This study examined the recidivism rates of 195 adult male sex offenders who were referred to a prison-based cognitive-behavioral treatment program. Of this sample, 56 participants completed treatment, 49 entered but did not complete treatment, and 90 refused treatment services. Although participants were not randomly assigned to treatment conditions, there were no between-group differences on participants' pre-treatment risk for sexual recidivism as appraised on two actuarial risk measures, the RRASOR and Static-99. Over a mean follow-up period of almost 6 years, the sexual reoffense rate for the completed-treatment group was 5.4% versus 30.6% for the some-treatment and 30.0% for the no-treatment groups. Lower sexual recidivism rates were also found among those participants who received aftercare treatment and correctional supervision services in the community.

Outcome of a Treatment Program for Adult Sex Offenders

From Prison to Community

ROBERT J. McGRATH
GEORGIA CUMMING
Vermont Department of Corrections
JOY A. LIVINGSTON
Flint Springs Consulting
STEPHEN E. HOKE
Vermont Department of Corrections

Incarceration is a common sentence for individuals who have been convicted of a sexual offense. In fact, sex offenders now represent approximately one quarter of the total incarcerated population in state prisons throughout the United States (West, Hromas, & Wegner, 2000). The court and community typically view incarceration of a sex offender as a just punishment. In addition, they take some measure of comfort in knowing that the offender cannot reoffend in the community while so incapacitated. This comfort is generally short-lived, however, because almost all sex offenders eventually

Authors' Note: We would like to thank Katherine Burns, Shelly Goddard, and Angela Ross for their assistance with data collection and entry and Euan Bear for her helpful editorial suggestions. Please address all correspondence to Robert J. McGrath, Vermont Treatment Program for Sexual Aggressors, Vermont Department of Corrections, 105 Happy Valley Road, Middlebury, VT 05753; e-mail: rmcgrath@sover.net.

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return to the community, often after serving only a small portion of their original sentence (Maguire & Pastore, 1995). Consequently, society has a vital interest in the broader question of how incarceration and follow-up community services affect a sex offender's long-term risk to reoffend.

The notion that the unpleasantness of prison will deter individuals from reoffending and teach them that "crime does not pay" is often accepted at face value. In reality, there is little evidence to support this view. Recent meta-analyses of the effect of prison sentences on the recidivism rates of criminal offenders conclude that the prison experience actually may produce slight increases in recidivism (Gendreau, Goggin, & Cullen, 1999; Gendreau, Goggin, Cullen, & Andrews, 2000). Furthermore, lower risk offenders appear more negatively affected by incarceration than higher risk offenders (Gendreau et al., 1999). Unfortunately, although the samples in these studies included sex offenders, they were not partitioned out for separate analyses. Nevertheless, there is reason to believe that sex offenders are also negatively affected by incarceration. The prison experience may be even harsher on sex offenders, as they hold a low status among other prisoners and may be more subject to harassment and abuse.

Ideally, incarceration should reduce, not increase, an offender's propensity to reoffend. Gendreau et al. (2000) argue that cognitive-behavioral treatments provide the best strategy for reducing an offender's risk to recidivate. In the United States, 39 states now have formal sex offender treatment programs in their prisons, almost all of which report using cognitive-behavioral treatment methods (West et al., 2000). Similarly, cognitive-behavioral treatments form the foundation of sex offender treatment programs within the prison systems in several other countries, including Canada (Correctional Service of Canada, 2000), England (Mann & Thornton, 1998), and New Zealand (Hudson, Wales, & Ward, 1998).

The effectiveness of these types of treatment programs has been the topic of much debate and public interest. Two often-cited and influential reviews have concluded that there is no evidence that sex offender treatment reduces recidivism (Furby, Weinrott, & Blackshaw, 1989; U.S. General Accounting Office, 1996). Lately, however, as newer treatment methods have been tested and analyses of outcome studies have become more sophisticated, confidence in the efficacy of sex offender treatment has risen. This optimism is strengthened by two relatively recent and large-scale meta-analytic studies of the sex offender treatment outcome literature (Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Hanson et al., 2002). The most well-designed of these concludes that state-of-the-art treatment results in an absolute reduction in sexual recidivism of about 8% after 4 years (Hanson et al., 2002).

