SPECIAL PERSPECTIVES

A Three-Tiered Approach to the Rehabilitation of Incarcerated Sex Offenders

W. L. Marshall, Ph.D, A. Eccles, Ph.D. and H. E. Barbaree, Ph.D.

A description is provided of a program for dealing with convicted sex offenders. This program includes: incarceration and treatment of high risk offenders in maximum and medium security institutions; movement of successfully treated offenders and lower risk offenders to a less extensive treatment program in a minimum security jail; and then release to the community where offenders are reassessed and treated, while they begin supervised implementation of a relapse prevention plan. The evidence suggests that this overall approach is not only effective in reducing recidivism, but also cost-effective in reducing the expense to society of dealing with reoffenders.

Although an undetermined number of sex offenders, whose crimes go unreported, remain at large in the community, many detected sex offenders either remain in the community after sentencing (e.g., they are placed on probation) or are released back into the community after having served a prison sentence. These latter adjudicated offenders are under jurisdictional control and, therefore, something constructive may be done with them to reduce the likelihood that they will reoffend and damage some innocent woman or child.

Untreated sex offenders reoffend at a rate in excess of those who receive treatment. From a recent review of the treatment outcome literature (Marshall, Jones, Ward, Johnston, & Barbaree, 1991; Marshall, Ward, Jones, Johnston, & Barbaree, 1991), it appears that 20–60% of untreated sex offenders (depending upon type of offense and offense history) reoffend over the 5 years following release, whereas typically 15% or less of treated offenders repeat their crimes. Of course not all treatment programs are effective. Comprehensive cognitive-behavioral programs (Marshall & Barbaree, 1990a) seem to be the most consistently effective, although some more traditional programs (Pacht, Halleck, & Erhmann, 1962; Prendergast, 1978) have also produced demonstrable benefits for treated offenders. The question is not whether sex offenders can be treated, but rather which offenders can be optimally treated with which treatment.
TREATMENT OR PUNISHMENT

Sex offenders represent a class of criminals whose crimes call for both punishment and treatment. However, sex offenders represent a broad and heterogeneous class and obviously not all would, or should, be deemed candidates for a period of incarceration. Nevertheless, we believe that all men who sexually assault an adult woman or who molest children, should receive at least a minimal period of imprisonment. This would serve as both a specific and general deterrent, and provide the opportunity and leverage to get the offender into treatment. For the less directly injurious sex offenders (e.g., exhibitionists, obscene telephone callers, etc.) a clear punishment seems necessary but imprisonment (at least for the initial offenses) seems a bit harsh. The rest of this article will, therefore, be restricted to a consideration of issues concerning the best way to deal with child molesters and rapists.

Of course, simply reducing the scope of this paper to child molesters and rapists, does not eliminate the problem of heterogeneity. All researchers and clinicians are acutely aware of differences, on a variety of dimensions, among these offenders. As yet, however, there is no agreed upon way of reducing this heterogeneity. Knight and Prentky (1990) have devised a classification system that appears to have relevance for treatment and release decisions, and we are in the process of examining its utility within our clinical settings. To date, however, we have ignored individual differences in designing overall programs, although such differences directly affect both the setting in which the offender is placed and the emphases within treatment for each individual.

The psychiatric diagnostic manual (American Psychiatric Association, 1987) notwithstanding, we do not believe that sex offenders have either a disease or a congenital defect which renders their sexual behavior outside their control. Child molesters and rapists typically carefully plan their offenses to maximize the probability that they can enact their desired behavior while minimizing the possibility of detection, apprehension and punishment. It is clear that the majority of sex offenders fantasize about what they are going to do prior to offending (Dutton & Newlon, 1988; MacCulloch, Snowden, Wood, & Mills, 1983; Pithers, Beal, Armstrong, & Petty, 1989) and many make explicit plans to offend (Pithers et al., 1989). They know what they are doing; they know it is a criminal offense; and they expect to be punished if caught. In all these respects they do not differ from other criminals and accordingly they deserve punishment as much as do other offenders.

