

Community Supervision of Sex Offenders—Integrating Probation and Clinical Treatment

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THE COMMON REACTION to the criminal acts committed by sex offenders includes disgust, anger, and a feeling of increased vulnerability. Not surprisingly, many people feel that convicted sex offenders should be locked up indefinitely, castrated, or put to death. In reality, however, nearly 60 percent of convicted sex offenders live in our communities under conditional supervision.¹ The inherent problem with releasing convicted sex offenders into the community is the likelihood that they will repeat their crimes. To address this problem, intensive treatment programs for sex offenders have been developed to be used in combination with traditional measures such as incarceration, probation, and parole. These programs are continually evolving and require re-evaluation to assure sex offenders are not as dangerous when they are released into communities as they were at the time of their arrest.

Research on the success of sex offender intervention has proven problematic for many reasons. The label “sex offender” represents a heterogeneous mix of individuals. Sex offenders can vary from the 19-year-old statutory rapist of a 16-year-old victim, to the sexual predator who carefully plans his offense, stalking and grooming his young victims in public playgrounds and parks. In classifying these various types of sex offenders into a single group, differing elements that relate to recidivism will be masked, potentially creating inconsistent results across studies. Similarly, there are a variety of operational definitions of recidivism, ranging from re-

arrest to conviction for a subsequent sex offense. This can be problematic because it assumes that the offender will be caught and reported after committing a subsequent offense. In reality, sex offenses are not reported to the authorities in 85 percent to 90 percent of cases.² Further, in the United States, the lack of a national reporting requirement for sex offenders has made it difficult to track offender recidivism, particularly if an offender moves from one state to another.

Despite these limitations in sex offender research, several studies have attempted to determine and compare the recidivism rates of sex offenders who have undergone treatment to those who have not. In one study, Janus and Meehl estimated that a “20 percent base rate for sexual recidivism seems reasonable as a low-end estimate” for a group of sex offenders set to be released from prison.³ This study reported that 45 percent was an accurate upper estimate of untreated sex offender recidivism.⁴ In a randomized controlled study, Marques and colleagues reported data from sex offenders who volunteered for “treatment” and “no treatment,” finding higher recidivism rates for untreated sex offenders.⁵ A survey of this and other studies supported the finding that treatment decreases recidivism among sex offenders, indicating that in one study, nearly three-fourths of untreated sex offenders re-offend, compared to one-eighth of offenders receiving treatment.⁶ In more recent research, Lowden and colleagues found that sex offenders who did not participate in treatment were 8.5 times

more likely to be arrested for a violent crime in the first twelve months after release from prison or discharge from parole. This study also found a correlation between severity of criminal history and eventual recidivism, and reported that offenders who were re-arrested tended to be younger on average, more likely never to have been married, and more often non-Anglo.⁸

This paper will describe one model program specially designed to provide intensive supervision of conditionally released sex offenders in Illinois, and will discuss how theories of rehabilitation are concurrently enacted into treatment and balanced with public safety concerns.

How Did We Get Here? Illinois’ Evolving Sex Offender Laws

As early as the 1930s, American criminal laws began to acknowledge that certain sex offenders needed specialized treatment. In 1938, the Illinois legislature enacted a civil commitment statute for sex offenders known as the Criminal Sexual Psychopathic Persons Act.⁹ As an alternative to traditional imprisonment, this law and similar statutes in other states allowed indefinite hospitalization for repeat sex offenders, as well as allowing for detention and supervision.

By 1960, twenty-six states and the District of Columbia had some form of sexual psychopath statute allowing for the treatment of sexual offenders in lieu of punishment.¹⁰ In the decades to follow, however, treatment of sex offenders was found to be largely ineffec-

tive, and growing numbers of persons convicted of sexual offenses were reincorporated into the general prison system. In 1977, the Group for the Advancement of Psychiatry publicly called for the repeal of sex offender treatment statutes due to their reliance on questionable predictions of dangerousness, and the lack of effective treatment.¹¹ As a result of these concerns, as well as civil rights issues, half of the states that had sexual psychopath laws in 1960 had repealed them by 1990.¹²

