenders had developed “sex offense-specific” treatment programs for working with sex offenders. Similarly, the national Association for the Treatment of Sexual Abusers (ATSA) had been formed around sex offense-specific treatment. The reason

this organizing was centered on offense-specific treatment was wide recognition that standard treatment didn't provide for public safety. This development was itself an outgrowth of the 1970's women's movement and the push to stop domestic violence.

### **The Importance of Offense-Specific Treatment**

Since sex offense-specific treatment was first ordered to ensure public safety, the primary client is the community. Even though it is the sex offender who is being treated, citizens have a direct stake in the standards, especially the fact that there is no known cure, that direct the nature of sex offense-specific treatment.

What distinguishes sex offense-specific treatment from other forms of treatment is that the patient is court-ordered into a treatment program (as a function of probation or parole's terms and conditions) to stop the pain, harm and threat the patient (sex offender) produces in the lives of others. The degree to which the offender-patient has his own personal life issues, unmet development needs and other personal problems dealt with in therapy is held-up against the prime obligation of public safety, the impact on victims and the sex offender's general accountability.

Traditional standard adult therapy is used in one of two situations: One, the client voluntarily seeks therapy to better himself. Two, the client is conspicuously, mentally addled in some fashion (crazy) and suffering. Conversely, sexual, offense-specific treatment is court-ordered for sex offenders regardless of the sex offender's will. Adding to the complication, sex offenders generally appear to be average human beings without obvious mental afflictions. It is the no known cure language in the statute that allows offense-specific treatment to maintain its effectiveness.

### **Who Does No Known Cure Benefit?**

No known cure benefits five key groups: victims, citizens, family and friends of sex offenders, sex offenders themselves and management and treatment professionals.

### **Benefits to Victims**

The first thing victims want is for the abuse to stop. The second thing they want is to know is that the abuse will not happen again. Victims rely on their fellow citizens to insist, through their legislative representatives, that the management of the offender who sexually assaulted them ensures their continued safety. Since the most threatening aspect of a sex offender is the fact that there is no known cure, victims need and deserve the interventions with sex offenders to be based upon that most significant characteristic of the sex offender.

### **Benefits to Citizens**

Citizens primarily want to know: can this convicted sex offender be treated so he won't offend again. Citizens are not satisfied with an answer that a sex offender will sexually assault at a slower rate. Citizens want to know whether or not there is a cure. A cure means zero reoffending. Most citizens intuitively understand that there is no known cure. What citizens want in the face of this dilemma is reliable assurances that the sex offender is being sufficiently and safely managed and treated for as long as necessary. Since citizens have no contact with the management and treatment professionals, they rely on the voice of legislators to represent their interest in how the professionals do their job.

Citizens have no seat on the SOMB, so the no known cure language in statute is the only means they have to direct professionals' treatment of sex offenders so that it is focused on public safety. No known cure is the point of contrast against which citizens get to say, "Show me that you've changed the sex offender enough to guarantee my safety."

### **Benefits to the Family and Friends of Sex Offenders**

The fact that there is no known cure is the most difficult truth for family and friends of the sex offender to cope with because it means that the family members, if they are to be responsible, must remain ever-vigilant. This vigilance requires anxiety, which is not a relaxed state. Healthy family living is based upon the sense of safety and relaxation, not anxiety and vigilance. Consequently, despite frequent claims that they can keep a watchful eye on the sex offender, it is not realistic to expect that this will happen.

Another problem the sex offender presents to his family and friends is that he possesses a unique power in the relationship that they do not. Only the sex offender knows what his intentions are from one moment to the next. The family and friends have to trust that the sex offender will always be forthcoming about his intentions. This too is unrealistic to expect of sex offenders given their history of manipulation and lying.

There are many unfortunate "no known cure problems" in life in general, such as diabetics or those with eating disorders, who try to hide what they do or don't eat that require the vigilance of family and friends to ensure they aren't putting themselves in danger. Sex offenders present a predatory form of no known cure. Therefore, family and friends of sex offenders absolutely need to be reminded of the fact that there is no known cure if there is any hope of their coping with that unpleasant reality without resorting to minimization and denial.