Imprisonment not only provides punishment for wrongdoing, and serves to protect society while the offender is incarcerated, it also offers leverage to get the offender involved in treatment. Such leverage, however, is maximally influential only when parole decisions are based on effective and successful participation in treatment, and when the input from therapy staff is given significant weight in release decisions. In addition to this obvious leverage, agreement to enter treatment and effective participation can result in a change of security status such that the offender can be moved to lower levels of security (maximum to medium to minimum), or be given longer and more frequent visits, or be granted escorted or unescorted passes from the institution. Very few people, sex offenders included, voluntarily change their behaviour attitudes and beliefs, unless they see it is to their advantage, and probably no one enters treatment without the hope that their resultant changes will benefit them. Of course, there are a great many benefits to be derived by a
Rehabilitation of incarcerated sex offenders

sex offender for entering treatment, but the immediate advantages, of less restrictive living circumstances and possible parole, may be the main incentive we have to offer incarcerated sex offenders. We should take full advantage of this if we are to as fully as possible protect society. Largely as a result of these incentives we are able to recruit into treatment close to 90% of all sex offenders incarcerated in Ontario regional federal penitentiaries.

While evidence suggests that incarceration has some deleterious effects (Andrews, 1990), there is no evidence that it increases the subsequent rate of sex offenses among rapists and child molesters. Indeed the opposite appears to be true. For example, Soothill and Gibbens (1978) found that sexual recidivism rates over 20 years were higher among men found not guilty by British courts than among those found guilty. Since apparently all of those found guilty went to jail, these data tend to deny the notion that incarceration worsens these offenders. In any case, many sex offenders constitute such a serious threat to innocent women and children that they must be held in a secure setting to protect society, at least while they are being treated.

TREATMENT

Sex offenders appear to differ from most other criminals in that treatment clearly reduces their offensive propensities (Marshall, Jones, et al., 1991). Although in most reports (Marshall & Pithers, in press) child molesters seem to profit more from treatment than do rapists, Marques (in press) has reported better outcome with rapists. Among child molesters, untreated incest offenders have quite low recidivism rates, but even these can be further reduced by treatment (Marshall & Barbaree, 1988). Thus incarceration is not enough; we must also treat these men. With sex offenders, punishment (by way of a prison sentence) and treatment are not incompatible so long as certain conditions are met. The problem is that most correctional systems do not even closely approximate the appropriate conditions for changing these men.

In some jurisdictions in Western industrialized societies, child molesters and rapists are often not imprisoned. While such decisions seem based on the notion that these particular offenders do not constitute a sufficient threat to society, or have not harmed their victims seriously enough to deserve imprisonment, the basis for making this judgement often seems haphazard. More of these men should be sentenced to jail and given sentences commensurate with their crimes, not only to provide some satisfaction to victims and society, but also to allow for a sufficient length of incarceration to permit adequate treatment. When societies do imprison sex offenders, however, they all too frequently offer treatment to only a limited few. Furthermore, in many cases this treatment occurs under less then optimal circumstances.

In some cases treatment is provided in institutional settings that are inadequately treatment-oriented, where other inmates are hostile, and where other sex offenders, who are not in treatment, may express and encourage antitherapeutic deviant attitudes. In other cases, treatment is too brief or insufficiently comprehensive to effect the sort of changes necessary to reduce future offending. Finally, the timing of treatment is often problematic. If treatment is given only at the commencement of a sentence, offenders may be discharged from therapy into an aversive institutional
environment which may erode any benefits derived from treatment. On the other hand, if treatment is delayed until near the end of the offender's sentence, time spent in prison prior to treatment may lead either to severe discouragement or to the development or enhancement of pro-offending attitudes. Even though most prison programs do, in fact, operate under one or another of these less than optimal conditions, their treatments do appear to have some benefits (Davidson, 1984; Gordon, 1989), although such benefits are not always remarkable and in some cases may be little better than no treatment at all (Leger, 1989).