In the early 1990s, the attention of the nation was drawn to the risks of harm posed by individuals convicted of sexual offenses once again. Following the much publicized rape and murder of seven-year-old Megan Kanka in 1994, the New Jersey legislature passed the first sex offender registration and public notification statute in the United States.¹³ Federal legislation, the Jacob Wetterling Crimes Against Children and Sexually Violent Offender Registration Act, was passed soon after, encouraging individual states to adopt "Megan's Laws" to mandate sex offender registration.¹⁴ Subsequently, all 50 states enacted registration acts requiring sex offenders to register with the state, and to provide certain personal information to law enforcement officials and ultimately, to other members of the community in which they live and work.¹⁵ Recently, a Connecticut sex offender registration statute was challenged as violating the right to procedural due process for sex offenders. On appeal, the United States Supreme Court upheld the sex offender registry law.¹⁶ In his concurring opinion, Justice Scalia asserted that even if registration requirements infringe on a sex offender's liberty interest, "the categorical abrogation of the liberty interest by a validly enacted statute suffices to provide all the process that is due—just as a state law providing that no one under the age of 16 may operate a motor vehicle suffices to abrogate that liberty interest."¹⁷ Based on this reasoning, a sex offender has no right to establish that "he is not dangerous [any more] than...a 15-year-old boy has a right to process enabling him to establish that he is a safe driver."¹⁸ Overall, the publicity surrounding Megan's Law and related legislation triggered American society's newly found sensitivity to and awareness of individuals who violate the law by committing sex offenses. Currently, there is greater concern for public safety interests. Recognizing that incarceration by itself does not guarantee that sex offenders will not re-offend once released, state legislatures have shown a renewed inter-

est in enacting treatment statutes for sexual offenders over the past decade.

On January 1, 1998, Illinois revised what was formerly the Criminal Sexual Psychopathic Persons Act, renaming it the Sexually Dangerous Persons Act.¹⁹ Across the country, the Sexually Dangerous Person (SDP) laws targeted violent recidivism, and differed from the earlier sexual psychopath laws in that they allowed for indefinite involuntary commitment after completion of the criminal sentence if the sexual offender is found to have a mental abnormality and to be dangerous.²⁰ The Act allows sexually violent persons to be detained indefinitely in order to prevent violent recidivism. Despite this change, the goal of the Illinois SDP Act continues to be the treatment instead of the incarceration of persons suffering from mental disorders.²¹

The Illinois SDP Act and similar laws applicable to other states have been at the center of considerable controversy. Criminal justice and mental health professionals, along with members of the public, have been unclear whether to focus public funds on punishing, treating, or detaining sex offenders in order to prevent post-release criminal behavior. Opponents of SDP statutes challenge that these laws violate constitutional guarantees of due process, and amount to double jeopardy and *ex post facto* lawmaking. The U.S. Supreme Court rejected these arguments in 1997, upholding the Kansas SDP law by a narrow margin.²² In a five to four majority opinion, the Court decided that indefinite hospitalization was constitutional as long as treatment was provided.

The tension surrounding confinement, supervision, and treatment of persons convicted of sexual offenses has been even more intense in the assessment of probation programs. Program officials must find ways to respect the rights of offenders, enable effective, ongoing treatment, and maintain public safety. These programs often must function at the center of competing demands and under the weight of decades of controversy. By the time of the Supreme Court's decision, the Cook County Adult Probation Department in Chicago had already begun restructuring its programming for sex offenders.

Theory Guiding Practice: Cook County Adult Sex Offender Program

A 1993 study by the probation division of the Administrative Office of the Illinois Courts reported that more than 2,500 adult sex

offenders were on probation in Illinois.²³ Recognizing that traditional probation was insufficiently rigorous to supervise sex offenders, the Cook County Adult Probation Division developed and implemented a specialized program of intensive probation for sexual offenders, the Adult Sex Offender Program (ASOP). The Illinois Criminal Justice Information Authority provided much of the funding for the development and implementation of the ASOP program. The targeted offender group for the ASOP program consisted of offenders convicted of aggravated criminal sexual abuse or criminal sexual assault against a family member.

Over the past five years, ASOP program officials have recognized that probation officers often have to manage the competing demands surrounding the treatment of sex offenders. They are asked to ensure public safety while coordinating the delivery of essential services. In order to function effectively, probation officers need to understand the mental health and criminal justice systems, the demographics and clinical criteria that predict violent recidivism, and therapeutic techniques that can facilitate engagement in treatment. In the following pages, we will elucidate the lessons that have been learned during the past five years and offer suggestions for training probation officers to work amidst such competing demands.

The primary objective of managing sex offenders in the community is to prevent future victimization. With that goal in mind, the ASOP program follows the framework of the national containment model for the supervision of sex offenders as defined by English and colleagues.²⁴ The containment model provides a comprehensive approach to sex offender management. English contends that a key to the successful implementation of the containment approach is to adopt a multidisciplinary, multi-agency strategy that proactively counteracts the fragmentation that is inherent in systems incorporating several diverse agencies.²⁵ The containment model is centered around five core components: a) a consistent multi-agency philosophy focused on community safety, b) a coordinated multidisciplinary implementation strategy, c) an individualized case management and control plan for each offender, d) consistent multi-agency policies and protocols, and e) program quality-control mechanisms.²⁶ The ASOP program follows the containment model by providing a comprehensive and integrated system of services to provide intensive supervision of offenders through home searches and other modes of monitoring, weekly group ther-

apy supplemented by individual counseling, and institutionalized communication between probation officers and treatment providers.

