ANNUAL EVALUATION OF CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION CONTRACTED SEX OFFENDER TREATMENT PROGRAMS

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Glossary

AA	Alcoholics Anonymous
AASI	Abel Assessment of Sexual Interest
AOR	Agent of Record
CBT	Cognitive Behavioral Therapy
CCCMS	Correctional Clinical Case Management System
CDCR	California Department of Corrections and Rehabilitation
CEBC	Center for Evidence-Based Corrections
CPAI	Correctional Program Assessment Inventory
CPC	Counseling and Psychotherapy Center (treatment provider)
CSRA	California Static Risk Assessment
DA	Discharge Assessment
DAPO	Division of Adult Parole Operations
DRP	Division of Rehabilitative Programs
ESL	English as a Second Language
FY	Fiscal Year
HHC	Helping Hand Counseling (treatment provider)
HRSO	High Risk Sex Offender
LCSW	Licensed Clinical Social Worker
LS/CMI	Level of Service/Case Management Inventory
MFT	Marriage and Family Therapist
MH	Mental Health
MPG	Maram Psychological Group (treatment provider)
NA	Narcotics Anonymous
OBIS	Offender-Based Information System
ODC	Open Door Counseling (treatment provider)
PC	Penal Code
POC	Parole Outpatient Clinic
PPG	Penile Plethysmography
RNR	Risk Needs Responsivity
RTC	Return to Custody
RTF	Residential Treatment Facility
SA	Substance Abuse
SF	Sharper Future (treatment provider)
SRA-FV	Structured Risk Assessment – Forensic Version
UCI	University of California, Irvine

EXECUTIVE SUMMARY

California Penal Code Section 3007 requires a research component for any contracted sex offender treatment program funded by the California Department of Corrections and Rehabilitation (CDCR). The University of California, Irvine, (UCI), under contract with CDCR, is providing a status report on current contracted sex offender treatment programs for the Fiscal Year (FY) 2012-2013.

During FY 2012-2013, the Division of Adult Parole Operations (DAPO) continued to provide community-based treatment via contracts with treatment providers. The DAPO oversaw nine contracts for outpatient treatment programs for high risk sex offenders (HRSO) and, for the first time, non-high risk sex offenders (non-HRSO). Contracts were established for a two-year term, covering the period from January 1, 2013 until December 31, 2014. Approval for the new contracts was slightly delayed, and contracts were signed between the months of February - March 2013. This resulted in a shortened window for data capture for this evaluation. Although contracts were approved for treatment of HRSO and non-HRSO offenders, funding for services for non-HRSO offenders was not made available until July 2013. The funding for these contracts is $32,721,779 over two years.

The CDCR Office of Research developed a standardized, electronic data collection form called a *Legislative Report* that was included in the new contracts. The *Legislative Report* was completed and submitted by treatment providers on a monthly basis, and was initiated to assist with program evaluation. The current report describes the demographic and background characteristics of sex offenders referred to contracted treatment, based on information obtained from these participant rosters. It also provides a summary of program characteristics obtained from the rosters, as well as qualitative information gathered from telephone interviews with a sample of treatment providers.

An examination of demographic and offender characteristics of the offenders who were referred to treatment revealed that:

- The majority of participants (94.5 percent) were high risk sex offenders (as classified by DAPO based on the Static-99 risk assessment tool).
- Nearly all offenders were male (98.7 percent).
- Two-thirds of the sample were first-releases (66.6 percent) and one-third were re-releases (33.4 percent).
- Two-thirds were aged between 30 and 54 years (66.6 percent), with relatively few offenders aged younger than 30 (17.8 percent) or older than 55 years (15.4 percent).
- Over a third of the offenders were Black/African American (39.4 percent), followed by White (28.7 percent), and then Hispanic/Latino (25.5 percent).

- The majority of participants were committed to prison for crimes against persons (72.7 percent), followed by drug crimes (10.7 percent), property crimes (10.4 percent), and other crimes (6.2 percent).
- Less than half of participants (41.7 percent) were identified as having committed a serious/violent crime.
- As intended, all of the offenders have a sex registration requirement.
- Three-quarter of offenders had served determinate sentences for their most recent prison stay (74.6 percent) and one-quarter were second strikers (25.0 percent).
- Over half of the participants had a low CSRA risk score (52.3 percent), followed by moderate risk (29.6 percent), and then high risk (17.7 percent).
- Overall, 85.0 percent of participants had a Static-99 score that met CDCR criteria to be designated as a high risk sex offender.

The findings from the analysis of participant data suggest that the contracted sex offender treatment program providers are serving the appropriate offender population, as all participants are required to register as sex offenders and most had a moderate to high risk to recidivate (as assessed by the Static-99). However, for reasons discussed in this report, we are unable to determine with certainty the extent to which contractors are meeting the service needs (in terms of the number of sex offenders receiving treatment) of sex offenders in the community.

An examination of program characteristics data contained in the participant rosters revealed that:

- Almost all offenders had a referral date (99.6 percent).
- Only a small proportion of offenders (15.1 percent) were listed as having individual treatment plans completed.
- More than one-third of the sample was missing program start date information (36.9 percent), leaving 63.1 percent of offenders with a program start date.
- As expected, too few participants had a program end-date to perform a meaningful analysis (3.6 percent of the sample).
- Just over one-third of the sample (36.0 percent) had a reason for discharge from the treatment program; however, it was difficult to determine precisely the reason for discharge, due to the variety of discharge reasons provided by contractors.

Interviews with clinical directors provided useful qualitative information on sex offender treatment services, and established that providers met contractual obligations by conducting mandatory assessments, individual and group counseling, and polygraph testing.

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INTRODUCTION

California Penal Code (PC) Section 3007 requires the California Department of Corrections and Rehabilitation (CDCR) include a research component for any sex offender treatment contract funded by the Department.[1] This research component permits the Department's Office of Research or an independent contractor to evaluate the effectiveness of each contract in reducing recidivism among participants. The enabling PC Section 3007 requires a report to be sent to the Legislature by January 10th annually. This report evaluates contracted sex offender treatment for the period FY 2012-13.

BACKGROUND

Currently, California does not offer in-prison treatment for sex offenders. CDCR's Division of Rehabilitative Programs (DRP) is developing a pilot program to provide evidence-based treatment services to address the risks and needs of sex offenders prior to their release. The proposed in-prison sex offender pilot program will be implemented in FY 2013-14.

Since 2006, treatment programs have been provided to high risk sex offenders (HRSOs) in the community on a contracted outpatient basis. External contracts with treatment providers are managed by CDCR's Division of Adult Parole Operations (DAPO). A report on the status of community-based treatment contracts for HRSO in FY 2011-12 was prepared by CDCR's Office of Research and provided to the Legislature in July 2013.

The current report provides an update for FY 2012-13. It discusses the implementation of new contract arrangements with treatment providers in early 2013. The new contracts provide treatment services to HRSO and, for the first time, non-high risk sex offender (non-HRSO) participants. The Office of Research developed a standardized, electronic data collection form called a *Legislative Report* (included as Appendix A and hereafter referred to as "participant rosters") that was included in the new contracts. The *Legislative Report* was completed and submitted by treatment providers on a monthly basis, and was initiated to assist with program evaluation. The current report describes the demographic and background characteristics of sex offenders referred to contracted treatment based on information obtained from these participant rosters. It also provides a summary of program characteristics obtained from the rosters, as well as qualitative information gathered from telephone interviews with a sample of treatment providers.

[1] *California Penal Code 2012 Desktop Edition.* Thomson Reuters/West, 2012.

CDCR CONTRACTED SEX OFFENDER TREATMENT PROVIDERS

In FY 2012-13, DAPO put in place nine new contracts for outpatient sex offender treatment. Contracts were established for a two-year term, covering the period from January 1, 2013 until December 31, 2014. Approval for the new contracts was slightly delayed, and contracts were signed between the months of February - March 2013. Contracts were approved for treatment serving HRSO and non-HRSO offenders, although funding for services to non-HRSO offenders was not made available until July 2013. The total amount of funding for the nine contracts over the two year period was $20,512,531 for HRSO participants, with an additional $12,209,248 for non-HRSO participants. The total funding was thus $32,721,779 over two years.

The nine contracts cover nine parole "sites". Each site operates multiple treatment locations that take referrals from neighboring parole units. The 29 outpatient sex offender treatment program locations funded during FY 2012-13 are located across three parole regions statewide. Table 1 presents the contract providers operating in each parole region and the number of locations operated within each region. Sharper Future has locations in all three parole regions and operates a total of 17 locations (with between three and eight locations per region). The remaining four contractors operate within a single region. The Counseling and Psychotherapy Center has four locations in Region II. Open Door Counseling has three locations in Region III. Maram Psychological Group has three locations in Region IV. A Helping Hand Counseling has two locations in Region IV.

Table 1. Sex Offender Treatment Contract Providers by Parole Region, FY 2012-13

Parole Region	Number of Locations in Region	Sex Offender Treatment Contract Provider
Region II	8	Sharper Future (SF)
Region II	4	Counseling and Psychotherapy Center (CPC)
Region III	6	Sharper Future (SF)
Region III	3	Open Door Counseling (ODC)
Region IV	3	Maram Psychological Group (MPG)
Region IV	3	Sharper Future (SF)
Region IV	2	Helping Hand Counseling (HHC)

Although bids were received for Region I, a decision was made to not award a new contract for this region. A second round of contract negotiations is currently in process and a contract is expected to be awarded in February 2014 for treatment services to commence in April 2014. Until the new contract is awarded, the 815 HRSO offenders in

Region I are receiving mental health services through the Parole Outpatient Clinic (POC) in lieu of sex offender treatment.[2]

Each contract was awarded for an estimated number of HRSO and non-HRSO participants. The estimated number of participants is specific to each site and was calculated by DAPO in 2011 based on a "snapshot" of the number of sex offenders in the community at that time. However, since 2011, parole has been impacted by Public Safety Realignment (AB 109) and, as a result, several parole offices have been closed or consolidated. As a consequence, the HRSO and non-HRSO participant numbers estimated in 2011 may no longer be an accurate reflection of service needs.