Once their sentence is over, or after they have completed a treatment program, sexual offenders are released back into the community. Unfortunately, until very recently, these release programs involved little more than superficial supervision by an overworked parole officer untrained in the complexities of dealing with sex offenders. Although there have been recent applications of relapse prevention programs to released sex offenders (Marques, 1988; Pithers, Martin & Cumming, 1989), there are few such programs. In any case, post-release jurisdictional control is often time-limited and may not allow sufficient time for adequate supervision and corrective treatment to be implemented in the community. Obviously, the sentencing and paroling of sex offenders needs to take this into account. In Canada, a judge can add an additional period of probation (up to 3 years) onto a sentence, if, and only if, the sentence is less than 2 years (a longer sentence would place the offender under federal jurisdiction in a penitentiary, while a sentence of less than 2 years places the offender in a provincial prison). Obviously it would be a considerable advantage to the post-release supervision and treatment of sex offenders if periods of probation could be added to the end of longer terms of imprisonment.

In order to maximize the benefits that child molesters and rapists might derive from treatment while in prison, we propose a three-tiered approach. Tier 1 would consist of intensive treatment for moderate to high risk sex offenders in maximum or medium security levels within a separate prison housing only sex offenders. Tier 2 would serve both the lower risk offenders and graduates of the Tier 1 program and be provided in the same prison in circumstances of minimum security. Upon their release from prison, these offenders would enter Tier 3 to be followed-up and, if necessary, given further treatment in community-based programs.

Considering the high risk for reoffense and the severity of problems among sex offenders, we have elsewhere argued (Marshall & Barrett, 1990) that sex offenders should be housed in a separate facility where they can get some form of treatment throughout their entire term of imprisonment. When sex offenders are housed in a prison with nonsex offenders, it becomes very difficult to establish a therapeutic environment. Prison administrators and guards in mixed institutions are, quite properly, concerned with internal security and their job is made all that much harder by the presence of sex offenders. Indeed, all too often internal security concerns become so primary that treatment is considered an annoyance to the management of the prison. Guards and other staff cannot easily be integrated into a therapeutic climate in mixed institutions. Not that a separate institution guarantees the ready implementation of a maximally beneficial treatment environment; it does, however, make such an environment more easily attainable.

According to this view, any time in prison which does not involve therapy is a waste for the sex offender and results in a risk to the community. However, we believe it is impractical for sex offenders to be involved in intensive treatment during
their entire stay in a penitentiary setting. In the first place, the costs would be enormous, and the evidence to date suggests that treatment effects can be secured with 6–12 months intensive treatment, provided such prison-based treatment is followed by careful supervision of each offender’s relapse-prevention plans once he is released (Marshall, Hudson, & Ward, 1992). There are, in fact, prisons devoted exclusively to sex offenders (e.g., Avenell in New Jersey, and Kia Marama in New Zealand, to name just two) although it is not clear how well tied treatment is in these institutions to the sort of benefits we have pointed to earlier (i.e., movement to lower security levels, greater freedom of visits and passes into the community, and an increased likelihood of early parole). Our guess is that the benefits derived from having a separate institution may be somewhat reduced unless effective treatment leads to reasonably immediate benefits.

Therapy involves learning new skills which must be practiced if they are to be maintained. In the artificial environment of a therapy group or laboratory setting, newly acquired behaviors may come relatively easily to the inmate. However, treatment success depends on the individual being able to use the new skills in unfamiliar settings with acquaintances or even strangers who may not be unconditionally supportive, helpful or understanding. Having to use and test these newly formed skills outside of the protective environment of the treatment program will reinforce these behaviors when they are successful, and alert both inmate and therapist to problems when they fail. These new skills can be practiced with staff and with inmates not presently involved in treatment, and also with the offender’s visitors. Conjugal visits are, therefore, a very valuable facet of treatment and are a standard feature in Canadian penitentiaries. Failures, having occurred in a secure setting, pose less threat to society than when they occur after an inmate has been released. Using the extra-therapeutic environment of the penitentiary as a setting in which to try out new skills requires treatment and institutional staff to communicate often and freely concerning the successes and failures of inmates, and this requires that the treatment program and its staff be integrated broadly within the institution and its staff. Such integration is impossible to achieve when inmates are transferred to another institution when treatment is completed.

