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National Institute of Corrections

-An Administrator's Overview-

Questions and Answers on Issues Related to the Incarcerated Male Sex Offender

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Project Staff

Adapted by Barbara Krauth and Roger Smith from *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender,* to be published by the National Institute of Corrections in Spring 1989.

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Contents

Foreword iii
Acknowledgements v
Introduction 1

Sex Offenders: Causes and Types 2
Is there more than one type of sex offender? 2
What causes sexual deviance? 4

Importance of Intervention/Treatment 4
Why not just lock them up? 4
Does treatment "cure" a sex offender? 5
Have sex offender treatment programs in institutions been successful? ... 5
Can every sex offender be treated successfully? 6

Approaches to Assessment and Treatment of Sex Offenders 7
How are good candidates for successful treatment identified? 7
Can any mental health professional provide treatment? 8
What kinds of staff work best with sex offenders? 8
Will my staff need special training? 9
What techniques are used in sex offender treatment programs? 10
Interpersonal Techniques-Individual and Group Therapy 10
Psycho-Educational Modules 10
Behavioral Techniques/Penile Plethysmograph 11
Techniques for Reducing Deviant Arousal 12
Techniques for Increasing Appropriate Sexual Arousal 13
Cognitive Restructuring 13
Relapse Prevention 13
Hormonal Therapy 14
How important is the penile plethysmograph in assessing and treating sexual deviance? 14

Planning Issues 15
Who needs to be involved in planning a treatment program? 15
What kinds of policy decisions are involved? 16
What will a sex offender treatment program cost? Are there less expensive alternatives? 17

Will a treatment program affect security and custody practices? 18
Will a treatment program increase the size of the inmate population? ... 18
Should sex offenders be housed in a separate therapeutic living unit or in general population? 19
Do sex offenders in treatment constitute increased suicide risks? 19
How should I handle the media? 19
How can we build public support for treating sex offenders? 20
How important is program evaluation? 20

Program Management 21
How long should treatment last? 21
Should sex offenders participate in other institutional programs, such as jobs or education? 22
Should sex offenders be allowed conjugal visits? 22
Should sex offenders be allowed to participate in furloughs, home visits, work release, or other temporary leave programs? 22
How can sex offenders be reintegrated into the community after they serve their sentences? 23

Legal Issues 23
Do incarcerated sex offenders have a legal right to treatment? 23
Can inmates be forced to participate in treatment? 24
Can treatment providers legally possess sexually explicit or pornographic materials? 24
Does the institution assume any liability as a result of the treatment methods used? 24
Is a state or institution liable if a sex offender who has received treatment commits a sex offense after being released? 25

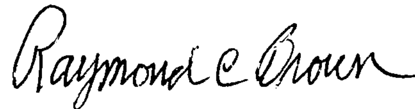
Foreword

This **Administrator's Overview** is intended for correctional administrators, planners, and others responsible for dealing with incarcerated male sex offenders. The **Overview** discusses treatment techniques that are proving effective in reducing the extremely high rate of recidivism exhibited by many of these offenders.

As we have become more aware of the extent of sexual violence in our society and the impact rapists and child molesters have on their victims' lives, demands have increased to minimize the potential of these offenders committing other crimes. The burden has fallen primarily on corrections to assume responsibility for specialized supervision and treatment programs necessary to interrupt the sex offender's often compulsive and repetitive victimization of others.

In 1986, the first of a series of special issue seminars entitled "A Systems Approach to Managing Sex Offenders" was presented at the National Academy of Corrections in Boulder, Colorado. The seminars approached treatment and supervision of sex offenders from a systems perspective, in which legislators, judges, prosecutors, victim advocacy groups, and mental health agencies are important co-participants in corrections' efforts to reduce the levels of sexual victimization in this country.

This Overview contains information drawn from the NIC monograph, *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender,* which incorporates information presented in the earlier NIC seminars. We are pleased to make this publication available to those in corrections and related fields who have an important stake in planning and implementing programs for incarcerated sex offenders.



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Introduction

Incarcerated male sex offenders represent a major problem for correctional administrators in the United States. Increasingly, there is public, legislative, and legal pressure to "do something" about this highly visible group of offenders. Most correctional systems in the U.S. and Canada now offer some form of treatment for sex offenders, ranging from individual or group counseling to highly intensive therapeutic communities that use state-of-the-art treatment methods.

The results of a 1987 survey reported in Contact Center's *Corrections Compendium* revealed that 37 states have experienced a significant increase in the numbers of incarcerated sex offenders. Nearly 55,000 sex offenders were incarcerated at the time of the survey; some institutions reported that sex offenders constituted 25% to 30% of their inmate population.

Surprisingly, many studies conducted during the 1920s and 1930s indicated rates of sexual assaults comparable to those shown in more recent studies. The question, then, is why sexual assault has recently come to be seen as such a pressing problem for corrections. Several factors are important:

- Increasingly, public attention has focused on rape and child sexual abuse and on the long-term effects of sexual assault on victims.
- Victims' advocacy groups have changed the way victims of sexual assault are viewed by the criminal justice system.
- Teachers, youth workers, mental health professionals, and others have been more aware of the signs and symptoms of child sexual abuse. This awareness, coupled with mandatory reporting laws, has led to increased intervention and reporting.
- Legislators, reacting to public concern, have imposed more severe penalties for sex crimes. Prosecutors are more willing to pursue such cases and judges are more likely to impose longer sentences.
- Many parole boards have become reluctant to release potentially dangerous sex offenders.

The responsibility for treating and supervising sex offenders has increasingly shifted from mental health institutions to corrections, as the Mentally Dangerous Sexual Psychopath laws adopted by many states during the 1940s have been phased out. Treatment professionals have concluded that most sex offenders are not mentally ill and have not benefited from traditional psychiatric treatment. Fortunately, as the burden has shifted from mental health to corrections, promising new approaches to treating sex offenders have been developed.