Note that participant numbers refer to the number of "treatment slots" available, rather than the number of offenders. An HRSO treatment slot over the course of a two-year contract would usually include an initial assessment, four treatment plan updates, four supplemental assessments, three polygraphs, 24 sessions of individual therapy (one per month), 192 sessions of group therapy (eight per month) and a discharge assessment. A single treatment slot may be filled with multiple offenders. Overall, the new contracts provide treatment for an estimated 1,357 HRSO treatment slots and (funded as of July 2013) 3,247 non-HRSO treatment slots: a combined total 4,604 sex offender treatment slots.

The number of estimated treatment slots per region is as follows: 1,364 in Region II; 1,165 in Region III; and 2,075 in Region IV. Sharper Future has the highest number of treatment slots (2,836 in total, representing 62% of all treatment slots), followed by Maram Psychological Group (652 treatment slots), Helping Hand (468 treatment slots), Open Door Counseling (332 treatment slots) and Counseling and Psychotherapy Center (316 treatment slots). Under the new contracts, providers are not required to provide services for a minimum number of offenders: the goal is for every sex offender in the community to be in sex offender treatment.

METHODOLOGY

The UCI worked collaboratively with the Office of Research and DAPO in the fall of 2013 to collect program participant data. Each contractor submitted participant rosters (via the new *Legislative Report*) that contained the name and CDC number of HRSO and non-HRSO participants who were referred to services in FY 2012-13. Since the new contracts were approved in early 2013, and the data reporting process was implemented with the new contracts, participant data was obtained from March through June 2013 only.[3]

The data obtained from the contractors was matched to CDCR's Offender-Based Information System (OBIS) to provide demographic and offender characteristics for offenders referred to treatment at each site. In total, 1,195 HRSOs and 69 non-HRSOs

[2] The previous Region I contract was extended to October, 2013, extending service provision for 100 sex offenders.

[3] We also examined July rosters in order to obtain retrospective information for June.

are reflected in this report.[4] The total sample was thus 1,264. The first section of this report examines the background and demographic characteristics of program participants.

The UCI collated and analyzed the roster data to examine program characteristics, such as reasons for discharge and the extent to which individual treatment plans were completed. The second section of this report discusses program characteristics.

In addition, UCI contacted a representative sample of clinical directors from contractors operating treatment programs within each parole region in order to conduct a telephone interview. The telephone interview was designed to capture qualitative information about the program (e.g., staff backgrounds, assessment tools used, program evaluation). A copy of the interview questions is included as Appendix B. Interview responses are included as Appendix C. The final section of this report discusses findings from the telephone interviews.

PROGRAM PARTICIPANT CHARACTERISTICS

This section of the report presents an analysis of OBIS demographic and background information on program participants. Table 2 (next page) depicts the total and contractor-specific program participant characteristics of the sex offender population referred to the 29 outpatient sex offender treatment sites during FY 2012-13.

Treatment Provider

The total number of sex offenders referred in FY 2012-13 was 1,264. Regions II and IV both had more than twice as many participants (about 40 percent of the total each) as Region III (17 percent of the total).

High risk and non-high risk sex offenders

Separate rosters were submitted by contractors for HRSO and non-HRSO referrals. The majority of participants in our sample were HRSOs (94.5 percent). Two of the seven contractors – Counseling and Psychotherapy Center in Region II and Sharper Future in Region IV – served some non-HRSO participants during the reporting period.[5] All other contractors served only HRSO clients for the FY 2012-13 reporting period. We compared the number of HRSO participants referred for treatment to the estimated number of HRSO treatment slots specified in the contract.

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[4] If CDC number or other relevant information could not be found in OBIS for a particular offender, then that person was dropped from the analysis. This data cleaning process resulted in the exclusion of 13 participants whose information could not be found using the name or CDC number provided on the rosters, or because the participant was an out-of-state offender. Additionally, two of the clients had received treatment from more than one region/location and their data is included at each location they received treatment.

[5] Funding for non-HRSO treatment became available in July. The small number of non-HRSO participants included in this report were likely to have been deemed by DAPO as presenting a high risk to the community and required to attend treatment, despite their formal designation as non-HRSO.

Table 2. Demographic Characteristics by Treatment Provider

	CPC Region II		SF Region II		ODC Region III		SF Region III		MPG Region IV		SF Region IV		HHC Region IV		Total	
Characteristics	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total	93	100.0	431	100.0	126	100.0	87	100.0	218	100.0	166	100.0	143	100.0	1264	100.0
Sex Offender Risk Type																
High Risk Sex Offender	41	44.1	431	100.0	126	100.0	87	100.0	218	100.0	149	89.8	143	100.0	1195	94.5
Non-High Risk Sex Offender	52	55.9	0	0.0	0	0.0	0	0.0	0	0.0	17	10.2	0	0.0	69	5.5
Gender																
Male	92	98.9	428	99.3	123	97.6	87	100.0	212	97.2	165	99.4	141	98.6	1248	98.7
Female	1	1.1	3	0.7	3	2.4	0	0.0	6	2.8	1	0.6	2	1.4	16	1.3
Release Type																
First Release	57	61.3	270	62.6	100	79.4	70	80.5	148	67.9	98	59.0	99	69.2	842	66.6
Re-Release	36	38.7	161	37.4	26	20.6	17	19.5	70	32.1	68	41.0	44	30.8	422	33.4
Age at Release																
18-19	0	0.0	1	0.2	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.1
20-24	4	4.3	31	7.2	15	11.9	6	6.9	18	8.3	11	6.6	7	4.9	92	7.3
25-29	15	16.1	49	11.4	11	8.7	8	9.2	19	8.7	21	12.7	9	6.3	132	10.4
30-34	11	11.8	70	16.2	18	14.3	10	11.5	25	11.5	25	15.1	29	20.3	188	14.9
35-39	10	10.8	41	9.5	13	10.3	8	9.2	19	8.7	15	9.0	16	11.2	122	9.7
40-44	11	11.8	64	14.8	13	10.3	14	16.1	23	10.6	22	13.3	19	13.3	166	13.1
45-49	17	18.3	63	14.6	16	12.7	13	14.9	35	16.1	23	13.9	19	13.3	186	14.7
50-54	9	9.7	55	12.8	18	14.3	14	16.1	38	17.4	21	12.7	25	17.5	180	14.2
55-59	9	9.7	34	7.9	9	7.1	8	9.2	24	11.0	17	10.2	10	7.0	111	8.8
60 and over	7	7.5	21	4.9	13	10.3	6	6.9	17	7.8	11	6.6	9	6.3	84	6.6
Missing	0	0.0	2	0.5	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	2	0.2
Race/Ethnicity																
White	32	34.4	117	27.1	38	30.2	5	5.7	89	40.8	37	22.3	45	31.5	363	28.7
Hispanic/Latino	44	47.3	69	16.0	39	31.0	29	33.3	54	24.8	54	32.5	33	23.1	322	25.5
Black/African American	12	12.9	198	45.9	44	34.9	52	59.8	67	30.7	67	40.4	58	40.6	498	39.4
Native American/Alaskan Native	2	2.2	14	3.2	1	0.8	0	0.0	1	0.5	3	1.8	5	3.5	26	2.1
Asian	0	0.0	8	1.9	1	0.8	0	0.0	1	0.5	0	0.0	1	0.7	11	0.9
Native Hawaiian/Pacific Islander	0	0.0	1	0.2	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.1
Other	3	3.2	24	5.6	3	2.4	1	1.1	6	2.8	5	3.0	1	0.7	43	3.4

Table 2. Demographic Characteristics by Treatment Provider (continued)

	CPC Region II		SF Region II		ODC Region III		SF Region III		MPG Region IV		SF Region IV		HHC Region IV		Total	
Characteristics	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Commitment Offense Category																
Crimes Against Persons	76	81.7	315	73.1	99	78.6	56	64.4	154	70.6	122	73.5	97	67.8	919	72.7
Property Crimes	9	9.7	40	9.3	18	14.3	7	8.0	27	12.4	13	7.8	18	12.6	132	10.4
Drug Crimes	6	6.5	36	8.4	6	4.8	16	18.4	28	12.8	20	12.0	23	16.1	135	10.7
Other Crimes	2	2.2	40	9.3	3	2.4	8	9.2	9	4.1	11	6.6	5	3.5	78	6.2
Serious and/or Violent																
Yes	65	69.9	169	39.2	69	54.8	36	41.4	80	36.7	61	36.7	47	32.9	527	41.7
No	28	30.1	262	60.8	57	45.2	51	58.6	138	63.3	105	63.3	96	67.1	737	58.3
Sex Registration Flag																
Yes	93	100.0	428	99.3	126	100.0	87	100.0	218	100.0	164	98.8	142	99.3	1258	99.5
No	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Missing	0	0.0	3	0.7	0	0.0	0	0.0	0	0.0	2	1.2	1	0.7	6	0.5
Sentence Type																
Second Striker	17	18.3	80	18.6	44	34.9	29	33.3	47	21.6	47	28.3	52	36.4	316	25.0
Determinate Sentence	76	81.7	351	81.4	82	65.1	58	66.7	170	78.0	117	70.5	89	62.2	943	74.6
Life	0	0.0	0	0.0	0	0.0	0	0.0	1	0.5	2	1.2	2	1.4	5	0.4
CSRA Risk Score																
Low	61	65.6	191	44.3	79	62.7	54	62.1	120	55.1	85	51.2	71	49.7	661	52.3
Moderate	23	24.7	135	31.3	39	31.0	24	27.6	64	29.4	47	28.3	42	29.4	374	29.6
High	9	9.7	103	23.9	7	5.6	9	10.3	34	15.6	33	19.9	29	20.3	224	17.7
Missing	0	0.0	2	0.5	1	0.8	0	0.0	0	0.0	1	0.6	1	0.7	5	0.4
Static-99 Score																
Low	27	29.0	4	0.9	34	27.0	14	16.1	4	1.8	2	1.2	1	0.7	86	6.8
Moderate-Low	25	26.9	13	3.0	20	15.9	21	24.1	1	0.5	2	1.2	5	3.5	87	6.9
Moderate-High	27	29.0	256	59.4	48	38.1	32	36.8	143	65.6	116	69.9	94	65.7	716	56.6
High	13	14.0	155	36.0	21	16.7	20	23.0	65	29.8	44	26.5	40	28.0	358	28.3
Missing	1	1.1	3	0.7	3	2.4	0	0.0	5	2.3	2	1.2	3	2.1	17	1.3

Overall, there were 1,195 HRSO referrals for the 1,357 contracted treatment slots. Two contractors had more HRSO referrals than treatment slots. Open Door Counseling in Region III had 126 referrals and 94 treatment slots (i.e., 34 percent more referrals than treatment slots). Sharper Future in Region II had 431 HRSO client referrals and 341 treatment slots (26 percent more referrals than slots). Two contractors (Maram Psychological Group and Helping Hand Counseling, both in Region IV) had only slightly fewer HRSO referrals than estimated treatment slots (i.e., referrals for 96 percent and 95 percent of treatment slots respectively). The remaining three contractors had fewer referrals than estimated in the contract (with referrals for 37 percent, 41 percent, and 72 percent of treatment slots).

