An Implementation Evaluation of the Specialized Sex Offender Projects in DuPage, Lake and Winnebago Counties

Prepared for the
Illinois Criminal Justice Information Authority

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EXECUTIVE SUMMARY

This brief document is an Executive Summary of findings from an evaluation of sex offender probation programs in DuPage, Lake and Winnebago Counties conducted from June 1998 through June 1999 by Loyola University Chicago. Reference is made to a companion evaluation of sex offender probation programs in Coles, Vermilion and Madison Counties conducted by the University of Illinois at Springfield during the same time period. This Executive Summary presents an overview of the background of this evaluation, followed by a review of the evaluation's study design, a description of the programs in DuPage, Lake and Winnebago Counties, and a report of major findings and recommendations for each program, and summary of findings from a comparative analysis of all three programs.

Background

The recognition, based on a variety of studies, that regular probation was insufficiently rigorous to supervise sex offenders led key players in Illinois to stimulate the development of specialized intensive supervision probation programs for sex offenders in several counties in Illinois. The Illinois Criminal Justice Information Authority (Authority) in July, 1997 through federal Anti-Drug Abuse Act monies funded six sex offender probation programs in DuPage, Lake, Winnebago, Vermilion, Coles, and Madison Counties. The programs in DuPage, Lake, and Winnebago only serve adult offenders. The Coles and Vermilion County programs serve both adult and juvenile sex offenders while Madison County serves only juveniles. Each of these probation units is modeled on the containment approach, which includes (a) intensive supervision of offenders with frequent field searches of offender's homes

and the verification of information obtained verbally from offenders; (b) treatment which emphasizes a cognitive-behavioral group therapy approach supplemented with cognitive-behavioral individual counseling; and (c) a partnership between probation officers and treatment providers that includes frequent communication and sharing of relevant information on each offender. In July 1998 the Illinois Criminal Justice Information Authority contracted with Loyola University Chicago and the University of Illinois Springfield to conduct a process and short term impact evaluation of each of these programs. Using a similar design and method, Loyola University conducted the evaluation of the DuPage, Lake and Winnebago County programs while the University of Illinois conducted the evaluation of the Coles, Madison, and Vermilion County programs. It was originally planned to present a complete document reporting on the evaluation of all six programs, but we have elected to present our finding in two separate reports primarily because the volume of data simply made a single document too lengthy. The study reported here is the findings from Loyola University's evaluation of the DuPage, Lake and Winnebago programs. The findings from the University of Illinois' evaluation of the Coles, Vermilion and Madison programs are presented in a separate but companion report. A third report compares the programs across all six counties.

Evaluation of
The DuPage, Lake and Winnebago Sex Offender Programs

These three programs had been operating for about a year prior to the start of the evaluation. The evaluation had two basic elements: The first was a process evaluation of each program, and the second was a short term impact evaluation of each program. The evaluation design and method we adopted for each element is described below.

Process Evaluation

The process evaluation examined three key stages of each probation unit: program development; program implementation, and program operation. Program development examined the time period from the decision to apply for grant funds to the receipt of the grant award. Based on a review the Authority grant files, program documents and extensive interviews with program administrators and staff we documented the history of each program from conception to award of funding, the circumstances that led the county to apply for grant funds and the overall goals for each program.

Project implementation concerned the time period from the date of the interagency agreement (grant award document) to the receipt of the first case. Using program documents and on-site interviews, the evaluation team collected data on each program's administrative structure and chain of command, supervisory and line staff selection procedures, physical location of the project within the department and the relationship of this project to other special caseload projects and the department in general. We also examined the projects' overall policies and procedures, particularly those describing the planned target population, eligibility criteria, referral process, case screening procedures, case assessment process, case assignment process, and supervision and surveillance standards. We interviewed all project staff concerning prior educational and professional background, the amount and type of training received on sex offenders/offenses, and the degree of job satisfaction each expressed.

Program operation concerned the extent to which the project actually operated in line with pre-operational expectations as stated in the grant application and in program policies and procedures. Given the design of these probation units and their emphasis upon use of the containment approach, our evaluation of program operation focused on four major program activities: intake caseload and offender

profiles; supervision and surveillance; the team approach; and the nature of treatment. Data on each of these program operation activities were collected from reading and coding case files and/or event records, from review and analysis of monthly statistical reports, monthly treatment reports, from review of treatment assessment documents, from a survey of probation and treatment providers, and from a variety of site visits with program administrators. Analysis of these data allowed the evaluation team to document caseload and intake, to develop offender profiles and risk characteristic for each program's offender population and to assess the degree to which each program was able to meet its supervision and surveillance standards. Analysis of these data also permitted an evaluation of the extent and quality of treatment assessments, of the team approach and of treatment attendance and progress. To allow time for data analysis, review, comment and input from each program staff, revision and comparative analysis, we stopped collecting most program data at the end of February 1999.

Short term Outcomes

Given the recent implementation of these projects, the assessment of impact was limited to the assessment of intermediate probation and treatment outcomes. Intermediate outcomes are results that should be achieved after a short period of program implementation. Our analysis of probation outcomes was based on approximately 16 months of program operational data. Most programs began operation in October or November 1997 and we collected program statistics and case-level data through the end of February 1999. We first examined short-term probation outcomes. Based on monthly statistical reports and examination of case records we calculated "success" and "failure" rates for each program which consisted of the number of cases defined as successful by each program's definition and the number of cases defined as failures. Data on the number of arrests, the number of

technical violations and the number of violation of probation petitions filed were also analyzed. Data on short-term treatment outcome were obtained from standardized monthly treatment progress reports developed by the evaluation team. Treatment providers completed a form each month for all offenders receiving treatment. Analysis was based on reports submitted between September, 1998, through February, 1999. These data allowed for an assessment of treatment progress across six critical dimensions of treatment: participation in therapy sessions; commitment to treatment; acknowledgement of personal responsibility for the offense; understanding of the consequences of reoffending; willingness to disclose details of additional inappropriate behavior; and acceptance of responsibility for emotional/physical damage their actions caused the victim. Using N-of-1 statistical analysis we also assessed the degree to which offenders were responsive to treatment on each of these six dimensions. Finally, we also collected data on the number of missed appointments, number of unexcused absences, and completion of homework assignments.

The DuPage County Sex Offender Probation Program
Program Description and Key Findings

Program Description

The DuPage program adopted a mixed caseload-sex offender specialist model comprised of six probation officers assigned to a sex offender team and two sex offender specialists. Team members carried a mixed caseload of primarily regular probation cases along with approximately 13 to 20 sex offender cases. The two adult sex offender specialists (designated "grant officers") carried sex offender cases only. The program serves adult misdemeanor and felony sex offenders convicted of statutorily identified sex offenses, adult felony or misdemeanor offenders convicted of a non-sex offense whom the court specifically orders into the sex offender program, and sex offenders sanctioned into the grant

program from the sex offender team caseload. Participants must be DuPage County residents and there must be an order of probation. The decision to place a case in the sex offender grant program is usually made at the department level. All cases that meet target population criteria are initially referred to the two grant officers. Based on a previously obtained judicial agreement, a set of 15 special sex offender probation conditions become part of the probation order once the case is assigned to the sex offender program. Cases are assessed within 45 days and sex offender treatment is provided by carefully selected sex offender treatment providers. Supervision and surveillance standards are based on a three-level step down model. The program has averaged approximately six intakes a month from November, 1977 through February, 1999, and the current (February, 1999) caseload is 86 cases with approximately 43 cases per grant officer. The program goal was to maintain sex offender grant caseload at 30 cases per officer.

Key Findings

- The DuPage County Sex offender program was well managed based on a very detailed policy and procedure document that serves to guide all phases of the program.
- Case identification, case referral, and program intake procedures were followed as outlined in the grant document.
- The profile of offenders served by the program conformed to the target population defined in the grant document.
- The two grant officers were well trained and enthusiastic about their jobs.
- Monthly statistical reports submitted to the Authority provided useful information on caseload and case movement but there was little data on supervision and surveillance contacts.

- The DuPage County sex offender program set fairly rigorous supervision and surveillance standards that required two home visits and four face-to-face visits per month for level I cases with some reduction for level II cases. Findings indicate that the DuPage program failed to meet home visit expectations in all 16 months examined. The program did much better in terms of face-to-face visits exceeding expectations in one month, exactly meeting expectations in another month and coming close to expectations in the remaining months. The evaluation team identified a variety of realistic factors that contribute to this program's failure to meet its supervision standards.
- The interaction between probation staff and treatment providers in DuPage County was exemplary. Survey findings indicate a very high degree of mutual respect and trust characterized by open and productive communication on a regular basis.
- Treatment evaluations were adequate and submitted on time but deficient in that 90% did not contain an objective measure of sexual preference.
- DuPage program was the only program of the three to make extensive use of polygraph examinations and was found to have a high rate (63.6%) of offenders that admitted to the most relevant parts of the offense.
- Preliminary data on short-term probation outcome indicate that in 80.4% of cases terminated from the grant program were successfully moved to lower levels of supervision without any known serious violations during the grant portion of their probation.
- The DuPage County program technical violation rate was 12.1% of intake.
- There were a total of 10 arrests, four of which were for new misdemeanor sex offenses.
- DuPage sex offenders in treatment received the highest average ratings on all six critical dimensions of sex offender treatment.

- Over two thirds (62.1%) of the DuPage offenders in treatment made at least one positive life change.
- Few significant changes in offenders after six months of treatment were identified by N-of-1 analysis, which measures an individual's improvement during the observation period.
- There was no well-developed uniform policy on unexcused absences and lateness that probation and treatment providers could use to bolster offender compliance with treatment.

DuPage Program Recommendations

- **The program should revise the monthly data reporting procedure to accurately reflect case supervision contacts. Until a reliable computer-based system is developed, grant officers should keep a paper record of contacts for submission to and summary by the unit supervisor.**
- **The department should give careful consideration to adopting a surveillance officer model by adding a surveillance officer position to the two grant officer program or otherwise adopting a procedure to insure that home visit standards are met.**
- **The department should give most careful consideration exempting sex offender cases from the department's policy of announcing home visits.**
- **While remaining fully committed to the necessity of home/field visits for sex offender cases, the program should revise standards for such visits especially in the first month after the case is assigned.**
- **The department should require that treatment providers submit written results of objective personality tests and objective sexual interest tests as part of the initial treatment evaluation.**
- **The department, in collaboration with treatment providers, should create uniform written policies on graduated sanctions that are available to deal with noncompliance in therapy as well as uniform rules on how lateness to treatment in handled, how many unexcused absences are acceptable before the client is terminated and a violation of probation (VOP) filed, what counts as an unexcused absence, and how new sex offenses reported to the therapist should be handled.**
- **The long-term evaluation of the probation and treatment outcomes should be conducted to assess the effectiveness of the additional surveillance and treatment of sex offenders.**

The Lake County Sex Offender Program
Program Description and Key Findings

Program Description

The Lake County program uses a mixed caseload-surveillance officer model in which six sex offender specialists carry a caseload of both regular and sex offender cases and two surveillance officers provide intensive supervision and surveillance of the sex offender cases. The essential element in this design is that the surveillance officers do not carry their own caseload but rather devote full time to community supervision and surveillance of sex offenders on the sex offender specialists caseload especially during evenings and weekends. The program's target population includes adult felony and misdemeanor offenders and is broadly defined as including any offender convicted of any offense that is sexual in nature who has been sentenced to probation. To this extent, the target population is not limited to sex offense convictions but can embrace a wide range of convicting offenses that have a sexual component. In the majority of cases after an offender is sentenced to probation, the case is reviewed at probation intake and the decision made to include or not include the case in the sex offender program. In some cases the decision is based on a presentence investigation and/or a direct order for assignment to the sex offender program. Although the Lake County program developed and uses a set of 20 special conditions for sex offender cases, these are not usually made a part of the probation order since assignment to the sex offender program is most often made after the sentence to probation. The general probation order, that includes a condition that the offender shall abide by the rules and regulations established by the probation department, is seen as the justification for demanding compliance with the 20 conditions. All sex offender cases are assessed upon entrance into the program or as part of the presentence investigation process. Sex offender treatment is provided by four carefully selected sex

offender treatment agencies. The planned supervision standards for the Lake County program were that all sex offenders were to be supervised at a high level throughout their probation period. The program has averaged approximately 12 intakes per month from October, 1997 through February, 1999 and the current caseload (February, 1999) is 244 sex offender cases with an average of 41 cases per officer. The program goal is to maintain sex offender caseloads at approximately 40 cases per officer and total caseload per officer to 80 cases. The former goal is being met but is in jeopardy since the number of sex offender cases is sure to increase. The second goal has been harder to maintain and caseloads now exceed 90 cases.

Key Findings

- The evaluation team found the Lake County program to be exceptionally well managed under the administrative supervision of the department's deputy administrator and the day-to-day operational direction and supervision of the unit supervisor. We were particularly impressed with the knowledge, leadership and motivational skills of the unit supervisor, which resulted in a high degree of unit cohesion and a well functioning team.
- Case identification, case referral, and program intake procedures as outlined in the grant document were being followed.
- The profile of offenders served by the program conformed to the target population defined in the grant document.
- The Lake County program has a strong commitment to training and made excellent use of scarce training resources available.
- The two surveillance officers as well as the sex offender specialists were very enthusiastic about

their jobs.

- Monthly statistical reports submitted to the Authority were exemplary. They were informative, presented in an understandable and readily usable manner and included essential data on all key elements of the program's monthly operation.
- The Lake County program set comparatively rigorous supervision standards that required a total of five face-to-face contacts a month, three of which were home/field visits. Findings indicate that the program failed to meet these high home/visit standards and also fell short of the five face-to-face contacts standard. The evaluation team identified a variety of realistic factors that contribute to this program's failure to meet supervision standards.
- During the months when the unit was fully staffed and trained, the program was able to meet a standard of 2 home/field visits and a total of 4 face-to-face visits a month, the standard set for phase I cases that use a phased approach to sex offender supervision.
- The interaction between probation staff and treatment providers in Lake County was excellent, characterized by mutual respect and trust.
- Treatment evaluations were acceptable and submitted on time but were deficient in a number of key areas.
- Preliminary data on short-term probation outcome indicate that 75.3% of offenders terminated from the program did so successfully in that they completed their probation without violations or arrests that would lead to their probation being revoked by the court.
- The Lake County program had a technical violation rate that was 37.3% of intake. While this is partly a reflection of offender behavior, it is also indicative the high level of supervision and surveillance provided by this program.

- There were a total of 68 new arrests, 20 of which were for new sex offenses.
- The Lake program sex offenders in treatment received above average ratings on all six critical dimensions of sex offender treatment.
- Over three-fifths (61.5%) of the Lake County program offenders in treatment made at least one positive lifestyle change.
- The majority (63.0%) of the Lake County program offenders in treatment had no unexcused absences from treatment.
- Few significant changes in offenders after six months of treatment were identified by N-of-1 analysis, which measures an individual's improvement during the observation period.
- There was no well-developed uniform policy on unexcused absences and lateness that probation officers and treatment providers could use to bolster offender compliance with treatment.

Lake County Program Recommendations

- **Because the broad target population definition leads to large caseloads, the use of a more selective case selection procedure should be developed perhaps based on risk assessment.**
- **Program staff should work with the state's attorney's office to develop a procedure whereby the 20 special conditions for sex offender probation cases are more formally made a part of the probation order.**
- **Consideration should be given to adopting more realistic supervision/surveillance standards or to develop more formal written criteria to determine which cases receive higher levels of surveillance.**
- **The department should clarify the role and duties of treatment providers. Treatment providers should be required to submit written results of objective personality tests and objective sexual interest tests as part of their treatment evaluation. All treatment evaluations should contain an objective test of psychopathic deviancy.**

- **The department should obtain a computer system to collect data on all individual sex offenders that can be used to assess outcomes.**
- **The department should create, in collaboration with treatment providers, a standardized treatment progress report that covers all major aspects of treatment, and allows therapists to indicate both positive lifestyle changes and inappropriate sexual behaviors/thoughts since the last report. All therapists should be required to submit this written standardized report for all offenders at least once every two months. Such reports should supplement rather than replace in-person or phone contacts with therapists.**

- **The department, in collaboration with treatment providers, should create uniform written policies on graduated sanctions that are available to deal with noncompliance in therapy as well as uniform rules on how lateness is handled and how many unexcused absences are acceptable before the client is terminated and a VOP filed, what counts as an excused absence, and how new sex offenses reported to therapists should be handled.**

- **A long-term evaluation of the probation and treatment outcomes should be conducted to assess the effectiveness of the additional surveillance and treatment of sex offenders.**

The Winnebago County Sex Offender Probation Program
Program Description and Key Findings

Program Description

The Winnebago County program uses a specialized sex offender officer model in which all sex offenders on probation are assigned to two experienced sex offender specialists. These two officers handle sex offender cases exclusively. The program's target population includes all adult felony offenders convicted of a sex offense that require the offender to register as a sex offender. A unique feature of this program is that it is restricted to felony offenders. In addition to offense, criteria for admission to the program include an order of probation and acceptance into sex offender treatment. Cases are accepted on a contingency basis pending the treatment decision. In most cases, assignment to the sex offender program is made a part of the probation order but does not contain any specific reference to special sex offender probation conditions. In a limited number of cases, potential program participants are identified through a presentence investigation (PSI), but most of the time the state's

attorney and defense attorney agree to the program as part of the plea bargaining process. Most cases are assessed within 30 days of sentencing. Two sex offender therapists provide sex offender treatment. Supervision standards are based on a three-level model that requires two home/field visits and a total of four face-to-face contacts a month for level I offenders with decreased contacts for level II and III. One special feature of this program is that the two sex offender officers continued to supervise sex offender cases they had on their caseload prior to the start of the grant program. The officers' sex offender caseload is thus a mix of pre-program sex offender cases and grant program sex offender cases. The program has averaged four grant program intakes a month, from August, 1997, through February, 1999. The current caseload (February 1999) is 68 grant program cases and approximately 20 pre-program cases per officer for a per-officer caseload of 52 cases each. The program's goal was a per-officer caseload of 50 cases.

Key Findings

- The evaluation team found the Winnebago County program to be adequately managed. The two senior probation officers were experienced in the supervision of sex offenders and tended to operate somewhat independently.
- Case identification, case referral, and program intake procedures were followed as outlined in the grant document.
- The profile of offenders served by the program conformed to the target population defined in the grant document.
- Both officers are well trained and well motivated.
- Monthly fiscal and program reports were not submitted on a regular basis to the Authority, due to an administrative problem at a level beyond the control of the program administrator.

- Monthly statistical reports were adequate but did not contain sufficient data to allow for examination of supervision contacts without some additional data.
- The Winnebago County program supervision and surveillance standards required two home/field visits and a total of four face-to-face contacts a month for level I cases and one home/field and two face-to-face contacts a month for level II cases. Level III cases were to have one face-to-face contact a month. Our analysis was restricted to levels I and II in the belief that level III were essentially regular probation as far as contact standards were concerned. Findings indicate that the Winnebago County program failed to meet level I or level II home visit standards, failed to meet level I face-to-face standards, but was much closer to meeting level II face-to-face standards. The evaluation team identified a variety of practical reasons why supervision standards were not achieved by this program.
- The interaction between probation staff and treatment providers in Winnebago County was excellent and characterized by mutual trust and respect.
- Treatment evaluations submitted by treatment providers for the Winnebago County program were generally inadequate. In addition to no measures of sexual preference, most evaluative reports lacked objective personality tests and polygraphs. Clinical interviews were unsuccessful at eliciting, from offenders, reports of additional inappropriate sexual acts that were not part of the official record.
- There were insufficient data to estimate the program's "success" although, inspection of casenotes suggests that the majority of offenders will successfully complete their period of probation.
- The Winnebago County program technical violation rate was 6.3% of intake.
- There were a total of seven new arrests, none of which were for a new sex offense.

- Winnebago County sex offenders in treatment received below average ratings on all six critical dimensions of sex offender treatment.
- A little over one third (38.0%) of Winnebago County offenders in treatment made at least one positive lifestyle change.
- Over one quarter (29.0%) of Winnebago County program offenders in treatment had no unexcused absences from treatment.
- In Winnebago County, 18 statistically significant changes in offenders in treatment were identified after six months of treatment, which measures an individual's improvement during the observation period.
- There was no well-developed uniform policy on unexcused absences or lateness that probation officers and treatment providers could use to bolster compliance with treatment.

Winnebago County Program Recommendations

- **Some consideration should be given to restructuring the work week of the sex offender officers to permit evening and weekend home/field visits. An alternative would be to assign a surveillance officer to the team.**
- **Program statistics should be revised to provide a better accounting of case flow thus allowing for accurate indicators of probation outcomes.**
- **Some consideration should be given to assigning level III sex offender cases to the general caseload unit within the department.**
- **The department should create, in collaboration with treatment providers, a standardized treatment progress report that covers all major aspects of treatment, and allows therapists to indicate both positive lifestyle changes and inappropriate sexual behaviors/thoughts since last report. All therapists should be required to submit this standardized form on all offenders at least once every two months. Probation officers can review these written documents for treatment progress, and will have the opportunity to refresh their memory on critical information before home/office visits. Such standardized reports should supplement rather than replace in person or phone contacts with therapists. Standardized reports, moreover, allow officers to assess which offenders are less responsive to**

treatment across treatment agencies.

- **The department should require that treatment providers submit written results of objective personality and sexual interest tests as part of the initial treatment evaluation.**

- **The department, in collaboration with treatment providers, should create uniform written policies on graduated sanctions that are available to deal with noncompliance in therapy as well as uniform rules on how lateness is handled and how many unexcused absences are acceptable before the client is terminated and a VOP is filed, what counts as an excused absence, and how new sex offenses reported to therapists should be handled.**

Overall Conclusions and Recommendations

Our overall conclusion from both an analysis of individual programs and a cross-program analysis is that each of these programs successfully implemented their sex offender program that was designed to fit within the particular configuration of individual departments and environments. All three met basic requirements of the containment model in that they increased sex offender supervision/surveillance beyond that provided prior to receipt of grant funds. Each program provided more sex offender supervision but not as much as expected. Each program implemented a well functioning system of sex offender treatment characterized by a team approach of mutual respect and trust. Short-term probation outcomes and short-term treatment outcomes indicate that the majority of sex offenders in all three programs are complying with probation and treatment conditions that are part of their probation order. No one program excelled at all three elements of the containment model but some programs did better than others at various elements. While all three programs were excellent in their implementation of the team approach, DuPage County was particularly notable, especially in its use of bi-monthly group meetings. Lake County's surveillance officer model resulted in the highest level of sex offender supervision contacts of all three programs. Winnebago County was the only program to focus on felony offenders and had the highest percentage of family-related offenses.

There were two aspects of each program that did not meet expectations. All three programs were unable to meet their individual home/field visit standards and to some extent, their face-to-face contact standards. Secondly, treatment evaluations from treatment providers were of mixed quality in all three programs. However, it should be noted that DuPage County made the greater use of polygraphs and was very successful in eliciting reports from offenders of additional inappropriate sexual acts that were not part of the official record.

We offer a number of recommendations.

- **A revised program model should be considered following the Lake County program model but with more realistic supervision/surveillance standards.**
- **Supervision/surveillance standards should be non-declining.**
- **The Authority and AOIC should work with the Illinois State's Attorneys Association to insure the greater participation of probation in state's attorneys decisions to recommend probation especially for sex offender cases.**
- **Case selection and identification for sex offender programs should be made at the probation department level with a procedure implemented to revise probation orders as needed.**
- **The Probation Division of the AOIC should expand its sex offender training program.**
- **The Authority should promptly develop and implement a uniform monthly data form to be used by all funded sex offender programs.**
- **The Authority should give serious consideration to extending the funding of each of these programs allowing for the adoption of a surveillance officer model in DuPage and Winnebago Counties.**

CHAPTER I

INTRODUCTION AND OVERVIEW

Few criminal justice professionals and therapists who have worked closely with sex offenders would disagree with the characterization of sex offenders as: manipulative, deceitful, and tenacious repeat offenders. Recent research indicates that sex offending may be a life-long problem for many sex offenders. Prentky, Lee, Knight, and Cerce (1997) conducted a longitudinal [over a 25 year period] analysis of recidivism rates among 251 sex offenders who were discharged from the Massachusetts Treatment Center for Sexually Dangerous Persons. The failure rate for having a new sexual offense charge among child molesters at the end of the study period was 52%, with an average of 3.64 years before reoffense. The failure rate for having a new sexual offense charge among adult rapists was 39%, with an average of 4.55 years before reoffense.

Society engenders substantial costs from the recidivism of sexual offenders. In addition to emotional and physical health of victims, the public carries the monetary costs of investigating, prosecuting, and sentencing sex offenders and carries the burden of constraints that fear of sexual assaults generate. Despite the serious nature and costs of these crimes, convicted sex offenders often receive a term of community-based probation as their sentence. A study that analyzed almost 1,000 cases of child sexual assault from ten jurisdictions found that 64% of the convicted sex offenders received probation and in 61% of those cases counseling was ordered as a condition of probation (Smith, Elstein, Trost, & Bulkeley, 1993). A 1993 study by the Probation Division of the Administrative Office of the Illinois Courts (AOIC) documented that more than 2,500 adult sex offenders were on probation in Illinois. The study's report issued on January 18th, 1994 by the

Administrative Office of the Illinois Courts (AOIC, 1994) concluded that:

> …Illinois probation services currently offer no uniform standards for effective control and case management (of sexual offenders). Probation departments do not currently have either the expertise or resources to adequately monitor sexual offenders. (p. 1)

Although no comparable study was conducted of the juvenile probation caseload, a recently published analysis of juvenile probation intakes in Illinois revealed that 3.6% of juvenile probation intakes in 1990 and 1995 were sex offenders (Lurigio, et al 1999). Many jurisdictions across the nation now have recognized that standard probation provides insufficient monitoring and surveillance of convicted sex offenders serving community-based sentences (Lurigio, Jones, & Smith, 1995).

This recognition of the inadequacy of regular probation to effectively supervise sex offenders led key players in Illinois to stimulate the development of specialized intensive supervision probation programs for sex offenders in several counties in Illinois. The Illinois Criminal Justice Information Authority in July 1997 funded six sex offender probation programs in DuPage, Lake, Winnebago, Vermilion, Coles, and Madison Counties. The programs in DuPage, Lake, and Winnebago Counties serve adult offenders only. The Coles and Vermilon County programs serve a mix of adult and juvenile sex offenders while Madison County serves only juveniles. Each of these probation units is modeled on the containment approach, which includes: (a) intensive supervision of offenders with frequent field searches of offender's homes and the verification of information obtained verbally from offenders; (b) treatment which emphasizes a cognitive-behavioral group therapy approach supplemented with cognitive-behavioral individual counseling; and (c) a partnership between probation officers and treatment providers that includes frequent communication and sharing of relevant information on each offender. In July, 1998 the Illinois Criminal Justice Information Authority contracted with Loyola University Chicago and the University of Illinois-Springfield to conduct a process and short-term impact

evaluation of each of these programs. Loyola University conducted the evaluation of the DuPage, Lake and Winnebago County programs while the University of Illinois conducted the evaluation of the Coles, Madison, and Vermilion County programs. We have elected to present our findings in two separate reports, primarily because the volume of data simply made a single document too lengthy. The study reported here is the findings from Loyola University's evaluation of the DuPage, Lake and Winnebago County programs. The findings from the University of Illinois' evaluation of the Coles, Vermilion and Madison County programs are presented in a separate but companion report. A third report compares the programs across all six counties.

Evaluation of
The DuPage, Lake and Winnebago County Sex Offender Programs

As the report title implies this evaluation had two basic elements. The first was a process evaluation of each program and the second was a short-term impact evaluation of each program.The evaluation design and method we adopted for each element is described below.

Process Evaluation

Following a brief description of each program and its geographical location, the process evaluation examined three key stages of each probation unit: program development; program implementation; and program operation. Program development examined the time period from the decision to apply for grant funds to the receipt of the grant award. Based on a review of the Authority grant files, program documents and interviews with program administrators and staff, we documented

the history of each program from conception to award of funding. We determined and documented why a sex offender project was identified as needed by each department at this particular time; what procedures were followed in deciding on design, budget, and other operational parameters; what was the time frame and key dates for the project development phase, and what was the amount and term of the award.

Project implementation concerned the time period from the date of the interagency agreement (grant award document) to the receipt of the first case. During this time period key administrative, staffing, and operational decisions made during the development phase were finalized. Using program documents and on-site interviews, the evaluation team collected data on each program's administrative structure and chain of command, supervisory and line staff selection procedures, physical location of the project within the department and the relationship of this project to other special caseload projects and the department in general. We also examined the projects' overall policies and procedures, particularly those describing the planned target population, eligibility criteria, referral process, case screening procedures, case assessment process, case assignment process, and supervision and surveillance standards. We interviewed all project staff concerning prior educational and professional background, the amount and type of training received on sex offenders/offenses, and the degree of job satisfaction each expressed.

Program operation concerned the extent to which the project actually operated in line with pre-operational expectations as stated in the grant application and in program policies and procedures. Given the design of these probation units and their emphasis upon use of the containment approach, our evaluation of program operation focused on four major program activities: intake, caseload and offender profiles; supervision and surveillance; the team approach; and the nature of treatment. Data on each of

these program operation activities were collected from reading and coding case files and/or event records, from review and analysis of monthly statistical reports, monthly treatment reports, from review of treatment assessment documents, a survey of probation and treatment providers, and a variety of site visits with program administrators. Analysis of these data allowed the evaluation team to document caseload and intake, to develop offender profiles and risk characteristics for each program's offender population and to assess the degree to which each program was able to meet its supervision and surveillance standards. Analysis of these data also permitted an evaluation of the extent and quality of treatment assessments, of the team approach and of treatment attendance and progress.

Short-term Outcomes

Given the recent implementation of these projects, the assessment of impact was limited to the assessment of intermediate probation and treatment outcomes. Intermediate outcomes are results that should be achieved after a short period of program implementation. Our analysis of probation outcomes was based on approximately 16 months of program operational data. Most programs began operation in October or November 1997 and we collected program statistics and case-level data through the end of February 1999. We first examined short-term probation outcomes. Based on monthly statistical reports and examination of case records we calculated "success" and "failure" rates for each program which consisted of the number of cases defined as successful by each program's definition and the number of cases defined as failures. Data on the number of arrests, the number of technical violations and the number of violation of probation petitions filed were also analyzed. Data on short-term treatment outcome were obtained from standardized monthly treatment progress reports developed by the evaluation team. Treatment providers completed a form each month for all offenders

receiving treatment. Analysis was based on reports submitted between September, 1998, through February, 1999. These data allowed for an assessment of treatment progress across six critical dimensions of treatment: participation in therapy sessions; commitment to treatment; acknowledgement of personal responsibility for the offense; understanding of the consequences of reoffending; willingness to disclose details of additional inappropriate behavior; and acceptance of responsibility for emotional/physical damage their actions caused the victim. Using N-of-1 statistical analysis we also assessed the degree to which offenders were responsive to treatment along each of these six dimensions. Finally, we also collected data on the number of missed appointments, number of unexcused absences, and completion of homework assignments.

This report is organized into six chapters. Following this brief introduction (Chapter I) we present our findings on and recommendations for each of the programs — DuPage County, Chapter II; Lake County, Chapter III; and Winnebago County, Chapter IV. Chapter V is a comparative analysis of these three programs and includes specific recommendations for the design and operation of sex offender probation programs that stem from our analysis. Finally, Chapter VI is a brief outline of a long term evaluation of selected sex offender programs.

CHAPTER II

DUPAGE COUNTY SEX OFFENDER PROGRAM

Program Description and Development

The sex offender program in DuPage County is made up of two components. A six-officer sex offender team that carries a caseload of adult sex offenders plus other regular probation cases, and a two-officer sex offender grant program that carries adult sex offender cases only. Sex offender team members carry a caseload of approximately 100 cases each, of which an average of 13 are sex offender cases. The grant officer caseload as of February, 1999 was a total of 86 cases. Grant officers provide a much higher level of community contacts and supervision than do regular officers on the sex offender team provide to sex offender cases. For the most part, all newly sentenced adult felony and misdemeanor sex offenders and those directly sentenced to sex offender probation are first assigned to the two grant officers. Cases residing outside of the county, court supervision cases, those based on assessment not requiring treatment, and selected other sex offender cases are assigned to the sex offender team. The focus of this report is upon the grant officer portion of the sex offender program.

Program's Location and Setting

DuPage County is the state's second largest county with a 1990 census population of 781,666. The county seat and judicial center are located in the city of Wheaton which is approximately 35 miles directly west of the city of Chicago. DuPage County forms the 18th Judicial Circuit in Illinois. The probation department, known officially as the Department of Probation and Court Services, serves both adult and juvenile offenders. The department caseload as of December 31, 1997 consisted of 3,457

adult cases and 798 juvenile cases.[1] As of July, 1998 the adult division[2], which now includes the former division of Adult Special Services, had a staff of 40 probation officers, 9 senior probation officers, 7 supervisors and a deputy director or a total staff complement of 56. Adult caseloads in the department as a whole average about 100 cases per officer but actual caseloads vary widely.

In addition to an administrative caseload unit, the sex offender team, and the sex offender grant program, the adult division has a total of six other specialized units. These include two teams, one for mentally ill offenders and the other for young offender/gang youth, and specialized units for presentence investigations: DUI, Specialized Drug Program, and Public Service. The DuPage County Department of Probation and Court Services is located on the first floor and one wing of the judicial center. All probation staff is located in the same general area and, like most probation departments, is cramped for space.

Program Development

The circumstances that led DuPage County to develop a sex offender program and eventually apply for grant funds can be traced to 1990. Department staff were asked to identify the type of offenders that were the most difficult to supervise on probation. Three types of offenders were identified: the young offender/gang member; mentally ill offenders, and sex offenders. This process led to the decision to establish special probation officer teams to focus on each type of offender identified. Supervisors were invited to select which particular team they would like to supervise, and probation staff were invited to join various teams. In October, 1991, the sex offender

[1] Annual Report, Eighteenth Judicial Circuit Court, Department of Probation and Court Services.

team was established. Supervision and treatment standards for sex offenders assigned to the team evolved over a number of years as a result of meetings with sex offender treatment specialists, a visit by the Deputy Director to Maicopa County, Arizona, and review of the literature and other programs in other states. In early 1996, the program received judicial approval to use 15 specific sex offender conditions of probation. However, since the staff of the sex offender team carried a mixed caseload of sex offenders and regular cases, there was insufficient time to monitor condition compliance to the level desired. There was a need to increase staff in order to provide the level of supervision needed. However, the probability of obtaining new adult division positions for the program from county resources was low given tight county budgets. The department saw the availability of grant funds as a well-timed opportunity to increase staff and thereby increase offender monitoring and surveillance. The intent was to hire two sex offender "grant officers" who would carry a caseload of sex offenders only and who would sharply increase the level of community contacts and surveillance of such offenders in the program. The caseload of each sex offender grant officer was set at 30 each for a maximum of 60 cases. When and if the caseload exceeded 60, a case selection process was to be implemented to identify cases to be assigned from the grant officers to the sex offender team.

The grant program's two major goals are to maintain a caseload of 60 sex offenders and provide a high level of surveillance and monitoring during the first two levels of the program. Included in this overall approach are the additional goals of maintaining contact with and obtaining supervision assistance from law enforcement agencies in the county. The program was funded with $88,694 in grant funds from the Illinois Criminal Justice Information Authority through Federal Anti-Drug Abuse Act funds and $29,565 from probation fees received by the county. The grant period was from August

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[2] Discussion of the Dupage County programs is restricted to adult cases.

1, 1997 to July 31, 1998, and was renewable each year for three years. In DuPage County, the time from the decision to apply for grant funds, made in mid-February, to the receipt of grant funds was approximately four and a half months.

Program Implementation

Program implementation concerns the time period from the date of funding to receipt of the first case. During this time key administrative, staffing and program policy decisions are finalized and the basic operational design of the program established.

Staffing

The overall staffing pattern of the sex offender program in DuPage County includes a sex offender team of six officers who carry a mixed caseload of sex offenders and regular probationers and two grant officers who carry sex offender cases only. All eight sex offender probation officers (six team officers and two grant officers) are supervised by the same supervisor. The availability of the two grant positions was posted in July 1997 and four people applied. Of the two selected, one was an internal transfer from the sex offender team and one was a new hire from outside the department. The criteria for selection included a Bachelor's degree plus writing skills, oral skills, interviewing skills, organization skills, an understanding of, or a willingness to learn applicable statutes and state standards, working knowledge of alcohol and other addictions, and knowledge of sex offenders and the current research on how to handle them.[3] In addition, six key elements from a behavioral interview were used. These were, ability to live with ambiguity, leadership ability, ability to follow policy and procedures, assertiveness,

[3] Grant position notice, July 2, 1997.

spoken communication, and decision making. The two positions were filled by August 1997. During the first year of the grant, August 1, 1997 to July 31, 1998, there has been only one staff change in the grant program. The officer hired from outside the department left in April when her fiancee was transferred out of state. The position was filled by one of the sex offender team officers in the same month. In early October, 1998 one sex offender team member left on maternity leave and was not planning on returning to the unit, electing instead to work part-time when she returned. As of November 1, 1998 replacements for all vacant positions had been hired so the unit was again fully staffed. Of the grant officers, one is female and the other male. The sex offender team is currently composed of four males and two females.

Staff Training and Experience

The DuPage County program has a well structured approach to staff training. All members of the sex offender team and the two grant officers, as a minimum, are required to attend an annual department-sponsored day long training session. The majority of officers interviewed[4] had received far in excess of this minimum. In addition, the program supervisor provides a constant stream of articles, books and other materials which team members are expected to review to keep current on supervision and treatment of sex offenders. Since sex offender team members carry a regular caseload in addition to sex offenders, their availability for and focus on sex offender training are limited especially since caseloads have been averaging 100 to 110 cases each in recent months. The two grant officers have received more intensive training by virtue of their being able to attend out-of-state conferences and training seminars. For example, both officers have attended the Midwest Conference on Child Abuse

and Incest in Wisconsin the past two years, visited the Maricopa County, Arizona's program, recently returned from reviewing Vermont's approach to sex offender supervision, and attended the week-long ATSA conference in Vancouver in October. Also, one of the grant officers attended the 80 hour Sinclair Seminar series in Cleveland which consists of a series of two-day seminars spread over a six month period. The total number of hours of sex offender training received as of October, 1998, varied considerably ranging from approximately 240 hours for one of the grant officers who had been supervising sex offenders for five years to approximately 48 hours[5] for the newest member of the team who had been in the program only six months. Two team members with probation officer experience of over 10 years were not able to accurately quantify the number of sex offender training hours received beyond indicating they had received "a lot". The median number of hours received was 68. For the two grant officers, the number of training hours received was 240 and 148. The content of sex offender training workshops ranged from general topics identified as "Treatment and Supervision of Sex Offenders" offered at two day training workshops to specific topics such as "Sex Offender Profiling" and "Family Reunification of Sex Offenders" offered at department-sponsored training sessions. Other topics identified were serial sexual homicide, verbal judo, and domestic violence. All seven officers interviewed found all of the training sessions very helpful and did not identify any particular one as most helpful. There was some question as to the relevance of the material on serial sexual homicide since such offenders are not placed on probation.

The number of years of probation officer experience for the five team members was quite varied. Three officers had more than 11 years experience, one 2.5 years, and one 1.5 years. Of the

[4] A total of seven officers were interviewed (five team and two grant officers). The team was short one member when interviewed in October.

two grant officers, one had five years the other one and a half. The same pattern was observed in the number of years of experience supervising sex offenders. Two team members had at least eight years experience, one had five years, one had one and a half years, and one 6 months. Grant officers had five years and one and a half years respectively. All had at least a BS/BA degree most commonly in Criminal Justice. One of the grant officers had a Masters Degree in Social Work.

All of the seven officers interviewed indicated that they had, in one way or another, volunteered for or elected to remain in the sex offender unit. All, without exception but with varying degrees of enthusiasm, indicated that they believed they had made a good choice. There was a wide range of "positives" about the unit stated. These included team cohesiveness, supervisor enthusiasm, challenge and diversity of the caseload, excellence of training, and interaction with treatment providers. The most frequently cited negative was the potential for burn out and uncertainty whether sex offenders who, on the surface, are very compliant, were really involved in repeat offenses. There was an expressed need for surveillance officers. All of the officers would recommend employment in this unit to fellow probation officers if asked.

Administrative Structure

Since the sex offender team had been in operation for six years, there was no need to develop a new administrative structure for the two grant officers. They were essentially absorbed into the team structure and supervised by the same supervisor. The grant officers report to the team supervisor who reports to the deputy director for adult services who reports to the department director. Monthly reports on grant officer caseload activities are prepared by the unit supervisor from reports submitted by the staff. The deputy director is the contact person listed on grant documents.

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[5] Sixteen of these 48 hours were received while a probation officer in another state.

Target Population

There are five basic criteria that define this program's target population. These are:

1. An adult, felony or misdemeanor offender, convicted of one or more of the following statutory sex offenses: aggravated criminal sexual abuse; aggravated criminal sexual assault[6]; child abduction; child pornography, criminal sexual abuse; criminal sexual assault; disorderly conduct – peeping; exploitation of a child; indecent solicitation of a child; indecent exposure; juvenile pimping; keeping a place of juvenile prostitution; lewd exposure/conduct; obscenity; patronizing a juvenile prostitute; permitting the sexual abuse of a child; predatory criminal sexual assault of a child; public indecency; ritualized abuse of a child; sexual exploitation of a child; sexual relations within families; sexually dangerous persons act; and, soliciting for a juvenile prostitute.

2. The offender is a DuPage County resident.

3. An adult, felony or misdemeanor offender convicted of a non-sex offense whom the judge specifically orders into the sex offender program.

4. Sex offender cases sanctioned into the grant program from the sex offender unit.

5. There is an order of probation.

All such cases are assigned to the two grant officers. Sex offender cases placed on court supervision and offenders charged with failure to register as a sex offender are assigned to the sex offender team and are not eligible for the grant program. In addition, cases convicted of a non-sex offense but later investigation reveals a sexual component are assigned to the sex offender team unless, as noted, they have been ordered into the sex offender program in which case they are assigned to grant officers.

Case Referral Process

In the DuPage program, eligible sex offender cases are identified primarily when the probation order is received by the department or when a presentence report (PSI) is ordered. The decision to

place a case in the sex offender grant program or the sex offender team is usually made at the probation department level. Upon receipt of the probation order the case is screened by the department receptionist to identify those that meet the above stated five criteria. Cases that meet the criteria are automatically assigned to the sex offender grant program. The 15 special sex offender probation conditions become a part of the probation order once the case is assigned to the sex offender grant program. Although it was originally planned to have a PSI ordered on all sex offender cases, this proved to be impractical since a good proportion of these cases are plea bargained and defense attorneys often express reluctance to having a detailed PSI conducted. On occasion, the state's attorney's office will alert the unit to a specific case and seek their concurrence on a sentence of sex offender probation. There is also frequent contact between the unit and the state's attorney's office. However, for the most part, there appears to be no formal process by which the probation department is involved in the state's attorney's decision to place a sex offender on probation. The primary referral document is the order of probation.

Case Assessment

This program's policy is that all cases received by the grant unit must have a sex offender evaluation with a polygraph completed within 45 days of sentencing. These evaluations must contain a detailed description of the testing used and should include, minimally, a sexual history, a personality inventory, the Marital Satisfaction Inventory (MSI) I or II, as well as a personal interview. A written evaluation report is expected within 30 days after completion of the assessment. Penile plethysmographs are to be conducted as needed. All cases are to be referred for a full disclosure polygraph but the timing may be delayed because of limited resources. When the need for treatment is

[6] This charge, a Class X offense, is usually reduced before probation is granted.

indicated by the evaluation and not contraindicated by the polygraph, the offender is expected to begin treatment. If the assessment indicates that sex offender treatment is not needed, and this in not contraindicated by the polygraph, the case is transferred to the sex offender team. On a few occasions the assessment is done before sentencing at the request of the defendant and is used as a bargaining tool to obtain probation rather than incarceration.

Supervision Standards

The main difference between the sex offender team and the sex offender grant program is in the level of supervision required and the requirement that 15 special conditions of probation be met. Initially, all sex offenders in the sex offender team are classified as maximum supervision cases, which require two face-to-face contacts per month and one home visit every other month. The supervision standards for the grant program are much more demanding. The grant program uses a three level supervision structure that mandates key supervision activities as follows:[7]

Level I – Approximately three to six months

- Four face-to-face contacts per month, two of which must be home or field visits.
- The offender reviews and signs agreement to fifteen special sex offender conditions within seven days of sentencing.
- Urinalysis and breathalyzer test at each office visit.
- Offender is to keep a daily log of activities that the grant officer reviews carefully at each office visit.
- Contact with spouse or significant partner of the offender to seek her/his assistance to supervise the offender.

[7] The policy and procedure document lists 19 separate activities that should occur during level I. We have selected those that most closely reflect officer-offender interaction.

Level II – Approximately 6 to 12 months

- Three face-to-face contacts a month, one of which must be a field or home visit.
- Urinalysis and breathalyzer tests once a month.
- Daily log maintained and reviewed minimally once a month.
- Successful completion of maintenance polygraph.
- Weekly contact between grant officer and treatment provider.
- Offender is to attend and make successful progress in individual and group therapy.

Level III

Upon successful completion of a maintenance polygraph and progress in sex offender treatment for a minimum of six months, the case is transferred to the sex offender team under maximum supervision standards for six months and then at a level determined by the department. Offenders may be sanctioned back into the grant program if needed.

It should be noted that this supervision structure is based on a sentence to sex offender probation for a minimum of two years. Probation sentences, especially for misdemeanor offenses are frequently less.

Program Operation

As noted earlier, program operation analysis examines the extent to which the program actually operated in line with pre-operational expectations as stated in the grant application's program policy and procedures. Although each program used a different model, each was designed to deal with convicted sex offenders, to increase supervision and surveillance and implement sex offender treatment. With this in mind, the evaluation team's operational analysis focused upon four major activities: intake, caseload and offender profiles; supervision and surveillance; the team approach; and the nature of treatment.

Intake and Caseload

DuPage program statistical reports submitted to the Authority from November, 1997 through February, 1999 were examined to document the pattern of intakes, total caseload and caseload per officer by month. Intakes averaged approximately six cases per month and the total caseload increased steadily from four cases in November, 1997 to 86 cases at the end of February, 1999. DuPage program caseload data, and similar data from one other county in this report, differs somewhat with that stated in monthly reports mainly because it was often unclear whether closed cases were still part of the caseload when the reports were submitted. The evaluation team elected to simply start with the number of cases at the start of each month, add new cases, subtract closed cases and thus obtain a closing caseload count. The DuPage program caseload data is presented in Table II-1.

The program's caseload goal was to maintain caseloads of approximately 30 cases per officer for a maximum of 60 cases. When that maximum was reached there was to be an attempt to balance entry into the program with exits from the program, with priority for program retention to be given to the more serious cases and all cases where children are victims. Not surprisingly, the program has not been completely successful in controlling intake. Caseloads now exceed 40 cases per officer.

Table II-1

DuPage County
Monthly Caseload and Caseload per Officer
November 1997-February 1999

Year	Month	Beginning Caseload	Intakes	Closings	Ending Caseload	Caseload Per Officer
1977	November	4	8	0	12	
	December	12	3	0	15	8
1998	January	15	8	0	23	8
	February	23	4	0	27	14
	March	27	11	0	38	19
	April	38	8	0	46	23
	May	46	6	0	52	26
	June	52	7	1	58	29
	July	58	6	2	62	31
	August	62	4	1	65	33
	September	65	5	3	67	34
	October	67	7	0	74	37
	November	74	5	2	77	39
	December	77	6	6	77	39
1999	January	77	8	1	84	42
	February	84	3	1	86	43

Offender Profiles and Risk Characteristics

In addition to caseload counts, the evaluation team examined offender characteristics to gain an understanding of the program's population and the extent to which these offenders fit the target population defined in the original grant application. The DuPage County program's target population was to consist of all sex offenders sentenced under Illinois sex offense statutes including both felonies and misdemeanors. The following description of offender characteristics and offenses indicate that the program is serving its intended target population.

The evaluation team coded all available cases handled by the two grant officers of the DuPage

County Sex Offender Probation Unit from September 1, 1997 to September 30, 1998 with the exception that sixteen of the cases could not be located at the time of coding. The total caseload is 49 sex offenders. All information is based upon data obtained from the intake interviews and treatment evaluations in the probation files.

Demographic and Mental Health Characteristics

The data indicate that in DuPage County all the sex offenders are male, with 83.7% Caucasian, 6.1% African-American, and 10.2% Latino. Age ranges from 17 to 64 with a median age of 35. Most offenders are either single (40.8%) or currently married (42.9%), with 64.1% currently in a sexually active relationship. Most offenders (77.6%) are employed full-time. Income ranges from under $13,500 to over $50,000 with the median income between $20,001 to $25,000 and 14.6% have an income over $40,000. Almost all offenders have graduated high school, and 18.3% have either a Bachelor or Masters Degree. Only 16.3% failed to complete high school. Most offenders (82.9%) had a history of stable work and school adjustment (Table II-2).

This caseload presents problems of substance abuse and mental health that are typical of other probationers. Over half of the population disclosed that they used both alcohol and illicit drugs, and one-fourth had prior treatment for substance abuse. Current treatment plans for these offenders also recommended that 22.5% participate in substance abuse treatment. One third of the offenders have mental health problems, and 25.6% have had prior mental health treatment. In addition, ten offenders had previous suicide thoughts and five offenders had thoughts and a history of suicide attempts. Eight offenders were classified as depressed based on their treatment evaluations. Current treatment plans recommended that seven offenders receive psychiatric treatment, and five offenders receive antidepressants.