It is not practical for inmates to be involved in therapy for a full day every day of their entire stay in prison. Most prisons depend on inmate labour for their day-to-day operation. Inmates are employed in the kitchens, the shops, the laundry, the library, the chapel, and in the offices of the institutions. If all inmates in an institution were in treatment every day, for the full day, the operation of the institution would be in jeopardy, and if inmate labour had to be replaced by non-inmate employees, the increase in costs would be stagger ing and would drain potential resources from treatment programs. Besides, there is a therapeutic benefit to inmate employment. Given that many sex offenders have very spotty records of employment in the community, and that as a group, incarcerated sex offenders lack vocational and work skills, the experience of working at a job in the institution can help prepare them for life on the outside. From this perspective, inmate employment, when it fosters improvement in job skills and cooperative work, may assist in meeting the treatment program objectives of reducing the incidence of future offending. What must be achieved is a balance among the inmate’s needs for treatment, his need for experience and practice at vocational activities, and the labour required for running the institution.
Objections are often raised regarding housing sex offenders in a separate institution. It is suggested that this will be resisted by these offenders and it will cause them difficulties when they are released, since the community (and prospective employers) will know they are sex offenders when their institution is identified. However, our experience with the separate institution in New Zealand revealed none of these problems (Marshall, Johnston, Ward, Jones, & Hudson, 1991). Indeed, sex offenders have eagerly sought placement at Kia Marama both to enter treatment and to avoid harassment. The community response to these men upon release has been, for the most part, quite positive, since Kia Marama is seen as a place where offenders attempt to rehabilitate themselves.

Maximum security levels in the separate institution should maintain tight control over inmates, both in terms of what they are allowed to do, and with whom they are allowed to interact. Restrictions should be placed on movement and exercise opportunities for offenders housed in maximum security conditions, but there should be ready and prompt transfer to medium or minimum security levels (depending on treatment needs and management or escape risk) once the offender begins to properly participate in treatment. Of course, the reverse should also be true; that is, movement to more secure levels should occur if participation in treatment drops off. Medium security should, like maximum security, provide a secure perimeter, but within this inmates should have nearly free access to much of the institution during most of the day and be free to interact with one another. Minimum security would, of course, be meaningless within the walls of a peripherally secure institution. Therefore, the minimum security aspect of the facility should be outside the secure walls, but on the same property to allow continuity of contact with therapy staff. Along with increasing freedoms and trust, inmates in the minimum security level should be allowed to wear their own street clothes and have access to most of the institution and other inmates, for the whole day. Having all sex offenders in the one institutional setting reduces the bane of all institutional programs; that is, the effective movement of relevant information. Indeed, the inability to effectively pass on crucial information about treated offenders from one institution to another, has all too frequently resulted in disastrous decisions being made about the management or release of a sex offender.

INSTITUTIONAL PROGRAMS

Once sex offenders are imprisoned they need to be thoroughly assessed to determine their treatment needs and priorities. This assessment process should occur within the sex-offenders-only institution, and result in the allocation of offenders to two groups: (1) those deemed to be at moderate to high risk to reoffend if released untreated; and (2) those determined to be at relatively low risk. The determination of risk category should be based on the inmate’s offense history (e.g., number of victims, use of force or threats, intrusiveness of sexual acts, nonsexual criminal offenses, etc.), the degree of his acknowledgement of responsibility for his sexual offenses, his psychopathic tendencies (e.g., impulsiveness, lack of concern for others, no remorse, etc.), inappropriate attitudes (e.g., negative views of women, acceptance of rape myths, distorted views of sex with children), the extent of his sexually deviant arousal (determined by phallometry), his social and relationship skills, patterns of
substance abuse, anger control, ability to deal with stress, and emotional stability (Barbaree & Marshall, 1988; Quinsey, 1984; 1986; Rice, Harris, & Quinsey, 1990; Rice, Quinsey & Harris, 1991). This evaluation process should be done in the maximum security wing of the prison and should take no more than 4 weeks.