Nevertheless, the field of sex offender treatment is still young, and debates about treatment efficacy continue. There is a pressing need for further research in this area. For example, because recidivism rates even among untreated sex offenders are quite low and most outcome studies rarely exceed 200 participants, more studies are needed from which aggregate data can be pooled to achieve enough statistical power to conduct meaningful treatment efficacy analyses (Barbaree, 1997). As another example, because programs in incarcerated settings appear to be less effective than those in the community (e.g., Hall, 1995), innovations in prison programming warrant increased attention. One such promising approach is the provision of community aftercare supervision and treatment services for offenders following their release from prison (Cumming & McGrath, 2000; Pithers, Martin, & Cumming, 1989).

This study is an evaluation of a prison treatment program for adult male sex offenders that includes a community aftercare component. It extends a preliminary evaluation of this program (McGrath, Cumming, Livingston, & Hoke, 2000) by increasing the sample size and lengthening the follow-up period. The purposes of this study were to identify the characteristics of men who completed treatment and compare them with those who refused or dropped out of treatment and then to compare the reoffense rates among these three groups. It is hoped that the results of these analyses will suggest ways to improve policy and practice about how to enhance community safety by managing sex offenders more effectively.

METHOD

Participants

The Vermont Department of Corrections (DOC) began computerizing offender records in 1989, providing the authors with an opportunity to identify a cohort of treated and untreated sex offenders who were all incarcerated and released during the same prescribed time period. The 195 adult male participants in this study each met four criteria. They (a) were convicted of a sexual or sexually related offense, (b) were sentenced to 4 or more years of incarceration, which made them eligible for the DOC's intensive incarcerated sex offender treatment program, (c) served part of their sentence between January 1, 1989, and December 31, 1993, and (d) were released to the community between January 1, 1989, and December 31, 1997. The follow-up period for this study ended on December 31, 2000.

The mean age of the sample at release was 38.2 years (*SD* = 10.5, range = 20 to 73). One half (51.8%) of participants had completed 12 or more years of education. Consistent with Vermont's lack of racial diversity, only two participants (1%) were non-White.

Participants were classified by offender type using definitions established by the Association for the Treatment of Sexual Abusers (Gordon et al., 1998). Based on these criteria, the sample was made up of 58 rapists (30%), 4 noncontact sex offenders (2%), 51 incest offenders (26%), and 82 child molesters (42%). Of these child molesters, 27 of the men molested boys (14%) and 55 molested girls (28%).

Assignment of Treatment Conditions

All participants met with a correctional caseworker shortly after being incarcerated. The caseworker recommended to each participant that he complete a sex offender assessment and any recommended sex offender treatment. Although treatment was not mandatory, earning of meritorious good time was contingent on program participation. In addition, Vermont has indeterminate sentencing and participants recognized that parole decisions would be significantly influenced by their program participation.

Most of the participants (n = 90) did not receive any sex offender treatment. Individuals in this "no-treatment" group said that they did not commit the sexual offense for which they were convicted, that they did not need sex offender treatment, or otherwise refused services. Some participants' psychiatric diagnoses were missing from files and a few participants in the no-treatment group (as many as 3, or 3.3%) may have been refused program services due to mental illness. The 56 participants who entered and completed treatment made up the "completed-treatment" group. Participants in the completed-treatment group substantially achieved their treatment goals or were enrolled in the program at the time of their release to the community. The remaining 49 participants, the "some-treatment" group, entered but later dropped out or were terminated from and did not reenter the treatment program. Reasons for being terminated from treatment included nonparticipation, assaultiveness, and use of alcohol or drugs.