### **Benefits to Sex Offenders**

The no known cure language is needed by sex offenders because not only is treatment critical, but offers sex offenders a path to change and ultimately, a better life. Much like alcoholics in treatment programs like Alcoholics Anonymous, treatment with the right controls can be successful in managing the willing-to-be-managed sex offenders in the community. The words "no known cure" clearly express the depth of the management and treatment challenges sex offenders' sexually abusive behavior create for himself. Convicted sex offenders need the strength and clarity of hearing "no known cure" if they are to have any hope of relinquishing the power struggle to reclaim control of their lives and let themselves be managed and aided into pro-social living.

### **Benefits to Treatment Professionals**

It is the fact that no known cure is in statute that most strongly reminds and ultimately confronts the therapist that they are being directed by society as to how to base their interventions with sex offenders. The professionals gain revenue stream and receive professional opportunities from citizens via the court. It is this principal in statute that most clearly orients their professional interventions to manage sex offenders in light of the fundamental truth of no known cure.

- 4. We are seeking to require that the treatment providers demonstrate some data to support the use of the treatments. (*The implied question is "what should the legislature require of treatment in the service of demonstrating the reasonableness of the legislature's support of treatment – specifically legislative support of treatment based on the principle of "no known cure."*)**

The SOMB has already developed a set of treatment completion standards that are both comprehensive and attainable if the sex offender will accept the fact that he has a problem for which there is no known cure, and accordingly orient his life to be

externally accountable and appropriately self-limiting. Beyond that, there are objective tools, protocols and tests that measure this progress.

## **Part B - Additional Questions Legislators Might Ask**

### **5. Where's the hope? How can we expect any person to engage in treatment when we tell them, "There is no known cure and we expect you to positively engage in treatment, improve and complete treatment?"**

When the sex offender enters treatment, invariably the primary hope he has is to regain his private life so he can continue to enjoy the same freedoms he enjoyed (and abused) prior to being court-ordered into treatment. The challenge for the professional is that the sex offender must achieve "hopelessness" that his former ways of thinking and behaving will provide fulfillment. It is only after becoming hopeless about his ability to rely upon his own judgment in the running of his life that the sex offender can accept help and be guided towards healthy and appropriate forms of hope and living. There is no known cure, but there is real hope that through treatment, the sex offender can reorient his life and develop a healthy and fulfilling life. This becomes the answer to "where's the hope."

This is very similar to the "powerlessness" (first step of the 12 step program) that alcoholics must accept before they respond to help. Reaching this "bottoming out" is difficult, uncomfortable and greatly resisted.

### **6. Isn't "no known cure," Indeterminate Sentencing, the SOMB standards and the Containment Model a "One Size Fits All" approach?**

No. Actually, it is the focus on public safety and attending to the fact that there is no known cure that forces the professionals to be intimate with and to know the sex offender well enough to be able to manage him while living in the community. If we are going to manage someone outside of prison, we have to know that person very well and remain intimately engaged in his life if we are to guide him in safe and productive directions that are going work for him - as an individual.

This package of four management policies includes:

- A. statutory guiding principle – no known cure,
- B. criteria-based release – indeterminate sentencing,
- C. management & treatment guiding principles and standards - the SOMB
- D. tight and professionally collaborative containment model that produces public safety and individualization - the "community supervision teams". This is the Containment Model.

Of note, every "community supervision team" is formed around each sex offender individually. For example, if a therapist has 25 sex offenders on his case load, he has 25 different containment teams. What drives the sense of urgency for each containment team is the fact that they, as a group of professionals, have to create public safety knowing that it is known that there is no known cure.

No known cure being in statute functions as the driver making it clear to the professionals that public safety is what the citizens care about.

It is the collection of these four management policies that orient us to treat each sex offender as an individual, because so much is at stake with each sex offender. If you remove any one of these features, it inclines the professionals to create

more simplistic treatment models and suggests an unrealistically optimistic treatment conclusion.

**7. Isn't the language "risk-oriented" or "safety-focused" enough on its own?**

No, for all the reasons given above. To summarize, the use of other words like "risk-based needs assessment" without also using the words "no known cure" suggests that there is no legitimate presumptive threat level and that risk is predictable on a case-by-case basis. Unfortunately, professionals cannot reliably state which convicted sex offender will not reoffend because of the truth of no known cure. Public safety demands that if there is a difficult truth, we must cope with it. No known cure is that difficult truth.