Table II-2

Description of Sex Offenders and Their Needs At Intake for DuPage County

Demographic Characteristics	Frequency	Valid Percent
Age of Offender		
17	1	2.0
18 to 26	9	18.4
27 to 35	15	30.6
36 to 43	14	28.6
44 to 52	5	10.2
53 to 74	5	10.2
Marital Status		
Single	20	40.8
Divorced	7	14.3
Separated	1	2.0
Currently Married	21	42.9
In a sexually active relationship?		
No	14	35.9
Yes	25	64.1
Missing	10	
Current Employment Status		
Unemployed	6	12.2
Employed Part-time	3	6.1
Employed Full-time	38	77.6
Retired	2	4.1
Income		
13,500 or under	13	26.5
13,501 to 25,000	19	39.6
25,001 to 40,000	9	18.8
40,001 and higher	7	14.6
Missing	1	
Education		
Less than 12th grade	8	16.3
High school graduate	20	40.8
Some College	12	24.5
Completed B.A./B.S.	6	12.2
Completed M.A./M.S.	3	6.1

Characteristic	Frequency	Valid Percent
History on Work/School Adjustment		
Stable work/school history	34	82.9
Unstable work/school history	7	17.1
Missing	8	
Whether Defendant Disclosed Any Drug Use?		
No	7	14.6
Yes, alcohol	16	33.3
Yes, Illicit Drugs	0	
Yes, both alcohol and drugs	25	52.1
Has Prior Treatment for Substance Abuse	12	25.0
Missing	1	
Recommended Substance Abuse Treatment?	9	22.5
Missing	9	
Has Mental Health Problems	14	32.6
Missing	6	
Has Had Prior Mental Health Treatment	11	25.6
Missing	6	
Suicide History		
No suicide thoughts or attempts	27	65.9
Suicide thoughts/No attempts	10	24.4
Suicide thoughts and attempts	5	9.8
Missing Information	7	

Offense and Offender Characteristics Potentially Related to Risk

Prior research has examined the predictors of committing a new sex offense while serving a community-based sentence or after successful completion of a community-based sentence (See for a review Hall, 1995; Hanson & Bussiere, 1998). Several static characteristics of the offense have been identified as leading to a higher risk of reoffense. These characteristics include: the gender of the victim, the age of the victim, and the nature of the offense. Offenders who victimize non-family members are at a higher risk of reoffense. Homosexual or bisexual offenders are at a higher risk of reoffense. Offenders who commit voyeurism or exhibitionism are at a higher rate of reoffense. Other static

characteristics have not received adequately empirical attention in the research literature. For example, the amount of time the abuse has been occurring may be related to risk. Offenders who have been abusing for a longer period are more likely to reoffend. A meta-analysis has found that prior arrest records significantly predict reoffense for any crime, but is not consistently related to sexual reoffending (Hanson & Bussiere, 1998). The weak relationship of prior criminal history to sexual reoffending may be due in part to the fact that such records do not reflect the complete history of an offender's activity of committing sexual crimes. A meta-analysis of prior research indicates that history of being a victim of child sexual abuse is not significantly associated with recidivism for a sexual offense. Only a few studies that have examined the level of denial and remorse at intake as predictors of reoffense; a meta-analysis of the findings in these studies indicates that these clinical presentation variables are related to general recidivism for any crime, but are not related to recidivism for sexual offenses.

As can bee seen from Table II-3, the majority of offenders were convicted of a misdemeanor (65.3%), and 30.6% of these offenders were convicted of public indecency. Only 32.7% of offenders were convicted of a felony sex crime. Most offenders (72.9%) were not acquainted with their victims. Only 21.7% of offenders had one or more charges of a sex crime against a family member filed against them. Due in part to the large concentration of public indecency cases, 45.7% of offenders had only one charge filed against them. The majority of offenders (77.8%) did not use force to achieve molestation. Over half of the offenderd (59.2%) expressed an interest in "hands off" sex offenses such as exhibitionism or voyeurism or reported that they had committed such offenses in the treatment evaluation. We also attempted to determine how many offenders were potential/actual pedophiles. Pedophiles were defined as offenders who expressed interest (as measured through an objective sexual preference test) or reported fantasies about forcing sex on children aged 10 or younger, or had

committed a sex crime against a child aged 10 or younger. Pedophiles comprised 45% of the sample.

A little over half of the offenders (60%) committed crimes against only one victim, and most offenders (78.3%) violated only girls or women. Consistent with national statistics (Greenfield, 1996), most victims were children under the age of 18 with 20% aged 3 to 8 years and 35% aged 15 to 17. Only 27.5% were 18 years old or older. Sixty percent of the cases involved penetration whereas 40% involved some sort of fondling of private parts or exposing private parts. Most cases (71.1%) consisted of multiple episodes of abuse across a number of months with only 28.9% of the cases involving single incidents. The mean number of months that offenders continued sexual abuse as reported by the victim in the police report or the offender during a clinical interview to evaluate treatment needs was 43 (median = 36 with a maximum length of 360 months). The majority of victims (91.3%) stated that the intercourse occurred without their consent, though four victims indicated that they consented to the intercourse. Ten offenders reported interest in sadistic sex acts and/or had problems with aggression.

The majority of sex offenders are familiar with the criminal justice system. About two-thirds had been arrested before (67.4%), and had been convicted before the current offense (62.2%). Half of the sex offenders have at least two prior arrests. A little over half of the sample (51.0%) had a prior arrest for a misdemeanor crime. Furthermore, almost a quarter of the sex offenders (23.6%) have a prior arrest for a sex crime, 21.7% have a prior arrest for a violent crime, 17.4% have a prior arrest for a felony property crime, 23.9% have an arrest for a drug crime, and 15.2% have a prior arrest for domestic violence. Thus, these sex offenders have already been handled by the criminal justice system, and have not been deterred from misusing

Table II-3

Offender and Offense Characteristics at Intake Related to Risk of Reoffending for Sex Offenders in DuPage County

Characteristics Related to Risk	Frequency	Valid Percent
Current Convicted Offense		
Criminal Sexual Assault	4	8.2
Aggravated Criminal Sexual Abuse	12	24.5
Other Misdemeanor Sex Crime	17	34.7
Public Indecency	15	30.6
Out of State Charges	1	2.0
Total Number of Charges Against Offender		
One	21	45.7
Two	9	19.6
Three	8	17.4
Four or More	8	17.4
Missing	3	
Whether Force was used to achieve molestation?		
No	35	77.8
Yes	10	22.2
Missing	4	
Number of Family-Related Charges		
None	36	78.3
One or more	10	21.7
Missing	3	
Relationship of Offender to Victim		
Unrelated	35	72.9
Father/Step-father	10	20.8
Uncle	1	2.1
Other Relative	2	4.2
Missing	1	
Gender of Victims		
Only Women or Girls	36	78.3
Only Men or Boys	9	19.6
Both	1	2.2
Missing	3	

Characteristic	Frequency	Valid Percent
Number of Victims		
One	27	60.0
Two	7	15.5
Three-Four	3	6.7
Five or more	8	.4
Missing	4	
Age of Youngest Victim		
3-8	8	20.0
9-11	2	5.0
12-14	5	12.5
15-17	14	35.0
18-21	8	20.0
Over 21	3	7.5
Missing	9	
Did Penetration Occur?		
No	27	55.1
Yes	18	36.7
Missing	4	8.2
Number of Months Abuse has been occurring?		
Single incident	13	28.9
1 to 6 months	11	24.4
7 to 12 months	4	8.9
13 to 24 months	6	13.3
Over 24 months	11	24.4
Missing	4	
Victim stated intercourse was consensual	4	8.7
Missing	3	
Defendant has an antisocial personality	6	12.2
Total Number of Prior Arrests		
None	19	40.4
One to Two	18	38.3
Three to Four	7	14.9
Five or More	3	6.4
Missing	2	
Total Number of Prior Arrests for Sex Offenses		
None	36	76.6
One	3	6.4
Two or More	8	17.0
Missing	2	

Characteristic	Frequency	Valid Percent
Total Number of Prior Arrests for Domestic Violence		
None	41	87.2
One or more	6	12.8
Missing	2	
Total Number of Prior Convictions		
None	21	
One to Two	18	39.1
Three to Four	6	13.0
Five or More	1	2.2
Missing	3	
Was Offender Abused as a Child?		
No	27	65.9
Yes, Physically Abused	8	19.5
Yes, Sexually Abused	4	9.8
Yes, Both Physical and Sexually	2	4.9
Missing	8	
Extent of Offender's Denial		
Completely Denies Offense Occurred	4	9.1
Denies Important Parts of Offense	12	27.3
Admits To Most Relevant Parts of Offense	28	63.6
Missing	5	
Whether Offender Reports Remorse		
No	17	40.5
Yes	25	59.5
Missing	7	

their power and control to achieve their desires. To determine whether sex offenders have learned that arrests often do not lead to convictions, we compared the ratio of arrests to convictions for each defendant. Most defendants who had at least one prior arrest had an equal number of arrests and convictions (N = 17; 63.0%). The average number of arrests beyond convictions was only .56, and ranged from one to four. Over half of the offenders had at least one prior conviction (54.3%). Twenty-three percent of the offenders (N = 11) had a prior conviction for a sex offense, 2.1% had a prior conviction for a drug offense, 39.1% had a prior conviction for a misdemeanor crime, and 6.4% had a

prior conviction for a domestic violence offense. None of the offenders had prior convictions for violent offenses or for felony property crimes. Despite this criminal history, only six offenders, however, were classified as psychopathic deviants based on treatment evaluation using an objective test; this low number, however, reflects in part that treatment evaluations often did not assess psychopathic deviancy. Twenty percent of the offenders had served a prior term of probation, and 13.3% had served an incarceration sentence.

Most sex offenders, however, do not admit to being sexually or physically abused as a child, though almost one-fourth (24.4%) do indicate that they were sexually abused as children. Surprisingly, 63.6% of the DuPage program offenders confess to most of the relevant parts of the offense and only 9.1% outright deny that the offense occurred. Most offenders charged with public indecency and misdemeanor charges admitted to the victim's version of the offense. A little over half of the offenders (59.5%) express some remorse for their crime.

Supervision and Surveillance

This program's supervision strategy included a three-level approach described in detail above. The essential elements were that in level I, offenders were to be seen face-to-face at least four times a month with two of these face-to-face contacts being in the field, i.e. home or at work etc. Level I was to last approximately 3 to 6 months. Level II offenders were to be seen face-to-fact three times per month with at least one of these face-to-face contacts being in the field. Level II was to last approximately 6 to 12 months. Upon completion of level II, the case was to be transferred to the sex offender team's caseload. Monthly statistical reports from the DuPage program did not provide detail on the number of home visits or face-to-face visits per month for all cases. The evaluation team therefore counted office and home/field visits for each month from individual computerized "case notes"

maintained by the department's case management system. The program staff graciously provided the print outs for each case. The actual number of visits one could reasonably expect for each case was determined by both the level the case was in as well as when in the month the case was assigned. For example, a case assigned during the third week in a month could not realistically be expected to have two home visits and four face-to-face contacts even though it would be placed in level I. The DuPage data included the date the case was assigned and most often, the point during the case when it moved from level I to level II. Based on these data, the evaluation team developed a program to identify the number of home visits and the number of face-to-face visits expected for each case each month, adjusted for the week during the month that the case was assigned, the level the case was in and whether or not the offender was in jail. In DuPage, 46.9% of the offenders were required to serve some jail time as part of their probation sentence. The expected number of visits was as follows:

Week Assigned	Level	Home Visits Expected	Face-to-Face Visits Expected
1	I	2	4
2	I	1	3
3	I	1	2
4	I	0	1

Most of the time newly assigned cases were placed in level I. On those occasions where a newly assigned case was in level II, expectations were for 1 home visit and 3 face-to-face visits if week 1, to as few as .5 if week 2 etc. Due to the logistics of intake, offenders who were assigned in week 2, level I were expected to have only one home visit. On numerous occasions a case was assigned but the offender was required to serve some jail time as part of the probation sentence. The offender was usually visited in jail for intake interviews, which were counted as face-to-face visits but obviously no

home visits were expected.

We looked first at the number of home visits. The total number of home visits conducted by the two sex offender grant officers is quite impressive, totaling 348 over a 16-month period. However, as can be seen from Table II-4, when the average number of home visits is calculated (number of home visits/number of cases) the DuPage program was not able to achieve the expected number of home visits per case per month even when adjusted for assignment date and level. Overall, the average number of actual home visits conducted ranges from 0 to 1.1. In no one month is the expected number of home visits achieved. The data indicate that an average of less than one home visit per month is conducted for each case in 14 of the 16 months for which data were available. These findings are also presented in Figure II-1.

There are a variety of reasons that the number of home visits conducted by this program were not as expected. Both sex offender grant officers were involved in numerous training sessions out-of state and home visits were not conducted during these times. In addition, in March of 1998 one of the sex offender grant officers left the program. Although her position was filled during the same month, some time was required for the new officer to "get up to speed". Program staff also offered some useful insights to account for the difference between actual and expected number of home visits. One significant factor is that numerous offenders were on work release status, which is similar to a jail status as far as home visits are concerned. Although 33.3% of the offenders had work release as part of their sentence, work release status was not reflected in the case notes upon which this analysis is based. Additional reasons relate to the realities involved in scheduling and conducting home visits in this program. Among theses are the fact that home visits require time to schedule especially in those instances where the offender is required to move out of the home and establish residence elsewhere;

that in a number of instances the new residence was in a different county and finally, visits were mainly to be conducted during the day but most of the offenders worked during these times. A final observation offered by program staff was that practice and experience had led the program to avoid scheduling home visits quickly in order to allow the officer to get to know the case and to assess the residential configuration before going out on a home visit. This experience suggested that the home visit standards might fruitfully be reexamined in light of practice. It should be noted that departmental policy for all probation staff in DuPage County is that there shall be no unannounced home visits. The evaluation team's concern is that announced home visits for a sex offender caseload may not be too effective in uncovering the type of behavior involved in these offenses.

Table II-4

DuPage County
Average Number of Expected and Actual Home Visits
By Month and Year

Year and Month		Average Number of Expected Home Visits	Average Number of Actual Home Visits
1997	November	.4	0
	December	1.8	.5
1998	January	1.2	.9
	February	1.8	.8
	March	1.6	.9
	April	1.6	1.1
	May	1.8	.7
	June	1.7	1.0
	July	1.6	.7
	August	1.7	.8
	September	1.6	.7
	October	1.5	.5
	November	1.6	.7
	December	1.6	.7
1999	January	1.5	.6
	February	1.7	.6

We next examined the number of face-to-face visits which were a total of home/field visits plus office visits. The number of face-to-face visits is quite impressive totaling 1,235 over a 16-month period. However, as can be seen from Table II-5, the average number of face-to-face visits (number of face-to-face visits/number of cases) falls short of expectations even when assignment date and level is considered but the average number of such visits is much closer to expectations than was the case for home visits. In fact, the number of face-to face visits exceeds expectations in one month (December 1997), exactly meets expectations in another (January,

Table II-5

DuPage County
Average Number of Expected and Actual Face-to-Face Visits
by Month and Year

Year and Month		Average Number of Expected Face-to-Face	Average Number of Actual Face-to-Face Visits
1997	November	2.2	2.0
	December	3.6	3.9
1998	January	2.9	2.9
	February	3.8	3.4
	March	3.4	3.0
	April	3.5	3.4
	May	3.8	2.4
	June	3.7	3.1
	July	3.6	2.6
	August	3.6	2.8
	September	3.5	2.5
	October	3.4	2.0
	November	3.6	2.5
	December	3.6	2.5
1999	January	3.4	2.6
	February	3.7	2.3

(Data on home visits and face-to-face visits are presented in graph form in Figures II-1 and II-2)

1998), and is virtually identical in another month (April, 1998). Also see Figure II-2.

There are also a variety of reasons for these findings. The reasons the averages fall below expectations are the same as for home visits…training time and staff changes. Average number of face-to-face visits is closer to expectations perhaps because office visits are easier to schedule around the day-to-day case activities that do not require the officer to leave the office. It should be noted that the DuPage program requires offenders to report to the office and drop off a report on days that the probation officer is not available due to training sessions. These "contacts" are designated in the record as "mail in" and are counted as office visits by the program. However, the evaluation team was reluctant to count such visits as face-to-face.

Figure II-1

DuPage County
Average Number of Home Visits
Expected and Actual

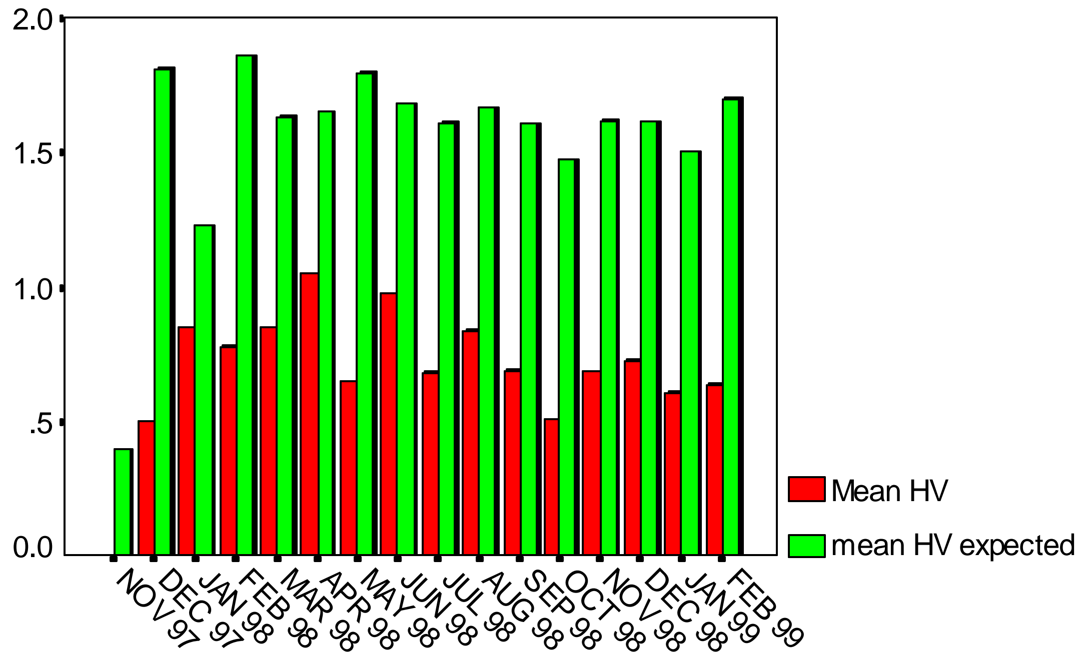
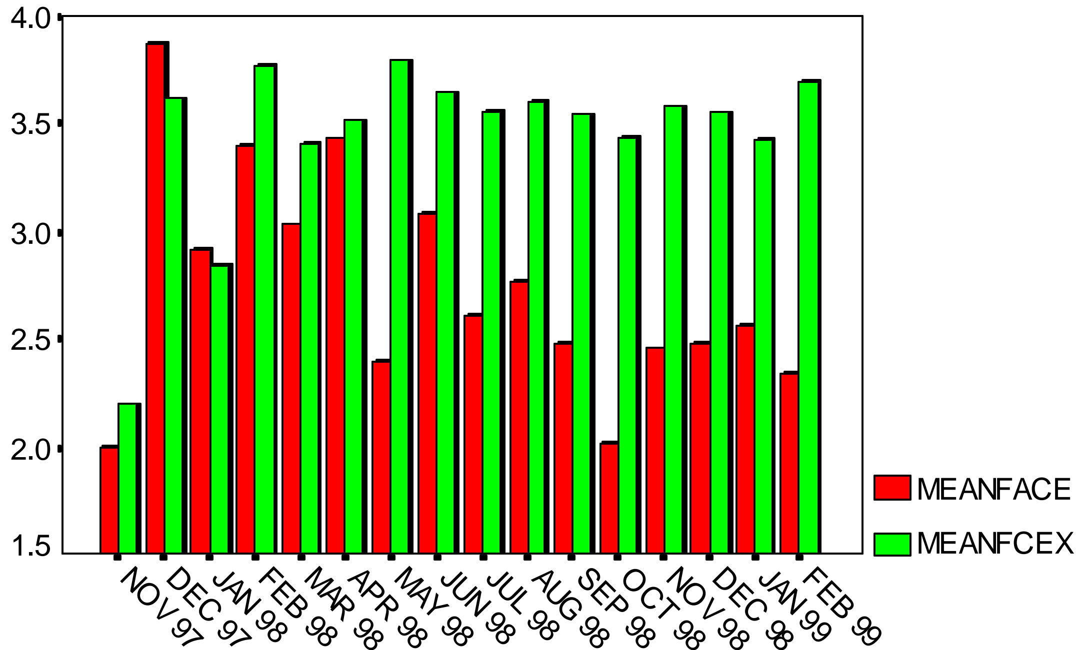


Figure II-2

DuPage County
Average Number of Face -to -Face Visits Expected and Actual



<u>Evaluation of the Team Approach</u>

The most recognized model for the supervision and treatment of convicted sex offenders in the community is the containment model. The containment model utilizes a team approach between probation officers, polygraph examiners, and treatment providers to monitor and treat effectively sex offenders on probation. Through this team approach, offenders cannot tell different versions of their crimes to probation officers and therapists, and both probation officers and therapists acquire information on the current risk and treatment needs of offenders to provide effective surveillance and treatment. The central characteristics of the team approach are the same features of any effective team (O'Brien, 1995):

- Probation officers and treatment providers agree on the primary goal of treatment. The primary goal should be to reduce inappropriate sexual behavior so that victim and community safety will not

be further compromised (English, Pullen, Jones, & Krauth, 1996).

- Consistent with this common goal, therapists perceive that the probation department is their primary client or that the probation department and defendant are equally their primary clients (e.g., Knapp, 1996). This perspective differs from traditional therapy in that therapists typically perceive the best interests of clients as their primary concern.

- Probation officers and treatment providers constantly share information about offenders' risks and treatment progress.

- Probation officers and treatment providers understand each team members' role and establish agreed upon policies to insure that all team members can perform their jobs in the most ethical and effective manner.

- Both probation officers and treatment providers work cooperatively to establish policies thereby eliminating adversarial and unequal power relationships.

- Regular face-to-face meetings are held to discuss difficult cases and to plan ways to improve treatment and monitoring strategies.

- Through mutual respect and cooperation, all team members feel safe to disagree about case management without jeopardizing their membership or status. Disagreements are communicated directly to other team members in a respectful manner, and agreed upon resolutions and promises are implemented and followed in practice.

The Loyola evaluation team distributed a survey to all therapists serving sex offender clients who are on probation in the sex offender unit of DuPage County Adult Probation, and to all probation officers in the sex offender unit including grant officers and the supervisor. The survey assessed the amount of face-to-face, phone, and written communication between probation officers and therapists, the topics discussed, how disagreements and discussions are handled, and their perceptions of the other team members' knowledge about risk and treatment, willingness to share information, and respectfulness toward them. All questions about the amount of communication focused on the last six months. The questionnaires were distributed February 24th, and were returned by the third week of March. The DuPage County Sex Offender Unit relies primarily on six treatment provider agencies. We

received a total of four questionnaires from therapists. All six probation officers, two grant probation officers, and the supervisor of the DuPage County Adult Sex Offender Unit completed the questionnaire. All respondents completed the questionnaires anonymously, and therapists mailed the questionnaires directly back to the evaluators to insure confidentiality.

Both therapists and probation officers are very satisfied with the way the team approach is operating. On a ten point scale where ten is completely satisfied, therapists and probation officers provided an average rating of 8.6 on satisfaction. This high level of satisfaction may reflect in part the frequent, open, and direct communication between probation officers and therapists. All treatment providers and probation officers in the sex offender unit have a regular group meeting once every two months. All four therapists and seven of the probation officers confirmed that they have face-to-face conversations with probation officers on a bi-monthly basis. One probation officer reported bi-weekly face-to-face conversations and one probation officer reported face-to-face conversations on a monthly basis. Therapists report that on the average they have interacted with eight probation officers, and probation officers report that on the average they have interacted with ten therapists. On the average, therapists and probation officers reported attending 2.75 group meetings in the last six months.

Face-to-face conversations were supplemented with more frequent phone calls and written correspondence. The frequency of phone calls varied widely across therapists with one reporting twice a week, one reporting once a week, one reporting bi-weekly, and one reporting monthly. This variation may be due to the number of clients that they are treating from DuPage County Probation Department. Probation officers also varied widely in their reports of the frequency of phone calls. Four officers reported bi-weekly, one officer reported once a week, one officer reported, twice a week and one reported bi-monthly. Therapists reported providing written correspondence monthly or twice a week,

though one reported less than once every two months. All therapists should be required to submit written reports on treatment progress once every two months. Most therapists reported that they receive letters from probation officers either bi-monthly or less than once every two months, and over half of the probation officers (5) reported that they wrote correspondence to therapists either bi-monthly or less than once every two months.

An effective team approach requires that team members are available for meetings. All therapists reported that probation officers were always or very available for meetings, and eight of the nine probation officers reported that therapists were very or somewhat available. One probation officer reported that therapists were very unavailable. Interestingly, seven probation officers and two therapists believe that they both initiated about an equal amount of the telephone and face-to-face contact whereas the others believed that they initiated 75 percent or more of this contact. Most therapists and probation officers indicated that their calls to the other team member were returned somewhat quickly. All therapists believed that one day was a reasonable amount of time to return a call. Half of the probation officers, however, believed that two days was a reasonable amount of time to return a call. Given the clientele, the standard for returning phone calls should be one day to address problems before offenders' behaviors escalate and threaten community and victim safety. Only one probation officer indicated that therapists were somewhat slow at returning their calls. Both therapists and probation officers were equally positive about the helpfulness of their conversations with each other. They indicated that the conversations were moderately helpful (M = 5.5 to 6.2) at creating strategies to keep specific offenders from reoffending, and at detecting offenders' attempts to deceive either the treatment provider or probation officer handling their case.

Probation officers and therapists reported spending most of their time discussing issues concerning the progress of specific offenders. The quality of treatment provider and probation officers' conversations were assessed with three questions: (a) how often do most (treatment providers/probation officers) try to take over team discussions and act on their own personal agendas; (b) how often do (treatment providers/probation officers) actually listen to your ideas and concerns; and (c) when you disagree with a (treatment provider/probation officer), how often do you tell the (treatment provider/probation officer) how you feel? Each question was answered using one of five options: never, rarely, occasionally, frequently, and always. All therapists reported that probation officers rarely or occasionally take over team discussions. Six probation officers reported that treatment providers rarely take over team discussions, and one reported that therapists never take over team discussions. Two probation officers noted that treatment providers occasionally or frequently take over team discussions. Both probation officers and therapists reported that the other team member frequently or always listened to their ideas. The team also seems built on trust in that most members feel free to express disagreements. One therapists and four probation officers indicated that they always expressed their disagreements whereas the other three therapists and five probation officers frequently expressed their disagreements. These self-report data thus suggest that both sides of the team believe that the team is a cooperative effort built on mutual respect and trust.

Data on treatment providers' perceptions of probation officers and probation officers' perceptions of treatment providers further support that the team has a solid foundation of mutual respect and trust. Probation officers reported that on the average 82 percent of therapists are very informed about treatment issues, and only about 4.8% of therapists are somewhat or very uninformed. Treatment providers reported that on the average 75% of probation officers are very informed about treatment

issues, and only 10% are somewhat uninformed. Probation officers reported that on the average 87% of therapists are very informed about risk factors, and therapists reported that on the average 76% of probation officers are very informed. All therapists and probation officers indicated that most of the other team members were somewhat or very willing to share information. Probation officers on the average reported that 80% of therapists were very willing to share information, and therapists reported that 95% of probation officers were very willing to share information. Probation officers, however, reported that 4% of therapists were somewhat unwilling or very unwilling to share information, and therapists reported that 1.25% of probation officers were somewhat unwilling to share information. Both probation officers and therapists indicated that the majority of members from both sides were completely supportive of the team approach. Probation officers indicated that on the average 63% of therapists are completely supportive whereas therapists indicated that 68.75% of probation officers are completely supportive. On the average, probation officers indicated that 2.22% were somewhat not supportive of the team approach, and therapists indicated that 1.25% of probation officers were somewhat not supportive of the team approach.

Three therapists and five probation officers reported disagreements on an important issue. Most disagreements were resolved by settling on a compromise or through working together to find a solution that they both agreed was right; though one therapist reported that they went along with probation officers' position, one probation officer persuaded the treatment provider, and two probation officers reported that the issue was still not resolved. Probation officers reported that they disagreed with therapists about: quality of an evaluation or treatment, whether a defendant needed treatment, sending a defendant to a night educational class, whether defendants belonged in group therapy, timeliness of progress reports and evaluations. Therapists reported similar quality control issues such as

need for a polygraph, frequency of treatment, need for group and individual treatment, whether a client was a sex offender, and the type of treatment provided, and management issues as well as lack of follow through on a previously discussed topic. These topics indicate that the DuPage County Probation Sex Offender Unit takes a very active role in assessing the quality of evaluation and progress reports, and attempts to find treatment for clients that is individualized to fit the clients' needs.

Every therapist and probation officer indicated that there was agreement about the most important goal(s) of the program. The primary goal focused on controlling and changing inappropriate sexual behavior, and all therapists and probation officers also agreed that it was moderately to extremely important that offenders accept responsibility for the harm caused to the victims and reduce their inappropriate self-statements. Probation officers believed it was extremely important to avoid additional offenses while on probation whereas therapists believed that this goal was only moderately important.

Overall, the team approach appears to be operating quite effectively in DuPage County. Moreover, most probation officers (6) correctly indicated that the probation department and defendant were equally the therapists' primary clients. All therapists indicated that the probation and defendant were equally the therapists' primary clients or that the probation department was their primary client. This correct attribution of loyalty highlights the commitment to the team approach among both therapists and probation officers in DuPage County.

The Nature of Treatment-Comprehensiveness of Treatment Evaluations

The evaluation team coded information from the probation case files of 49 DuPage County sex offenders who are on active probation and currently living in DuPage County. Forty of these case files

included a treatment evaluation. Most of the 40 available treatment evaluations were written by one of the following three treatment providers: one of two licensed clinical social workers (LCSW) (n = 26) or a Psy.D. from Clinical Behavioral Consultants (n = 13). The remaining evaluations (n = 5) were each written by a different treatment provider. We assessed the quality of these treatment evaluations by examining: (1) the range of issues that were addressed, and (2) how comprehensively each issue was addressed. Quality treatment evaluations should include at least seven specific components:

- A comparison of the victim's statement with the offender's version to assess the offender's attempt to minimize and deny responsibility for the offense
- A review of police/court records and a full disclosure polygraph examination to assess the complete history of an offender's sexual offending
- A review of substance abuse history, mental health history, educational/employment history
- Use of objective sexual preference tests such as the ABEL to assess deviant sexual preferences
- Use of objective personality tests such as the MMPI or Hare's Psychopathy checklist to assess personality disorders and psychopathic deviancy
- A referral to a psychiatrist on an as needed basis to assess medication needs for controlling depression or sexual arousal
- Use of standardized questions to assess power/control issues and attitudes toward women

Offender Denial and Minimization

Most of the treatment evaluations addressed offender denial by comparing the victim's version of the offense (per the police report) to the offender's version of the offense (n = 36, or 90.0%). In addition, all of the treatment evaluations addressed offender denial in enough detail to allow the reader to draw a reasonable conclusion regarding the extent of the offender's denial. And, all of the treatment

evaluations addressed whether the offender attributes responsibility for the offense to himself, or tends to blame his victim or circumstance for the offense.

A majority of the offenders (65.0%) gave a version of the offense that was consistent with the police report and, thereby, admitted to most aspects of the offense. Similarly, a majority of the offenders admit to all aspects of the offense (n = 26, 65.0%). However, the remaining offenders either deny parts of the offense (n = 11, 27.5%) or completely deny having committed the offense (n = 3, 7.5%). Finally, the evaluations indicate that approximately half of the offenders place at least some blame for the offense on the victim (47.5%).

History of Offending

One index of sex offense history is whether the offender has been arrested for sex-related crimes in the past. However, only 67.5% of the evaluations made any explicit reference to the offender's prior arrest history. Nonetheless, the treatment evaluations included an adequate amount of information regarding the offenders' prior sexual offense history. This information came from two sources: (1) clinical interviews, and (2) polygraph examinations.

All treatment evaluations included information that offenders revealed during the course of initial clinical interviews. Over half of the offenders (57.5%) revealed at least one additional sex-related crime (i.e., one that was not a part of the official record) during the course of these initial interviews. Many of these additional crimes were "hands off" offenses, such as exhibitionism or voyeurism (n = 18), but several offenders revealed additional sex-related crimes directly perpetrated against children (n = 8) or adults (n = 4).

Most of the treatment evaluations contained information about polygraph examinations (n = 34). However, in some cases, the polygrapher did not ask the offender questions about prior sexual

offending. Only 21 of the 34 polygraph examinations included such questions. Additional sex-related crimes were revealed in only 4 of these 21 examinations (two "hands-off" offenses, one offense against a child, and one offense against an adult).

Overall, 25 of the 34 offenders (73.5%) failed the polygraph examination. The results for an additional 7 offenders were inconclusive (20.6%). Thus, only two offenders passed the polygraph examination. Of the 32 offenders who either failed the examination or received inconclusive results, only 14 (43.8%) attempted to clarify the results with further disclosure. Ten offenders provided partial disclosure and four offenders provided full disclosure after learning about the results of their examination.

Generally, information about polygraph examinations was included as an attachment to the written treatment evaluation (i.e., the polygrapher's report was included as an attachment). Most treatment evaluations did a nice job of integrating information regarding offense history that was available from the attached polygraphs and from police reports. However, the evaluation team found two instances where additional offenses were clearly suggested in these sources, yet ignored in the written report.

Finally, the treatment evaluations all provided a great deal of information regarding the offenders' family history, substance abuse history, mental health history, and educational/employment history.

Objective Sexual Preferences

The evaluation team is particularly concerned about the number of treatment evaluations that do not include an objective report of offender sexual preferences (i.e., the ABEL test or the plethysmograph). Of the 40 case files we examined, only 6 included such measures (either by including

an attached report or by indicating in the written evaluation that such a test had been given). Offender arousal patterns have significant large implications for the selection of an appropriate and effective course of treatment. Moreover, a meta-analysis of the findings from studies on the predictors of sexual reoffending indicated that "sexual interest in children as measured by phallometric assessment was the single strongest predictor" (Hanson & Bussiere, 1998, p. 351) Reliance on offender self-report seems insufficient in light of: (1) the potential desire for offenders to present themselves in a socially acceptable manner and, (2) the percentage of offenders (as reported above) who either deny aspects of the current offense (35.0%) or tend to at least partially blame the victim (47.5%); such individuals may be less than forthright.

Objective Personality Tests

Of the 40 reports, only 27 (67.5%) indicated that they had administered an objective personality test to the offender such as the Minnesota Multiphasic Personality Inventory (MMPI) (N=25) or the Million Clinical Multiaxial Inventory (MCMI) (N=3). The scores of 9 of these 26 offenders (34.6%) indicated an elevation in at least one test scale. The MSI also was frequently administered (N=31; 77.5%).

The evaluation team encourages treatment providers to consistently administer an objective personality test to all sex offenders. There are two primary reasons for this. First, the MMPI, MCMI, and Hare's Psychopathy Scale include a scale that measures psychopathic deviancy. Several studies have indicated that psychopathic deviancy is a consistent predictor of reoffending, independent from an offender's sexual preferences or demographic/background characteristics. If treatment providers do not know this information, then treatment may not focus as heavily on issues such as extreme self-

centerness, lack of consciousness, manipulative ways of acting, and lack of empathy for others. Second, these objective personality tests provide information on whether an offender meets the criteria of clinical depression. This can aid in decisions as to whether an offender should be referred to a psychiatrist for an assessment of medication needs.

In addition to these objective personality tests, other psychological tests were administered. Subjective psychological tests were administered to some offenders. Six offenders took the Personal Sentence Completion test, two took the Rorschach Ink Blot test, and one offender took the Thematic Apperception Test (TAT). Several self-report measures of sexual fantasy/preferences and sexual attitudes were used. Nineteen offenders took the Wilson Sexual Fantasy; 12 took the Burt Rape Myth; 7 took the Sone Sexual History; 5 took the Hansen Sex Attitudes; 4 took the Abel & Becker Sexual Interest Card Sort, and 6 took the Carich-Adkerson Victim Empathy and Remorse. In addition, four offenders took the Buss-Durkee Hostilty Index, and nine took the Bumby Cognitive Distortion Scale, and nine took the Cognitions Scale. Two offenders were administered an IQ test. The remaining tests were administered to no more than one offender: Obsessive-Compulsive Assessment; the Michigan Alcohol Screening; the Wechsler Memory; the CA Verbal Learning; the Woodcock Johnson; the Tests of Achievement; Psychosocial History; Attitudes Towards Women Scale; the Beck Depression; the Symptom Checklist; the 16 Personality Factors; and the Shipley Institute of Living.

Psychiatric Referrals/Treatment Plans

All of the 40 treatment evaluations addressed whether the offender needed psychiatric treatment and, related, whether the offender should be on antidepressants. Seven evaluations (17.5%) explicitly recommended that the offender should receive psychiatric treatment. Five treatment evaluations explicitly suggested that the offender should be on antidepressants; an additional five noted that the

offender was already on antidepressants.

The evaluation team also examined specific treatment plans to determine how well the plans were being tailored to idiosyncrasies in offenders' needs. The evaluations were rather uniform in their recommendations of group therapy (n = 38, 95.0%) and/or individual therapy (n=31, 77.0%) to address issues such as offenders' acceptance of responsibility for the offense, awareness of their sexual assault cycle, and other cognitive-behavioral treatment goals. There was, however, a great deal of tailoring to individual needs. Ten of the plans (25.0%) recommended family or couples' counseling. Nine of the plans (22.5%) recommended substance abuse counseling (an additional plan recommended a substance abuse evaluation to assess a potential need for counseling). Two of the plans (5.0%) recommended dealing with an offender's aggressive/sadistic behaviors. However, the evaluation team also noted two instances where, even though the written report noted elevated levels of aggression and anger, the treatment plan did not explicitly address these issues.

In addition, 34 of the 40 treatment plans (85.0%) included some other unique recommendation for treatment. These unique recommendations were generally tailored to offenders' individual needs and/or differences surrounding the nature of the offense.

However, no treatment plans explicitly indicated a need to address offenders' attitudes toward women. Only one treatment plan explicitly indicated a need to address offenders' power and control tactics in relationships. However, both of these issues may potentially be addressed in family/couples' therapy.

The Nature of Treatment - Description of Treatment Provided

This report describes the treatment being provided to adult male sex offenders referred to treatment programs by the DuPage County probation department. It is based on two primary sources of information collected between March and May of 1999. The first was a series of interviews with probation officers (PO) working in the sex offender program in each county. The relevant points and results of these interviews are presented below, intermingled with the results of the second and more primary source of information for this aspect of the evaluation, a survey of providers who had been referred treatment cases from the DuPage probation department.

For the purposes of this evaluation, the participants were defined as those treatment providers who had been referred cases and were maintaining active caseloads of adult sex offenders on probation in DuPage County. At the time the survey was mailed out, there were 6 such providers identified by the DuPage probation.

The evaluation team developed the survey. The intent of the instrument was to collect information on a number of areas deemed to be important aspects of treatment. Additionally, the inclusion of certain questions was based upon knowledge gained during the evaluation of sex offender treatment in Cook County currently being conducted by the authors. For example, we learned in that evaluation that only one of the three treatment providers evaluated had consistent, written policies on tardiness, and absences from treatment. As a result, at one treatment program, participants could be violated for two unexcused absences, while it was not clear how many unexcused absences would result in a violation at the other two treatment programs. Thus, we wanted to know if the providers in DuPage County had developed such policies.

The final instrument consisted of 18 questions, though many questions had multiple parts. The following general content areas were each covered by a series of short answer, yes/no, and multiple choice questions: organizational characteristics, clinical characteristics (e.g., number of therapists, past experience of the therapists providing treatment, the clinical orientation(s) of the treatment programming offered by each provider); providers' views on the most salient clinical aspects of treatment; the extent to which programs had written policies about attendance, lateness, and treatment participation; and the PO's degree of participation in treatment and the providers' perceptions about the impact of the parole officers attendance and participation.

The survey also included a few open-ended questions, one of which asked providers for recommendations on how to improve the delivery and effectiveness of sex offender treatment in their county. And finally, we requested that providers send us any written documentation on the nature of treatment provided; giving as examples exercises they routinely use, handouts, and homework assignments. We estimated that it would take providers from 15 to 20 minutes to complete the survey.

Using a mailing list of the principal contacts at each treatment provider, the survey was mailed to the six DuPage providers. The initial mailing was done in late March of this year. The providers were instructed in an accompanying cover letter to complete and mail their surveys back in as timely a fashion as possible.

By the middle of May, approximately six weeks after the initial mailing, only a few of the forms had been returned. To foster greater participation, we called each of the six providers reminding them of the survey and asking them to complete and fill out their surveys if they had not already done so. This first round of calls yielded several additional completed surveys for a total of four or 66% of the treatment programs in DuPage County.

Administration of the surveys was anonymous and confidential. By design, we did not collect any identifying information on the survey forms, other than county, to foster as much candidness on the part of the providers as possible. Thus, in this report, we present findings either in aggregate or without information that would identify the provider.

Organizational Characteristics

The first few questions on the survey addressed quantitative issues about how many cases were being seen and how many therapists were providing care at each clinic. The mean number of active cases reported was 22, ranging from 7 to 35 open cases at the time of the survey. In sum, 87 cases had been referred for treatment from the DuPage probation department. The four providers reported a total of six therapists involved with seeing sex offenders for an average of between 1 to 2 therapists per clinic.

We next wanted to determine the professional qualifications and experience of the therapists providing sex offender treatment. Providers were asked to give the highest academic degrees that therapists on their staffs had attained, whether or not the therapists in their program had any prior experience working with sex offenders and, if so, how long they had been working specifically with sex offenders. Most of the DuPage therapists providing treatment to probationed sex offenders are social workers. The majority of therapists, four (66%), have MSWs or LCSWs. Of the remaining two therapists listed, one has a bachelor's degree and one has a Ph.D. None of the therapists providing services in DuPage had an M.D.

The providers responding to our survey said that all their therapists had experience working with sex offenders, with the average number of years experience at about eight. Based on these findings, it appears that the therapists providing treatment in DuPage have significant clinical experience working

with sex offenders. If this self-reported information is valid, it would suggest that the therapy provided in these three counties is at least of reasonable quality (though this would require direct observation to confirm.)[8]

Clinical Characteristics

The next sequence of questions was designed to assess more information about the exact nature of the therapy being provided. Providers could select from among four pre-determined options as to the preferred modality of treatment in their programs: individual counseling; group counseling; couples and family therapy; or a mixture of group, individual, and family therapy. The Dupage providers mostly preferred group therapy with 75% indicating it was their preferred modality while only one provider indicated a preference for offering a mixture of group, couples, and family therapy. The providers were evenly divided as to whether their clients received medication in conjunction with counseling.[9]

Since the preceding question on preferred modality of treatment was a forced choice question limiting respondents to a single, preferred modality, it might not accurately characterize all of the different types of services that clients were receiving (even though one kind of service might be preferred.) Therefore, in the next question, we asked the providers to assign percentages to different packages of treatment options to better reflect the actual balance of services offered to clients. The options provided on the survey form were: only group therapy; only individual therapy; only medication management; only

[8] This is a large and generalized caveat to the entire report and methodology. We found in our direct observations of treatment in Cook County that therapists varied widely in their skill conducting the groups. We observed this variation even among experienced and credentialed therapists, some of whom ran groups effectively and others who let the groups drift and remain unfocused for many sessions. Therefore, while credentialing and experience may be minimal requirements for conducting therapy of good quality, there are other personal and professional factors that contribute heavily to whether or not any individual therapist will be effective.

[9] Unfortunately, we did not ask for details on the specific kinds of medication used, the timing of medications, or how it was determined that any particular client should be on medications. Moreover, the wording of the question does not allow us to determine if the medications were for more general psychiatric conditions such as depression or were specifically for treating the sexual offending.

couples/family therapy; a combination of group, individual, and couples; and a combination of group, individual, couples, and medication management. Providers were asked to give what percentage of their sex offender clients received services consisted with each of the options.

There are three statistics to report for each option in order to best characterize the responses received: First, how many of the providers endorsed the option at all. Second, of those providers endorsing an option, what was the average percentage of clients receiving that particular configuration of services. And third, what was the range of responses, which would provide an indication of the variation in service options among the providers. Three of the providers (75%) said that some proportion of their clients only received group therapy, with an average of about 40% of the clients in their programs seen exclusively in group sessions (range 3% to 80%). All of the providers indicated some of their clients were seen in individual therapy alone but, reinforcing the notion that group therapy is the preferred modality of treatment for sex offenders, the average percentage of cases characterized as being solely in individual therapy was only 9% (range 5% - 10%). None of the four providers indicated that any of their sex offender clients were exclusively receiving medication management or couples-family therapy. These two forms of treatment, when used, appear to be used only in conjunction with group and/or individual therapy.

Group size is an important parameter. In as much as the therapeutic value of groups depends on size, groups that are too small, under five participants or so, lack the necessary group dynamics and interchanges between participants; factors posited to be among the principal therapeutic elements of group treatment. Alternatively, groups that are too large, over about 10 participants, often allow many participants to "hide" during sessions and not contribute in a meaningful fashion (this is also a problem with unskilled therapists who tend towards a passive or *laissez faire* style of leading groups). In our

questioning of the providers on average group size, we found they had calibrated their group sizes to be within this theoretical range. The average group size across providers was 7 with a range of 5 to 10 participants per group.

The final two options for this survey question represented combinations of the first four items. The first of these options included all of the aforementioned treatment modalities *excepting* medication management; 80% of the providers endorsed this option indicating that an average of 45% of their clients received this rather extensive service bundle (range 10% - 90%). A slightly smaller proportion but still a majority of the providers endorsed the final option, 60%, which indicated that some of their clients were receiving all 4 types of services with an average of 27% of the clients for these 6 providers falling into this category (range 5% to 100%). The pattern of responses for this item show that while group therapy is the preferred treatment modality, the majority of sex offenders are receiving multiple treatment services.

While individual therapy was not a primary treatment mode compared to group, the above series of questions indicated that individual treatment *is* used by most of the DuPage providers. Several follow-up questions asked about average caseloads for therapists who provided individual therapy. Again, caseload size is important but primarily of concern when a therapist has too large a caseload to effectively deal with all of the cases and carry out other responsibilities such as coordinating assessments and reporting on therapy to the DuPage probation department. On average, therapists at these clinics saw 12 clients on an individual basis ranging from 4 to 30 clients. We would suggest that a caseload on the high side of that range is probably approaching the maximum number of individual hours that is optimal given the intensive assessment, monitoring, and clinical needs of sex offenders along with the demands of running group sessions.

Recognizing that the therapists might also see other types of clients in addition to sex offenders, we asked them to specify their total caseloads and include all of the clients they see on an individual basis. The reported average total caseload was 30 clients, ranging from 17 to 45 clients per therapist. These are indeed busy therapists and some are clearly operating at or beyond their peak levels of efficiency. At these levels, things like paper work, monitoring, and timely reporting tend to slip and ultimately affect programming overall. If there is an increase in the referral stream of sex offenders from the probation departments, one of the factors that should be discussed is whether a given clinic can handle the additional cases with existing staff or whether they might require more staff. If more staff is required, this could affect funding rates. The DuPage probation department should be aware of individual and group caseloads and be prepared to negotiate for additional therapists (or clinics) accordingly.

With respect to each program's clinical orientation, an open-ended question was provided that allowed each respondent to write in detail about his/her approach. Table II-6 shows the verbatim responses (with some minor editing) of the providers.[10] It can be readily seen that almost every provider indicated his/her program used a cognitive-behavioral approach that included relapse prevention. Some of the providers elaborated that their treatment model included other types of interventions such as sensitization techniques, or used an AA philosophy in groups, but it is clear that clinically, the cognitive-behavioral approach predominates and can be said to have been virtually universally adopted by the treatment providers in DuPage County.

[10] In a few instances, comments were slightly edited to add clarity. In a few others, the writing was not legible or was not deemed relevant to the question asked and was omitted.

Table II-6

Descriptions of Treatment Orientation

Relapse prevention, cognitive-behavioral, and psychodynamic...
Cognitive-behavioral and relapse prevention with group sessions modeled after alcohol treatment (AA meetings).
I combine cognitive-behavioral methods with a clinical social-work approach aimed at both reducing dysfunctional shame (which blocks learning and growth) and breaking the process of secrecy which perpetuates the climate that supports sexually offensive acts.
Cognitive-behavioral, relapse prevention

Finally, in this section, providers were asked to estimate the percentages of clients who paid at least some portion of their treatment and assessment fees and to indicate at what point in the process treatment assessments are performed. The results indicate that most offenders are required to pay for some portion of their treatment and their assessments. All of the providers said that their sex offender clients paid for treatment, with an average across all providers of 94%. Similarly, 94% of the offenders in treatment are required to pay at least some part of their assessment fees, which according to all of the Dupage County providers are conducted after sentencing but prior to treatment referral.

