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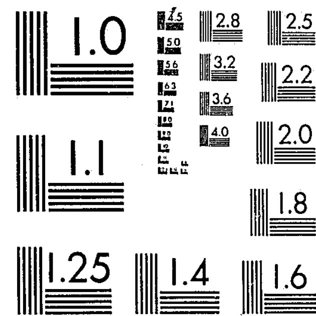

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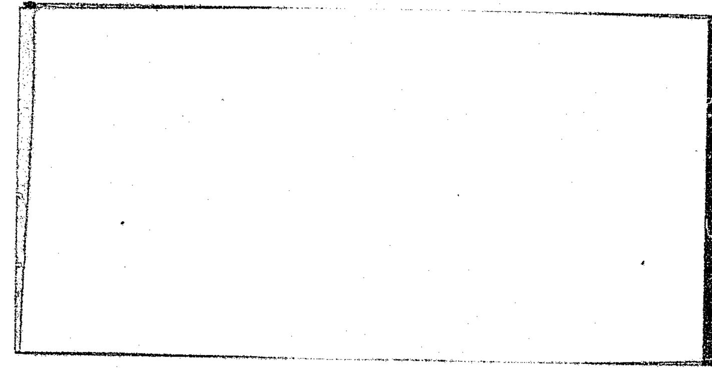

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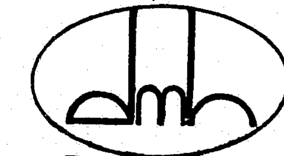

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AN EVALUATION OF PSYCHIATRIC COUNSELING FOR SEXUAL OFFENDERS IN STATE PRISONS

Final Report to the Legislature
in response to SB 1716

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June 6, 1980

NCJRS

JUN 29 1981

ACQUISITIONS

ACKNOWLEDGMENTS

The Department of Mental Health evaluation team which conducted this study wishes to thank the Department of Corrections for contributing to the successful completion of the project. Special appreciation goes to the following CDC staff for their interest in this evaluation, and for their efforts in providing important background information and in coordinating the site visits required for the study: Dr. J.R. Prest, Dr. L.I.C. Kim, Mr. C.C. Jew and Mr. Don Sorenson (California Medical Facility); Dr. James Hollingsworth (California Men's Colony); Dr. Bruce Dainard (San Quentin Prison); Mr. Denny Wipf (Folsom Prison); Mr. Alf Christensen and Mr. Dan Bird (Correctional Training Facility); Dr. Mel MacComper (Deuel Vocational Institution); Dr. Dick Heim (Southern Reception Center); Ms. Dona Goode (Management Information Section, CDC) and Dr. E.P. South (Chief of Medical Services, CDC).

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EXECUTIVE SUMMARY

Senate Bill 1716 (Robbins) mandated the State Department of Mental Health to conduct a study of psychiatric counseling provided for sexual offenders confined in California state prisons, and to submit the findings to the Legislature by July 1, 1980. SB 1716 operationally defined sexual offenders as inmates convicted of sexually aggressive crimes (rape, sodomy and oral copulation).

The research task set out by SB 1716 was both descriptive and evaluative. First, the number of sexual aggressives receiving psychiatric counseling was to be determined; second, any counseling or treatment provided was to be evaluated for adequacy and value. The first task was accomplished by having the treatment program administrators at correctional facilities report which of their sexual aggressives were in psychiatric treatment at the time of the study. The evaluative task was accomplished through a clinical review panel which visited six correctional facilities, interviewed samples of inmates and staff, and determined the extent to which treatment provided: (1) was consistent with current knowledge and clinical practice; (2) was regarded as helpful and relevant by the consumers; and (3) could be shown to be effective in reducing recidivism.

Most of the sexual aggressives receiving psychiatric counseling were at the two designated treatment facilities, California Medical Facility (CMF) and California Men's Colony (CMC). Over half (82/157) of the sexual aggressives at CMF were in active treatment at the time of this study, and approximately one fifth (60/305) of those at CMC were actively involved in therapy at that time. Treatment typically consisted of weekly group therapy sessions, which most inmates described as helpful but not necessarily relevant to the problem of sexual aggression which caused their incarceration. Neither institution had a treatment project, assessment procedure, or therapy group specifically designed for the sexually aggressive offender, and therapists at CMF and CMC were operating without the benefit of ongoing clinical supervision or specialized training in the area of treating sexual aggressives. Data regarding treatment outcomes (effects on recidivism) were generally unavailable to the panel conducting this study; such information will require continuing longitudinal study.