The following outlines several basic elements of the ASOP model that are necessary for the successful implementation of the containment model.

Communication and Interagency Cooperation

Sexual offenses themselves are shrouded in deception, and perpetrators typically resort to dishonesty, deceit, and secrecy when pursuing their victims. Because of this, it is essential that those charged with the supervision and treatment of sex offenders go beyond relying on the self-reports of sex offenders when monitoring adherence to the conditions of their probation. All parties involved in the supervision of the sex offender, including probation officers, treatment providers, prosecutors, defense attorneys, and the judge, must stay in regular communication concerning the offender's current status, risk factors, and progress in treatment. Each party provides essential information that must be reviewed and updated to continually re-evaluate the offender's progress and potential for recidivism. It is the role of the probation officer to coordinate the flow of information between all parties, and to act as the point person to be contacted when new facts emerge concerning the sex offender's status. The probation officer must not only integrate reports about the offender, but must also keep open the dialogue about whether modifications should be made in the offender's treatment and supervision plan based on new findings.

Delineation of Roles

While communication and cooperation are essential to successfully supervise and reduce the risk posed by sex offenders, it is also essential to clearly define the roles of these two professions (treatment providers and probation officers) as being distinct from one another. The therapist is charged with providing the offender with a treatment program designed to decrease denial and minimization, increase victim empathy, increase appropriate social skills, develop an individualized relapse prevention plan, as well as addressing secondary issues such as offender substance abuse or anger management problems. In order to successfully do this the therapist must be able to create a rapport conducive to treatment. This includes maintaining a difficult balance, however, as the therapist must provide some

degree of confidentiality while reminding the offender that certain treatment information is communicated back to probation and the court. Additionally, the therapist is a mandated reporter of child abuse and must break confidentiality in the event that any additional sexually abusive acts are discussed or if the offender reports any illegal activity in therapy.

The role of the probation officer differs in that his or her job is to closely monitor the behavior of the offender while at home, at work, and in the community. The probation officer's task is to gather as much information as possible and to continually re-assess the potential risk posed by the offender. Many of the offenders in the ASOP program have expressed the view that their probation officers serve as an external conscience. The probation officer is seen as being critical of the offender's non-compliance with the expectations of the program and serves to constantly remind each probationer of the consequences for re-offense. Over time, the offenders in the ASOP program appear to internalize the expectations of their probation officers and eventually earn some degree of trust from those charged with their supervision. It appears that probation officers who familiarize themselves with the treatment goals and theory behind the sex offender specific therapy are best able to manage the delineation of roles while seeing themselves as working in conjunction with the therapist.

Collaborative Needs

Therapists and probation officers rely on one another to better provide services and supervision to the sex offenders with whom they work. Therapists need external information about the offender's life to supplement what the offender says in treatment, as well as to corroborate the veracity of what the offender discusses in sessions. The offender may at times lose motivation for treatment, as is typically evidenced by poor attendance, minimal engagement, and failure to complete assigned tasks. When this occurs, the therapist can rely on the probation officer to remind the offender that therapy is a condition of probation, and to strongly encourage a reevaluation of the probationer's motivation for treatment. Probation officers receive regular reports of attendance and treatment progress from the therapists, including an evaluation of the offender's level of participation, willingness to disclose sexually inappropriate thoughts and behaviors, compliance with assignments, and understanding of consequences for re-offense. Weekly reports of attendance as well

as monthly reports of treatment progress occasionally need to be supplemented by longer reports to the court addressing specific questions raised by the probation officer, state's attorney, defense attorney, or judge. Examples include reports by the therapist addressing an offender's potential risk of harm when deciding on issues of visitation with children, removal of curfews, or continuation of specialized sex offender probation. Therapists must be able to provide this information to probation and court officials in both writing and in oral testimony, if necessary. In addition, therapists need to receive feedback about the treatment program from the probation officers, whose first-hand view of the offender's behavior in the community is essential to treatment success. Anecdotal reports of how certain interventions are understood and implemented by the offender in the real world are invaluable in fine tuning the content of the therapy program.