Table II-7

Rankings of Salient Treatment Characteristics/Exercises
Scale 0 to 7: Where 0 = not at all clinically important and 7 = extremely important

Category 1: Extremely Important	**Mean rating**
Confronting denial so the offender accepts full responsibility	6.8
Teaching offenders specific behavioral and cognitive skills they can use to reduce their risk of offending	6.8

Helping offenders understand the affect their actions have had on their victims	6.8
Helping offenders recognize and stop deviant thoughts and urges	6.3
Covering and understanding the sexual abuse cycle	6.5
Category 2: Important but not Extremely	**Mean rating**
Teaching appropriate sexuality and sexual outlets	5.8
Routine polygraph testing	5.8
Teaching anger management skills	5.5
Demonstrating assertiveness skills and appropriate social interaction skills with other adults	5.3
Directly lowering sexual arousal to inappropriate persons/acts by using behavioral techniques or medication management	4.3
Category 3: Non-Important	**Mean rating**
Regular attendance of probation officers at group sessions	2.5

Salient Aspects of Treatment

Providers were presented with a series of 11 session characteristics or exercises and asked to rate them in terms of their clinical importance on an 8 point scale. A score of 0 meant the characteristic or exercise was not at all clinically important while a score of 7 meant that it was extremely important. For the purposes of presentation, the results for this survey question are presented in three groups as shown in Table II-7 above: Those characteristics deemed extremely important by almost all the providers; those deemed important but not as essential; and a single characteristic seen as being non-important by the providers.

For the most part, the session characteristics/exercises deemed most important were those directly related to sexual offending and to relapse prevention – confronting denial, teaching new cognitive and behavioral skills to reduce the likelihood of relapse, understanding the effects of the behavior on the victim, and understanding the sexual abuse cycle. Activities that were somewhat less directly related to the actual offending behavior such as anger management and assertiveness training, and routine polygraph testing were ranked as being in a second tier of importance. And finally, the attendance of PO's at sessions was seen as being unimportant from a clinical standpoint. A series of additional questions about the non-clinical aspects of PO's attending treatment are presented below.[11]

Another issue related to clinical saliency is relapse and the signs that suggest an offender is at increased risk for committing a new sexual offense. In an open-ended question, providers were asked what specific behaviors or indicators signified to them that a client was at increased risk for relapsing. Table II-8 presents the verbatim results from this question. Reviewing the responses, it appears that the providers interpreted the question in two different ways. Some providers thought we were asking them to identify the cohort of high-risk-for-relapse offenders, period. Closer to the intent of the question were the providers who attempted to identify the *changes* in an offender's behavior that signal an increasing likelihood of relapse during treatment. While there is considerable variability in the responses (in contrast to the open-ended responses given to, for example, the question on clinical orientation where most of the providers said they used cognitive behavioral therapy), it is possible to identify common themes. These are: increased social stress, psychological distress, pathological thinking or

[11] This evaluation included collecting the same surveys from providers in Lake and Winnebago counties. The responses across counties were very consistent as to which treatment characteristics/exercises were most important. There were some differences in ordering within the three larger categories in the table, but characteristics seen as extremely important in DuPage were also viewed as such by the Lake and Winnebago providers and so on.

fantasies, and behaviors indicating a lack of engagement from or rebelliousness against treatment and probation.

Table II-8

Information or Actions Indicating High-risk of Relapse

This depends on each individual's particular risk factors but generally an intensification of negative stressors contributing to feelings of emotional vulnerability (e.g., sadness, hopelessness, etc.)
If they talk about fantasies involving stalking or if they are in denial and not taking responsibility.
All of these combined: Shame and isolation (e.g., much secrecy) are high; social stress triggers (e.g., fatigue, frustration); prevailing sense of unworthiness, and no reliable adoption of sex offense cycle awareness and no awareness off physiological sexual abuse signs.
Not taking an active role in treatment, being defensive, believing that it will never happen again depending on "will power", thinking they no longer need treatment, and anger.

Probation Officer Participation in Treatment

While the providers rated PO's participation in treatment as clinically unimportant, we wanted to understand if they also felt it adverse to the groups in any way, how often PO's attend sessions, and how active they are in sessions they attend. Three of the four providers said that POs attended treatment sessions offered by their programs. Interestingly, within Dupage, there was at least one program where the PO's did not come to the group sessions; a finding that mirrored the pattern of PO attendance at treatment programs we found in Cook County. It is not clear why PO's attend some

groups and not others, but on the surface, it seems an uneven way of monitoring treatment participation. The result of this unevenness is that some offenders have their POs attend sessions while others do not. Or, it could be that some providers make themselves more available to the POs and are more active in fostering PO attendance. The interviews with the DuPage POs, however, seems to rule out the latter as the officers noted that all providers were open to their attending group sessions. This issue deserves further investigation as to the factors underlying the uneven monitoring of treatment by POs to determine if there are programmatic factors contributing to this issue, if it reflects a policy decision of the probation departments, if it is simply related to differences among POs, some of whom are inclined to attend treatment sessions and other who are not, or if it is related to attributes and attitudes of the providers.

It appears that in most cases, when POs do attend treatment sessions, it is infrequently. Of the three providers who said POs attended treatment sessions at their programs, two indicated that it was on less than a quarterly basis. However, one provider said that PO attendance was on a quarterly basis. Again, there appear to be differences in the level of treatment monitoring among POs that do attend. When POs attend sessions, they apparently do so in an unobtrusive fashion. In no instance did a provider indicate that POs attempted to lead the sessions and when the POs did talk during sessions, it was only occasionally (100%). Thus, the POs who do attend therapy sessions are there mostly in an observational role. Perhaps because of the unobtrusive nature of their attendance at groups, POs attendance at groups was given a positive rating, an average score of 5 on an 8 point scale, indicating the POs presence was more helpful and beneficial than unhelpful and disruptive. Apparently, providers make a distinction between the clinical significance of PO group attendance, which they rated as low, and the helpfulness of POs session attendance. Attendance may not be critical clinically, but the

providers who did have POs attending sessions did not feel their attendance was disruptive to the treatment process and was modestly beneficial.

PO attendance of the treatment sessions did provide an interesting glimpse into some potentially qualitative differences between the treatment providers that did not come across in the survey responses. Following are the PO descriptions of the providers' therapy styles highlighting the differences in how group sessions and individual counseling are conducted among the DuPage treatment providers:

> Provider 1: *The sessions are very structured, offenders work at their own pace, and offenders have homework assignments. Typically does not conduct individual counseling, but does meet with the sex offender's partner.*
>
> Provider 2: *Offenders have therapy each week with group and individual counseling alternating. Individual treatment is counseling, not behavioral though [the therapist] is starting to learn about behavioral techniques. Offenders have some homework.*
>
> Provider 3: *Group therapy is relatively unstructured, confrontational, and can sometimes get carried away. Group therapy focuses primarily on awareness of the sexual assault cycle. Provides individual counseling on a case-by-case basis.*
>
> Provider 4: *Very professional and thorough. Has three sessions of individual counseling to prepare offender for group therapy. High risk offenders are required to have both individual treatment and group therapy. Individual treatment focuses on behavioral approaches to reduce deviant sexual arousal.*
>
> Provider 5: *Group therapy sessions are unstructured without specific topics or standards to measure progress.*

Written Policies

The rationale for including questions on written policies regarding things like lateness, absences, and payment schedules was discussed above. Most of the providers in this sample, 75%, responded they had written policies on treatment rule violations and that these policies had been discussed with therapists on staff. Specifically, the treatment rule violations most often covered were the number of unexcused absences allowed (75%) and what constituted an unexcused absence (75%). However, most providers said they did not have written policies on what constituted being late for a session (75%), and no provider had written policies on the number of late sessions allowed. Only one provider had a written policy on payment schedules and requirements.

The interviews conducted with the DuPage probation officers confirmed that the providers did not have consistently applied policies on lateness. One provider was described as follows by the interviewed probation officers:

> *"...is very liberal about absences. An excused absence is given if the offender calls and informs the therapist that he will not be attending group. No specific number of unexcused absences before treatment is terminated."*

While another was described in the simplest of terms this way:

> *"... is strict on attendance."*

The lack of written policies on lateness was also a problem for the Cook County providers and one that led to conflicts in some of the observed sessions. Some Cook County clients would come 5 minutes late to sessions, others 15 minutes late, and on a few occasions, several clients came 30 minutes

late. Lacking an enforceable, written policy, the providers were left to develop ad hoc rules that were quickly contested by the clients or they would engage in contentious debates about whether or not the lateness was excusable (every one who was late had *some* excuse.) Precisely because the lack of written policies on tardiness can often lead to these kind of problems, we would advise the DuPage probation department and providers to jointly come to some kind of an agreement and develop clear, specific, and written policies on tardiness (and, apparently, absences) and enforce these policies consistently.

Provider Recommendations

The last question on the survey asked the providers to make recommendations for improving treatment effectiveness. Only two of the providers responded to this question. One provider used the opportunity to praise the DuPage County probation department while the second wanted to see the creation of halfway house programs for sex offenders.

Summary

As already noted, we wish to stress that the survey method of evaluation is limited to the validity of the providers' self-report. With that important caveat, and based on the above survey results for DuPage County, we make the following observations and recommendations:

- The referral stream of clients from the DuPage County probation department appears to be funneling adequate numbers of cases to the treatment providers. The program appears to be successfully linking sex offenders with treatment programs and to be using a variety of treatment programs.
- All of the providers rely primarily on group treatment as the preferred treatment modality though many offenders receive a variety of services such as individual and family counseling.

The primary clinical orientation of the programs is cognitive-behavioral. As best we can tell from the surveys, the treatment being provided is at least adequate and appropriate. The therapists have good clinical credentials and are experienced in providing sex offender treatment.

- However, the interviews with the DuPage probation officers suggest that there are differences among the providers in the nature of treatment offered ranging from "very professional" to unstructured.
- The average number of attendees at group sessions is within the appropriate range. However, some of the therapists appear to be carrying rather large individual caseloads in conjunction with their work with sex offenders. If the number of sex offenders referred to these programs increases substantially, the DuPage probation department should monitor this issue and make sure that no therapist has a caseload of greater than about 30-35 clinical hours per week.
- The DuPage County probation officers attend therapy sessions at most of the providers. This issue should be addressed so that the monitoring of treatment is consistent from provider to provider. Attendance at treatment is on a less than quarterly basis, is unobtrusive and appropriate, and is viewed as modestly beneficial by the providers though not especially salient from a clinical standpoint.
- The providers tend not to have written policies on session lateness and payment requirements. With the DuPage County probation department, they should develop such policies to avoid confusion and inconsistent application of treatment requirements.

Short-term Probation Outcomes

From November of 1997 to February of 1999, DuPage County provided monthly statistics on the number of successful moves to level III, the number of technical violations, the number of arrests, and the number of recycles back to level II. The DuPage program had 99 individual intakes during the 16 month period covered by data analysis. A total of 48 cases are still active either in the grant program or via transfer to other counties. Of the remaining 51 cases, 41 or 80.4% were successfully moved from grant program supervision to level III supervision by the sex offender team. While this does not mean that these offenders' level I and II probation periods were violation-free, it does indicate that they completed the intensive supervision/surveillance level of their probation without violations serious enough to warrant revocation of probation by the court. Eight of these 51 cases or 15.7% of the offenders could be classified as failures by virtue of sentence to DOC, to jail, deportation, or being on fugitive status. In addition, four cases that were at one point successfully moved to level III were sanctioned back to the grant program. Arrests included charges of burglary, falsification of sex offender registration, resisting a police officer, possession of a controlled substance (2 defendants), public indecency (2 defendants), operating vehicle without a license, disorderly conduct (peeping), trespassing, and possession of drug paraphernalia. A total of 12 technical violations were committed for a technical violation rate approximately of 12.1%[12]

The evaluation team coded all event records for number of urine and breath tests conducted and the results of such tests from October of 1997 to February of 1999. A total of 325 urine drops were made, 119 breath analysies were conducted, and 72 times offenders received both an

[12] This is approximate because multiple violations may be filed on some cases so the base number of cases is often smaller than the total intake figure used to calculate the technical violation rate. We used this base to allow for

urine drop and a breath analysis. For 30 of these tests (5.9%), the results were unknown, and for 88.8% of the tests the results were negative, and 1.2% of the tests returned as "negative, diluted". Twenty tests (3.9%) returned with positive results for drugs/alcohol in the defendant's body. Two defendants refused to submit to a urine drop. The DuPage program statistics did not contain consistent references to probation condition compliance so this variable could not be measured. This is consistent with most corrections programs that do well at documenting noncompliance but rarely refer to compliance. Based on treatment provider reports, 12 polygraphs were conducted between September 1998 and February of 1999.

Short-term Treatment Outcomes

The evaluation team asked all treatment providers to complete a standardized monthly progress report for all offenders receiving treatment in our sample. The standardized monthly report assessed the progress of the offender on six critical dimensions of treatment: (1) participation in therapy sessions; (2) commitment to treatment; (3) acknowledgment of personal responsibility for the offense; (4) understanding of the consequences if he re-offends; (5) willingness to disclose details of additional inappropriate behavior; and (6) acceptance of responsibility for emotional/physical damage their actions caused the victim. All of these dimensions were rated on ten-point scales where 1 is equal to none of the dimension (e.g., no acceptance), 5 is equal to moderate, and 10 is equal to complete on the dimension (e.g., complete acceptance). In addition, therapists provided specific information about the number of scheduled and missed therapy appointments, the number of unexcused absences, and whether offenders completed all homework assignments. Therapists also provided information about any positive lifestyle changes since last report, and about any admissions to inappropriate sexual

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program comparisons.

behavior since last report. Therapists also indicated whether a polygraph test had been administered.

Responsiveness to treatment is an important intermediate outcome in evaluations of how well treatment reduces recidivism. Responsiveness to treatment can be measured in several ways. For example, at least two independent neutral experts could observe and interview each offender at several points during the entire treatment period; unfortunately, this design though ideal at reducing response biases, is intrusive, expensive, and could interrupt the treatment process. The evaluation team, therefore, decided to obtain monthly treatment reports from providers on each offender and to measure systematically critical dimensions that treatment is designed to change.

There are both advantages and disadvantages to using progress reports from therapists as a measure of whether offenders are responsive. One important advantage is that the therapist knows where the offender began and how well they have met treatment standards. Therapists also judge the progress of offenders in relative terms to how previous and current clients are responding to similar treatment. A potential disadvantage, however, is that therapists will tend to cast offender's progress in the best possible light to show that treatment is effective. In an attempt to reduce this positive bias, we instructed therapists that all data would be grouped in each county and analyses on separate agencies would not be performed. We also instructed therapists that our primary goal was to understand the predictors of treatment responsiveness and not to address the question of whether treatment was effective. We believe progress reports can be reliably used to determine the characteristics that distinguish offenders who are responsive from those who are not responsive. These data, however, are quite limited to determine the effectiveness of treatment, which is better answered with matched-control sample designs that have long-term follow-up.

We had a total of 29 offenders from DuPage County in which treatment providers submitted

monthly treatment reports. We received treatment reports from three of the four major treatment providers in DuPage County. For 28 of these offenders, we had four or more months of monthly progress reports from September of 1998 to February of 1999, most of these offenders had all months of data. For one offender, we had only three months of progress reports. Three offenders were not in sex offender treatment. DuPage County had 17 offenders who were in treatment for which we did not receive monthly progress reports.

Two basic indications of offenders' lack of participation in treatment are how often they miss sessions with unexcused absences and how many times they fail to complete homework assignments. Eighteen offenders (64.3%) had no unexcused absences, and the rest of the offenders had between one to four unexcused absences with the majority of these offenders (N = 7; 25%) having only one unexcused absence. Offenders were also diligent about completing homework assignments. Homework assignments were applicable to all offenders. Twenty offenders (71.4%) completed all homework assignments for all months that monthly treatment reports were completed. The remaining offenders missed from one to seven homework assignments during these months, with a mean of two missed homework assignments across all months. One indication that therapists took the task of completing these monthly treatment reports in as accurate manner as possible is that offenders who were rated lower on the scale of participation did not attend all therapy sessions and did not complete all homework assignments.

Classifying Offenders as Responsive to Treatment

In order to classify offenders as responsive or unresponsive to treatment, we first conducted N-of-1 statistical analyses. N-of-1 statistical analyses are an improvement over visual inspection of the

data because they provide a reliable standard by which improvement can be measured.[13] Ispative N-of-1 analyses address the question, did this offender improve during the course of treatment compared to when the offender entered treatment? We performed ipsative analyses for each of the six dimensions for each individual.[14] Ipsative analyses did not reveal any significant changes across time. There are several theoretical and methodological reasons for these null findings. First, most offenders were already in treatment for many months before we obtained any ratings of their progress; thus, we do not have a true baseline point. Second, sex offenders are in treatment for behaviors and attitudes that require a long period of time to change. Sex offenders do not quickly obtain victim empathy, acceptance of responsibility, or recognition of the inappropriateness of their behavior. Indeed, most sex offenders received similar ratings across the months on these dimensions. This stability in ratings means that sex offenders are changing more slowly than month to month.

A more relevant question that normative N-of-1 analyses can address is: Within this sample of offenders, who is more responsive to treatment? Normative N-of-1 analyses have more practical implications. These analyses can address questions such as: (1) if treatment resources are scarce, which offenders will most likely benefit from treatment? and (2) which offenders are most likely to terminate prematurely from treatment due to noncompliance with treatment rules?

The normative-based N-of-1 analyses revealed nine significant changes at $\underline{p} < .05$.[15] One

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[13] As Mueser, Yarnold & Foy (1991) note, "statistical analysis of single-subject data provides a rule-governed, systematic approach to assessing outcome that simply is not possible with visual inspection alone." (p. 135) N-of-1 analysis takes into account an individual's performance at baseline compared to their performance during the observation months. Because numerous data points are needed in order to employ time series analysis, we chose to employ N-of-1 analyses derived from classical test theory (see Yarnold, 1992).

[14] Ipsative single-case analyses first convert an individual's raw data into standard z scores using an individual's own mean and standard deviation for the variable being standardized.

[15] N-of-1 normative analyses convert the raw data to z scores using the mean and standard deviation of the entire sample, which allows relative comparisons across offenders. To standardize the data, we used the mean and standard deviation across time for each question based on all monthly treatment reports collected from Lake, Winnebago, and DuPage County. In all three counties, therapists provide cognitive-behavioral group therapy. Grouping data from all three counties insured that we had a more representative population of sex offenders and did not create an artificial restricted range on our measures.

offender showed significant improvement on acknowledging personal responsibility for the offense. Two offenders showed significant improvement on understanding the consequences if he re-offends. Three offenders showed significant improvement on willingness to disclose details of additional inappropriate sexual behavior. Three offenders showed significant improvement on acceptance of responsibility for emotional/physical damage to victim.

Because offenders had been in treatment for an average of nine months and ten had been in treatment for over one year, we also developed absolute criteria to classify offenders as responsive or unresponsiveness. Based on monthly progress reports from three counties (Lake, DuPage, and Winnebago), we calculated the mean, median, and 60th percentile for each of the six dimensions. Table II-9 presents these data.

Therapists in DuPage County consistently had higher mean ratings than therapists as a whole, but made distinctions between offenders as evident from the lowest and highest mean rating across time for individual offenders. Table II-10 presents the means for the total sample of sex offenders in all three counties compared to the means for sex offenders in DuPage County, the lowest mean across time for an offender in DuPage County, and the highest mean across time for an offender in DuPage County. DuPage County therapists utilized the entire rating scales as evident by the lowest mean for an individual across time and the highest mean for an individual across time.

Table II-9

Descriptive Statistics of Therapists' Ratings of Sex Offenders' Progress in Three Counties

Dimension	Mean	Standard Deviation	Median	60th Percentile
Participation in therapy	5.88	2.41	5.88	6.43
Commitment to treatment	5.57	2.50	5.41	6.29
Acknowledge personal responsibility	6.33	2.69	7.0	7.20
Understand consequences if re-offends	7.41	1.83	7.55	8.2
Willing to disclose inappropriate sexual behavior	4.90	2.70	4.68	5.5
Accepts responsibility for emotional/ physical damage to victim	5.69	2.72	5.88	7

Table II-10

Comparison of Mean Ratings of Therapists Across All Counties to DuPage County Therapists

Dimension	Mean Across All 3 Counties	Mean for DuPage County	Lowest Mean Across Time	Highest Mean Across Time
Participation in Treatment	5.88	6.98	2.5	9.8
Commitment to Treatment	5.57	6.56	1.0	9.8
Acknowledge Personal Responsibility	6.33	7.61	1.0	10
Understands Consequences if reoffends	7.41	8.63	4	10
Willing to disclose inappropriate sexual behavior	4.90	6.04	1.0	10
Accept responsibility for emotional/physical damage to victim	5.69	6.86	1.0	10

To classify offenders based on absolute cut-points of reaching some standard, we established that offenders were responsive on a given dimension if they were at or above the 60th percentile for that dimension. We selected this cut-off based for two reasons. The mean and median seemed to be too

lenient of criteria to label someone as successful on a dimension given the fact that success should mean more than 50%. Given the distribution of the data and the fact that these behaviors and attitudes are slow to change, the 60th percentile (which is the mean + .5 standard deviation) made empirical and conceptual sense. After classifying each on all six dimensions, offenders were classified as overall responsive if they were classified as responsive on 4 of the 6 dimensions or if they were classified as responsive on 3 of the 6 dimensions and showed a statistically significant improvement on one of these dimensions.[16] For the entire sample, twenty-two offenders (55%) were classified as overall responsive.

Therapists reported a mean of 1.26 positive lifestyle changes per an offender for all months in which progress reports were obtained. Eleven offenders (35.5%), however, did not have any positive lifestyle changes. Several offenders had more than one positive lifestyle change. Nine offenders were reported to have better relationship with their spouse or intimate partner. Four offenders had improvements in their employment. Other lifestyle changes included: supervised visits with children, open to coming in for individual counseling, trying to take better care of self, asked for individual treatment, paying more attention to wife's feelings, satisfactory termination, risking more to expose own vulnerabilities and imperfections to others, moving out of mother's house, left unhealthy living situation, attends AA regularly, more assertive, got rid of destructive roommate, and attempting to be involved in more healthy relationships.

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[16] Interestingly, across the six dimensions, only one sex offender was classified as unresponsive on all dimensions. Five offenders were classified as unresponsive on 5 of the 6 dimensions, and two offenders were classified as unresponsive on four of the six dimensions. Thirteen offenders were classified as responsive on all six dimensions, three offenders were classified as responsive on five of the six dimensions, and two offenders were classified as responsive on four of the six dimensions. Three offenders were classified as responsive on only three of the six dimensions, and two of these offenders had significant improvement on at least one dimension.

Fifteen offenders were reported as having revealed additional inappropriate sexual behaviors. Many of these offenders had more than one additional inappropriate behavior/thought. Ten offenders disclosed inappropriate thoughts or fantasies: three offenders fantasized about going to forest preserves, two fantasized about exposing private parts to others, two had unspecified fantasies about offending. Other offenders revealed fantasies about prostitutes, sadistic and masochistic sexual acts, using chat rooms, having sex with underage girls. Three offenders admitted sexual offenses: incest and having sex in forest preserves, and peeping. Other offenders committed less extreme inappropriate sexual behaviors: grooming a child before being placed on probation, use of pornographic material, and touching penis outside his clothing in his truck. One offender failed to start treatment, and one was re-arrested for shoplifting.

In order to determine the progress of the 17 clients who were in treatment but did not have monthly treatment reports, we requested from the probation department an update on the status of offenders as well as ten offenders for whom we had treatment reports that we wanted to clarify their current status. The probation department was asked to indicate treatment status (ongoing, terminated prematurely, successfully completed), probation status (active, on active warrant, successfully completed, probation revoked), whether a violation of probation (VOP) was filed for failure to comply with treatment, and whether the offender was arrested while on probation and the nature of the offense. Based on this information, we were able to classify 10 of the 17 offenders who did not have monthly treatment reports as unresponsive to treatment based on the criteria that treatment was prematurely terminated due to noncompliance with treatment rules. Four of the 17 offenders were classified as responsive based on the fact that they had successfully completed treatment. The total sample for DuPage County for analyses on the predictors of responsiveness is 40 of the 46 offenders ordered to

undergo sex offender counseling, which is 87.0% of the relevant sample.

Predicting who is responding well in treatment

Overall, twenty-two of the forty-six offenders were classified as responsive. It is critical to understand the characteristics that differentiate offenders who are responsive to treatment from offenders who are unresponsive. Characteristics that accurately predict whether offenders were classified as responsive or unresponsive to treatment are called "significant predictors".[17] Significance simply means that information obtained from the predictor does better than chance at accurately classifying each offender into either the responsive or unresponsive category. To determine the significant predictors of treatment responsiveness, we employed a statistical tool that provides the maximum possible accuracy in classifying cases. This tool is called optimal discriminant analysis (ODA).[18]

We considered forty potential predictor variables. Demographic and background predictors were age, ethnicity, marital status, number of biological children that offender with whom the offender associates, whether the offender is on welfare, income level, education, and sexual orientation. We considered eight characteristics of the offense: statutory type of current offense, relationship of offender to victim, age of youngest victim, whether force was used, location of the crime, whether penetration

[17] For all analyses statistical significance refers to the probability of claiming that a predictor is related to treatment responsiveness and it actually will not predict treatment responsiveness in future samples. This is known as the type I error rate or p. The type I error rate, p, was assessed as an exact permutation probability, and for each comparison $p < .05$ was used to establish statistical significance. This probability level was chosen to maximize the power of detecting predictors that discriminate between responsive and unresponsive offenders while still maintaining a relatively low probability of making a Type I error.

[18] Parametric statistical analysis was inappropriate due to non-normality and range restriction, and traditional nonparametric analyses were inappropriate due to many tied data values (Soltysik & Yarnold, 1993; Yarnold & Soltysik, in press). Due to the small number of misclassified observations for any single predictor variable, we could not build a model containing additional predictor variables; such models are built using "multivariate statistical tools".

occurred, and number of months that sexual abuse continued. We considered five measures of prior record: total number of prior arrests, number of prior arrests for sex offenses, number of prior arrests for violent crimes, number of prior arrests for misdemeanor crimes, number of prior convictions for violent crimes, and number of prior convictions for sex offenses. We considered ten measures of psychological and social adjustment: whether offender had a drug/alcohol problem; used drugs/alcohol before the offense, had prior treatment for substance abuse, had a serious mental disorder, had prior treatment for a mental disorder, was currently in a sexually active relationship, suicide history, whether the offender was depressed, the severity of the personal history of child abuse/neglect, and whether offender was a victim of physical and/or sexual abuse. Level of functioning on clinical presentation characteristics at the time of intake using the Bays & Freeman-Logo Scale (to evaluate sexual offenders' risk of reoffending): willingness to discuss offense, acceptance of responsibility for offense, and remorse about offense. Based on multiple sources of data from offenders' self-reports, objective personality or sexual preference tests, Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM IV) diagnosis, and prior disclosed offense history and fantasies, we created measures of whether the offender was a pedophile or not, had interest in aggressive or sadistic sexual behavior/fantasies, had engaged in or expressed interest in "hands-off" sexual offenses (e.g., exhibitionism or voyeurism). We could not create a measure of whether the offender had been diagnosis as a psychopathic deviant based on objective personality tests such as the MMPI or MCMI or a DSM IV classification as an antisocial personality because the treatment evaluations were consistently missing this information.

In order to determine the relative performance of each significant predictor, we used the percentage of total theoretical possible improvement in classification accuracy achieved with the

predictor--above the classification accuracy that could be achieved based only on chance. This measure is a standardized test statistic called the "effect strength for sensitivity" (ESS). ESS can range from 0 to 100 where 0 means no improvement in classification accuracy above chance and 100 means that the predictor explains all variation (100%) in classification accuracy above what can be achieved by chance. Predictors can be ranked as weak, moderate, or strong based on the ESS. ESS < 25% indicates that a predictor provides only weak accuracy in classification above what is achieved by chance alone, ESS between 25% to 49% indicates moderate accuracy in prediction above chance performance, and ESS equal to 50% or higher indicates strong accuracy in prediction above chance performance. In addition to the strength of a predictor, it is important to know whether the predictor would perform at the same level of accuracy at classifying a new set of cases; predictors are reliable if they have the same accuracy at classifying cases (measured by the ESS) in the new sample as in the original sample. We report whether a predictor was reliable and provide the ESS for the new sample if the predictor is unreliable.[19] Another factor that can affect the ability of predictors to classify accurately a new sample of data is the distribution of the outcome variable. All predictor variables reported have stable accuracy in classification of cases irrespective of the percentage of cases classified as responsive.[20]

Analyses on all predictor variables revealed four significant relationships, which means that there is only a low probability that these relationships are just chance occurrences that will not replicate.[21]

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[19] A jackknife validity analysis was used to assess how reliable each significant predictor would be in classifying a new sample of data; the jackknife validity analysis employed was a leave-one-out (LOO) analysis where classification for each observation is based on all data except the case that is being classified.

[20] An efficiency analysis was conducted to assess how well a predictor performed over all possible base rates of the outcome variable. The outcome variable, however, could not have all cases classified in only one of the categories (e.g., responsive) (Ostrander, Weinfurt, Yarnold, & August, 1998).

[21] Four significant effects are 1.6 times the number of significant predictors expected by chance.

Only one variable was a stable significant predictor of treatment responsiveness: offenders' acceptance of responsibility for the offense at initial treatment evaluation. If the offender fully accepted responsibility for all aspects of the offense at the time of the treatment evaluation, the model predicted responsive to treatment. The predictor was a strong performance in classification accuracy, ESS = 51.5, $p < .0006$.

Three additional predictors were significant and had moderate to strong performance on classification accuracy, but their performance would be lower (but still statistically significant) if applied to new samples. Significant predictors with unstable classification performance were: age at conviction, marital status, and time in treatment. Offenders who were 33 years of age or older were more responsive to treatment than were younger offenders.[22] Information about marital status improved the accuracy of classification above what would be expected using chance alone. Married offenders were classified as responsive to treatment whereas single, separated, or divorced offenders were classified as unresponsive.[23] Offenders who had been in treatment for four months or longer were predicted to be responsive.[24] Given the small size of our sample, practitioners should regard these findings as tentative until they are replicated using a large number of cases.

Summary and Recommendations

This section summarizes the key findings from our evaluation of the DuPage Country Sex Offender Program and offers some recommendations for program enhancement. We focus upon four

[22] Age at first conviction had the following statistical indicators: (Sample size = 40; $p < .004$; total sample ESS = 53.0; jackknife ESS = 37.4).
[23] Marital status had the following statistical indicators: (Sample size = 40; $p < .048$, total sample ESS = 36.9, jackknife ESS = 31.3).
[24] Time in treatment had the following statistical indicators: (Sample size = 40; $p < .04$; total sample ESS = 39.9; jackknife ESS = 34.3).

key elements that include program design; supervision and surveillance; treatment; and outcome.

Program Design and Management

The DuPage program adopted a mixed caseload-sex offender specialist design comprised of six probation officers assigned to a sex offender team and two sex offender specialists. Team members carried a mixed caseload of primarily regular probation cases along with approximately 13 to 20 sex offender cases. The two adult sex offender specialists (designated "grant officers") carried sex offender cases only. The program serves adult misdemeanor and felony sex offenders convicted of statutory identified sex offenses, adult felony or misdemeanor offenders convicted of a non-sex offense whom the court specifically orders into the sex offender program, and sex offenders sanctioned into the grant program from the sex offender team caseload. Participants must be DuPage County residents and there must be an order of probation. The decision to place a case in the sex offender grant program is usually made at the department level with all cases that meet target population criteria initially referred to the two grant officers. Based on a previously obtained judicial agreement, a set of 15 special sex offender probation conditions become apart of the probation order once the case is assigned to the sex offender program. Cases are assessed within 45 days and sex offender treatment provided by carefully selected sex offender treatment providers. Supervision and surveillance standards are based on a three-level step down model. The program has averaged approximately six intakes a month from November, 1977 through February, 1999[25] and current (February, 1999) caseload is 86 cases with approximately 43 cases per grant officer. The program goal was to maintain sex offender grant caseload at 30 cases per officer. The program plans to implement a case review procedure to identify cases that could safely

[25] Unless otherwise stated, program statistics refer to the 16 month period - November, 1997-February, 1999. We stopped collecting monthly statistics at the end of February to allow time for submission in March and for analysis and review

be assigned from the grant program to the sex offender team thus maintaining the 30 case standard.

The DuPage County Sex Offender Program was found to be functioning smoothly under the clear and consistent supervision of the unit supervisor and administrative oversight of the deputy director for adult services. The unit supervisor is responsible for supervision of both the six sex offender team officers and the two grant officers which assures continuity between the two units. We found the program to be well managed and were particularly impressed with the very detailed policy and procedure document that served to guide all levels of the program. The two grant officers were well trained and enthusiastic about their jobs. One major deficiency was in the quality of monthly statistics maintained by the program. Monthly reports submitted to the Authority provided useful data on caseload and case movement but there was little data on supervision and surveillance contacts. A special computer program designed for this program proved to be inefficient, time consuming and impractical to use and was abandoned. The result was that case contact data were entered into the departments case notes data system that allowed the officer to carefully list all important case contacts and events. The system, however, did not permit aggregation of supervision and surveillance data that could usefully have been included in monthly reports to the Authority.

Supervision and Surveillance

The DuPage County sex offender program set fairly rigorous supervision and surveillance standards that required two home visits and four face-to-face visits per month for level I cases with some reduction for level II cases. Based on assignment date and supervision level, the evaluation team

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during April and early May.

was able to identify specific supervision expectations for each case and, based on a review of case notes determine the number of visits that actually occurred. Findings indicate that the DuPage program failed to meet home visit expectations in all 16 months examined. The program did much better in terms of face-to-face visits exceeding expectations in one month, exactly meeting expectations in another month and coming close to expectations in the remaining months. The evaluation team identified a variety of realistic factors contributing to this program's failure to meet its supervision standards. Some revision in these standards appear appropriate.

Treatment

The evaluation team found the interaction between probation staff and treatment providers in DuPage County to be exemplary. Survey findings indicate a high degree of mutual respect and trust characterized by open and productive communication on a regular basis. These findings result, no doubt, from the fact that all treatment providers and probation offices in the sex offender unit have a regular group meeting once every two months. Probation staff and treatment providers both indicated they were very satisfied with the way the team approach was implemented in this program.

The DuPage program was also found to make extensive use of polygraphs (85% of evaluations), and 61% were full disclosure polygraphs in that they contained questions about prior sexual offending. Most offenders (73.5%) failed at least one question on the polygraph examination, though a high rate (63.6%) of offenders admitted to most of the relevant parts of the offense. The polygraph yielded information on only four additional sex-related crimes that were not part of the offenders' criminal records. However, clinical interviews and polygraphs combined resulted in over half

of the offenders revealing at least one additional sex-related crime (i.e., one that was not part of their official record).

Treatment evlauations were generally adequate in all areas except that 90% did not contain an objective measure of sexual preferences (i.e., the ABEL test or the plethysmograph). An objective personality test was administered to over two-thirds of the defendants, and of these defendants 34.6% had an elevation on at least one personality dimension. Most evaluations also did not address offenders' power and control tactics in relationships and their attitudes toward women. Treatment evaluations for DuPage County were exemplary in the area of psychiatric referrals: all 40 of the treatment evaluations addressed whether the offender needed psychiatric treatment and whether the offender should be on antidepressants. The evaluations were rather uniform in their recommendations of group therapy (95%) and/or individual therapy (77%) to address issues such as offenders' acceptance of responsibility for the offense, awareness of their sexual assault cycle, and other cognitive-behavioral treatment goals. Despite this uniformity, most evaluations (85%) also tailored recommendations for treatment to the individual's needs.

Therapists in DuPage County had considerable clinical experience working with sex offender with an average of eight years of experience. Most therapists endorsed group therapy as the preferred modality of treatment; however, one therapist indicated a preference for offering a mixture of group, couples, and family therapy. The average group size across providers was seven with a range of 7 to 10 participants per group, which is in the optimal theoretical range of group size. Approximately, 87 cases had been referred for treatment from the DuPage probation department. The average number of group sessions scheduled per offender per month was 2.75. Almost every provider indicated that their program used a cognitive-behavioral approach that included relapse prevention. The most important

aspects of the cognitive-behavioral approach were: (a) confronting denial so the offender accepts full responsibility; (b) teaching offenders specific behavioral and cognitive skills they can use to reduce their risk of offending; (c) helping offenders understand the effect their actions have had on their victims; (d) helping offenders recognize and stop deviant thoughts and urges; and (e) covering and understanding the sexual abuse cycle. Anger management, demonstrating assertiveness skills, and social interaction skills were much less central to the cognitive-behavioral approach. In addition, directly lowering sexual arousal to inappropriate persons/acts by using behavioral techniques or medication management also was rated as only moderately important. Though group is the preferred treatment modality, the majority of probation sex offenders are receiving multiple treatments. The average number of individual sessions scheduled (which are typically behavioral for two providers and counseling for one provider) per defendant per month was 1.67.

Three of the four DuPage County providers indicated that probation officers attended treatment sessions offered by their agency. Providers all agree that probation officer attendance was not a necessary part of treatment, and when probation officers attended they typically just observed. Attendance of probation officers at group therapy sessions was on a quarterly basis or less frequent.

Most providers (75%) had written policies on treatment rule violations in particular on the number of unexcused absences allowed and what constitutes an unexcused absence. Most providers did not have written policies on what counts as lateness, the number of late sessions allowed, and payment schedules and requirements. The probation department may wish to standardize such policies across agencies for sex offender probationers. All providers said that their sex offender clients paid for treatment, with an average of 94% of offenders paying for treatment. Similarly, 94% of the offenders are required to pay at least some part of their assessment fees.

Outcome: short -term probation outcome

It is, of course, premature to judge a program as successful based on analysis of only 16 months of data. However, preliminary data on short-term probation outcomes for the DuPage program indicate that a 80.4% of cases terminated from the grant program were successfully moved to lower levels of supervision without any known serious violations during the grant portion of their probation. Although these cases are still on probation, it can be said that they successfully completed the sex offender grant program portion of their probation sentence. Approximately 15.7% of the cases could be classified as failures by virtue of sentence to DOC, jail, deportation or being on fugitive status. Four offenders were sanctioned back to the grant program from the sex offender team. Program monthly reports indicate that there were a total of 12 technical violations yielding a violation rate of approximately 12.1 percent. There were a total of 10 arrests. The program staff noted that sex offenders under their supervision tend to be compliant with probation conditions. Most offenders kept office appointments, permitted home visits, submitted to drug screens with satisfactory results and were not found to be in violation of the program's strict behavioral conditions. This is at least partly due to the enhanced reporting requirements built into the program.

Outcomes: Short-term treatment outcomes

Treatment providers submitted monthly treatment reports for twenty-nine offenders from September of 1998 to February of 1999. The monthly treatment reports assessed using ten point scales offenders' status on participation in therapy, commitment to treatment, acknowledgement of

personal responsibility for the offense, understanding of consequences if offender reoffends, willingness to disclose inappropriate sexual behavior, and acceptance of responsibility for emotional/physical damage to victim. Therapist in DuPage County consistently provided higher mean ratings compared to therapists in the other two counties, and tended to make distinctions between offenders using the entire rating scale as evident by the lowest mean for an individual offender across time (M = 1.0) and the highest mean for an individual offender across time (M = 9.8). For offenders in which monthly treatment reports were submitted, we performed N-of-1 analyses to determine whether offenders had made statistically significant progress from the therapist's point of view. Normative N-of-1 analyses revealed nine statistically significant changes across all offenders and dimensions of treatment. The fact that such few statistical changes were evident indicates that offenders were changing slower than the six month assessment of their progress. This slow change is expected given that sexual offending is based on attitudes and behaviors of a long-standing nature.

Seventeen offenders were in treatment, but we did not receive any progress reports; for these offenders, probation officers indicated their probation and treatment status. Ten of the seventeen offenders were classified as unresponsive to treatment due to the fact that they were terminated prematurely from treatment based on their noncompliance with treatment rules, and three offenders were classified as responsive based on the fact that they successfully completed treatment.

Based on treatment provider's ratings and information about treatment status, 55% of the offenders were classified as responsive to treatment. Further evidence of responsiveness of the DuPage offenders is based on absences and completion of homework assignments. Eighteen of 29 offenders (64.3%) had no unexcused absences, and 20 of 29 offenders (71.4%) completed all homework assignments for all months that monthly treatment reports were completed. Therapists reported a mean

of 1.26 positive lifestyle changes per an offender for all months in which progress reports were obtained. The two biggest categories of positive lifestyle changes were better relationship with spouse or intimate partner and improvements in employment. All offenders, however, were not as responsive to sex offender treatment. Therapists did not report any positive lifestyle changes for 11 offenders, and reported additional inappropriate sexual behaviors for 15 offenders. Many of the 15 offenders with inappropriate sexual behaviors disclosed more than one such behavior; these behaviors, however, cannot be viewed as entirely negative since such disclosures by offenders indicates that therapy is working to allow the offender to admit to their problems. Ten offenders disclosed inappropriate thoughts or fantasies, three offenders admitted sexual crimes such as incest, and other offenders admitted to high risk behaviors that may lead to sexual crimes (grooming a child, use of pornographic material, etc.).

The small size did not allow the Loyola evaluation team to develop a CTA model that determine the factors which best distinquished offenders who were responsive to treatment from those who were unresponsive. Univariate optimal discriminant analyses, however, revealed four significant predictors. The one predictor that had jack-knife stability was whether the offender accepted responsibility for all aspects of the offense at the time of the initial treatment evaluation before treatment began. Future research will have to address whether such a good initial clinical presentation actually means a lower likelihood of recidivism or whether offenders have simply learned that in order to make progress in treatment they must appear to accept responsibility. A larger sample size and longer follow-up period will be able to build upon these initial intriguing results to address the question: for which offenders is treatment effective?

Recommendations

- **The program should revise the monthly data reporting procedure to accurately reflect case supervision contacts. Until a reliable computer-based system is developed, grant officers should keep a paper record of contacts for submission to and summary by the unit supervisor.**

- **The department should give careful consideration to adopting a surveillance officer model by adding a surveillance officer position to the two grant officer program or otherwise adopting a procedure to insure that home visit standards are met.**
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- **The department should give most careful consideration exempting sex offender cases from the department's policy of announcing home visits. Announced home visits for sex offender cases are unlikely to reveal violation of probation conditions or high risk behaviors, and are therefore less cost-effective than unannounced home visits.**
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- **While remaining fully committed to the necessity of home/field visits for sex offender cases, the program should consider adopting a policy to not require home visits during the first month that the case is assigned to allow officers' an opportunity to know better each offender.**

- **The department should create, in collaboration with treatment providers, a standardized treatment progress report that covers all major aspects of treatment, and allows therapists to indicate both positive lifestyle changes and inappropriate sexual behaviors/thoughts since last report. All therapists should be required to submit this written standardized report for all offenders at least once every two months. Probation officers can review these written documents for treatment progress, and will have the opportunity to refresh their memory on critical information before home/office visits. Such standardized reports should supplement rather than replace in person or phone contacts with therapists. Standardized reports, moreover, allow officers to assess which offenders are less responsive to treatment across treatment agencies.**

- **The department should require that treatment providers submit written results of objective personality and objective sexual interest tests as part of the initial treatment evaluation.**

- **The department, in collaboration with treatment providers, should create uniformed written policies on graduated sanctions that are available to deal with noncompliance in therapy as well as uniformed rules on how many unexcused absences are acceptable before the client is terminated and a VOP is filed, what counts as an excused absence, and how new sex offenses reported to therapists should be handled.**

- **A long-term evaluation of the probation and treatment outcomes should be conducted to assess the effectiveness of the additional surveillance and treatment for sex offenders.**

CHAPTER III

LAKE COUNTY SEX OFFENDER PROGRAM

Program Description and Development

The sex offender program in Lake County uses a mixed caseload-surveillance officer approach. Six probation officers, who are designated sex offender specialists, carry a caseload of 80 to 100 cases each, made up of approximately one half sex offenders and the other half regular probationers. Two additional probation officers, designated as surveillance officers, are a key part of the unit. These surveillance officers do not carry their own separate caseload but rather devote full time to community supervision and surveillance of sex offenders on the sex offender specialists' caseloads especially during evenings, weekends and holidays. The program includes any adult felony or misdemeanor offender convicted of any offense that is sexual in nature and is sentenced to probation. The total number of active sex offender cases carried by this unit as of February, 1999 was 244.

Program's Location and Setting

Lake County is the State's third largest county with a 1990 census population of 516, 418. Its main population center and the county seat is the city of Waukegan which is approximately 45 miles north of the city of Chicago. Lake County is part of the 19th Illinois Judicial Circuit which also includes McHenry County. The sex offender program, however, is limited to Lake County. The probation department , or more officially the Lake County Court Services Division, serves both adult and juvenile

offenders. The department caseload in 1997 consisted of 4,141 adult cases and 567 juvenile cases[26]. Adult Court Services,[27] as of July, 1998 had a staff of 54 probation officers, 5 supervisors, 5 probation clerks and 7 support staff. Adult caseloads in the department as a whole averaged approximately 111 in 1997.

In addition to a Standard Probation Unit and the Sex Offender Unit, adult court services maintains a total of six other specialized caseload units. These include a Pretrial Unit, a Presentence Investigation Unit, DUI Unit, Intensive Probation Supervision Unit, a Domestic Violence Unit and a Public Services Unit. The Sex Offender Unit and the Presentence Investigation Unit are located next to each other in the same room because the same person supervises both units. The Standard Probation Unit is also located in the same room. Other units are located in another part of the building. The department also has a Psychological Services Unit available to all department cases.

Program Development

The circumstances that led Lake County to develop a sex offender program and eventually apply for grant funds really go back to 1990. Parole and probation officer training sponsored by the Administrative Office of the Illinois Courts in early 1990 as well as a review of probation caseloads alerted the department to the fact that there was a need to develop specific programming for sex offenders in their county. Adult court services established an ad hoc task force made up of administrators, managers, and line staff to develop presentence

[26] Annual Report, Nineteenth Judicial Circuit, 1997.
[27] Discussion of the Lake County Program is restricted to adult cases only since juveniles are not part of this program's caseload.

investigation (PSI) and supervision standards for sex offenders on probation caseloads and produced a Sex Offender Manual. The department established a specialized sex offender unit in 1995 and adopted the mixed caseload approach at that time. The original unit was staffed with four probation officers (sex offender specialists) who carried sex offenders as part of their regular caseload and had caseloads which averaged about 115-120 cases per officer. These large caseloads did not permit the officer to engage in the intensive surveillance required of most sex offender units.

The department saw the opportunity to use grant funds to enhance their current program in two ways: hire surveillance officers who would devote full time to community surveillance, supervision and monitoring of sex offenders on the sex offender specialists caseloads, and hire two additional sex offender specialists to reduce the caseload of each officer in the unit from an average of 115-120 to about 80, half of which (40) would be sex offenders. It is unlikely, given the tight county budgets, that the enhancements made possible by grant funds would have been implemented with department funds.

The program's two major goals were to reduce caseloads from 115-120 to 80 with approximately half being sex offenders and to increase the surveillance of all sex offenders. Surveillance was increased through community contacts with offenders in their homes, places of employment and areas of recreation at a minimum of three contacts per month and as much as several times a week for those offenders identified as predatory and posing a significant threat to the community.

The program was approved for funding in the amount of $171,373, of which $128,530 was from grant funds from the Illinois Criminal Justice Information Authority through Federal Anti-Drug Abuse Act funds, and $42,843 in matching funds from probation fees received by the county. Funds were to be used to pay the salaries of the two surveillance officers and to purchase specialized equipment such as beepers, police scanners to alert the officers to possible trouble spots. The chief

judge, county board chairman, court administrator, and the deputy director on August 12, 1997 signed the interagency agreement. The grant period was from July 31, 1997 to June 30, 1998, and was renewable each year for three more years. The time from the decision to apply for funds to award of the grant was four months.

Program Implementation

Program implementation concerns the time period from the date of funding to receipt of the first case. During this time period key administrative, staffing and program policy decisions are finalized and the basic operational design of the program established.

Staffing

The total number of staff assigned to this unit is nine. The unit is composed of a supervisor, a unit coordinator, a principal probation officer, a senior probation officer and five line staff. Everyone except the supervisor carries a caseload. However, the two surveillance officers' caseload, one for the north and one for the south portions of the district, are composed of cases assigned to other officers in the unit. Grant funds were used to hire two surveillance officers and two sex offender specialists. Only the two surveillance officers were new hires into the probation department. The other staff were already part of the probation staff. The availability of these two positions was posted in July and two candidates applied. The criteria for selection included a Bachelor's degree, preferably in law enforcement, social work, psychology, or related fields.

During the first year of the grant, essentially August 1, 1997 through July 31, 1998, there were two staff changes. One surveillance officer left in January to accept a position with a suburban police department. One of the sex offender specialists accepted a position with the county's Child Advocacy

Center. Both positions were quickly filled. However, the unit underwent considerable change in staffing in September, 1998. One of the surveillance officers who had been on staff for approximately a year was hired as a unit probation officer to replace a sex offender specialist who left to take an administrative position with the county more in line with her Ph.D. studies in administration. Another sex offender specialist, who had left in late June to pursue her Ph.D. at the University of Delaware, was replaced by the sex offender specialist who had left the unit last year to work with victims but who elected to return. Finally, the remaining surveillance officer terminated his employment with the program on October 8th after finding that he was not really suited to working with an adult caseload. Both surveillance officers have been replaced but one result was that the surveillance unit was without experienced staff for approximately two months and understaffed for approximately six months. The unit is made up of two male and four female sex offender specialists and one male and one female surveillance officer. Two of the line staff also are Spanish speaking.