Risk Assessment Measures

Two actuarial measures, the RRASOR and Static-99 (described below), were used to determine each participant's pretreatment risk for sexual reoffending. Both measures consist of items that are almost exclusively historical in nature and, therefore, are unchangeable. Scoring of these instru-

ments was completed through file review by either the first, second, or fourth author. Difficult scoring decisions were resolved by consensus between at least two of the scorers. To establish interrater reliability, independent scoring of every sixth case ($n = 32$) was conducted by a probation officer not associated with the study.

RRASOR. The RRASOR (Hanson, 1997) is a four-item actuarial risk measure used to aid in assessing sexual recidivism risk among convicted adult male sex offenders. RRASOR items are number of prior charges or convictions for sexual offenses, age at placement in the community, any male victims, and any unrelated victims. Scores fall into one of six levels reflecting the probability of sexual reoffending at 5- and 10-year intervals.

Static-99. The Static-99 (Hanson & Thornton, 2000) includes the 4 items that make up the RRASOR as well as 6 other items: prior sentencing dates, any convictions for noncontact sexual offenses, index offense of a nonsexually violent nature, prior nonsexually violent offense, any stranger victims, and lack of a substantial cohabitation history. The resulting 10-item actuarial risk measure is used in a similar manner as the RRASOR. Scores fall into one of seven levels reflecting the probability of sexual reoffending at 5-, 10-, and 15-year intervals.

Program Description

Treatment offered to participants in prison was located in closed units in medium security facilities and is best described as cognitive-behavioral and relapse-prevention in nature. The program was a component of the Vermont Treatment Program for Sexual Aggressors (VTPSA), an integrated, statewide continuum of inpatient and outpatient programs for sex offenders operated by the Vermont DOC. The VTPSA was started under the direction of William Pithers in 1982 (Pithers et al., 1989), who served as its director until 1995. The first author has been clinical director of the VTPSA since 1996 and clinical coordinator of the VTPSA network of outpatient programs since 1987. The second author has been program coordinator of the VTPSA since 1986 and has served in key program development roles since the inception of the program.

Program participants, upon release from prison, were typically referred for aftercare treatment to 1 of 11 geographically dispersed outpatient programs that also serve sex offenders on probation. Treatment procedures evolved over the course of the study but all prison and outpatient programs followed the same general treatment approach. Detailed program descrip-

tions can be found elsewhere (e.g., Cumming & McGrath, 2000; McGrath, 1995; McGrath, Hoke, & Vojtisek, 1998; Pithers, 1993; Pithers, Cumming, Beal, Young, & Turner, 1988; Pithers et al., 1989).

Outcome Measures

Recidivism data were obtained for all new charges for sexual, violent, and other offenses. The definition of sexual offenses also included any substantiation of a new sexual offense by Vermont's state child protective service agency. Violent offenses concerned nonsexual violence. "Other" offenses were defined as those that were nonsexual and nonviolent. For detailed definitions, see Vermont Department of Corrections (1996). Charges were based on criminal record checks in the states where each participant was known to have resided during the study.

RESULTS

Participant Characteristics

Because participant assignment to treatment groups was not random, group differences on factors related to reoffense risk were of particular importance. Identified risk factors as well as other participant characteristics are presented in Table 1. Groups were quite similar. In terms of criminal history variables, the only significant between-group difference was that the some-treatment group had a lower frequency of prior nonsexual violent convictions than either of the other two treatment groups, $X^2 = 17.94$ ($df = 2$), $p < .001$.

There were significant between-group differences for time at risk in the community, $F = 3.9$ (2, 192), $p < .02$. Overall, participants were at risk in the community for an average of almost 6 years ($M = 68.6$ months, range = 1 to 139 months). Participants in the completed-treatment group were, on average, at risk in the community for a longer period of time than offenders in the no-treatment group, $t(144) = 2.74$, $p < .01$.