Gender

Most of the offenders (98.7 percent) referred to treatment were male. Sharper Future in Region III had no female participants; the remaining contractors each had a small number of female offenders.

Release Type

Two-thirds of the sample were first releases (66.6 percent) and one-third were re-releases (33.4 percent). Across all contractors, first releases significantly outnumbered re-releases (ranging from 59.0 percent to 80.5 percent).

Age at Release

The age distribution of the sample was fairly similar across contractors. The average age ranged from 41.5 years at Sharper Future in Region II to 43.8 years at Maram Psychological Group in Region IV. Two-thirds of the population was between the ages of 30 and 54 years (66.6 percent). Relatively few offenders were younger than 30 (17.8 percent) or older than 55 years (15.4 percent).

Race/Ethnicity

Overall, over a third of offenders were Black/African American (39.4 percent), followed by White (28.7 percent), and then Hispanic/Latino (25.5 percent). The ethnic composition of the sample varied across the different treatment providers. Counseling and Psychotherapy Center in Region II served a higher proportion of Hispanic/Latino offenders (47.3 percent) than other contractors, Maram Psychological Group in Region IV served a higher proportion of White offenders (40.8 percent) than other contractors, and Sharper Future in Region III treated a higher proportion of Black/African American offenders (59.8 percent) than other contractors.

Commitment Offense Category

The majority of participants were committed to prison for crimes against persons (72.7 percent), followed by drug crimes (10.7 percent), property crimes (10.4 percent) and other crimes (6.2 percent). Although crimes against persons was the most common commitment offense across all treatment providers, there was some variation in the remaining three commitment offense categories across providers. Drug crimes, for example, ranged from

4.8 percent of commitment offenses at Open Door Counseling to 18.4 percent at Sharper Future (both in Region III).

Serious/Violent Commitment Offense

Less than half of the population (41.7 percent) was identified as having committed a serious/violent crime.[6] This finding was consistent across individual treatment providers, except for Counseling and Psychotherapy Center in Region II and Open Door Counseling in Region III where the majority of offenders were serious/violent (69.9 percent and 54.8 percent respectively).

Sex Registration Flag

As intended, all of the offenders have a sex registration requirement.[7]

Sentence Type

Three-quarters of offenders had served determinate sentences for their most recent prison stay (74.6 percent) and one-quarter were second strikers (25.0 percent). These percentages fluctuated slightly over the different treatment providers, with the proportion of second strikers ranging from 18.3 percent to 36.4 percent.

California Static Risk Assessment Risk Score (CSRA)[8]

Over half of the offenders in the sample had a low CSRA risk score (52.3 percent), followed by moderate risk (29.6 percent), and then high risk (17.7 percent). Sharper Future in Region II served slightly higher risk offenders than other contract providers.

Static-99 Score[9]

A Static-99 score of “moderate-high” or “high” is the primary criteria used to designate a sex offender as a high risk sex offender, although a DAPO Unit Supervisor may consider aggravating or mitigating factors when making a final determination. Overall, 85.0 percent of participants in the sample had a Static-99 score designating them as a high risk sex offender. Few offenders had a Static-99 score of “low” or “moderate-low” (173 participants, or 13.9% of the population). Since the sample included both HRSO and non-HRSO participants, we further examined these 173 offenders who scored “low/moderate-low” on the Static-99 to determine whether they were non-HRSO referrals; 30.6 percent were.

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[6] Although 72.7 percent of the sample were committed for a crime against persons, some of these crimes do not result in a serious/violent flag.

[7] Six offenders (0.5 percent of the sample) had missing data for this variable.

[8] The CSRA is a tool used to calculate an offender’s risk of being convicted of a new offense after release from prison. Based on their age, gender, and criminal history, offenders are designated as having either a low, moderate, or high risk of being convicted of a new offense after release. For more information about the CSRA, visit the University of California, Irvine, Center for Evidence-Based Corrections web site at: http://ucicorrections.seweb.uci.edu/files/2009/11/CSRA-Working-Paper.pdf

[9] The Static-99 is a risk assessment tool designed to predict sexual and violent recidivism in male adult sexual offenders. Total scores on the Static-99 can be translated into the following relative risk categories: low, moderate-low, moderate-high, and high. For more information about the Static-99, visit the Static-99 Clearinghouse web site at: http://www.static99.org/

PROGRAM CHARACTERISTICS

This section of the report presents an analysis of information contained in the participant rosters. UCI worked with DAPO to ensure that the analysis was based on rosters from all treatment locations for all months. Since the *Legislative Report* was a recently introduced data collection system, DAPO also worked extensively with the treatment providers to improve the completeness of essential data required for the report (e.g., missing referral dates and start dates). Due to time constraints, UCI decided to limit the extent of follow-up for missing information deemed non-essential (e.g., treatment plans) in favor of working with DAPO to revise the *Legislative Report* and improve data reporting and quality control procedures in the future.

Roster data were cleaned in order to delete identical records for the same offender, consolidate information contained in multiple records for the same offender, and fix typographical errors in data entry. This cleaning process reduced the number of records in the roster data set from 2,769 to 1,302.[10] There were 1,224 offenders with only one record in the data (96.8 percent of the sample). Thirty-six offenders (2.8 percent) had two records, and two offenders (0.2 percent) had three records, indicative of offenders cycling in and out of treatment (and thus explaining why there are slightly more records than offenders).

Number of Participants

This report presents information on the sample of 1,264 sex offenders whose names and CDC numbers were listed in participant rosters provided by contractors to DAPO. Since we do not know how many participants appearing on the rosters actually received treatment (as opposed to merely appearing on the rosters), in this section we examine how many participants had other information entered into the rosters indicative of treatment being provided.

Number with a Referral Date

During data cleaning, UCI identified 28 offenders who were missing a referral date (2.2 percent of the sample) and these were sent to DAPO for follow-up with treatment providers. As a result of this follow-up work, almost all offenders in the sample (99.6 percent) had a referral date. Only five individuals were missing a referral date after the data cleaning and follow-up process (0.4 percent).

Number with a Treatment Plan

Of the 1,264 participants included in the rosters, only 191 were listed as having individual treatment plans completed (15.1 percent). The majority of offenders had missing data for the “individual treatment plan completed” field (60.7 percent). A further 306 offenders (24.2 percent) were reported as not having a treatment plan completed. Of these, 267 offenders (or 87.3 percent) had a reason entered into the “reason for discharge” field, indicating that

[10] UCI is collaborating with DAPO to refine the *Legislative Report* in an effort to minimize the data cleaning needed in future reports.

the offender was incarcerated, for example, had absconded, or was otherwise unable to attend treatment.

Number with a Program Start Date

A total of 797 offenders (63.1 percent of the sample) had a start date in the rosters. More than one-third of the sample (36.9 percent) was missing a program start date in the rosters.[11] Because of the data quality problems, it is unknown how many offenders with missing start date information commenced treatment (i.e., had missing data on the rosters) or did not commence treatment (i.e., whose missing start date accurately reflected that treatment did not commence).

Number with a Program End Date

Due to the short timeframe of data capture and the recent approval of contracts, we did not expect a large proportion of offenders to have completed treatment and, as such, have a "program end date". Some contractors entered an offender's prospective end date by calculating an end date that was 18 months post-start date. Once we cleaned the data to remove end dates that did not fall in FY 2012-13, we were left with 46 offenders with an end date (3.6 percent of the sample). Of these, 33 also had a start date entered into the rosters. Consequently, we could calculate the average length of time in the program for 33 offenders (2.6 percent of the sample). Due to this small sample size, the average program length varied greatly among contractors, from 0.8 months to 22.6 months, and is not a meaningful analysis.

Number with a Reason for Discharge from the Program

Contractors were provided with guidance from DAPO regarding entering reasons for a parolee discharging from the treatment program (e.g., discharged from parole, parole revoked). We found that contractors used a multitude of reasons in this field, making analysis difficult. UCI worked with DAPO to code the variety of reasons into a 7-point coding scheme that was developed and used by one of the contractors.[12] Of the 1,264 participants, 455 offenders had a reason for discharge (36.0 percent). The most common reason was "other" (28.0 percent of the sample), followed by "in custody" (4.4 percent) and "discharged from parole" (1.9 percent).[13]

Summary of roster data

We examined the number of participants in the sample (from a starting total of 1,264 offenders) who had complete roster information: that is, a referral date, a program start date, a treatment plan, and a program end date (within the 2012-13 FY). For those with missing information, we examined whether they had a reason for discharge from the

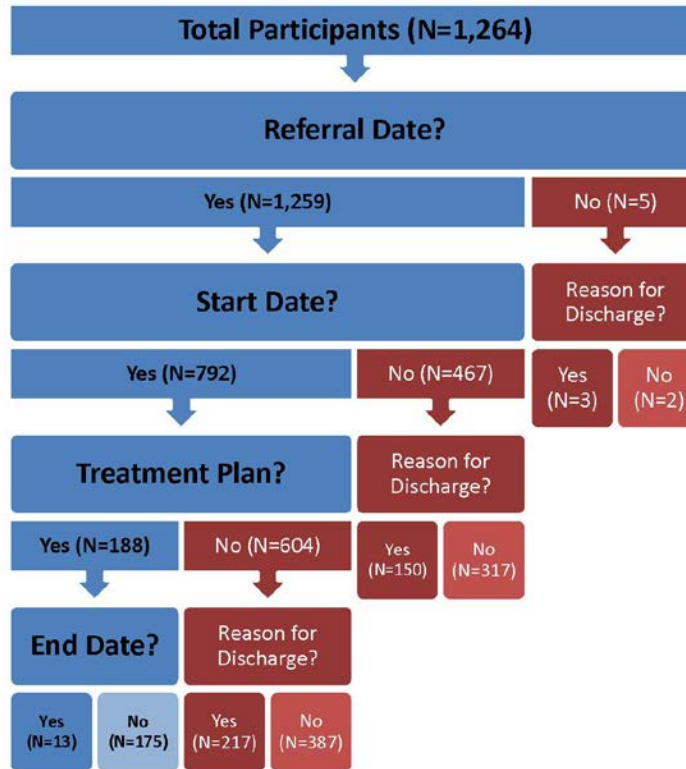
[11] The rate of missing data for "start date" was originally higher than 36.9%. At UCI's request, DAPO followed-up with treatment providers for 260 offenders with missing start dates; many of these were obtained. However, UCI then received additional rosters and, due to time constraints, did not request further follow-up for missing dates contained in this batch of data, which is why the rate of missing data was high.

