

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



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DEPARTMENT OF CORRECTIONS AND REHABILITATION

JEFFREY A. BEARD, Ph.D.
Secretary

DIANA TOCHE, D.D.S.
Undersecretary (A), Administration & Offender Services

BRYAN BEYER
Director,
Division of Internal Oversight & Research

WAYNE BABBY
Deputy Director (A),
Office of Research

DENISE ALLEN
Research Manager III (A)
Research and Evaluation Branch

DIONNE MAXWELL, Ph.D.
Research Manager II (A)
Research and Evaluation Branch

ASHLEY GABBARD
Staff Services Analyst
Research and Evaluation Branch

Distributed by the:

CDCR Research and Evaluation Branch
1515 S St., Suite 221-N, Sacramento, CA 95811
(916) 323-2919
www.cdcr.ca.gov/offices/research/index.html

EXECUTIVE SUMMARY

California Penal Code Section 3007 requires a research component for any contracted sex offender treatment funded by the California Department of Corrections and Rehabilitation (CDCR). Eventually, the effectiveness of each program, including both institutional and community-based treatment, will be evaluated for its ability to reduce recidivism rates among participants. The Office of Research is providing a status report on current contracted sex offender treatment programs for Fiscal Year (FY) 2011-2012.

To date, sex offender treatment programs have not been implemented in CDCR's Division of Adult Institutions, although an in-prison sex offender treatment program is planned for FY 2013-14.

The Division of Adult Parole Operations (DAPO), however, has continued contracting for community-based treatment. In FY 2011-12, DAPO oversaw six contracts for outpatient high-risk sex offender treatment programs located across all four parole regions in California. Each contractor oversees between three and four program sites within each region. The programs provided by each contractor are intended to serve a total of 600 high-risk sex offenders, with an 18-month designed length of stay. The funding for these contracts is \$3.9 million annually (from June 1, 2010 through June 30, 2013). When one parolee leaves the provider (e.g., was discharged from parole or violated parole and was returned to custody), the slot becomes available to another parolee. Therefore, it is expected that the providers are potentially able to provide treatment services to more than 600 individuals, or more than 100 offenders per program site, by the end of the 3-year period.

During FY 2011-12, five of the six contractors reported treating the number of high-risk sex offenders specified in the contracts (i.e., 100 per contractor per year), while the remaining contractor reported treating 92 high-risk sex offenders during the same time period. A total of 1,125 high-risk sex offenders received treatment from these DAPO-funded treatment providers. An examination of basic demographic and offender characteristics of the offenders who received treatment revealed that overall:

- All of the offenders receiving treatment were male.
- Nearly three-quarters of the sample were re-releases (74.5 percent) and one-quarter were first-releases (25.5 percent).
- Over half of the offenders were ages 45 or older (54.2 percent) and very few were ages 24 or under (2.0 percent).
- Most offenders were Black/African American (38.7 percent), followed by White (32.6 percent), and then Hispanic/Latino (23.2 percent).
- The majority of participants were committed to prison for crimes against persons (70.8 percent), followed by drug crimes (11.8 percent), property crimes (10.6 percent), and other crimes (6.5 percent).

- Nearly two-thirds of the total population was identified as having committed a serious/violent crime (64.9 percent).
- As intended, all of the offenders have a sex registration requirement.
- Most offenders had served determinate sentences for their most recent prison stay (72.4 percent).
- Many offenders had a moderate CSRA risk score (62.8 percent), followed by high (32.8 percent) and low (4.4 percent).
- About 86 percent of the participants had a Static-99 score that met CDCR criteria to be designated as a high-risk sex offender.

The information provided by the contractors and DAPO suggest that the services being provided to offenders through DAPO's contracted high-risk sex offender treatment programs are targeting the appropriate offender population since the treatments are largely being directed towards moderate- to high-risk sex offenders, as designed.

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INTRODUCTION

California Penal Code (PC) Section 3007 requires the California Department of Corrections and Rehabilitation (CDCR) to 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 covers the period for FY 2011-12.

