



**Responding to Sexual Offenses:  
Research, Reason and Public Safety**

**Kostas A. Katsavdakakis, Marsha Weissman, and Alan Rosenthal\***

**A Call to Reason**

There is likely no criminal behavior that breeds as much condemnation and fear as sex offending. There are tragic examples of young victims of sex offenders in New York State and across the country that have raised our concerns, and prompted calls for increased surveillance, control and incapacitation. It is responsible public policy to address these concerns in ways that will increase public protection that are based on research and evidence. An evidence-based approach ensures that we will sequester only those who are likely to reoffend by committing serious, violent sexual offenses and affording treatment and effective supervision for those who do not fall into this category.

To date, much of the debate about sex offenders has been driven by the most horrific and heinous crimes that contribute to the myth that nothing works. This ignores a growing body of research that documents what works, for whom and in what setting and context. This policy alert calls attention to some of the literature, and urges that new legislation on sex offenders, both criminal and civil penalties, be guided by this research and further expert consultation. We briefly address three key areas: assessment of people who commit sex offenses, the efficacy of treatment - what works for whom, and the use and misuse of civil commitment. Finally, we draw upon lessons learned from the past and New York's experience with legislation that was driven by fear and political rhetoric - the Rockefeller drug laws.

This call for a more thoughtful, research-based approach to the assessment, sentencing and post-release supervision of sex offenders does not emanate solely from criminal justice reform organizations and defender associations. There are law enforcement and

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\* Kostas A. Katsavdakakis , PhD, PC, is a Clinical and Forensic Psychologist in private practice and an Assistant Professor at John Jay College of Criminal Justice. Dr. Katsavdakakis' area of expertise includes the diagnosis, evaluation and treatment of sexual offenders. He was previously the Assistant Director of Psychology at a maximum security forensic hospital on Ward's Island, New York City where he coordinated the development of an integrated assessment and treatment program for sexual offenders. Dr. Katsavdakakis can be reached at 718-926-9489 or [www.drforensic.com](http://www.drforensic.com) and [info@drforensic.com](mailto:info@drforensic.com). Marsha Weissman, Ph.D. and Alan Rosenthal, Esq. are respectively CCA's Executive Director and Director of Justice Strategies, CCA's Research and Policy Division.

mental health professionals who raise concerns about the overreaching of these laws. In a statement issued in January 2006, the Iowa County Attorneys Association (an association of state prosecutors) opposes certain residency restrictions as unnecessary as defined, unenforceable, causing undue harm and hardship to offender families, and preventing effective prosecution of sex offenders. They call instead for more careful and specific definitions of areas from which people who commit sex offenses are banned, such as schools and libraries, and targeting a more precise and limited offender group to be identified by competent and expert assessment. The statement concludes *“The observations of Iowa prosecutors are not motivated by sympathy for those committing sex offenses against children, but by our concern that legislative proposals designed to protect children must be both effective and enforceable. Anything else lets our children down. The Iowa County Attorneys Association strongly urges the General Assembly and the Governor to act promptly to address the problems created by the 2,000 foot residency restriction by replacing the restriction with measures that more effectively protect children, that reduce the unintended unfairness to innocent persons and that make more prudent use of law enforcement resources.”*

The Center for Sex Offender Management (CSOM), a project of the National Institute of Justice, U.S. Department of Justice (Bynum, 2001), also urges that decisions about and responses to sex offending be made based on assessment and with knowledge of treatment and custodial and non-custodial supervision options that make sense for different individuals: *“... criminal justice practitioners must avoid reactionary responses that are based on public fear of this population. Instead, they must strive to make management decisions that are based on the careful assessment of the likelihood of recidivism. The identification of risk factors that may be associated with recidivism of sex offenders can aid practitioners in devising management strategies that best protect the community and reduce the likelihood of further victimization.”*

People who commit sex offenses are now at the forefront of the interchange between mental health and the law. Sexual offense arrests and convictions are high profile events, attracting the public's attention, and demands for swift justice. While the question of punishment or application of justice should by no means be cast aside, legislators, mental health professionals and the community are responsible for developing evidence-based assessment practices that identify the risk an offender poses to the community, as well as what type of evidence-based treatment is available to reduce the likelihood of recidivism. The absence of an informed risk assessment leading to an accurate diagnosis and treatment leaves the community and offender at risk. Contrary to popular beliefs and common misperceptions, not all people who commit sexual offenses are the same, and there are valid and reliable risk assessment methods that can inform which treatments may be most effective in reducing risk. Assessment, classification and treatment are the keys to public safety.