The National Institute of Corrections, responding to increasing requests for technical assistance from correctional administrators and clinicians, began in 1986 to offer a series of week-long training seminars through the National Academy of Corrections. These training seminars stressed the importance of a systems approach to program planning, design, and management. This approach requires the active participation and support of legislators, prosecutors, judges, mental health professionals, advocacy groups, and all elements of the corrections system. Because of the highly sensitive nature of sex crimes and the probability that some treated offenders will re-offend, the seminars also emphasized the need to educate the media and the public about the goals and methods of treating sex offenders.

This **Administrator's Overview** highlights material contained in the monograph, *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender,* produced as a result of the NIC training seminars. The **Overview** is directed toward correctional administrators, who must make critical decisions regarding the allocation of limited resources. It grows out of an awareness of the important role that informed and supportive administrators play in developing and operating effective treatment programs for sex offenders in custody. Without their support, it is unlikely that the vicious cycle of abuse, in which victims frequently become offenders, will ever be broken.

Sex Offenders: Causes and Types

Is there more than one type of sex offender?

Sex offenders are an extremely diverse group. They cannot be characterized by single motivational or causal factors. Many typologies have been developed to account for the varieties of sexual deviance. The categories developed by the FBI, which are based on other typologies, are currently used in most criminal investigations. These categories follow.

Child molesters turn to prepubescent youths for sexual gratification. Two main categories of child molesters exist: (1) situational and (2) preferential (often referred to as pedophiles). Each of these main categories subsumes several subtypes.

- **Situational child molesters are** individuals who do not have a defined sexual preference for children. They include the following subtypes:

  Regressed-an immature, socially inept individual who relates to children as peers. This individual may have experienced a brief period of low self-esteem and turned to his own children or others for sexual satisfaction.

  Morally Indiscriminate-an antisocial individual who uses and abuses

everything he touches. His victims are chosen on the basis of vulnerability and opportunity and only coincidentally because they are children.

Sexually Indiscriminate-an individual with vaguely defined sexual preferences who will experiment with almost any type of sexual behavior.

Inadequate-a social misfit who may be developmentally disabled, psychotic, senile, or organically dysfunctional.

- **Preferential child molesters are** fixated. That is, they have been attracted to children throughout their lives and have been unable to attain any degree of psychosexual maturity. Subtypes include:

  Seductive-has exclusive sexual interest in children and tries to court and seduce them

  Introverted-has a fixated interest in children but does not have the social skills to seduce them. Typically he molests strangers or very young children or marries women with children the age of his preference.

  Sadistic-has a sexual preference for children, coupled with a need to inflict pain in order to obtain sexual gratification.

Rapists are motivated by a fusion of anger and power needs and sexuality. They are often classified according to the characteristics of the assault as well as of the assailant.

- **The anger rape** is marked by gratuitous violence and the intention to hurt, debase, and express contempt for the victim. This type of assault is often opportunistic and is usually committed in response to a precipitating stress.
- **The power rape** serves as a means of exercising dominance, mastery, strength, authority, and control over the victim. There is little need for excessive physical force beyond that needed to gain the victim's submission. While less physically dangerous than anger rapists, power rapists may be more compulsive and often engage in elaborate fantasies and plans
- **The sadistic rape** represents the most severe pathology on the part of the offender as well as the most dangerous type of assault. The ritual of torturing the victim and the perception of her suffering and degradation become eroticized. As the assailant's arousal builds, so may the violence of his acts, progressing in some cases to lust murder.

Almost all incarcerated sex offenders in treatment are rapists or child molesters. Exhibitionists, voyeurs, or obscene phone callers may be jailed on misdemeanor charges and referred for counseling, but they are rarely

imprisoned unless their behavior involves other criminal conduct. In fact, however, the actual intent of an individual arrested for a misdemeanor sex offense is frequently difficult to ascertain; the voyeur at someone's window may be about to enter the window and commit a rape. Some experts believe that misdemeanor sex offenders are often engaged in an escalating pattern of deviant behavior. One study suggests that sex offenders typically do not specialize in one type of sexual abuse, but engage in multiple forms of abuse (e.g., rape, child molestation, voyeurism).

What causes sexual deviance?

Behavioral scientists, psychoanalysts, anthropologists, psychologists, and political scientists have all speculated about the causes of sexual deviance. Their theories, which identify causes ranging from biological determinism to cultural influences, tend to reflect the biases of the theorist's discipline:

- Biological explanations point to genetic factors, such as Klinefelters Syndrome (i.e., XXY chromosome structure), or such factors as high testosterone levels, as associated with increased likelihood for deviance.
- Psychoanalytic theory posits traumatic sexual experiences in the lives of offenders, causing a fixation at an inappropriate psychosexual stage of development.
- Behaviorists maintain that deviant behavior is learned in childhood through sexual assault or deviant masturbatory fantasies.
- Psychologists see deviance as the product of the learning process.
- Anthropologists, sociologists, and criminologists tend to seek explanations in culture or society.

There is no way to prove any of these theories, but all have some merit. Depending on the individual. sexual deviance may be the product of any or all of these factors.

Importance of Intervention/Treatment

Why not just lock them up?

Sex offenses are sensational crimes that the public views with horror. Providing treatment for inmates whose crimes are so repugnant can be controversial. Some corrections officials are reluctant to spend scarce resources to create treatment opportunities for this group of offenders, believing that punishment and deterrence are more appropriate.

However, the atmosphere of a typical prison tends to aggravate the problems of most sex offenders. Secrecy, inappropriate methods of handling emotions, negative social interactions, poor self-esteem, denigrating beliefs about women, and deviant sexual arousal are often reinforced in prison. However, recent studies tend to contradict the philosophy that "nothing works"-that treatment does no good. The federal government recently began funding efforts to revive prison-based treatment for a variety of problems, and the President's Commission on Pornography (1986) recommended treatment of sex offenders.

Without treatment, sex offenders are highly likely to re-offend. Statistics suggest that the recidivism rate of untreated offenders is about 60 percent, while recidivism among those who have been treated is about 15 to 20 percent and, in some cases, much less. Recidivism rates will be affected by the types of offenders admitted to treatment and by the availability of specialized follow-up therapy and supervision. For the sake of protecting potential victims, then, treatment is important.