Of the four other institutions surveyed, only San Quentin Prison was carrying on an active psychiatric treatment program. Nearly 10% (13/143) of the sexual aggressives at San Quentin were in therapy, and most of those sampled rated their treatment as generally valuable and relevant. As at CMF and CMC, however, none of the therapists had specialized training in treating sexual aggressives, nor were they focusing directly on reducing the inmate's propensity toward sexual assault.

Less than 1% (2/325) of the sexual aggressives at Folsom Prison, the Correctional Training Facility (CTF), and the Deuel Vocational Institution (DVI) were in therapy at the time of the study. The policy at these three institutions was to identify and transfer inmates in need of therapy to the treatment facilities; however, 25% of the sexual aggressives interviewed at Folsom, CTF and DVI reported they were "very interested" in receiving treatment at the time of this study.

Two major recommendations are forwarded based on the information gathered in this study:

1. The active treatment programs at CMF, CMC and San Quentin are advised to improve their therapeutic interventions with sexual aggressives by: (a) intensifying treatment schedules; (b) employing interventions specifically designed for sexual aggressives; (c) organizing their treatment programs (e.g., systematically assessing inmates' needs and assigning the appropriate treatment components); (d) developing or hiring staff specialists to treat sexual aggressives and to supervise other therapists; and (e) measuring the relative effectiveness of the interventions which are provided. Collaborative projects among the Departments of Corrections, Mental Health and the California Youth Authority are also recommended to facilitate clinical training and outcome research designed to improve treatment programs for these offenders.

2. Folsom, CTF and DVI are advised to improve their evaluation and referral procedures, and to offer earlier and more direct services to inmates. Specifically, professional time should be increased and should focus on (a) developing criteria for the systematic identification and referral of inmates who need long-term treatment (offered at CMF or CMC), and inmates who need short-term, problem-specific therapies (which could be offered at all facilities); (b) designing, directing, and supervising short-term, offense-relevant group therapy programs; (c) training correctional counselors as co-therapists; and (d) supporting and supervising the development of inmate self-help programs.

I. Introduction

In recent years, public awareness and concern about the incidence of sexual assault have increased dramatically. As rape became the nation's fastest growing violent crime in the 1970's, and as more alarming statistics and sensational reports of sexual violence were published each year, the issue also became a major focus of the women's movement. Feminists began to challenge the effectiveness of the criminal justice system in deterring rape; as a result, a considerable amount of legislation has been recently enacted which supports the rape victim and facilitates conviction of the offenders.

Despite legal and social reforms, California Department of Justice figures for 1977-78 showed that most of the over 10,000 reported rapes a year were not resulting in arrest or conviction, and that most rapists who were convicted of felonies were not going to prison. In 1978, 2105 arrest dispositions were made for adults on forcible rape charges, and 954 of these ended in convictions. Of those convicted, 366 were convicted of rape, 181 of other sexual offenses, and 407 of other (non-sexual) offenses. A total of 55.9% (534) of those convicted received some form of probation (probation only or jail and probation), while 27.9% (267) went to prison.

These statistics, coupled with increased publicity regarding brutal crimes committed by known offenders on probation or parole, resulted in further measures to reduce recidivism. One obvious way to limit the number of rapes committed each year by known offenders is to "get tough" on these men by keeping them in prison longer. The California Legislature has been active in this area, and recent enactments have provided both mandatory and longer prison terms for convicted rapists. A second approach is to seek rehabilitation of convicted rapists by providing psychiatric counseling to reduce their proclivity toward sexual aggression. Unfortunately, few data exist regarding the effectiveness of such counseling or psychotherapy with rapists, and no evaluation studies of the counseling services in California prisons have been available.

In 1979, the Legislature authorized the Department of Mental Health to conduct a study of such therapies. SB 1716 (Robbins) directed the Department to determine the number of convicted sexual offenders in California state prisons who are receiving psychiatric counseling, and to evaluate the adequacy and value of that counseling (see Appendix A). The bill defined sexual offenders as those convicted of violating Sections 261 (rape), 286 (sodomy) or 288 (a) (oral copulation), of the California Penal Code. It also required that the Department transmit its findings to the Legislature prior to July 1, 1980. The following sections of this report describe the methods used in the study, and present the major findings, conclusions, and recommendations of the Department of Mental Health evaluation team.

II. Project Objectives and Methods

Objectives

The research task set out by SB 1716 was both descriptive and evaluative. First, it required that the "number of sexual offenders confined in State prisons who are receiving psychiatric counseling" be determined. Second, it required that the psychiatric counseling provided be evaluated as to its "adequacy and value".