[12] 1 (discharged from parole), 2 (long term custody), 3 (absconded), 4 (moved to another location), 5 (physical health problems), 6 (mental health or substance abuse problems), or 7 (other).

[13] Examples of "other" reasons are "no show", "no packet", and "therapist availability".

treatment program (shown in red). Results are presented in Figure 1, showing that only 188 offenders had a referral date, start date and a treatment plan completed.

Figure 1. Participants in the sample (Total N = 1,264) with complete roster information



INTERVIEWS WITH CLINICAL DIRECTORS

We selected a representative sample of clinical directors for telephone interviews, ensuring that the interview sample included at least one location per contractor per region. Two locations with sub-contracting arrangements with alternate providers were not included in the interview sample. We contacted eleven clinical directors. Interviews were voluntary - all eleven locations agreed to p

articipate in the interviews. Interview questions were developed by UCI in consultation with CDCR Office of Research and DAPO. Clinical directors were provided with interview questions several days prior to the telephone interview (interview questions are include as Appendix B). They also received a Study Information Sheet explaining the research. Two locations provided written responses to the interview questions; a follow-up telephone call with a clinical director was conducted to clarify responses. Telephone interviews took approximately 30 minutes to complete. Clinical directors were informed of the specific location for which information was sought (since in some cases a clinical director oversaw several locations). During one interview, preliminary discussion revealed that it was difficult to separate two locations; as a result, we combined these two locations (Region IV locations C/D). Researchers wrote down responses during the interview on a blank

interview form, and at a later time compiled responses into a summary table (included as Appendix C). This section provides a summary of themes arising from the interviews.

Program characteristics and staffing

When asked the maximum number of participants at the location, five contractors provided detailed information on the number of participants specified in the DAPO contract. In addition, three contractors provided approximate numbers. Two contractors interpreted this question in terms of the number of clinical hours of treatment per week. The remaining contractor indicated that they were unsure of how many participants received treatment at their location.

We also asked clinical directors for the number of HRSO and non-HRSO clients currently receiving treatment. Eight locations provided this information, two contractors were unsure of client numbers and provided a ratio of HRSO to non-HRSO participants, and the remaining contractor did not know current numbers and indicated that it was low. One contractor (Region II Location D) had a higher number of HRSO clients than specified in the contract, five contractors had fewer, and for the remaining five contractors this information could not be determined due to insufficient detail of responses. The general consensus among contractors was that they were operating at under-capacity levels. Six locations mentioned that there was a state-wide shortage of qualified staff. The number of non-HRSO participants was generally low, probably due to the contracts for non-HRSO participants being approved fairly recently. Five contractors had waiting lists for entry into the program, although one was not due to capacity and was instead a result of contacting/scheduling referred offenders. In addition, one contractor did not have a waiting list, but had contacted DAPO and requested that they slow the referral of non-HRSO participants.

All contractors indicated that they accepted all offenders referred to them for treatment. Contractors followed standard procedures for handling clients with severe mental health, substance abuse or behavioral problems; they referred them to the POC for stabilization and/or treated them on an individual basis if group participation was judged inappropriate.

Contractors were complying with the dosage of treatment specified in the contract, in terms of the length of sessions and the number of group/individual sessions provided to HRSO and non-HRSO offenders. Treatment providers work with parole on a case-by-case basis if dosage needs to be adjusted based on client needs. Nine contractors complied with the maximum group size of 9 participants; two contractors, however, indicated that in some circumstances (e.g., when clients changed groups) the maximum group size reached 10 participants.

Therapists were predominantly licensed psychologists, marriage and family therapists (MFTs), or social workers. Many contractors also employed interns and post-doctoral staff who operated under the licenses of other (licensed) staff on site. Many staff were part-time and/or worked across multiple locations. All contractors were seeking to hire new qualified therapists, or recognized the need to hire more staff once the number of referrals

increased. It was widely recognized that a staff shortage exists in California and that it is especially difficult to recruit qualified staff in rural areas.

Program basis and use of technology

When asked to name the theoretical basis for their program, all contractors responded with Cognitive Behavior Therapy (CBT). Contractors also mentioned Risk-Needs-Responsivity (RNR; four contractors), the Good Lives Model (three contractors), the containment model, a psychodynamic approach, psycho-educational approach, and Maslow's needs.

Contractors also were asked to name specific evidence-based practices used in treatment. This question elicited a similar response to above: CBT, RNR, containment model, relapse prevention, and the Good Lives Model.

Polygraph testing is a requirement of the contract and was a treatment technology listed by ten of the eleven contractors interviewed (one director in Region III stated that no technology was used in treatment, perhaps overlooking polygraph testing). In addition, the Abel assessment was widely used (i.e., listed by eight directors). Only one contractor (i.e., Region II Location C) used penile plethysmography (PPG).

Risk and needs assessment

It is mandated in California that the following instruments be used with all HRSO and non-HRSO parolees: the Static-99R (risk score), the SRA-FV (Structured Risk Assessment – Forensic Version), and the LS/CMI (Level of Service/Case Management Inventory). The Static-99 score is provided to the treatment providers by DAPO. All eleven contractors indicated that they administer both a version of the SRA and the LS/CMI at intake, and that scores on these instruments form the basis of an individual treatment plan, thus meeting contractual obligations. In addition to these tools, the Abel Assessment of Sexual Interest (AASI) is used at seven treatment locations.

At five locations, the mandated assessment tools are re-administered during the treatment program while reviewing the offender. At four locations, these tools are re-administered on an "as needed" basis (e.g., based on a change in the offender's clinical presentation or as requested by a parole agent).

All clinical directors reported that 100% of offenders who complete or are otherwise discharged from treatment will have a Discharge Assessment. Many providers have not performed Discharge Assessments, since they have not yet had parolees complete or drop-out of treatment. In general, the Discharge Assessment provides a summary of progress in treatment based on a file review and clinical judgment. One location (Region IV Location B) indicated that during the Discharge Assessment they would re-administer assessment tools (although they had yet to do so); two locations indicated that they re-score assessment instruments if scores are older than three months at time of discharge.

Psychological and psycho-physiological assessment

The contract provides a list of allowable assessment tools that includes psychological tests (e.g., tests of personality or intelligence) and inventory resources (e.g., tests of cognitive functioning or aggression). These instruments are not mandatory and in practice are rarely used by treatment providers. The exceptions were Locations B and C/D in Region IV (spanning two different contractors) that include instruments for measuring depression, anger, cognitive distortions, and drug and alcohol use. One clinical director commented that results from these instruments helped to determine "where clients were at" and identify issues (e.g., depression) that could be addressed during treatment.

Responsivity

Treatment providers use a range of strategies to adapt treatment in order to be responsive to the needs of clients with mental health, substance abuse, learning difficulties or other need areas. Several clinical directors commented that mental health and substance abuse needs are common in this population. When clients have mental health concerns, contractors collaborate with the DAPO POC to stabilize the client. For substance abuse needs, clients may be referred to an external program (e.g., Alcoholics Anonymous), in addition to incorporating substance abuse goals into their current treatment plan. For illiterate clients, treatment providers offer assistance with paperwork and oral instead of written assignments. It is common for clients to be treated on an individual-basis if they are assessed as being inappropriate for a group treatment setting. Several contractors also offer specialized groups, often with fewer offenders per group. Female offenders are treated individually (if low in numbers) or in a female-only group (if numbers permit).

Program completion, evaluation and effectiveness

All contractors have procedures in place for responding to an offender failing to appear for treatment. Immediate steps include documenting the absence, notifying parole, and attempting to contact the offender. In repeated instances, several contractors indicated that they establish an attendance contract with the offender, arrange a "containment meeting" with the parole agent, contact the parole Unit Supervisor, or suspend the offender from the program.[14]

Most treatment providers lack a mechanism for tracking offenders who successfully complete or drop-out of the program. As a consequence, most contractors do not know program and cannot compute completion rates or drop-out rates. Three contractors (Region II Locations D and E, Region IV Locations C/D) have a spreadsheet that tracks clients and captures the reasons for program termination. One contractor indicated that they would be able to collate this information from participant records (Region II Location A); one contractor (Region III Location A) said that they are developing a system for measuring this in the future.

[14] A containment meeting is a "collaborative effort establishing a mechanism of consistent communication with all involved parties, for the purpose of discussing case factors and progress for sex offender treatment".

Contractors do not know the long-term recidivism outcomes of program participants, since they have no knowledge of offenses committed after program completion. Four contractors commented on the recidivism rate of participants while in the program, stating that no new sexual offenses had been committed by participants (two contractors) or that recidivism rates were extremely low (two contractors).

Two locations reported that they have undergone a formal evaluation or review (Region II Locations D and E). However, this evaluation was of a parent program located in Maine and not the Californian program.[15]

Contractors were asked how they measured the effectiveness of their program in reducing sexual reoffending. Most noted that, although they were not measuring this in a formal way, anecdotal evidence included reoffending while in the program, program compliance and participation, improvement in societal functioning (e.g., life skills, relationships, employment, pro-social attitudes and non-distorted thought patterns, self-regulation), and abstinence from drug/alcohol abuse. Two locations also mentioned an improvement in progress reports and risk assessments.