Staff Training and Experience[28]

The Lake County program evidences a very strong commitment to staff training. Some form of sex offender training was offered during an average of five months a year in the past two years. Topics included: mandated reporting; positive drug tests; victim sensitive interviewing; sex offender profiling; domestic violence; sex abuse intervention network; drug/substance abuse; offender surveillance techniques; functions of denial; sexual deviance and relapse prevention; treatment and supervision of sexual offenders and Abel assessment. A number of these sessions were offered a number of times each

[28] Data on training and experience were collected in July and reflect the staff complement as it was at that time.

year allowing the full staff to attend at one time or another. The number of sex offender program staff attending each session ranged from three to eight with an average of seven. The length of time for each training session varied from a low of two hours to a high of eight hours. The most common was four hours. The number of hours of sex offender training each staff member had received varied considerably. This ranged from approximately 300 hours for the unit supervisor and coordinator who have been involved in sex offender supervision for many years, to as few as 16 hours for the most recently hired staff. Most staff had received at least 60 hours of sex offender training. Staff did not identify any particular topic or training session that was not useful. Of the eight officers who attended, all found the session on sex offender surveillance particularly useful in that it covered basic surveillance strategies used by police officers to follow and observe offenders, an essential skill in the supervision of sex offenders who tend to hide their behavior. There was also strong endorsement of Sexual Abuse Intervention Network (SAIN) conferences which allowed interaction among a wide range of people working with sex offenders including probation officers and treatment providers. On the other hand, five of the nine persons interviewed expressed a need for increased training in the application, interpretation, and use of the polygraph. There was a striking difference in the amount of sex offender training received by the two surveillance officers. One, who had been a probation officer for about one year had received 65 hours while the newest member who had been on staff only three months had received 16 hours.[29]

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[29] These were the two surveillance officers on staff in July when training data were collected. Both have since been replaced and the new officers are in training.

The number of years of probation officer experience of the sex offender unit staff (excluding the supervisor) ranged from three months to 17 years, with a median of 3.5 years. Two had been on staff less than a year, one for six months, the other for three months. At the other extreme, three had been probation officers for nine years or more. The number of years of sex offender supervision experience ranged from three months to ten years with the median being about three years. All staff members had at least a B.A/B.S degree, most commonly in criminal justice. One staff member had earned her Masters in Criminal Justice and was working on herPh.D. in Public Administration. As noted earlier, this officer left the unit in September.

Six of the eight sex offender unit officers stated that they volunteered for the unit. Of the two who did not initially volunteer, one was appointed by the unit supervisor because of her previous experience and the other wanted a probation officer position but took the surveillance position when offered.[30] Seven of the eight felt they had made a good choice. One was currently uncertain and appeared to be thinking of leaving the unit[31]. Of the seven who felt they had made a good choice, six were unrestrained in their support of their judgment. They loved their job. One felt both ways, enthusiastic about the job but undermined by paperwork. The most commonly stated "positives" about the unit were its supervisor and the unit cohesiveness. The most frequently stated "negatives" was only one, the amount of paperwork occasioned by the required collateral contacts associated with sex offender supervision. Surveillance officers cited the unbalanced schedule. All except one would recommend being assigned to this unit to fellow probation officers.

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[30] He moved to the sex offender unit when a vacancy occurred and brings a former surveillance officer's perspective to the unit as a whole.

[31] As noted, he did so in September.

Administrative Structure

Since this unit was already in operation, no new administrative restructuring was needed except to assign the new staff. The eight officers in the unit report to the unit supervisor or, in his absence, to the unit coordinator. The unit supervisor reports to the deputy director for adult services, who reports to the court administrator. After the sex offender specialists and surveillance officers submit their data, the Unit Supervisor prepares and submits monthly reports.

Target Population

This program embraces a relatively broad target population that includes but is by no means limited to statutory sex offenses. The target population includes any offender convicted of any offense that is sexual in nature who has been sentenced to probation. It includes misdemeanors and felonies. The unit is aggressive in identifying cases in the system that have a sexual offending component. The unit searches out bench cases that started as an arrest for a sexual offense that are later dropped to battery, disorderly conduct etc. For example, an offender sentenced to probation for theft whose theft offense was sexually related (e.g. he stole women's underwear) would be targeted for the program. It is the unit's experience that these "hidden sex offender" cases sometimes turn out to be the most serious in terms of risk to the community. The unit also includes prostitutes and their customers if sentenced to probation.

Case Referral Process

The case identification and referral process is relatively unstructured. Cases usually get identified at a variety of points. If a presentence investigation (PSI) is ordered, they are identified at this point and the PSI includes a recommendation for placement on sex offender probation. In most cases, if an offender is placed on probation, the probation order is sent to the department and the case is identified

at intake or from the probation order which may indicate sex offender probation. The unit staff is not in court at the time probation is ordered. Another source is walk-ins from offenders placed on misdemeanor probation who are ordered to report to the department. Also, interstate compact cases are identified through review of paperwork or by interview. In essence, if a probation case is found at any point in the system to have a sexual offense component it gets referred to the unit. There appears to be a close working relationship between the state's attorney's office and this unit once a case is placed on probation but less so in identifying cases prior to court hearings. The majority of cases are the result of plea bargaining, but probation is not party to these decisions. Although the unit has developed a set of 20 special conditions for sex offender probation cases the process by which these are made an official part of the probation order is not uniform. There is no formal referral document other than the probation order. Any case identified as a sex offense case is automatically accepted into the program, but before assignment the unit supervisor screens all cases.

Case Assessment

Cases in which a PSI is ordered before sentencing are referred to the department's psychological services or an outside provider for assessment before sentencing. All other cases are assessed after sentencing. The specific assessment techniques/tests used depends on the provider. While no specifically designated PSI is used for sex offenders, the Sex Offender Manual, prepared in 1992 contains guidelines officers should follow when conducting PSI for sex offenders. PSIs are conducted in approximately 20 to 30 percent of the cases. In addition, a risk-needs assessment is prepared for each offender.

Supervision Standards

All sex offenders are carried as maximum supervision cases until such time as they have successfully completed treatment which usually lasts for 24 months. The planned supervision standards are not clearly listed in the grant application except to indicate an expected increase in the number of home and field contacts on each offender from six a year to a minimum of three monthly or 36 a year.

Program Operation

As noted earlier, program operation analysis examines the extent to which the program actually operated in line with -pre-operational expectations as stated in the grant application's program policy and procedures. Although each program used a different model, each was designed to deal with convicted sex offenders, to increase supervision and surveillance and implement sex offender treatment. With this in mind, the evaluation team's operational analysis focused upon four major activities: intake, caseload and offender profiles; supervision and surveillance; the team approach; and the nature of treatment.

Intake and Caseload

The Lake County program statistical reports submitted to the Authority from October 1997 through February, 1999 were examined to document the pattern of intakes and total caseload by month. Intakes averaged approximately 12 cases per month and the total caseload increased steadily from a beginning of 191 cases in October 1997 to 244 cases at the end of February, 1999. Lake County program caseload data slightly differ from data contained in monthly reports because it was unclear whether cases on warrant status were still counted as part of the caseload. The evaluation team elected to simply start with the number of cases at the start of each month, add new cases, subtract

closed cases and thus obtain a closing caseload count. The Lake County program's caseload data are presented in Table III-1.

One of the key operational goals of the Lake County program was to maintain sex offender caseloads at a maximum of 40 cases per officer and a total offender caseload of 80 cases at least for the first year. Despite increasing sex offender caseloads, the program had succeeded in holding to the 40 case limit beyond the first year and up to until February, 1999. Maintaining

Table III-1

Lake County
Monthly Caseload and Caseload Per Officer
October 1997-February 1999

Year	Month	Beginning Caseload	Intakes	Closings	Ending Caseload	Caseload per Officer
1997						
	October	191	10	6	195	32
	November	195	5	8	192	32
	December	192	12	9	195	33
1998						
	January	195	9	8	196	33
	February	196	18	6	208	35
	March	208	18	15	211	36
	April	211	9	11	209	35
	May	209	9	10	208	35
	June	208	13	9	212	35
	July	212	14	9	217	36
	August	217	7	7	217	36
	September	217	9	7	219	37
	October	219	12	6	225	38
	November	225	6	5	226	38
	December	226	14	11	229	38
1999						
	January	229	13	10	232	39
	February	232	19	7	244	41

the 80 case goal was more difficult. The number of "regular" probation cases carried by each officer in the unit has increased so the total caseload per officer has risen from approximately 91 cases in October 1997 to over 100 in January, 1999.

Offender Profiles and Risk Characteristics

In addition to caseload counts, the evaluation team examined offender characteristics to gain an understanding of the program's population and the extent to which these offenders fit the target population criteria. The Lake County program adopted a very broad definition of its target population indicating that virtually any case referred to probation for a sex offense was included in the target population. The following description of offender characteristics and offenses indicated that the program is serving its intended target population.

The evaluation team coded all cases handled by the Lake County Sex Offender Probation Unit from September 1, 1997 to September 30, 1998. The total caseload is 85 sex offenders. All information is based upon data obtained from intake interviews and treatment evaluations obtained from the probation files. Table III-2 provides demographic characteristics and mental health needs of Lake County sex offenders on probation. Most sex offenders are male, though there is one female sex offender. The caseload consists of 58.3% Caucasian, 14.3% African- American, 25% Latino, one Asian-American, and one Native-American. Age ranges from 17 to 58 with a median age of 29. Most offenders are either single (50.6%) or currently married (30.1%), with 69.3% currently in a sexually active relationship. Most offenders (68.7%) are employed full-time. Income ranges from under $13,500 to over $50,000 with the median income between $13,501 to $15,000. Many (44.9%) have incomes in the poverty range (under $13,500), and only 7.7% have an income over $40,000. Most

Table III-2

Description of Sex Offenders and Their Needs At Intake in Lake County

Demographic Characteristics	Frequency	Valid Percent
Age of Offender		
17	2	2.4
18 to 26	33	39.5
27 to 35	20	24.0
36 to 43	17	20.4
44 to 52	9	10.8
53 to 74	3	3.6
Marital Status		
Single	42	50.6
Divorced	11	13.3
Separated	5	6.0
Currently Married	25	30.1
In a Sexually Active Relationship?		
No	23	30.7
Yes	52	69.3
Missing	8	
Current Employment Status		
Unemployed	14	16.9
Employed Part-time	8	9.6
Employed Full-time	57	68.7
Employed, unspecified	4	4.8
Income		
$13,500 or under	35	44.9
$13,501 to $25,000	23	29.5
$25,001 to $40,000	14	18.0
$40,001 and higher	6	7.7
Missing	6	
Education		
Less than 12th grade	23	28.4
High school graduate	30	37.1
Some College	22	27.2

Completed B.A./B.S.	5	6.2
Completed M.A./M.S.	1	1.2
Missing	3	
Characteristic	Frequency	Valid Percent
History of Work/School Adjustment		
Stable work/school history	55	69.6
Unstable work/school history	20	25.3
Chronic extremely unstable	4	5.1
Missing	5	
Whether Defendant Disclosed Any Drug Use?		
No	22	26.8
Yes, alcohol	21	25.6
Yes, both alcohol and drugs	39	47.6
Has Prior Treatment for Substance Abuse	16	19.5
Missing	2	
Recommended Substance Abuse Treatment	11	16.9
Missing	19	
Has Mental Health Problems	31	41.9
Missing	10	
Has Prior Mental Health Treatment	19	25.7
Missing	10	
Suicide History		
No suicide thoughts or attempts	61	82.4
Suicide thoughts, but no attempts	11	14.9
Suicide thoughts and attempts	2	2.7

offenders (71.7%) have graduated high school, but only 7.4% have a Bachelor or Masters Degree. The majority of offenders (69.6%) had a history of stable work and school adjustment.

This caseload presents problems of substance abuse and mental health that are typical of other probationers. Almost half of the population (47.6%) disclosed that they used both alcohol and illicit drugs, and 19.5% have had prior treatment for substance abuse. Current treatment plans for these offenders also recommended that 16.9% participate in substance abuse treatment. Many offenders (41.9%) have mental health problems, and 25.7% have had prior mental health treatment. In addition,

thirteen offenders had suicidal thoughts or a history of suicide attempts. Twenty offenders were classified as clinically depressed based on treatment evaluations and objective tests such as the Minnesota Multiphasic Personality Inventory (MMPI). Current treatment plans recommended that four offenders receive psychiatric treatment, and four offenders receive antidepressants.

Offense and Offender Characteristics Potentially Related to Risk

Prior research has examined the predictors of committing a new sex offense while serving a community-based sentence or after release from prison or hospital (See for a review Hall, 1995; Hanson and Bussiere, 1998). Several static characteristics of the offense have been identified as leading to a higher risk of reoffense. These characteristics include: the gender of the victim, the age of the victim, and the nature of the offense. Offenders who victimize non-family members are at a higher risk of reoffense. Homosexual or bisexual offenders are at a higher risk of reoffense. Offenders who commit voyeurism or exhibitionism are at a higher risk rate of reoffense. Other static characteristics have not received adequately empirical attention in the research literature. For example, the amount of time the abuse has been occurring may be related to risk with offenders who have been abusing for a longer period of time more likely to reoffend. A meta-analysis has found that prior arrest records significantly predict reoffense for any crime, but not consistently related to sexual offending. The weak relationship between prior criminal history and sexual reoffending may be due in part to the fact that such records do not reflect the complete history of an offender's activity of committing sexual crimes. A history of being a victim of child sexual abuse has not been consistently related to sexual reoffending across past studies (Hanson & Bussiere, 1998). Only a few studies have examined the level of denial and remorse at intake as predictors of reoffense. A meta-analysis of the findings in these studies

indicates that these clinical presentation variables are related to general recidivism for any crime, but are not related to recidivism for sexual offenses (Hanson & Bussiere, 1998). Data on risk factors that may be related to reoffending for the Lake County offenders are presented in Table III-3.

The majority of the offenders were convicted of a misdemeanor (68.9%), and 22.7% of these offenders were convicted of public indecency. Only 22.7% of offenders were convicted of a felony sex crime such as criminal sexual assault or aggravated criminal sexual abuse. Table III-3 shows that most offenders (74.4%) were not acquainted with their victims. (Only five offenders had one or more charges of a sex crime against a family member.) Due in part to the large concentration of public indecency cases, 39.4% of offenders had only one charge filed against them. The majority of offenders (75.3%) did not use force to achieve molestation. However, 27.4% of the offenders either expressed interest in sadistic sex acts or had problems with aggression as indicated in their treatment evaluations.

Over one-third (34.5%) of the offenders expressed an interest in "hands-off" sex offenses such as exhibitionism or voyeurism or reported in the treatment evaluation that they had committed such offenses. We also attempted to determine how many offenders were potential/actual pedophiles. Pedophiles were defined as offenders who expressed interest (as measured through an objective sexual preference test) or self-reported fantasies about coercing children 10 or younger to engage in sex acts or had committed a sex crime against a child 10 or younger. Thirty-eight percent of the sample were classified as pedophiles.

About three-fourths of the offenders (74.7%) committed crimes against only one victim, and most offenders (80.8%) limited their victims to girls or women. Consistent with national statistics, most victims were children under the age of 18 with 15.5% aged 3 to 8 years and 16.7% aged 15 to 17. Only 25.2% were 18 years old or older. Almost half of the cases (49.3%) involved penetration

whereas the other half involved some sort of fondling of private parts or exposing private parts. About half of the cases involved a single incident (49.3%) and the other half consisted of multiple episodes of abuse that occurred across a number of months. The mean number of months that offenders continued sexual abuse as reported by the victim in the police report or the offender during a clinical interview to evaluate treatment needs was 30.8 months (median = 1 with a maximum length of 480 months) The majority of victims (84.6%) stated that the intercourse occurred without their consent, though eleven victims indicated that they consented to intercourse.

The majority of the sex offenders are familiar with the criminal justice system. Over two-thirds (69%) had been arrested before, and over half (57%) had been convicted of a crime before the current offense. Furthermore, 20 % had a prior arrest for a sex crime, 5% had a prior arrest for a violent offense, 3% had a prior arrest for a felony property crime, 8% had a prior arrest for a drug offense, and 9% had a prior arrest for domestic violence. Thus, these sex offenders have already been handled by the criminal justice system, and have not been deterred from misusing their power and control to achieve their desires. To determine whether sex offenders have learned that arrests often do not lead to convictions, we compared the ratio of arrests to convictions for each defendant. Less than half of the defendants who had at least one prior arrest had an equal number of convictions (44%). Half of the defendants had at least one more arrest than convictions, with the greater number of arrests to convictions ranging from 1 to 49. Over half of the offenders had at least one prior conviction (57.7%). Forty percent of the offenders had a prior conviction for a misdemeanor crime. Twenty percent of the offenders had a prior conviction for a sex offense, about 5% had a prior conviction for a violent crime, 3.7% had a prior conviction for a felony property offense, 7.6% had a prior conviction for a drug offense, and 8.9 % had a prior conviction for a domestic violence offense. In addition, 28.6% of the

offenders were classified as psychopathic deviants based on objective personality tests. Thirty offenders (38.9%) had served at least one prior term of probation. Seventeen offenders (21.7%) had served at least one incarceration sentence.

Most sex offenders, however, do not admit to being sexually or physically abused as a child, though over one-fourth (25.3%) indicate that they were sexually abused as children. Most offenders (43.7%) deny that some important aspects of the offense occurred, with 16.9% denying that they even committed a sex crime. Most offenders charged with public indecency and misdemeanor charges admit to the victim's version of the offense. Most offenders (62.3%) do not express remorse for their sex crime.

Table III-3

Offender and Offense Characteristics at Intake Related to Risk of Reoffending for Sex Offenders in Lake County

Characteristics Related to Risk	Frequency	Valid Percent
Current Convicted Offense		
Criminal Sexual Assault	4	4.8
Aggravated Criminal Sexual Abuse	16	19.0
Other Misdemeanor Sex Crime	39	46.4
Public Indecency	19	22.6
Out of State Charges	6	7.1
Total Number of Charges Against Offender		
One	28	39.4
Two	21	29.6
Three	8	11.3
Four or More	14	19.7
Missing	13	
Whether Force was used to achieve molestation?		
No	61	75.3
Yes	20	24.7
Missing	3	
Number of Family-Related Charges		
None	67	93.1
One or more	5	7.0
Missing	12	
Relationship of Offender to Victim		
Unrelated	61	74.4
Father/Step-father	11	13.4
Uncle	1	1.2
Other Relative	6	7.3
State	3	3.7
Missing	2	
Gender of Victims		
Only Women or Girls	63	80.8
Only Men or Boys	11	14.1
Both	4	5.1
Missing	5	

Characteristic Related to Risk	Frequency	Valid Percent
Number of Victims		
One	59	74.7
Two	8	10.1
Three-Four	3	3.8
Five or more	6	7.6
Missing	5	
Age of Youngest Victim		
3-8	13	15.5
9-11	7	8.4
12-14	17	20.2
15-17	14	16.7
18-21	7	8.4
Over 21	14	16.8
Missing	12	
Did Penetration Occur?		
No	41	50.6
Yes	40	49.3
Missing	3	
Number of Months Abuse has been occurring?		
Single incident	38	49.3
1 to 6 months	12	15.6
7 to 12 months	6	7.8
13 to 24 months	7	9.1
Over 24 months	14	18.2
Missing	7	
Victim stated that intercourse was consensual	12	15.4
Missing	6	
Defendant has an antisocial personality	24	28.6
Total Number of Prior Arrests		
None	28	33.3
One to Two	24	28.6
Three to Four	15	17.9
Five or More	17	20.2
Total Number of Prior Arrests for Sex Offenses		
None	68	81.0
One	9	10.7
Two or More	7	8.3

Characteristics Related to Risk	Frequency	Valid Percent
Total Number of Prior Arrests for Domestic Violence		
None	67	79.8
One or more	17	20.2
Total Number of Prior Convictions		
None	35	44.9
One to Two	26	33.3
Three to Four	11	14.1
Five or More	6	7.7
Missing	6	
Was Offender Abused as a Child?		
No	47	70.1
Yes, Physically Abused	3	4.5
Yes, Sexually Abused	10	14.8
Yes, Both Physical and Sexually	7	10.4
Missing	17	
Extent of Offender's Denial		
Completely Denies Offense Occurred	12	16.9
Denies Important Parts of Offense	31	43.7
Admits To Most Relevant Parts of Offense	28	39.4
Missing	13	
Whether Offender Reports Remorse		
No	43	62.3
Yes	26	37.7
Missing	15	

Supervision and Surveillance

The Lake County program did not adopt a strategy whereby the amount of supervision decreased as offenders progressed to higher levels of probation supervision (level I, II and III). Their rational was that, if anything, supervision should be increased not decreased as offenders' progress through the program. Offenders are likely to be most compliant during the early level of the

program and then begin to test it approximately six months into supervision. While staff limitations did not allow for increasing supervision, Lake County opted to maintain a high level of supervision throughout. Given this rational, the supervision expectations for this program were that all sex offenders would be supervised at "a high level" all the time. Prior to this program's operation, home and field contacts with sex offenders occurred approximately six times a year. The goal of the grant was to increase field contacts to three per month, and to maintain office visits at the state standard for maximum supervision cases of two a month. Based on these goals, the evaluation team's expectations for Lake County were that there would be an average of three home/field visits each month for each case and an average of two office visits per month for a total of five face-to-face contacts per month.

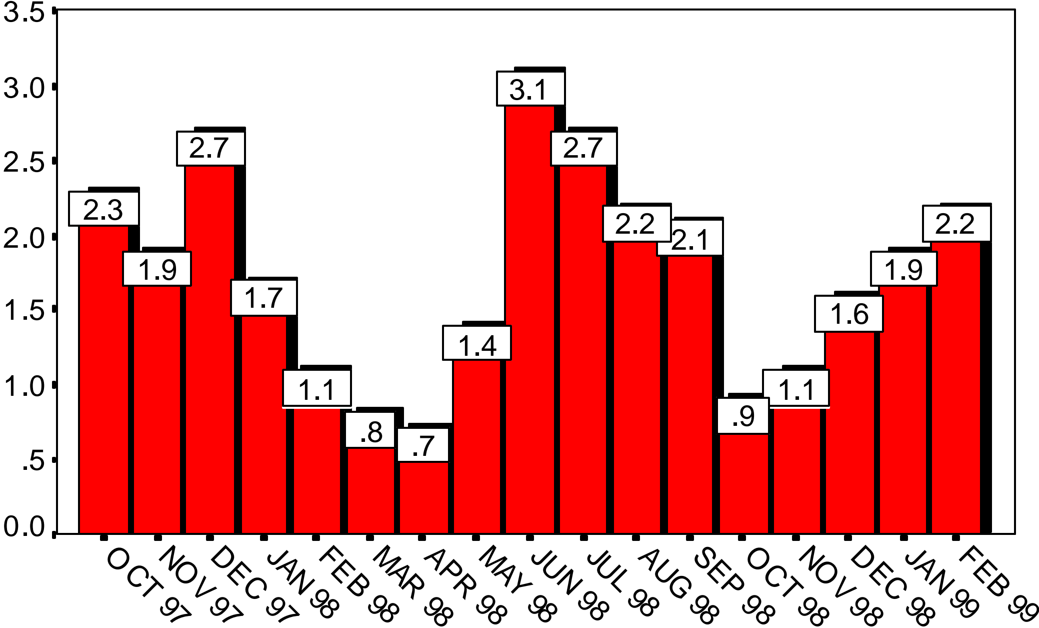
Monthly statistical reports submitted to the Authority were analyzed to determine the extent to which the Lake County program met supervision expectations. We looked first at the number of home/field visits conducted by the sex offender unit. The Lake County program provided extensive data on this variable which included the number of home/field visits by unit officers and by surveillance officers and the total monthly caseload as well as the number of cases assigned to the surveillance officers which was somewhat lower than total caseload each month because of delays in assignment due to jail or other non-community status. As expected, surveillance officers conducted the greater number of these visits. The overall numbers of home/field visits are impressive averaging 325 a month over a 17 month period for the surveillance officers and 52 a month for unit officers. However, when the average number of home/field visits per month is examined per case (i.e. number of visits/number of cases)[32] the findings are less clear. The expectation was a minimum of three visits per case per month. The findings

[32] To control for when during the month a case was assigned we used the caseload count at the beginning of each month.

indicate an overall average of 1.7 home/field visits per case per month. June, 1998 was the only month in which the expectation of three home visits was met. In six other months the number of home/field visits averaged between 2 to 2.7 per case. These findings are presented in Figure III-1.

Figure III- 1

Lake County: Average Number of Home/Field Visits for Sex Offender Cases



While the three-visit standard applied to the total unit, it was expected that this standard would be more closely met by the surveillance officers who's primary role was to conduct such visits on cases carried by the rest of the unit. The number of home/field visits for each of the cases assigned to the surveillance officers was examined for each month and the average calculated (i.e. number of visits/number of assigned cases). Findings are that, while the surveillance officers did much better, they did not achieve the three-visit standard on a consistent basis. They achieved an overall average of 2.1

home/field visits per month and met or exceed the three-visit standard in three of the 17 months (December, 1997, June and July 1998). However in three other months (February, March and October, 1998), the average sank below one.

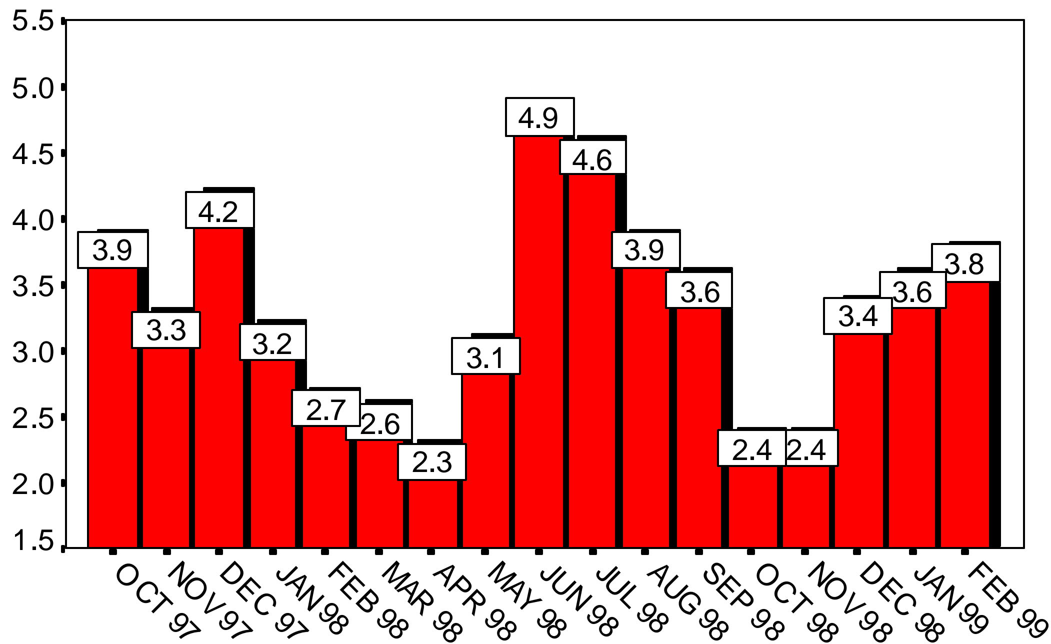
There are a variety of reasons the three-visit standard was not consistently met. Chief among them is the fact that for six of the 17 months the surveillance unit had only one officer (January, February, March, April, September and October 1998) and the replacement officer was in training for all or part of the month he/she was hired thus reducing productivity. The average number of home/field visits by the surveillance unit was 1.4 with one officer and 2.6 with two. When training time of the new officer is factored in, the average number of home/field visits for the fully staffed and trained surveillance unit was 2.7 per month which is very close to the standard envisioned.

The number of face-to-face contacts standard was five per month. Total face-to-face visits were a combination of home/field visits and office visits. As was the case with home/field visits, the number of total face-to-face visits is impressive. The total number of such visits (unit and surveillance officers combined) ranges from 495 to 1020 for an average 716 per month over a 17 month period. However, when the average number of face-to-face contacts is computed per case per month the findings are mixed. As can be seen from Figure III-2, the five face-to-face contact standard is not achieved in any month. The figures range from 2.3 to 4.9 for an overall average of 3.4 face-to-face contacts per month. If the figures are rounded, the 5 contact standard is achieved in only two months, (June and July 1998). These results are, of course, influenced by the home/field visit data which when low reduces the total number of face-to-face contacts. However, it was expected that the number of office visits would contribute to a large number of face-to-face visits and thus raise the average closer to the five visit standard. The average number of office visits ranges from 1.3 to 1.9 for an overall average

of 1.6 per month, somewhat below the state standard of two per month. It should be remembered that unit officers in the Lake County program carry a mixed case load of sex offender and regular probation cases and also make a large number of collateral contacts with treatment providers and others in the

Figure III-2

Lake County:
Average Number of Fact-to-Face Contacts on Sex Offender Cases



community on sex offender case all of which take time away from being able to conduct office visits and maintain a five face-to-face contact standard.[33] With this in mind we also examined the face-to-face visit standard under conditions of a fully staffed and trained unit as was done for home/field visits. Under these conditions, the unit (unit and surveillance officers combined) achieved an average of 4 face-to-face visits a month, not the five envisioned but much better than the 1.6 per month noted earlier.

[33] Total of all contacts on sex offender cases averaged 1,291 per month and over six per case which is reflective of the level of activity demanded of a sex offender caseload.

The extensive time demands presented by sex offender cases along with those imposed by regular probation cases contribute to this program's difficulty in meeting its high standards for both home/field visits and face-to face contacts. An important additional factor is that the Lake County program placed heavy emphasis on training that was provided almost monthly to at least some of the officers which, of necessity, reduced their availability for both home/field and office visits. Finally, this program also stressed the need for intensive contact with the more serious offenders, which often led to longer sessions with a few offenders reducing the overall average. An important finding from this analysis, however, is the fact that when fully staffed and trained, the surveillance officer model used in Lake County achieved the level I maximum supervision standard of two home/field visits and four face-to-face visits a month adopted by many other sex offender supervision programs but rarely achieved. We comment on this finding in greater detail at a later point in this report.

Evaluation of the Team Approach

The most recognized model for the supervision and treatment of convicted sex offenders in the community is the containment model. The containment model utilizes a team approach between probation officers, polygraph examiners, and treatment providers to monitor and treat effectively sex offenders on probation. Through this team approach, offenders cannot tell different versions of their crimes to probation officers and therapists, and both probation officers and therapists acquire information on the current risk and treatment needs of offenders to provide effective surveillance and treatment. The central characteristics of the team approach are the same features of any effective team (O'Brien, 1995):

- Probation officers and treatment providers agree on the primary goal of treatment. The primary goal should be to reduce inappropriate sexual behavior so that victim and community safety will not be further compromised (English, Pullen, Jones, & Krauth, 1996).

- Consistent with this common goal, therapists perceive that the probation department is their primary client or that the probation department and defendant are equally their primary clients (e.g., Knapp, 1996). This perspective differs from traditional therapy in that therapists typically perceive the best interests of clients as their primary concern.

- Probation officers and treatment providers constantly share information about offenders' risks and treatment progress.

- Probation officers and treatment providers understand each team members' role and establish agreed upon policies to insure that all team members can perform their jobs in the most ethical and effective manner.

- Both probation officers and treatment providers work cooperatively to establish policies thereby eliminating adversarial and unequal power relationships.

- Regular face-to-face meetings are held to discuss difficult cases and to plan ways to improve treatment and monitoring strategies.

- Through mutual respect and cooperation, all team members feel safe to disagree about case management without jeopardizing their membership or status. Disagreements are communicated directly to other team members in a respectful manner, and agreed upon resolutions and promises are implemented and followed in practice.

The Loyola evaluation team distributed a survey to all therapists serving sex offender clients who are on probation in the sex offender unit of Lake County Adult Probation, and to all probation officers in the sex offender unit including surveillance officers and the supervisor. The survey assessed the amount of face-to-face, phone, and written communication between probation officers and therapists, the topics discussed, how disagreements and discussions are handled, and their perceptions of the other team members' knowledge about risk and treatment, willingness to share information, and respectfulness toward them. All questions about the amount of communication focused on the last six months. The questionnaires were distributed February 24th, and were returned by the third week of

March. The Lake County Sex Offender Unit relies primarily on four treatment provider agencies. We received a total of eight questionnaires from therapists with more than one therapist from some treatment provider agencies completing the questionnaire. All six probation officers, two surveillance officers, and the supervisor of the Lake County Adult Sex Offender Unit completed the questionnaire. All respondents completed the questionnaires anonymously, and therapists mailed the questionnaires directly back to the evaluators to insure confidentiality.

Both therapists and probation officers are very satisfied with the way the team approach is operating. On a ten point scale where ten is completely satisfied, therapists and probation officers provided an average rating of 8.8 on satisfaction. This high level of satisfaction may reflect in part the frequent, open, and direct communication between probation officers and therapists. Each treatment provider agency, according to the probation department, has a regular face-to-face meeting with the supervisor and probation officers.

Four of the therapists confirm that they meet monthly, one therapist meets weekly, and the other three therapists meet bi-monthly or less than once every two months. Therapists reporting less frequent face-to-face contact may be at agencies that have multiple therapists. The regular monthly meetings tend to be with the director of the treatment provider agency. Therapists report that on the average they have interacted with six probation officers, and probation officers report that on the average they have interacted with seven therapists.

Lake County generally does not hold large group meetings with all treatment providers and probation officers present. Probation officers and the supervisor may attend meetings with each treatment provider separately. In addition, Lake County has a formal professional community-wide coalition that meets bi-monthly and includes representatives from all treatment agencies serving sex

offenders, therapists serving victims of sex crimes, state's attorney office, and the probation office. On the average, therapists reported attending a group meeting once in the last six months whereas probation officers reported attending a group meeting where both probation officers and treatment providers were present an average of eight times in the last six months.

Face-to-face conversations were supplemented with more frequent phone calls and written correspondence. Most therapists and half of the probation officers reported that they talked on the phone about twice a week. (Surveillance officers and the supervisor of probation may have less need for such frequent phone contact). Therapists reported that on the average they wrote letters or correspondence about once a month, and received correspondence from probation officers about once a month. Probation officers confirmed that they received written correspondence from therapists about once a month, but generally wrote letters to therapists on the average less than once every two months.

An effective team approach requires that team members are available for meetings. All but one therapist reported that probation officers were always or very available for meetings, and seven of the nine probation officers reported that therapists were very or somewhat available. Interestingly, half of the probation officers and therapists believe that they both initiated about an equal amount of the telephone and face-to-face contact whereas the other half believed that they initiated 75 percent or more of this contact. Most therapists and probation officers indicated that their calls to the other team member were returned somewhat quickly, and believed that one day was a reasonable amount of time to return a call. Only one therapist indicated that probation officers were very slow at returning their calls. Both therapists and probation officers were equally positive about the helpfulness of their conversations with each other. They indicated that the conversations were very helpful at creating strategies to keep specific offenders from reoffending, and at detecting offenders' attempts to deceive

either the treatment provider or probation officer handling their case.

Probation officers and therapists reported spending most of their time discussing issues concerning the progress of specific offenders. The quality of communication was assessed with three questions: (a) how often do most (treatment providers/probation officers) try to take over team discussions and act on their own personal agendas; (b) how often do (treatment providers/probation officers) actually listen to your ideas and concerns; and (c) when you disagree with a (treatment provider/probation officer), how often do you tell the (treatment provider/probation officer) how you feel? Each question was answered using one of five options: never, rarely, occasionally, frequently, and always. All therapists reported that probation officers never or rarely take over team discussions, and seven probation officers reported that treatment providers rarely take over team discussions. Two probation officers noted that treatment providers occasionally take over team discussions. Both probation officers and therapists reported that the other team member frequently or always listened to their ideas. The team also seems built on trust in that most members feel free to express disagreements. Five therapists and six probation officers indicated that they always expressed their disagreements whereas the other therapists and probation officers occasionally or frequently expressed their disagreements. These self-report data thus suggest that both sides of the team believe that the team is a cooperative effort built on mutual respect and trust.

Data on treatment providers' perceptions of probation officers and probation officers' perceptions of treatment providers further support that the team has a solid foundation of mutual respect and trust. Probation officers reported that on the average 92% of therapists are very informed about treatment issues, and only about 3% of therapists are somewhat uninformed. Treatment providers reported that on the average 71% of probation officers are very informed about treatment issues, and

only 4% are somewhat or very uninformed. Probation officers reported that on the average 97% of therapists are very informed about risk factors, and therapists reported that on the average 80% of probation officers are very informed. All therapists and probation officers indicated that the other team member was somewhat or very willing to share information. Probation officers on the average reported that 87% of therapists were very willing to share information, and therapists reported that 97.5% of therapists were very willing to share information. Both probation officers and therapists indicated that the majority of members from both sides were completely supportive of the team approach. Probation officers indicated that on the average 70.5% of therapists are completely supportive whereas therapists indicated that 87.5% of probation officers are completely supportive. On the average, probation officers indicated that less than 1% of therapists were somewhat not supportive of the team approach. None of the therapists indicated that probation officers were not supportive of the team approach.

Less than half of the therapists and probation officers, however, reported disagreements on any important issue. Three therapists and four probation officers reported disagreements. Most disagreements were resolved through working together to find a solution that they both agreed was right; though two therapists and one probation officer reported that they held firm and insisted on their own position. Probation officers reported that they disagreed with therapists about: client's dismissal from treatment; having an offender return home or have overnight visits; progress of an offender; requirements for safety; testing; amenability of an offender for treatment; risk of an offender to the community. Therapists reported similar case management issues as well as lack of follow through on a previously discussed topic.

Every therapist and probation officers indicated that there was agreement about the most important goal(s) of the program. The primary goal focused on controlling and changing inappropriate

sexual behavior, and all therapists and probation officers also agreed that it was moderately to extremely important that offenders accept responsibility for the harm caused to the victims and reduce their inappropriate self-statements.

Overall, the team approach appears to be operating quite effectively in Lake County. However, there is one point of departure from the ideal team approach. Over half of the probation officers (five) reported that the defendant is the primary client of the therapist whereas the other (four) reported that the defendant and department are equally the primary client. Most therapists (five) did not answer this question. Two therapists reported that the department and defendant were equally the primary clients and one reported that the defendant was the primary client. Part of this misperception on where treatment providers' loyalty should lie may be due to lack of uniform policies. The probation department in cooperation with therapists should develop uniform policies that all therapists must follow. For example, all treatment providers should be provided with written policies on the graduated sanctions that are available to deal with noncompliance with therapy, on how many unexcused absences are acceptable from therapy before the client is terminated and a VOP is filed, what counts as an excused absence, and how new sex offenses reported to the therapist can be handled.

The Nature of Treatment-Comprehensiveness of Treatment Evaluations

The Loyola evaluation team has coded information from the case files of 85 Lake County sex offenders. Our information indicates that, for various reasons (the offender was suspended from treatment, the offender moved out of the county, the offender was reassigned to probation because he failed to register as an offender, etc.), 18 of these 85 offenders are not currently receiving treatment in Lake County. The other 67 defendants had an evaluation from either a private treatment provider or the

pre-sentence court psychological services.

Most of the 67 offenders are assigned to one of the following four treatment providers: Community Youth Network (n = 17), Adelante (n = 14), Gerald Blain (n = 9), or Associates in Family Therapy (n = 8). Of the remaining offenders, two are assigned to another treatment provider, 16 defendants had only evaluations from the court psychological services, and one defendant had transferred into Lake County and an evaluation from another county was available in the file. Finally, some of these defendants had two evaluations one from a private treatment provider and one from either a court-ordered evaluation or an out of town evaluation (n = 9). For these offenders, we combined the information available in the two reports.

The quality of these treatment evaluations is assessed on two factors: (1) the range of issues that were addressed, and (2) how comprehensively each issue was addressed. Quality treatment evaluations should include at least seven specific components:

- A comparison of the victim's statement with the offender's version to assess the offender's attempt to minimize and deny responsibility for the offense.
- A review of police/court records and a full disclosure polygraph examination to assess the complete history of an offender's sexual offending.
- A review of substance abuse history, mental health history, educational/employment history.
- Use of objective sexual preference tests such as the ABEL to assess deviant sexual preferences.
- Use of objective personality tests such as the MMPI, MCMI, Million Clinical Multiphasis Personality Inventory or Hare's Psychopathy checklist to assess personality disorders and psychopathic deviancy.
- A referral to a psychiatrist on an as needed basis to assess medication needs for controlling depression or sexual arousal.
- Use of standardized questions to assess power/control issues and attitudes toward women.

Offender Denial and Minimization

All treatment evaluations addressed offender denial in enough detail to allow the reader to draw a reasonable conclusion regarding the extent of the offender's denial. In addition, many of the treatment evaluations also addressed offender denial by comparing the victim's version of the offense (per the police report) to the offender's version of the offense (n = 54; 80.6%); a majority of these 54 evaluations reported that there were inconsistencies between the two versions (n = 25, or 61.0%), suggesting a tendency to deny or minimize aspects of the offense. Consistent with this observations, 61% of the treatment evaluations that adequately addressed denial indicated that the offender denies at least some part of the offense.

All treatment evaluations also addressed whether the offender accepts responsibility for the offenses or attributes responsibility to the victim or the circumstances surrounding the offense. The majority of evaluations concluded that the offender places at least some blame on the victim or on other circumstances (n = 31; 43.7%) or denies all aspects of the offense (N = 12; 16.9%).

History of Reoffending

It may be a cause for concern that the treatment evaluations do not generally provide the reader with an adequate indication of offenders' history of perpetrating sex-related crimes. There are at least three sources from which treatment providers can obtain information regarding offenders' sex-crime history: (1) from the offenders' prior arrest and conviction history, (2) from polygraph examinations, and (3) from clinical interviews. There is not a real strong indication in the evaluations that treatment providers attempted to or were able to obtain criminal history information from any of these three potential sources.

Only 70.1% of the evaluations made any explicit reference to the offender's official arrest and conviction history. More notably, only six of the 67 treatment evaluations included any polygraph information, either by integrating results of a polygraph test into the written evaluation or by including an actual polygraph report as an attachment to the written evaluation. Four of the offenders failed the polygraph and two offenders passed the polygraph. Moreover, none of the six treatment evaluations that included polygraph information made any reference to examination questions pertaining to sex offense history. Interestingly, despite the fact that only five of the treatment evaluations included polygraph information, 16 of the 67 evaluations (23.8%) specifically indicated that the offender should take a polygraph test.

Finally, only 16 treatment evaluations indicated that the offender revealed at least one additional sex-related crime (i.e., one that was not a part of the official record) during the course of the clinical interview. Fourteen offenders revealed additional "hands off" offenses such as exhibitionism or voyeurism. In addition, a few offenders revealed additional sex-related crimes directly perpetrated against children (n = 4) or adults (n = 2). Overall, the small number of additional crimes revealed may, in part, be the product of the fact that the treatment evaluations tend to be written rather early in the therapeutic process. It is likely that rapport must be developed before the offender feels comfortable revealing further criminal activity.

It should also be noted that although the treatment evaluations appeared to be lacking information regarding sex offense history, the evaluations all provided a great deal of information regarding the offenders' family history, substance abuse history, mental health history, and educational/employment history.

Objective Sexual Preferences

The evaluation team is particularly concerned about the number of treatment evaluations that do not include an objective report of offender sexual preferences (i.e., the ABEL test or the plethysmograph). Of the 67 case files included in this report, only 3 treatment evaluations mentioned the results of an objective measure of sexual preference. However, four treatment plans (4.3%) indicated that the offender should take either the ABEL test or the plethysmograph. Interviews with probation officers indicate three possible explanations for this low number of objective sexual preference tests. First, the court requires that treatment providers must recommend all objective measures. The extent to which treatment providers use objective sexual preference tests varies widely across the agencies. Two agencies obtain these tests for almost all of their clients. One agency rarely obtains the test, and one agency decides on a case-by-case basis. Secondly, there is a shortage of treatment providers who are qualified to give objective sexual preference tests. Thirdly, even when the tests are given, probation officers typically do not receive written reports on these tests. The general results are communicated verbally to the officers, and officers must be very assertive to obtain a written report. The evaluation team recommends that the probation department establish a policy that written reports on these tests are forwarded to the department in a timely manner.

Offender arousal patterns have significant implications for the selection of an appropriate and effective course of treatment. Indeed, a meta-analysis of past research on predictors of committing a sex reoffense found that "sexual interest in children as measured by phallometric assessment was the single strongest predictor" (Hanson & Bussiere, 1998, p. 351). Reliance on offender self-report seems insufficient in light of: (1) the potential desire for offenders to present themselves in a socially acceptable manner and, (2) the fact that the majority of sex offenders supervised by Lake County Probation Sex

Offender Unit either denied aspects of the current offense and/or attributed some responsibility to the victim for the offense; such individuals may be less than forthright about their sexual preferences.

Objective Personality Tests

Of the 67 reports with treatment evaluations (either private or pre-sentence court evaluation), 47 (55.6%) treatment evaluations administered an objective personality test such as the MMPI, MCMI, or the Million Multiphasis Personality Inventory. The evaluation team encourages treatment providers to consistently administer an objective personality test to all sex offenders. There are two primary reasons for this. First, several studies have indicated that psychopathic deviancy is a consistent predictor of reoffending, independent from an offender's sexual preferences or demographic and background characteristics. If treatment providers do not know this information, treatment may not focus as heavily on issues such as extreme self-centerness, lack of consciousness, manipulative ways of acting, and lack of empathy for others. The MMPI, MCMI, and the Hare's Psychopathology Test all provide a valid measure of psychopathic deviancy. Second, most objective personality tests provide information on whether an offender meets the criteria of clinical depression. This can aid in decisions as to whether an offender should be referred to a psychiatrist for an assessment of medication needs.

Other psychological tests also were administered. Thirteen offenders took the MSI. Subjective psychological tests were administered to a small minority of offenders. The Rorschach Ink Blot Test was the most frequently administered subjective test, which was administered to 28% of the defendants. Ten defendants completed the Comprehensive Sentence Completion Test. Three or fewer defendants took the Rotter Incomplete Sentences Test, House-Tree-Person Test, the Projective Drawing Test, the Kenetic Drawings Test and the Draw a Person in the Rain Test. Three defendants were assessed on

intelligence level. One defendant participated in unspecified neurological tests, and one defendant was assessed for attention deficit disorder using the Brown Attention Deficient Disorder Test. Twelve defendants were assessed on their sexual attitudes or history using self-report measures such as the Sexual Sentence Completion Test, the Mental Health/Sexual History Inventory, Burt's Rape Myth Scale, Sone Sexual History Background or the Gender Motor Gestalt Test. In addition, five defendants were administered the Shipley Institute of Living Scale

Psychiatric Referrals/Treatment Plans

Most treatment evaluations included specific recommendations for particular types of treatment. Only two treatment evaluations did not include such recommendations. The majority of evaluations (73.8%) recommended sex offender group therapy, and/or individual therapy (87.7%). These modes of treatment typically address an offenders acceptance of responsibility for the offense, awareness of their sexual assault cycle, and other cognitive-behavioral treatment goals. Group therapy is the accepted mode of treatment in the field, and is often supplemented with individual behavioral therapy or counseling and other treatment strategies including medication management. Ten evaluations recommended that the offender take antidepressants, and four recommended psychiatric treatment. Additionally, one evaluation suggested that the offender should receive a psychiatric evaluation to assess their need for psychiatric treatment.

The evaluation team also examined specific treatment plans to determine how well the plans were being tailored to idiosyncrasies in offenders' needs. A little over half of the evaluations (52.3%) made very specific recommendations that were tailored to a specific offender's needs. Five plans recommended family or couples' counseling. Eleven of the plans recommended substance abuse

counseling. Two plans recommended anger management treatment to deal with aggressive behaviors. Four plans recommended periodic urine tests.

In addition, treatment providers tailored recommendations to specific offenders with several unique recommendations. These recommendations included no pornographic materials, continue with education, learn independent living, limit contact with children, undergo domestic violence treatment, lifetime therapy, treat ADHD, and explore defendant's abuse by his father. One evaluation concluded that the defendant did not need sex offender treatment.

No treatment plans explicitly indicated a need to address offenders' attitudes toward women. One treatment plan did indicate a need for the offender to receive treatment for domestic violence. Attitudes towards women and power tactics in relationships may be addressed in family/couples counseling. However, few offenders are receiving such counseling.

The Nature of Treatment

This report describes the treatment being provided to adult male sex offenders referred to treatment programs by the Lake County probation department. It is based on two primary sources of information collected between March and May 1999. The first was a series of interviews with probation officers (POs) working in the sex offender program in each county. The relevant points and results of these interviews are presented below, intermingled with the results of the second and more primary source of information for this aspect of the evaluation, a survey of providers who had been referred treatment cases from the Lake County probation department.

For the purposes of this evaluation, the participants were defined as those treatment providers who had been referred cases and were maintaining active caseloads of adult sex offenders on probation

in Lake County. At the time the survey was mailed out, there were four such providers identified by the Lake County probation department.

The evaluation team developed the survey instrument. The intent of the instrument was to collect information on a number of areas deemed to be important aspects of treatment. Additionally, the inclusion of certain questions was based upon knowledge gained during the evaluation of sex offender treatment in Cook County. For example, we learned in that evaluation that only one of the three treatment providers evaluated had consistent, written policies on tardiness, and absences from treatment. As a result, at one treatment program, participants could be violated for two unexcused absences, while it was not clear how many unexcused absences would result in a violation at the other two treatment programs. Thus, we wanted to know if the providers in Lake County had developed such policies.

The final instrument consisted of 18 questions, though many questions had multiple parts. The following general content areas were each covered by a series of short answer, yes/no, and multiple choice questions: organizational characteristics, clinical characteristics (e.g., number of therapists, past experience of the therapists providing treatment, the clinical orientation(s) of the treatment programming offered by each provider); providers' views on the most salient clinical aspects of treatment; the extent to which programs had written policies about attendance, lateness, and treatment participation; and the PO's degree of participation in treatment and the providers' perceptions about the impact of the probation officers' attendance and participation.

The survey also included a few open-ended questions, one of which asked providers for recommendations on how to improve the delivery and effectiveness of sex offender treatment in their county. And finally, we requested that providers send us any written documentation on the nature of

treatment provided; giving as examples, exercises they routinely use, handouts, and homework assignments. We estimated that it would take providers between 15 minutes to 20 minutes to complete the survey.