Definitions of Terms Employed in the Study

1. Sexual Offender/Sexual Aggressive: As specified in the legislation, a sexual offender is a person convicted under any of the following California Penal Code Sections:

   PC 261 Rape
   PC 286 Sodomy
   PC 288(a) Oral Copulation

   Since concern about the effectiveness of treatment with inmates who used force in commission of the crime was determined to be fundamental to the intent of this legislation, violations which were committed without the element of force were excluded from this definition, and the term "sexual aggressive" is used in the text instead of "sexual offender".

2. Psychiatric Counseling: Any intervention of a behavioral or psychotherapeutic nature carried out by a psychiatrist, psychologist, social worker, counselor, or rehabilitation therapist or by other persons under supervision of above listed professional. Such counseling must be part of a formally conducted program which keeps records. Casual contacts, spontaneous interventions, and counseling focused only on vocational or institutional programming issues were excluded from this definition. In order to avoid confusion with non-psychiatric services provided by most "correctional counselors", the terms "therapy" or "treatment" are used in place of "counseling" in this report, and those providing psychiatric services are referred to as "therapists" or "treatment personnel/staff".

3. Adequacy and Value: The extent to which provided psychiatric counseling or treatment: (a) is consistent with current knowledge and clinical practice, in terms of intensity, relevance, professional expertise, and program organization; (b) is regarded as helpful and relevant by the consumers; and (c) has been shown to be effective in terms of inmates' postrelease performance (e.g., in reducing recidivism).

Procedures

Before this study began, approval was obtained from the State's Institutional Review Board and from the Health and Welfare Agency's Committee for the Protection of Human Subjects.

The number of sexual aggressives receiving treatment in State prisons was determined by: (1) obtaining from the Department of Corrections a list of all sexual aggressives in California correctional facilities; and (2) obtaining from the treatment program administrator at each institution a list of those sexual aggressives who were receiving psychiatric treatment.

The evaluation of the treatment provided was performed by a clinical review panel which included Department of Mental Health staff, and consultants employed by the Department specifically for this study. The panel which reviewed the designated treatment facilities (California Medical Facility and California Men's Colony) consisted of:

Janice Marques, Ph.D., Department of Mental Health (CMC only)
William DeRisi, Ph.D., Department of Mental Health
Gene Abel, M.D., Columbia University
David Fisher, Ph.D., New Mexico State Hospital
Ray Hosford, Ph.D., University of California, Santa Barbara

The remaining correctional facilities were reviewed by Dr. Marques, Dr. DeRisi, and Mr. James Stratten, a retired member of the California Youth Authority Board. All reviews were conducted between August and October, 1979.

The reviewers conducted a 1-3 day site visit at each facility which consisted of: (1) an introductory meeting with the superintendent (or his designee), the chief psychiatrist (or treatment program administrator), and other interested administrative or treatment personnel; (2) structured interviews with a sample of inmates in therapy; (3) structured interviews with all available treatment staff; (4) a review of inmate records; (5) a tour of treatment facilities; and (6) an exit interview with those listed under (1) above, to provide initial feedback regarding the panel's findings. At those facilities with less active treatment programs (involving less than 10% of the sexual aggressives), interviews were also conducted with a sample of inmates who were not in therapy.

The purpose of the study was explained to the sampled inmates and staff before the interviews began, and written, informed consent was obtained from all inmates in the study. The inmate consent form is presented in Appendix C, and the outlines used for the structured interviews are presented in Appendix D. For inmates in treatment, the interview focused on obtaining their descriptions of treatment, and their evaluations of its relevance and effectiveness. For those not in treatment, a needs assessment interview was conducted, in which the inmate was asked about his interest in therapy and about possible treatment goals and benefits. The staff interviews focused on obtaining the therapist's description of his/her specialty areas, most effective treatment techniques, and knowledge about the treatment of sexual aggressives.

Sampling

The population of sexual aggressives from which this study's samples were drawn is represented in Table 1. As is shown in the table, nearly 80% of

this population resided in the six institutions listed. Most of the remaining 20% were in one of the two reception centers, and a few were in other correctional facilities and camps.