In determining risk level and treatment needs, greatest weight should be given to the offense history. For some years, apparently as a result of limited treatment resources, the Correctional Service of Canada determined treatment needs for sex offenders on the basis of the man’s sexual arousal responses as determined by phallometric testing. Indeed, phallometry appears more generally to have a status well beyond its empirical bases (Blader & Marshall, 1988; Marshall & Eccles, 1991a). We (Barbaree & Marshall, 1989a; Marshall, Barbaree, & Butt, 1988; Marshall, Barbaree, & Christophe, 1986; Marshall, Barbaree, Laws, & Baxter, 1986) have shown that a substantial proportion of sex offenders display no arousal to any stimulus at phallometric testing and that a further significant number respond normally rather than displaying a deviant pattern. This means that phallometric testing can be expected to reveal deviance in only a limited number of offenders. Yet, obviously, a man with an extensive or violent history of sexually assaulting women or molesting children is in need of treatment, even if he does not display deviant arousal at assessment.

Since we assume that all sex offenders entering prison are in need of treatment, no assessment of treatability is conducted. Well over half the sex offenders in Canadian penitentiaries deny, upon entry to the system, that they committed the offenses for which they are incarcerated. Many of the rest minimize the nature of their offenses. Were we to reject as untreatable those who denied or minimized their offenses, we would have very few sex offenders in treatment. A related but similar problem concerns motivation for treatment. Even among those sex offenders who admit to all aspects of their offenses, there are some who claim to have been so affected by arrest, conviction and incarceration, that they will never offend again and so do not need treatment. It is our view, however, that the impact of the judicial process is significant, but not necessarily permanent. We see it as the tasks of therapists both to motivate offenders to devotedly participate in treatment, and to overcome their denial and minimization. Of course, having a separate institution for sex offenders should reduce denial and minimization since this is often adopted as a protective strategy against the abuse by nonsex offender inmates. Those who show a broad range of difficulties (i.e., those at moderate to high risk) would, in our proposed system, enter the extensive Tier 1 program at either maximum or medium security status. Maximum security should be reserved for those offenders who are deemed to be a potential management problem (e.g., aggressive toward others) or who have violent offense histories and yet are refusing treatment. Those determined to be at low risk (i.e., who show a limited range of deficits and have a limited number of offenses of a nonviolent nature and are deemed to be at low risk to escape) should be transferred to the less extensive Tier 2 program and be held under minimum security restrictions.

Tier 1: Extensive Program

Over the past several years we have developed comprehensive programs (Marshall, Earls, Segal, & Darke, 1983) for sex offenders and have operated them in maximum
These programs, and their theoretical bases, have been described elsewhere (Marshall & Barbaree, 1989; 1990a; 1990b; Marshall & Eccles, 1991a) so we will simply summarize them here.

Our present Tier 1 program runs for 6 months with 3 hours of group treatment each working day and an additional 1 or 2 hours each week of individual therapy. Individual treatment is directed at changing deviant sexual interests and providing counselling to resolve problems arising within the group. Most offenders meet the goals of treatment within the 6-month period, but some require up to a further 6 months, depending on how many of the treatment targets they attained. The group treatment deals with problems in an experiential way, and is meant to both help the offender identify and develop greater control over his thoughts, feelings and behaviors, and to provide him with skills so that he can meet his needs in more prosocial ways. It is not meant to “cure” him since it is not assumed that he has a “disease” in need of cure.

Offenders who enter treatment but do not appropriately participate should be dealt with quickly and effectively so as not to allow their behaviour to discourage others. We give these offenders a warning that if they do not become effectively involved they will be removed from the group and placed in maximum security. If they do not respond they are removed, but they are told that if they change their mind they will be allowed to return.

Targets in the treatment program at Tier 1 involve: cognitive distortions and inappropriate attitudes, sexual issues, social competence, lifestyle problems and training in relapse prevention. Correction of cognitive distortions, is aimed at denial of any wrongdoing, minimization of the admitted offenses, misattribution of responsibility for the offense (e.g., the woman wanted to be raped, the child was seductive, my life history caused me to offend, I was intoxicated, I was sexually deprived, etc.), lack of awareness of victim impact, and misperceptions about the nature of sexual offending. Inappropriate attitudes to be changed include: hostility toward women; viewing children as property; acceptance of violence; and beliefs that women and children desire sex to be forced on them and do not suffer as a consequence of sexual assault.