**8. What is the harm of *removing* 'no known cure' from the statutory language, when you can keep it in the standards?**

To begin, it is the responsibility of those who wish to change or create a new statute to provide sufficient explanation for doing so. While we are writing this explanatory paper for why to keep the existing statute, the burden of explanation should be on the shoulders of those who wish to make the change. As of yet no meaningful explanation for the recommended change has been forthcoming, even though it has been sought.

The second answer to this question is that both legislation and legislation change is done to send a very significant signal from the citizens to those who are governed by the scope of the legislation. The removal of the no known cure language will communicate to sex offenders and those who professionally work with them that there is no longer an interest from the legislature (or the citizens) in the fact that there is no known cure for adult sex offenders.

A third answer to this question is that without the no known cure language in statute there is less or no justification for the life-time supervision legislation.

Finally the use of the word "cure" is sometimes challenged with the argument that it is inappropriate to use this word because it is a medical term and thus does not fit in the field of sex offender treatment. This is not true. "Cure" is rightfully used in all sorts of fields from medicine to gluing wood together. More importantly it means "fixed" - and that is what the citizens and victims care about and what is impossible to do because there is no end point to the management needs of adult sex offenders. The lack of a cure underscores that there is no final fix or solution.

**9. What seems to be going on to bring up this attempt to change the statute?**

Unfortunately, there appears to be more voices at the SOMB gaining traction to move away from a focus on public safety, at least to the point of discounting the significance of the difference between some recidivism numbers and the clear (though not directly provable with data) fact that the real rate of eventual re-offense is above 50 percent. This shift in orientation is partially driven by the fact there are three positions on the board being held by defense attorneys and that the chair is himself a defense attorney, and that there is a defense bar sub-committee to the SOMB. Until recently, the one prosecutor representative on the board showed up for board meetings very sporadically and did not seem to understand the issues that were being discussed, e.g., the concept of no known cure. Only at the end of this last year did the SOMB gain a district attorney representative who is willing to get involved. The other factor that is affecting the ability of the professionals on the

board to cope with the reality of there being no known cure for adult sex offenders is the fact that juvenile sex offender professionals sit on the same board and discuss and decide on adult sex offender based issues.

One more factor that seems to influence this drift toward doing away with no known cure language and thinking has to do with a type of sheer numerical dynamics. On a case by case basis, once there is a sex offender conviction, each victim related to that case, reasonably enough, drops out of the matter. But at the time of sentencing the sex offender has just re-begun his power struggle and battle of wills for control. Because there is no known cure, and because of legislative intent that there be long sentences for sex offenders, the number of sex offenders who want to see the criminal justice consequences reduced stacks up. Over time there seems to be an amassing of enabling family members of sex offenders joining the defense community. One of the results appears to be this current attempt to remove no known cure from the legislation.

These sex offender-centric voices appear to be the ones challenging the existence of the no known cure language in statute. No known cure is a reality that they and the sex offenders want pushed out of sight. Quite literally, the political interests of sex offenders appears to be trumping public safety interests, at least as far as no known cure is concerned.

## **SUPPORTING APPENDIX**

**Re-Offense Rates of Adult Sex Offenders, August 2007**

**The Effectiveness of Treatment for Adult Sex Offenders, March 2010**

**Re-Offense Rates of Adult Sex Offenders**  
**Stephen Brake, Ph.D. and Greig Veeder, M.S.W.**  
**August 2007**

**Introduction**

The rate of re-offending among adult sex offenders seems to be a controversial topic. Some state that the rate is quite low, others that it is quite high.

Sex offenses include both undetected offenses (the crime occurred but was not detected) and detected offenses (those which were reported). It is difficult to ascertain actual re-offense rates since many sex crimes go unreported. Accordingly, researchers must rely on studies of *recidivism* (detected sex crimes).

The following is a review of the literature pertaining to the frequency with which sex crimes are reported or detected and the recidivism rates of adult sex offenders.