TABLE 1

Location of Sexual Agressives in California Department of Corrections Facilities as of May 31, 1979

Institution	Rape-Force	PC 288(a)	PC 286	Totals	Percent of All Sexual Aggressives
CMF (Vacaville)	136	21	0	157	13.2%
CMC (San Luis Obispo)	255	41	9	305	25.7%
San Quentin	125	14	4	143	12.0%
Folsom	85	13	4	102	8.6%
CTF (Soledad)	140	15	6	161	13.6%
DVI (Tracy)	55	4	3	62	5.2%
Sub-Total	796	108	26	930	78.3%
Sexual aggressives in other correctional institutions and reception centers				258	21.7%
Total sexual aggressives:				1,188	100.0%

A list (by ID number) of the sexual aggressives in each of the institutions listed in Table 1 was obtained from the Department of Corrections, and the treatment program administrator at each facility was asked to indicate which of these inmates were in treatment. For the designated treatment facilities (California Medical Facility and California Men's Colony), a random sample of 10% of those in treatment was selected. For each of the remaining four facilities, a 10% sample of all the sexual aggressives was selected. Included in this sample were all of the sexual aggressives in treatment at the institution, and a random sample of those who were not in treatment.

After the sample was selected, the treatment program administrator (or his designee) met individually with the selected inmates to ask if they were interested in participating. Those who indicated interest were scheduled to meet with one of the clinical review panel members during the site visit. A total of 98 inmates were seen by the panel, 92 of whom formally consented and participated in the study.

The sample of treatment staff at each facility included the Chief Psychiatrist (or treatment program administrator), and all of the therapists who were available during the site visit. With the exception of CMF, (where 25% of the staff were interviewed), over 70% of the therapists at each facility participated. A total of 41 treatment staff were interviewed in this study.

Methodological Limitations of the Study

Two methodological issues must be considered before the results of this study are interpreted. The first concerns the representativeness of the samples included in the evaluation. Since inmate samples were randomly selected from lists of those convicted of PC 261, 286, and 288(a), there is no reason to suspect bias in this representation. As Department of Corrections staff frequently noted during the site visits, however, many rapists have been convicted of lesser or non-sexual offenses (e.g., assault or burglary). Thus, the definition of sexual aggressives by their conviction codes resulted in the systematic exclusion of those with "silent beefs".

The extent of this problem is estimated in the figures shown in Table 2. As was noted in the Introduction, 954 adults were arrested for forcible rape and convicted in California courts during 1978, 267 of whom went to prison. Although a majority (588/954) of those arrested for forcible rape were convicted of non-rape offenses (primarily assault), most (188/267) of those who went to prison were convicted of rape. Thus, 70% of those going to prison were identified as rapists, while the remaining 30% went to prison on non-rape offenses, or "silent beefs". It is important to note, however, that the samples included in this study consisted only of identified sexual aggressives in prison, and may not be representative of this 30%.

The second methodological consideration is that of process vs. outcome evaluations. Because of time constraints and the limited inmate tracking data available, the present evaluation could not include the measurement of treatment outcomes. The focus was on process variables, and the findings reflect the extent to which the programs studied were rated as useful by their consumers and were consistent with current knowledge and standards of clinical practice. Although the process approach is a well-accepted evaluation strategy, it does not directly measure the effectiveness of a program. Thus, while this study closely examined the treatment provided, and systematically evaluated its adequacy, the results cannot answer the critical question of whether these treatments reduce the inmate's likelihood of raping again. Continuation of the study on a longitudinal basis would be necessary to provide such information.

TABLE 2

ADULTS ARRESTED FOR FORCIBLE RAPE OFFENSES

AND CONVICTED IN CALIFORNIA COURTS, 1978
(BY CONVICTED OFFENSE)

CONVICTED OFFENSE

	TOTALS	HOMICIDE	FORCIBLE RAPE	ROBBERY	ASSAULT	BURGLARY	THEFT	MOTOR VEHICLE THEFT	DRUG LAW VIOLATIONS	KIDNAP	OTHER SEX	ALL OTHER
Total Convictions	954	0	366	18	234	40	5	1	10	9	181	90
Guilty Plea	781	0	243	14	211	37	5	1	10	8	168	84
Jury Trial	140	0	105	4	18	2	0	0	0	1	8	2
Court Trial	30	0	17	0	4	1	0	0	0	0	4	4
Trial by Transcript	3	0	1	0	1	0	0	0	0	0	1	0
Sentence	954	0	366	18	234	40	5	1	10	9	181	90
Prison	267	0	188	12	18	17	0	0	0	6	23	3
Youth Authority	33	0	23	0	4	1	0	0	0	0	5	0
Probation	132	0	5	0	53	3	0	0	0	0	40	31
Probation With Jail	402	0	107	6	125	17	5	1	6	3	93	41
Jail	55	0	3	0	29	1	0	0	2	0	9	11
Fine	7	0	0	0	1	0	0	0	2	0	1	3
CRC	1	0	0	0	0	1	0	0	0	0	0	0
MDSO	55	0	40	0	3	0	0	0	0	0	12	0
Other	2	0	0	0	1	0	0	0	0	0	0	1