Accountability

Successful treatment and community supervision of the sex offender requires all parties to take full responsibility for their part of the process. True collaborative relationships depend on trust, respect, and responsibility. Programs whose culture is marked by constant vigilance and fear of accusations and attributions of liability by other agencies cannot succeed in effectively addressing the supervision and treatment needs of the sex offender. It is only when probation officers and therapists take full responsibility for the role they play in the program that interagency trust can be established. Sex offenders often employ defensive strategies such as splitting, and typically rely on elaborate systems of cognitive distortions in order to continue their cycle of offending. It is likely that the offender will, at times, pit probation officers against therapists, reporting select information to each in order to create interagency conflict. When each agency openly accepts responsibility for its shortcomings, and is accountable for its share of the treatment and supervision, the likelihood of splitting is diminished, thereby maintaining the focus on the offender.

ASOP Probation Officer Survey

In order to better understand what is necessary to successfully supervise sex offenders in the community, a brief survey was administered to probation officers in the Cook County ASOP program. The survey specifically asked questions to assess their views of

what makes a good probation officer, what makes a good therapist, how important empathy is, and what aspects of their training were most beneficial to their work with adult sex offenders.

When asked how they perceive their role from a systematic standpoint, the probation officers surveyed unanimously indicated that they viewed probation as an extension of the criminal justice system. Many of the probation officers went on to explain that they are part of the larger court system and that they see themselves as working for the presiding judge. In this role, probation officers reported that they attempt to facilitate the rehabilitation of offenders as an alternative to incarceration, and work closely with the state's attorney and public defenders. They see themselves as empowered by the court system to monitor and enforce the conditions of probation.

In answer to the question of what personality characteristics are desirable for a probation officer working with sex offenders, the overwhelming majority of responses emphasized the importance of maintaining a professional stance marked by an ability to put personal feelings aside in order to continuously deal with difficult cases. Self control was stressed as a means of dealing with the challenges presented by sex offenders who become oppositional or manipulative toward their probation officers. Nearly all of those surveyed indicated that a good probation officer must be able to maintain a firm stance with probationers, with common responses including "stand strong," "put your foot down," and "be tough." Other factors that were considered desirable characteristics for probation officers included having a good sense of humor, good communication skills, confidence, patience, and being open minded. In addition, most probation officers denied that their role is at all therapeutic to the offenders. The majority of respondents stated that probation officers leave the therapy to the clinicians, and they are reluctant to see their interactions with probationers as being at all curative.

When asked about the need for probation officers to possess empathy with the offenders they supervise, the majority indicated that there is no place for empathy in their work. Some respondents went on to explain that the sex offender will use empathy to manipulate the probation officer, ultimately defeating the purpose of the conditional supervision. Other respondents indicated that empathy may be a necessary quality in the probation officer, but only secondary to providing community safe-

ty and ensuring compliance with the terms of probation. One respondent stated that empathy, like trust, must be earned over time only after the offender has consistently been compliant with the terms of probation. Another explained that it is difficult to find empathy for the sex offenders because of the strong tendency to feel empathic towards the victim. It may be that some of the probation officers surveyed equated empathy with sympathy when responding to this question.

Probation officers indicated that, in general, their view of sex offenders is overwhelmingly negative. The view of most probation officers seems largely influenced by the offenses committed by individual probationers. Nearly all surveyed used terms like "repugnant," "perverted," and "disgusting" in describing the behavior of their clients. Still others stated that they viewed sex offenders with great caution, listening to what they say with some degree of skepticism and distrust. Another respondent indicated that sex offenders are viewed as "lawbreakers" lacking remorse and responsibility for their criminal behavior. The probation officers surveyed emphasized, however, that they don't let their negative reactions toward their clients' offending behaviors interfere with the performance of their job.

Finally, survey respondents were fairly positive in describing their perceptions of and working relationships with the clinicians who provide sex offender-specific treatment. The clinicians with whom probation officers interact when working with sex offenders were described as "well informed," "knowledgeable," and as generally being aware of limitations of treatment. The majority of respondents stated that they work well with therapists, viewing their relationship as collaborative and helpful. When asked about distinguishing the roles of the probation officer from the clinicians, a typical response indicated that communication is essential, including being explicit about the differing roles of all parties involved, including the sex offender. Specifically, the role of the clinician was seen as treating, managing, and changing undesirable behaviors in the offender. The probation officer, on the other hand, was described as being responsible for supervising and monitoring the offender's behavior, as well as reporting to the court and enforcing the conditions of probation.

The same survey questions discussed above were reviewed by the two first authors, as clinicians, in an attempt to ascertain characteristics desirable for a therapist working

with sex offenders. The responses to these questions indicate that the most important characteristics of clinicians working with sex offenders include using a structured approach, a specific model for treatment, well articulated treatment goals, ways to measure treatment outcome, and an ability to combine a psycho-educational approach with more traditional group process style. Clinicians must have some degree of empathy when working with sex offenders, but must also be cautious not to allow themselves to be manipulated by their clients. In general, a good therapist working with sex offenders will view their clients as impaired individuals with a range of emotions and needs similar to the rest of the population, but lacking the appropriate internal resources for expressing their affect and satisfying their interpersonal needs. Rather than viewing them as monsters or disgusting individuals, clinicians should recognize their clients as having severe functional limitations. Typically, the clinicians working with sex offenders recognize that without a compelling mechanism such as arrest and probation, these individuals would likely never seek help nor focus on necessary change.