Participants' sentence structure was also examined because it could have been a motivator for participants to enroll in and complete treatment. This is because Vermont has an indeterminate sentencing structure and those who completed treatment were theoretically eligible for release at their minimum sentence as opposed to their maximum sentence. Although there were no significant overall between-group differences among the three treatment groups in terms of sentence structure, further statistical analyses revealed some

TABLE 1: Participant Characteristics by Treatment Group

	Treatment Group			
Participant Characteristic	*Completed* (n = *56*)	*Some* (n = *49*)	*No* (n = *90*)	*Total* (N = *195*)
Mean participant age	36.3	38.6	39.2	38.2
Never married	39.3%	38.8%	30.0%	34.9%
Education (12 or more years)	60.8%	52.2%	45.3%	51.8%
Prior sex convictions	32.7%	42.9%	24.4%	31.3%
Prior nonsex violent convictions	37.5%[a]	4.1%[b]	33.3%[a]	27.2%
Prior nonsex nonviolent convictions	46.4%	55.1%	60.0%	54.9%
Mean RRASOR score	1.5 (1.2)	1.9 (1.2)	1.5 (1.3)	1.6 (1.2)
Mean Static-99 score	3.1 (2.0)	3.0 (1.8)	2.7 (2.0)	2.9 (2.0)
Mean minimum sentence (months)	43.4 (38.1)	34.5 (22.3)	39.3 (19.6)	39.3 (26.8)
Mean maximum sentence (months)	120.2 (64.3)	102.6 (52.8)	98.1 (53.5)	105.6 (57.1)
Maximum minus mininum sentence	76.8 (50.2)	68.1 (42.7)	58.8 (43.8)	66.3 (45.9)
Mean months incarcerated	52.7 (29.4)	62.1 (25.1)	57.7 (25.6)	57.4 (26.7)
Mean months of prison treatment	30.6 (11.4)[a]	14.5 (10.9)[b]	0.0 (0.0)[c]	12.4 (15.3)
Mean months at risk in community	78.6 (35.4)[a]	68.9 (32.9)	62.1 (35.5)[b]	68.6 (35.3)
Received community supervision	87.5%[a]	42.9%[b]	47.8%[b]	57.9%
Mean months community supervision	33.5 (28.9)[a]	6.8 (13.9)[b]	9.6 (21.9)[b]	15.7 (25.2)
Received community treatment	83.6%[a]	16.3%[b]	11.4%[b]	33.3%
Mean months community treatment	25.4 (21.3)[a]	3.3 (9.3)[b]	2.5 (7.6)[b]	9.2 (16.9)

NOTE: Figures in parentheses indicate standard deviations. Means in the same row that do not share superscripts differ at $p < .05$.

important patterns. Participants who completed treatment had significantly longer maximum sentences than those who had no treatment, $t(44) = 2.24$, $p < .05$. In addition, completed-treatment group participants also had a longer mean time between their minimum and maximum sentence than no-treatment group participants, $t(144) = 2.29$, $p < .05$.

Risk Assessment Measures

The most important finding in terms of participants' reoffense risk was that there were no between-group differences in mean scores on the RRASOR and Static-99. This finding is even more significant in that both of these measures proved to be reliable and valid in this sample.

Interrater reliability calculated as Pearson correlations between total scores for the RRASOR was .94 and for the Static-99 was .92. These measures predicted sexual recidivism with moderate accuracy, all at an alpha level of at least .01. The RRASOR had an r of .34 and Area Under the Curve (ACU) of .71. The Static-99 had an r of .29 and ACU of .68.

Treatment Outcome

Recidivism data were analyzed for both the number of reoffenders and the number of reoffenses (i.e., sexual, violent, and other). As detailed in Table 2, almost one quarter of the sample (23.1%) were found to have committed a new sexual offense during the follow-up period. The number of sexual reoffenders in the completed-treatment group (5.4%) was significantly lower than that of the some-treatment (30.6%) and no-treatment groups (30.0%), $X^2 = 13.90$ ($df = 2$), $p < .001$. There were also differences in the number of violent reoffenders, $X^2 = 8.20$ ($df = 2$), $p < .02$. The completed-treatment group had a lower number of violent reoffenders compared to the no-treatment group, $X^2 = 6.56$ ($df = 1$), $p < .01$. When the number of participants who committed either a sexual or violent reoffense were combined, the completed-treatment group had a lower number of reoffenders than either the some-treatment group, $X^2 = 5.72$ ($df = 1$), $p < .01$, or the no-treatment group, $X^2 = 13.37$ ($df = 1$), $p < .001$. No significant between-group differences were found for the number of "other" or the number of "any" reoffenders.