**Neither perpetrators nor victims tend to report sex crimes.  
Victims report only a fraction of sex offenses to authorities.**

Various surveys and research projects have been conducted over the years on the frequency with which victims of sexual assaults report their experiences. Researchers estimate that somewhere between 64% and 99% of sexual assaults are never reported by victims and most studies indicate that fewer than 16% of sex offense victims eventually report their crimes (Abel and Rouleau, 1990; Besserer and Trainor, 2000; Bolen and Scannapieco, 1999; Cardarelli, 1998; Elliott, 1994; Fisher, Daigle, Cullen, and Turner, 2003; Freyd, Putnam, Lyon, Becker-Blease, Cheit, Siegel, and Pezdek, 2005; Kaplan, 1985; National Victims Center and Crime Victims Research and Treatment Center, 1992; Ringel, 1997; Russell, 1983; Snyder, 2000).

In Colorado, it is estimated that 84% of sexual assault cases are never reported to law enforcement (Colorado Department of Public Health and Environment and the Colorado Coalition Against Sexual Assault, 1998) and the authors of one study concluded that only 1% of sex offenders' crimes were officially reported to authorities (Ahlmeyer, Heil, McKee, and English, 2000).

**Many if not most adult sex offenders self report only a fraction of their crimes at the time of their arrest. Many if not most have a long history of committing sex offenses prior to getting caught.**

A number of studies have shown that sex offenders disclose in treatment or in surveys that they committed large numbers of offenses before they were first caught or arrested.

In one of the first large scale studies of sex crimes, Gene Abel and his colleagues reported that adult sex offenders who were guaranteed anonymity disclosed having committed an average of 533 sex offenses over a 12-year period before being detected (Abel, Becker, Cunningham-Rathner, Mittelman, and Rouleau, 1988; Abel, Becker, Mittelman, Cunningham-Rathner, Rouleau, and Murphy, 1987). The researchers concluded that Re-Offense Rates of Adult Sex Offenders 2

“arrest records of paraphiliacs do not provide a reliable indication of the true scope of paraphilic acts” and that “most paraphilic acts are not reported”.

Others have reported similar findings. For example, one study found that rapists given assurances that their responses would remain anonymous reported having six times as many victims as could be identified from official records and each of the child molesters in the study reported having hundreds of previously unknown sexual contacts with children (Weinrott and Saylor, 1991). The authors concluded that there is an “iceberg of undocumented offenses beneath the tip of official records”.

Another study found that child molesters eventually report, while in treatment, having committed an average of 88 crimes each (Underwood, Patch, Cappelletty, and Wolfe, 1999). Another reported that adult sex offenders who were known to have an average of 2 victims at the time of their arrest subsequently report having an average of 184 victims after taking polygraph tests while in treatment (Ahlmeyer, et al., 2000). Other researchers have reported that the number of sex offenses disclosed by sex offenders in treatment increased by 3-4x (Emerick and Dutton, 1993) or by 5x (Janes, 1993) following polygraph testing.

**Sex crimes go undetected for years because neither offenders nor victims tend to report sex crimes.**

On average, 10 to 16 years elapses between a sex offender’s first sex offense and his first arrest (Abel, et al., 1988; Abel, et al., 1987; Ahlmeyer, et al., 2000). Between 10 and 20 years may elapse between the time an incest victim is first assaulted and the time he or she reports the abuse (Lamb and Edgar-Smith, 1994; Resler and Wind, 1994).

**The re-offense rate for adult sex offenders is high.**

**Because sex crimes aren’t often reported, recidivism rates derived from arrest records are under-estimates of the actual number of sex offenses committed by adult sex offenders.**

**Researchers find that recidivism rates steadily increase as offenders are followed for longer periods of time allowing for a greater probability of detection.**

**Many researchers have found relatively high recidivism rates even when offenders are tracked for short periods of time.**

We surveyed 36 recidivism studies of adult sex offenders conducted over the past 19 years (28 individual studies and 8 meta-analyses; a small number of studies of adolescents were present in some meta-analyses). We do not purport to have reviewed *all* studies (several of the meta-analyses cited here, for example, include a greater number of studies) but we believe we have included most of the studies, including meta-analyses, that are the most prominent or frequently cited of recent years.



studies and 4 meta-analyses) found recidivism rates to be greater than the 13-19% found in the Hanson and Brussiere (1998) meta-analyses. Re-Offense Rates of Adult Sex Offenders 4.

As researchers track offenders for even longer periods of time, recidivism rates increase more noticeably. Of the 10 groups of offenders in our survey tracked for 15 years or more, none had recidivism rates below 20% and 5 of 7 groups of offenders tracked for 19 years or longer had recidivism rates greater than 35%.