Clinicians should view themselves as part of a team with probation officers. Other members of that team include the client, the judge, and other treating professionals involved with the case. In our experience, probation officers are extremely knowledgeable of the client and their problems, and share common goals and similar observations as the clinicians orchestrating the treatment. Clinicians in our program hold the probation officers in high regard and respect their input in tailoring the treatment towards the individual offender's needs. Oftentimes, the probation officer's role is to confront the offender about his or her denial and to ensure that conditions of the court are fully satisfied. The clinician in turn works with the offender to break through denial, and help them see how to re-shape their behaviors in order to comply with the law without exacerbating their existing mental health issues. Together, the clinician and the probation officer provide the offender with complementary styles that serve to facilitate progress in treatment, and decrease the risk of re-offending.

Integrating Theory, Practice, the Individual, and the Court: Sample Cases

Thus far, this paper has provided an overview of legal history, the theory behind the ASOP program, and the role of the probation officers and clinicians in facilitating community supervision of sex offenders and providing treatment to change maladaptive behavior patterns. Even when all of these elements are balanced, however, there may still be obstacles to successfully integrating sex offenders into the community. The following case examples illustrate instances in which the theory behind community supervision of sex offenders is put into action as well as obstacles that may be encountered when implementing such a program.

Case 1

J.R. is a middle-aged, African-American man who has been employed as an auto mechanic for the last seven years. J.R. dropped out of high school, has been married twice, and is separated from his current wife. One evening, after returning from the bar, J.R.'s teenaged daughter walked in on him while he was changing. Partially clothed, J.R. requested that his daughter enter the room and touch his penis. The next morning, J.R. told his wife about the incident and turned himself in to the police at the nearest station. Prior to adjudication he enrolled on his own in individual counseling at his local community mental health center. He also began to attend and participate in Alcoholics Anonymous (AA) meetings. This continued for about a year at which point he was court-ordered into an ASOP treatment group as a condition of probation. He resisted, insisting that he had been involved in his own treatment, and had received great benefit. When asked about his relapse prevention plan, however, J.R. responded with a confused blank stare. With reluctance he left individual therapy and AA, and joined the ASOP. J.R. participated in weekly sex offender-specific group therapy. When asked about his actual offense, J.R. admitted that his judgment was impaired from heavy drinking and that he felt immense guilt when he sobered-up the following morning.

About six months into treatment, his wife initiated couples and family therapy sessions which eventually included his daughter, the victim. The family therapist, a doctoral level psychologist, engaged in this treatment with great zeal, acting as advocate, ombudsperson, case manager and therapist, to the point of advising them legally as well as appearing in court to testify on their behalf. Unfortunately,

this new therapist failed to communicate with the ASOP court-appointed therapist and probation officer until immediately prior to court dates. Rather than enhancing J.R.'s sex offender treatment, the independent work of the family therapist hindered J.R.'s progress in sex-offender specific treatment, including a period during which he removed himself from ASOP treatment only to later return, exhibiting many regressive behaviors and cognitive distortions.

In *Case 1*, the goals of the ASOP program were hindered by the work of an outside therapist. While believing that his actions were in the best interests of the client and his family, the therapist's intervention, combined with his failure to understand the unique treatment needs of sex offenders, caused a setback in the offender's treatment. The offender in this case believed he would expedite his recovery and eventual reunification with his family by pursuing the additional therapy services. By not collaborating with the therapists and probation officers providing the sex-offender specific services, the family therapist in this case reinforced the offender's pattern of cognitive distortions that contributed to the commission of his original offense. Outside services such as family therapy may assist in the treatment of sex offenders in the community, but only when they are integrated with the already existing structure for the supervision and treatment of the offender.

Case 2

B.T. is a single, Caucasian man in his late twenties who has been unemployed for several years. He has a history of abusing alcohol and cannabis dating back to high school. While babysitting an 11-year-old neighbor girl, B.T. entered her room while she slept, placed his hand beneath her clothing and fondled her genitals. Several weeks later, the girl reported the incident to her counselor at school. B.T. was subsequently charged with aggravated criminal sexual abuse of a minor and sentenced to 24 months of specialized sex offender probation.