The number of reoffenses among each treatment group for each category of reoffense was quite low. The mean number of sexual reoffenses per offender was .50, for violent offenses .55, for sexual or violent offenses 1.05, for other offenses 1.02, and for any offenses 2.07. The pattern of statistical significance for number of reoffenses was the same as for number of reoffenders.

Community Aftercare Services

Prison treatment was not the only intervention provided to participants. Many also received community treatment and supervision. Consequently, analyses were conducted to determine whether there was an association between receiving aftercare services and lower reoffense rates. As noted in Table 1, there were clear and important differences with respect to the types of intervention services that participants in each group received. Obviously, the completed-treatment group received more prison-based treatment services than the some-treatment group, $t(102) = 7.4$, $p < .001$, and the no-treatment group, $t(55) = 20.1$, $p < .001$, who received no such treatment services. Of more interest was the fact that upon release from prison, the completed-treatment group was much more likely to have had correctional supervision in the community, $X^2 = 28.5$ ($df = 2$), $p < .001$. This supervision, when compared to the some-treatment and no-treatment groups, was quite lengthy, $F = 24.5$ (2, 192), $p < .001$. The completed-treatment group also was more

TABLE 2: Reoffenders by Type of Reoffense and Treatment Group

	Treatment Group							
	Completed (n = *56)*		*Some* (n = *49)*		*No* (n = *90)*		*Total* (N = *195)*	
	n	%	n	%	n	%	n	%
Sexual	3	5.4[a]	15	30.6[b]	27	30.0[b]	45	23.1
Violent	7	12.5[a]	8	16.3	28	31.1[b]	43	22.1
Sexual or violent	10	17.9[a]	19	38.8[b]	43	47.8[b]	72	36.9
Other	17	30.4	17	34.7	32	35.6	66	33.8
Any	20	35.7	24	49.0	52	57.8	96	49.2

NOTE: Reoffense categories are mutually exclusive, but some participants committed more than one type of reoffense. Means in the same row that do not share superscripts differ at $p < .05$.

likely than the other two groups to receive outpatient aftercare sex offender treatment, $X^2 = 88.1$ ($df = 2$), $p < .001$. This treatment, on average, lasted several months longer than community treatment services provided to the other two treatment groups, $F = 55.6$ (2, 190), $p < .001$.

Of those participants who sexually reoffended, few did so while receiving aftercare services. Only 4 of the 45 sexual recidivists (9%) reoffended while in community sex offender treatment and only 7 (16%) while under community correctional supervision. In addition, sexual recidivists were also less likely to have received community supervision. Sixteen participants (14%) who received community supervision reoffended compared to 29 recidivists (35%) among offenders not receiving supervision, $X^2(1) = 12.04$, $p < .001$. Similarly, sexual reoffenders were less likely to be in community treatment. Five reoffenders (8%) were in community treatment as compared to 40 (31%) who were not in community treatment, $X^2(1) = 13.38$, $p < .001$. Finally, the longer that participants were in outpatient treatment, the less likely they were to sexually reoffend, $r = –.24$, $p < .001$. This same aftercare effect was found for community correctional supervision as well, $r = –.24$, $p < .001$. A reduction in violent recidivism was also found for those in community treatment, $r = –.16$, $p < .05$, and community supervision, $r = –.21$, $p < .001$. There were no statistically significant associations with being in treatment or in supervision with other criminal reoffending. Further examination of the data using multiple regression models to determine the relative contribution of these aftercare services on reoffense rates were inconclusive. The data failed to meet assumptions of various regression models limiting the ability to apply either linear or logistic models.