Does treatment "cure" a sex offender?

No. Sex offenders are not cured. Successful treatment does not permanently eliminate the attraction of deviant sexual acts for sex offenders, who are always at risk of repeating their behavior. However, many offenders can learn, through treatment, to control their disorder.

It is important to encourage realistic expectations on the part of the sex offender. Although treatment can sometimes diminish the attraction of deviant sexual acts, it is considered successful if sex offenders use what they have learned to maintain control over their behavior. Treatment can enable an offender to recognize a situation in which he is likely to re-offend and teach him how to control his behavior in these situations.

Have sex offender treatment programs in institutions been successful?

Recidivism rates are the central issue m evaluating program success. The goal of treatment is to reduce the likelihood of further victims; it is on these grounds that "success" must be measured.

Unfortunately, however, comparable experimentally based data are rare. A number of treatment programs have followed their patients over a period of time and reported the results. However, the data were collected in many different ways and tracked widely divergent groups of offenders, and programs usually did not employ classic experimental design.

One problem in comparing results of various programs is that the data are not collected on comparable offenders. While some treatment programs admit any sex offender who is willing to participate, others refuse to treat certain categories of offenders, such as preferential pedophiles or sadistic rapists. The "success" data for the latter programs are obviously better.

Another problem in interpreting recidivism data is that the definition of recidivism itself can vary. While some programs track offenders only for a short period of time and consider only sex-related crimes as re-offenses, others follow released offenders for a long period of time and consider any crime a re-offense.

As the number of sex offender treatment programs increases, administrators are becoming aware of the importance of keeping outcome data for their programs. Therefore, the availability of reliable data on success should improve in coming years.

Despite the dearth of reliable data on recidivism, providing treatment for sex offenders clearly makes a difference. In general, as stated earlier, most institutional programs have found that approximately 15 to 20 percent of treated offenders will commit a sex offense within three years of their release, while approximately 60 percent of those who have not received treatment will re-offend. Community-based outpatient programs, which are likely to have more treatable clients, report even lower recidivism rates.

Can every sex offender be treated successfully?

Some, but not all, sex offenders can be treated successfully. Those with life-long histories of antisocial acts are not good candidates for treatment. Extremely violent or sadistic offenders, sociopathic offenders, and those not motivated for treatment are almost impossible to treat. However, encouraging success rates have been achieved by programs treating many types of child molesters and some types of rapists.

Candidates with the best prognosis for treatment have committed few sex crimes, have little history of drug or alcohol dependence, are not mentally ill, and are of normal intelligence. In addition, they have the capacity to be aroused by age-appropriate sexual partners and have a supportive family and a good work history. While offenders with all these qualities are rarely found in prison, many incarcerated sex offenders will have one or more of these characteristics.

Approaches to Assessment and Treatment of Sex Offenders

How are good candidates for successful treatment identified?

Because not all sex offenders are equally amenable to treatment, it is important to develop effective assessment procedures to identify good candidates. Techniques used to assess sex offenders include clinical interviews; self-reporting; psychological tests; questionnaires; and physiological methods, such as the plethysmograph, to measure deviant sexual arousal.

The following types of information are important in assessing candidates for treatment:

- **Nature of the offense** -level of violence
- **Characteristics of the victim** - age, gender.
- **Circumstance of the offense** - drug or alcohol use, presence of stress or a psychological state such as depression.
- **Criminal history** - career criminals and those with antisocial personalities rarely respond to this specialized form of treatment.
- **Developmental history** - nature of the offender's relationship to his parents and siblings, especially information about abuse, neglect, parental death or abandonment, methods of discipline, family sexual behavior, and the adequacy of parental role models.
- **Educational, social, and sexual history.**
- **Inhibiting beliefs -** sex offenders are sometimes from backgrounds that have instilled repressive sexual attitudes and a fear of adult sexuality.
- **Level of anger** - anger serves as the primary motivation for many sex crimes, especially for rapists.
- **Acceptance of responsibility -** offenders who accept responsibility for their actions are more amenable to treatment.
- **Ability to empathize -** offenders who can empathize with their victims are better candidates for treatment.
- **Awareness of emotions -** sex offenders are often unaware of. or unable to express, their feelings.
- **Cognitive distortions -** sex offenders often blame their victims or have distorted notions about sex.

- **Degree of sexual arousal to deviant** stimuli-this must be considered in relation to the degree of arousal to appropriate stimuli.

In addition to their usefulness in identifying good candidates for treatment, the assessment procedures can help to create a detailed clinical picture of an offender and identify specific areas to target for intervention and treatment. They also permit some judgments to be made about changes in the offender as treatment progresses.

Can any mental health professional provide treatment?

A common concern of administrators is who should provide treatment for sex offenders in an institution. Since very little specific training in sex offender treatment is provided by any degree programs in mental health, no discipline is recognized as singularly expert in this area. The leaders in the field include psychologists, social workers, rehabilitation counselors, criminologists, and educators. Both professionals and paraprofessionals can make valuable contributions. Correctional officers. counselors, and caseworkers can all be trained to facilitate groups and teach modules. Inmates in treatment can also be trained to assist in providing certain treatment techniques under supervision.

Substance abuse counselors often do quite well in this work, as many of the dynamics of the two conditions are similar. Institutional chaplains, trained to understand and treat sexual deviancy, can also be effective members of a treatment team.

What kinds of staff work best with sex offenders?

The personality of the treatment provider is more important than his or her degree. Most effective therapists, either professional or paraprofessional, have personalities suitable to working with this group. They must be confrontive. but caring in their attitudes. They must also be comfortable with their own sexuality. Staff must be capable of being objective with offenders whose behavior they may find personally repugnant. Staff who have themselves been sexually victimized must successfully resolve their own issues if they are to interact effectively with sex offenders.

Where at all possible, male-female teams should be used to conduct group therapy sessions. The advantages of this approach are:

- An appropriate male role model can demonstrate correct social skills and attitudes toward women.