As part of his probation through ASOP, B.T. participated in weekly, sex offender-specific group therapy. At the start of treatment B.T. vehemently denied the charge against him, and argued that he signed his probation agreement under duress. After several weeks of confrontation by the other group members, B.T. admitted to the offense, but blamed his behavior on "being too high" that night.

B.T. continued to attend group meetings for almost one year and was superficially compliant, glib, and always upbeat in his responses. He was marginal in terms of meaningful inter-

nalization of the material and process, vaguely referring to various life situations regarding his relationships with adult girlfriends and their children. Despite concerns of the clinician and probation officers involved with B.T., the judge entered an order discontinuing his treatment and probation without any indication or communication to the treatment program or probation. Within two months following discharge, B.T. re-offended and was arrested and incarcerated for aggravated criminal sexual assault of a minor.

In *Case 2*, the community supervision of the offender was terminated prematurely, to the detriment of a subsequent minor victim. In this case, the offender was able to convince the judge that he was successful in treatment, without ever supporting his claims with the opinions of the therapist. Had the judge postponed his decision pending a report from the therapist, an assessment of B.T.'s true risk of reoffending would have been made available to the court. By trusting the offender to accurately report his current progress in treatment, this case resulted in an illustration of a worst case scenario when dealing with the manipulative behavior of sex offenders.

Case 3

C.J. is a single, Latino man in his early twenties. Over the past several years, C.J. has maintained intermittent employment in various fast food restaurants. As a teenager, C.J. was in foster care following his mother's death. C.J. never completed high school, where it was determined that he had a learning disability and a borderline IQ. While watching television at his aunt's home one afternoon, C.J. encouraged his six-year-old nephew to disrobe and climb onto his lap. He was subsequently arrested for aggravated criminal sexual assault, and sentenced to a term of four years of intensive probation including a sex offender treatment program. C.J. was initially enrolled in a sex offender treatment program for two years and was terminated unsuccessfully. According to this agency, C.J. apparently stole a watch and a knife from an unlocked office. When confronted about the theft on the following day, C.J. returned the watch but was ejected from the program. Probation requested that the ASOP program consider him for inclusion in their program. During his assessment interview, C.J. seemed appropriate for treatment, and was accepted into the ASOP program. Treatment records and a discharge summary were requested from the former program, but never received.

In the new program, C.J.'s attitude was that he had already learned what he needed to know

during his prior treatment. As a result, his progress, despite persistent and creative attempts at intervention, was negligible. Due to several impulsive and aggressive episodes of violent behavior in the workplace, it was determined that C.J. posed significant risk of harm to self and others and was terminated from the second treatment program from which he was deriving little, if any, benefit. The clinicians from the second agency testified concerning C.J.'s current status, including the results of an Abel assessment indicating that he actually posed a greater tendency toward sadistic pedophilia than when he was first arrested prior to treatment. Unable to find a facility willing to treat C.J. on an outpatient basis, the judge decided to allow C.J. to continue serving his term of probation without requiring any treatment.

Case 3 represents a lack of available services to meet the varied needs of different offenders. In this case, C.J. deteriorated over time, and actually posed a greater risk after treatment in the community. The judge felt that C.J. had been complying with the services to the extent that he should not be incarcerated in prison. An ideal alternative for a client like C.J. would be to provide sex offender-specific residential treatment, in which he could receive more intensive supervision and treatment services outside of prison. At the time of writing, this type of treatment was not available. It is likely that there are many sex offenders similar to C.J. who require more intensive treatment than is available within the community, but whose behaviors would likely worsen if sent to the penitentiary.

Case 4

R.M. is a single, forty-year-old Caucasian male, who has been married and divorced twice. Following his second divorce, R.M. started in a live-in relationship with a similarly aged woman and her fifteen-year-old daughter. This relationship lasted for several years. For most of R.M.'s adult life, he worked as a landscaper and was a self-described "loner," who was uncomfortable interacting with others. R.M. actively discouraged others from approaching him in part because of his "short fuse," marked by his tendency to launch into an explosive verbal onslaught without apparent provocation. R.M. committed his sexual offense against his paramour's daughter. On two separate occasions R.M. entered the fifteen-year-old's bedroom during the night, and fondled her genitals underneath her clothing. The victim was aware of these assaults and eventually reported them to her mother. The police were called and R.M.

was arrested and convicted of aggravated criminal sexual assault with a sentence of four years of intensive probation including participation in ASOP.

When treatment began, R.M.'s appearance was disheveled, he exhibited poor hygiene, and was dressed in what appeared to be the same set of dirty clothes he had worn to work. During the first several months of group sessions, R.M. was quiet and withdrawn, appearing somewhat frightened. When asked during his initial evaluation, R.M. admitted to committing the offense. In group, R.M. quietly responded to questions posed to him by stating that he was not comfortable speaking in groups. He stammered and was visibly nervous. As R.M. progressed in treatment, he became less anxious and more participative, eventually contributing to the group process.