Treatment of sexual issues attempts to reduce deviant sexual preferences (i.e., a preference for forced sex or sex with children rather than for consenting sex with an adult), and increase appropriate sexual interests, as well as expand the offenders’ understanding of sexuality and how it is expressed by well-functioning partners. In addition we try to improve participants’ appreciation of the needs they are seeking to satisfy by deviant sex, and we also attend to any sexual dysfunctions the offenders may have.

Social competence training is meant to increase the offenders’ problem-solving abilities, to enhance their conversational skills and assertiveness, to increase their control over anger and anxiety, and improve their relationship skills and self-confidence. Among the lifestyle problems targeted in treatment are a general criminal propensity and a criminal style of thinking, associated with difficulties in managing stress, excessive use of intoxicants, poor use of leisure time, and little or no understanding of financial management.

As noted earlier, we (Marshall, Jones et al., 1991) have found that these programs
are not as effective with rapists as they are with child molesters, and we (Marshall, in press) have suggested a modified version of the program for rapists emphasizing more directly their evident deficiencies. This revised program covers all of the areas noted above, but adds, or places additional emphasis upon, the following problems: motivations for treatment; lack of empathy; low self-esteem; issues concerning power, aggression, and the intent to humiliate; inappropriate attitudes toward women and sex; a lack of intimacy and its associated experience of emotional loneliness; and alcohol/drug abuse. Our proposal for changes in programs for rapists suggest that the current practice of integrating child molesters and rapists in treatment groups may be inappropriate. We may, accordingly, have to develop alternative program streams, although there remain good arguments on both sides of this issue.

The final part of the Tier 1 program focuses on teaching offenders to recognize their offense cycle and identify factors that put them at risk to reoffend. Offenders are assisted in detailing all the steps in their offense cycle, including how they plan offense opportunities or allow such opportunities to occur. Negative emotional states, feelings of deprivation, a tendency to do too much (workaholic style) or to excessively please others, idle time, intoxication, and various other factors, have all been shown to increase the risk of reoffending (Pithers et al., 1989). The men are trained to recognize these factors and to see how they put them at risk. Of course the main risk factor is allowing themselves to be in situations where they can readily reoffend (e.g., roaming the streets at night for a predatory rapist, or being alone with children for a child molester). The offenders are taught ways they can deal with these risks when they arise and how to reduce the likelihood that they will occur. They also identify a set of warning signs that might indicate they are slipping back into old ways that put them at increased risk. Some of these signs are observable only to the offender (e.g., fantasizing deviant acts), but most should be observable to others (e.g., heavy drinking, or being unable to account for extensive periods of time away from home). This part of the program is referred to as the “internal management” component of relapse prevention and will be further developed when the offender moves to the Tier 2 program.

A current problem with implementation of the Tier 1 program in Canadian penitentiaries is that the program is offered only when it is estimated that the offender is approaching release. A long delay in jail without treatment may sufficiently discourage the offender, or instill such pro-offense attitudes, as to render it very difficult to motivate the offender and secure his full participation in treatment. Moreover, selecting the time to offer treatment requires the therapy team to second-guess the Parole Board's decision about when best to release the man. Delaying treatment until late in the offender's sentence may also jeopardize the chance to move him through the three-tiered program in an optimal manner. All too often, in fact, the timing of Tier 1 treatment is such that the offender's sentence ends (or his mandatory release date arrives) before he can be moved on to Tier 2; indeed, sometimes the present practice leaves too little time after release to do anything constructive even in the Tier 3 (i.e., community-based) stage of the program.

Treatment involvement should commence immediately after assessment has determined the sex offender's appropriate placement. If he is deemed to need Tier 1 treatment, and his sentence is short (i.e. 4 years or less), he should immediately commence the full Tier 1 program. If evaluation shows that he needs the Tier 1 program but he has a long sentence (i.e., 5 or more years), the offender should
be involved in a group that meets once or twice each week until he approaches the appropriate time to enter the full program. This “maintenance” group could be co-facilitated by a skilled inmate graduate of the full Tier 1 program who is awaiting transfer to Tier 2, thereby obviating excessive staff investment. This maintenance program is meant to sustain the offender’s spirits, instill motivation for treatment, and commence the process of dealing with denial and minimization.