- An appropriate female role model can help the offender practice social skills, as well as work through anger, power. or other issues.

- A male-female team can model appropriate interactions, conflict reso lution. and nonsexual relationships.

Will my staff need special training?

Training for institutional staff at all levels is a critical factor in developing successful treatment programs for sex offenders. Training should be provided to security, administrative, chaplaincy, and other staff, as well as to those who are directly involved in providing treatment to offenders.

Staff sometimes erect barriers to inmates' participation in treatment programs by creating inflexible schedules, displaying negative attitudes toward sex offenders, or publicly labeling inmates who are in treatment. Workshops designed to inform staff about sex offender treatment programs can be effective in promoting understanding and cooperation.

Correctional chaplains are often in a position to facilitate an inmate's decision to seek assistance. Sex offenders sometimes distort religious beliefs in an effort to avoid treatment. Some may claim to have religious conversion experiences following their arrest and incarceration and believe that professional treatment is unnecessary. Other inmates may resist particular forms of behavioral techniques used in treatment on religious grounds. Chaplains must be trained in the causes of sexual deviance, the program's approach, and the rationale for the techniques employed in order to counsel both offenders who seek their guidance and those who are looking for ways to avoid treatment. If not trained, chaplains may unintentionally defeat the goals of treatment.

All who work directly with sex offenders in a treatment setting must receive formal training. In general, this training should focus on the following four areas:

- Procedural or operational training, which includes institutional rules, regulations, procedures, and legal aspects.

- Treatment program philosophy, goals, and the roles that staff are expected to play, particularly in their interactions with offenders.

- Psychological dynamics of sex offenders, including etiology, typologies, and the unique psychodynamics of sex offenders.

- Specialized treatment techniques, including group therapy methods, behavioral treatment, psycho-educational modules, and medical treatment methods.

Experienced clinicians are often available in an institution to assist in staff training. There is also a growing body of professional literature that provides an excellent resource for staff interested in specific treatment methods. Educational workshops and seminars are available nationwide. Finally. many programs have developed their own training manuals to orient new staff.

What techniques are used in sex offender treatment programs?

Because sexual deviance is a complex and multi-faceted behavior, a variety of treatment approaches is usually required. Different types of treatment may be appropriate at different stages in the treatment process

This summary of treatment techniques includes those used by most correctional sex offender treatment programs. A few comprehensive programs use all the techniques described, while other programs focus on a limited number of approaches. All of these techniques are described in greater detail in *A Practitioner's Guide to Treating the Incarcerated Male Sex Offender.*

Interpersonal Techniques: Individual and Group Therapy

Most treatment programs include both group and individual therapy. Individual therapy, however, is not the treatment method of choice in most programs because of the denial and secrecy that are characteristic of many sex offenders. Group methods are regarded as a more effective way to break down denial or minimization. Group therapy enables the offender to realize that his behavior is not unique, encourages honest feedback from other offenders, and can be a powerful motivator to change behavior. Group therapy is also more cost-effective than individual therapy

Group therapy may be used for a variety of purposes, including:

- Developing empathy for victims.
- Dealing with feelings surrounding the offender's past victimization
- Working with family members or spouses who will assist the offender upon his release.
- Learning about the individual's cycle of sexual assault by identifying the emotional, cognitive, and behavioral patterns that lead to sexual misconduct, as well as ways to intervene in this cycle.

Psycho-Educational Modules

Psycho-educational modules are effective m addressing social and interpersonal deficiencies in offenders. Introductory modules dealing with how men become sex offenders and what is required to change are often used as a way to motivate inmates to participate in more intensive treatment

Topics typically addressed in psycho-educational modules include:

- Drug and alcohol abuse
- Criminal thinking errors
- Victim empathy and awareness
- Deviant sexual acting-out cycles
- Assertiveness training
- Social skills training
- Stress management
- Human sexuality.

Psycho-educational modules can be a cost-effective means of providing basic information to offenders, testing their motivation for treatment. developing a common therapeutic language, and overcoming offenders' reluctance to discuss personal topics. Further, they help to establish the authority and credibility of staff who teach these modules, thus improving the staff's effectiveness in later stages of treatment.

Psycho-educational modules are taught by clinicians, paraprofessionals, and correctional officers. Prepared modules are widely available and may be modified to meet the needs of a specific program.

Behavioral Techniques/Penile Plethysmograph

It is widely accepted that deviant sexual arousal is a critical element in many sex crimes. Indeed, many clinicians argue that the best predictor of long-range success with sex offenders is the reduction of deviant sexual arousal, along with indications of adequate levels of appropriate sexual arousal. The most common method of assessing both deviant and appropriate sexual arousal involves the direct measurement of penile erection in response to the presentation of audiotapes or slides depicting sexually explicit scenes. The penile plethysmograph, which consists of a gauge or transducer that the offender attaches to the penis, measures changes in penile circumference in response to the sexual stimuli presented. These changes are recorded on a strip chart. giving the clinician a record of the individual's response to each sexual stimulus presented.

The plethysmograph accurately identifies sexual interests. Deviant arousal during a plethysmographic evaluation should not be interpreted as an indication that an individual is going to engage in sexually abusive behaviors. However, when a convicted sex offender reveals greater sexual interest in deviant than consenting acts, behavioral treatment should be provided to help the offender modify his interests.

The behavioral techniques summarized below are used to alter patterns of sexual arousal in order to reduce the potential for future sexual victimization. The techniques are presented in two sections-those used to decrease deviant arousal and those used to increase appropriate sexual arousal.

Some behavioral techniques described here may appear controversial. The reader is advised that the behavioral techniques prescribed by treatment specialists require a thorough understanding of behavioral theory, and they must be used ethically and legally. As with other intrusive treatment procedures, informed consent is necessary and offenders should clearly understand the rationale for the techniques used.

The use of behavioral techniques requires that a small private area be designed as a behavioral laboratory. In some programs, a small room or cell is converted for this purpose. Behavioral exercises that do not require plethysmograph monitoring can be conducted in other suitably private areas. Some of these methods require offenders to audiotape exercises several times each week.