R.M. saw his probation officer as a stern, symbolic conscience and extant moral compass. The group context provided a structured support system that allowed R.M. to make the necessary behavioral changes. R.M.'s treatment goals included managing and resolving his depression, improving anger management, and developing and applying appropriate social skills and non-deviant sexual behavior. Over the course of treatment, each of these goals was addressed. Additionally, R.M. also developed and demonstrated improved self esteem, trust, and respect of others over the course of treatment. After approximately 13 months of treatment, R.M. became a peer group leader, confronting and supporting the recovery of other offenders. Following a two-year treatment regimen he was successfully discharged, and at one-year follow-up, has not re-offended.

In Case 4, R.M. was able to benefit from probation because his perspective that the treatment group was safe and supportive balanced his experience that his probation officer was ever vigilant and would be intolerant of his noncompliance with the terms of probation. R.M., like many sex offenders, had undiagnosed mental health problems and lacked the necessary social skills to engage in appropriate relationships with others. Rather than voluntarily seek services to help him address his deficits, R.M. tried to meet some of his unsatisfied needs through committing a sex offense against a minor. Fortunately, R.M. was caught, placed on probation, and succeeded in treatment that addressed both his mental health problems and his lack of appropriate social skills. It is unlikely that R.M. would have resolved his difficulties and attained these skills if he had been incarcerated rather than placed on probation.

Similarly, it is doubtful that R.M. would have succeeded in treatment without the strong influence of his probation officer. It is clear that R.M. required the services of both probation and mental health treatment providers to resolve his clinical and interpersonal problems and to address the problems that contributed to his offending behavior. Through collaboration with the therapists and probation officers providing the sex-offender specific services, R.M. was able to correct his deviant cognitions and behaviors, greatly decreasing the likelihood of committing subsequent sex offenses.

Case 5

S.B. is a single African-American male in his mid-twenties. He had a history of special education and unemployment. While babysitting his four-year-old niece, he "took a nap with her" which resulted in S.B. sexually molesting this young girl. S.B. was convicted of aggravated criminal sexual assault and was sentenced to a term of five years of intensive probation including completion of a sex offender treatment program. It was apparent early on that S.B. was cognitively limited (exhibiting borderline intellectual functioning) and was socially maladjusted. S.B. initially denied the offense. During the post conviction polygraph, S.B. admitted the offense, although he minimized his responsibility.

Throughout treatment, S.B.'s participation was limited, despite always completing all assignments to the best of his ability. His responses both in group and to the written assignments were brief and concrete, but accurate as to the core issues at hand. His regularly scheduled individual sessions were productive, allowing S.B. a greater opportunity to express himself verbally and emotionally, and permitting him to reveal more aspects of himself than he was able to discuss in the group setting. Throughout the course of treatment, S.B. revealed family dynamics of abuse and rejection, his own lack of social skills, and a deep dependency on others.

The most significant turning point of S.B.'s treatment program, however, occurred during the few sessions in which his probation officer participated. The officer carefully confronted S.B. with facts of his daily life that were not known to the group or the therapist. These events were crucial in bringing secrets into the open and pointing out stressors and challenges that had to be reckoned with in order to facilitate S.B.'s positive behavior change. In part, S.B. didn't raise these issues voluntarily because of his limited cognitive abilities. It is likely that he

was unaware how these outside issues could possibly help him in his treatment as a sex offender. Examining these issues, however, was a crucial part of S.B.'s treatment.

S.B. was required to extend his treatment and probation to allow him to make the necessary changes in his behavior. Eventually, S.B. completed the treatment program, created a personal relapse prevention plan, and passed the discharge polygraph examination.

During the last half of the treatment process, S.B. was employed as a stock clerk at a food mart in his neighborhood and later attained a supervisory position. He also initiated and maintained a long-term relationship with an age-appropriate female. Through combined treatment and probation, S.B. worked through the interpersonal problems cited above and developed many other positive coping skills, and correcting other deficits. One year following discharge, S.B. has not re-offended.

Case 5 illustrates the unique problems posed by sex offenders with limited cognitive abilities. S.B. was able to succeed with probation and his treatment, but only after the group leader recognized his limitations during group sessions. By supplementing S.B.'s treatment with individual sessions, treatment providers were able to help S.B. more fully understand his personal issues, and usefully engage in the group sessions. If the treatment component included solely group sessions with a rigid curriculum, S.B. would likely have continued to struggle, superficially completing assignments while never coming to understand how his personal issues related to his offending behavior. It would be dangerous to lower the expectations of probation and treatment for cognitively limited offenders like S.B. By providing additional individual sessions and lengthening the time spent in treatment, S.B. was able to fully benefit from treatment and decrease his potential to re-offend. Such flexibility by both probation and clinical staff is necessary to ensure that offenders receive the maximum benefit of probation and treatment, and to reinforce the skills and insights necessary to protect society from future sex offending by these individuals.