Ten of the 11 locations provided follow-up treatment after discharge; six of these were on a fee-for-service basis, three were offered at no cost to the client, and one depended on the circumstances of the client (either fee-for-service or at no cost).

REPORT LIMITATIONS

This is the second report evaluating DAPOs contracted sex offender treatment programs and the first report to use the new *Legislative Report* as a data source. The major limitation of this evaluation was the short time period for which participant rosters were available (since March 2013), due to new contracting arrangements. In addition, the provision of treatment was impacted by realignment in that a number of lower level sex offenders were realigned to the counties and some parole offices were closed and/or consolidated. As a result, it is difficult to determine the extent to which treatment providers served the number of sex offender participants estimated for their site.

The brevity of the data collection period (from March through June, 2013) also meant that it was not possible to reliably examine program completions or program length. In addition, the participant roster data used for this report suffered from the following problems (solutions to which are discussed in the Next Steps section shortly):

[15] The Maine parent program was the subject of a Correctional Program Assessment Inventory (CPAI) review in 2007 by the Muskie School of Public Service, University of Southern Maine. It received a score of 71% (scores above 70% were rated as “Very Satisfactory”, the highest rating attainable).

- Missing data: treatment providers often left some fields blank, particularly with respect to dates and whether individual treatment plans were completed.[16] Corrective steps were taken during report preparation to obtain some, but not all, missing data. If these steps had not been taken then this report would have been further limited. In addition, if complete data were available a more extensive analysis of program characteristics would have been possible.
- Inconsistency across contractors: there was inconsistency in the manner in which contractors completed the *Legislative Report*; for example, some contractors ignored columns completely, added a column, used a variety of text to describe "reasons for discharge", or submitted the document in Microsoft Word format (instead of Excel).
- Data quality: during data analysis UCI found multiple cases of erroneous dates (e.g., a start date prior to a referral date, or multiple referral dates with obvious data entry errors) and during data matching there were approximately 30 incorrect CDC numbers (which may be a result of the offender providing the wrong CDC number or a transcribing error when completing the *Legislative Report*).

CONCLUSION

It appears that the contracted sex offender treatment program providers are serving the appropriate offender population, as all participants are required to register as sex offenders and most had a moderate to high risk to recidivate as assessed by the Static-99. We are unable to determine with certainty the extent to which treatment providers are meeting the service needs of sex offenders in the community (i.e., the number of sex offenders receiving treatment) due to (a) initial estimates of sex offender numbers being impacted by realignment (b) the closure/consolidation of parole offices (c) the short time period covered in this report, (d) funding for non-HRSO participants commencing in July 2013, (e) poor data reporting on behalf of the treatment providers using the *Legislative Report* form that was provided by DAPO, and (f) poor parolee tracking mechanisms on behalf of some contactors. However, it was not a requirement of the new contracts that contractors provide services to a minimum number of offenders. During interviews, many treatment providers indicated that they would like to receive more referrals, but that there was a state-wide shortage of qualified therapists.

We were unable to conduct a complete analysis of program characteristics based on participant rosters due, in part, to the lack of diligence with which some contractors completed the *Legislative Report* (a situation that is being rectified for future reports). Although we counted all 1,264 referred offenders as participants in this report, only 63.1 percent of these had a start date, indicative of treatment being provided.

Given the limitations listed above, interviews with clinical directors provided useful qualitative information on sex offender treatment services and established that providers met contractual obligations by conducting mandatory assessments, individual and group

[16] While clinical directors indicated during interviews that 100% of participants have individual treatment plans, only 15.1% of the sample had a treatment plan listed as completed in the roster data.

counseling, and polygraph testing. Treatment providers should benefit from the dissemination of this information.

NEXT STEPS

The UCI is collaborating with the Office of Research and DAPO to improve data collection procedures. The *Legislative Report* has been refined. It now includes clearer instructions for completion, the requirement that all fields be completed (such that none are left blank), and records whether offenders are in active treatment for that month. Additionally, treatment providers now keep a master roster that is appended with new clients each month (as opposed to submitting a new roster each month), which should facilitate the tracking of individuals over time. Also, contractors now submit one comprehensive roster that covers all sites, instead of a separate roster for each location within a site, which greatly reduces the number of rosters and the potential for duplication. DAPO has initiated data quality procedures and is reviewing submitted rosters every month and returning rosters to treatment providers if they contain omissions or errors. UCI will provide extensive feedback to DAPO on the data cleaning procedures used to prepare this year's report to determine if additional steps (e.g., the creation of a secure sex offender database, resources permitting) should be considered to further improve data quality.

A report on contracted sex offender treatment services will be provided in January 2015.

APPENDIX A
LEGISLATIVE REPORT

Parole Office	Referral to (Contractor's Name)	Referral Location	CDCR#	Parolee Last Name	Parolee First Name	Parolee DOB	Program Referral Date	Parolee Program Start Date	Individual Treatment Plan Completed?	Parolee Program End Date	Reason for Parolee Discharge

APPENDIX B

CDCR's CONTRACTED SEX OFFENDER TREATMENT EVALUATION
TREATMENT PROVIDER INTERVIEWS WITH CLINICAL DIRECTORS

Program characteristics

1. What is the maximum number of participants you can accommodate at this location?

    b. At this location, are your participants designated as HRSO, non-HRSO, or both?

    c. Are you currently operating at full capacity?

    d. Do you currently have a waiting list for entry into the program?

2. Do you accept all offenders referred by DAPO into the program or do you have eligibility restrictions?

3. On average, how many hours per week does a HRSO attend your program?

    b. How many hours for a non-HRSO offender? (if applicable)

4. Are HRSO treatments delivered in individual format, group format, or both?

    What percentage would you estimated is group work?

    What is your maximum group size?

Staffing

5. How many therapists are employed or on contract at this site?

6. Do you currently have any unfilled staff positions?

Program theoretical basis

7. Please name the primary theory or model upon which your program is based.

8. Please name specific evidence-based treatment practices that your program uses.

9. Please name any technology that your program uses for treatment.

Risk and needs assessment

10. Does the program include a pre-treatment risk and/or needs assessment of referred offenders?

    Please name all instruments that you use and whether it assesses risk, needs, or both:

    How do you use the scores on these instruments?

11. What percentage of your offenders has individual treatment plans?

12. When are treatment plans reviewed?

13. Do you perform interim risk/needs assessments during the course of the program?

    Are the same instruments used?

    At what point in an offender's program are they administered?

14. What percentage of offenders who complete/terminate/discharge from the program have a Discharge Assessment completed?

    Are the same risk/needs instruments used?

    How do you measure an offender's progress in treatment?

Psychophysiological and psychological assessment

15. Do you perform a psychological/psycho-physiological assessment at intake?

    Please name all measures/instruments that you use:

    To what extent do you adapt the treatment based on scores from these measures?

Responsivity

16. How do you handle clients who are illiterate or have other special needs (e.g., substance abuse/mental health)?

17. If females are accepted into the program, are they integrated with males?

Program completion, evaluation and effectiveness

18. What steps do you take if a referred offender fails to appear for treatment?

    b. How do you define and report a "no show"?

19. Do you measure the percentage of offenders who successfully complete the program?

    If so, are you able to provide us with this information?

20. Do you measure the percentage of offenders who are terminated or drop out of your program?

    If so, do you track the reasons for drop out/termination?

    If you do measure terminations, are you able to provide us with this information?

21. Do you know the rate of sexual recidivism of program participants?

    If so, what is the recidivism rate?

    How was the rate calculated and where was the information obtained?

22. Has your program undergone a formal evaluation or scientific review?

    If so, by whom, when, and is a report available?

23. How do you measure the effectiveness/success of your program at reducing sexual reoffending?

24. I realize that you are not contractually obliged to, but do you provide any after-care or follow-up services after discharge from the program?

    If you provide after-care or follow-up services, please describe:

Additional comments:

	Region II					
Program characteristics	**Location A**	**Location B**	**Location C**	**Location D**	**Location E**	**Location F**
1. Maximum number of participants at location	up to 220	182 slots: 53 HRSO; 129 non-HRSO	Not sure of the number of treatment slots in the contract	44 HRSO; 73 non-HRSO	28 HRSO; 70 non-HRSO	The equivalent of 80 clinical hours per week
Current HRSO and non-HRSO numbers	47 HRSO; 13 non-HRSO	Fewer than specified in the contract	25 HRSO; no non-HRSO	16-20 HRSO; approximately 5 non-HRSO	37 HRSO; 48 non-HRSO (received DAPO permission for increased HRSO)	10-15 HRSO; approximately 10 non-HRSO
Operating at full capacity?	No	Not at capacity of contracted numbers, but operating at capacity levels due to being short-staffed	No	No, haven't been getting many referrals, only started receiving non-HRSO referrals last 4-6 weeks	Yes	No
Is there a waiting list?	No	Yes	No. They have the clinical staff and are waiting for more referrals	No, although they are currently trying to fit some referrals into groups	Yes	No, trying to get more participants
2. Do you accept all clients?	Yes	Yes	Yes	Yes	Yes	Yes
Restrictions on eligibility	Provider has not rejected anyone thus far. If client has a low IQ or is psychotic, they receive individual therapy.	Only in rare instances - provider may delay entry if client has pressing mental health issues. Client is re-referred to DAPO until stabilized on medication before re-entering program.	It is rare that someone is not appropriate for treatment. Referrals denied on two occasions only.	All referrals are accepted for assessment. If not appropriate for group, they are seen individually. If not a good match for treatment, referred back to Parole/POC.	All referrals are accepted for assessment. If not appropriate for group, they are seen individually. If not a good match for treatment, referred back to Parole/POC.	Previously, accepted all referrals but currently have a client who is too mentally ill (who is now in jail) with a S/A problem, not taking medication and is a menace, so not accepting this client.
3. Average # hours HRSO attends per week	Two 1.5 hour group sessions per week, plus a one-hour individual session per month	Two 1.5 hour group sessions per week, plus a one-hour individual session per month	Two 1.5 hour group sessions per week, plus one-hour individual session per month	3 hours of group per week, plus 1 hour individual per month (but provider works with parole if they need more)	3 hours of group per week, plus 1 hour individual per month (but provider works with parole if they need more)	3.5 to 4.0 hours per week
Average # hours non-HRSO per week	One 1.5 hour group session per week, plus 1 hour individual session per month	One 1.5 hour group session per week, plus 1 hour individual session per month	N/A	Ninety minutes of group per week, individual treatment as needed	Ninety minutes of group per week, individual treatment as needed	1.0 to 1.5 hours per week
4. Format of HRSO treatments delivered	Both individual and group	Both individual and group	Both individual and group	Both individual and group	Both individual and group	Both individual and group
Maximum group size	Try not to go over 8, but if people change groups then may go to 10. Aim for 6-8.	With 1 facilitator, max is 9. With 2 facilitators, max is 11.	8	9	9	8
Staffing						
5. Number of therapists employed/on contract	2 psychologists, 2 social workers plus clinical director (all licensed)	11 total staff (F/T and P/T). One LCSW and the remainder of staff are psychologists	2 MFT, 1 LCSW (plus polygrapher)	2 LMFTs, 1 social worker	1 LMFT, 1 MFT intern, 1 social worker, 1 psychologist / clinical supervisor	4 P/T social workers, 1 P/T psychologist, 1 F/T MFT
6. Number of current unfilled positions	Looking for 1 other therapist, depending on number of referrals	3 full-time staff (to cover several locations)	2 new positions, but need more referrals in order to fill them	Actively seeking to hire/train add'l staff. Would like to operate at capacity, would require 5-6 P/T positions to do so	Actively seeking to hire/train add'l staff	1 F/T, but difficult to get qualified staff