DISCUSSION

The results of this study have several implications for how to manage sex offenders. One of the most challenging types of decisions that treatment providers, parole boards, and correctional professionals make is whether or when to release a sex offender back to the community. These data highlight the importance of considering sex offender treatment completion as a factor in making release decisions. In this study, the reduction in the sexual recidivism rate among participants who completed treatment was statistically as well as clinically significant. Treatment completers were almost six times less likely to be charged for committing a new sexual offense than were participants who refused, dropped out, or were terminated from treatment. This finding, that men who completed cognitive-behavioral sex offender treatment sexually reoffended at a comparatively low rate, is consistent with other recent outcome research (Gallagher et al., 1999; Hanson et al., 2002).

Despite the fact that treatment completion in this study was strongly associated with reductions in sexual recidivism, inferences about the meaning of this association are confounded by some methodological difficulties. One of these difficulties concerns the degree to which treatment groups were equivalent. Because this was a retrospective study and random assignment was not possible, treatment groups were compared on a variety of risk factors. As highlighted in Table 1, treatment groups were found to be quite comparable on variables related to pretreatment risk. Especially noteworthy was the fact that treatment groups did not differ statistically on their risk scores on two well-established actuarial risk instruments. These group similarities and the fact that the completed-treatment group was at risk in the community for almost 10 more months than the some-treatment group and more than 16 months longer than the no-treatment group bolster the contention that treatment had a positive effect on reducing the sexual reoffense rate of the completed-treatment group.

Of course, the variables on which treatment groups were compared were almost exclusively historical in nature as opposed to dynamic participant features such as personality characteristics and current behavioral functioning. Participants in the some-treatment and no-treatment groups may have been higher risk because they could have been less motivated, more impulsive, and more involved in the abuse of drugs than the completed-treatment group. If so, these or other dynamic risk factors could explain why participants in these groups dropped out of or refused to enter treatment. On the other hand, some participants may have refused treatment because they did not commit the sexual offense for which they were convicted or correctly believed that they did not need treatment.

Another methodological weakness relates to the complexity of sorting out the relative effects of the three interventions examined, namely, prison treatment, community treatment, and community supervision. Analyses of these effects were inconclusive because of how these interventions were confounded with each other. As is evident in Table 1, men who completed the prison program were very likely to have received, and received for several months, both community treatment and supervision, whereas those in the some-treatment and no-treatment groups were not. Clearly, these data suggest interesting hypotheses that require further examination.

Providing community aftercare supervision and treatment services to sex offenders upon their release from prison seems quite important (Cumming & McGrath, 2000). It is encouraging that few men committed new sexual offenses while receiving aftercare services, and significantly fewer men who received aftercare services, as compared to those who did not, reoffended at all during the follow-up period. Also noteworthy was the fact that the longer participants were in aftercare services, the less likely they were to sexually reoffend. This finding raises the important policy question about what constitutes an optimal length of community supervision and treatment for offenders at various levels of risk and treatment need.

Whereas completion of treatment was associated with marked reductions in sexual reoffending rates, differences in violent reoffending rates among treatment groups were more modest and there were no statistically significant between-group differences in general criminal recidivism rates. This is not surprising because the program was initially designed to address sexual offending behavior. Recently, cognitive treatments that address general criminal behavior have been introduced into the program in an effort to broaden the range of treatment targets beyond sexual offending. These newer treatments are based primarily on work in the Vermont correctional system by Henning and Frueh (1996).

The sentence structure differences between the completed-treatment and no-treatment groups may have influenced program participation. This finding suggests that the "carrot" of getting out of prison earlier by completing treatment or the "stick" of staying in prison longer because of not completing treatment were possible motivating factors for some participants. Regardless, given the overall positive treatment outcome results of this study, the practice of sentencing sex offenders, especially those who are higher risk, to a large range between their minimum and maximum sentence seems quite sensible. Offenders who show that they may be at lower risk to reoffend by virtue of having completed treatment can be given the opportunity for early release. Early release can result in enormous financial savings to society, as the cost of incarceration is considerably higher than the cost of community supervision

and treatment. Offenders who remain at high risk for reoffense because they have not completed treatment, or for some other reason, can remain incarcerated for longer periods of time to protect the community.