Techniques for Reducing Deviant Arousal

- **Covert sensitization** - This technique has been used for more than two decades in treating a variety of disorders, including obesity, alcoholism, and smoking. When used with sex offenders, the offender is asked to fantasize about a highly arousing deviant sexual scene and then to imagine a highly negative scene. Over time, pairing the highly negative scene with the deviant fantasy reduces the strength of the deviant fantasy. Scenes are designed specifically for the individual (i.e., the deviant scenes describe the types of situations and victims that are most arousing to the offender; the negative scenes include images that are particularly frightening, disgusting, nauseating, or anxiety-producing).

- **Assisted covert sensitization -** This method is essentially the same as covert sensitization but is used when the offender cannot generate scenes sufficiently negative to reduce arousal. When this happens, the offender employs a noxious odor (valeric acid, ammonia, etc.), paired with an arousing deviant sexual scene.

- **Olfactory Conditioning** - This method involves the presentation of slides, audiotapes, or videotapes of sexually deviant themes, followed by the clinician's presentation of a noxious odor. This is normally done in an enclosed, ventilated room or behavioral laboratory.

- **Satiation Therapy** - There are two approaches to satiation therapy: masturbatory and verbal. Masturbation therapy involves the offender's masturbating to ejaculation in response to appropriate fantasies, and then immediately continuing to masturbate with a flaccid penis to deviant

fantasies. Verbal satiation involves the offender's repeatedly verbalizing deviant fantasies for at least 30 minutes on at least three occasions per week. Both approaches have been found effective in reducing deviant sexual arousal.

- **Aversive Behavioral Rehearsal** - This powerful technique involves the offender's acting out his sexual offense in the presence of others, usually with props such as a mannequin. This session is videotaped and subsequently viewed by the offender. This procedure allows the offender to see what he looks and sounds like while abusing someone. Because it is highly intrusive and has potentially negative side effects, it is not in common use in correctional programs.

Techniques for Increasing Appropriate Sexual Arousal

Within an institutional program, the only method of increasing appropriate sexual arousal is through masturbatory exercises. The most straightforward method encourages masturbation to appropriate sexual fantasies or stimuli. For offenders who indicate no arousal to appropriate sexual stimuli, a technique may be used that involves masturbating to deviant stimuli and shifting to appropriate themes at the point of orgasmic inevitability. Over time, the offender shifts to the appropriate theme earlier in his masturbation until his complete fantasy involves socially accepted sexual acts and partners.

Cognitive Restructuring

Sex offenders, like other offender groups, employ distorted patterns of thinking, or cognition, that allow them to initiate and then rationalize destructive behavior. Many programs require offenders to participate in psychoeducational modules on thinking errors or to keep daily journals, which are examined by therapists or group members.

The goal of this method is to identify irresponsible and deviant patterns of thinking and to help the offender learn and practice alternate thinking patterns.

Relapse Prevention

Relapse prevention helps an offender recognize situations that create a potential for relapse and identify ways of controlling deviant behavior or avoiding high-risk situations. The technique is a useful tool for helping the offender control his deviant behavior after his release from the institution. It therefore has potential importance for parole officers, mental health professionals, family members, and others who will monitor the offender in the community.

While sex offenses often might appear to be impulsive, random acts, most clinicians now agree that there is an identifiable deviant cycle, or set of

precursors, leading up to a sex offense. Clinicians have identified a distinct sequence of precursors to such offenses: Emotion - Fantasy - Cognitive Distortion - Plan - Act.

For many sex offenders, failure to avoid a high-risk situation and a subsequent lapse (buying pornography, having a fantasy about children) can destroy their view of themselves as in control and lead them inevitably into a situation in which they will relapse. Offenders are taught that they are responsible when they place themselves in high-risk situations and that they can learn the interventions necessary to avoid relapse. Likewise, probation officers, therapists, and others can be taught to recognize an offender's pattern of relapse and to intervene in a timely fashion. The creation of an informed network of individuals familiar with relapse prevention methods has proven to be an effective approach to managing treated sex offenders in the community.

Hormonal Therapy

A small number of state correctional programs use medroxyprogesterone acetate (MPA), known by its trade name Depo Provera (tm), to treat offenders who have highly intrusive sexually deviant fantasies that are not reduced by behavioral treatment methods. MPA lowers serum testosterone levels in males and effectively reduces the degree of sexual fantasy and preoccupation.

MPA is not "chemical castration," as it is often portrayed in the media Men taking the drug are capable of obtaining an erection, having intercourse, and even impregnating a female. The drug simply causes a significant reduction in the rapidity with which an individual responds to an external sexual stimulus. MPA also reduces the frequency and intensity of fantasies.

MPA may produce several short-term side effects, such as weight gain and increased blood pressure; its long-term consequences have not been well researched. While MPA has not been formally approved for treatment of sexual deviance by the Food and Drug Administration (FDA), it has been FDA-approved for other uses. Physicians may legally use any approved drug for any purpose they see fit.

Because of the highly intrusive nature of this treatment and the potential liability for correctional systems, caution should be used in initiating MPA programs. Medical advisory boards may be appointed to evaluate current medical literature and to advise administrators on the use of MPA in a correctional setting. Informed consent is essential.

How important is the penile plethysmograph in assessing and treating sexual deviance?

Sexual deviance is not the result of any one single factor, but a product of the interplay of many. A thorough assessment of an offender must evaluate his ability to manage emotions, his early childhood sexual experiences,

cognitive distortions, and social skills, etc. An important characteristic of many child molesters and rapists, however, is a disordered sexual arousal pattern.

Offenders' subjective reports of arousal are generally inaccurate or deliberately distorted. Clinicians without access to an objective measurement of sexual arousal are unable to judge the degree to which an individual is aroused by deviant sexual themes; nor can they ascertain when deviant arousal has been reduced. Thus, without the plethysmograph, clinicians cannot make good judgments regarding the need for specific behavioral techniques to either reduce deviant arousal or increase appropriate arousal.