	Region II					
Program characteristics	**Location A**	**Location B**	**Location C**	**Location D**	**Location E**	**Location F**
Program basis						
7. Primary theory/model of program	CBT and Good Lives Model	Psychodynamic, CBT	CBT, and some aspects of the Good Lives Model. Maslow needs (housing, security, job) and primary needs from RNR model	RNR focus utilizing CBT/psycho-educational approach, Containment Model	RNR focus utilizing CBT/psycho-educational approach, Containment Model	CBT is the major theoretical orientation
8. Specific evidence-based practices used	CBT, relapse prevention (wellness plan), risk assessment with static & dynamic factors	Containment Model, RNR, CBT, psycho-education, relapse prevention, trauma-focused work	CBT, relapse prevention plans, tailored treatment plans, primary needs	RNR	RNR	Thinking for a Change, Good Lives Model, other CBT approaches
9. Technology utilized for treatment	Polygraph testing, ABEL assessment	Polygraph testing, ABEL assessment	Clinical polygraph, PPG	ABEL, polygraph, assessment and management tools, confidential case file database, online billing system	ABEL, polygraph, assessment and management tools, confidential case file database, online billing system	Polygraph, ABEL assessment (does not use PPG)
Risk and needs assessment						
10. Pre-treatment risk/needs assessment instruments used	ABEL, Stable-2000, ACUTE, SRA, LS/CMI	Pre-treatment interview assessment done (to determine if group appropriate / pscyh. referral needed). Full intake assessment at 3 months (due to staffing): LS/CMI, SRA-FVL	STABLE, ACUTE, LS/CMI, SRA-FVL, Static-99 provided, plus an alcohol/drug assessment	SRA-FVL, LS/CMI, Static-99R, Risk Matrix 2000, polygraph, AASI-2 as indicated	SRA-FVL, LS/CMI, Static-99R, Risk Matrix 2000, polygraph, AASI-2 as indicated	Clients come in with Static-99 score. Provider adds LS/CMI, SRA to identify risk factors
11. What % of offenders have individual treatment plans?	100%	All clients have an informal treatment plan, in that they have treatment goals and progress recorded. But a formal treatment plan does not get submitted to parole.	100%	100% within first three months	100% within first three months	100%
12. When are treatment plans reviewed?	HRSOs reviewed every 3 months, all others reviewed every 6 months.	N/A	This is fluid. Contractor every month spends time reviewing the relapse prevention plan. Every 6 months, treatment plans are reviewed formally.	Reviewed and updated every 6 months	Reviewed and updated every 6 months	Every 3 months
13. Interim risk/needs assessments during the program?	Yes	Not currently, will do so in the future when they transition from the SRA-FVL (not sensitive to changes and hence cannot be re-scored) to the STABLE 2007	No	Re-administer SRA, LS/CMI	Every 6 months with treatment plan update	Yes
(If yes) Are the same instruments used?	During treatment review use same instruments as at intake - SRA, dynamic and acute risk.		Sometimes the ACUTE is used again (or PPG), but this is rare.	Yes, but ABEL assessment is not performed again unless clinically indicated.	Yes, but ABEL assessment is not performed again unless clinically indicated.	Will use MSI II and ABEL, but since the contract is new have not yet done re-assessment.

	Region II					
Program characteristics	**Location A**	**Location B**	**Location C**	**Location D**	**Location E**	**Location F**
14. What % of offenders who complete/terminate/discharge have a Discharge Assessment (DA)?	All who successfully complete the program	100%	100% of those who reach 18 months of treatment	100% if they are leaving for significant amount of time (violation) or if being discharged	100% if they are leaving for significant amount of time (violation) or if being discharged	None yet; have not had anyone discharge yet
(If yes) Are the same instruments readministered in the DA?		Unsure what is in the Discharge Assessment, due to the new contract.	DA is generally a summary/review of what has happened in treatment, and does not involve assessments. Apart from clients returned to custody, the contractor has not encountered drop-outs, so no DAs have been completed to date.	Yes. If assessments have not been scored within the last 3 months, should be rescored for DA.	Yes. If assessments have not been scored within the last 3 months, should be rescored for DA.	
(If yes) How is treatment progress measured?		In the future, by using the STABLE 2007, but this is not currently done using assessment tools		Monthly RULE progress report, dynamic risk assessments, treatment plan updates, containment team meetings	Monthly RULE progress report, dynamic risk assessments, treatment plan updates, containment team meetings	
Psych/physiological assessment						
15. Psychological/psycho-physiological assessment instruments used at intake	Not at this stage, but later if needed	ABEL done at intake	PPG and polygraph; offender already tested for core psychological history. Other psychological tools are not helpful for this population.	ABEL assessment for Sexual Interest (AASI)	ABEL assessment for Sexual Interest (AASI)	Using only tools specifically designed for sex offenders, so no personality testing
Responsivity						
16. How are illiterate clients or those with other special needs handled?	**Mental health:** Collaborate with psychiatrist & DAPO, monitor medication, symptoms, behavior. If deterioration, DAPO called. **Substance Abuse:** Referred to outside program in addition to provider's S/A program. **Deaf:** Interpreters provided. **Illiterate:** Receive help with homework / paperwork.	**Mental health:** Individual treatment if client is not group-appropriate, or additional individual treatment sessions. **Substance Abuse:** Client also receives early recovery S/A program, and abstinence becomes part of their treatment goals. **Illiterate:** Client receives help with homework.	**Mental health**: Ensure they stay on their meds if they are CCCMS. Requires a judgment call whether the meds are something they need now or something taken in prison to help them sleep/get through the day. May refer clients back to parole psych. **Substance abuse:** Encourage 12-step meetings. If chemical dependency issue, the contractor provides a specialized group.	**Mental health:** Sometimes referred to POC. If not appropriate for group, then individual treatment given. **Substance Abuse:** Referred to programs such as AA/NA. **Illiterate:** Audio CD with assignments completed orally at home, presented orally in treatment. Add'l individual sessions as needed. ABEL-BLASINGAME used if intellectual disabilities are present. May use Spanish-speaking therapists if ESL.	**Mental health:** Sometimes referred to POC. If not appropriate for group,then individual treatment given. **Substance Abuse:** Referred to programs such as AA/NA. **Illiterate:** Audio CD with assignments completed orally at home, presented orally in treatment. Add'l individual sessions as needed. ABEL-BLASINGAME used if intellectual disabilities are present. May use Spanish-speaking therapists if ESL.	**Substance Abuse / Mental health:** Most have these issues. Provider tries to cooperate with parole agent to get MH treatment but it is difficult due to rural location. Many don't get Medi-Cal and have no income; may be better off in RTFs but often aren't accepted due to restrictions. **Illiterate:** Info is read to them.
17. What about female offenders?	No females	No females	No females	Females are generally seen individually unless there is a female-only group.	Females are seen individually unless there is a female-only group.	No females

	Region II					
Program characteristics	**Location A**	**Location B**	**Location C**	**Location D**	**Location E**	**Location F**
Program completion, evaluation and effectiveness						
18. What steps do you take if a referred offender fails to appear?	System - parole notified. Client contacted by phone if tardy or no-show.	"Status alert" sent to agent along with additional information (e.g., whether the client called). Maximum of 3 unexcused absences - if 4th, client gets attendance contract recognizing the client may be terminated, and a containment meeting with the parole agent.	Monthly report produced of meetings missed. Internal policy of 100% attendance. Offender can miss 2 appointments per cycle with an excuse but they must make these up (unless they are in jail).	Immediate notification to parole. If this continues, non-compliance report sent. Discuss course of action at containment meeting. If not attending, we attempt to "stay in struggle", but eventually will suspend from program and alert parole.	Immediate notification to parole. If this continues, non-compliance report sent. Discuss course of action at containment meeting. If not attending, we attempt to "stay in struggle", but eventually will suspend from program and alert parole.	Offender is called, sometimes the next day (if the offender has a number). Fax to DAPO for failure to appear. If no response from DAPO, follow up with email to DAPO.
How do you define/report a 'no show'?	No show: doesn't call and doesn't appear.	Two types: (1) No show - no contact from client, or (2) late cancellation marked as an unexcused absence	Monthly report is sent to DAPO. Use sign-in sheets that record (in/out) for every service.	Reported via phone or email within 24 hrs, generally following a missed session. All absences are recorded. An absence is a "no show" if they did not inform the provider at least 24 hours before session. Parole can excuse absence, but it is still noted as an absence.	Reported via phone or email within 24 hrs, generally following a missed session. All absences are recorded. An absence is a "no show" if they did not inform the provider at least 24 hours before session. Parole can excuse absence, but it is still noted as an absence.	Reported same as failure to appear. No show is defined as one who doesn't appear at the scheduled appt on time, or has a late cancellation. Both are reported on a form to DAPO.
19. Do you measure the % of offenders who successfully complete the program?	No. Provider hasn't calculated this but could probably get this from participant records.	No, due to the newness of the contact. No client has had the opportunity to complete treatment yet. The provider noted that they did not record this information under the previous parole contract	No, provider is just getting started. No resources for research.	Client files & monthly RULE progress reports identify those who successfully complete the program objectives. Provider can collate results, but it is too early to do so because none have completed yet.	Client files & monthly RULE progress reports identify those who successfully complete the program objectives. Provider can collate results, but it is too early to do so because none have completed yet.	Have not had completers yet.
20. Do you measure the % of offenders who terminate/drop-out?	No. Provider hasn't calculated this but could probably get this from participant records.	No	Have not had any drop-outs so far.	Provider has an activity roster tracking system to record terminations and drop-outs, and reason for drop-out. This information is available.	Provider has an activity roster tracking system to record terminations and drop-outs, and reason for drop-out. This information is available.	Not really had anyone drop-out/terminate. Offenders are referred to them who live 1.5 hours away, with no means of transportation (there is a bus service but expensive). Some offenders are therefore seen once but not again - there's an understanding with parole that they cannot get to treatment so treatment is not a requirement.
21. Do you know the rate of sexual recidivism of participants?	Low so far. Know of one case of a new sexual offense committed by a participant in the program. Provider doesn't know recidivism rate after program completion.	No	No, provider cannot measure the true effectiveness because no information is provided once the offender has left the program. Provider would like to measure this.	Not for this specific program, provider generally reviews this further into the contract.	Not for this specific program, provider generally reviews this further into the contract.	There is no recidivism that we know of; none accused of offense.