Using a mailing list of the principal contacts at each treatment provider, a copy of the survey was mailed to the four Lake County providers. The initial mailing was done in late March of this year. The providers were instructed in an accompanying cover letter to complete and mail their surveys back for tabulation in as timely a fashion as possible. By the middle of May, approximately six weeks after the initial mailing, only a few of the forms had been returned. To foster greater participation, we called each of the four providers reminding them of the survey and asking them to complete and fill out their surveys if they had not already done so. This first round of calls yielded the remaining surveys for all four of the treatment programs in Lake County. Thus, we had a 100% response rate for this county.

Administration of the surveys was anonymous and confidential. By design, we did not collect any identifying information on the survey forms, other than county, to foster as much candidness on the part of the providers as possible. Thus, in this report, we present findings either in aggregate or without information that would identify the provider.

Organizational Characteristics

The mean number of active cases at each clinic was 27, ranging from 20 to 32 open cases at the time of the survey. In sum, 80 cases had been referred for treatment from the Lake probation department. The four providers reported a total of 13 therapists involved with seeing sex offenders for an average of between two to three therapists per clinic.

We next wanted to determine the professional qualifications and experience of the therapists providing sex offender treatment. Providers were asked to give the highest academic degrees that

therapists on their staffs had attained, whether or not the therapists in their program had any prior experience working with sex offenders and, if so, how long they had been working specifically with sex offenders. Most of the Lake County therapists providing treatment to probationed sex offenders are social workers with the majority of 13 therapists, 9 (70%) having MSWs or LCSWs. Of the remaining four therapists listed, three have a Ph.D. or Psy.D. A degree was not specified for one of the therapists. None of the therapists providing services in Lake have an M.D.

All providers had experience working with sex offenders with an average of eight years of experience. Based on these findings, it appears that the therapists providing treatment have significant clinical experience working with sex offenders. If this self-reported information is valid, it would suggest that the therapy provided in this county is at least of reasonable quality (though this would require direct observation to confirm.)[34]

Clinical Characteristics

The next sequence of questions were designed to assess more information about the exact nature of the therapy being provided. Providers could select from among four pre-determined options as to the preferred modality of treatment in their programs: individual counseling; group counseling; couples and family therapy; or a mixture of group, individual, and family therapy. The Lake providers were evenly split with half endorsing group therapy and the other half indicating mixed group and family

[34] This is a large and generalized caveat to the entire report and methodology. We found in our direct observations of treatment in Cook County that therapists varied widely in their skill conducting the groups. We observed this variation even among experienced and credentialed therapists, some of who ran groups effectively and others who let the groups drift and remain unfocused for many sessions. Therefore, while credentialing and experience may be minimal requirements for conducting therapy of good quality, there are other personal and professional factors that contribute heavily to whether or not any individual therapist will be effective.

therapy as the preferred modality. A majority of the providers (75%) said their clients received medication in conjunction with counseling.

Since the preceding question on preferred modality of treatment was a forced choice question limiting respondents to a single, preferred modality, it might not accurately characterize all of the different types of services that clients receive (even though one kind of service might be preferred.) Therefore, in the next question, we asked the providers to assign percentages to different packages of treatment options to better reflect the actual balance of services offered to clients. The options provided on the survey form were: Only group therapy; only individual therapy; only medication management; only couples/family therapy; a combination of group, individual, and couples; and a combination of group, individual, couples, and medication management. Providers were asked to give what percentage of their sex offender clients received services consistent with each of the options.

Three statistics best characterize the responses: First, how many of the providers endorsed the option at all. Second, of those providers endorsing an option, what was the average percentage of clients receiving that particular configuration of services. And third, what was the range of responses, which would provide an indication of the variation in service options among the providers. Three of the providers (75%) said that an average of about 30% of the clients in their programs were seen exclusively in group sessions (range 20% to 50%). Three of the providers also indicated that some of their clients were seen in individual therapy alone but, reinforcing the notion that group therapy is the preferred modality of treatment for sex offenders, the average percentage of cases characterized as being solely in individual therapy was only 6% (range 0% - 10%). None of the four providers indicated that any of their sex offender clients were exclusively receiving medication management or couples-family therapy. These two forms of treatment, when used, appear to be used only in conjunction with

group and/or individual therapy.

The final two options represented combinations of the first four items. The first of these options included all of the aforementioned treatment modalities *excepting* medication management; 75% of the providers endorsed this option indicating that an average of 32% of their clients received this rather extensive service bundle (range 30% - 60%). The same percentage of providers endorsed the final option which indicated that some of their clients were receiving all four types of services with an average of 32% of the clients for these four providers falling into this category (range 10% to 100%). The pattern of responses for this item show that while group therapy is the preferred treatment modality, the majority of sex offenders are receiving multiple treatment services.

Based on monthly treatment reports submitted by therapists, the median number of group therapy sessions scheduled per month for Lake County offenders is 3.6, and the median number of meetings attended is 2.9. The size of the group of offenders in group therapy is an important parameter. In as much as the therapeutic value of groups depends on their size, groups that are too small, under five participants or so, lack the necessary group dynamics and interchanges between participants; factors posited to be among the principal therapeutic elements of group treatment. Alternatively, groups that are too large, over about 10 participants, often allow many participants to "hide" during sessions and not contribute in a meaningful fashion (this is also a problem with unskilled therapists who tend towards a passive or *laissez faire* style of leading groups). In our questioning of the providers on average group size, we found they had calibrated their group sizes to be within this theoretical range. The average group size across providers was 8 with a range of 7 to 10 participants per group.

While individual therapy was not a primary treatment mode compared to group, the above series of questions indicated that individual treatment *is* used by most of the Lake County providers.

For offenders who have individual treatment, the median number of individual sessions scheduled per month per offender is 2.3, and the median number attended is 2.0.

The average caseloads for therapists who provided individual therapy is important but primarily of concern when a therapist has too large a caseload to effectively deal with all of the cases and carry out other responsibilities such as coordinating assessments and reporting on therapy to the Lake County probation department. On average, therapists at these clinics saw 14 clients on an individual basis ranging from 5 to 32 clients. We would suggest that a caseload on the high side of that range is probably approaching the maximum number of individual hours that is optimal given the intensive assessment, monitoring, and clinical needs of sex offenders, along with the demands of running group sessions.

Recognizing that the therapists might also see other types of clients in addition to sex offenders, we asked them to specify their total caseloads and include all of the clients they see on an individual basis. The reported average total caseload was 27 clients, ranging from 20 to 32 clients per therapist. These are indeed busy therapists but at this point, none appear to be operating beyond peak levels of efficiency. However, if there is an increase in the referral stream of sex offenders from the Lake probation department, one of the factors that should be discussed is whether a given clinic can handle the additional cases with existing staff or whether they might require more staff. If more staff are required, this could affect funding rates. The Lake County probation department should be aware of individual and group caseloads and be prepared to negotiate for additional therapists (or clinics) accordingly.

With respect to each program's clinical orientation, respondents answered an open-ended question. Table III-4 shows the verbatim responses (with some minor editing) of the providers.[35] It can be readily seen that almost every provider indicated their programs used a cognitive-behavioral approach that included relapse prevention. Several of the providers noted following ATSA protocols. Thus, treatment providers in Lake County have universally adopted the cognitive-behavioral approach.

Table III-4
Descriptions of Treatment Orientation

Our treatment is cognitive behavioral in nature. We have developed our own discharge criteria and our own methods to assist clients to achieve discharge criteria. We rely heavily on the use of sexual assault cycles, and relapse prevention. We ascribe to ATSA protocols.

We follow the cognitive-behavioral model in terms of our treatment approach. The [clinical director] was trained in the 40 hour training that followed the Northwest training model… Most of the providers of Lake County attended the initial sex offender training in 1989 and 1990. We have added to and modified the original model.

Our program uses a cognitive-behavioral relapse prevention integrative approach. We tend to have a specialty area in the use of behavioral techniques (i.e., covert sensitization, etc.) All therapists have received specialized training in sexual offender treatment and evaluation. Our model most closely follows the philosophy used at Northwest Treatment Associates, Seattle Washington and we follow the ATSA recommended standards.

Cognitive-behavioral is treatment approach; relapse prevention model; based on model used at Northwest Treatment Association, Seattle Washington.

Finally, in this section, providers indicated that all Lake County offenders are required to pay for some portion of their treatment and their assessments. A high percentage of offenders of the offenders in

[35] In a few instances, comments were slightly edited to add clarity. In a few others, the writing was not legible or was not deemed relevant to the question asked and was omitted.

treatment, 90% are also required to pay at least some part of their assessment fees (though one provider said only 15% had to pay for assessments). According to two of the Lake County providers, assessments are conducted after sentencing but prior to treatment referral; one provider said that assessment occurred before sentencing and another said it occurred after sentencing and after treatment referral. We do not have additional information to explain this discrepancy in the timing of assessments among providers.

Salient Aspects of Treatment

Providers were presented with a series of 11 session characteristics or exercises and asked to rate them in terms of their clinical importance on an 8 point scale. A score of 0 meant the characteristic or exercise was not at all clinically important while a score of 7 meant that it was extremely important. For the purposes of presentation, the results for this survey question are presented in three groups as shown in Table III-5: Those characteristics deemed extremely important by almost all the providers; those deemed important but not as essential; and a single characteristic seen as being non-important by the providers.

For the most part, the session characteristics/exercises deemed most important were those directly related to sexual offending and to relapse prevention – confronting denial, teaching new cognitive and behavioral skills to reduce the likelihood of relapse, understanding the effects of the behavior on the victim, and understanding the sexual abuse cycle. Activities that were somewhat less directly related to the actual offending behavior such as anger management and assertiveness training, and routine polygraph testing were ranked as being in a second tier of importance. And finally, the attendance of PO's at sessions was seen as being unimportant from a clinical standpoint. A series of

additional questions about the non-clinical aspects of PO's attending treatment are presented below. [36]

Table III-5

Rankings of salient treatment characteristics/exercises

Scale 0 to 7: Where 0 = not at all clinically important and 7 = extremely important

Category 1: Extremely Important	**Mean rating**
Confronting denial so the offender accepts full responsibility	7.0
Teaching offenders specific behavioral and cognitive skills they can use to reduce their risk of offending	7.0
Helping offenders understand the affect their actions have had on their victims	6.8
Helping offenders recognize and stop deviant thoughts and urges	7.0
Covering and understanding the sexual abuse cycle	6.5
Category 2: Important but not Extremely	**Mean rating**
Teaching appropriate sexuality and sexual outlets	5.8
Directly lowering sexual arousal to inappropriate persons/acts by using behavioral techniques or medication management	5.3
Routine polygraph testing	5.3
Teaching anger management skills	4.5
Demonstrating assertiveness skills and appropriate social interaction skills with other adults	4.5
Category 3: Non-Important	**Mean rating**
Regular attendance of probation officers at group sessions	1.3

[36] This evaluation included collecting the same surveys from providers in DuPage and Winnebago Counties. The responses across counties were very consistent as to which treatment characteristics/exercises were most important. There were some differences in ordering within the three larger categories in the table, but characteristics seen as extremely important in Lake County were also viewed as such by the Lake and Winnebago providers and so on.

Another issue related to clinical saliency is relapse and the signs that suggest an offender is at increased risk for committing a new sexual offense. In an open-ended question, providers were asked what specific behaviors or indicators signified to them that a client was at increased risk for relapsing. Table III-6 presents the verbatim results from this question. Reviewing the responses, it appears that the providers interpreted the question in two different ways. Some providers thought we were asking them to identify the cohort of high-risk-for-relapse offenders, period. Closer to the intent of the question were the providers who attempted to identify the *changes* in an offender's behavior that signal an increasing likelihood of relapse during treatment. While there is considerable variability in the responses (in contrast to the open-ended responses given to, for example, the question on clinical orientation where most of the providers said they used cognitive behavioral therapy), it is possible to identify common themes. These are: increased social stress, psychological distress, alcohol use, blaming the victim, and

Table III- 6

Information or Actions Indicating High-Risk of Relapse

We look at past history to predict future behavior, We look at thoughts, feelings, behaviors, and stressors and measure risk of recidivism using these categories.

Alcohol use, poor disclosure, failed attendance, resurgence of pre-abuse risk factors that are a part of the offenders' offense pattern.

Shows cycle behavior (isolation, withdrawal); too eager to terminate treatment; deception; pattern of lying; drop out of treatment abruptly.

Blaming the victim, lack of victim empathy, disregard of rules of probation, weak support systems.

behaviors indicating a lack of engagement from or rebelliousness against treatment and probation such as failed attendance and/or disregard for probation rules.

Probation Officer Participation in Treatment

While the providers rated PO's participation in treatment as clinically unimportant, we wanted to understand if they also felt it adverse to the groups in any way, how often PO's attend sessions, and how active they are in sessions they attend. However, only one of the four Lake County providers said that POs attended treatment sessions offered by their programs. Interviews with the POs in Lake confirmed this survey finding. ***Probation officers noted that they either never have sat in on group sessions or very rarely do so, and that they never talk in group sessions.***

For the one provider who did indicate POs attended session, it was less than quarterly, the POs did not speak often in the sessions and never attempted to lead the sessions. This provider did make a distinction between the clinical significance of PO group attendance, which they rated as low, and the helpfulness of PO's session attendance which they rated as a 5 on an 8 point scale.

It is not clear why the POs in Lake County attend sessions at this particular provider and do not attend sessions at other providers. This is an issue worth exploring. Additionally, compared to DuPage County, PO monitoring of treatment is much less common. This may reflect the Lake County probation department's philosophy, but again, it is worth exploring to determine if the lack of treatment attendance is at the policy level or if it has simply been an oversight.

Despite the lack of attendance to monitor treatment first hand during interviews, the POs did offer some observations about the differences and similarities among treatment providers.

Provider 1

Treatment is unstructured, open-ended group therapy. This provider is still a novice at behavioral therapy… and is most flexible in offenders' ability to pay – often allowing the balance to run up before termination.

Provider 2

This provider is not very effective with deniers. Group therapy is very structured. Offenders go through phases, specific topics are discussed, and they have homework. Much focus is given to the sexual assault cycle and an offenders' awareness of their own sexual assault cycle. Individual treatment is on a case-by-case basis, as is counseling. Therapists do not conduct behavioral treatment.

Provider 3

This provider is good for high-risk cases. Group therapy is the preferred modality and it is structured in that specific topics are discussed each session and the offenders have homework. Offenders, however, do not go through phases. Most offenders also receive individual behavioral therapy that uses masturbation sedation techniques.

Provider 4

Group therapy is the preferred modality and it is structured, with phases, homework, and specific topics. They are also good on behavioral treatment, and conduct individual treatment on a case-by-case basis.

Written Policies

The rationale for including questions on written policies regarding things like lateness, absences, and payment schedules was discussed above. Most of the providers in this sample, 75%, responded they had written policies on treatment rules violations and that these policies have been discussed with therapists on staff. Specifically, the treatment rules violations covered are the number of unexcused absences allowed (75%) and what constituted an unexcused absence (75%). In addition, 75% of the providers said they also have written policies on what constituted being late for a session, on the number of late sessions allowed, and on payment schedules and requirements. The comprehensiveness of written policies on all of these issues by the Lake providers is commendable and should provide the treatment participants with clear guidelines on what is expected of them in treatment.

Table III-7

Recommendations For Improving Treatment Effectiveness

Additional resources to assist needy clients with adjunct individual-behavioral treatment. Many clients could really benefit from group and individual but simply can not afford it.

Availability of psychiatric services with a provider who understands sex offender treatment and is willing to work cooperatively.

Improved polygraph system
Less direct sentencing without evaluation and recommendations.

More legislative and court supported policy on how to integrate the use of the polygraph and plethysmograph into the judicial-clinical interface.

More grant money for polygraph, ABEL screen, more behavioral treatment

Provider Recommendations

The last question on the survey asked the providers to make recommendations for improving treatment effectiveness. The responses of the providers in Lake County indicated they primarily want additional resources for a variety of services including individual therapy, psychiatric care, and improved system for polygraphs and greater numbers of polygraph tests.

Summary

As already noted, we wish to stress that the survey method of evaluation is limited to the validity of the providers' self-report. With that important caveat, and based on the above survey results for Lake County, we make the following observations and recommendations:

- The referral stream of clients from the Lake County probation department appears to be funneling adequate numbers of cases to the treatment providers. The program appears to be successfully linking sex offenders with treatment programs and to be using a variety of treatment programs.
- All of the providers rely primarily on group treatment as the preferred treatment modality though many offenders receive a variety of services such as individual and family counseling. The primary clinical orientation of the programs is cognitive-behavioral. As best we can tell from the surveys, the treatment being provided is at least adequate and appropriate. The therapists have good clinical credentials and are experienced in providing sex offender treatment.
- However, the interviews with the Lake County probation officers suggest that there are differences among the providers in the nature of treatment offered ranging from "very professional" to unstructured.

- The average number of attendees at group sessions is within the appropriate range. However, some of the therapists appear to be carrying rather large individual caseloads in conjunction with their work with sex offenders. If the number of sex offenders referred to these programs increases substantially, the Lake County probation department should monitor this issue and make sure that no therapist has a *total* caseload of greater than about 30-35 clinical hours per week.
- The providers have written policies on various treatment parameters including what constitutes session lateness and payment requirements. This is unusual compared to the providers in other counties that we have evaluated and is commendable.

Short-Term Probation Outcomes

From October of 1997 to February of 1999, the Lake County Sex Offender Unit provided very detailed and useful monthly statistics on the number of new arrests, number of new arrests for a sex offense, number of technical violations, and number of violation of probation petitions filed. Some measure of this program's short-term probation success rate can be obtained by examining intake and case outcomes. The program began with a caseload of 191 sex offender cases and added a total of 197 new cases through the 17 month period examined. Of this total of 388 cases reviewed, 182 have been terminated from the program in the following manner: 16 to DOC, 24 to jail/work release, 5 to IPS, and 137 classified as successful terminations. This yields a successful completion rate of 75.2%. Successful completion does not necessarily mean that the offender's probation was problem free, as violation rates indicate. It simply means that there were no known serious violations or new arrests that led to probation being revoked by the court. As the following paragraphs indicate, this program has been very

diligent in responding to condition violations which its surveillance officer program design is perhaps more likely to uncover than is the case with other programs.

Across these seventeen months, Lake County averaged four arrests per month, and had a total of 68 new arrests. Of these new arrests, Lake County averaged one arrest per month for a new sex offense, and had a total of 20 arrests for new sex offenses. A total of 32 arrest warrants also were issued for offenders who primarily failed to show-up for probation appointments.

Probation officers in the Lake County Sex Offender Unit appropriately enforced probation conditions as evident by the 145 total number of technical violations filed across these 17 months. The unit filed an average of 8.5 technical violations per month which is a technical violation rate of approximately 37.4%[37]. This relatively high rate is to be expected in a program that maintains a high level of offender supervision and surveillance. The unit filed a total of 186 violation of probation petitions to revoke probation, which is an average of 11 violation of probation petitions filed per month. Of offenders who had violation of probation petitions filed, 105 petitions were accepted. Sixty offenders were resentenced to probation for an extended period, and, as noted, five were resentenced to intensive supervision probation, 24 offenders were sentenced to jail or work release, and 16 offenders were sentenced to the Illinois Department of Corrections. In this 17 month period, 32 arrest warrants were issued with a mean of 1.88 per month.

The evaluation team also examined all violation of probation petitions filed and administrative sanction reports filed between September, 1998 and March, 1999 on sex offenders in our sample. Seven offenders (8.3% of sample) were arrested while on probation for a total of 13 times of being

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[37] This is approximate because multiple violations may be filed on some cases so the base number of cases is smaller than the total intake figure used to calculate technical violation rates. We used this base to allow for program

placed under arrest. Two offenders were arrested for two offenses, and one offender was arrested for traffic offenses and driving without a license on five separate occasions. Other arrest charges were theft of cigarettes, retail theft, two disorderly conduct, battery, criminal damage to property, domestic violence, possession of cannabis, drug paraphernalia, and resisting a peace officer. Eighteen offenders (21.4% of sample) had at least one violation of probation petition filed against them during this period. A total of 27 violation of probation petitions were filed during this period, with six offenders having two violation of probation petitions filed against them, and one offender having five violation of probation petitions filed.

The nature of the violation of probation centered around probation conditions such as: (1) two offenders continued to violate a court order to have no contact with their children; (2) violation of probation petitions were consistently filed for offenders who were arrested for any offense; (3) failure to attend, comply, or complete sex offender treatment was stipulated in six violation of probation petitions; (4) one violation of probation petition was filed due to the fact that the offender's whereabouts were unknown; (5) failure to pay court costs, probation fees, restitution also was stipulated in many of the petitions, but never was the sole reason for the violation of probation petition. In addition, three offenders were entered into the administrative sanction program for driving with suspended license, two positive urine tests for marijuana, and not making probation payments.

The Lake County statistics and data did not contain any consistent reference to probation condition compliance so this variable could not be measured. This is consistent with most corrections programs that do well at documenting noncompliance but rarely refer to compliance. During this time period, therapists reported that 12 polygraph examinations were conducted.

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comparisons.

Short-term Treatment Outcomes

The evaluation team asked all treatment providers to complete a standardized monthly progress report for all offenders receiving treatment in our sample. The standardized monthly report assessed the progress of the offender on six critical dimensions of treatment:

(1) participation in therapy sessions; (2) commitment to treatment; (3) acknowledgment of personal responsibility for the offense; (4) understanding of the consequences if he re-offends; (5) willingness to disclose details of additional inappropriate behavior; and (6) acceptance of responsibility for emotional/physical damage their actions caused the victim. All of these dimensions were rated on ten-point scales where 1 is equal to none of the dimension (e.g., no acceptance), 5 is equal to moderate, and 10 is equal to complete on the dimension (e.g., complete acceptance). In addition, therapists indicated the number of scheduled and attended therapy appointments, the number of unexcused absences, and whether offenders completed all homework assignments. Therapists also provided information about any positive lifestyle changes since last report, and about any admissions to inappropriate sexual behavior since last report. Therapists also indicated whether a polygraph test had been administered.

Responsiveness to treatment is an important intermediate outcome in evaluations of how well treatment reduces recidivism. Responsiveness to treatment can be measured in several ways. For example, at least two independent neutral experts could observe and interview each offender at several points during the entire treatment period; unfortunately, this design though ideal at reducing response biases is intrusive, expensive, and could interrupt the treatment process. The evaluation team, therefore, decided to obtain monthly treatment reports from providers on each offender and to measure systematically critical dimensions that treatment is designed to change.

There are both advantages and disadvantages to using progress reports from therapists as a measure of whether offenders are responsive. One important advantage is that the therapist knows where each offender began and how well he has met treatment standards. Therapists also judge the progress of offenders in relative terms to how previous and current clients are responding to similar treatment. A potential disadvantage, however, is that therapists will tend to cast offender's progress in the best possible light to show that treatment is effective. In an attempt to reduce this positive bias, we instructed therapists that all data would be grouped in each county and analyses on separate agencies would not be performed. We also instructed therapists that our primary goal was to understand the predictors of treatment responsiveness and not to address the question of whether treatment was effective. We believe progress reports can be reliably used to determine the characteristics that distinguish offenders who are responsive from those who are not responsive. These data, however, are quite limited to determine the effectiveness of treatment such questions are better answered with matched-control sample designs that have long-term follow-up.

We had a total of 26 offenders from Lake County in which treatment providers submitted monthly treatment reports. Three treatment providers out of the four primary treatment providers provided reports on their offenders. For 20 of these offenders, we had four or more months of monthly progress reports from September of 1998 to February of 1999 most of these offenders had all months of data. For six offenders, we had only two to three months of progress reports. Twenty-three offenders were either not ordered to have sex offender treatment or were not in treatment at the time of this data collection. Thus, Lake County had 35 offenders who were in treatment for which we did not receive monthly progress reports.

Two basic indications of offenders' lack of participation in treatment are how often they miss sessions with unexcused absences and how many times they fail to complete homework assignments. Sixty-three percent of the offenders attended all scheduled therapy sessions, 15.8% missed one session with an unexcused absence, 15.8% missed two sessions with an unexcused absence, and one offender missed three sessions with an unexcused absence. Offenders were less diligent about completing homework assignments. Homework assignments were applicable to all offenders except one. Two-thirds of the offenders completed all homework assignments for all months that monthly treatment reports were completed. The remaining offenders missed between one and six homework assignments during these months. One indication that therapists took the task of completing these monthly treatment reports in as accurate manner as possible is that offenders who were rated lower on the scale of participation did not attend all therapy sessions and did not complete all homework assignments.

Classifying Offenders as Responsive to Treatment

In order to classify offenders as responsive or unresponsive to treatment, we first conducted N-of-1 statistical analyses. N-of-1 statistical analyses are an improvement over visual inspection of the data because they provide a reliable standard by which improvement can be measured. Ispative N-of-1 analyses address the question, did this offender improve during the course of treatment compared to when the offender entered treatment?[38] For each individual offender, we performed ipsative analyses

[38] As Mueser, Yarnold & Foy (1991) note, "statistical analysis of single-subject data provides a rule-governed, systematic approach to assessing outcome that simply is not possible with visual inspection alone." (p. 135) N-of-1 analysis takes into account an individual's performance at baseline compared to their performance during the observation months. Because numerous data points are needed in order to employ time series analysis, we chose to employ N-of-1 analyses derived from classical test theory (see Yarnold, 1992). Ipsative single-case analyses first converts an individual's raw data into standard z scores using an

on each of the six dimensions. Ipsative analyses did not reveal any significant changes across time. There are several theoretical and methodological reasons for these null findings. First, most offenders were already in treatment for many months before we obtained any ratings of their progress; thus, we do not have a true baseline point. Second, sex offenders are in treatment for behaviors and attitudes that require a long period of time to change. Sex offenders do not quickly obtain victim empathy, acceptance of responsibility, or recognition of the inappropriateness of their behavior. Indeed, most sex offenders received similar ratings across the months on these dimensions. This stability in ratings means that sex offenders are changing more slowly than month to month.

A more relevant question that normative N-of-1 analyses can address is: Within this sample of offenders, who is more responsive to treatment? Normative analyses have more practical implications. These analyses can address questions such as: (1) if treatment resources are scarce, which offenders will most likely benefit from treatment? and (2) which offenders are most likely to terminate prematurely from treatment due to noncompliance with treatment rules?[39]

The normative-based N-of-1 analyses revealed only one significant change: one offender significantly decreased on acceptance of personal responsibility for the offense. Because offenders had been in treatment for an average of nine months and ten had been in treatment for over one year, we also developed absolute criteria to classify offenders as responsive or unresponsiveness. Based on monthly progress reports from three counties (Lake, DuPage, and Winnebago), we calculated the

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individual's own mean and standard deviation for the variable being standardized.

[39] N-of-1 normative analyses convert the raw data to z scores using the mean and standard deviation of the entire sample, which allows relative comparisons across offenders. To standardize the data, we used the mean and standard deviation across time for each question based on all monthly treatment reports collected from Lake, Winnebago, and DuPage County. In all three counties, therapists provide cognitive-behavioral group therapy. Grouping data from all three counties insured that we had a more representative population of sex offenders and did not create an artificial restricted range on our measures.

mean, median, and 60th percentile for each of the six dimensions. Table III- 8 presents these data.

Table III-8

Descriptive Statistics of Therapists' Ratings of Sex Offenders' Progress in Three Counties

Scale Ranges From 1 to 10 with higher numbers indicating more of the characteristic

Dimension	Mean	Standard Deviation	Median	60th Percentile
Participates in therapy	5.88	2.41	5.88	6.43
Committed to treatment	5.57	2.50	5.41	6.29
Acknowledges personal responsibility	6.33	2.69	7.0	7.20
Understands consequences if re-offends	7.41	1.83	7.55	8.2
Willing to disclose inappropriate sexual behavior	4.90	2.70	4.68	5.5
Accepts responsibility for emotional/ physical damage to victim	5.69	2.72	5.88	7

Therapists in Lake County did not make significantly more positive ratings than therapists as a whole, and made distinctions between offenders as evident from the lowest and highest mean rating across time for individual offenders. Table III-9 presents the means for the total sample of sex offenders in all three counties compared to the means for sex offenders in Lake County, the lowest mean across time for an offender in Lake County, and the highest mean across time for an offender in Lake County. Lake County therapists did not provide significantly higher means than therapists in the population and as evident by the lowest and highest mean for individual offenders made distinctions among their clientele.

Table III-9

Comparison of Mean Ratings of Therapists Across All Counties to Lake County Therapists

Scale Ranges from 1 to 10 with Higher Numbers Indicating More of the Characteristic

Dimension	Mean Across All 3 Counties	Mean for Lake County	Lowest Mean Across Time	Highest Mean Across Time
Participates in Treatment	5.88	6.14	3.17	9.25
Committed to Treatment	5.57	6.46	3.5	9.67
Acknowledges Personal Responsibility	6.33	6.59	3.5	9.25
Understands Consequences if reoffends	7.41	7.61	3	10
Willing to disclose inappropriate sexual behavior	4.90	5.48	2.25	9
Accepts responsibility for emotional/physical damage to victim	5.69	6.18	3	10

To classify offenders based on absolute cut-points of reaching some standard, we established that offenders were responsive on a given dimension if they were at or above the 60th percentile for that dimension. We selected this cut-off based for two reasons. The mean and median seemed to be too lenient of criteria to label someone as successful on a dimension given the fact that success should mean more than 50%. Given the distribution of the data and the fact that these behaviors and attitudes are slow to change, the 60th percentile (which is the mean + .5 standard deviation) made empirical and conceptual sense. After classifying each on all six dimensions, offenders were classified as overall responsive if they were classified as responsive on four of the six dimensions or if they were classified as responsive on three of the six dimensions and showed a statistically significant improvement on one of these dimensions. Interestingly, across the six dimensions, most offenders were either classified as unresponsiveness for all dimensions or responsiveness on all dimensions. Ten offenders were classified

as unresponsive on all dimensions, and six offenders were classified as responsive on all dimensions. No offenders were only responsive on four dimensions, and only two offenders were responsive on three dimensions; thus, the distribution of the data did not produce many close calls on whether in the therapist's mind the offender was doing better or worse relative to other offenders.

Therapists reported a mean of 1.25 positive lifestyle changes per an offender for all months in which progress reports were obtained. Ten offenders (35.7%), however, did not have any positive lifestyle changes. Several offenders were reported to have better relationships with significant others: two offenders had better relationships with their spouse, one offender had better relationship with parents and sister, two offenders had better relationships with co-workers, and one offender became engaged to live-in girlfriend. Other lifestyle changes included: has almost graduated or graduated from treatment (two offenders), entered phase two of four phase program, improved employment by getting a job, looking for a better job, getting a promotion, or starting a business (five offenders), has been complying with rules of work release program (two offenders), improved communication skills, improved presentation of sexual offense, more open to disclosure of sexual offending, involved spouse in treatment, changed schedule/pattern to avoid risk of reoffense, and asked son to move out of house due to son's drug use.

Only three offenders were reported as having revealed additional inappropriate sexual behaviors. One offender revealed five such behaviors including trying to get two minor females into his car, use of pornographic material, and use of prostitutes. One offender revealed that he had violated the court order not to have contact with the victim. One offender admitted to inappropriate fantasies at times.

In order to determine the progress of the 35 clients who were in treatment but did not have monthly treatment reports, we requested from the probation department an update on the status of offenders who did not have any monthly treatment reports. The probation department was asked to indicate treatment status (ongoing, terminated prematurely, successfully completed), probation status (active, on active warrant, successfully completed, probation revoked), whether a VOP was filed for failure to comply with treatment, and whether the offender was arrested while on probation and the nature of the offense. We also obtained the date treatment started and ended. Based on this information, we were able to classify 14 of the 35 offenders as unresponsive to treatment based on the criteria that treatment was prematurely terminated due to noncompliance with treatment rules. Two offenders were coded as responsive based on the fact that they successfully completed treatment and probation. The total sample for Lake County for analyses on the predictors of responsiveness is 40 of the 65 offenders ordered to undergo sex offender counseling, which is 61.5% of the relevant sample.

Predicting Who Is Responding Well in Treatment

Overall, 12 of the 40 offenders were classified as responsive. It is critical to understand the characteristics that differentiate offenders who are responsive to treatment from offenders who are unresponsive. Characteristics that accurately predict whether offenders were classified as responsive or unresponsive to treatment are called "significant predictors."[40] Significance simply means that

[40] For all analyses statistical significance refers to the probability of making a false claim that a predictor is related to treatment responsiveness when it actually will not predict treatment responsiveness in future samples. This is known as the Type 1 error rate or p. The Type 1 error rate, p, was assessed as an exact permutation probability, and for each comparison $p < .05$ was used to establish statistical significance. This probability level was chosen to maximize the power of detecting predictors that discriminate between responsive and unresponsive offenders while still maintaining a relatively low probability of making a Type

information obtained from the predictor does better than chance at accurately classifying offenders into either the responsive or unresponsive category. To determine the significant predictors of treatment responsiveness, we employed a statistical tool that provides the maximum possible accuracy in classifying cases. This tool is called optimal discriminant analysis (ODA).[41]

We considered forty potential predictor variables. Demographic and background predictors were age, ethnicity, marital status, number of biological children that offender with whom the offender associates, whether the offender is on welfare, income level, education, and sexual orientation. We considered eight characteristics of the offense: statutory type of current offense, relationship of offender to victim, gender of victim, age of youngest victim, whether force was used, location of the crime, whether penetration occurred, and number of months that sexual abuse continued. We considered five measures of prior record: total number of prior arrests, number of prior arrests for sex offenses, number of prior arrests for violent crimes, number of prior arrests for misdemeanor crimes, number of prior convictions for violent crimes, and number of prior convictions for sex offenses. We considered ten measures of psychological and social adjustment: whether offender had a drug/alcohol problem; used drugs/alcohol before the offense, had prior treatment for substance abuse, had a serious mental disorder, had prior treatment for a mental disorder, was currently in a sexually active relationship, suicide history, whether the offender was depressed, the severity of the personal history of child abuse/neglect, and whether offender was a victim of physical and/or sexual abuse. Level of functioning

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1 error.

[41] Parametric statistical analysis was inappropriate due to non-normality and range restriction, and traditional nonparametric analyses were inappropriate due to many tied values (Soltysik & Yarnold, 1993; Yarnold & Soltysik, in press). Due to the small number of misclassified observations for any single predictor variable, we could only build a two variable model for treatment failure. This model was built using classification tree analysis (CTA).

on clinical presentation characteristics at the time of intake using the Bays & Freeman-Logo Scale (to evaluate sexual offenders' risk of reoffending): willingness to discuss offense, acceptance of responsibility for offense, remorse about offense, and number of self-reported sexual paraphilia. Based on multiple sources of data from offenders' self-reports, objective personality or sexual preference tests, DSM IV diagnosis, and prior disclosed offense history and fantasies, we created measures of whether the offender was a pedophile or not, had interest in aggressive or sadistic sexual behavior/fantasies, had engaged in or expressed interest in "hands-off" sexual offenses (e.g., exhibitionism or voyeurism). We also created a measure of whether the offender had been diagnosis as a psychopathic deviant based on objective personality tests such as the MMPI or MCMI or a DSM IV classification as an antisocial personality.

In order to determine the relative performance of each significant predictor, we used the percentage of total theoretical possible improvement in classification accuracy achieved with the predictor—above the classification accuracy that could be achieved based only on chance. This measure is a standardized test statistic called the "effect strength for sensitivity" (ESS). ESS can range between 0 and 100 where 0 means no improvement in classification accuracy above chance and 100 means that the predictor explains all variation (errorless classification) in classification accuracy above what can be achieved by chance. Predictors can be ranked as weak, moderate, or strong based on the ESS. ESS < 25% indicates that a predictor provides only weak accuracy in classification, ESS between 25% to 49% indicates moderate accuracy in classification above chance performance, and ESS equal to 50% or higher indicates strong accuracy in prediction above chance performance.

In addition to the strength of a predictor, it is important to know whether the predictor would perform at the same level of accuracy at classifying a new set of cases; predictors are reliable if they

have the same accuracy at classifying cases (measured by the ESS) in the new sample as in the original sample. We report whether a predictor was reliable and provide the ESS for the new sample if the predictor is unreliable.[42] Only reliable predictors were allowed to enter the classification tree analysis. Another factor that can affect the ability of predictors to classify accurately a new sample of data is the distribution of the outcome variable. All predictor variables reported have reliable accuracy in classification of cases irrespective of the percentage of cases classified as one category of the outcome variable (e.g., responsive).[43]

Analyses revealed five significant predictors of treatment responsiveness.[44] Three of the five variables were reliable predictors, and all three predictors indicate the extent to which the offender may learn new cognitive skills and coping strategies. Remorse was the strongest predictor, and offender who expressed great remorse about the offense were classified as responsive($N = 40$; $p < 0.0034$; ESS = 51.2). Moderate classification accuracy was obtained using income (if the offender has an income greater than $20,000 per year then predict that the offender is responsive to treatment; $N = 38$; $p < 0.032$; ESS = 43.6, a moderate effect), and drug treatment (if the offender had any prior treatment for substance abuse then predict that the offender is responsive to treatment; $N = 40$; $p < 0.015$; ESS = 34.5, a moderate effect). In addition, if an offender has been in treatment for 8 months or more, he was

[42] A jackknife validity analysis was used to assess how reliable each significant predictor would be in classifying a new sample of data; the jackknife validity analysis employed was a leave-one-out (LOO) analysis where classification for each observation is based on all data except the case that is being classified.

[43] An efficiency analysis was conducted to assess how well a predictor performed over all possible base rates of the outcome variable. The outcome variable, however, could not have all cases classified in only one of the categories (e.g., all offenders are responsive and none are classified as unresponsive) (Ostrander, Weinfurt, Yarnold, & August 1998).

[44] Based on a .05 probability level and forty tests, two "significant" effects would be expected based on chance alone. Five significant effects is over 2 times the number of effects expected due to chance alone.

predicted to be responsive.[45] Finally, ethnicity was a significant predictor of responsive to treatment, but was very unreliable. Given the small number of misclassified observations, we could not create a model that contained more than one variable (i.e., "CTA multivariate model).

Qualitative Description of Offenders Predicted as Responsive to Treatment

The three stable predictors of responsiveness to treatment, remorse at intake, prior drug treatment, and length of time in treatment, have a common foundation: all three factors indicate the extent to which the offender may potentially learn new cognitive skills and coping strategies. Remorse was the strongest factor, and one goal of group therapy is to acquire remorse for one's sexual offense through coming to accept full responsibility for the offense and to acquire an empathic ability to understand how these actions caused great emotional harm to the victim. Thus, offenders who express great remorse at the time of the evaluation have a positive clinical presentation, and may be able to establish better rapport with the therapist whereas offenders who express no remorse have a negative clinical presentation and may lead the therapist to expect a difficult and slow treatment process. Expressions of remorse can reflect true character or can be used to manipulate the social consequences of one's offense. Offenders who present with expressions of great remorse may be truly remorseful or may be attempting to fool the therapist. The evaluation team, thus, believes it is informative to examine in detail offenders who expressed great remorse and received a responsive label based on therapist's positive and high ratings.

Seven offenders were accurately predicted using remorse whereas two offenders expressed great remorse, but received an unresponsive label based on therapists' low ratings

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[45] Length of time in treatment had the following statistical indicators: ($N = 45$; $p < 0.0008$ and total sample ESS = 64.3 (a strong effect), but showed diminished classification performance in jackknife validity analysis (jackknife ESS = 47.6).

across the six dimensions. First, there are some clear differences between the correctly predicted and incorrectly predicted offenders. All seven of the correctly predicted cases are white, have completed high school, are employed full-time, have a stable work and school history and make an average income of $35,000 (one case however makes below poverty). The two misclassified cases are Hispanic, high school dropouts, have unstable work and school history, and make less than $15,000.

Expressions of great remorse should be judged in light of the offenders' prior history of offending and deviant sexual paraphilia and interests. For example, has the offender learned that if he expresses great remorse he will not be convicted or will receive a reduce charge? Six of the seven offenders have been arrested before and most have been arrested more than once. Have offenders learned from prior mental health treatment or substance abuse treatment what therapists expect and reward as progress? Four of seven of the offenders have prior treatment for mental health or substance abuse problems. Is an expression of great remorse an indication that the offender understands the harm he has caused or is it an indication that the offender understands the serious consequences he faces if he is discovered as violating treatment rules?

These short synopses illustrate the multiplicity of mental health problems and the seriousness of the crimes that is masked by the convicted charge. Offender C has engaged in sexual crimes for over 144 months. He has eight prior arrests and six prior convictions for sex crimes. He has received diagnoses of exhibitionism, depression, and pedophilia. He has a prior history of being sexually abused as a child over a long period of time. Offender D has one prior arrest for a sex crime, but no conviction. He is into pornography and has had prior mental health problems. He also has a alcohol dependence problem. He committed five counts of aggravated criminal sexual abuse against a fourteen year old girl that included both oral and vaginal penetration. Offender G has three prior arrests (two

misdemeanors and one drug charge), and three prior convictions. He also has one prior probation term and one incarceration term. In addition to his knowledge of the criminal justice system, he is well-versed in the mental health system. He has participated in prior treatment for alcoholism and for mental health problems. He admits to using marijuana, hash, and cocaine. He was charged with four counts of aggravated criminal sexual abuse against an unrelated eleven year old girl. The abuse continued for eight months and included vaginal penetration. Offender A is diagnosis as a pedophile. He has a prior history of being sexually abused as a child over a long period of time, and has a cannabis dependence. He also has a prior domestic battery arrest, but no conviction. He was convicted of four counts of aggravated criminal sexual abuse, which included anal penetration, against a five year old girl. Offender E also knows both the criminal justice and mental health systems. He has two prior arrests for misdemeanors, but no previous convictions. He has prior treatment for alcoholism, and currently uses alcohol. He currently has morbid obsessions. He is convicted of public indecency in front of a woman. He has been committing sex crimes over an 18 month period, and based on the probation officer's intake never refers to the victim's feelings.

The last two correctly predicted offenders have less knowledge of both the criminal justice and mental health systems. Offender B has one prior arrest and conviction of a sex crime. He is currently serving probation for a conviction of public indecency in front of a 26 year old woman. He reports being sexually abused as a child, but reports no drug or alcohol usage or problems. He, however, never referred to the victim's feeling during intake. Offender F has no prior arrests or convictions. He is convicted of an incest crime. He committed vaginal penetration against his nine year old step-daughter. He reports interest in pornography and depression.

Future research is needed to determine whether offenders who provide positive clinical presentation during the evaluation stage and receive high ratings from therapists actually refrain from committing additional offenses. Given the serious nature of these offenses, the longevity of offending, and the offenders' knowledge of the mental health and criminal justice systems, therapists face difficult tasks of trying to determine who is faking good and who has truly changed. The treatment evaluations did not label any of these offenders as psychopathic deviants or antisocial personality. Though four of the offenders took the MMPI and MCMI, the results were reported only for one of the offenders. This offender had a significantly high score on desirability.

Predicting Premature Treatment Termination

In the above analysis, we focused on trying to predict who was doing well in treatment. We were fortunate to have information on who was violating treatment rules or failing to cooperate with treatment evaluations. Sixty-five offenders were ordered to undergo sex offender treatment in our sample. Of these 65 offenders, 23 offenders (35.4%) exhibited a serious violation of the treatment order. A serious violation included: (a) failure to undergo evaluation for sex offender treatment; (b) premature termination from sex offender treatment due to noncompliance with treatment rules; (c) failure to complete successfully sex offender treatment during the probation period; (d) being arrested while on probation for any offense; and (e) admitting serious inappropriate sexual behavior to the therapist (e.g., one offender tried to get two minor females into his car and used adult pornography on three different occasions; two other offenders had repeated contact with the victim (their minor children) despite a no contact order).

Only one variable was significant and reliable predictor of treatment failure: If the offender had a diagnosis of psychopathic deviant then predict that the offender committed a serious violation of treatment rules.[46] Several studies have shown that psychopathic deviancy is a strong predictor of recidivism after controlling for demographic, criminal history variables, and deviant sexual interest (Quinsey et. al., 1995). Consistent with the results predicting who performed well in treatment, level of remorse at intake predicted serious violation of treatment rules: if offender showed minimal or no remorse for offense then predict serious violation of treatment rules (ESS = 25.24, $p = .053$, one-tailed); however this variable was unreliable.[47] (ESS = 14.05).

We next built a model that combined the predictors of treatment failure to optimize classification accuracy at each level of the tree.[48] As the authors of a recent meta-analysis of research on predictors of recidivism in sex offender samples note, it is extremely important to examine how predictors combine to indicate clusters of offenders who are at a higher risk of treatment failure (Hanson & Bussiere, 1998). Past research has not provided information about how predictors should be combined; our preliminary analysis is a major advancement over previous studies in that it assesses the reliability of predictors and indicates how to combine these predictors. Most prior research has not assessed the stability of their

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[46] We performed "univariate ODA" using the same predictors as described in the treatment responsiveness section. Psychopathic deviancy had the following statistical indicators: N = 61; $p < .021$; ESS = 26.81. In addition, age showed a strong effect (ESS = 40.58, $p < .008$), but the jackknife validity analysis indicated that it was extremely unreliable (i.e., had a negative ESS in LOO analysis).

[47] Remorse is an unreliable predictor as the reduced performance in jackknife analysis (ESS = 14.05) indicates.

[48]Classification Tree Analysis (CTA) was the statistical tool; it has been shown to have better predictive and classification accuracy than alternative (logistic, discriminant analysis, stepwise OLS regression) and nonlinear (Chaid, CART) statistical classification methodologies (Soltysik & Yarnold, 1993; Soltysik & Yarnold, 1994; Yarnold, 1996; Yarnold & Soltysik, 1991). At each step, CTA selects the predictor that has the highest accuracy at classifying the class variable (e.g., arrested or not arrested while on probation). The root variable (or beginning variable of the tree) is the one with the strongest predictive accuracy that is stable in a jackknife validity analysis. Only variables that are shown to be reliable are allowed to load in multivariate models. CTA also insures that the model can be replicated with new data because it conducts what is known as a jackknife validity analysis, in which every observation is classified using a model created on the basis of all the data except the observation being classified (Soltysik & Yarnold, 1993, 1994; Yarnold & Soltysik, 1991).

prediction models, or how well these models perform with samples of different percentages of treatment failures.[49]

A two-variable multivariate CTA model had an overall classification accuracy of 73.7% and provided a moderate performance at predicting treatment failures (ESS = 41.9%). The model identified three clusters of sex offenders. The largest cluster is of offenders who do not commit serious violations of treatment rules. These offenders are not diagnosed as psychopathic deviants and have none or only one sexual paraphilia. These two criteria provided 80 percent predictive accuracy of not committing serious violations. Offenders who are psychopathic deviants are more likely to commit a serious violation of treatment rules, though psychopathic deviancy alone only had 58.8% predictive accuracy. A smaller group who is likely to terminate treatment prematurely are offenders who are not psychopathic deviants, but have two or more sexual paraphilia. Future research on a larger sample can build on these promising results to create a scale to assess the risk that offenders will commit serious violations of treatment rules while on probation.

Summary and Recommendations

This section summarizes the key findings from our evaluation of the Lake County Sex Offender program and offers some recommendations for program enhancement. We focus upon

[49] Most prior studies have utilized linear statistical procedures (e.g., OLS regression, logistic regression) to predict recidivism, which does not provide information about how to combine the significant predictors. Our nonlinear CTA identifies clusters of offenders who have a high probability of recidivating. Moreover, CTA specifically optimizes classification accuracy at each node of the tree whereas linear and nonlinear statistical procedures are sub-optimal procedures. For each CTA model presented in this manuscript, we performed an efficiency analysis that indicates how well the model performs if it were used to classify a future group of sex offenders that had a different amount of recidivism (see Ostrander, Weinfurt, Yarnold, & August, 1998).

four key elements that include program design and management; supervision and surveillance; treatment; and short-term outcomes.

Program Design and Management

The Lake County program uses a mixed caseload-surveillance officer design in which six sex offender specialists carry a caseload of both regular and sex offender cases and two surveillance officers provide intensive supervision and surveillance of the sex offender cases. The essential element in this design is that the surveillance officers do not carry their own caseload but rather devote full time to community supervision and surveillance of sex offenders on the sex offender specialists caseload especially during evenings and weekends. The program's target population includes adult felonies and misdemeanors and is broadly defined as including any offender convicted of any offense that is sexual in nature who has been sentenced to probation. To this extent, the target population is not limited to sex offense convictions but can embrace a wide range of convicting offenses that on the surface are not sexual but have a sexual component. For example, a theft of women's clothing by a male offender, burglary of a pornographic shop, while not statutory sex offenses, would be included as sex offender cases in the Lake County program. In the majority of cases after an offender is sentenced to probation, the case is reviewed at probation intake and the decision made to include or not include the case in the sex offender program. In some cases the decision is based on a presentence investigation and/or a direct order for assignment to the sex offender program. Although the Lake County program developed and uses a sex of 20 special conditions for sex offender cases, these are not usually made a part of the probation order since assignment to the sex offender program is most often made after the sentence to probation. The general probation order that includes a condition that the offender shall abide by the

rules and regulations established by the probation department is seen as the justification for demanding compliance with the 20 conditions. All sex offender cases are assessed upon entrance into the program or as part of the presentence investigation process. Sex offender treatment is provided by four carefully selected sex offender treatment agencies. The planned supervision standards for the Lake County program were that all sex offenders were to be supervised at a high level throughout their probation period. This included three home/field visit and two office visits per month for a total of five face-to-face contacts per case per month. The program has averaged approximately 12 intakes per month from October, 1997 through February, 1999[50] and current caseload (February, 1999) is 244 sex offender case with an average of 41 cases per officer. The program goal was to maintain sex offender caseloads at approximately 40 cases per officer and total caseload per officer to 80 cases. The former goal is being met but is in jeopardy since the number of sex offender cases is sure to increase. The second goal has been harder to maintain and caseloads now exceed 90 cases.