In the few studies in which offenders are tracked for at least 25 years, recidivism rates are uniformly high. One study found recidivism for a mixed group of offenders to be 48% after 28 years (Hanson, Steffy, and Gauthier, 1993), another found recidivism to be 39% for rapists and 52% for child molesters after 25 years (Prentky, Lee, Knight, and Cerce, 1997), and another found recidivism for a mixed group of offenders to be 61% after 25 years (Langevin, Curnoe, Federoff, Bennett, Langevin, Pever, Pettica, and Sandhu, 2004).

Langevin and his colleagues (Langevin, et al., 2004) found recidivism among a mixed group of adult sex offenders to be 88% after 25 years if the self-reports of the offenders are included as a measure of recidivism along with re-arrest records. (This group is not represented as a "dot" in the graph). Re-Offense Rates of Adult Sex Offenders 5

#### Footnotes

1. Stephen C. Brake, Ph.D., Brake and Associates, 1181 South Parker Road, #103, Denver, CO, 80231, [www.stephenbrakeassociates.com](http://www.stephenbrakeassociates.com)
2. Greig Veeder, M.S.W., Teaching Humane Existence, 7995 East Hampden, #208, Denver, CO, 80231, [www.about-the.org](http://www.about-the.org)

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<b>Code For Studies Represented in Graph</b> <u>Years</u>	<u>Study Code</u>
(bottom to top)	
1	Z, CC, CC, E
2	F, F, Z
3	Q, Z, A, W, W, W, A, A, A, W, A, A
4	V, J, DD, J, C, FF, V, DD, C
5	A, HH, A, B, B, HH, JJ, Z, T, S, I, M, A, CC, I, CC, II, A, A, E, A, II, EE
6	Y, L, AA, K, Y, GG, AA, GG
7	G, G
8	X, X
9	D, JJ, E
10	JJ, Z, M, U, CC, JJ, CC, BB, U
11	
12	H, H, O
13	
14	
15	P, M, P
16	
17	
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19	N
20	M, N
21	
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# The Effectiveness of Treatment for Adult Sex Offenders

Stephen Brake, Ph.D.  
March 2010

## Introduction

Evaluating the effectiveness of treatment for adult sex offenders is a difficult task. Designing research studies with adequate control groups is challenging and executing them is even more so. The fact that sex crimes are grossly under-reported lowers the (apparent) base rate of sex offending and limits conclusions that can be drawn about the significance of treatment effects. In addition, individual research studies require years to complete and so data about treatment effectiveness are very slow in coming. Meta-analyses of studies already completed are complicated by difficult decisions that must be made about what studies to include and how to compare treatment effectiveness among the disparate individual studies.

Because of these difficulties, conclusions about the effectiveness of treatment for adult sex offenders are difficult to reach. Yet it is important to know what the research tells us.

We examined 31 research studies concerning treatment outcome (24 individual studies and 7 meta-analyses) published since 1984. These studies are easily accessible and required no particular expertise to interpret; we relied upon the authors' conclusions about whether a finding was significant. Our review is not intended to be a review of all studies ever completed on the effectiveness of treatment for adult sex offenders but we included all we could locate with reasonable effort and we excluded none we found. We believe we have included the most recent and commonly referenced studies.

The form of treatment most commonly offered sex offenders in the studies is cognitive/behavioral or relapse prevention therapy (although other forms of treatment are addressed as well). The duration of treatment in the studies surveyed varies from just a few weeks to four years and the amount of time an offender was at risk following treatment ranged from 2 years to 28 years (in some studies, the duration of treatment and amount of time at risk were difficult to determine).

**No definitive conclusions can be drawn from individual studies about the effectiveness of treatment. About half suggest treatment may be effective in reducing recidivism and about half suggest that treatment is statistically ineffective.**