	Region II					
Program characteristics	**Location A**	**Location B**	**Location C**	**Location D**	**Location E**	**Location F**
22. Has the program undergone a formal evaluation/scientific review?	No	No	No	Yes	Yes	No
Details	Expecting audit from CDCR	Has undergone a CDCR audit		Independent audit by Muskie Institute, 12/17/2007 (copy supplied)	Independent audit by Muskie Institute, 12/17/2007 (copy supplied)	
23. How do you measure the effectiveness/success of your program at reducing sexual reoffending?	Reoffense while in program, compliance with program & DAPO, level of program participation, improvement in life skills, abstinence from drugs/alco, getting a job, takes responsibility, prosocial attitudes	Not measuring it in a formalized way, but therapists note whether clients improve. Would like to measure this but needs add'l funds.	If provider knew the recidivism outcomes they could measure this; evaluating effectiveness is impossible without this information	Effectiveness measured by client's progress on the RULE progress report, risk assessments, reduction in overall recidivism, and successful life adjustment in relationships, work, support network, general self-regulation	Effectiveness measured by client's progress on the RULE progress report, risk assessments, reduction in overall recidivism, and successful life adjustment in relationships, work, support network, general self-regulation	Success is when parole is completed, client is stable, leads a satisfying and productive life, and has a better life than when they started. Hard to measure effectiveness-no data given to them post-completion of the program.
24. After-care or follow-up treatment after discharge?	Yes	No	Yes	Yes	Yes	Yes
(If yes) Please describe:	Clients are invited to come back and attend groups without charge if they need to.	Under previous contract, this was done on a voluntary basis; clients paid reduced fees to stay in program.	Currently have some parole clients attending once a month after discharge, free of charge. It provides a form of fellowship. It's a good sign when offenders attend treatment voluntarily - linked to lower rates of recidivism.	Particpation in continued services is encouraged to clients with treatment plans and risk scores indicating further treatment would be beneficial. Clients would be responsible for a differential participation fee, and special agreements for testing/risk reporting.	Following discharge, if a client chooses to continue with the program, they are invited to do so. They are responsible for a differential program fee. This is always offered and encouraged for those who wish ongoing support and work on areas continuing to present risk.	Follow-up care is always offered, sometimes fee for service and sometimes pro bono, depending on the circumstances

	Region III		Region IV		
Program characteristics	Location A	Location B	Location A	Location B	Locations C/D
1. Maximum number of participants at location	Approximately 400	Approximately 200	At least 500 (not sure of exact number)	450	600 client hours
Current HRSO and non-HRSO numbers	Approximately 200: 85% HRSO; 15% non-HRSO	30 HRSO; 16 non-HRSO	70% HRSO; 30% non-HRSO	approximately 1/3 HRSO; 2/3 non-HRSO (not sure of current numbers)	182 HRSO; 133 non-HRSO
Operating at full capacity?	No, due to a staff shortage. Looking to increase space to add extra capacity.	No	Not operating at full capacity but doing the maximum they can handle due to staff shortage.	No	No, not in terms of space, but at capacity due to staff shortage.
Is there a waiting list?	Yes	No	Yes	Yes, but not due to capacity issues. Contractor has difficulty contacting clients/gaining cooperation (some parole agents have not informed offenders they must attend treatment, leading to resistance).	No, but had to slow down referrals for non-HRSO.
2. Do you accept all clients?	Yes	Yes	Yes	Yes	Yes
Restrictions on eligibility	No predetermined restrictions but if client has significant mental health, substance abuse, language difficulties or behavioral problem, they may be referred to DAPO for re-evaluation and can return to treatment later.	All referrals are accepted, however if client has significant MH disability, they may be sent back to parole. If unsuitable for group, then individual treatment used. Provider has not sent anyone back yet (there is a mechanism in place but they have not had to use it).	After a client enters the program, if MH problems are significant they may be temporarily returned to DAPO for medication management.	If actively psychotic or dangerous (threatening harm), they are returned to parole. If psychotic, they are treated individually only.	If a client refuses to sign their agreement then they are returned to parole, but there are no other restrictions on who gets accepted into the program.
3. Average # hours HRSO attends per week	Two 1.5 hour group sessions per week, plus 1 hour individual session per month (may be increased / decreased on case-by-case basis)	3 hours of group per week	Two 1.5 hour group sessions per week, plus 1 hour individual session per month	3 hours per week	3 hours per week
Average # hours non-HRSO per week	One or two 1.5 hour group session(s) per week, plus 1 hour individual session per month	1 hour of group per week	One 1.5 hour group session per week, plus 1 hour individual session every three months	1.5 hours per week	1.5 hours per week, plus one individual session at a minimum every quarter
4. Format of HRSO treatments delivered	Both individual and group	Both individual and group	Both individual and group, unless severe MH problems -then individual treatment only	Both individual and group, unless severe MH problems - then individual treatment only	Both individual and group. Some clients are not appropriate for group work and are seen individually.
Maximum group size	9	Target is 9 but average is 7-10	9	9	9
Staffing					
5. Number of therapists employed/on contract	4 licensed clinicians, 6 unlicensed clinicians (operating under the licensed clinical staff), plus 9 other treatment staff (interns, practicum students)	2 psychologists, 1 MFT	2 psychologists, 1 MFT, 2 unlicensed post doctoral psychologists	13 staff (mixture of psychologists, MFTs and LCSWs)	3 psychologists, 4 MFTs, 3 psych. assistants, 10 interns (unlicensed associate positions)

	Region III		Region IV		
Program characteristics	**Location A**	**Location B**	**Location A**	**Location B**	**Locations C/D**
6. Number of current unfilled positions	4 clinical staff	3 staff, but there is a state shortage	3 psychologists	When contractor becomes full contingency (more referrals) will need 3 extra staff	2 psychologists and 1 psych. assistant. Would possibly hire more if staff were available
Program basis					
7. Primary theory/model of program	RNR, CBT, accepted principles of correctional programming	CBT	Mixture of models but CBT is the foundation. RNR principles focus on dynamic risk factors.	CBT and Good Lives Model	CBT
8. Specific evidence-based practices used	RNR assessments, frequency and intensity of treatment matched to needs and tailored to client (responsivity)	Provider does not believe that evidence-based treatment practices exist, other than evidence-based assessment instruments. Provider is not aware of any empirically proven treatment modalities.	Good Lives Model, self-designed CBT/RNR model	CBT	Dynamic, stable risk factors
9. Technology utilized for treatment	Polygraph, ABEL assessment, audio-visual for group work	None	Polygraph testing, ABEL assessment, DVDs, PowerPoint presentations	Polygraph, computers, fax, email, videos/DVDs	Polygraph testing, ABEL assessment, other individual tests as needed (does not use PPG)
Risk and needs assessment					
10. Pre-treatment risk/needs assessment instruments used	LS/CMI, SRA, ABEL, Static-99	LS/CMI, SRA, SOTIPS, SORAG	SRA, LS/CMI, ABEL, plus a rubrik to determine risk score	SRA-FV, LS/CMI, Beck Depression Inventory, MAST, DAST, Novaco Anger Scale, ABEL, Becker Cognition Scale, Bumby (Cognitive Distortions Scale, Rape Scale)	ABEL, LS/CMI, SRA-FVL, sex history questionnaire, Beck Depression Inventory
11. What % of offenders have individual treatment plans?	100%	100%	100%	100%	100%
12. When are treatment plans reviewed?	Plan created at program start, and then reviewed quarterly.	Every 6 months	Every 3 months and a key internal assessment at 6 months	At intake, then every 3 months	Every 90 days, although they are re-examined weekly during formal staff meetings and if treatment issues arise
13. Interim risk/needs assessments during the program?	Assessment tools are not usually re-administered mid-program, but if the client is HRSO, problematic, or agent requests it, then may use tools for reassessment.	Yes	On occasion do re-administer an instrument (probably the SRA) if a violation, RTC, or a major life change.	Yes, as needed. Offenders with high scores may be monitored and reevaluated in problem areas. Assessments also repeated when client undergoes change in presentation during treatment.	Yes, as needed.
(If yes) Are the same instruments used?	Not usually	Provider uses at least one assessment tool (e.g., the SRA) because clients may not be 100% truthful at intake and treatment reveals certain tendencies. Add'l info is collated from parole, group sessions, and individual sessions.	SRA readministered because it can measure change. In future will be using the STABLE and ACUTE; the ACUTE looks at the last 30 days and is more appropriate for readministration	Same instruments	SRA readministered at 6 months