The evaluation team found the Lake County program to be exceptionally well managed under the administrative supervision of the department's deputy administrator and the day- to-day operational direction and supervision of the unit supervisor. We were particularly impressed with the knowledge, leadership and motivational skills of the unit supervisor which resulted in a high degree of unit cohesion and a well functioning team. Also of particular note is the Lake County program's commitment to training. There was usually some training event participated in by at least some of the unit staff on a monthly basis. The unit supervisor made excellent use of scarce training resources available. The evaluation team also found the program's monthly statistics to be exemplary. They were informative,

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[50] Unless otherwise stated, Lake County program statistics refer to the 17 month period of October, 1997-February, 1999. We stopped analyzing monthly statistics at the end of February to allow time for analysis.

presented in an understandable and readily usable manner and included essential data on key elements of the program's monthly operation.

Supervision and Surveillance

The Lake County program set comparatively rigorous supervision standards that required a total of five face-to-face contacts a month, three of which were home/field visits. Overall, for a variety of practical and realistic reasons, the program experienced difficulty in meeting home/visit standards and also fell short of the five face-to-face standard. However, during the months when the unit was fully staffed and trained, the program was able to meet a standard of two home/field visits and a total of four face-to-face visits a month. This is still short of their high standards but is the standard set for level I cases that use a phased approach to sex offender supervision. In light of practical realities presented by probation supervision in general and sex offender supervision in particular, some revision in supervision standards and/or program design appears warranted.

Treatment

The treatment evaluations for Lake County offenders varied widely from treatment provider to treatment provider, suggesting that standards need to be utilized. The Lake program did not make extensive use of polygraphs (9% of evaluations), though an additional 16 evaluations mentioned that the offender should take a polygraph test. Clinical interviews and polygraphs combined resulted in 23.8% of the offenders revealing at least one additional sex-related crime (i.e., one that was not part of their official record).

Few treatment evaluations (only three) contained an objective measure of sexual preferences (i.e., the ABEL test or the plethysmograph). An objective personality test, however, was administered to over half (55.6%) of the defendants. Most evaluations also did not address offenders' power and control tactics in relationships and their attitudes toward women. Treatment evaluations for Lake County utilized psychiatric referrals for some defendants: 20.8% of the treatment evaluations either recommended psychiatric treatment or antidepressants. The evaluations were rather uniform in their recommendations of group therapy (73.8%) and/or individual therapy (87.7%) to address issues such as offenders' acceptance of responsibility for the offense, awareness of their sexual assault cycle, and other cognitive-behavioral treatment goals. Despite this uniformity, a little over half of the evaluations (52.3%) also tailored recommendations for treatment to the individual's needs.

Therapists in Lake County had considerable clinical experience working with sex offenders' with an average of eight years of experience. Therapists were evenly split on the preferred modality of treatment with half endorsing group and half indicating a mix of group and family therapy. The average group size across providers was 8 with a range of 7 to 10 participants per group, which is in the optimal theoretical range of group size. Approximately, 80 cases had been referred for treatment from the Lake probation department. The average number of group sessions scheduled per offender per month was 3.5. Almost all providers indicated that their program used a cognitive-behavioral approach that included relapse prevention. The most important aspects of the cognitive-behavioral approach were: (a) confronting denial so the offender accepts full responsibility; (b) teaching offenders specific behavioral and cognitive skills they can use to reduce their risk of offending; (c) helping offenders understand the affect their actions have had on their victims; (d) helping offenders recognize and stop deviant thoughts and urges; and (e) covering and understanding the sexual abuse cycle. Anger

management, demonstrating assertiveness skills, and social interaction skills were much less central to the cognitive-behavioral approach. Though group is the preferred treatment modality, the majority of probation sex offenders are receiving multiple treatments. The average number of individual sessions scheduled (which are typically behavioral for two providers and counseling for one provider) per defendant per month was 2.3.

Only one of four of the Lake County providers indicated that probation officers attended treatment sessions offered by their agency. Providers all agree that probation officer attendance was not a necessary part of treatment, and when probation officers attended they typically just observed. Attendance of probation officers at group therapy sessions was less than on a quarterly basis.

Most providers (75%) had written policies on treatment rule violations in particular on the number of unexcused absences allowed and what constitutes an unexcused absence, what constituted being late for a session, the number of late sessions allowed, and payment schedules and requirements. The probation department may wish to standardize such policies across agencies for sex offender probationers. All Lake County offenders are required to pay for some portion of their treatment and 90% are required to pay at least some portion of their assessment fee.

Outcome: Short-term Probation Outcome

Findings on short-term probation outcomes for the Lake County program are based on an analysis of only 17 months of program data, certainly a far too limited time period to reach any firm assessment of program success. The data do indicate that the majority (75.3%) of offenders terminated from the program did so successfully in that they completed their probation without violations or arrests that led to their probation being revoked by the court. Approximately 24.7% were

unsuccessful in that their probation was revoked and another sentence imposed. Program data indicate that program officers filed a total of 145 technical violations, which is an approximate technical violation rate of 37.3%. While this is partly a reflection of offender behavior, it is also indicative of the level of supervision and surveillance provided by this program. There were a total of 68 new arrests, 20 of which were for new sex offenses.

Outcomes: Short-term Treatment Outcomes

Treatment providers submitted monthly treatment reports for 26 offenders from September of 1998 to February of 1999. The monthly treatment reports assessed using ten point scales of offenders' status on participation in therapy, commitment to treatment, acknowledgment of personal responsibility for the offense, understanding of consequences if offender reoffends, willingness to disclose inappropriate sexual behavior, and acceptance of responsibility for emotional/physical damage to victim. Therapists in Lake County did not make either significantly higher or lower ratings as a whole compared to therapists in the other two counties, and tended to make distinctions between offenders using almost the entire rating scale as evident by the lowest mean for an individual offender across time (M = 2.25) and the highest mean for an individual offender across time (M = 10). For offenders in which monthly treatment reports were submitted, we performed N-of-1 analyses to determine whether offenders had made statistically significant progress from the therapist's point of view. Normative N-of-1 analyses revealed only one statistically significant change across all offenders and dimensions of treatment. The fact that such few statistical changes were evident indicates that offenders were changing more slowly than the assessment of their progress. This slow change is expected given that sexual offending is based on attitudes and behaviors of a long-standing nature. Thirty-five offenders were in treatment, but we did

not receive any progress reports; for these offenders, probation officers indicated their probation and treatment status. Fourteen of the 35 offenders were classified as unresponsive to treatment due to the fact that they were terminated prematurely from treatment based on their noncompliance with treatment rules, and two offenders were classified as responsive based on the fact that they successfully completed treatment.

Based on treatment provider's ratings and information about treatment status, 30% of the offenders were classified as responsive to treatment. Further evidence of responsiveness of the Lake County sex offenders is based on absences and completion of homework assignments. Most offenders (63%) had no unexcused absences, and 66% completed all homework assignments for all months that monthly treatment reports were completed. Therapists reported a mean of 1.25 positive lifestyle changes per an offender for all months in which progress reports were obtained. The three biggest categories of positive lifestyle changes were better relationship with spouse or intimate partner, improvements in employment, and improvements in therapy. All offenders, however, were not as responsive to sex offender treatment. Therapists did not report any positive lifestyle changes for 10 offenders, and reported additional inappropriate sexual behaviors for 3 offenders. The three defendants with inappropriate sexual behaviors revealed seven such behaviors that included using prostitutes, using pornographic material, trying to get two females into his car, having contact with the victim against a court-order, and inappropriate fantasies.

The Loyola evaluation team determined the factors that distinguished offenders who were responsive from offenders who were not responsive. Five significant predictors were found: amount of remorse at time of treatment evaluation; level of income; prior treatment for substance abuse; length of time in treatment; and ethnicity. The strongest and reliable predictor was amount of remorse at time of

treatment evaluation with the model predicting responsive to treatment if the offender showed great remorse at the evaluation. A qualitative analysis of offenders who expressed great remorse at intake and were accurately predicted to be responsive revealed that these offenders had a long history with the criminal justice system and mental health system. Given this experience, offenders may have learned what therapists want from them in order to progress in treatment, and may be feigning remorse rather than truly remorseful. Future research will have to address whether such a good initial clinical presentation actually means a lower likelihood of recidivism or whether offenders have simply learned that in order to make progress in treatment they must appear to accept responsibility. For Lake County, the evaluation team had a sufficient sample size of 65 to build a CTA model that predicted which offenders would have a serious violation of the treatment order. Twenty-three of 65 offenders (35.4%) had a serious violation of a treatment order. A two-variable multivariate CTA model was obtained, and had moderate performance. The two factors were: whether diagnosed as a psychopathic deviant, and whether had two or more sexual paraphilia. Two groups were likely to commit a serious violation of a treatment order: (1) Psychopathic deviants; and (2) offenders who were not psychopathic deviants, but had two ore more sexual paraphilia were likely to commit a serious. These results with this small size are quite consistent with the literature on predictors of recidivism among sex offenders who have primarily been released from prison. A long-term outcome evaluation and a large sample size can build upon these intriguing results to address the question: for which offenders is treatment effective?

Recommendations

- **Because the broad target population definition leads to large caseloads that exceed practical ability to meet surveillance standards, the use of a more selective case selection procedure should be developed perhaps based on risk assessment.**

- **Program staff should work with the state's attorney's office to develop a procedure whereby the 20 special conditions for sex offender probation cases are more formally made a part of the probation order.**

- **Consideration should be given to adopting more realistic supervision/surveillance standards or to developing more formal written criteria to determine which cases receive higher levels of surveillance**.

- **The department should clarify the role and duties of treatment providers. Treatment providers should be required to submit written results of objective personality and objective sexual interest tests as part of their treatment evaluation. All treatment evaluations should contain an objective test of psychopathic deviancy.**

- **The department should obtain a workable computer system to collect data on all individual sex offenders that can be used to assess outcomes.**

- **The department should create, in collaboration with treatment providers, a standardized treatment progress report that covers all major aspects of treatment, and allows therapists to indicate both positive lifestyle changes and inappropriate sexual behaviors/thoughts since last report. All therapists should be required to submit this written standardized report on all offenders at least once every two months. Probation officers can review these written documents for treatment progress, and will have the opportunity to refresh their memory on critical information before home/office visits. Such standardized reports should supplement rather than replace in person or phone contacts with therapists. Standardized reports, moreover, allow officers to assess which offenders are less responsive to treatment across treatment agencies.**

- **The department, in collaboration with treatment providers, should create uniform written policies on graduated sanctions that are available to deal with noncompliance in therapy as well as uniform rules on how many unexcused absences are acceptable before the client is terminated and a VOP is filed, what counts as an excused absence, and how new sex offenses reported to therapists should be handled.**

- **A long-term evaluation of the probation and treatment outcomes should be conducted to assess the effectiveness of the additional surveillance and treatment for sex offenders.**

CHAPTER IV

WINNEBAGO COUNTY SEX OFFENDER PROGRAM

Program Description and Development

The sex offender program in Winnebago County consists of a two-officer specialized sex offender unit that deals with only sex offender cases. The unit is made up of two senior probation officers experienced with sex offender probation. The caseload planned maximum is for 50 cases for each officer. The two sex offender officers are responsible for all adult felony and misdemeanor sex offenders sentenced to probation. The caseload consists of a mix of pre-program cases on probation as of August 1, 1996 and program cases newly sentenced as of August, 1, 1997, when the grant program was funded. As of November, 1998, the grant sex offender caseload totaled 56 offenders with a corresponding number of pre-grant sex offender cases so the maximum of 50 cases each has been exceeded. The sex offender officers provide a higher level of supervision and surveillance than was possible prior to the receipt of grant funds. The focus of this report is on the program and sex offender cases beginning as of August 1, 1997.

Program's Location and Setting

Winnegago County is located approximately 90 miles north west of Chicago and had a 1990 census population of 252, 913. The probation department, or more officially, the Department of Court Services, is located in the court complex is in the city of Rockford which in the second largest city in Illinois (1990 population 139,943). Winnebago County, along with Boone County, forms the

Seventeenth Judicial Circuit. The sex offender program serves only Winnebago County. The probation department serves both adult and juvenile offenders organized into two divisions. This report is concerned only with the adult division since the Winnebago program is restricted to adult offenders. The adult division is made up of three supervisors, four senior probation officers and 26 probation officers. The caseload in the general caseload unit averages approximately 202 per officer.

In addition to the general caseload unit and the Sex Offender Unit, the department maintains an Intake Unit, PSI Unit, a Pre-Trial Services Unit, a Drug Court Unit, a DUI Unit and a Domestic Violence Unit. The sex offender unit is located in two offices on the ground floor of the court building separate from the rest of the department which is located on upper floors of the court building.

Program Development

The circumstances that led Winnebago County to develop a sex offender program and apply for grant funds arose from a recognized inability to supervise sex offender cases at the level desired. The department practice for a number of years had been to assign sex offender cases to four officers in the regular case load unit who also carried a full load of regular cases. Caseloads for these four officers in early 1997 averaged 208 per officer. Two senior probation officers carried an average of 40 sex offender cases each as part of their general caseload and two other offices carried about 10 cases each along with their regular caseload. The demands of the regular caseload did not allow sufficient time to provide the intense level of supervision essential in sex offender cases. The department tried assigning sex offender cases to additional officers but this resulted only in additional overworked staff. The

desired solution was to assign a number of officers to handle only sex offender cases but this would have raised caseloads for the remaining officers to unacceptable limits. Hiring additional adult probation staff was not an option given limited county funds.

When the county was initially approached by the Authority about the possibility of funding of probation programs they immediately saw this as an opportunity to address the staff overload and supervision problems they were experiencing with sex offender supervision. The plan was to seek funds to designate two senior probation officers as sex offender officers who would supervise sex offender cases only. These two officers were already trained and supervising the majority of sex offender cases already on probation. To avoid overload on other probation staff, two additional line level probation officers would be hired to replace the two senior staff who would be paid from grant funds. The caseload of each sex offender officer was set at 50 each based on general caseload unit statistics in March of 1997 that showed a total of 100 sex offenders under supervision. The plan also called for the training of an "overload officer" to be assigned sex offender cases when the 50 case maximum was reached.

The primary goals of the sex offender program were to enhance the level of supervision of adult sex offenders and to provide a more comprehensive, structured and intensive strategy to address supervision and treatment issues of sex offenders. One goal initially stated was to reduce the number of sex offenders requiring registration by 10%. Basically this was a goal to reduce arrests by 10%. Staff questioned the feasibility of achieving such a goal and advised against its inclusion. This goal was included in the grant application, but later dropped.

The program was approved for funding in the amount of $104,504 in grant funds from the Illinois Criminal Justice Information Authority through Federal Anti-Drug Abuse Act funds, $34,835 in matching funds primarily from probation fees received by the county and $817 in "non-match" funds. The grant period was from August 1, 1997 through July 31, 1998 and was renewable for three years. The time from the decision to apply for grant funds to receipt of grant funds was about seven months.

Program Implementation

Program implementation concerns the time period from the date of funding to receipt of the first case. During this time key administrative, staffing and program policy decisions are finalized and the basic operational design of the program established.

Staffing

The staffing pattern for the Winnebago program consists of two senior probation officers. The criteria for the two positions were a Bachelors degree, senior probation officer standing and experience with sex offenders. Only the two senior probation officers already supervising sex offenders qualified. The availability of the two positions was not posted since this was to be a grant funded program. There was no delay in filling the positions since the two sex offender officers simply moved from the general caseload unit to the new unit. Both sex offender officers are male. As of November 30, 1998 there have been no changes in the staffing of this program at the line staff level. However, there was a significant change in program administration. The deputy director for adult probation developed the program, wrote the application and in general took lead responsibility for the program. While he was

doing this, the deputy director for juvenile probation was developing a program and application for a juvenile day reporting program and in general took lead responsibility for that program. In November 1997, about 2 months into the sex offender program, the department director switched deputy directors. The result is that both deputy directors are running the program the other developed. This has had minimal effect on program operations since the sex offender program is not complex.

Staff Training and Experience

The Winnebago County program has only been able to offer a limited amount of staff training in the past two years. Both sex offender program officers attended an eight hour workshop on offender supervision, presented by Garry Lowe, at the AOIC offices on August 17, 1998 and a two day (16) hour workshop on polygraph presented in Arlington, Texas, in April 1998. Both found the Gary Lowe session to be of great value. The workshop on polygraph was a disappointment in that it often strayed from the program content. Both officers also attended the ATSA conference in Vancouver, British Columbia in October, 1998. What other training was received has largely been on the job training. The AOIC workshop was attended mainly by probation officers but the Texas workshop was a mixture of treatment providers and probation staff. Caseloads have hovered around 50 cases each and there is little time available for training. The grant application originally planned to train a "backup" officer to assume a sex offender caseload when caseloads reached 50. However, this was contingent on staff being available from the general caseload unit. With the creation of a domestic violence unit and the corresponding assignment of two officers from the general caseload unit to that program, no staff were available for assignment and training as a "backup" officer. Thus a good idea was not able to be

implemented.

Both of the sex offender program staff are senior probation officers, one with 13 and the other with 12.5 years of probation officer experience and have been involved one way or another in supervising sex offenders for that length of time. Both have a bachelor of science degree. Each in his own way expressed satisfaction with the unit citing the fact that they worked well together as a major positive. Another positive was having more funds for treatment and greater flexibility about how to handle a case. The main negative was the paper work involved and the lack of time to really do the case work on a case that was required. The unit is also responsible for overseeing the DNA testing process for all sex offenders including those not on probation and this is a time consuming task that takes away time that could be devoted to their probation cases.

Administrative Structure

There is no supervisor designated for this program. Instead, the two sex offender officers both of whom are senior probation officers function pretty independently. They report to and are officially supervised by the deputy director for adult services. The reason for this is to avoid a supervision overload on other department supervisors who already assume responsibility for supervising a number of specialized units. The deputy director reports to the department director. Each officer prepares monthly statistical reports, submits them to the deputy director whom, after review, gives them to the director's administrative secretary who submits them, along with fiscal reports, to the Authority.

Target Population

The target population for this program consists of all offenders convicted and placed on probation for any sex offense that requires the offender to register as a sex offender. These include: criminal sexual assault, aggravated criminal sexual assault[51], criminal sexual abuse, aggravated criminal sexual abuse, sexual relations within families, predatory criminal sexual assault of a child, indecent solicitation of a child, sexual exploitation of a child, soliciting for a juvenile prostitute, patronizing a juvenile prostitute, juvenile pimping, exploitation of a child, child pornography, ritualized abuse of a child, and child abduction involving a child under 16 into a motor vehicle. No sex offenses are excluded from the program. All such cases are assigned to one or the other sex offender officer. Other than offense, the criteria for admission into the program include a probation order and acceptance into treatment. Cases are accepted on a contingency basis depending on the treatment assessment. Should the case be assessed as not eligible for treatment, the case is referred to another unit within the department.

Case Referral Process

There are no formal referral documents other than the probation order. If a presentence investigation (PSI) is ordered, the case is identified at that point. For the majority of cases the process is somewhat informal. When the state's attorney decides that a plea bargain will be offered and a sentence to sex offender probation is part of the bargain, he/she calls the probation officer into court and

[51] This is included in the list provided by the Winnebago staff although the actual probation offense would be some other since aggravated criminal sexual assault is a non-probationable offense.

the probation order is signed in court. The order does not as yet contain clear and specific conditions for sex offender probation but it does include the order that the offender be assigned to the program. The probation officer then takes the defendant, (now called a client in Winnebago County), to his office and completes a basic probation intake form and establishes reporting requirements etc. The client signs the sex offender registration form which the officer and the client immediately take over to the sheriff's office or Rockford Police Department. If the client lives in another jurisdiction he must register immediately. A standard risk/needs assessment form is also completed. The case is treated as accepted and subject to all supervision requirements contingent upon an assessment from the treatment team. The client is scheduled for assessment as early as possible.

Case Assessment

All cases received into the program must have a case assessment. It was originally planned that every sex offender would have a presentence investigation conducted before sentencing that would include a sex offender evaluation and a victim impact statement to assist in the decision to refer to the sex offender program. However, in practice, most unit cases result from plea bargaining and no presentence investigation is ordered. All cases must, however, be referred to a treatment provider for assessment as soon as possible. The program documents do not include any time frame for assessment referrals nor their completion, but most cases are referred within a few days of sentencing and most reports received within 30 days of referral. There is no uniformity of the specific assessments conducted. Sexual preference assessments, psychological assessments, and psychiatric assessments are conducted on an as needed basis. Full disclosure polygraphs are not usually included and, if used, are

used mainly as a reality test in treatment.

Supervision Standards

This program's strategy of designating two senior probation officers to handle only sex offender cases was implemented in order to increase the supervision level from the basic standard of two face-to-face contacts a month and a home visit every other month, which are the state standards for a maximum supervision case. The Winnebago program did not develop a separate policy and procedure document and uses the standards and procedures written in the grant application as their procedural guide. The Winnebago program uses a three level, step-down offender supervision strategy as follows:

Level I – First six months for a case sentenced in Winnebago County and first three months for a case transferred from another jurisdiction.

- Four face-to-face contacts a month, two of which must be home or field visits.
- Random phone contacts.
- One collateral contact each week (including significant other(s), employer, treatment provider, law enforcement).
- One victim contact each month.
- Random urine drops.
- Verification of employment and residence at each face-to face contact.
- Arrest checks daily.
- Ongoing treatment interventions as needed. Attendance and progress verified by regular probation officer/ treatment provider contacts.

- Conference with supervisor to assess offender's readiness to move to level II.

Level II – Second six months

- Two face-to-face contacts a month one of which must be in the home or field.
- Random phone contacts.
- Collateral contacts as needed.
- Victim contacts as needed.
- Random urine drops.
- Verification of employment and residence at each face-to-face contact.
- Arrests checks daily.
- Ongoing treatment interventions. Attendance verified by regular probation officer/treatment provider contacts.
- Conference with supervisor to assess readiness to move to level III based on duration of court order, completion of treatment, and client is consistently compliant and situation is stabilized.

Level III

- One face-to face contact a month.
- Field contacts, phone contacts, victim contacts and urine drops as needed at the discretion of the probation officer.
- Verification of employment and residence at each monthly face-to-face contact.
- Arrest checks daily.

The victim contacts are limited to verification of the “no contact” condition if applicable, ensuring that restitution is being paid regularly and in full, and to keeping the victim informed of the offender’s location and current legal standing. The officers also maintain close communication with local law enforcement to ensure compliance with sex offender registration requirements. All supervision and other contacts are made within the 8 am to 5 p.m. weekday schedule. Evening and weekend/holiday supervision contacts are not part of the program at this point.

Program Operation

As noted earlier, program operation analysis examines the extent to which the program actually operated in line with pre-operational expectations as stated in the grant application's program policy and procedures. Although each program used a different model, each was designed to deal with convicted sex offenders, to increase supervision and surveillance and implement sex offender treatment. With this in mind, the evaluation team's operational analysis focused upon four major activities: intake, caseload and offender profiles; supervision and surveillance; the team approach and the nature of treatment.

Intake and Caseload

The Winnebago County program statistical reports submitted to the Authority from August, 1997 through February, 1999 were examined to document the pattern of intakes and total caseload by month. Intakes averaged approximately four cases per month and the total caseload increased steadily from 18 cases in September 1997 to 68 cases at the end of February, 1999. The program data are shown in Table IV-1.

The program's goal was to work with approximately 50 sex offenders per officer. This caseload was made up of sex offender cases on probation as of August 1996, designated as pre-program cases and sex offenders on probation beginning in August, 1997, designated as new sex offender cases. The data in Table IV-I reports on new sex offender cases only. The number of new cases per officer as of February, 1999 is 34. Each officer currently carries approximately 20 pre-program cases so that the caseload per officer slightly exceeds the goal.

Offender Profiles and Risk Characteristics

In addition to caseload counts, the evaluation team examined offender characteristics to document the population and the extent to which these offenders fit the target population described in the grant application. The target population for the Winnebago program was to include any sex offender required to register as a sex offender under Illinois' sex offender registration act in effect on August, 1997. Specific offenses were identified earlier in this report. Of the programs examined in this study, Winnebago County was the only program to focus its target population on felony offenders. The following description of offender characteristics and offenses indicate that this program is serving the intended target population.

Table IV-1

Winnebago County
Monthly Caselaod and Caseload Per Officer
August 1997-February 1999

Year	Month	Beginning Caseload	Intakes	Closings	Ending Caseload	Caseload per Officer
1997	August	00	18	0	18	9
	September	18	5	0	23	12
	October	23	2	0	25	13
	November	25	2	0	27	14
	December	27	4	0	31	16
1998						
	January	31	3	0	34	17
	February	34	9	0	43	22
	March	43	5	0	48	24
	April	48	2	0	50	25
	May	50	4	1	53	27
	June	53	4	2	55	28
	July	55	1	2	54	27
	August	54	4	2	56	28
	September	56	0	0	56	28
	October	56	4	1	59	30
	November	59	2	0	61	31
	December	61	4	0	65	33
1999						
	January	65	3	0	68	34
	February	68	2	2	68	34

The evaluation team coded all cases handled by the Winnebago County Sex Offender Probation Unit from September 1, 1997 to September 30, 1998. The total caseload is 50 sex offenders. All information is based upon data obtained from intake interviews and treatment evaluations obtained from the probation files. Table IV-2 provides demographic characteristics and mental health

needs of Winnebago County sex offenders on probation. All sex offenders are men. The caseload consists of 80.0% Caucasians, 16.0% African-American, 2.0% Hispanic-Americans, and 2.0% Asian-American. Age ranges from 17 to 74 with a median age of 35. Relationship status is rather diverse with 34% single, 38% separated or divorced, and 28% currently married. A little over half (51.2%) are in a sexually active relationship. The majority of offenders are either unemployed (40.8%) or employed full-time (34.7%). Income ranges from under $13,500 to $40,000 with the median income in the poverty range of $13,500 or less. Most offenders (68.0%) have incomes in the poverty range (under $13,500), and only 8.5% have an income between $25,001 and $40,000. Almost half (46.0%) of the offenders did not complete high school, and no offenders graduated from college. The majority of offenders also have a history of unstable work and school adjustment.

This caseload presents problems of substance abuse and mental health that are typical of other probationers. Over half of the population (52.0%) disclosed that they used both alcohol and illicit drugs, and 26% have had prior treatment for substance abuse. Current treatment plans for these offenders also recommended that 38.5% participate in substance abuse treatment. Over one-quarter of the offenders (28.6%) have mental health problems, and 25% have had prior mental health treatment. In addition, four offenders either had suicide thoughts or suicide attempts. Seven offenders were classified as depressed based on their treatment evaluations. Current treatment plans recommended that one offender receive psychiatric treatment, though no plans specifically recommended prescriptions for antidepressants for any offenders.

Table IV-2

Description of Sex Offenders and Their Needs At Intake For Winnebago County

Demographic Characteristics	Frequency	Valid Percent
Age of Offender		
17	1	2.0
18 to 26	14	28.0
27 to 35	13	26.0
36 to 43	10	20.0
44 to 52	9	18.0
53 to 74	3	6.0
Marital Status		
Single	17	34.0
Divorced	12	24.0
Separated	2	10.0
Widowed	2	4.0
Currently Married	14	28.0
In A Sexually Active Relationship?		
No	22	51.2
Yes	21	48.8
Missing	7	
Current Employment Status		
Unemployed	20	40.8
Employed Part-time	3	6.1
Employed Full-time	17	34.7
Employed, unspecified	4	20.0
Income		
13,500 or under	34	70.8
13,501 to 25,000	10	20.8
25,001 to 40,000	4	8.3
Education		
Less than 12th grade	23	46.0
High school graduate	19	38.0
Some College	8	16.0
History on Work/School Adjustment		
Stable work/school history	13	35.1
Unstable work/school history	13	35.1
Chronic, extremely unstable	11	29.7
Missing	13	

Demographic Characteristics	Frequency	Valid Percent
Whether Defendant Disclosed Any Drug Use?		
No	7	14.0
Yes, alcohol	16	32.0
Yes, Illicit Drugs	1	2.0
Yes, both alcohol and drugs	26	52.0
Prior Treatment for Substance Abuse?		
No	37	74.0
Yes	13	26.0
Missing	11	
Treatment Plan Recommended Substance Abuse Treatment	15	38.5
Has Mental Health Problems	14	28.6
Missing	1	
Has Prior Mental Health Treatment	12	25.0
Missing	2	
Suicide History		
No suicide thoughts or attempts	35	89.7
Suicide thoughts, but no attempts	2	5.1
Suicide thoughts and attempts	2	5.1
Missing	11	

Offense and Offender Characteristics Potentially Related to Risk

Prior research has examined the predictors of committing a new sex offense while serving a community-based sentence or after release from prison (See for a review Hall, 1995; Hanson & Bussiere, 1998). Several static characteristics of the offense have been identified as leading to a higher risk of reoffense. These characteristics include: the gender of the victim, the age of the victim, and the nature of the offense. Offenders who victimize non-family members are at a higher risk of reoffense. Homosexual or bisexual offenders are at a higher risk of reoffense. Offenders who commit voyeurism or exhibitionism are at a higher rate of reoffense. Offenders who use physical force are at a higher risk

of reoffense. Other static characteristics have not received adequately empirical attention in the research literature. For example, the amount of time the abuse has been occurring may be related to risk with offenders who have been abusing for a longer period more likely to reoffend. Offenders who penetrate the victim may be more likely to reoffend. A meta-analysis of prior research findings concludes that prior arrest records significantly predict reoffense for any crime, but is not consistently related to sexual reoffending. The weak relationship of prior criminal history and sexual reoffending may be due in part to the fact that such records do not reflect the complete history of an offender's activity of committing sexual crimes. Prior research also indicates that history of being a victim of child sexual abuse is not significantly associated with recidivism for a sexual offense (Hanson & Bussiere, 1998). Only a few studies have examined the level of denial and remorse at intake as predictors of reoffense. These clinical presentation variables are related to general recidivism for any crime, but are not related to recidivism for sexual offenses (Hanson & Bussiere, 1998).

The majority of offenders (Table IV-3) were convicted of a felony sex crime with 54% convicted of aggravated criminal sexual abuse and 24% convicted of criminal sexual assault. Most offenders (73.5%) were related to their victims with 26.5% either a father or step-father, 18.4% uncles, and 28.6% other relatives. Only 26.5% of the offenders were unrelated to the victim. The data on charges is missing for most defendants. Consistent with the high concentration of cases involving family-related sex crimes, most offenders (88.2%) had two or more sex crimes filed against them, and 29.4% had four or more charges filed against them. The majority of offenders (75.5%) did not use force to achieve molestation. Nine offenders (18%) either expressed interest in sadistic sexual fantasies/acts or were assessed as aggressive.

Only four offenders expressed an interest in exhibitionism or voyeurism or reported that they

had committed such a crime. We also attempted to determine how many offenders were potential/actual pedophiles. Pedophiles were defined as offenders who expressed interest (as measured through an objective sexual preference test) or reported fantasies about forcing sex on children age 10 or younger, or had committed a sex crime against a child age 10 or younger. Half of the sample was classified as pedophiles.

About three-fourths of the offenders (77.6%) committed crimes against only one victim, and most offenders (91.8%) violated only girls or women. Consistent with national statistics, most victims were children under the age of 18 with 28.6% aged 3 to 8 years, 22.4% aged 9 to 11 and 22.4% aged 12 to 14. Only 10.2% were 18 years old or older. Almost two-thirds of the cases (65.3%) involved penetration whereas the remaining 34.7% involved some sort of fondling of private parts or exposing private parts. Only 31.3% involved a single incident, 35.4% involved multiple episodes of abuse that occurred between one month to one year, and 33.3% involved multiple episodes that occurred for longer than a one year period. The majority of victims (89.8%) stated that the intercourse occurred without their consent, though five victims indicated that they consented to intercourse.

The majority of sex offenders are familiar with the criminal justice system. Sixty-eight percent had at least one prior arrest, and sixty-three percent had at least one prior conviction. A little over half (52.1%) had a prior arrest for a misdemeanor, and 47% had a prior conviction for a misdemeanor. In addition, only three sex offenders (6.5%) have a prior arrest for a sex crime, 21.7% have a prior arrest for a violent offense, 17.4% have a prior arrest for a felony property crime, 23.9% have a prior arrest for a drug offense, and 15.2% have a prior arrest for domestic violence. Thus, these sex offenders have already been handled by the criminal justice system, and have not been deterred from misusing their power and control to achieve their desires. To determine whether sex offenders have learned that

arrests often do not lead to convictions, we compared the ratio of arrests to convictions for each defendant. Less than half of the defendants who had at least one prior arrest (N = 13; 43.3%) had an equal number of arrests and convictions. The average number of arrests beyond convictions was 2.3 with a range from 1 to 12 additional arrests beyond the number of convictions. The median number of convictions was one. Three offenders (6.5%) had a prior conviction for a sex offense, 10.8% had a prior conviction for a violent offense, 13% had a prior conviction for a felony property offense, 19.6% had a prior conviction for a drug offense, and 15.2% had a prior conviction for a domestic violence offense. Almost half of the offenders (46%) had served a prior probation term, and 15.5% had at least one prior conviction.

Most sex offenders, however, do not admit to being sexually or physically abused as a child, though almost one-fourth (24.4%) indicate that they were sexually abused as children. Most offenders (75.0%) deny that some important aspects of the offense occurred, with 25% denying that they even committed a sex crime. Most offenders charged with public indecency and misdemeanor charges admit to the offense as the victim described it. Most offenders (64.3%) do not express remorse for their sex crimes.

Table IV-3

Offender and Offense Characteristics at Intake Related to Risk of Reoffending for Sex Offenders in Winnebago County

Characteristics related to risk	Frequency	Valid Percent
Current convicted offense		
Criminal sexual assault	12	24.0
Aggravated criminal sexual abuse	27	54.0
Other misdemeanor sex crime	6	12.0
Out of state charges	5	10.0
Total number of charges against offender		
One	2	11.8
Two	6	35.3
Three	4	23.5
Four or More	5	29.4
Missing	33	
Whether force was used during the sex crime?		
No	37	75.5
Yes	12	24.5
Missing	1	
Number of family-related charges		
None	10	76.9
One or more	3	23.1
Missing	37	
Relationship of offender to victim		
Unrelated	13	26.5
Father/step-father	13	26.5
Uncle	9	18.4
Other relative	14	28.6
Missing	1	
Gender of Victims		
Only women or girls	45	91.8
Only men or boys	2	4.1
Both	2	4.1
Missing	1	
Number of victims		
One	38	77.6
Two	9	18.4
Three to four	2	4.1
Missing	1	

Characteristics related to risk	Frequency	Valid Percent
Age of youngest victim		
3-8	14	28.6
9-11	11	22.4
12-14	11	22.4
15-17	8	16.3
18-21	3	6.1
Over 21	2	4.1
Missing	1	
Did penetration occur?		
No	17	34.7
Yes	32	65.3
Missing	1	
Number of Months Abuse has been occurring?		
Single incident	15	31.3
1 to 6 months	7	14.6
7 to 12 months	10	20.8
13 to 24 months	5	10.4
over 24 months	11	22.9
Missing	2	
Victim stated that intercourse was consensual	5	10.2
Missing	1	
Defendant has an antisocial personality	0	0
Total number of prior arrests		
None	15	31.9
One to Two	12	25.5
Three to Four	9	19.2
Five or More	10	21.7
Missing	4	
None	43	93.5
One	2	4.3
Two or More	1	2.2
Missing	4	
Total number of prior arrests for domestic violence		
None	39	83.0
One or more	7	17.0
Missing	4	

Characteristics related to risk	Frequency	Valid Percent
Total number of prior convictions		
None	18	39.1
One to Two	18	39.1
Three to Four	9	19.6
Five or More	1	2.2
Missing	4	
Was offender abused as a child?		
No	28	68.3
Yes, physically abused	3	7.3
Yes, sexually abused	8	19.5
Missing		
Extent of offender's denial	9	
Completely denies offense occurred		
Denies important parts of offense	11	25.0
Admits to most relevant parts of offense	22	50.0
Missing	11	22.0
Whether Offender Reports Remorse	6	
No		
Yes	27	64.3
Missing	15	35.7
	8	

Supervision and Surveillance

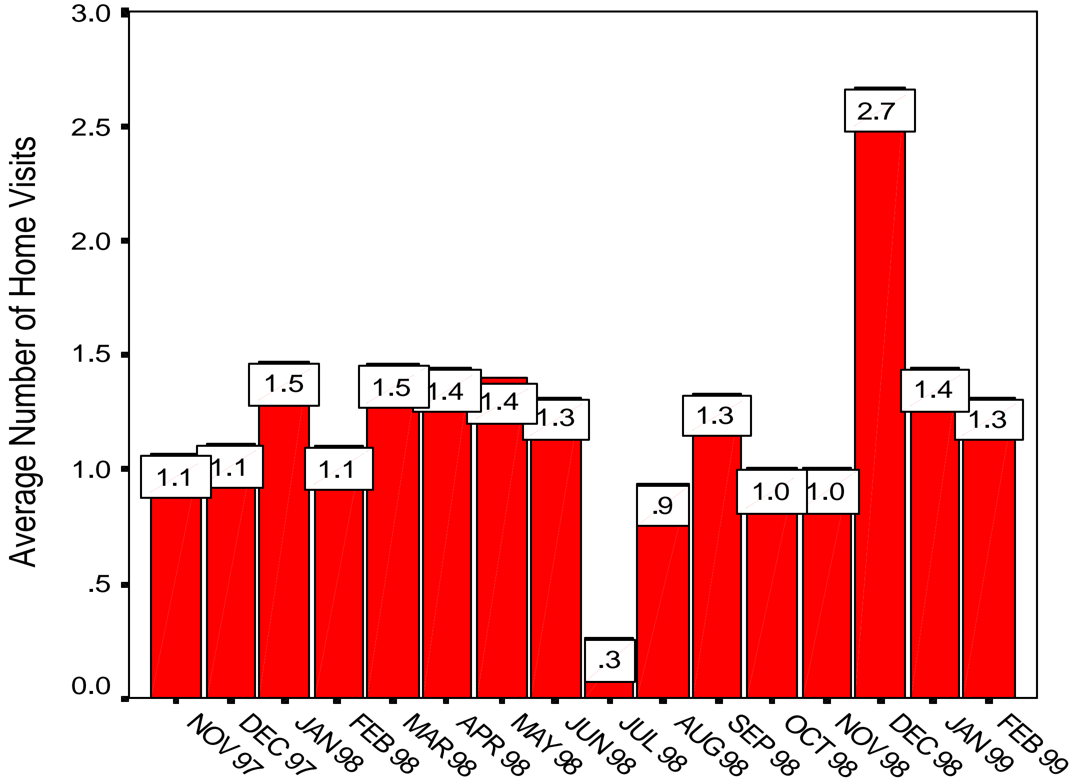
The intent of the Winnebago program grant application was to assign two staff officers to deal exclusively with sex offenders and thereby significantly increase the number of home/field visits and the total number of face-to-face visits. The program adopted a three level supervision strategy in which level I offenders were to have four face-to-face visits a month, two of which were to be home/field visits. Level II offenders were to have two face-to-face contacts a month, one of which was in the home/field. Level III offenders were to have one face-to-face contact a month. Monthly statistical reports were graciously provided by the Winnebago program staff that listed the number of cases that

were active at each supervision level each month and the number and type of contacts at each level. This allowed us to examine the achievement of contact standards at each level. Our analysis was limited to level I and level II contacts in the belief that once a case was assigned to level III it was essentially a regular probation case as far as contact standards were concerned. Also, although the Winnebago County program began operations in August, 1997 data were analyzed from November 1997 through February 1999, a period compatible with other programs examined in this report.

We looked first at the number of home visits at each level. The total number of home visits conducted by the two sex offender officers is impressive. A total of 368 home visits were conducted for level I offenders and 239 for level II offenders for a grand total of 607 home visits over a 16 month period. However, when the average number of home visits is calculated

Figure IV-1

Winnebago County
Average Number of Home Visits for Level I Offenders

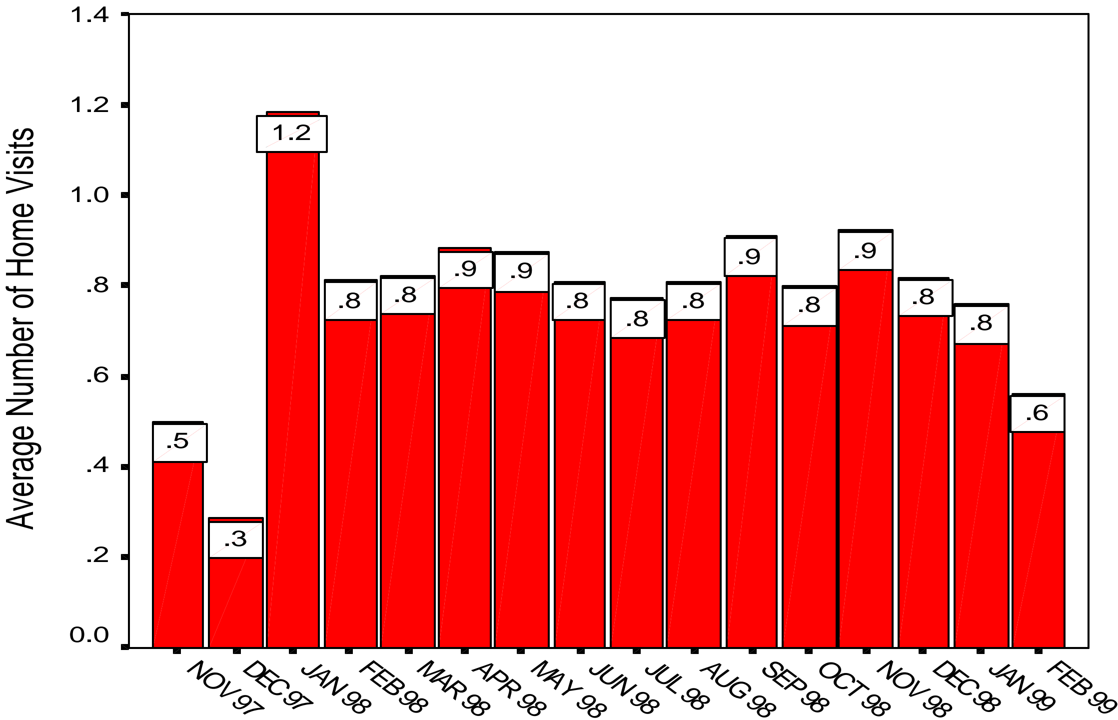


(number of home visits/number of cases) for each month the findings are less clear. As can be seen for Figure IV-1, the average number of home visits for level I offenders range from less one a month (.3) in close to three a month. The standard of two home visits a month for level I case was met in only one month (December, 1998). If the figures are rounded, the two visits standard is met in two additional months (January and March, 1998). Overall, the program averaged approximately 1.3 home visits for level I offenders.

Level II offenders were to receive at least one home visit a month. Review of Figure IV-2 indicates that the Winnebago program is much closer to achieving this standard

Figure IV-2

Winnebago County
Average Number of Home Visits for Level II Offenders

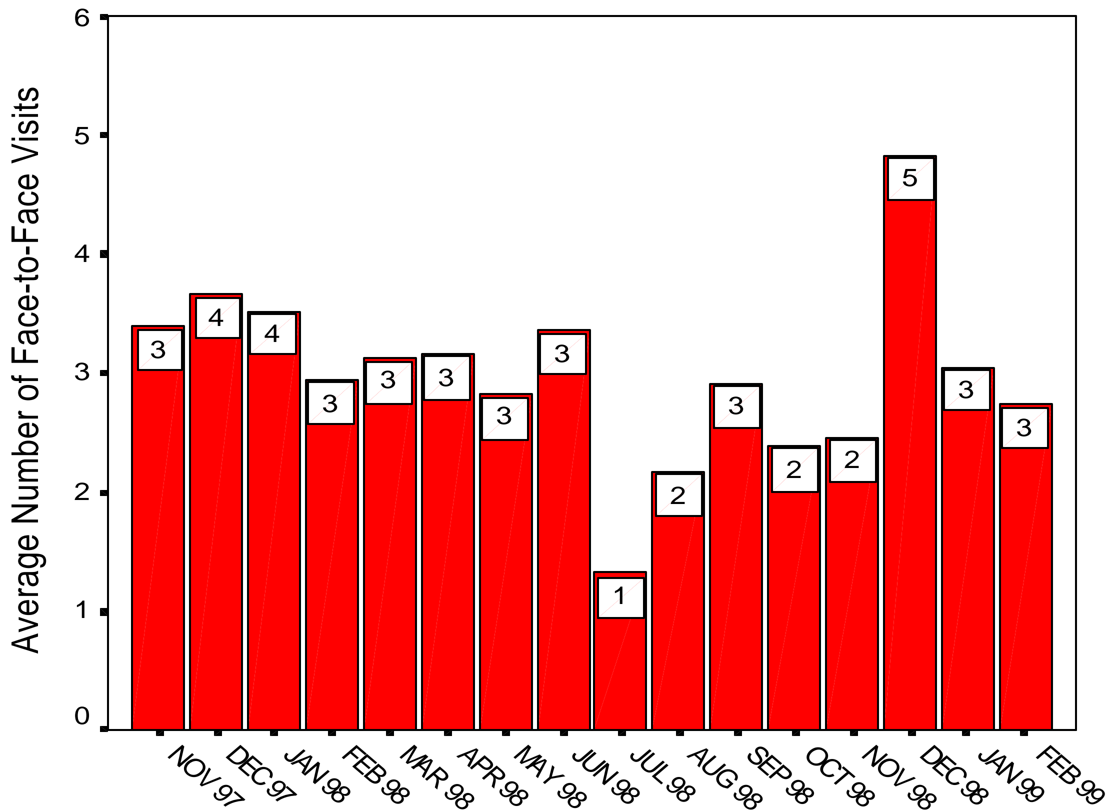


although it is actually met in only one month (January, 1998). While the averages range from less than one a month (.3 and .5) to more than one a month (1.2). The majority are close to one a month and in fact, if the are rounded, the one visit standard is met in a total of 13 of the 16 months.

The total number of face-to-face visits these two officers conducted is also very impressive. This includes a total of 868 face-to-face visits for level I offenders and 585 for level II offenders for a grand total of 1,453 such visits over a 16 month period. However, when the average number of face-to-face visits is calculated (number of face-

FigureIV-3

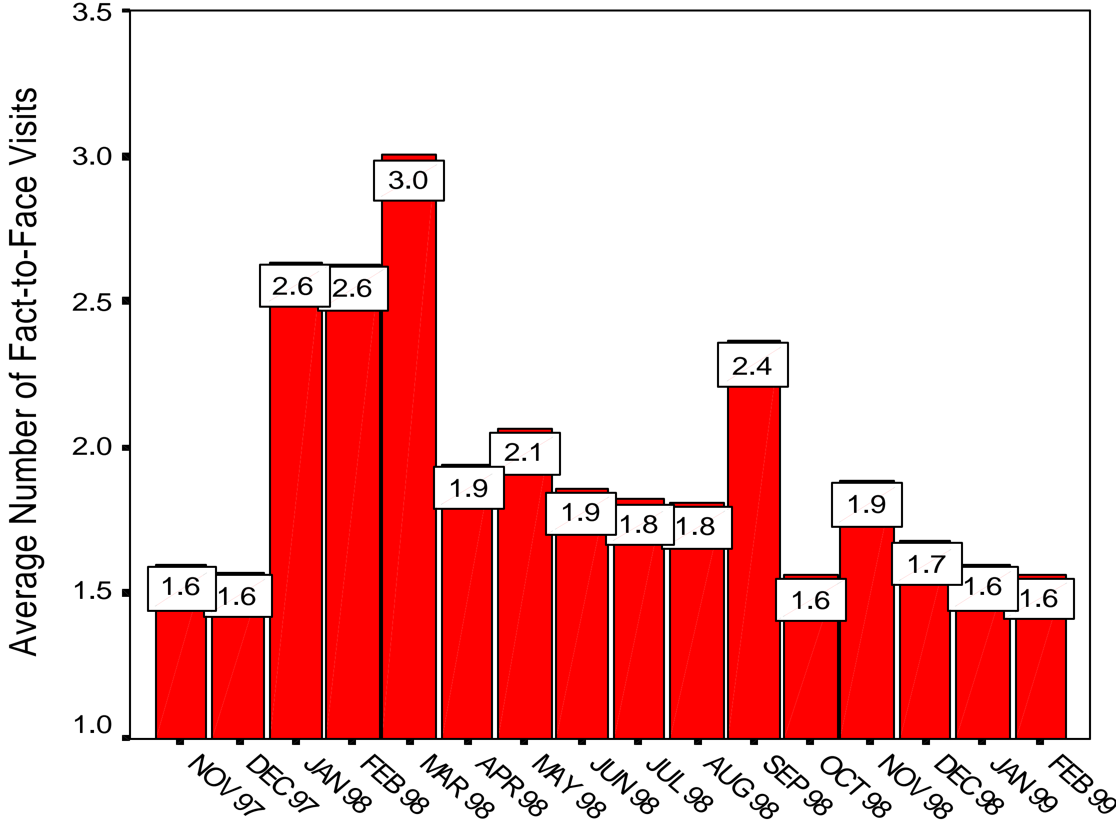
Winnebago County
Average Number of Face-to-Face Visits for Level I Offenders



to-face visits/number of cases) the findings are mixed in that the level I standard is not achieved but the level II standard is achieved. The level I face-to-face visits standard was four such visits a month. As can be seen from Figure IV-3, the number of face-to-face visits ranges from one to five. The four visits standard is met in 3 of the 16 months (December, 1997; January and December, 1998). The overall average is approximately three per month.