Of the 24 individual studies surveyed, 11 (46%) concluded that some form of treatment significantly reduces recidivism (Aytes, Olsen, Zakrajsek, Murray, and Ireson, 2001; Duwe and Goldman, 2009; Hildebrand, deRuiter, and deVogel, 2004; Looman, Abracen, and Nicholaichuk, 2000; Maletzky, Tolan, and McFarland, 2006; Marshall and Barbaree, 1988; Marshall, Eccles, and Barbaree, 1991; McGrath, Cumming, Livingston, and Hoke, 2003; McGrath, Hoke, and Vojtisek, 1998; Nicholaichuk, Gordon, Gu, and Wong, 2000; and West, Hromas, Wengler, and Suthers, 2000 - data from "Alaska"). Another 10 of the 24 studies (42%) concluded that treatment did not statistically reduce recidivism (Barnoski, 2006; Davidson, 1984; Friendship, Mann, and Beech, 2003; Hanson, Broom, and Stephenson, 2004; Hanson, Steffy, and Gauthier, 1993; Lowden, Hetz, Harrison, Patrick, English, and Pasini-Hill, 2003; Marques, Wiederanders, Day, Nelson, and van Ommeren, 2005; Quinsey, Khanna, and Malcolm, 1998; Rice, Quinsey, and Harris, 1991; and Schweitzer and Dwyer, 2003). Three studies (12%) did not offer statistical analyses

of their findings (West, et al., 2000 - data from "Kentucky", "New Hampshire", and "Vermont"). Effectiveness of Treatment for Adult Sex Offenders 2.

Three of these studies may be particularly notable because they are recent, large-scale, and well-designed. The findings from what may be regarded as the best designed study of the efficacy of sex offender treatment, the Sex Offender Treatment and Evaluation Project in California, revealed no statistically significant differences in recidivism among offenders treated for 1-2 years and then released from treatment (with one year of parole supervision following treatment) and untreated sex offenders (Marques, et al., 2005).

The recent large scale study conducted by the Washington Institute for Public Policy (Barnoski, 2006) revealed that there was no reduction in sex offense recidivism for participants in the Washington Department of Corrections treatment program compared to those who did not participate in the program.

On the other hand, another recent and well designed study out of Minnesota (Duwe and Goldman, 2009) found that treatment produced "a significant albeit relatively modest reduction in sex offender recidivism".

**The methodologies of many of the individual studies have been questioned making it even more difficult to reach definitive conclusions.**

The conclusions of some of the individual studies suggesting a positive treatment effect are qualified by (sometimes unavoidable) design flaws. For example, two studies (Looman, et al., 2000; Nicholaichuk, et al., 2000) were criticized for having inadequate control groups (Hanson and Nicholaichuk, 2000; Rice and Harris, 2003). Two other studies (Aytes, et al., 2001; Hildebrand, et al., 2004) included as control groups sex offenders who had failed to complete treatment when it might have been equally appropriate to consider the failure of those offenders to be a poor outcome of a treatment endeavor rather than consider them as similar to offenders who never received treatment.

Another study showed a robust treatment effect (Maletzky, et al., 2006) but it should be noted that the treatment employed was hormonal/pharmacological, not the standard cognitive behavioral treatment employed by most sex offender treatment programs.

It should also be noted that one study which found no significant effect of treatment on sexual recidivism did find a significant positive effect of treatment on violent recidivism and overall recidivism (Lowden, et al., 2003). The authors concluded, in part, that sex crimes were the least commonly reported offenses making it difficult to compare groups using measures of sexual recidivism. .

**Most meta-analyses conclude that there is a small but significant effect of treatment on recidivism but the methodologies are subject to criticism.**

Of the 7 meta-analyses we reviewed, four concluded that treatment had a small but significant positive effect on lowering recidivism (Gallagher, Wilson, Hirschfield, Coggeshall, and MacKenzie, 1999; Hall, 1995; Hanson, Gordon, Harris, Marques, Murphy, Quinsey, and Seto, 2002; Losel and Schmucker, 2005) while two concluded that there was no such effect (Furby, Weinrott, and Blackshaw, 1989; Kenworthy, Adams, Bilby, Brooks-Gordon, and Fenton, 2004) and one (Alexander, 1999) provided no statistical analysis.

Two meta-analyses (Gallagher, et al., 1999; Hall, 1995) have been critiqued about the particular studies which were chosen for inclusion. The Gallagher et al. meta-analysis has been criticized for including studies with “significant threats to validity” including early reports of studies which were contradicted by later versions of the same studies (Hanson, et al., 2004). The Hall meta-analysis has been criticized for including studies in which comparison groups were shown not to be equivalent; when these studies were removed from the analyses, the effect of treatment was no longer found to be significant (Hanson, Morton, and Harris, 2003; Harris, Rice, and Quinsey, 1998). Effectiveness of Treatment for Adult Sex Offenders  
3 |

The authors of another meta-analysis (Losel and Schmucker, 2005) concluded that there is a significant effect of treatment on recidivism and that cognitive-behavioral treatments considered separately had a small but significant effect but much of the overall treatment effect appears to have come from studies in which treatment consisted of surgical castration.