BACKGROUND

Currently, California does not offer in-prison treatment for sex offenders. In 2007, the California Sex Offender Management Board contracted with researchers from Colorado to develop a proposed in-prison treatment plan.² Based on recommendations outlined in this proposal, CDCR's Division of Rehabilitative Programs (DRP) plans to implement a small, in-prison sex offender pilot program in FY 2013-14. According to the project blueprint for sex offender treatment released by DRP:

CDCR proposes developing services for incarcerated sex offenders, a very difficult subpopulation to program safely in prisons. CDCR intends to evaluate national best practices to develop a pilot and to implement the model at one institution beginning FY 2013-14. Treatment will follow evidence-based practices, using individualized treatment plans that focus on issues such as strength and skill building, emotional regulation, and developing appropriate relationships. The specific institution will be selected once the model is developed and the target population is identified.

This report provides an update on the status of community-based sex offender treatment contracts for FY 2011-12 and presents program participant information, including offender demographics, and program characteristics.

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

² <http://www.casomb.org/docs/SOMBReport1.pdf>.

CDCR CONTRACTED SEX OFFENDER TREATMENT PROVIDERS

In FY 2011-12, the DAPO oversaw six contracts for outpatient sex offender treatment programs. The term of each contract was from June 1, 2010 through June 30, 2013. Total funding for all contracts over the three-year period was approximately \$3.9 million, annually.

The 22 outpatient sex offender treatment program sites funded during FY 2011-12 are located across all four parole regions statewide. Table 1 presents the contract providers operating in each region. The Counseling and Psychotherapy Centers of Greater Boston, Inc. have sites in two parole regions and operates four sites in each region. Sharper Future has sites in three parole regions and operates between two to four sites per region. About Face: Domestic Violence Intervention is responsible for operating two sites in a single region. These programs are designed to serve a total of 600 high-risk sex offenders over a three-year period, or 100 offenders per individual program site. Treatment is designed for an 18-month length-of-stay. When one parolee leaves the provider (e.g., discharged from parole, violates parole and is returned to custody), the slot is made available to another parolee.

Table 1. Sex Offender Treatment Contract Providers by Parole Region, FY 2011-12

Parole Region	Number of Sites in Region	Sex Offender Treatment Contract Provider
Region I	4	Counseling and Psychotherapy Centers of Greater Boston, Inc.
Region II	4	Sharper Future
Region II	4	Counseling and Psychotherapy Centers of Greater Boston, Inc.
Region III	2	About-Face: Domestic Violence Intervention Project
Region III	2	Sharper Future
Region IV	3	Sharper Future

METHODOLOGY

The Office of Research worked collaboratively with DAPO in the fall of 2012 to collect high-risk sex offender program participant data. Each contractor submitted rosters that contained the name and CDC number for offenders who received their services during FY 2011-2012. The data obtained from the contractors was matched to CDCR's Offender-Based Information System (OBIS) to provide demographic and offender characteristics for the high-risk sex offenders receiving treatment at each site.³ In total, 1,125 high-risk sex offenders are reflected in this report.

In addition, each DAPO regional representative was asked to complete a self-report questionnaire that was designed to capture basic program information (e.g., curriculum, type of treatment provided, number and type of groups). A copy of the questionnaire is included in Appendix A. All of the contractors submitted the questionnaire; however, only items 1 and 2 were reliably reported. As such, the responses to questionnaire items 1 (What curriculum are you providing?) and 2 (What type(s) of treatment are you providing?) from each contractor are only available in Appendices B and C, respectively, and are not reflected in the body of this report.

PROGRAM PARTICIPANT CHARACTERISTICS

Table 2 depicts the total and contractor-specific program participant demographic and offender characteristics of the high-risk sex offender population served at the 22 outpatient sex offender treatment sites during FY 2011-12.

Treatment Provider

Five of the six contractors reported being able to provide treatment to the number of high-risk sex offenders specified in the contract (i.e., 100 per contractor per year), with most exceeding the specified number.

Sex

All of the offenders receiving treatment were male.

Release Type

Nearly three-quarters of the sample were re-releases (74.5 percent) and one-quarter were first-releases (25.5 percent). With the exception of About-Face, re-releases significantly outnumbered first releases (ranging from 67.8 percent to 81.7 percent). About-Face, however, had a fairly even balance of first and re-releases in its program (46.7 percent and 53.3 percent, respectively).