Figure IV-4

Winnebago County
Average Number of Face-to-Face Visits for Level II Offenders



The face-to-face visit standard for level II offenders was two a month. The data in Figure IV-4 reveals that this standard is exceeded in 5 of the 16 months, virtually achieved (1.9) in 5 additional

months and, if the figures are rounded, the standard is met in all 16 months. The overall average is two a month, exactly the standard set for level II offenders.

There are a variety of reasons why this program has struggled to achieve its supervision standards. The two officer's caseloads included both new sex offender cases assigned to the unit in or after August 1997 as well as pre-program sex offender cases that were already on probation beginning as early as August 1996. The supervision data analyzed here applied only to the new cases but they also carried approximately 20 preprogram cases each. Of perhaps greatest import in this program's difficulty in achieving sex offender supervision standards is the fact that the two officers maintained a 9-to-5 work day schedule that does not include weekends. This significantly reduces the contact hours available as do training days and days off. Additional reasons include the fact that, lacking data on assignment dates and beginning caseloads, it is possible that cases assigned late in the month were "expected" to have a whole month's worth of contacts. Also, unlike other programs, scheduled office and home visits which the offender failed to keep were not counted in the program statistics presented by staff. A final factor perhaps more a factor in Winnebago County is the distances required to make home visits in this rural environment.

Evaluation of the Team Approach

The most recognized model for the supervision and treatment of convicted sex offenders in the community is the containment model. The containment model utilizes a team approach between probation officers, polygraph examiners, and treatment providers to effectively monitor and treat sex offenders on probation. Through this team approach, offenders cannot tell different versions of their

crimes to probation officers and therapists, and both probation officers and therapists acquire information on the current risk and treatment needs of offenders to provide effective surveillance and treatment. The central characteristics of the team approach are the same features of any effective team (O'Brien, 1995):

- Probation officers and treatment providers agree on the primary goal of treatment. The primary goal should be to reduce inappropriate sexual behavior so that victim and community safety will not be further compromised (English, Pullen, Jones, & Krauth, 1996).

- Consistent with this common goal, therapists perceive that the probation department is their primary client or that the probation department and defendant are equally their primary clients (e.g., Knapp, 1996). This perspective differs from traditional therapy in that therapists typically perceive the best interests of clients as their primary concern.

- Probation officers and treatment providers constantly share information about offenders' risks and treatment progress.

- Probation officers and treatment providers understand each team members' role and establish agreed upon policies to insure that all team members can perform their jobs in the most ethical and effective manner.

- Both probation officers and treatment providers work cooperatively to establish policies thereby eliminating adversarial and unequal power relationships.

- Regular face-to-face meetings are held to discuss difficult cases and to plan ways to improve treatment and monitoring strategies.

- Through mutual respect and cooperation, all team members feel safe to disagree about case management without jeopardizing their membership or status. Disagreements are communicated directly to other team members in a respectful manner, and agreed upon resolutions and promises are implemented and followed in practice.

The Loyola evaluation team distributed a survey to both therapists serving sex offender clients who are on probation in the sex offender unit of Winnebago County Adult Probation, and to the two probation officers and one supervisor in the sex offender unit. The survey assessed the amount of face-to-face, phone, and written communication between probation officers and therapists, the topics discussed, how disagreements and discussions are handled, and their perceptions of the other team members' knowledge about risk and treatment, willingness to share information, and respectfulness toward them. All questions about the amount of communication focused on the last six months. The questionnaires were distributed February 24th, and were returned by the third week of March. Winnebago County Sex Offender Unit relies primarily on two treatment providers. We received two questionnaires from therapists. Both probation officers and the supervisor completed a questionnaire for a total of three. All respondents completed the questionnaires anonymously, and therapists mailed the questionnaires directly back to the evaluators to insure confidentiality.

Both therapists and probation officers are very satisfied with the way the team approach is operating. On a 10 point scale where 10 is completely satisfied, therapists and probation officers provided an average satisfaction rating of 8. This high level of satisfaction may reflect in part the frequent, open, and direct communication between probation officers and therapists. Probation officers in the sex offender unit meet once a week or bi-weekly with therapists. The two therapists reported having face-to-face conversations twice a week and once a week because each therapist meets separately with each probation officer to discuss his cases. On the average, the two probation officers reported attending nine group meetings with therapists in the last six months.

Face-to-face conversations were supplemented with more frequent phone calls and written correspondence. Both therapists reported phone contact twice a week, and the probation officers reported phone contact on a weekly basis. One therapist reported writing correspondence bi-weekly, and the other reported written correspondence less than every two months. Probation officers reported receiving letters on a weekly or bi-weekly basis. Probation officers, however, write to therapists on a monthly or bi-monthly basis. Despite this frequent correspondence, probation officers reported to the evaluators that at least one of the two therapists was very reluctant to submit written reports on treatment progress. Uniform reports on treatment progress will allow the probation officers to gauge how each client is progressing in treatment. All therapists should be required to submit written reports on treatment progress once a month.

An effective team approach requires that team members are available for meetings. Therapists and probation officers reported that the other team member was always or very available for meetings. Interestingly, two probation officers and one therapist believed that they both initiated about an equal amount of the telephone and face-to-face contact whereas one therapist believed that he initiated 75 percent or more of this contact. Most therapists and probation officers indicated that their calls to the other team member were returned somewhat quickly. The therapists had different views on the promptness of returning phone calls: one defined prompt as less than four hours and the other the next day. Probation officers believed that within the same day was a reasonable amount of time to return a call (up to eight hours). Given the clientele, the minimal standard for returning phone calls should be one day to address problems before offenders' behaviors escalate and threaten community and victim safety. Both therapists and probation officers were equally positive about the helpfulness of their conversations with each other. They indicated that the conversations were moderately helpful

(responses range from four to seven) at creating strategies to keep specific offenders from reoffending, and at detecting offenders' attempts to deceive either the treatment provider or probation officer handling their case.

Probation officers and therapists reported spending most of their time discussing issues concerning the progress of specific offenders, and managing the quality of treatment through requesting reports, discussing risk, and obtaining polygraphs. The quality of treatment provider and probation officers' conversations were assessed with three questions: (a) how often do most (treatment providers/probation officers) try to take over team discussions and act on their own personal agendas; (b) how often do (treatment providers/probation officers) actually listen to your ideas and concerns; and (c) when you disagree with a (treatment provider/probation officer), how often do you tell the (treatment provider/probation officer) how you feel? Each question was answered using one of five options: never, rarely, occasionally, frequently, and always. Both probation officers and therapists reported that rarely did the other team member take over discussions and act on their own personal agenda. All agreed that the other team member frequently or always listened to their ideas. The team also seems built on trust in that most members feel free to express disagreements. One therapist and one probation officer indicated that they frequently or always expressed their disagreements. These self-report data thus suggest that both sides of the team believe that the team is a cooperative effort built on mutual respect and trust.

Data on treatment providers' perceptions of probation officers and probation officers' perceptions of treatment providers further support that the team has a solid foundation of mutual respect and trust. Probation officers reported that all therapists were very informed about treatment issues, and very informed about risk factors. Probation officers estimated that on the average 76 percent of therapists are very willing to share information, and that 60% of therapists are very supportive of the team approach. All probation officers indicated that none of the therapists were unwilling to share information or unsupportive of the team approach. The therapists indicated that probation officers were somewhat or very informed about treatment issues and risk factors. Therapists indicated that most probation officers are very willing to share information and are very or completely supportive of the team approach.

Both therapists and one probation officer reported disagreements on any important issue. Most disagreements were resolved by settling on a compromise or through working together to find a solution that they both agreed was right. Probation officers reported that they disagreed with therapists about assessment recommendations. Therapists reported that they disagreed with probation officers on individual risk, length of treatment, public funding needs, and selection of group membership. These topics indicate that the Winnebago County Probation Sex Offender Unit takes an active role in assessing the quality of evaluation and progress reports, and attempts to find treatment for clients that is individualized to fit the clients' needs.

All respondents indicated that there was agreement about the most important goal(s) of the program. The primary goal focused on controlling and changing inappropriate sexual behavior and the therapist and probation officers also agreed that it was moderately important that offenders accept responsibility for the harm caused to the victims and reduce their inappropriate self-statements.

Overall, the team approach appears to be operating effectively in Winnebago County. Moreover, one therapist and both probation officers correctly indicated that the probation department and defendant were equally the therapists' primary clients. This correct attribution of loyalty highlights the commitment to the team approach among at least one therapist and probation officers in Winnebago County. One therapist, however, indicated that the defendant was his primary client and his interest came first. We recommend that written monthly treatment progress reports are uniform across treatment provider agencies, and that probation officers and therapists jointly create uniform written policies on the graduated sanctions that are available to deal with noncompliance with therapy, on how many unexcused absences are acceptable from therapy before the client is terminated and a VOP is filed, what counts as an excused absence, and how new sex offenses reported to therapists can be handled.

The Nature of Treatment -Comprehensiveness of Treatment Evaluations

The Loyola evaluation team coded information from the probation case files of 50 Winnebago County sex offenders. Of these 50 case files, 42 included treatment evaluations. Sex offender probationers in Winnebago County primarily receive treatment from one of two therapists. As such, most of the treatment evaluations were written by one of these two clinical social workers. However, two of the evaluations come from other treatment providers.

We assessed the quality of these treatment evaluations by examining: (1) the range of issues that were addressed, and (2) how comprehensively each issue was addressed. Quality treatment evaluations should include at least seven specific components:

- A comparison of the victim's statement with the offender's version to assess the offender's attempt to minimize and deny responsibility for the offense
- A review of police/court records and a full disclosure polygraph examination to assess the complete history of an offender's sexual offending
- A review of substance abuse history, mental health history, educational/employment history
- Use of objective sexual preference tests such as the ABEL to assess deviant sexual preferences
- Use of objective personality tests such as the MMPI or Hare's Psychopathy checklist to assess personality disorders and psychopathic deviancy
- A referral to a psychiatrist on an as needed basis to assess medication needs for controlling depression or sexual arousal
- Use of standardized questions to assess power/control issues and attitudes toward women

Offender Denial and Minimization

Most of the treatment evaluations addressed offender denial by comparing the victim's version of the offense (per the police report) to the offender's version of the offense (n = 35, 83.3%). In addition, most of the treatment evaluations (all except for one) addressed denial in enough detail to allow the reader to draw a reasonable conclusion regarding the extent of the offender's denial. And, most of the treatment evaluations (all except for three) addressed whether an offender accepted responsibility or attributed responsibility for the offense to his victim or circumstances surrounding the offense.

A majority of the offenders (68.9%) gave a version of the offense that differed from the police report and, hence, may be denying aspects of the offense. Similarly, a majority of the offenders

(75.6%) deny parts of the offense (n = 20) or deny committing the offense at all (n = 10). Finally, a majority of the offenders (82.1%) partially (n = 15) or completely (n = 17) blame the victim or circumstance.

History of Offending

One index of sex offense history is whether the offender has been arrested for sex-related crimes in the past. However, only 64.3% (n = 27) of the treatment evaluations made any explicit reference to the offenders' prior arrest history. Information about offenders' sexual offense history can also be obtained from other sources, such as via clinical interviews or polygraph examinations.

However, we were unable to obtain a clear picture of any offender's prior sexual offense history from either of these two sources. All treatment evaluations mentioned information that offenders revealed during the course of initial clinical interviews. However, only one written report noted that the offender had revealed an additional sex-related crime during the clinical interview. Of course, it is conceivable that treatment providers must first establish rapport before offenders would be willing to reveal such information. Nonetheless, it is very possible for treatment providers to obtain information about prior sexual offending early in the therapeutic process by requiring offenders to take a polygraph examination. Yet, only two treatment evaluations included a polygraph examination. However, the written reports all provided a great deal of information regarding the offenders' family history, substance abuse history, mental health history, and educational/employment history.

Objective Sexual Preferences

None of the treatment evaluations included an objective report of offender sexual preferences (i.e., the ABEL test or the plethysmograph). This is a cause for concern. Offender arousal patterns would seem to have large implications for the selection of an appropriate and effective course of treatment. Reliance on offender self-report seems insufficient in light of: (1) the potential desire for offenders to present themselves in a socially acceptable manner, and (2) the percentage of offenders who either deny aspects of the offense or tend to blame the victim; such individuals may be less than forthright.

Objective Personality Tests

Only one of the treatment evaluations indicated that they had administered the Minnesota Multiphasic Personality Inventory (MMPI) to the offender. We encourage treatment providers to consistently administer an objective personality test such as the Million Clinical Multiaxial Inventory (MCMI), MMPI, or Hare's Psychopathy Scale. There are two primary reasons for this. First, these tests include a scale that measures psychopathic deviancy. Several studies have indicated that psychopathic deviancy is a consistent predictor of reoffending, independent from an offender's sexual preferences or demographic/background characteristics. If treatment providers do not know this information, then treatment may not focus as heavily on issues such as extreme self-centerness, lack of conscience, manipulative ways of acting, and lack of empathy for others. Second, these scales provide information on whether an offender meets criteria of clinical depression. This can aid in decisions as to whether an offender should be referred to a psychiatrist for an assessment of medication needs.

Psychiatric Referrals/Treatment Plans

Two of the 42 treatment evaluations did not include any specific treatment plans or recommendations. For the most part, the remaining 40 evaluations failed to address whether the offender needed psychiatric treatment and, related, whether the offender should be on antidepressants. Only one treatment plan suggested that the offender should receive psychiatric treatment. Five treatment plans noted that the offender was already on antidepressants. However, no treatment plan explicitly suggested that an offender who was not on antidepressants may benefit from them. These numbers all seem rather low in comparison to the prevalence of clinical depression and/or mental illness in the sex offender population.

The evaluation team also examined specific treatment plans to determine how well the plans were being tailored to idiosyncrasies in offenders' needs. The treatment plans were rather uniform in their recommendation of group therapy (n = 32, 82,1%) and/or individual therapy (n = 34, 87.2%) to address issues such as offenders' acceptance of responsibility for the offense, awareness of their sexual assault cycle, and other cognitive-behavioral treatment goals. There was, however, a great deal of tailoring to individual needs. Fifteen of the plans (37.5%) recommended substance abuse treatment. Nine of the plans (22.5%) recommended family/couples counseling. Four of the plans (10.0%) indicated that the offender needs to deal with aggressive/sadistic behaviors. In addition, 33 of the 40 treatment plans (82.5%) included some other unique recommendation for treatment. These unique recommendations were generally tailored to individual needs. Interestingly, 10 treatment plans (25.0%) specifically recommended that the offender should receive a plethysmograph. Yet, as was previously indicated, no information regarding objective sexual preferences was included in any of the case files. In addition, seven treatment plans specifically recommended that the offender should take a polygraph test.

Yet, only two case files included information regarding polygraph results. Presumably, if these recommendations were followed up on, plethysmograph and/or polygraph reports would appear in the case files and treatment recommendations would be modified in accordance with the results of these tests. None of the treatment plans explicitly indicated a need to address offenders' attitudes toward women or power and control tactics in relationships. However, it is certainly conceivable that these issues would be addressed in family/couples counseling.

The Nature of Treatment

This report describes the treatment being provided to adult male sex offenders referred to treatment programs by the Winnebago County probation department. It is based on two primary sources of information collected between March and May 1999. The first was a series of interviews with probation officers working in the sex offender program in each county. The relevant points and results of these interviews are presented below, intermingled with the results of the second and more primary source of information for this aspect of the evaluation, a survey of providers who had been referred treatment cases from the Winnebago County probation department.

For the purposes of this evaluation, the participants were defined as those treatment providers who had been referred cases and were maintaining active caseloads of adult sex offenders on probation in Winnebago County. At the time the survey was mailed out, there were two such providers identified by the Winnebago County probation department.

The intent of the survey was to collect information on a number of areas deemed to be important aspects of treatment. Additionally, the inclusion of certain questions was based upon

knowledge gained during the evaluation of sex offender treatment in Cook County. For example, we learned in that evaluation that only one of the three treatment providers evaluated had consistent, written policies on tardiness, and absences from treatment. As a result, at one treatment program, participants could be violated for two unexcused absences, while it was not clear how many unexcused absences would result in a violation at the other two treatment programs. Thus, we wanted to know if the providers in Winnebago County had developed such policies.

The final instrument consisted of 18 questions, though many questions had multiple parts. The following general content areas were each covered by a series of short answer, yes/no, and multiple choice questions: organizational characteristics, clinical characteristics (e.g., number of therapists, past experience of the therapists providing treatment, the clinical orientation(s) of the treatment programming offered by each provider); providers' views on the most salient clinical aspects of treatment; the extent to which programs had written policies about attendance, lateness, and treatment participation; and the PO's degree of participation in treatment and the providers' perceptions about the impact of the probation officers' attendance and participation.

The survey also included a few open-ended questions, one of which asked providers for recommendations on how to improve the delivery and effectiveness of sex offender treatment in their county. And finally, we requested that providers send us any written documentation on the nature of treatment provided; giving as examples, exercises they routinely use, handouts, and homework assignments. We estimated that it would take providers between 15 minutes to 20 minutes to complete the survey.

Using a mailing list of the principal contacts at each treatment provider, the survey was mailed to both Winnebago County providers. The initial mailing was done in late March of this year. The providers were instructed in an accompanying cover letter to complete and mail their surveys back in as timely a fashion as possible.

By the middle of May, approximately six weeks after the initial mailing, neither provider had returned their forms. We then called each provider reminding them of the survey and asking them to complete and fill out their surveys if they had not already done so. This first round of calls yielded surveys from both of the treatment programs in Winnebago. Thus, we had a 100% response rate for this county.

Administration of the surveys was anonymous and confidential. By design, we did not collect any identifying information on the survey forms, other than county, to foster as much candidness on the part of the providers as possible. Thus, in this report, we present findings either in aggregate or without information that would identify the provider.

Organizational Characteristics

The mean number of active cases reported was 29, with one provider seeing 15 cases and the other 43 cases at the time of the survey. In sum, 58 cases had been referred for treatment from the Winnebago probation department. The two providers reported a total of three therapists involved with seeing sex offenders for an average of between one to two therapists per clinic.

We next wanted to determine the professional qualifications and experience of the therapists providing sex offender treatment. Both providers were asked to give the highest academic degrees that

therapists on their staffs had attained, whether or not the therapists in their program had any prior experience working with sex offenders and, if so, how long they had been working specifically with sex offenders. Two of the three Winnebago County therapists providing treatment to sex offenders are social workers with the remaining therapists listed as having a Psy.D. None of the therapists providing services in Winnebago have an M.D.

All therapists had experience working with sex offenders with the average number of years experience about 10. Based on these findings, it appears that the therapists providing treatment have significant clinical experience working with sex offenders. If this self-reported information is valid, it would suggest that the therapy provided in this county is at least of reasonable quality (though this would require direct observation to confirm.)[52]

Clinical Characteristics

The next sequence of questions was designed to assess more information about the exact nature of the therapy being provided. Providers could select from among four pre-determined options as to the preferred modality of treatment in their programs: individual counseling; group counseling; couples and family therapy; or a mixture of group, individual, and family therapy. Both Winnebago providers

[52] This is a large and generalized caveat to the entire report and methodology. We found in our direct observations of treatment in Cook County that therapists varied widely in their skill conducting the groups. We observed this variation even among experienced and credentialed therapists, some of who ran groups effectively and others who let the groups drift and remain unfocused for many sessions. Therefore, while credentialing and experience may be minimal requirements for conducting therapy of good quality, there are
other personal and professional factors that contribute heavily to whether or not any individual therapist will be effective.

said their preferred modality of treatment was mixed group and family counseling. Both providers also indicated that their clients did not receive medication in conjunction with counseling.

Since the preceding question on preferred modality of treatment was a forced choice question limiting respondents to a single, preferred modality, it might not accurately characterize all of the different types of services that clients were receiving (even though one kind of service might be preferred.) Therefore, in the next question, we asked the two providers to assign percentages to different packages of treatment options to better reflect the actual balance of services offered to clients. The options provided on the survey form were: Only group therapy; only individual therapy; only medication management; only couples/family therapy; a combination of group, individual, and couples; and a combination of group, individual, couples, and medication management. Providers were asked to give what percentage of their sex offender clients received services consistent with each of the options.

There are three statistics to report for each option in order to best characterize the responses received: First, how many of the providers endorsed the option at all. Second, of those providers endorsing an option, what was the average percentage of clients receiving that particular configuration of services. And third, what was the range of responses, which would provide an indication of the variation in service options among the providers. Both providers said that an average of about 40% of the clients in their programs were seen exclusively in group sessions (30% in one program and 50% in the other). Both providers also indicated that some of their clients were seen in individual therapy alone with the average percentage of cases characterized as being solely in individual therapy as 30% (20% in one program and 40% in the other). Both therapists indicated that none of their sex offender clients were exclusively receiving medication management or couples-family therapy. Couples-family therapy, when used, appears to be used only in conjunction with group and/or individual therapy.

The final two options for this survey question represented combinations of the first four items. The first of these options included all of the aforementioned treatment modalities *excepting* medication management; both providers endorsed this option indicating that an average of 30% of their clients received this rather extensive service bundle (10% at one program and 50% at the other). Since the final option included medication management, and since both providers indicated they did not use medication, neither reported any clients receiving the full service bundle. The pattern of responses for this item show that many of the probationed sex offenders in Winnebago County are receiving multiple treatment services.

In as much as the therapeutic value of groups depends on size, groups that are too small, under five participants or so, lack the necessary group dynamics and interchanges between participants; factors posited to be among the principal therapeutic elements of group treatment. Alternatively, groups that are too large, over about 10 participants, often allow many participants to "hide" during sessions and not contribute in a meaningful fashion (this is also a problem with unskilled therapists who tend towards a passive or *laissez faire* style of leading groups). Providers had calibrated their group sizes to be within this theoretical range; one provider reported having groups of six participants while the other said the average group size was eight participants.

While individual therapy was not a primary treatment mode compared to group, the above series of questions indicated that both therapists use individual treatment. Several follow-up questions asked about average caseloads for therapists who provided individual therapy. Again, caseload size is important but primarily of concern when a therapist has too large a caseload to effectively deal with all of the cases and carry out other responsibilities such as coordinating assessments and reporting on

therapy to the Winnebago probation department. On average, therapists at these two clinics saw 16 sex offender clients on an individual basis ranging from 8 to 25 clients.

Recognizing that therapists might also see other types of clients in addition to sex offenders, we asked them to specify their total caseloads and include all of the clients they see on an individual basis. The reported average total caseload was 25 clients. These caseloads are within the range of allowing for additional coverage and should not be overly burdensome to the therapists in Winnebago. However, if there is a large increase in the referral stream of sex offenders from the Winnebago County probation department, one of the factors that should be discussed is whether a given clinic can handle the additional cases with existing staff or whether they might require more staff. The Winnebago County probation department should be aware of individual and group caseloads, and be prepared to negotiate for additional therapists should the average number of cases seen per therapist rise above 35.

With respect to each program's clinical orientation, an open-ended question was provided that allowed each respondent to write in detail about his approach. Both providers indicated their programs used a cognitive-behavioral approach with one elaborating that his included relapse prevention.

Finally, in this section, providers were asked to estimate the percentage of clients who paid at least some portion of their treatment and assessment fees and to indicate at what point in the process treatment assessments are performed. One provider said that all of their clients (100%) paid for some portion of their treatment while the other said that only 10% of their clients paid for treatment. Similarly, one provider said 30% of their clients paid for their assessments while the other said that 100% did. It is not clear why this discrepancy exists, and the impact it has on programming and referral patterns. It is worth exploring to see why one program demands universal payment for services from its clients while the other program does not require payments. The two Winnebago providers also differed in when they

said assessments were conducted, one said that they occurred after sentencing but prior to treatment referral while the other said that assessment occurred after sentencing and after treatment referral. We do not have additional information to explain this discrepancy in the timing of assessments among providers and hence do not know if it is a clinic policy or differential requirement of the probation department.

Salient aspects of treatment

These two providers were presented with a series of 11 session characteristics or exercises and asked to rate them in terms of their clinical importance on an 8 point scale. A score of 0 meant the characteristic or exercise was not at all clinically important while a score of 7 meant that it was extremely important. For the purposes of presentation, the results for this survey question are presented in two groups as shown in Table IV-4: those characteristics deemed extremely important by both providers and those deemed important but not as essential.

Table IV-4

Rankings of Salient Treatment Characteristics/Exercises

8 point Scale 0 = clinically unimportant and 7 = extremely important

Category 1: Extremely Important	**Mean rating**
Confronting denial so the offender accepts full responsibility	6.0
Teaching offenders specific behavioral and cognitive skills they can use to reduce their risk of offending	6.0
Helping offenders recognize and stop deviant thoughts and urges	6.5
Covering and understanding the sexual abuse cycle	6.5
Category 2: Important but not Extremely	**Mean rating**
Helping offenders understand the affect their actions have had on their victims	5.5
Teaching appropriate sexuality and sexual outlets	5.5
Teaching anger management skills	5.0
Regular attendance of probation officers at group sessions	5.0
Routine polygraph testing	4.5

For the most part, the session characteristics/exercises deemed most important were those directly related to sexual offending and to relapse prevention – confronting denial, teaching new cognitive and behavioral skills to reduce the likelihood of relapse, helping offenders recognize and stop deviant thoughts and urges, and understanding the sexual abuse cycle. Activities that were somewhat less directly related to the actual offending behavior such as anger management and assertiveness training and routine polygraph testing were ranked as being in a second tier of importance. The

Winnebago County providers were unusual compared to treatment providers in other counties in that they gave PO attendance at group sessions a much higher rating clinically. In other counties, PO attendance at sessions was rated very low, basically as being unimportant. A series of additional questions about the non-clinical aspects of PO's attending treatment are presented below[53].

Another issue related to clinical saliency is relapse and the signs that suggest an offender is at increased risk for committing a new sexual offense. In an open-ended question, providers were asked what specific behaviors or indicators signified to them that a client was at increased risk for relapsing. Table IV-5 presents the verbatim results from this question. Both of the providers in Winnebago County stressed that offenders placing themselves in at-risk situations without supervision were clearly headed for relapse. One provider further elaborated that increased rationalizations, changes in lifestyle, or having contact with the victim were also red flags.

Table IV-5

Information or Actions Indicating High-Risk of Relapse

Place self in situation involving children i.e. opportunity without supervision
Obvious shift/change in presentation in treatment sessions; inclusion in identified risk situations, whether environmental or internal; increased rationalizations, justification, etc. notable lifestyle changes; contact with victim.

[53] This evaluation included collecting the same surveys from providers in DuPage and Lake Counties. The responses across counties were very consistent as to which treatment characteristics/exercises were most important. There were some differences in ordering within the two larger categories in the table but, excepting the participation of POs in sessions, the clinical characteristics seen as extremely important in Winnebago were also viewed as such by the DuPage and Lake providers and so on.

Probation officer participation in treatment

We next asked a series of questions to understand if PO attendance at groups sessions had any adverse effects on groups, how often PO's attend sessions, and how active they are in sessions they attend. However, only one of the two Winnebago County providers said that POs attended treatment sessions offered by their programs. For the one provider who did indicate POs attended session, it was on a weekly basis, the POs speak only occasionally in sessions and never attempted to lead the sessions. Given the positive clinical ratings of PO attendance on groups clinically, it would seem that this provider felt in general positive about PO participation or at the very least, neutral.

It is not clear why the POs in Winnebago County attend sessions at one provider and do not attend sessions at the other. This is an issue worth exploring.

Written policies

Both providers responded they had written policies on treatment rules violations and that these policies that have been discussed with therapists on staff. Specifically, the treatment rules violations covered are the number of unexcused absences allowed and what constitutes an unexcused absence. In addition, both providers said they also have written policies on what constituted being late for a session and on the number of late sessions allowed. However, only one of the two providers had written policies on payment schedules and requirements. The comprehensiveness of written policies on all of these issues by the Winnebago County providers is commendable and should provide the treatment participants with clear guidelines on what is expected of them in treatment.

Provider recommendations

The last question on the survey asked the providers to make recommendations for improving treatment effectiveness. Only one of the providers responded to this question, indicating that they would like more support from the court on issues of follow-through or the lack thereof. This provider also pointed out the need for more funding because of the indigent status of many of the offenders.

Summary

As already noted, we wish to stress that the survey method of evaluation is limited to the validity of the providers' self-report. The primary limitation in this regard is that we do not have an independent assessment of the quality of the treatment services provided due to resource and time constraints. With that important caveat, and based on the above survey results for Winnebago County, we make the following observations and recommendations:

- The referral stream of clients from the Winnebago County probation department appears to be funneling adequate numbers of cases to the treatment providers. The program appears to be successfully linking sex offenders with treatment programs and to be using a variety of treatment programs.

- Both providers rely primarily on group treatment in conjunction with family counseling and many offenders also receive individual counseling. The primary clinical orientation of the programs is cognitive-behavioral. As best we can tell from the surveys, the treatment being

provided is at least adequate and appropriate. The therapists have good clinical credentials and are experienced in providing sex offender treatment.

- The average number of attendees at group sessions is within the appropriate range. The therapists do not appear to be carrying overly large individual caseloads in conjunction with their work with sex offenders. However, if the number of sex offenders referred to these programs increases substantially, the Winnebago County probation department should monitor this issue and make sure that no therapist has a *total* caseload of greater than about 30-35 clinical hours per week.

- The providers have written policies on various treatment parameters including what constitutes session lateness and payment requirements. This is unusual compared to the providers in other counties that we have evaluated and is commendable.

- It is not clear why the POs in Winnebago County attend sessions on a weekly basis at one of the providers but do not attend any sessions at the other. This is a discrepancy that should be explored because it suggests an unevenness in the monitoring of the sex offenders contingent upon what treatment program in Winnebago they are referred to.

Short-term Probation Outcomes

From August of 1997 to February of 1999, Winnebago County provided monthly statistics on the number of drug screens, number of new arrests, and number of violation of probation petitions filed.

Across these 19 months, Winnebago County conducted 50 drug screens, with an average of 2.6 drug screens per month. Overall, only seven arrests were made during this time period. The offenders were arrested for disorderly conduct, DUI, a drug offense, traffic offenses, retail theft, battery of a police officer, resisting a peace officer and possession of marijuana. There were no arrests for a new sex offense. The number of violation of probation petitions filed was low: only six were filed in this 19 month period.

The two probation officers also provided specific information about treatment progress, arrests, and probation status for a sample of 47 cases. Analysis of these data provides some insight into probation performance. Of these 47 cases, nine could be classified as "failures". Two were sentenced to DOC, one to jail, three were AWOL, one had probation revoked and two were on warrant status based on Wisconsin warrants. Two cases had successfully completed probation which yields a "success" rate of 2/11 or 18.1%. The remaining 36 cases were still active with the program. It should be noted that the data provided on these 47 cases reveals that the majority of offenders are performing quite well and that most will successfully complete sex offender probation. Four offenders received verbal warnings for missing treatment sessions. Four offenders completed group treatment and are involved in only individual treatment. One offender entered inpatient mental health treatment for two months in 1998. Based on probation officers' reports, three polygraphs were conducted on these offenders. Based on treatment provider reports, one polygraph was conducted between September of 1998 and February of 1999.

Short-term Treatment Outcomes

The evaluation team asked all treatment providers to complete a standardized monthly progress report for all offenders receiving treatment in our sample. The standardized monthly report assessed the progress of the offender on six critical dimensions of treatment: (1) participation in therapy sessions; (2) commitment to treatment; (3) acknowledgment of personal responsibility for the offense; (4) understanding of the consequences if he re-offends; (5) willingness to disclose details of additional inappropriate behavior; and (6) acceptance of responsibility for emotional/physical damage their actions caused the victim. All of these dimensions were rated on 10 point scales where 1 is equal to none of the dimension (e.g., no acceptance), 5 is equal to moderate, and 10 is equal to complete on the dimension (e.g., complete acceptance). In addition, therapists provided specific information about the offenders' participation in treatment which included the number of scheduled and missed therapy appointments, the number of unexcused absences, and whether offenders completed all homework assignments. Therapists also provided information about any positive lifestyle changes since last report, and about any admissions to inappropriate sexual behavior since last report. Therapists also indicated whether a polygraph test had been administered.

Responsiveness to treatment is an important intermediate outcome in evaluations of how well treatment reduces recidivism. Responsiveness to treatment can be measured in several ways. For example, at least two independent neutral experts could observe and interview each offender at several points during the entire treatment period; unfortunately, this design though ideal at reducing response biases is intrusive, expensive, and could interrupt the treatment process. The evaluation team, therefore, decided to obtain monthly treatment reports from providers on each offender and to measure systematically critical dimensions that treatment is designed to change.

There are both advantages and disadvantages to using progress reports from therapists as a measure of whether offenders are responsive. One important advantage is that the therapist knows where the offender began and how well they have met treatment standards. Therapists also judge the progress of offenders in relative terms to how previous and current clients are responding to similar treatment. A potential disadvantage, however, is that therapists will tend to cast offender's progress in the best possible light to show that treatment is effective. In an attempt to reduce this positive bias, we instructed therapists that all data would be grouped in each county and analyses on separate agencies would not be performed. We also instructed therapists that our primary goal was to understand the predictors of treatment responsiveness and not to address the question of whether treatment was effective. We believe progress reports can be reliably used to determine the characteristics that distinguish offenders who are responsive from those who are not responsive. These data, however, are quite limited to determine the effectiveness of treatment such questions are better answered with matched-control sample designs that have long-term follow-up.

We had a total of 37 offenders from Winnebago County in which treatment providers submitted monthly treatment reports. Both treatment providers submitted reports on their offenders. For 31 of these offenders, we had four or more months of monthly progress reports from September of 1998 to February of 1999, most of these offenders had all months of data. For six offenders, we had only two to three months of progress reports. One offender was not in treatment at the time of this data collection. Thus, Winnebago County had 12 offenders who were in treatment for which we did not receive monthly progress reports.

Two basic indications of offenders' lack of participation in treatment are how often they miss sessions with unexcused absences and how many times they fail to complete homework assignments. Twenty-nine percent of the offenders attended all scheduled therapy sessions, 9.7% missed one session with an unexcused absence, 9.7% missed two sessions with an unexcused absence, 9.7% missed three sessions with an unexcused absence, 19.4% missed four sessions with an unexcused absence, and 22.6% missed five to seven sessions with an unexcused absence. Offenders were also irresponsible about completing homework assignments. Homework assignments were applicable to all offenders except one. Twenty-three percent of the offenders completed all homework assignments for all months that monthly treatment reports were completed. The remaining offenders missed between one and 14 homework assignments during these months, with a mean of four missed homework assignments across all months. One indication that therapists took the task of completing these monthly treatment reports in as accurate manner as possible is that offenders who were rated lower on the scale of participation did not attend all therapy sessions and did not complete all homework assignments.

Classifying Offenders as Responsive to Treatment

In order to classify offenders as responsive or unresponsive to treatment, we first conducted N-of-1 statistical analyses. N-of-1 statistical analyses are an improvement over visual inspection of the

data because they provide a reliable standard by which improvement can be measured.[54] Ispative N-of-1 analyses address the question, did this offender improve during the course of treatment compared to when the offender entered treatment? Ipsative analyses did not reveal any significant changes across time. There are several theoretical and methodological reasons for these null findings. First, most offenders were already in treatment for many months before we obtained any ratings of their progress; thus, we do not have a true baseline point. Second, sex offenders are in treatment for behaviors and attitudes that require a long period of time to change. Sex offenders do not quickly obtain victim empathy, acceptance of responsibility, or recognition of the inappropriateness of their behavior. Indeed, most sex offenders received similar ratings across the months on these dimensions. This stability in ratings means that sex offenders are changing more slowly than month to month.

Normative N-of-1 analyses have more practical implications. These analyses can address questions such as: (1) if treatment resources are scarce, which offenders will most likely benefit from treatment?; and (2) which offenders are most likely to terminate prematurely from treatment due to noncompliance with treatment rules.[55]

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[54]. As Mueser, Yarnold & Foy (1991) note, "statistical analysis of single-subject data provides a rule-governed, systematic approach to assessing outcome that simply is not possible with visual inspection alone." (p. 135) N-of-1 analysis takes into account an individual's performance at baseline compared to their performance during the observation months. Because numerous data points are needed in order to employ time series analysis, we chose to employ N-of-1 analyses derived from classical test theory (see Yarnold, 1992). Ipsative single-case analyses first convert an individual's raw data into standard z scores using an individual's own mean and standard deviation for the variable being standardized. We performed ipsative analyses for each of the six dimensions for each individual.

[55] N-of-1 normative analyses convert the raw data to z scores using the mean and standard deviation of the entire sample, which allows relative comparisons across offenders. To standardize the data, we used the mean and standard deviation across time for each question based on all monthly treatment reports collected from Lake, Winnebago, and DuPage County. In all three counties, therapists provide cognitive-behavioral group therapy. Grouping data from all three counties insured that we had a more representative population of sex offenders and did not create an artificial restricted range on our measures. Significance was defined at the probability level of .05, which means that there is a 1 in 20 chance that we make a false claim that an offender showed significant improvement.

The normative-based N-of-1 analyses revealed 18 significant changes. Two offenders showed significant improvement on participation in treatment, and one offender showed a significant decrease in participation in treatment. Five offenders showed significant improvement on commitment to treatment, and two offenders showed significant decreases on commitment to treatment. Two offenders showed significant improvement on acknowledging personal responsibility for the offense. One offender showed significant improvement on understanding the consequences if he re-offends. Three offenders showed significant improvement on willingness to disclose details of additional inappropriate sexual behavior. Two offenders showed significant improvement on acceptance of responsibility for emotional/physical damage to victim.

Because offenders had been in treatment for an average of nine months and ten had been in treatment for over one year, we also developed absolute criteria to classify offenders as responsive or unresponsiveness. Based on monthly progress reports from three counties (Lake, DuPage, and Winnebago), we calculated the mean, median, and 60th percentile for each of the six dimensions. Table IV-6 presents these data. Therapists in Winnebago County consistently had lower mean ratings than therapists as a whole, but made distinctions between offenders as evident from the lowest and highest mean rating across time for individual offenders. Table IV-7 presents the means for the total sample of sex offenders in all three counties compared to the means for sex offenders in Winnebago County, the lowest mean across time for an offender in Winnebago County, and the highest mean across time for an offender in Winnebago County. In comparison to therapists in Lake and DuPage County, therapists in Winnebago County were more reluctant to use ratings of 9 or 10.

Table IV-6

Descriptive Statistics of Therapists' Ratings of Sex Offenders' Progress in Three Counties

Dimension	Mean	Standard Deviation	Median	60th Percentile
Participation in therapy	5.88	2.41	5.88	6.43
Commitment to treatment	5.57	2.50	5.41	6.29
Acknowledge personal responsibility	6.33	2.69	7.0	7.20
Understand consequences if re-offends	7.41	1.83	7.55	8.2
Willing to disclose inappropriate sexual behavior	4.90	2.70	4.68	5.5
Accepts responsibility for emotional/ physical damage to victim	5.69	2.72	5.88	7

Table IV-7

Comparison of Mean Ratings of Therapists Across All Counties to Winnebago County Therapists

Dimension	Mean Across All 3 Counties	Mean for Winnebago County	Lowest Mean Across Time	Highest Mean Across Time
Participation in Treatment	5.88	4.79	1.4	8.75
Commitment to Treatment	5.57	4.39	1.0	8.67
Acknowledge Personal Responsibility	6.33	5.10	1.0	8.83
Understands Consequences if reoffends	7.41	6.20	2.8	8.80
Willing to disclose inappropriate sexual behavior	4.90	3.68	1.0	7.17
Accept responsibility for emotional/physical damage to victim	5.69	4.42	1.0	8.29

To classify offenders based on absolute cut-points of reaching some standard, we established that offenders were responsive on a given dimension if they were at or above the 60th percentile for that dimension. We selected this cut-off based for two reasons. The mean and median seemed to be too

lenient of criteria to label someone as successful on a dimension given the fact that success should mean more than 50%. Given the distribution of the data and the fact that these behaviors and attitudes are slow to change, the 60th percentile (which is the mean + .5 standard deviation) made empirical and conceptual sense. After classifying each on all six dimensions, offenders were classified as overall responsive if they were classified as responsive on four of the six dimensions or if they were classified as responsive on three of the six dimensions and showed a statistically significant improvement on one of these dimensions. Interestingly, across the six dimensions, most (18 offenders) were classified as unresponsive on all dimensions. Six offenders were classified as responsive, and four of these offenders were classified as responsive on five of the six dimensions. One offender was classified as responsive on four of the six dimensions, and one offender who received an overall classification as responsive showed a significant positive change and was classified as responsive on three of the six dimensions. Thus, some of the offenders who showed a significant improvement on one dimension were classified as unresponsive on all of the other dimensions. For the entire sample, six offenders (13%) were classified as overall responsive.

Therapists reported a mean of .73 positive lifestyle changes per an offender for all months in which progress reports were obtained. Twenty-five offenders (61%), however, did not have any positive lifestyle changes. Five offenders were reported as having maintain sobriety or a drug-free lifestyle. Four offenders were reported to have better relationship with significant others: two offenders had better relationships with their spouse, and two offenders had better relationship with their extended family. Other lifestyle changes included: moving out of a dysfunctional family, looking to get off disability, maintaining stable employment, active participation in in-patient treatment, awareness of high risk situations, no contact with minors, with the probation department's permission, defendant made an

effort to reconcile with daughter who was victim, reported involvement in a number of community activities, recognition of own lack of assertiveness, visible attempts to improve appearance, and purchased own home. None of the offenders were reported as having revealed additional inappropriate sexual behaviors.

In order to determine the progress of the 12 clients who were in treatment but did not have monthly treatment reports, we requested from the probation department an update on the status of offenders. The probation department was asked to indicate treatment status (ongoing, terminated prematurely, successfully completed), probation status (active, on active warrant, successfully completed, probation revoked), whether a VOP was filed for failure to comply with treatment, and whether the offender was arrested while on probation and the nature of the offense. Based on this information, we were able to classify 9 of the 12 offenders who did not have monthly treatment reports as unresponsive to treatment based on the criteria that treatment was prematurely terminated due to noncompliance with treatment rules. The total sample for Winnebago County for analyses on the predictors of responsiveness is 46 of the 49 offenders ordered to undergo sex offender counseling, which is 93.8% of the relevant sample.

Predicting who is responding well in treatment

Overall, six of the 46 offenders were classified as responsive. It is critical to understand the characteristics that differentiate offenders who are responsive to treatment from offenders who are unresponsive. Characteristics that accurately predict whether offenders were classified as responsive or

unresponsive to treatment are called "significant predictors."[56] Significance simply means that information obtained from a predictor does better than chance at accurately classifying offenders into either the responsive or unresponsive category. To determine the significant predictors of treatment responsiveness, we employed a statistical tool that provides the maximum possible accuracy in classifying cases. This tool is called optimal discriminant analysis (ODA).[57]

We considered 40 potential predictor variables. Demographic and background predictors were age, ethnicity, marital status, number of biological children with whom the offender associates, whether the offender is on welfare, income level, education, and sexual orientation. We considered eight characteristics of the offense: statutory type of current offense, relationship of offender to victim, age of youngest victim, whether force was used, location of the crime, whether penetration occurred, and number of months that sexual abuse continued. We considered five measures of prior record: total number of prior arrests, number of prior arrests for sex offenses, number of prior arrests for violent crimes, number of prior arrests for misdemeanor crimes, number of prior convictions for violent crimes, and number of prior convictions for sex offenses. We considered ten measures of psychological and social adjustment: whether offender had a drug/alcohol problem; used drugs/alcohol before the offense, had prior treatment for substance abuse, had a serious mental disorder, had prior treatment for a mental disorder, was currently in a sexually active relationship, suicide history, whether the offender was

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[56] For all analyses statistical significance refers to the probability of making a false claim that a predictor is related to treatment responsiveness when it actually will not predict treatment responsiveness in future samples. This is known as the Type 1 error rate or p. The Type 1 error rate, p, was assessed as an exact permutation probability, and for each comparison $p < .05$ was used to establish statistical significance. This probability level was chosen to maximize the power of detecting predictors that discriminate between responsive and unresponsive offenders while still maintaining a relatively low probability of making a Type 1 error.

[57] Parametric statistical analysis was inappropriate due to many tied values (Soltysik & Yarnold, 1993; Yarnold & Soltysik, in press). Due to the small number of misclassified observations for any single predictor variable, we could only build a two-variable model for treatment responsiveness. This model was built using classification tree analysis (CTA).

depressed, the severity of the personal history of child abuse/neglect, and whether offender was a victim of physical and/or sexual abuse. Level of functioning on clinical presentation characteristics at the time of intake using the Bays & Freeman-Logo Scale (to evaluate sexual offenders' risk of reoffending): willingness to discuss offense, acceptance of responsibility for offense, and remorse about offense. Based on multiple sources of data from offenders' self-reports, objective personality or sexual preference tests, DSM IV diagnosis, and prior disclosed offense history and fantasies, we created measures of whether the offender was a pedophile or not, had interest in aggressive or sadistic sexual behavior/fantasies, had engaged in or expressed interest in "hands-off" sexual offenses (e.g., exhibitionism or voyeurism). We could not create a measure of whether the offender had been diagnosis as a psychopathic deviant based on objective personality tests such as the MMPI or MCMI or a DSM IV classification as an antisocial personality because the treatment evaluations were consistently missing this information.

In order to determine the relative performance of each significant predictor, we used the percentage of total theoretical possible improvement in classification accuracy achieved with the predictor—above the classification accuracy achieved based only on chance. This measure is a standardized test statistic called the "effect strength for sensitivity" (ESS). ESS can range between 0 and 100 where 0 means no improvement in classification accuracy above chance level and 100 means that the predictor explains all variation (errorless classification) in classification accuracy above what can be achieved by chance. Predictors can be ranked as weak, moderate, or strong based on the ESS. ESS < 25% indicates that a predictor provides only weak accuracy in classification, ESS between 25% and 49% indicates moderate accuracy in classification above chance performance, and ESS equal to

50% or higher indicates strong accuracy in prediction above chance performance.

In addition to the strength of a predictor, it is important to know whether the predictor would perform at the same level of accuracy at classifying a new set of cases; predictors are reliable if they have the same accuracy at classifying cases (measured by the ESS) in the new sample as in the original sample. We report whether a predictor was reliable and provide the ESS for the new sample if the predictor is unreliable.[58] Only reliable predictors were allowed to enter the classification tree analysis. Another factor that can affect the ability of predictors to classify accurately a new sample of data is the distribution of the outcome variable. All predictors reported have reliable accuracy in classification of cases irrespective of the percentage of cases classified as one category of the outcome variable (e.g., responsive).[59]

Analyses revealed three significant predictors of responsiveness.[60] Only prior mental health treatment was a significant and reliable predictor. If the offender had prior mental health treatment then predict that the offender is responsive to treatment.[61] Although the offender's acceptance of responsibility for the offense ($N = 41$, $p < 0.006$) and offender's personal history of abuse ($N = 39$, $p < 0.05$) scales were statistically significant, they were unreliable predictors.

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[58] A jackknife validity analysis was used to assess how reliable each significant predictor would be in classifying a new sample of data; the jackknife validity analysis employed was a leave-one-out (LOO) analysis where classification for each observation is based on all data except the case that is being classified.

[59] An efficiency analysis was conducted to assess how well a predictor performed over all possible base rates of the outcome variable. The outcome variable, however, could not have all cases classified in only one of the categories (e.g., all offenders are responsive and none are classified as unresponsive) (Ostrander, Weinfurt, Yarnold, & August, 1998).

[60] Based on a .05 probability level and forty tests, two significant effects would be expected based on chance alone. This set of analyses revealed 1.5 times the number of effects expected by chance.

[61] The statistical indicators were: sample size = 44; $p < .029$; ESS = 48.2, a moderately strong effect.

The multivariate CTA tree model for discriminating offenders who were versus were not responsive to treatment segmented the sample into three homogeneous offender clusters. The largest group, with N = 33 (71.7% of the sample of classified offenders), involved offenders who did not receive prior mental health treatment: only 6.1% of this cluster was responsive to treatment. Another largely unresponsive cluster involved offenders who had prior mental health treatment and who reported no substance use or only alcohol use (N = 5; 10.9% of sample; none were responsive to treatment). Finally, offenders who had prior mental health treatment and who reported using illicit drugs as well as alcohol were primarily responsive to treatment (N = 6; 13.0% of sample; 66.7% were responsive to treatment (four of six offenders)). The two offenders who were actually unresponsive to treatment, but the model classified as responsive actually had their probation revoked for failing to show up for treatment and drug use. This model correctly classified 42 of 46 offenders with sufficient data, corresponding to an overall classification accuracy of 91.3%. For this model, ESS = 69.7, reflecting a relatively strong effect. Future research should be conducted to determine the generalizability of this model with a large sample of sex offenders. It may be that offenders who acknowledge illicit drug use are also more open to treatment and to the fact that they have problems that should be addressed in therapy.

Summary and Recommendations

This section summarizes the key findings from our evaluation of the Winnebago County Sex Offender program and offers some recommendations for program enhancement. We focus on four key elements that include program design and management; supervision and surveillance; treatment; and short -term outcomes.

Program Design and Management

The Winnebago County program uses a specialized sex offender officer design in which all sex offenders on probation are assigned to two experienced sex offender specialists. These two officers handle sex offender cases only. The program's target population includes all adult felony offenders convicted of a sex offense that require the offender to register as a sex offender. A unique feature of this program is that it is restricted to felony offenders. In addition to offense, criteria for admission to the program include an order of probation and acceptance into sex offender treatment. Cases are accepted on a contingency basis pending the treatment decision. In most cases assignment to the sex offender program is made a part of the probation order but does not contain any specific reference to special sex offender probation conditions. In a limited number of cases, potential program participants are identified through a PSI, but most of the time the state's attorney and defense agree to the program as part of the plea bargaining process. Most cases are assessed within 30 days of sentencing. Sex offender assessment and treatment is provided by two sex offender therapists. Supervision standards are based on a three-level model that requires two home/field visits and a total of four face-to-face contacts a month for level I offenders with decreased contacts for level II and III. One special feature

of this program is that the two sex offender officers continue to supervise sex offender cases they had on their on their caseload prior to the start of the grant program. The officers sex offender caseload is thus a mix of pre-program sex offender cases and grant program sex offender cases. The program has averaged four grant program intakes a month from August, 1997 through February, 1999. The current caseload (February 1999) is 68 grant program cases and approximately 20 pre-program cases per officer for a per-officer caseload of 52 cases each. The program's goal was a per-officer caseload of 50 cases.