Alternatively, long-term offenders may participate in a brief 2-month treatment program early in their sentence, focusing on denial, minimization and victim empathy. At the conclusion of this program, a long-term offender could be involved in employment within the institution or other non-sex offender-specific treatment programs available in the institution (e.g., substance abuse, anger control, life skills). At a later time in their sentences, they may be involved in the more intensive program of longer duration.

Once the offender successfully completes Tier 1, he should be moved to the Tier 2 program in the minimum security annex.

**Tier 2: Pre-release**

In this aspect of the overall program, group treatment sessions do not need to be as frequent as they are in Tier 1 since the participants have either had treatment (Tier 1 graduates) or need only limited interventions. We currently have two, 3-hour group sessions each week plus whatever individual counselling is necessary to resolve group problems. Offenders typically remain in Tier 2 for a minimum of two months and a maximum of 4 months. If it is clear that more extensive treatment is necessary, such inmates are transferred to Tier 1. This has rarely proved necessary as the initial evaluation process is thorough and effective. As noted, Tier 2 accepts inmates who have graduated from Tier 1 as well as those whose initial evaluation indicates that their treatment needs are not extensive. Accordingly, the goals of Tier 2 are necessarily limited. The main targets are the modification of inappropriate cognitive processes, as well as the development of sound release and relapse prevention plans.

Those offenders entering Tier 2 from the Tier 1 programs, should not need the cognitive training component, but monitoring within the group process should determine whether or not appropriate views have been retained. Those offenders who have been transferred directly from the evaluation unit, and have not, therefore, already been in treatment, will need to go through the complete cognitive therapy component. However, this cognitive therapy component has some value for the Tier 1 graduates, as it helps them to clarify issues more precisely and it ensures the maintenance of treatment gains.

A sound release plan is developed primarily by the offender and his case management officer, with the job of the treatment program being to identify any features of this plan that may put the offender at risk. For example, in the case of a child molester, if part of the release plan involves living with a family who have children, the treatment group leader may insist on an alternative residence. For a rapist who has characteristically attacked hitchhikers, taking a job that puts him on the road for much of his time would likewise be an unwise feature of a release plan. Plans that expose offenders to alcohol abuse, give them excessive idle time, or involve recreational activities that put them at risk, are all challenged and the treatment leader will insist on changes.
An important part of a satisfactory release program, involves, as a first step, temporary absences from the minimum security annex. These temporary absences (initially supervised and, if successful, then unsupervised) are meant to complete the details of the release plan such as finding a job, establishing social contacts, and securing accommodation. Such a gradual release program also permits the offender to re-enter, with minimal stress, a world that may have changed significantly since he first entered jail. It also provides an opportunity to re-explore family relationships which may be quite different in the everyday world outside prison than they appeared to be on visiting days. Temporary absence programs, while essential to the effective return of the offender to the community, should not be too prolonged or they may discourage the offender. Such programs need to be seen as a temporary but essential stepping stone to full release.

The main focus in Tier 2, however, is on developing a relapse prevention plan. A sound relapse prevention plan involves an identification of both the offense cycle and those factors that put each offender at risk. In Tier 2, the relapse prevention plan is organized in complete detail and written out by the offender. The written copy is duplicated and copies are handed to each group member for appraisal. Suggested changes are made until a final version is ready. Copies of this final version are sent to the Parole Board and to the parole officer who will supervise the offender upon release, and a copy is kept by the offender to carry with him at all times after release. Parole officers who supervise sex offenders should have training in relapse prevention procedures so they can properly and effectively supervise these men.

**Tier 3: Community Programs**

Once the offender is released he enters the “external management” component of relapse prevention (Pithers, 1990). This involves direct supervision by a trained parole officer along with re-assessment and, if necessary, treatment by a community-based clinic. The offender may be released directly into the community if he is deemed to be low risk to reoffend and if he has a place to live. If, however, an offender’s history suggests that even with treatment he is at significant risk to reoffend, or if an offender has not been able to arrange accommodation, then he should be placed in a half-way house. Such half-way houses can provide a degree of security to society while allowing the offender to find accommodation and a job, and to adjust to community life.