Conclusion

The Cook County ASOP program was designed and implemented as a unique approach to the supervision and treatment of sex offenders in the community. This program represents a successful integration of the prevailing theories of sex offender treatment

with quality supervision by probation. The extensive collaboration between probation officers and therapists lends itself to the success of such a program. Even when probation and treatment providers closely communicate with each other, outside forces need to carefully consider the recommendations of this treatment team when deciding the disposition of the legal cases of convicted sex offenders on probation.

Based on our collective experience of working with sex offenders on probation, the authors assert that treatment within the context of the "containment model" indeed works. Although it is not a panacea, we have seen numerous offenders change their offending behavior with abatement in re-occurrence rates and lifestyle changes that manifest effective problem-solving skills and pro-social and productive lives. The research data supports this contention and is encouraging in this regard.

As the field continues to evolve, three major issues must be addressed before they pose more prominent impediments to successfully ameliorating this destructive social problem: 1) legislation needs to be amended to avoid the exceedingly punitive effect of generalizing punishment while ignoring differences in offenses and perpetrators; 2) individuals within the justice system need to be better informed and educated of the epidemiology, dynamics, and responsiveness to treatment of this at-risk population; and 3) the front-line criminal justice and clinical treatment professionals need additional support in their collaborative efforts.

As has been cited elsewhere, particularly in the literature on adolescent sex offenders, the punishment must fit the crime. A clear focus on the individual act and contingent penalty is needed. Lifetime registration may not be an adequate societal safeguard where lifetime parole would be more appropriate for some offenders. Additionally, mandating treatment immediately upon case disposition and incorporating it into an offender's sentencing to a detention facility may provide a more proactive solution, as opposed to proceeding with civil commitment after the fact. Extended probation sentences must be considered and used to provide ample time for the offenders to engage in treatment as well as to comply with the structured requirements of counseling. By ordering offenders to financially contribute to their treatment through payment of probation fees and a portion of counseling costs, offenders are more likely to feel committed to fully participating in treatment, and can also help

to partially defray the costs of providing these rehabilitation services.

More recently, special training events on treatment of sexual offenders have been made available to the legal and criminal justice communities. Professionals need to take advantage of these educational opportunities so that they can make informed decisions when working with sex offenders in their practice, and can better protect former and potential victims. Similarly, training programs should be continually revised and updated to reflect the latest empirical findings and advances in treatment practices. The importance of educating and updating the judiciary and attorneys cannot be overemphasized. Obviously, judges are the engines of ensuring a safer society and empirical data concerning best treatment practices can provide the fuel needed to achieve that goal.

The challenge faced by front-line criminal justice and clinical staff in dealing with the sex offender population on a daily basis is both daunting and dangerous. In order for them to stem the frightening social epidemic of deviant and predatory sexual behavior, people working with sex offenders must be supported and recognized for their difficult work. Imposing fair, reasonable, and consistent standards for dealing with sex offenders will facilitate this task.

Facilitating partnerships between probation and clinical professionals should further develop and advance the continually evolving field of sex offender assessment and treatment. Both clinicians and probation officers share the ultimate goal of rehabilitating offenders and enhancing community safety. Collaborative ventures such as the ASOP need to be continually assessed and adjusted so that they may continue to function effectively. These efforts can then contribute to the repair of a social fabric too often damaged by adults committing sexual offenses against children.

Endnotes

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⁶ Lucy Berliner, *Sex Offender: Policy and Practice*, 92 *Nw. U.L. Rev.* 1203, 1209-10 (1998).

⁷ Kerry Lowden, et al., *Evaluation of Colorado's Prison Therapeutic Community for Sex Offenders: A Report of Findings*, July 2003, accessed 9/28/03 at <http://dcj.state.co.us/ors/pdf/docs/WebTCpart1.pdf>.

⁸ *Id.* at 120.

⁹ Ill. Rev. Stat. ch. 38, para. 820 (1938). This statute stated: All persons suffering from a mental disorder, and not insane or feeble-minded, which mental disorder has existed for a period of not less than one (1) year, immediately prior to the filing of the petition hereinafter provided for, coupled with criminal propensities to the commission of sex offenses, are hereby declared to be criminal sexual psychopathic persons.

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¹⁸ *Id.* (Scalia, J., concurring).

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