³ If CDC number or other relevant information could not be found in OBIS for a particular offender, then that person was dropped from 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. Additionally, three of the clients had received treatment from more than one site and their data is included at each site they received treatment.

Table 2. Demographic Characteristics by Treatment Provider

Characteristics	CPC Region I		SF Region II		CPC Region II		AF Region III		SF Region III		SF Region IV		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total	160	100.0	240	100.0	217	100.0	92	100.0	199	100.0	217	100.0	1,125	100.0
Release Type														
First Release	37	23.1	44	18.3	54	24.9	43	46.7	64	32.2	45	20.7	287	25.5
Re-Release	123	76.9	196	81.7	163	75.1	49	53.3	135	67.8	172	79.3	838	74.5
Age at Release														
18-19	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
20-24	0	0.0	5	2.1	8	3.7	2	2.2	3	1.5	4	1.8	22	2.0
25-29	15	9.4	22	9.2	26	12.0	9	9.8	9	4.5	13	6.0	94	8.4
30-34	16	10.0	27	11.3	32	14.7	5	5.4	16	8.0	32	14.7	128	11.4
35-39	14	8.8	27	11.3	21	9.7	11	12.0	30	15.1	27	12.4	130	11.6
40-44	26	16.3	20	8.3	27	12.4	12	13.0	27	13.6	29	13.4	141	12.5
45-49	32	20.0	58	24.2	28	12.9	15	16.3	36	18.1	30	13.8	199	17.7
50-54	20	12.5	33	13.8	33	15.2	15	16.3	35	17.6	34	15.7	170	15.1
55-59	14	8.8	30	12.5	19	8.8	13	14.1	19	9.5	22	10.1	117	10.4
60 and over	23	14.4	18	7.5	23	10.6	10	10.9	24	12.1	26	12.0	124	11.0
Race/Ethnicity														
White	73	45.6	65	27.1	77	35.5	29	31.5	34	17.1	89	41.0	367	32.6
Hispanic/Latino	48	30.0	20	8.3	65	30.0	32	34.8	44	22.1	52	24.0	261	23.2
Black/African American	33	20.6	137	57.1	59	27.2	25	27.2	114	57.3	67	30.9	435	38.7
Native American/Alaska Native	1	0.6	6	2.5	3	1.4	1	1.1	0	0.0	4	1.8	15	1.3
Asian	0	0.0	1	0.4	0	0.0	0	0.0	0	0.0	0	0.0	1	0.1
Native Hawaiian/Pacific Islander	0	0.0	2	0.8	6	2.8	1	1.1	1	0.5	0	0.0	10	0.9
Other	5	3.1	9	3.8	7	3.2	4	4.3	6	3.0	5	2.3	36	3.2

Table 2. Demographic Characteristics by Treatment Provider (Continued)

Characteristics	CPC Region I		SF Region II		CPC Region II		AF Region III		SF Region III		SF Region IV		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Commitment Offense Category														
Crimes Against Persons	123	76.9	172	71.7	147	67.7	72	78.3	122	61.3	161	74.2	797	70.8
Property Crimes	7	4.4	27	11.3	32	14.7	5	5.4	27	13.6	21	9.7	119	10.6
Drug Crimes	24	15.0	23	9.6	21	9.7	7	7.6	36	18.1	22	10.1	133	11.8
Other Crimes	6	3.8	18	7.5	15	6.9	8	8.7	13	6.5	13	6.0	73	6.5
Missing	0	0.0	0	0.0	2	0.9	0	0.0	1	0.5	0	0.0	3	0.3
Serious and/or Violent														
Yes	80	50.0	87	36.3	54	24.9	36	39.1	68	34.2	70	32.3	395	35.1
No	80	50.0	153	63.8	163	75.1	56	60.9	131	65.8	147	67.7	730	64.9
Sex Registration Flag														
Yes	160	100.0	240	100.0	217	100.0	92	100.0	199	100.0	217	100.0	1,125	100.0
No	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Sentence Type														
Second Striker	39	24.4	64	26.7	64	29.5	27	29.3	61	30.7	76	35.0	331	29.4
Determinate Sentence	121	75.6	151	62.9	151	69.9	65	70.7	137	68.8	140	64.5	765	68.0
Life	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	1	0.5	1	0.1
Missing	0	0.0	2	0.8	2	0.9	0	0.0	1	0.5	0	0.0	5	0.4
CSRA Risk Score														
Low	16	10.0	3	1.3	3	1.4	15	16.3	10	5.0	3	1.4	50	4.4
Moderate	102	63.8	139	57.9	133	61.3	61	66.3	126	63.3	145	66.8	706	62.8
High	42	26.3	98	40.8	81	37.3	16	17.4	63	31.7	69	31.8	369	32.8
Static-99 Score														
Low	16	10.0	3	1.3	3	1.4	15	16.3	10	5.0	3	1.4	50	4.4
Moderate-Low	32	20.0	9	3.8	12	5.5	19	20.7	18	9.0	16	7.4	106	9.4
Moderate-High	70	43.8	124	51.7	127	58.5	42	45.7	108	54.3	129	59.4	600	53.3
High	42	26.3	81	33.8	98	45.2	16	17.4	63	31.7	69	31.8	369	32.8