The evaluation team found the Winnebago program to be adequately managed. The formal administrative structure is for the two sex offender officers to work under the supervision of the director for adult probation. Both officers are senior probation officers well versed in the supervision of sex offenders so they operate somewhat independently. In this manner the department avoids assigning an already overburdened supervisor to supervise the sex offender program. Both officers are well trained and well motivated. One administrative problem that has continued to plague this program is a lack of timely submission of monthly fiscal and program reports to the Authority. The evaluation team learned that while all such reports were indeed prepared by program staff and reviewed by the director for adult probation, they were required to first be submitted elsewhere in the department for submission to the Authority but were apparently never forwarded in a timely fashion. Although this road block situation shows signs of being resolved, the evaluation team was required to work with program staff to recreate and correct monthly program statistics required for performance analysis.

Supervision and Surveillance

The Winnebago program supervision and surveillance standards require two home/field visits and a total of four face-to-face contacts a month for level I cases and one home/field and two face-to-face contacts a month for level II cases. Level III cases were to have one face-to-face contact a month. Our analysis was restricted to levels I and II in the belief that level III was essentially regular probation as far as contact standards were concerned. Monthly program statistics reproduced by the two sex offender officers allowed the evaluation team to examine standard achievement at both level I and level II. This program experienced difficulty in meeting level I standards but was much closer to meeting level II standards. While home/field standards were not met for either level face-to-face contact standards for level II were met and in some months exceeded. There are a variety of practical reasons why supervision standards were not achieved by this program. One particular relevant program characteristic was that sex offender officers worked only a normal five day, 9-to-5 work day schedule that limited the number of contacts.

Treatment

The evaluation team found the interaction between probation staff and treatment providers in Winnebago County to be exemplary. Survey findings indicate a high degree of mutual respect and trust characterized by open and productive communication on a regular basis. These findings result, no doubt, from the fact that all treatment providers and probation offices in the sex offender unit have a regular weekly meeting. Probation staff and treatment providers both indicated they were very satisfied with the way the team approach was implemented in this program.

The Winnebago program can substantially improve its treatment evaluations. Only two of 42 evaluations included a polygraph examination. Clinical interviews and polygraphs combined resulted in only one offender revealing at least one additional sex-related crime (i.e., one that was not part of their official record). Thus, clinical evaluations did not provide adequate information about the history of sexual offending, and the number of additional sex crimes revealed during the clinical interview was substantially lower compared to the other counties. None of the treatment evaluations contained an objective measure of sexual preferences (i.e., the ABEL test or the plethysmograph). An objective personality test was administered to only one of the defendants. Most evaluations also did not address offenders' power and control tactics in relationships and their attitudes toward women. Treatment evaluations for Winnebago County also were inadequate in the area of psychiatric referrals: only six of the treatment evaluations addressed whether the offender needed psychiatric treatment and whether the offender should be on antidepressants. The evaluations were rather uniform in their recommendations of group therapy (82.1%) and/or individual therapy (87.2%) to address issues such as offenders' acceptance of responsibility for the offense, awareness of their sexual assault cycle, and other cognitive-behavioral treatment goals. Despite this uniformity, most evaluations (82.5%) also tailored recommendations for treatment to the individual's needs.

Therapists in Winnebago County had considerable clinical experience working with sex offender with an average of 10 years of experience. Both therapists indicated that their preferred modality of treatment was a mixture of group and family therapy. The average group size across providers was six to eight participants per group, which is in the optimal theoretical range of group size. Approximately 58 cases had been referred for treatment from the Winnebago County probation department. The average number of group sessions scheduled per offender per month was 3.4. Both providers indicated

that their program used a cognitive-behavioral approach. The most important aspects of the cognitive-behavioral approach were: (a) confronting denial so the offender accepts full responsibility; (b) teaching offenders specific behavioral and cognitive skills they can use to reduce their risk of offending; (c) helping offenders recognize and stop deviant thoughts and urges; and (d) covering and understanding the sexual abuse cycle. Anger management, demonstrating assertiveness skills, and social interaction skills were much less central to the cognitive-behavioral approach. Though group is the preferred treatment modality, the majority of probationed sex offenders are receiving multiple treatments. The average number of individual sessions scheduled (which are typically behavioral for two providers and counseling for one provider) per defendant per month was .33. Most defendants did not consistently have individual sessions.

Only one of the two Winnebago County providers indicated that probation officers attended treatment sessions offered by their agency. Both providers agreed that probation officer attendance was a moderately important part of treatment, and when probation officers attended they spoke occasionally, but typically just observed. Attendance of probation officers at group therapy sessions was on a weekly basis.

Both providers had written policies on treatment rule violations in particular on the number of unexcused absences allowed and what constitutes an unexcused absence, what constituted being late for a session, the number of late sessions allowed, and payment schedules and requirements. The probation department may wish to standardize such policies across agencies for sex offender probationers. One provider said that all of their clients paid for some portion of their treatment while the other said that only 10% of their clients paid for treatment. All offenders paid all of the assessment fees at one provider, and only 30% of the defendants paid the assessment fee at the other provider.

Short-term Probation Outcomes

The probation outcome data for the Winnebago program were limited to summary reports of violations and arrests so that little data on present case status of all grant program cases were available. This program had an intake total of 96 grant program cases. There were a total of seven arrests. There were a total of six violations of probation petitions filed for a violation rate of 6.3%. The two sex offender officers noted that they were often reluctant to file violations of probation because the local court invariably either denied their petitions or took many months to act on them. Data on a sample of 47 cases allowed for at least a reflection of probation performance. Of 11 “closed” cases 9, or 18.1%, were either sent to DOC, jail or were on some other "failure" status. Two cases had successfully completed the program. Thirty-six cases in this sample were still active and most were likely to successfully complete sex offender probation. These outcome statistics most likely do not accurately reflect program operation. However, the limited work week referred to above undoubtedly contributes to the low number of violations uncovered.

Outcomes: Short-term treatment outcome

Treatment providers submitted monthly treatment reports for 37 offenders from September of 1998 to February of 1999. The monthly treatment reports assessed using 10 point scales of offenders’ status on participation in therapy, commitment to treatment, acknowledgement of personal responsibility for the offense, understanding of consequences if offender reoffends, willingness to disclose inappropriate sexual behavior, and acceptance of responsibility for emotional/physical damage to victim.

Therapists in Winnebago County consistently provided lower mean ratings compared to therapists in the other two counties, and tended to make distinctions between offenders using the entire rating scale as evident by the lowest mean for an individual offender across time (M = 1.0) and the highest mean for an individual offender across time (M = 8.8). For offenders in which monthly treatment reports were submitted, we performed N-of-1 analyses to determine whether offenders had made statistically significant progress from the therapist's point of view. Normative N-of-1 analyses revealed 18 statistically significant changes across all offenders and dimensions of treatment. These findings indicate that offenders who were rated very low at the beginning of treatment on dimensions tended to improve quite a bit during the six month assessment. Other offenders were slower to change, which is expected given that sexual offending is based on attitudes and behaviors of a long-standing nature. Twelve offenders were in treatment, but we did not receive any progress reports; for these offenders, probation officers indicated their probation and treatment status. Nine of the 12 offenders were classified as unresponsive to treatment due to the fact that they were terminated prematurely from treatment based on their noncompliance with treatment rules, and three offenders were classified as responsive based on the fact that they successfully completed treatment.

Based on treatment provider's ratings and information about treatment status, 13% of the offenders were classified as responsive to treatment. Further evidence of responsiveness of the Winnebago offenders is based on absences and completion of homework assignments. Ten of 35 offenders (28.5%) had no unexcused absences, and 8 of 35 offenders (23%) completed all homework assignments for all months that monthly treatment reports were completed. Therapists reported a mean of .73 positive lifestyle changes per an offender for all months in which progress reports were obtained. Most offenders (61%) did not have any positive lifestyle changes. The two biggest categories of

positive lifestyle changes were better relationship with spouse or intimate partner and remaining drug or alcohol free. Therapists did not report additional inappropriate sexual behaviors for any of the offenders.

The research team first utilized univariate analyses to determine the factors which best distinguished offenders who were responsive to treatment from those who were unresponsive. Univariate optimal discriminant analyses revealed three significant predictors. The one predictor that had jack-knife stability was whether the offender had prior mental health treatment. The two-variable CTA model segmented the sample into three homogenous groups. The two groups that were not responsive to treatment were offenders without prior mental health treatment, and offenders who had prior mental health treatment, but did not report substance use. Similar to Lake and DuPage County, clinical presentation variables seem to predict responsiveness to treatment. Future research will have to address whether such a good initial clinical presentation actually means a lower likelihood of recidivism or whether offenders have simply learned that in order to make progress in treatment they must appear to accept responsibility. A larger sample size and longer follow-up period will be able to build upon these initial intriguing results to address the question: for which offenders is treatment effective?

Recommendations

- **The department should create, in collaboration with treatment providers, a standardized treatment progress report that covers all major aspects of treatment, and allows therapists to indicate both positive lifestyle changes and inappropriate sexual behaviors/thoughts since last report. All therapists should be required to submit this written standardized form on all offenders at least once every two months. Probation officers can review these written documents for treatment progress, and will have the opportunity to refresh their memory on critical information before home/office visits. Such standardized reports should supplement rather than replace in person or phone contacts with therapists. Standardized reports, moreover, allow officers to assess which offenders are less responsive to treatment across treatment agencies.**

- **Some consideration should be given to restructuring the workweek of the sex offender probation officers to permit evening and weekend home/field visits. An alternative would be to assign a surveillance officer to the team.**

- **Program statistics should be revised to provide a better accounting of case flow thus allowing for accurate indicators of probation outcomes.**

- **Some consideration should be given to assigning level III sex offender cases to the general caseload unit within the department.**

- **The department should require that treatment providers submit written results of objective personality and objective sexual interest tests as part of the Initial treatment evaluation.**

- **The department, in collaboration with treatment providers, should create uniform written policies on graduated sanctions that are available to deal with noncompliance in therapy as well as uniform rules on how many unexcused absences are acceptable before the client is terminated and a VOP is filed, what counts as an excused absence, and how new sex offenses reported to therapists should be handled.**

CHAPTER V

CROSS PROGRM COMPARISONS

The majority of this reports up to this point has related our findings for each of the three programs. In this chapter, we compare the programs to each other to learn which features of each program most closely match the containment approach. The emerging model for probation supervision of sex offenders is the containment approach. The containment approach has three basic components. First, more intensive supervision and surveillance is used to control offenders' behavior and protect victims and the community. Second, mandatory treatment is used to teach sex offenders about the internal thoughts and external triggers that lead to a reoffense. Finally, a team approach whereby the probation officer, treatment provider, and if possible, a polygraph examiner share information and collaborate on strategies to better control sex offenders' behavior and is used to monitor sex offenders (English et al., 1996). A coordinated team consisting of professionals who are specifically trained to handle the manipulation and deceit of sex offenders responds to the offenders' potential risks in an attempt to prevent new offenses. The containment model centers around probation officers who specialize in sex offender supervision and who have reduced caseloads to handle the greater supervision demands that sex offenders require.

Using this model as a guide we first compared the programs' development, implementation, operation, and probation outcomes. We then compared the programs' specific implementation of sex offender treatment with special emphasis upon assessment and the team approach.

Program Development

The DuPage and Lake County programs are located in high population suburban

areassurrounding Chicago and Cook County. The Winnebago County program is also in a high population area given its location in Illinois' second largest city, but it is more rural in character than the other two programs. Each of the three had a pre-existing sex offender program prior to applying for grant funds. DuPage County had a sex offender team that handled sex offenders as well as regular probationers since 1991. Lake County established a specialized sex offender unit in 1995 that handled both sex offenders and regular probationers, and Winnebago County assigned sex offenders to four probation officers two of whom carried most of these cases. All four officers also carried a caseload of regular probation cases. To this extent, all three programs had some experience in dealing with sex offenders prior to the grant program using a mixed caseload approach. However, all three were dissatisfied with the degree of sex offender supervision and surveillance their units were able to provide and each saw the availability of grant funds as an opportunity to hire additional staff and increase supervision and surveillance and better implement a team approach to sex offender treatment.

While the acquisition of additional staff was a common feature, the programs differed substantially in how they used staff and approached the problem. Using a mixed caseload-sex offender specialist approach, DuPage County hired two sex offender "grant officers" who would handle sex offender cases only and thus be able to provide a higher level of supervision and surveillance. The sex offender team officers continued to handle a mixed caseload of mostly regular probationers along with sex offenders not assigned to the grant officers or transferred from the grant program to the team. Lake County, using a mixed caseload-surveillance officer approach, hired two surveillance officers who would provide intensive supervision and surveillance to sex offender cases carried by other members of the sex offender unit. Sex offender unit officers carried a mixed caseload of approximately one half sex offenders and one half regular probationers. The surveillance officers did not have a separate caseload.

Winnebago County, using a sex offender specialist approached, designated two experienced senior probation officers to carry only sex offender cases. Two probation officers were hired to replace the two specialists and grant funds were used to pay salaries of the two sex offender specialists. The common feature is that each program now had specifically designated officers who would supervise sex offenders. Two programs had other probation officers also supervising sex offenders. Only Winnebago County restricted sex offender supervision to its two grant officers. The common goal of all three programs was to use the sex offender grant officers to increase the level of supervision and surveillance of sex offender cases compared to that achieved prior to receipt of grant funds and also to reduce or control caseloads. All three programs thus conformed to the containment model by designating sex offender specialists to increase sex offender supervision.

Program Implementation

Each of the programs was part of a fully functioning and busy probation department made up of a variety of specialized units. The supervision structure differed somewhat in that DuPage County had a supervisor designated to supervise the sex offender team and the two sex offender grant officers; Lake County had a supervisor who supervised the sex offender unit that included the two surveillance officers and also supervised the presentence investigation unit; Winnebago County had its two sex offender specialists operating more independently and reporting to the director for adult services. Each arrangement seemed to fit well within the department structure and each program appeared to be well managed.

We found major differences in the target populations each program served. DuPage County's target population consisted primarily of adult felony and misdemeanor offenders convicted of statutorily identified sex offenses and sentenced to probation and in some instances cases convicted of non-sex offenses that the court ordered into the program. Lake County's target population was more broadly defined as any adult felony or misdemeanor offender convicted of any sex offense or a non-sex offense that has a sexual component and who was sentenced to probation. The Winnebago County program restricted its target population to adult felony offenders convicted of any sex offense that required the offender to register as a sex offender and was sentenced to probation. This was the only program to select felonies only. Each of these definitions had implications for caseload size. Lake County had the least restrictive target population and thus the largest caseload and the largest staff of six officers. The program had an average monthly intake of 11.5 cases, an average monthly caseload of 214 cases and an average sex offender caseload of 37 cases per officer. The DuPage County program had an average monthly intake of 6.2 cases, an average monthly caseload of 54 cases and an average caseload of 27 cases per officer with a staff of two grant officers. The Winnebago County program had the most restrictive target population and also the lowest average monthly intake of 4.1 cases, an average monthly caseload of 47 cases and an average caseload per its two officers was 24 cases each.

There is a certain practical reality to limiting target populations to statutorily defined sex offenders since it allows everyone in the system to easily identify eligible offenders. The other side of the coin is that restricting target population to statutorily defined sex offenders tends to miss those offenders whose behavior is sexual and even predatory in nature but whose offense is listed as a non-sex offense. Program staff from the DuPage and Winnebago County programs expressed the belief that potentially serious sex offenders were not being included in their programs because of the offense-based target

population procedure. The Lake County program, on the other hand, was approaching caseload saturation. One possible approach to this situation, is to have case selection placed at the department level and a procedure developed that once a case is identified for the sex offender program the probation order could be revised accordingly. The case referral procedure in all three programs was relatively noncomplex and could be adjusted easily.

There are a number of differences in offender and offense characteristics of the sex offender cases supervised in these three counties. Winnebago County offenders are less educated, have less income, and are more likely to be divorced or separated than are Lake and DuPage County offenders. In Winnebago County, 70.8% of the offenders are below the poverty level whereas 44.9% of Lake County offenders and 26.5% of DuPage County offenders live below the poverty level. Winnebago and Lake County offenders are significantly more likely to have dropped out of high school (42.6%) compared to DuPage County offenders (14.8%). A substantial percentage of Winnebago County offenders are divorced or separated (38%) than are Lake (19.3%) or DuPage (16.3%) offenders. Winnebago County offenders also are more likely to be recommended to substance abuse treatment (38.5%) compared to Lake County offenders (16.9%) and DuPage County offenders (22.5%). Whereas over half (59.1%) of DuPage County offenders express remorse at the initial treatment evaluation only about one-third of Lake County offenders (37.1%) and Winnebago County offenders (31.8%) express remorse. Similarly, 63.6% of DuPage County offenders admit all aspects of the convicted offense at the treatment evaluation process compared to 37.8% of Lake County offenders and 24.4% of Winnebago County offenders.

These differences in clinical presentation of remorse and acceptance of responsibility of the offense may reflect in part the vast differences in the type of sex crimes that each program serves. Winnebago County serves primarily felony incest and family-related cases, and the other two counties serve both misdemeanor and felony sex crimes that include a significant proportion of offenders engaged in “hands off” sex crimes. The percentage of victims who were unrelated varied dramatically: 77.2% of Lake County cases, 72.9% of DuPage County cases, and 26.5% of Winnebago County cases. In about half of Winnebago County cases the offender was related to the victim as an uncle, grandfather or other relative, whereas these cases comprised less than 9% of Lake or DuPage County caseload. Consistent with this trend, the average age of victims in Lake County cases (M = 16.19) and DuPage County cases (M = 14.5) was much older than Winnebago County victims (M = 11.82). Penetration also was more likely to occur in Winnebago County cases: 65.3% of Winnebago County cases, 51.3% of Lake County cases, and 40% of DuPage County cases. The other major difference in the type of cases involved the percentage of public indecency cases and criminal sexual assault cases. Winnebago County did not supervise any public indecency cases whereas public indecency cases comprised 31.3% of DuPage County’s caseload and 24.4% of Lake County’s caseload. Criminal sexual assault cases comprised 26.7% of Winnebago County’s caseload, but only 5.1% of Lake County’s and 8.3% of DuPage County’s caseload.

One feature found in all three programs that is of concern to the evaluation team was the absence of a well defined sex offender case identification and referral procedure at the state's attorney's office. While staff in each program maintained close communication with that office, the probation departments were not often a party to the state's attorney's decision to recommend probation, let alone sex offender probation on any given case. Although turnover in the state's attorney's office contributed

to this situation, it seems appropriate that a recommendation for a sentence of probation be at least discussed with the department prior to the court order.

The staff in all the programs received basic training in supervision of sex offenders and ongoing training throughout the year. Staff in the DuPage and Winnebago programs participated in a number of excellent out-of-state training programs. DuPage County also on an annual basis brought in sex offender specialists. In Lake County, the unit supervisor was particularly creative in marshalling local resources and thus was able to provide a continuous stream of training opportunities to the unit without going out of state. While each approach, i.e. out-of-state or local is useful, the Lake County training model has a number of features to recommend it. More training can be obtained with the limited training funds available; more sex offender unit staff can be trained with less disruption to case supervision; sex offender training can be offered to other department probation officers to develop a pool of potential replacement officers for the unit, and national experts can be brought in without the staff travel cost associated with going out of state. A middle ground between these two models, is the expansion of sex offender probation training by the Administrative Office of the Illinois Courts (AOIC). This is perhaps out of county but not out of state.

Program Operation

The evaluation team's assessment of the degree to which each program operated in line with pre-program expectations was partly dependent upon monthly statistics provided to the Authority by each program. We found sharp differences in the content and quality of these reports and no uniformity. The Lake County monthly report was excellent, contained a wealth of information on intake, closings, caseload, office and field supervision/surveillance and collateral contacts, violations, arrests and

outcomes and was submitted on time each month. The DuPage County report was adequate in that it provided data on intake, caseloads at each level, violations, arrests and some limited data on outcomes and reports were submitted on time to the Authority. However, detailed data on supervision/surveillance contacts were not provided due to failure of a planned computerized data collection system. The Winnebago County reports contained useful data on intake and caseload, office and field supervision/surveillance contacts by supervision level, violations and arrests and also a wealth of data on treatment attendance. There were two problems with the Winnebago County data. The evaluation team's count of cases did not equate with the data submitted requiring probation staff to redo some of the data to provide information on the number of cases at each level. An administrative problem at a level beyond the control of the program administrator, resulted in a six month delay in submission of monthly reports to the Authority. The Authority would be well served were it to develop a uniform data collection form, perhaps modeled on the Lake County form, to be used by all sex offender programs.

The primary goal of each program was to increase the supervision/surveillance of sex offenders. While no data were provided in grant applications on the attainment of supervision standards prior to the grant, each program was operating according to AOIC standard for maximum supervision cases. This included two face-to-face contacts a month and one home/field visit every other month or .5 a month. Analysis of supervision/surveillance data from each program indicated that the number of home/field visits exceeded the .5 standard for 94% of the months studied in each program. The two a month face-to-face contact standard was exceeded in 98% of the months studied. Thus each program met its goal of increasing the number of supervision/surveillance contacts. Overall, the total number of home/field and face-to-face contacts is truly impressive. The three programs had a combined total of

7,364 home/field visits and 14, 860 face-to-face contacts. However, none of the programs succeeded in meeting the increased monthly contact standards each set for their funded sex offender program. Each did better than before but none as well as expected. DuPage and Winnebago Counties had similar standards. Both adopted a three-level supervision system. Level I required four face-to-face contacts a month, two of which were to be field/home visits. The number of contacts required declined as an offender moved from level I to II to III. Lake County used a uniform, non-declining standard of five face-to-face contacts a month, three of which were to be home/field visits. All three programs struggled with meeting their home/field visit standard. Comparisons are difficult because each program's data were analyzed differently because of differences in quality and completeness of monthly data and levels of supervision expected. However, a common statistic was the number of months that the standard was achieved. Lake County met its home/field visit standard in 3 of the 17 months or 17.6% of the time for surveillance officers but only for one month for the total program. Winnebago County met its standard in 1 out of 16 months or 6.3% of the time. DuPage County was not able to meet its home/field visit standard in any of the 16 month period examined. In terms of at least approaching their individual home/field visit standard, Lake County was closest, followed by Winnebago and DuPage Counties.

There are numerous practical reasons for this disappointing showing in terms of home/field visits. Some are unique to each program but we found three common factors. The day-to-day demands of supervising a probation caseload characterized by numerous court dates, abundant paper work, and the ever present phone calls all conspire to make the officer more office bound. This was found to be the case even with sex offender program's emphasis upon home/field visits. The second factor was time off for training. When officers were "off line" to attend training there were no back up officers to conduct

home/field visits since this is a very specialized function for sex offender cases. This was a problem more for the DuPage and Winnebago County programs but also to some extent for the Lake County program as well. The third factor was staff turnover. When a sex offender specialist leaves the unit it takes time to obtain and train a replacement. This was a serious problem for the Lake program's surveillance officer team and to a lessor extent for the DuPage County program.

All three programs did much well in meeting face-to-face contact standards. Although none of the programs met its standard in all months, all three met or exceeded their face-to-face standard in at least one of the months studied and came close in most other months. DuPage County met its four face-to-face contact standard, in one month, exceeded it in another month and was less than a tenth of a percentage point below expectations in six other months. Winnebago County met its four face-to-face contact standard in two months, exceeded it in another and was one visit below standard in nine other months. Lake County had the highest face-to-face contact standard ---five a month--- and did not achieve this standard in any of the months studied but was less than a tenth of a percentage point below standard in three months. The better showing for face-to-face contacts is, of course, a function of the fact that more office visits can be held with an office-bound probation staff.

An important finding that has implications for the design of sex offender programs, is that, when fully staffed and trained, the surveillance officer program adopted by Lake County was found to meet the four face-to-face and two home/field visit standard for level I cases adopted by DuPage and Winnebago Counties. It is possible then, under conditions of full staff, for DuPage and Winnebago Counties to meet their level I supervision/ surveillance standards if they added a surveillance officer element to their program. Another implication of this finding is that the three-level supervision approach in DuPage and Winnebago Counties could be revised to maintain a level I supervision standard

throughout the period of probation. Additionally, Lake County could reduce its standard to four face-to-face contacts a month.

Short-Term Probation Outcomes

Because of the relatively short period that these programs had been in operation, we were only able to assess short-term outcomes. These are outcomes that may be achieved while the case is in the program and included a measure of how many cases "successfully" completed the sex offender program, how many "failed" and how many had difficulty during their probation period. While definitions of success varied, success usually meant that an offender had completed his period of sex offender probation without an arrest or violation serious enough to warrant revocation of probation by the court. We had sufficient data from DuPage and Lake Counties to calculate rough estimates of success and failure rates. Based on the number of "closed" cases that were classified by these two programs as a "success" DuPage County had an 80.4% success rate and a 19.6% failure rate. Lake County had a 75.2% success rate and a 24.8% failure rate. These relatively high success rates are not surprising given the fact that sex offenders tend to be fairly compliant with probation regulations. In addition, the tight supervision most likely encouraged compliance. Lake County's lower rate is no doubt a reflection of its higher level of supervision. Winnebago County's data were incomplete and suggest that its 2 out of 11 or 18.1% success rate is not reflective of performance. Indeed, a review of active case notes suggests that the majority of the Winnebago County cases will also be "successes". The real test, of course, is long term recidivism, which is the subject of follow-up research being planned for these programs.

While a good number of the sex offenders were fairly compliant, some, of course, were not

leading to technical violations of probation. The programs varied in their technical violation rates, which were based on the percentage of total intake cases that had a technical violation. Because of variations in data quality and completeness, comparisons on technical violation rates are difficult to make. Any differences noted are tentative at best. Lake County had the highest technical violation rate of 37.4%, DuPage County had a technical violation rate of 12.1% and Winnebago County, 6.3%. Again, Lake County's higher rate is reflective of that program's higher level of supervision through the use of surveillance officers. This is consistent with probation and parole research, which finds that violation rates increase with increases in supervision. (Jones, 1991). An interesting finding common to all three programs is that few offenders failed drug/alcohol screens. DuPage County had the best data on this variable. Of 325 urine drops, only 3.9% were returned with positive results and an additional 1.2% returned with "negative but diluted" results. Lake County's data on the reasons for violations of probation filed refer to only two instances of drug use. Winnebago County's data made only one reference to positive results from an average of 2.6 drug screens a month. While profile data indicate that the sex offender population in each program presents problems of substance abuse typical of other probationers, available data suggests that substance abuse is not a serious compliance problem among the sex offenders supervised in these programs.

Because of the fact that arrest rates were based on non-comparable samples we did not compare programs in terms of arrests.

Implementation of Sex Offender Treatment

The second central element of the containment approach is sex offender treatment. Overall, we found the sex offender treatment component in all three programs to be exceptionally well implemented.

While there was some variability among programs, in general, probation officers and treatment providers interacted in a most positive manner and functioned as a team as the containment model mandates. In each program, satisfaction with how this team approach was operating was rated 8 or higher on a 10 point scale with an average rating of 8.5. The relationship between treatment providers and probation officers was characterized by mutual respect and trust and there was a free and open exchange of information in all three programs. The manner by which each program achieved this high level of positive interaction differed. In DuPage County, probation officers in the sex offender unit and treatment providers met in a regular group meeting once every two months. In Lake County, the most common approach was for sex offender probation staff and supervisor to attend meetings with each provider separately. But interaction was further enhanced by the units regular attendance at bi-monthly meetings of a community-wide coalition of all agencies serving sex offenders, therapists serving victims of sex crimes, and representative from the state's attorney office. In Winnebago County, interaction was encouraged by the fact that one of the two therapists provided treatment sessions at the probation department. In addition, both probation officers met weekly with each therapist and attended and participated in group treatment on a regular basis. One of the key points of the team approach to sex offender treatment is the perception, among both probation officers and treatment providers, that the probation department is the primary client or that the probation department and the offender are equally primary clients. There was some difference in opinion on this point in Lake and Winnebago Counties but not to such a degree as to undermine the team approach effectiveness.

The treatment process begins with a referral of cases to treatment providers for a treatment evaluation of the offender on a broad range of issues. We found that treatment evaluation reports were completed and returned to the program within acceptable time frames. However, there was

considerable variation in the quality and completeness of these evaluations. While DuPage County made extensive use of polygraphs (85% of evaluations), polygraphs were used in only 9% of evaluations in Lake and 5% in Winnebago Counties. Although locating and using polygraphers who are familiar with sex offenders can be difficult, our findings suggest that use or threat of use of the polygraph in combination with clinical interviews can be productive. In DuPage County, over half of the offenders revealed at least one additional sex-related crime that was not part of their official record. In Lake County, 23.8% of the offenders did so and in Winnebago County, 2.3%. While over half of the evaluations in DuPage County (66%) and Lake County (55.6%) contained an objective personality test, only 2.3% of the evaluations in Winnebago County contained such tests. Treatment evaluations for the DuPage County program were exemplary in assessing the offender's need for psychiatric treatment in that 100% of evaluation reports addressed this issue. This was addressed in approximately 20.8% of evaluations for the Lake County program and approximately 6% for Winnebago County. One major failing found in the vast majority of treatment reports examined from all three programs was the absence of an objective measure of sexual preference such as the ABEL or plethysmograph. Such measures were found in only 10% of the DuPage program reports, in 4.5% of the Lake program reports and in none of those from the Winnebago program. Also, most evaluations for all three programs did not address offenders' power and control tactics in relationships and their attitudes towards women. While there was certain uniformity in most evaluations in recommending group and/or individual therapy, there was also evidence that the treatment program recommended was tailored to individual needs. In general, we found the treatment evaluations performed for the DuPage County program to be adequate. Those for the Lake County program varied in quality from treatment provider to treatment provider and were deficient in important areas. Treatment evaluations performed for the Winnebago program were

inadequate.

The evaluation team interviewed probation staff and surveyed treatment providers to gain some assessment of the nature of treatment provided. There was a striking similarity in the nature of treatment provided in all three programs. Therapists had considerable clinical experience in working with sex offenders in all three programs, eight years in DuPage and Lake Counties and 10 in Winnebago County. All three used a cognitive-behavioral approach using a mixture of group, family, and individual therapy. Groups ranged in size from 7 to 10. While all programs used group therapy, there was some variability in therapist's views on group therapy as the preferred modality. While most (3/4) of the therapists in DuPage County preferred groups, at least half (2/4) of those in Lake County and all (2/2) in Winnebago County preferred a mix of group and family therapy. All programs also offered individual therapy. Interestingly, while DuPage County had the second largest caseload, it referred the most number of cases to treatment, 87. Lake County referred 80 and Winnebago County, 58. In all three programs, providers indicated that the vast majority of offenders paid or were required to pay for treatment and assessments. While most providers in all three programs indicated they had written policies on absences, lateness, and other treatment rule violations, there was no uniformity among providers and programs on these issues.

Short-Term Treatment Outcomes

Our evaluation of short-term treatment outcomes was based on standardized monthly progress reports from treatment providers on cases in treatment during September, 1998 to February, 1999. Treatment providers were generally prompt is submitting theses reports. Because treatment reports were not submitted for all offenders during this time period it was not possible to calculate comparable

treatment attendance rates. However, our findings indicate that the large majority of offenders complied with the probation requirement that they attend treatment. Only a small percentage, approximately 10% were terminated because of noncompliance with treatment rules. Treatment providers were also asked to rate offenders on six critical dimensions of treatment using a 10-point scale in which 10 was the most positive. Our findings indicate (Table V-1) that ratings on each dimension varied both within programs and between programs.

Table V-1

Program Comparison on Average Score on Six Critical Dimensions of Treatment

Dimensions	Mean Across All 3 Programs	Mean for DuPage Program	Mean for Lake Program	Mean for Winnebago Program
Participation in Treatment	5.88	6.98	6.14	4.79
Commitment to Treatment	5.57	6.56	6.46	4.39
Acknowledges Personal Responsibility	6.33	7.61	6.59	5.10
Understands Consequences of reoffending	7.41	8.63	7.61	6.20
Willing to disclose inappropriate sexual behavior	4.90	6.04	5.18	3.68
Accepts responsibility for emotional/physical damage to victim	5.69	6.86	6.18	4.42

The highest three-program average rating and the highest in each program was the offender's understanding of the consequences of reoffending followed by acknowledgement of personal responsibility. The rating on understanding the consequences of reoffending is understandable given that the programs deal with convicted sex offenders. The relative high average rating on personal responsibility is encouraging given sex offender's propensity to deny the offense let alone accept responsibility. Three program averages on the remaining dimensions hover around five to six an indication of moderate rating. The lowest rating, not surprisingly, was on a willingness to disclose inappropriate sexual behavior. While some caution in interpreting these therapist-generated ratings should be exercised in that they not only reflect offender performance but therapist performance as well, we are confident that ratings were made in as objective a manner as possible. Three aspects of the data buttress our confidence. First, therapists made participation and commitment ratings based in part of each individual's attendance and completion of homework assignments, and made distinctions between offenders using the entire rating scale. Second, therapists in Lake and DuPage County provided specific examples of positive lifestyle changes for the majority of offenders. Third, DuPage County therapists provided examples of additional inappropriate sexual behavior for a significant percentage of their clientele, and had the highest ratings on willingness to disclose additional inappropriate sexual acts.

Findings indicate that the ratings for the DuPage program offenders were the highest for all six dimensions followed by the Lake and Winnebago programs. These differences in ratings reflect in part differences in the clientele that each county serves. Few statistically significant changes in offenders from the start of treatment were identified in the DuPage or Lake County programs by N-of-1 analyses. In Winnebago County, however, 18 statistically significant changes were identified indicating that offenders rated very low at the beginning of treatment tended to improve quite a bit during the six month

assessment. For the most part, however, offenders were slow to change, which is not surprising given that sexual offending is based on attitudes and behaviors of a long-standing nature and that the treatment time examined covered only six months.

Additional indicators of treatment performance are percentage of offenders with no unexcused absences (DuPage County, 64.3%; Lake County, 63.0%; Winnebago County, 29.0%), percentage of offenders competing all homework (DuPage County; 71.4%; Lake County, 66.0%; Winnebago County, 23.0%) and percentage of offenders with at least one positive life change (DuPage County; 62.1%; Lake County 61.5%; Winnebago County, 38.0%). Winnebago County offenders as noted earlier typically live in poverty, have less than a high school education, and have committed felony crimes against related family members. Such offenders may be even slower to break denial and accept responsibility for the offense. On the other hand, Winnebago County therapists also conducted less thorough evaluations of their clients than therapists in the other two counties, and were less able to elicit additional inappropriate sexual acts that were not part of the official record during the evaluation process and during treatment.

Overall Conclusions and Recommendations

Our overall conclusion is that each of these programs successfully implemented their sex offender program that was designed to fit within the particular configuration of individual departments and environments. All three met basic requirements of the containment model in that they increased sex offender supervision/surveillance beyond that provided prior to receipt of grant funds. While each program provided more supervision than before, none, however, provided as much as expected. Each program implemented a well functioning system of sex offender treatment characterized by a team

approach of mutual respect and trust. Short-term probation outcomes and short-term treatment outcomes indicate that the majority of sex offenders in all three programs are complying with probation and treatment conditions that are part of their probation order.

No one program excelled in all three elements of the containment model but some programs did better than others at various elements. DuPage County was particularly notable in its use of bi-monthly probation officer/treatment provider group meetings to develop its team approach. The Lake County program's surveillance officer model resulted in the highest level of sex offender supervision contacts of all three programs, and its monthly statistical form was a model for all such programs. Winnebago County was the only program to focus on felony offenders, had the highest percentage of family-related offenses, and was the only program where all sex offenders on probation were handled by the two grant officers alone.

There were two aspects of each program that did not meet expectations. All three programs were unable to meet their individual home/field visit standards and to some extent, even their face-to-face contact standards. Secondly, treatment evaluations from treatment providers were of mixed quality in all three programs.

We offer a number of recommendations.

- **A revised program model should be considered following the Lake program model but with more realistic supervision/surveillance standards.**

- **Supervision/surveillance standards should be non-declining.**

- **The Authority and AOIC should work with the Illinois State's Attorneys Association to insure the greater participation of probation in state's attorneys decisions to recommendation probation especially for sex offender cases.**

- **Case selection and identification for sex offender programs should be made at the probation department level with a procedure implemented to revise probation orders as**

needed.

- **The Probation Division of the AOIC should expand its sex offender training program.**

- **The Authority should promptly develop and implement a uniform monthly data form to be used by all funded sex offender programs.**

- **The Authority should give serious consideration to extending the funding of each of these programs allowing for the adoption of a surveillance officer model in DuPage and Winnebago.**

CHAPTER VI

Longer-Term Impact Design For Northern Counties

The Loyola evaluation team is poised to begin a longer-term impact analysis of the Lake, DuPage, and Winnebago Counties. The process and short-term impact evaluation has provided critical information that informs our proposed impact design. Winnebago County's sex offender population and surveillance model are substantially different from the other two counties. Winnebago County also has less adequate information about the treatment needs of its sex offenders than the other two counties. DuPage County also differs from Lake and Winnebago County in a very significant way: a much higher proportion of defendants express remorse and accept responsibility for all major aspects of the crime at the initial treatment evaluation. Given these differences, an exclusively inter-jurisdictional comparison between counties on outcomes may distort the effectiveness of any one program. That is, population differences preclude using different counties as "comparable" control groups for the other counties.

We propose an equivalent control group design for the Lake and DuPage County programs. For Lake and DuPage County, we will collect a sample of 100 offenders who were sentenced to probation between September, 1995 and June, 1997.[62] We will attempt to match this sample on key predictor variables of recidivism including employment, income, education, prior criminal history, and offense type. We also will complete our collection of data to obtain a sample size of 100 offenders sentenced after September of 1997 when the grant programs began. For Lake County, we will only need to collect an additional 15 cases that can be obtained from cases sentenced in October of 1998. For DuPage County, we will need to collect an additional 51 cases, which caseload figures indicate that

[62] The Loyola evaluation team has used such a design in its evaluation of Cook County Sex Offender Program; for

we will need to collect all cases sentenced through the month of April, 1999. Given the smaller caseload of sex offenders in the Winnebago County program, the less informative casefiles, and the less intensive and nine to five supervision, we do not believe it would be cost-effective or informative to include a control group for this program in this evaluation. For the Winnebago County, we will collect an additional 50 cases sentenced during the grant program which will require us to collect all cases sentenced until April of 1999.

The within jurisdictional comparisons will focus on five outcome measures: (a) failure rates of new arrest for any crime; (b) failure rates for new arrest for sex crimes; (c) averaged time to new arrest for any crime; (d) averaged time for new arrest for sex crimes; and (e) whether a violation of probation petition was filed for treatment noncompliance. Survival analyses will be used to adjust for time at risk to reoffend, which will allow us to directly compare control and treatment samples.

In addition, we will collect additional intermediate outcome data for the treatment samples. The monthly treatment reports from treatment providers indicated stability from month to month for most offenders. Given this finding, we propose to collect treatment progress reports every two months to reduce the burden on treatment providers and to insure sufficient data collection on most clients. We will be asking the probation departments to incorporate such reporting as a part of their normal practice, and to urge treatment providers to convey information about additional inappropriate sexual behaviors/thoughts and positive lifestyle changes. These treatment reports will supplement the treatment reports collected for the short-term impact analysis, and N-of-1 analyses will be conducted to determine responsiveness for this extended period of treatment. Based on N-of-1 analyses and absolute criteria, we will classify offenders into responsive and unresponsive categories.

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that evaluation, the team has collected 208 control comparable felony cases and 75 ASOP cases.

The Loyola evaluation team will provide for each county, information about the predictors of treatment responsiveness, treatment noncompliance, and new arrests for the treatment sample. We will use univariate ODA analyses and CTA analyses with jackknife validity and efficiency analysis. We have already noted the advantages of these analyses over other analyses such as logistic, CHAID, or CART. The latest meta-analytic review of the research on predictors of recidivism in sex offender populations also indicates the need for nonlinear analyses (Hanson & Bussiere, 1998). The nonlinear CTA identifies clusters of offenders who have a high probability of recidivating whereas as other researchers (Hanson & Bussiere, 1998) have noted linear models do not provide information about how to combine the significant predictors. From these analyses, we will provide departments with recommendations about how characteristics can be combined to make judgments about risk of treatment noncompliance and new arrests. Based on the treatment providers' progress reports, we also will report on attendance rates, and homework completion rates in treatment.

Finally, Lake and DuPage Counties have unique outcome measure that can be assessed. In DuPage County, we can measure the number of maintenance polygraphs given and the results of these polygraphs, and the number of drug screens and results of these drug screens for our sample of 100 offenders. In Lake County, we can measure the number of admitted offenders to the administrative sanction program.

The univariate ODA analyses to determine the predictors of treatment responsiveness were very promising. In all three counties, clinical presentation variables such as prior mental health or drug treatment, level of remorse at evaluation, and level of accepting responsibility at the evaluation were the best predictors of therapists' ratings. The additional sample size and longer follow-up period will allow us to determine whether good clinical presentations actually are related to lower levels of noncompliance

while on probation and lower recidivism rates. In addition, for Lake County, we were able to construct a CTA model to predict serious noncompliance with treatment, which indicated that multiple paraphilia and psychopathic deviancy were the two best predictors of treatment noncompliance. This tentative model is very consistent with prior research conducted on sex offenders released from prison (see Hanson & Bussiere, 1998). For the longer-term impact analysis, we plan to measure treatment noncompliance and conduct CTA analysis to provide information about the factors that are related to a higher risk of treatment noncompliance.

In summary, the common outcome measures for all counties in treatment groups will be:

1. Failure rates for new arrests for any crime.
2. Failure rate for commission of new sex crime as measured by new arrest or self-report of offender to probation officer or therapist.
3. Failure rates for probation revoked.
4. Failure rates for serious noncompliance with treatment order.
5. Percentage of violation of probation petition filed and average number per offender.
6. Averaged time to first new arrest.
7. Averaged time to filing of violation of probation petition.
8. Averaged number of positive lifestyle changes and the types of changes.
9. Percentage of offenders who disclosed additional inappropriate sexual behavior/fantasies.
10. Percentage of offenders who attended all treatment sessions, and averaged total number of treatment sessions missed, and averaged number of missed treatment sessions with an unexcused absence.

11. Percentage of offenders who completed all homework assignments, and averaged number of homework assignments missed.

We will ask the probation departments to supply us with rap sheets on all sampled offenders at the cut-off date for opportunity to reoffend in order to assure that offenders have reported all arrests to the probation department. It will be critical that the probation departments check that offenders have not had new arrests in any states especially the states surrounding Illinois.

In addition to the static variables used in the short-term impact analysis, the Loyola evaluation team will use three measures to assess treatment participation, nature of treatment, and surveillance in its analyses of predictors of new arrest and treatment noncompliance: (a) averaged number of group therapy sessions attended; (b) type of treatment: group only, both individual and group, individual only; (c) averaged number of face-to-face contacts across three months of contacts; (d) averaged number of field contacts across three months; and (e) length of time in treatment. In making across-jurisdictional comparison. We will attempt to control for the strongest predictors of reoffense and treatment noncompliance by reporting rates for subsets of offenders.

The Loyola evaluation team would like to discuss the issue of length of time of the evaluation and time-frame for this outcome study. A recent study of the long-term outcomes of child molesters and rapists over a 25 year period indicates that the average time of new offense was 3.64 years for child molesters and 4.55 years for rapists (Prentky, Lee, Knight, & Cerce, 1997). Moreover, if their study had been restricted to the conventional 12 or 24 month period, they would have erred in their estimates of recidivism by approximately 45% for child molesters and 30% for rapists. The rates of recidivism begin to drop after the third year. Given that the treatment samples were collected between September 1997 and September 1998, we propose to conduct a eighteen month evaluation beginning

January 15, 2000 and ending July 15, 2001. The delay in start-up extends the time to reoffend for our proposed samples. The proposed time frame will allow us to collect the necessary data in one year, and to spend the remaining months in analysis and writing.

References

Administrative Office of Illinois Courts (1994). Probation Sex Offender Survey Results. AOIC, Division of Probation Services. Chicago, IL.

English, K., Pullen, S., Jones, L., & Krauth, M. (1996). A model process: A containment Approach. In English, K., Pullen, S., & Jones, L. (Eds). Managing Adult Sex Offenders: A Containment Approach. (pp. 2-1 to 2-45) Lexington, KY: American Probation and Parole Association.

Feinglass, J., Yarnold, P.R., Martin, G.J., & McCarthy, W.J. (1998). A classification tree analysis of selection for discretionary treatment. Medical Care, 36, 740-747.

Furby, L., Weinroll, M. R., & Blackshaw, L. (1989). Sex offender recidivism: A review. Psychological Bulletin, 105(1), 3-30.

Greenfeld, L. A. (1996). Child victimizers: Violent offenders and their victims. Washington, D.C.: U.S. Department of Justice (NJ-153258), Bureau of Justice Statistics.

Hall, G. C. N., (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. Journal of Consulting and Clinical Psychology, 63, 802-809.

Hanson, R. K. (1998). What do we know about sex offender risk assessment? Psychology, Public Policy, and Law, 4(1/2), 50-72.

Hanson, R. K., & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. Journal of Consulting and Clinical Psychology, 66(2), 348-362.

Heilbrun, K., Nezu, C. M., Keeney, M., Chung, S., & Wasserman, A. L. (1998). Sexual offending: Linking assessment, intervention, and decision-making. Psychology, Public Policy, and Law, 4(1/2), 138-174.

Harris, G. T., Rice, M. E., & Quinsey, V. L. (1998). Appraisal and management of risk in sexual aggressors: Implications for criminal justice policy. Psychology, Public Policy, and Law, 4(1/2), 73-115.

Jones, P. (1991). The risk of recividism: Evaluating the public safety implications of community corrections programs. Journal of Criminal Justice, 19, 49-66.

Knapp, M. (1996). Treatment of Sex Offenders. In English, K., Pullen, S., & Jones, L. (Eds). Managing Adult Sex Offenders: A Containment Approach. Lexington, KY: American Probation and Parole Association.

Lurigio, A.J., Jones, M., & Smith, B. E. (1995). Up to speed — child sexual abuse: Its Causes, Consequences, and Implications for Probation Practice. Federal Probation, 59, 69-76.

Lurigio, A. J., Seng, M., Ellsworth, T., & Weisheit, R. (1999). A comparative analysis of offenders on probation in Illinois,

Maletsky, B. (1990). Treating the Sexual Offender. Newbury Park, CA: Sage.

Mueser, K. T., Yarnold, P. R., & Foy, D. W. (1991). Statistical analysis for single-case designs. Behavior Modification, 15(2), 135-155.

Ostrander, R.,Weinfurt, K.P., Yarnold, P.R., & August, G. (1998). Diagnosing attention deficit disorders using the BASC and the CBCL: Test and construct validity analyses using optimal discriminant classification trees. Journal of Consulting and Clinical Psychology, 66, 660-672.

Prentky, R. A., Lee, A. F. S., Knight, R. A., & Cerce, D. (1997). Recidivism rates among child molesters and rapists: A methodological analysis. Law and Human Behavior, 21(6), 635-659.

Quinsey, V. L., Lalumiere, M. L., Rice, M. E., & Harris, G. T. (1995). Predicting sexual offenses. In J. C. Campbell (Ed.) Assessing Dangerousness: Violence in sexual offenders, batterers, and child abusers. (pp. 114-137) Thousand Oaks, CA: Sage.

Smith, B. E., Elstein, S. G., Trost, T., & Bulkley, J. (1993). The prosecution of child sexual and physical abuse cases. Final report, National Center on Child Abuse and Neglect. Washington, D. C.

Soltysik R.C., Yarnold, PR. (1993). ODA 1.0. Optimal data analysis for DOS. Chicago, IL: Optimal Data Analysis, Inc.

Soltysik, R.C., & Yarnold, P.R. (1994). Univariable optimal discriminant analysis: one-tailed hypotheses. Educational and Psychological Measurement, 4, 646-653.

Yarnold, P. R. (1988). Classical test theory methods for repeated measures N-1 research designs. Educational and Psychological Measurement, 48, 913-919.

Yarnold P.R., & Soltysik R.C. (in press). Optimal Data Analysis. Washington, D.C.: APA Books.

Yarnold, P.R. (1988). Classical test theory methods for repeated-measures N = 1 research designs. Educational and Psychological Measurement, 48, 913-919.

Yarnold, P.R. (1992). Statistical analysis for single-case designs. In F.B. Bryant, J. Edwards et al. (Eds). Social Psychological Applications to Social Issues, Volume 2, New York: Plenum Press.

Yarnold, P. R. (1996). Discriminating geriatric and non-geriatric patients using functional status information: An example of classification tree analysis via UniODA.

Educational and Psychological Measurement, 56, 656-667.

Yarnold, P. R., & Soltysik, R. C. (1991). Theoretical distribution of optima for univariate discrimination of random data. Decision Sciences, 22, 739-752.

Yarnold P.R., Soltysik R.C., & Bennett C.L. (1997). Predicting in-hospital mortality of patients with AIDS-related Pneumocystis carinii pneumonia: An example of hierarchically optimal classification tree analysis. Statistics in Medicine, 16 1451-1463.

Yarnold, P. R. (1992). Statistical analysis for single-case designs. In F. Bryant, J. Edwards et al. (Eds). Social Psychological Applications to Social Issues, Volume 2, New York: Plenum Press.

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