Over 25 percent of the nearly 300 sex offender programs surveyed nationally in 1986 used the penile plethysmograph for assessment and treatment purposes. Dr. James Breiling of the Antisocial and Violent Behavior Branch of the National Institute of Mental Health has stated that restricting a trained clinician's ability to use the penile plethysmograph for assessment and treatment of sex offenders "would be analogous to depriving a physician the right to obtain x-rays in cases of bone injuries."

Clearly, clinicians who employ this technology must be thoroughly trained and competent and must observe legal and ethical standards. Plethysmographic data must be viewed as only one part of the clinical picture, and the shortcomings of the method should be understood. Use of this technology for assessment and treatment of sexual deviance is currently regarded by most researchers and clinicians as a valuable tool, but one that will require continuing systematic research.

Planning Issues

Who needs to be involved in planning a treatment program?

The effective treatment and control of sexual aggression are not the sole responsibility of corrections, nor should the planning for treatment programs be confined only to corrections. Ideally, planning efforts on a statewide level would include representation from the following:

- Legislature
- Judiciary
- Prosecutor's office
- Victim advocacy groups
- Community corrections programs
- Parole board

- Mental health agencies
- Private treatment providers
- Correctional administrators and clinicians.

Each of those listed has an important stake in developing and maintaining effective sex offender treatment programs, and each may bring a unique perspective to the planning process. Ultimately, participation of these key players in the system ensures a broad understanding of the goals and methods, as well as recognition of the limitations. of treatment programs for sex offenders.

Few programs developed in isolation have survived. Typically, they were used inappropriately, expectations were unrealistic, or the needed resources were not made available. Good planning involving all the groups listed above can minimize the difficulties sex offender programs have encountered in the past.

What kinds of policy decisions are involved?

Each state or system faces a unique set of issues that must be considered in undertaking a systematic approach to managing sex offenders. Some of the critical issues include:

- Legislation-Existing statutes may need to be modified. For example, legislation might be introduced that mandates assessment of all convicted sex offenders prior to sentencing. Eliminating statutory restrictions on sex offenders' access to work release programs may be important for programs that stress transition to the community. Mandatory treatment language is often contained in a statute and may have a negative impact on the ability of a treatment system to operate effectively as a result of an influx of large numbers of unmotivated or inappropriate sex offenders (e.g., career criminals). Sentencing practices mandated by criminal codes may require revision to enable time for adequate treatment and supervision.
- **Lead agency**- On a statewide level, does mental health or corrections assume the primary responsibility for program implementation and operation? Is responsibility to be shared? If so, are formal interagency agreements needed to ensure a cooperative relationship?
- **Allocation of resources** - Sex offender programs are expensive and must compete with a variety of other critically needed programs. How much will be allocated for treatment of this group'? Will several programs be funded? Which are most cost-effective?

- **Program** site-Will the treatment program operate in maximum, medium, or minimum security facilities? In mental health facilities?
- **Priority populations** -Who should be included or excluded for treatment? At what stage of incarceration should treatment services be offered? Should treatment be available at any time prior to parole, or in the community as a condition of parole?
- **Transitional services** -What resources are available to assist the maintenance of therapeutic gains as the offender approaches his release?

These are just a few of the questions planners must grapple with as they seek to establish or improve their system's response to sex offenders. Decisions made at this level directly affect the operation of a clinical program and may either support or undermine its ultimate success.

What will a sex offender treatment program cost? Are there less expensive alternatives?

The cost of operating a sex offender treatment program depends on several factors. The most important variables are the number and types of staff. Programs located in hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) must maintain a high number of expensive professional staff, while a similar program in a correctional setting normally requires significantly fewer professional staff. Comprehensive prison residential programs (i.e., therapeutic communities) are more expensive to operate than prison out-patient programs in which inmates remain in the general population.

Dr. William Pithers, Clinical Director of the Vermont Treatment Program for Sexual Aggressors, estimates the cost of residential treatment in that program at approximately $5,500 per offender annually. He also estimates the cost associated with investigation, prosecution, and incarceration of a married offender in Vermont (with two children, sentenced to 10 years and serving 5 years in prison, with 2 years of parole, and one victim who receives treatment) at between $138,268 to $152,618. Therefore, successfully treating an offender and preventing his reincarceration results in a savings of $110,768 to $117,118-which represents the cost associated with incarceration minus the cost of treatment. In states where the costs of incarceration are considerably higher, the estimated savings would be much greater. Viewed from this perspective, effective treatment programs represent a considerable cost savings.

Institutional programs are significantly more expensive to operate than community-based programs. A state system can provide cost-effective alternatives to incarceration for offenders who do not require secure custody. This approach should be considered in the overall planning process.

Will a treatment program affect security and custody practices?

Incarcerated sex offenders pose no unique security problems for institutions. Many sex offenders are dependent and passive individuals without long criminal histories aside from their sexual deviance. However, staff who provide treatment should be trained in institutional security policies and procedures, as are other staff who interact with inmates. The treatment program should be held accountable for maintaining acceptable standards of custody.

In many institutions, sex offenders are highly stigmatized by other inmates because of the nature of their crimes, particularly when their victims are children. It is not uncommon for sex offenders to request protective custody to avoid harm from other inmates. Thus, any program designed specifically for sex offenders must exercise particular caution in the manner in which participation is handled. An inmate's name posted in a public place within an institution as a participant in sex offender treatment might cause anxiety, physical violence, or serve as a powerful disincentive to continued treatment. Reasonable confidentiality standards must be established and followed in order to avoid these potentially dangerous situations.

Protective environments or transitional placements must be available for these "at risk" inmates. Protective custody must be provided when requested, and prison officials may insist on it when they independently determine that an individual is in imminent danger. In those jurisdictions where protective custody space is at a premium, it is imperative that additional "safe space" be created or that an inmate at risk be locked in his cell as a temporary measure.

Will a treatment program increase the size of the inmate population?

A reasonable fear for correctional administrators already attempting to deal with severe overcrowding is that a quality treatment program in their institutions will increase the number of sex offenders committed by the courts. Historically, many excellent institutional programs have been destroyed when large numbers of offenders have been sentenced to facilities where specialized treatment was available.