Age at Release

The age distribution for the total population was fairly even across age groups with a slight skewing favoring older participants such that over half of the offenders were ages 45 or older (54.2 percent) and very few were ages 24 or under (2.0 percent). Approximately two-thirds of the offenders across all providers were older than age 35. Counseling and Psychotherapy Centers of Greater Boston, Inc., Region II, differed in that a larger percentage of its clientele was between the ages of 20 to 34 (30.4 percent).

Race/Ethnicity

Overall, most offenders were Black/African American (38.7 percent), followed by White (32.6 percent), and then Hispanic/Latino (23.2 percent). The ethnic composition of the offenders varied across the different treatment providers. Counseling and Psychotherapy Centers of Greater Boston, Inc. in Regions I and II, and Sharper Future in Region IV, served mostly White offenders, Sharper Future in Regions II and III served mostly Black/African American offenders, and About Face in Region III served mostly Hispanic/Latino offenders.

Commitment Offense Category

The majority of participants were committed to prison for crimes against persons (70.8 percent), followed by drug crimes (11.8 percent), property crimes (10.6 percent), and other crimes (6.5 percent). Although crimes against persons was the most common commitment offense across all treatment providers, commitment offense varied in that some providers served more property than drug crime offenders, and vice-versa.

Serious/Violent Commitment Offense

Nearly two-thirds of the total population was identified as not having committed a serious/violent crime (64.9 percent). This finding held for most of the individual providers. The exception was Counseling and Psychotherapy Centers of Greater Boston, Inc. in Region I, where it was a 50/50 split between offenders who were serious and/or violent and those who were not.

Sex Registration Flag

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

Sentence Type

Most offenders had served determinate sentences for their most recent prison stay (68 percent) and over one-quarter of the offenders were second strikers (29.4 percent).

California Static Risk Assessment Risk Score (CSRA)

Many offenders had a moderate CSRA risk score (62.8 percent), followed by high (32.8 percent) and low (4.4 percent).⁴

Static-99 Score⁵

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 the final determination. About 86 percent of the participants had a Static-99 score could designate them as being a high-risk sex offender.

LIMITATIONS

This report provides the first formal description of the population being treated by the contracted sex offender treatment providers serving high-risk sex offenders in their communities. This effort is preliminary and limited in scope due to the nature and quality of the available data. The analyses relied on existing roster data provided by the contractors which did not contain all of the information that would have been included in a more advanced evaluation (e.g., program start and end date). These data limitations make it difficult to evaluate how many offenders were served by each contractor because it is not possible to enumerate the number of successful program completions versus those offenders who just cycled in and out of a program without completing it. The contractors readily supplied the roster data requested, but due to time constraints and data collection differences across contractors and sites it was not possible to obtain all of the data necessary for a complete evaluation. Additionally, the qualitative information that was obtained was so limited that it could not be included in the full report.