	Region III		Region IV		
Program characteristics	**Location A**	**Location B**	**Location A**	**Location B**	**Locations C/D**
14. What % of offenders who complete/terminate/discharge have a Discharge Assessment (DA)?	100%	100%	100%	100% will be, but have not had anyone terminate yet under the new contract	100%
(If yes) Are the same instruments readministered in the DA?	May reassess using the same instruments, based on clinical judgment.	DA includes a summary of progress. Often don't get a lot of advance notice of a client terminating (some clients are secretive about their parole discharge date) so they most often work with what they have on file already.	The DA provides a summary of the treatment received and what happened in treatment.	Yes, same instruments as before.	The DA includes a summary of progress in treatment without re-assessment using instruments.
(If yes) How is treatment progress measured?	Observable and measurable goals, self-report disclosure to clinical staff, polygraphs, changes in assessment scores		Provider is developing a statistical system for measuring progress. Currently based on observed behavioral changes during treatment, key goals, overall client improvement.	Offenders with high scores will be reevaluated in problem areas.	
Psych/physiological assessment					
15. Psychological/psycho-physiological assessment instruments used at intake	A self-developed assessment that includes psycho-social factors and incorporates SRA, LS/CMI, ABEL, Static-99 items	In addition to the LS/CMI and SRA they use the SOTIPS and SORAG	ABEL assessment	SRA-FV, LS/CMI, Beck Depression Inventory, MAST, DAST, Novaco Anger Scale, ABEL, Becker Cognition Scale, Bumby (Cognitive Distortions Scale, Rape Scale)	Beck Depression Inventory. Plan on using the BRIEF-A test of executive functioning soon
Responsivity					
16. How are illiterate clients or those with other special needs handled?	**Mental health or Substance Abuse:** Referred to agent. Others have treatment tailored to needs (increased / decreased intensity of treatment). Program is simplified if needed. Clients are seen individually if not suitable for group work. Consult with agent if necessary.	**Illiterate:** Provider reads assessment if needed, acknowledges that client has understood, goes slowly. If not suitable for group, they give more individual treatment. If a client is non-responsive to treatment or low-functioning they are assigned to smaller group (6 or fewer) where they do better.	Special groups provided to those with special needs (mental health issues, literacy) to help them function better. If severe, then client is referred to parole until stabilized and can return.	**Mental health:** For those with psychological needs or who are on medication the provider speaks with their psychiatrist to make sure they are on the same page. **Substance Abuse:** Many clients have substance abuse needs which are dealt with during the treatment plan phase. If necessary, clients attend substance abuse program as well. All clients undergo random drug tests.	**Mental health or mental disability:** Follow a step-by-step procedure; slow; avoid abstractions. **Substance Abuse:** If a client is intoxicated they are excused from group; may refer them to parole substance abuse program. **Illiterate:** Help them complete packets; there are no take-home written assignments.
17. What about female offenders?	Run female-only groups	Females are seen on an individual basis due to their small numbers	Currently only a small number of females; individual treatment provided. In the past, provider had more females so they had female-only group sessions.	Run separate groups for females	Currently have a small number of females. There is a female-only group.

APPENDIX C: REGIONS III & IV

	Region III		Region IV		
Program characteristics	**Location A**	**Location B**	**Location A**	**Location B**	**Locations C/D**
Program completion, evaluation and effectiveness					
18. What steps do you take if a referred offender fails to appear?	"Status alert" sent to agent via email. It is always documented if a client is a no show or called (the reason for absence is also documented). If this becomes problematic then the parole Unit Supervisor is involved.	Attempt to contact the client. Fellow members of the group will also attempt to contact. As a last resort, a notice of failure to attend is sent to the agent of record (AOR).	Follow a process. A status alert is emailed to agent of record (AOR). Phone client to follow-up.	Contact parole, usually by email unless there is a major concern. In that case, parole is contacted by phone.	Contact parole agent and supervisor. If it becomes a pattern then we establish an attendance contract for the client to sign.
How do you define/report a 'no show'?	Does not appear for scheduled treatment	We provide cell phone numbers of therapists to all clients. If the client does not call, that's the first sign of a problem. Sometimes a client will call their agent but not the therapist. If the client does not answer their phone then we contact their agent via email.	When there is an established appointment a no-show is someone who didn't attend treatment and didn't call to notify, or who arrived late for treatment.	Contact parole agent.	The same way. They track it and notify parole
19. Do you measure the % of offenders who successfully complete the program?	No, not currently, although the provider is developing a system for measuring this in the future.	No	No. This is challenging. If clients go back to prison after completing the program then providers do not get this information from CDCR. Moving forward, the definition of "successful completion" should be more clearly defined (sexual offenses only? within what time period?)	New contract - haven't had anyone complete the program yet	Yes, informally, via an excel spreadsheet that tracks clients. But the contract only started in May.
20. Do you measure the % of offenders who terminate/drop-out?	No. It is difficult to define a 'drop out' - a client may terminate for a variety of reasons (in custody, not amenable to treatment, cut off GPS and disappeared, etc). Often the provider does not have this information from parole, or it takes a long time to receive the information from parole.	No. There is always a possibility that a client will return to the program. Provider may look at these numbers at the end of the contract. Provider has terminated only one client to date; if agent strongly recommends the client returns to treatment, then client is reaccepted.	Not measured per se. Just began sending off a no-show report, in addition to the Legislative Report. This is an area they will probably need to measure but there is no mechanism as yet.	To date only one temporary termination due to RTC, but offender returned to treatment upon release. Have not yet had termination under new contract.	Yes. An excel spreadsheet tracking clients records the reasons for leaving the program.
21. Do you know the rate of sexual recidivism of participants?	No, but the provider would like to know this information. The provider noted that the 'best' participant outcomes were associated with parole agents who were responsive and communicative.	Lower than the national average. Under the current contract no individual has reoffended sexually.	Not at all. If an offender returns to prison the provider is not notified, yet this is key information for them to know.	No	Yes. Matches the California average of 3%. It is difficult to know because we don't have access to files after a client leaves the program. But they know the number of people who violate while in treatment and these rates are low.

	Region III		Region IV		
Program characteristics	**Location A**	**Location B**	**Location A**	**Location B**	**Locations C/D**
22. Has the program undergone a formal evaluation/scientific review?	No	No	No	No	No
Details	Expecting audit from CDCR		CDCR audit	In the future, an audit by DAPO is expected	
23. How do you measure the effectiveness/success of your program at reducing sexual reoffending?	Provider does not measure this currently, but is putting a system in place to track incarcerations / violations etc.	Simple calculation: how many clients who completed the program have reoffended sexually? So far, in this location it's zero. Provider is sure this is lower than the national average.	This is the biggest area for improvement. As a clinician we look at the client to see whether they have met goals identified in the treatment plan, e.g., improved social skills, intimacy, relationships, friendships. There is no reliable way of measuring this - it's based on clinical judgment.	New contract-hasn't gotten that far yet. With other (non-parole) offenders, effectiveness is measured by clean polygraphs, clean drug tests, participation in group, non-distorted thought patterns, positive societal functioning.	A complex question. There's a difference between reoffending sexually, a criminal (non-sexual) offense, or a technical violation. We look at what gains were made in self-regulation, progress in treatment, functioning as an individual.
24. After-care or follow-up treatment after discharge?	Yes	Yes	Yes	Yes	Yes
(If yes) Please describe:	Provider offers continuing treatment/maintenance after discharge. Recommended to all participants. Fee for service.	As part of the standard client agreement ongoing treatment is provided as needed; this is how they have always done business. No fee to client.	Run maintenance groups on a fee-for-service basis that are open to anyone. Not a large percentage of clients continue - perhaps 10% of completers come once a month.	If offender desires, they may continue treatment on a fee-for-service basis, but to date have no parole completers	We always offer follow-up treatment on a fee-for-service basis using a sliding scale. Historically have only had a few clients return for a maintenance group but some attend for years.

Region II			Region 3		Region 4		
Location B	Location C	Location F	Location A	Location B	Location A	Location B	Locations C/D
There is a lack of thoughtfulness regarding which offenders need treatment; parole is administering the Static 99 to too many offenders (even offenders whose sex offense was 40 years ago). This causes people to be funneled into treatment based on erroneous information. Another issue was the lack of resources to examine the effectiveness of treatment. They would like to have more information regarding effectiveness, and would like to participate in research. Homelessness was a huge concern, due to their location (i.e., an urban environment) and local sentencing practices (judges are not giving stays to housing restrictions on sex offenders).	Parole was doing a good job. However, parole was not as actively involved as they could be. Probation officers are actively involved in case consultation, regularly attending meetings with the client/therapist. Since their original contract a few years ago, parole has lost some good agents; now there is a wide range of parole agents. They make additional effort to accommodate clients who work, by having groups early morning or on Sundays. Clients are receptive and supportive. Parolees may not have experienced this kind of support previously; some are wary at first but then receptive to treatment. Hopefully other locations are having the same positive experience with parole clients.	Discussed the "larger, systemic problem" of sex offender reentry. Homelessness (due to residency restrictions placed on sex offenders), difficulty in finding a job, substance abuse problems (due to residential programs not accepting sex offenders), and getting health insurance all interfered with the benefits of sex offender treatment. Offenders would benefit from a case management approach; it was problematic that resources were so limited.	They have suffered a slow start to the contract, and inconsistency in the number of referrals. Their knowledge of what referrals were coming in was limited, so they had to respond only as things came in: a 'fits and starts' approach. It would help if the provider knew in advance what was coming in.	How to measure or define success; provider prefers the definition "reoffending of a sexual nature". They were pleased to be involved in this evaluation process. Regarding 'evidence-based practices' - there are many different treatment methods used on clients. They would be interested to know what is meant by this, since in their view, this term is mostly applied to the validation of assessment tools, rather than techniques. Parolees are different from non-parolee clients. At first, parolees are resistant to treatment. They would be curious to see how parolees perform in a group with non-parole clients.	They used to be a 'mom and pop' provider, with a maximum of 60 clients. Under the new contract they potentially have 700-800 at three clinics: this creates the "potential for chaos".	Parole has been "absolutely incredible" - as good as any organization could be - and that they had no complaints.	New contracts were rolled out rapidly.