Other interesting clinical and policy issues concern program completion rates and standards. These issues may be related. Programs that place excessively high expectations on participants might have lower completion rates because clients cannot meet those standards. Conversely, those with less stringent expectations may have higher completion rates for the opposite reason. In this study, slightly more than half of participants enrolled in treatment, and of those who did, only slightly more than half completed the program. Whether the program could have been more successful in enrolling and retaining participants in treatment and still maintain a good treatment outcome is an important empirical question. Further study should examine how these factors are related to reoffense rates.

An incidental study finding concerned the predictive validity of the RRASOR and Static-99. These instruments predicted sexual recidivism with moderate accuracy in the sample. This finding adds further support for the generalizability of these actuarial risk instruments across a broad range of sociocultural contexts (e.g., Barbaree, Seto, Langton, & Peacock, 2001; Sjostedt & Langstrom, 2001).

As is evident in this study, the challenges of conducting sex offender treatment outcome research are numerous (for recent reviews, see Hanson, 2000; McConaghy, 1999; Miner, 1997). Although it is relatively easy to identify preferred research designs, they are often difficult to implement. Randomized control trials are the standard in much medical and psychological research, but Miner's (1997) observation about the sex offender field's reluctance to use randomization continues to be accurate. In our jurisdiction, as in most, the public and governmental agencies are averse to release untreated sex offenders in the community to determine how many will sexually reoffend in contrast to a comparison group of treated offenders.

Nevertheless, service providers have an obligation to evaluate what they do and should strive to use the best research designs possible given the practical realities of their setting. Several possibilities exist. Randomization does not require a no-treatment group. Participants can be randomly assigned to two theoretically plausible forms of sex offender treatment. If randomization cannot be used, efforts can be made to use equivalent comparison groups. One such example would compare offenders who were released in a community before the existence of a program with those released after the implementation of a program. When equal comparison groups are unavailable, research should attempt to examine group equivalency on as many factors as possible, as was the case in this study. It seems especially important to exam-

ine dynamic risk factors, including measures of motivation. These factors have been much less studied than static factors. Of course, all studies suffer some limitations and researchers must make use of available data to guide program delivery decisions.

In summary, the present results are consistent with other recent research indicating that men who complete cognitive-behavioral sex offender treatment programs sexually reoffend at relatively low rates. This finding is of significant practical value for those who make prison release decisions and supervise sex offenders in the community. Because major between-group differences on static risk factors related to sexual reoffense were not detected, we believe that treatment effect was one of the reasons for the positive outcomes in the completed-treatment group.

At the same time, there were likely differences between treatment groups on dynamic risk factors. Measurement of these potentially changeable risk factors is a critically important area of inquiry and is a focus of our current research efforts (McGrath, Livingston, & Cumming, 2002). The lack of available instruments to effectively assess dynamic risk factors is only highlighted more when contrasted with the rapid development of validated and useful static risk assessment measures, two of which were cross-validated in this study.

Other areas of future research should focus on how sex offender programs can be designed so that they have an impact on all types of criminal behavior, not just sexual offending. Last, the importance of aftercare services needs more research attention so that sex offenders who are released from prison can be reintegrated into society in as safe a manner as possible.

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Robert J. McGrath is the clinical director of the Vermont Department of Corrections' statewide network of prison and community-based sex offender treatment programs. His current research interests focus mainly on the areas of program evaluation and measurement of treatment progress.

Georgia Cumming is the program director of the Vermont Center for the Prevention and Treatment of Sexual Abuse. Her research interests are in the area of risk assessment and management.

Joy A. Livingston is a research psychologist in a private consulting practice.

Stephen E. Hoke is a district manager with the Vermont Department of Corrections. His research interests are in the area of risk assessment and management.