Alexander’s meta-analysis (1999) is sometimes cited as concluding that treatment is effective, probably because recidivism percentages derived from the analysis for treatment groups are somewhat lower than recidivism percentages for control groups, but Alexander offered no statistical analysis of these findings.

The two meta-analyses in which it was reported that no significant treatment effect could be demonstrated have been criticized as well. The Furby, et al. analysis (1989) has been criticized because many of the studies included in the analysis focused on outdated treatment modalities. The Kenworthy et al. analysis (2004) was withdrawn in 2008 pending an update.

Perhaps the most frequently cited recent meta-analysis is the ATSA Collaborative Outcome Data Project (Hanson, et al., 2002). The authors concluded that there was a small but statistically significant effect of treatment on sexual recidivism. It should be noted, however, the difference in recidivism rates between treated and non-treated offenders in the analysis was small (12% for treated and 17% for non-treated). It should also be noted that the decision rules employed about study inclusion have been questioned and it has been suggested that the conclusions reached by the authors are not supported because many of the studies included in the meta-analysis had serious design flaws (Rice and Harris, 2003). Rice and Harris concluded in reviewing this study that it offered “no convincing evidence” that treatment is effective in reducing recidivism.

It should also be noted that some other reviewers, while not conducting a formal meta-analysis, have concluded that treatment is effective. For example, a review of studies conducted in 1991 by Marshall and colleagues concluded that there is “an unequivocally positive answer” to the question of whether sex offender treatment reduces recidivism (Marshall, Jones, Ward, Johnston, and Barbaree, 1991). However, others criticized this review saying that the authors’ conclusion was not warranted because the review included too many studies that contained no adequate control groups and because the studies reviewed often could not ensure that comparison groups were equivalent (Quinsey, Harris, Rice, and Lalumiere, 1993).

**In summary, research has not consistently demonstrated that time-limited treatment lowers the recidivism rates of adult sex offenders once they leave treatment and supervision programs.**

Some individual research studies suggest that treatment lowers recidivism but others, including recent well-designed studies (and the only study to date employing randomized subject assignment), do not find such an effect. The findings of meta-analyses are encouraging but confusing and contested. Considered as a whole, it does not appear to us that research to-date persuasively demonstrates that time-limited treatment lowers sex offense recidivism.

Some intervention or set of interventions may eventually be shown to lower recidivism in some offenders. For example, Marques et al. (2005) indicated that a combination of treatment response measures was found to be a significant predictor of sexual re-offense in high risk offenders suggesting that some form of treatment might eventually be effective with these offenders. Effectiveness of Treatment for Adult Sex Offenders 4

Prolonged treatment, containment and supervision also appear to be important in lowering recidivism. The study of the Sex Offender Treatment Program at the Department of Corrections in Colorado revealed that re-arrest rates for all violent and sexual crimes (although, again, not specifically sexual crimes) were lower for offenders who remained in the DOC treatment program longer and who were subsequently placed on parole supervision when released (Lowden, et al., 2003).

The study of the prison-based treatment program in Vermont revealed that both the length of time in treatment and the degree to which offenders received aftercare and correctional supervision following treatment contributed to lower recidivism (McGrath, et al., 2003).

The study of the community-based treatment program in Oregon indicated that the effect of treatment in lowering recidivism was particularly strong for offenders who remained in the treatment program for longer than a year (Aytes, et al, 2001).

Finally, a study conducted by the Colorado Department of Public Safety Division of Criminal Justice (2004) showed that high risk adult sex offenders living in a quasi-milieu setting which typically provides increased supervision and monitoring ("shared living arrangement") had significantly fewer violations of probation than adult offenders with other living arrangements.

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### **Notes**

Stephen C. Brake, Ph.D., Stephen Brake Associates, 1181 South Parker Road, #103, Denver, CO, 80231, [www.stephenbrakeassociates.com](http://www.stephenbrakeassociates.com) Effectiveness of Treatment for Adult Sex Offenders 6

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