The purpose of a **systems approach** to planning and managing a sex offender program is to avoid commitment of sex offenders to correctional institutions if safe alternatives are available in other residential facilities or in out-patient community programs. The efficient use of limited resources depends on pre-sentence clinical assessments of offenders and the availability of a variety of sentencing options for the court.

Quality treatment resources in a correctional institution may actually result in an earlier parole release for some offenders who successfully complete treatment programs and for whom there is likely to be continued treatment and supervision on release to the community. Parole boards in many states are reluctant to release sex offenders without treatment.

Should sex offenders be housed in a separate therapeutic living unit or in general population?

Most clinicians would agree that correctional institutions are not the ideal environment for treatment programs. Yet for a variety of reasons, most large sex offender treatment programs are located in prisons.

Program goals play an important role in the decision on where to locate a program within an institution. Programs that are primarily educational or that use periodic group therapy sessions are normally out-patient programs requiring no special housing arrangements. More intense, multi-modality programs or therapeutic communities require separate space within the facility in order to accomplish their therapeutic goals.

Each institutional administrator should analyze the physical facilities available for a treatment program, the cost associated with converting an area into a residential treatment facility, and the impact this might have on other areas of the institution. As part of the planning process, correctional administrators should also consider whether alternative sites, such as state mental hospitals or transitional facilities, would be more appropriate settings for a program.

Do sex offenders in treatment constitute increased suicide risks?

At a certain point during treatment some sex offenders may have strong suicidal impulses. Treatment often begins with breaking down an offender's denial of his behavior, creating empathy for his victims, and inducing guilt for his actions. During this process, there is some danger that the offender may become seriously depressed, even suicidal

Every institution should require therapists to report to correctional personnel when an inmate appears to be suicidal or at risk of injuring himself. Upon such notification, officials should take appropriate steps to monitor the inmate's condition and take all necessary precautions to ensure his safety.

How should I handle the media?

Positive relationships with the media are important in order to educate the public about the goals, methods, and limitations of a correctional sex offender treatment program. Administrators should pursue a proactive and professional

approach to the media by providing media representatives with briefings, tours, and background material.

The media should not be oversold on the effectiveness of treatment. Some participants will inevitably re-offend. Policies and procedures for handling media inquiries during times of crisis should be developed well in advance of a crisis; during a crisis, the media should be kept fully informed in accordance with those policies. A well-informed media can generate support and understanding for programs in good times and bad. Evasiveness or manipulation of the media may have disastrous consequences for a program.

Administrators should anticipate that sex offender programs will generate a good deal of public and media interest. Even the best designed and managed programs will have detractors, including those who are opposed to spending public funds for sex offenders, or those who feel victims are not accorded adequate public support. Programs that appear to "coddle" sex offenders will be viewed negatively. Therefore, it is important to describe treatment programs in terms of their potential for reducing victimization.

How can we build public support for treating sex offenders?

Support for sex offender treatment is directly related to the degree to which program goals are understood. Positive media relationships are one important component in generating understanding and support. The planning process is also a key to generating support among legislators, judges, prosecutors, victims' groups, and others whose involvement is critical.

Knowledgeable program representatives can increase public understanding by addressing service organizations, professional groups, or political organizations, as well as concerned citizens or neighborhood groups. Time required to perform these functions should be considered during the planning process.

Finally, many programs have established citizen advisory groups, or professional/technical advisory bodies, that include prominent citizens representing a variety of interest groups. Those serving on these advisory panels can increase support by explaining the program to their peers.

How important is program evaluation?

For pragmatic, ethical, and professional reasons, it is crucial for sex offender treatment programs to include program evaluation components from their inception. The wide variety of current therapeutic approaches to treating sex offenders, the growing number of offenders, and the limited resources available for treatment create a practical necessity for developing ways to judge program effectiveness.

Evaluation is necessary to ensure that a quality program is both established and continued. Evaluation design should focus on developing a systematic process for eliciting information on the following issues:

- Which type of treatment is most effective with what type of offender and at what cost, and
- To what degree the program is achieving success in meeting its established goals and objectives.

In addition to improving an individual program's effectiveness, data obtained from that program's evaluations can contribute to the field in general. The more emphasis programs place on quality evaluation, the greater the potential for meaningful comparisons across programs and jurisdictions.

Because treatment programs are designed to reduce the number of future sex offenses, perhaps the most crucial aspect of program evaluation is the degree to which it succeeds in tracking the recidivism of treated offenders. General recommendations for collecting recidivism data include the following:

- When possible, evaluators should match treated sex offenders with an equal number of untreated sex offenders. Demographics of the treated sample should provide guidelines on sample size, age range, and type of crime.
- The follow-up period should be at least five years. At a minimum, FBI and state records should be used to collect recidivism data. However, because the use of these sources alone tends to underestimate re-offense rates, some experts recommend use of independent evaluators to conduct field investigations and review police reports.
- The definitions of "re-offense" and "recidivism" should be clearly stated.
- The "time-at-risk," or life-table, method of figuring recidivism rates provides the most realistic picture.

Program Management

How long should treatment last?

Because sexual deviance is both complex and multi-dimensional, it is impossible to define a specific period of time required to successfully complete treatment. For highly motivated, intelligent offenders with an intact family and good community support, treatment may take less than a year, while

highly compulsive, criminalized, and resistant offenders may require treatment lasting several years.

Length of treatment is also determined by the sentencing structure in each state. In determinate systems, treatment may be initiated only during a specific time period prior to release on parole and must continue in the community. In those states with indeterminate structures, release may depend upon clinicians' assessment of the offender's progress and the parole board's concurrence with their recommendations. Treatment in institutions may occur over a period of many years and involve several stages, from periodic participation in psycho-educational modules or group therapy sessions to intensive residential treatment prior to release.

Should sex offenders participate in other institutional programs, such as jobs or education?