The analyses in this report were based solely on data provided by the sex offender treatment contractors and DAPO. For this report, the following was not done by the Office of Research:

1. Verify the accuracy of data provided by the contractors and DAPO.
2. Evaluate the quality of services provided by the contractors.
3. Assess the contractors' compliance with the contracts' terms and conditions.
4. Review the qualifications of contractors' staff.
5. Review the participants' treatment records.

⁴ 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 criminal history, offenders are designated as having either a low, medium, 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/sites/ucicorrections.seweb.uci.edu/files/CSRA%20Working%20Paper_0.pdf.

⁵ The Static-99 is a risk assessment tool designed to predict sexual and violent recidivism in male adult sexual offenders. Total scores on Static-99 can be translated to 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/>.

CONCLUSION

Five of the six contractors provided the specified treatment to the number of high-risk sex offenders specified by contract (i.e., 100 per contractor per year), with most exceeding the number specified. The remaining contractor provided treatment to 92 high-risk sex offenders during the same time period. It appears that the contracted sex offender treatment program providers are serving the appropriate offender population as all participants are indeed required to register as sex offenders who have a moderate to high risk to recidivate.

NEXT STEPS

The close collaboration between the Office of Research and DAPO that occurred to provide the data for this report is ongoing. The two offices continue to work together to develop procedures and protocol for data collection processes for a more comprehensive evaluation. As a result of this collaboration, a standardized, electronic data collection form has been developed that will be provided to all of the contractors providing treatment services to high-risk sex offenders. Routine data submission on the part of the treatment providers is being built into the new contracts to help ensure that program evaluation can continue and expand.

APPENDIX A

Sex Offender Treatment Program Providers Fiscal Year 2011-2012 Evaluation Questionnaire for Basic Program Information

- 1) What curriculum are you providing?
- 2) What type(s) of treatment are you providing?
- 3) Average number of groups conducted per week?
- 4) What are the types of groups that are being conducted?
- 5) Average number of individual sessions provided per week?
- 6) Average program length?
- 7) How many parolees were referred to your program from July 1, 2011 – June 30, 2012?
- 8) How many of the parolees that were referred to your program were accepted into it?
- 9) How many parolees successfully completed your program from July 1, 2011 – June 30, 2012?
- 10) How many parolees terminated the program before completing from July 1, 2011 – June 30, 2012?
- 11) How many program participants had their parole violated from July 1, 2011 – June 30, 2012?
- 12) What program data are you collecting currently?
- 13) How is this information captured/being recorded?
- 14) Can we get a roster with participant names and cdcr# for all participants from July 1, 2011 – June 30, 2012?

APPENDIX B⁶

What Curriculum Are You Providing?

<p>CPC, Region I and II</p>	<p>CPC uses our own “RULE” Program Workbook as the base curriculum for our program. CPC developed and uses research based best practices and interventions in efforts to aid clients in gaining self-control of their behaviors while also working closely with institutional and community partners such as County or Federal Probation and State Parole agencies. Our RULE program, which stands for Responsibility, Understanding, Learning, and Experience, systematically organizes our clinical approach to therapeutic intervention.</p> <p>We expect the RULE Client Handbook to be used as a resource guide. The assignments are designed to aid clinicians and clients in systematically addressing a variety of issues. As discussed above, treatment plans and programming requirements are based on an individual’s assessment. Therefore, the RULE assignments are assigned on an as-needed basis for each client. There is not a linear implementation of the RULE Client Handbook assignments (i.e., clients should not start at page one and proceed to thoughtlessly do every assignment or project in the book). Rather, assignments are made in an effort to develop coping, relationship, and affect regulation skills and to gain mastery of the many concepts being taught in the course of treatment.</p>
<p>SF, Region II</p>	<p>Our curriculum is empirically-based on the most recent research that has determined the primary, contributing factors that lead to sexually offending to prevent recidivism. Our curriculum was internally developed over the years and is psychoeducational/cognitive-behavioral in its focus. (We use) proprietary curriculum that addresses risk factors related to sexual offense recidivism. These risk factors are based on the most current research regarding dynamic risk factors and interventions.</p>
<p>SF, Region III</p>	<p>Our curriculum uses a cognitive-behavioral approach. It teaches offenders how certain belief systems lead to criminal thinking which leads to criminal behavior that results in prison, parole and lifetime registration as a sex offender.</p>

⁶ If the contractors provided duplicate answers, then the information is reported only once. Responses from contractors who provided different answers representing different regions were reported separately.