### **ASSESSMENT: The first step...**

A standardized, valid and reliable assessment method is the first step to accurately classify the risk a specific offender poses to the community. The overall goal of the risk

**CENTER FOR COMMUNITY ALTERNATIVES**  
 115 East Jefferson Street, Syracuse, NY 13202  
 39 West 19<sup>th</sup> Street, New York, NY 10011

assessment is to guide intervention/treatment, protect the safety of the public, protect the patient or inmate, and liability management. Since the inception of the New York State Risk Assessment Instrument, empirical research, including large meta-analytic studies (Hanson & Bussière, 1996; Hanson & Morton-Bourgon, 2004), as well as theoretical-practice literature have yielded substantial new information about the nature of sexual offender risk assessment (Amenta, Guy, & Edens, 2003; Becker & Murphy, 1998; Beech, Fisher, & Thornton, 2003; Harris, Rice, & Quinsey, 1998; Harris, Rice, Quinsey, Lalumière, Boer, & Lang, 2003). This literature identified factors that increase and reduce risk for sexual re-offense in the community (Hanson & Bussière, 1996; Hanson & Harris, 2000; Hanson & Morton-Bourgon, 2004; Hanson, Scott, & Steffy, 1995; Hanson, Steffy, & Gauthier, 1992), limitations of risk assessments (Amenta, Guy, & Edens, 2003; Edens, 2006; Campbell, 2003; Levenson, 2004; Miller, Amenta, & Conroy; Salekin, 2001; Sjostedt, 2002), sexual re-offense base rates for various types of sexual offenders (Hanson, 2001; Hanson & Bussière, 1996; Harris & Hanson, 2004; Hanson & Morton-Bourgon, 2004; Lanagan, Schmitt, & Durose, 2003; Prentky, Lee, Kinght, & Cerce, 1997), dynamic risk factors (Hanson & Harris, 1998; Hanson & Thornton, 2000; Thornton, 2002; Douglas, K.S. & Skeem, J.L., 2005), and methods to communicate risk (Heilbrun, Dvoskin, Hart, & McNeil, 1999; Heilbrun, Nezu, Keeney, Chung, & Wasserman, 1998).

The current New York State Risk Assessment Instrument has not incorporated this evidenced based research, which is in contrast to widely utilized sexual offender risk assessment instruments such as the Sexual Violence Risk – 20 (SVR-20), and Static – 99, as well as other state risk assessment instruments (e.g. New Jersey). Moreover, the current Risk Assessment Instrument has not been subjected to examination as to the validity and reliability of the 3 risk levels which may contribute to high rates of classification errors.

Sound, research-based assessment is essential in the treatment and management of people who commit sex offenses. With the stakes so high - public protection and deprivation of liberty - it is critical to use assessment tools that comport with research on risk of reoffending.

**CLASSIFICATION: Not all people who commit sexual offenses ...**

The data are unequivocal that not all people who commit sex offenses are the same. Some behaviors are less likely to be repeated and some individuals are more amenable to treatment. Sexual recidivism rates in the community vary by key factors that must be carefully assessed in order to accurately identify the risk an offender poses to the community, and what steps must be taken to reduce or moderate risk for the community. These factors include perpetrator/victim relationship (Hanson, 2001; Hanson & Bussière, 1996; Harris & Hanson, 2004; Rice and Harris, 2002), number of previous arrests and/or convictions (Hanson, 1997; Hanson & Bussière, 1996; Hanson & Morton-Bourgon, 2004; Harris & Hanson, 2004; Quinsey, Lalumière, Rice & Harris, 1995), age of first sexual misconduct (Hanson & Bussière, 1996; Scalora & Garbin, 2003), number and nature of prior criminal activities (Hanson & Bussière, 1996; Hanson & Morton-Bourgon, 2004; Harris & Hanson, 2004; Quinsey, Lalumière, Rice & Harris,

1995; Scalora & Garbin, 2003), age of the offender at time of release (Harris & Hanson, 2004; Lanagan, Schmitt, & Durose, 2003), sexual offense-free behavior in the community (Harris and Hanson, 2004; Harris, Phenix, Hanson, & Thornton, 2003), drug and alcohol abuse (Hanson & Morton-Bourgon, 2004, Swanson, 1994, Hanson & Bussiére, 1996), and psychological/physical coercion (Scalora & Garbin, 2003; Hanson & Morton-Bourgon, 2004). Some of the evidence-based factors that show lower risk, such as offense-free behavior in the community or age at the time of release are not included in New York State's Risk Assessment Instrument. Moreover, approximately 20% of the Risk Assessment Instrument items have no significant relationship with risk for sexual reoffending in the community. In order to accurately classify an offender, the evidence-based factors listed above, must be considered and irrelevant factors discarded.

### **TREATMENT: Tailoring interventions to the offender...**

Because of headline cases, the public has received distorted information about the benefits of treatment for people convicted of sex offenses. In contrast to the "nothing works" response, there is evidence that some treatment approaches are effective for some people who commit sex offenses. Researchers are beginning to identify the relevant factors associated with the risk for sexual reoffending, and identify what approaches work for which type of offenders.