There is nothing to preclude a sex offender who is involved in an institutional treatment program from taking part in other institutional programs, so long as participation does not detract from his primary commitment to therapy. In many cases, institutional programs can complement the therapeutic process and help prepare an inmate for his eventual release. However, it must be clear that the goal in working with a sex offender is to reduce his potential for re-offending, not to develop his welding or printing skills. A serious commitment to treatment must take precedence over an inmate's participation in other institutional activities.

Should sex offenders be allowed conjugal visits?

Few states currently allow conjugal visitation. In those states that do, few sex offenders have intact marital relationships. For the few sex offenders in treatment with wives willing to participate in conjugal visitation, it is recommended that such visits be used as part of the process of marital therapy at an appropriate point in the offender's treatment. Sex offenders often exhibit sexual dysfunction, poor communication skills, and other interpersonal deficits. Strengthening marital relationships, both sexual and non-sexual, is an important part of treatment for an offender. It also provides the spouse with a better understanding of her husband's deviancy. Most clinicians regard marital therapy as an essential component of treatment for the married offender. A mature and satisfying relationship provides positive support to the offender upon his release.

Should sex offenders be allowed to participate in furloughs, home visits, work release, or other temporary leave programs?

Many states specifically forbid sex offenders to participate in work release, furloughs, or other temporary leave programs because of concern for public safety or liability. Most clinicians agree, however, that a slow reintegration of the sex offender back into the community increases his chance of success.

Sex offenders have little opportunity to re-offend while in prison; they need brief exposure to the community in order to process their therapy experiences. Institutional treatment, no matter how effective, occurs in an artificial environment. The skills learned must be practiced and reinforced in the real world. If the offender is gradually exposed to the community while continuing in treatment, he may practice these skills, learn to deal with high-risk situations, and establish relationships with therapists and supervisors in the community, which can continue after his release.

How can sex offenders be reintegrated into the community after they serve their sentence?

Research has clearly demonstrated that sex offenders just released from prison are at a high risk to re-offend. A strong aftercare component is a critical part of any institutional treatment program. In some states, institutional and aftercare treatment are highly integrated with parole supervision. Parole supervisors are already aware of an offender's relapse patterns before he is released. Mental health workers, family, and significant others become part of an informed network to monitor an offender's behavior in the community. Other states provide transitional treatment during the last 10 to 12 months of incarceration, followed by a required 4-month stay in a halfway house that includes ongoing therapy, assistance with a job search, and a gradual reintroduction to community life.

Many treatment programs begin to focus on reentry issues as an offender prepares to leave the institution. They teach practical matters, such as obtaining jobs, budgeting, developing and maintaining relationships, and dealing with high-risk situations, and encourage either temporary leaves or a gradual transfer into community-based treatment programs.

Legal Issues

Do incarcerated sex offenders have a legal right to treatment?

In terms of the United States Constitution, an inmate convicted of a sex offense has no right to treatment. Only if such an inmate is independently diagnosed as seriously mentally ill does the Constitution require treatment, and that treatment need not be aimed at a sexual deviance or practice. This is also true in terms of state statutes.

Although the courts have so far ruled that sex offenders committed under criminal laws do not have a legal right to treatment, an individual committed under a Mentally Disordered Sex Offender Act does have a constitutionally based right to treatment.

Can inmates be forced to participate in treatment?

The special legal status of offenders committed under Sexual Psychopath or Sexually Dangerous Offender Laws in the 1960s and 1970s often required those offenders to be treated. Although most of these laws have been either phased out or substantially changed, some states still mandate that convicted sex offenders participate in treatment programs regardless of their motivation, their willingness to accept responsibility for their crimes, or their intellectual and emotional amenability to treatment.

In general, however, clinicians agree that forced treatment is not likely to succeed and that treatment is effective only when offenders are motivated to change their behavior and acknowledge their guilt. In addition, experience has shown that treatment has little likelihood of success with certain types of offenders, including sadistic rapists, antisocial personalities, and certain mentally ill and intellectually low-functioning offenders. Offenders who refuse to actively participate tend to undermine more intensive programs; they can overload the program, defeat the efforts of other clients, and damage staff morale.

Some states conduct "pre-treatment" group sessions with relatively unmotivated offenders. These sessions are intended to educate them about the importance of treatment and the process of therapy, and to enhance empathy for victims of sexual abuse. As a result of these groups, some sex offenders who are initially reluctant to enter treatment may choose to do so.

Systems that operate under a mandate to provide treatment to all sex offenders can respond to this requirement by providing education-oriented programs to reluctant participants rather than insisting that they take part in all levels of the institutional treatment program. Where there is a choice between treating and not treating reluctant participants, each case should be analyzed carefully in terms of available resources and likelihood for success.

Can treatment providers legally possess sexually explicit or pornographic materials?

The courts have consistently ruled that sexually explicit materials used for treatment/research purposes comply with obscenity laws under the "Scientific Privilege Clause." Typically, a letter of permission to possess such material may be obtained from the State Attorney General.

Does the institution assume any liability as a result of the treatment methods used?

A clinician cannot guarantee the results of methods used to treat a sex offender. However, it is important to adhere to legally required steps in the decisionmaking process when providing treatment. Once undertaken, psy-

chiatric care cannot be given negligently. Although a clinician does not have to be right in the choice of interventions for a particular inmate, he or she does have to acquire and share relevant information with the offender and other clinicians and provide care in accordance with professional norms.

Prison clinical staff have little to do with an offender's actual release, but they are responsible for making recommendations about release or custody arrangements. Gathering, studying, and sharing information will help insulate a program from liability if a decision turns out to be erroneous.

Is a state or institution liable if a sex offender who has received treatment commits a sex offense after being released?

This question focuses in part on the issue of "negligent release." Suns on behalf of victims of crime challenging the release decision, its component parts, or the manner of supervision usually have not succeeded. This is as true for re-offending sex offenders as for other types of offenders.

Where liability has been found, it has been on the grounds of gross negligence or recklessness rather than simple negligence. The manner in which a decision is made to release an inmate is more important than the ultimate correctness of the decision. Although a state cannot guarantee results, it can guarantee adherence to minimal processes of rational decisionmaking, including collecting and making use of all relevant information.

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