What Curriculum Are You Providing?

AF, Region III

At About-Face we use material from “The Road to Freedom”, Rational/Emotive Therapy principles, and assertiveness training. The curriculum for male clients is from the Adult Relapse Prevention Workbook, by author Charlene Steen. The curriculum for female clients is from Choices, a Relapse Prevention Workbook, by author Charlene Steen.

SF, Region IV

We use manualized Cognitive Behavioral Therapy (CBT) and relapse prevention. The program uses a proprietary manual (Sharper Future Compendium) which includes worksheets and assignments that combines the relapse prevention/CBT model with the Good Lives Model (GLM).

APPENDIX C⁷

What Type(s) of Treatment Are You Providing?

CPC, Region I and II	<p>We differentiate levels of treatment and duration of treatment based on each client’s assessed risk level and dynamic, criminogenic needs. Using the Static-99R, Stable 2007 and in California, the Structured Risk Assessment scores in combination allows determination of low, moderate and high risk and needs; treatment planning then attends to the client specific characteristics associated with risk reduction. Differential selection of treatment assignments and expectations are based on these, and other, assessment outcomes. Low risk and need individuals will be offered less intense and shorter duration programming while those in the moderate or high risk groups will be offered programming commensurate with their risk and needs levels. Programming is not one-size fits all.</p> <p>We intend to implement client specific treatment plans. Clients with seemingly low levels of risk are not always actually low risk; many have sexual histories which were not known prior to preparing them for polygraph testing, administering a sexual interest measure, or reviewing their sexual history in detail. Once a comprehensive assessment is completed, some seemingly moderate risk individuals may be functioning at the low risk level while others may be functioning at a high level of risk. Treatment planning and assignment selection is based on client-specific needs; individualized treatment increases engagement by clients and improves motivation to participate and change.</p> <p>We believe that weekly group treatment with additional adjunct services, such as monthly individual or couples counseling, in conjunction with ongoing probation or parole supervision increases stability in the community. As a client progresses through his/her individualized treatment programming, frequencies and modalities can change based on the real needs of the client. We are aware that over-treating or under-treating offenders may have a negative effect on risk of re-offense. Ongoing monitoring by way of the Monthly or Quarterly Progress Report and periodic review of the dynamic risk assessment tools allows us to improve treatment specificity with individual clients. Decisions to modify a client’s treatment program are made in conjunction with a clinical supervisor and with the supervising officer when possible.</p> <p>The following are also components of our treatment model: cognitive behavioral treatment, trauma focused treatment for individual, psychodynamic treatment within group and individual, dialectical behavioral therapy, “Good Lives” model, and RNR (risk, needs, responsivity).</p>
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⁷ If the contractors provided duplicate answers, then the information is reported only once. Responses from contractors who provided different answers representing different regions were reported separately.

What Type(s) of Treatment Are You Providing?

**SF,
Region II**

Cognitive-behavioral/psychoeducational group and individual therapy that focuses on addressing dynamic (changeable) risk factors related to increased recidivism for sexual offending. Both group and individual therapy also includes time for psychodynamically-focused process when appropriate. Groups meet twice weekly for 1.5 hours sessions and clients are seen monthly for individual sessions. Clients deemed inappropriate for group are seen in individual weekly sessions.

**SF,
Region III**

We use what is called a containment model. Agents use their skills & authority to ensure that offenders come to treatment, pay attention and participate. Polygraphers provide support to clinicians in helping to understand behaviors of sex offenders. Clinicians use their skills to teach offenders how to shift out of their bad habits of thinking and behaving. We provide assessments, group therapy, individual therapy, and polygraphs in our treatment. Positive results occur when we collaborate closely. We cover all bases and stay on the same page.

**AF,
Region III**

Group, family, and individual, using cognitive-behavior therapy that is sex offender specific (CBT-SOS).

**SF,
Region IV**

We provide CBT sex offender treatment that includes relapse prevention, assertiveness training, boundary management and mindfulness.