The assumption of a "one size fits all" treatment approach for sexual offenders is clearly contradicted by the assessment literature which emphasizes how different risk factors increase or decrease sexual offense recidivism. Certain studies support the conclusion that treatment reduces the likelihood of sexual reoffense in the community (Hanson, Gordon, Harris, Marques, Murphy, Quinsey & Seto, 2002), other studies demonstrate mixed effects (Marques, Wiederanders, Day, Nelson & van Ommeren, 2005), emphasizing that offenders who met program goals have lower re-offense rates, while other studies showed no significant treatment effects (Hanson, 2005). Hanson et al. (2005) found no significant differences between the treated versus non-treated sexual offenders over the course of 8 years. However, the study clustered together all different types of sexual offenders because the data regarding victim characteristics was not available (R.K., Hanson, personal communication, March 2, 2006). Overall, there remain significant unanswered questions regarding the effectiveness of treatment, and only with accurate assessment and classification will reliable data be collected to develop evidenced-based treatment modalities.

### **Framing Policy**

While there is likely no criminal behavior that breeds as much condemnation and fear as sex offending, it is the responsibility of legislators, mental health professionals and the public to develop evidence based practices for the assessment, classification and treatment of sexual offenders and use this evidence to create sound policies. In general, and contrary to public opinion, people convicted of sex offenses reoffend at lower rates than people convicted of other offenses. The U.S. Department of Justice, Bureau of Justice Statistics (Langan, Schmitt & Durose, 2003) report on recidivism of people convicted of sex offenses shows that only 5.3% of sex offenders were rearrested for any type of new sex crime within three years after release from prison. Sex

offenders had lower overall rearrest rates than people convicted of non-sexual crimes: 43% of people convicted of sex offenses were rearrested post release compared to a 68% rearrest rate for people convicted of crimes other than sex offenses.

These recent data and findings are excluded in favor of confinement and incarceration. In Vermont, there is a proposal that would extend civil commitment to people convicted of violent crimes, not just sexual crimes. Legislative discussions in New York State have already suggested that civil commitment be extended to people convicted of non-sexual crimes, such as robbery, who are “suspected” of having a “sexual motivation.” While confinement may be the most appropriate response in some cases, it ignores the completion of a thorough risk assessment that protects the public, the individual, and identifies the treatment to lower sexual reoffending upon release.

The current concern about people who commit sex offenses and the prospect of a civil commitment law should be informed after consideration of the following questions:

1. How does New York State’s classification system compare to current research on best practices?
2. What are current methods and procedures for revising New York State’s sex offender risk assessment?
3. What is the current capacity for sexual offender treatment in New York State prisons?
4. How does current treatment in New York State prisons compare to best practice recommendations for sex offender treatment?
5. What data exist on recidivism rates for sex offenders in New York State now? Are we able to compare recidivism rates of sex offenders who received treatment, compared to those who have not? Will New York State make an investment in learning more about recidivism rates in order to be able to use data in constructing civil commitment laws?
6. Given the very high stakes involved in civil commitment, how will New York State ensure that all sex offenders have access to quality treatment?
7. What options to civil commitment will be available and for which type of offender? What supervision options would be available, what treatment options will be available?
8. What are the financial consequences for civil commitment? Will civil commitment be tied to equal spending on treatment options or will civil commitment further restrict funding for treatment?

### **Avoiding Mistakes of the Past**

New York’s Rockefeller drug laws are examples of how easy it is to enact draconian laws but how hard it is to repeal such legislation. First enacted in 1973 ostensibly to target drug dealing kingpins, these laws ensnared low level sellers/users and paved the way for a bevy of other mandatory sentences for other crimes. Despite evidence of the efficacy of drug treatment, and despite a shift in public opinion that supported treatment over incarceration, it was not until 2004, that even modest reform of these harsh and ineffective laws were enacted. The lessons of the Rockefeller drug laws - the relative ease of enacting these laws and the incredible challenge in undoing them - dictates that

caution be used in the creation of civil commitment and other draconian and “one size fits all” approaches to people who commit sex offenses in New York State. If civil commitment is to be used, it must be reserved for the most serious, chronic sexual offenders whose risk to others has not been reduced by prior treatment or other mitigating factors.

If New York State intends to go further down the path of civil commitment, registration and notification requirements, and residency and travel restrictions for people who who commit sex offenses, it must use an evidence-based approach to ensure that any new restrictions on our fellow citizens are not merely driven by fear and a penchant for punishment but rather by reason, research and science. To do less would merely repeat the mistakes of the past, and set us on a course that is not only inhumane but also counterproductive to public safety.

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