Re-assessment at a community-based program that specializes in dealing with sex offenders is necessary to the complete rehabilitation of those men with extensive histories of offending. For offenders who have just one victim and where there was no evidence of violence, re-evaluation upon release may be unnecessary and a waste of limited resources. However, for the most persistent or violent offender, assessments conducted within the jail setting of the potential for reoffense after release may be misleading. Of course pre-release evaluations are essential to the responsible management of these offenders. No one would think it appropriate to release sex offenders without such an appraisal. However, even when a sex offender is being completely honest (and in jail the contingency of possible freedom mitigates against such honesty), evaluating him while in the peculiar circumstances of a prison is unlikely to provide an accurate estimate of his probable behavior in society.
The community presents a more provocative environment as well as providing greater opportunities to offend. Also the transition from several years in jail back to the community is typically very stressful and we know that stress increases the risk to reoffend and reverses many treatment gains made by sex offenders (Marshall & Eccles, 1991a, Pithers et al., 1989). Re-assessment of sex offenders after they have been placed back in the community is critical to minimizing their risk to reoffend. We (Marshall & Eccles, 1991b) have reported our experience in running a community clinic for sex offenders released from Canadian penitentiaries and we noted instances where apparent gains derived from institutional programs were either eroded or lost altogether once offenders had been released for 1 or 2 months. Consequently, we strongly recommend re-appraisal of released offenders within the first 2 months with appropriate treatment implemented where necessary.

Treatment needs identified by this re-assessment may be added to the general aims of post-release management which concern primarily the systematic implementation of each offender’s relapse prevention plan. Additional problems apparent at re-evaluation and in need of direct treatment may include a return of deviant arousal and a reinstatement of inappropriate pro-offending cognitions. More generally, Tier 3 management can help the offender overcome setbacks in the community and monitor the offender’s ability to identify and deal effectively with any of the factors that put him at risk. In close cooperation with the offender’s parole officer, the therapist guiding Tier 3 treatment groups can institute intervention procedures to correct any emerging difficulties or any return to earlier pro-offending or high risk behaviors, attitudes, or emotional responses.

**THE VALUE OF TREATMENT**

The outcome of comprehensive cognitive-behavioral programs is positive whether they are institutionally-based or located in the community (Marshall, Jones et al., 1991). When such programs have the additional relapse prevention elements, they appear to be even more dramatically successful, with recidivism rates of less than five percent over four years follow-up (Marshall, et al., 1992).

In addition to the resulting reduction in the number of potential victims, effectively treating sex offenders is also remarkably cost-effective. We (Marshall, 1986) have calculated the costs involved in the investigation, prosecution, and incarceration (taking into account only the costs to clothe and feed the offender for just one year in jail) of re-offenders, and determined that the taxpayers must part with $200,000 Canadian for each re-offender. These costs estimates have subsequently been independently confirmed (Prentky & Burgess, 1991). Since treatment can be expected to reduce recidivism rates from approximately 35% to less than 10%, this means that for every 100 men treated, 25 who would otherwise have reoffended, will not. The savings to society, then, by treating 100 sex offenders, is 25 x $200,000, i.e., $5 million Canadian. To treat 100 men in the manner described above would cost approximately $700,000 Canadian (excluding the initial capital outlay of building a new institution and the usual operating costs which would be incurred anyway if we imprison these offenders). Thus, for every 100 sex offenders treated in this way, society potentially saves $4.3 million Canadian. When these men do reoffend they typically do so on average against two victims each (Barbaree & Marshall,
so that treating 100 of them potentially results in saving the suffering of 50 women and children who otherwise would be the victims of sex offenses.

CONCLUSIONS

Our proposed response to the problem of effectively dealing with sex offenders is broad-based and comprehensive, but not necessarily expensive. Child molesters and rapists should be imprisoned since they knowingly commit an offense which harms innocent people. They should be housed in a separate, therapeutically-designed and operated institution where they can receive comprehensive treatment. A gradual release program should be designed which moves them through progressively less secure environments with further treatment at each step. This program should culminate in their release into the community where they should be reassessed and treated if necessary, and where their relapse prevention plan can be put into practice under direct supervision.

From available evidence we can expect that this sort of program will markedly reduce re-offending among sex offenders released from prison, thereby saving society money and preventing the suffering of many innocent women and children.

REFERENCES