III. Designated Treatment Facilities: California Medical Facility (CMF)
California Men's Colony (CMC)

A. Introduction

Two facilities have been designated as the primary centers for psychiatric treatment in the Department of Corrections: the California Medical Facility (CMF) and the California Men's Colony (CMC). CMF, located near Vacaville, has the largest treatment staff and the most comprehensive program of psychiatric services in Corrections. Programs which have been developed at CMF include those for: (1) actively psychotic inmates in need of hospitalization; (2) effeminate homosexuals requiring segregation; (3) psychotics in remission; (4) inmates in need of psychiatric or neurological observation; and (5) inmates considered amenable to and in need of group psychotherapy. The latter three programs are also offered at CMC, near San Luis Obispo. About half of CMC is devoted to psychiatric programming, with staffing similar to that at CMF; the other half is focused on education, vocational training, and industrial operations.

Although these two facilities house less than 20% of California's 22,000 inmates, nearly 40% of those with sexually aggressive crimes were in CMF or CMC at the time of this study. Over half (462/930) of the sexual aggressives in the six institutions studied were in these two facilities, and 90% of those who were in therapy at the time of the study were being treated at CMF or CMC. The overrepresentation of sexual aggressives in the designated treatment facilities suggests that more of these offenders meet the Department of Corrections criteria for assignment to psychiatric programs. Thus, although the Department's Classification Manual does not instruct Reception Center or Classification staff to systematically refer this group of offenders for treatment, the data suggest that sexual aggressives are more likely to be placed in a treatment facility than are other offenders.

Because of the concentration of sexual aggressives and treatment programs at the two designated treatment facilities, the most extensive site visits were conducted at these institutions. At CMF, a four-member clinical review panel interviewed 15 inmates and 6 staff over a two-day period. A three-day site visit was conducted at CMC, during which five panel members interviewed 29 inmates and 11 staff. The following section of this report presents the panel's findings, conclusions and recommendations regarding the treatment of sexual aggressives at these two facilities.

B. Findings, Conclusions and Recommendations

1. Extent of Treatment

Findings

a. Number of inmates in program. Over half (82/157) of the sexual aggressives at CMF were in active treatment at the time of the study; approximately one-fifth (60/305) of those at CMC were in treatment at that time.[1]

None of the staff at these two facilities described any organized attempts to recruit more therapy candidates, either in the general population or among the subpopulation of sexual aggressives. At CMF, staff reported that waiting lists precluded recruitment; at CMC, staff explained that many inmates, particularly rapists with prior therapy experience, refused treatment when recruited. Members of the Peer Counseling Program (an inmate self-help organization) at CMC, however, did report recruiting new participants for their program. Approximately half of the inmates interviewed reported that they were prompted by staff to enter therapy, and the others reported that they volunteered. Though most had recalled some staff member having suggested counseling, the inmates indicated that the decision was their own. One inmate reflected the feeling of many of those interviewed when he said, "Why not go to counseling, after all, I got the time. It's a way to burn time." Very few inmates reported that their participation in therapy resulted in any harassment from staff or other inmates.

b. Frequency and types of sessions. Most inmates in treatment at both facilities were seen in groups of 4-20 members, which met once a week for 1½-2½ hours. Over half of the inmates at CMF reported that their group leaders were psychiatrists or psychologists. At CMC, the majority of group sessions were classes conducted by inmates in the Peer Counseling Program. At both institutions, less than one fourth of the inmates were being seen in individual therapy sessions, which were typically conducted by professional staff.

[1] These figures represent the number of inmates who were regularly attending group or individual therapy sessions at the time of this study, as reported by the treatment program administrators. It should be noted that some staff members expressed concern that the reported figures underestimated the extent of treatment provided, because: (a) inmates in the diagnostic program (Category D) were not included; (b) inmates in the psychotic programs were not included (unless they were regularly attending group or individual sessions); and (c) some of the services provided by counseling and psychology interns were excluded since the survey was conducted during the summer break. At CMC, staff estimated that the effect of excluding these categories was minimal; at CMF, however, staff estimated that if all diagnostic and treatment categories were included, the percentage of sexual aggressives "in treatment" would have exceeded 75%.

c. Treatment resources. CMF had ample facilities for both individual and group sessions. Professional staff at CMC had private offices, but limited space was available for interns (who shared offices) and for the Peer Counseling groups. Treatment resources at CMF included 18 professional staff and 11 Correctional Counselors; CMC's psychiatric services staff consisted of 12 professionals, plus 8-12 student interns for 9 months a year. CMC also had an established Peer Counseling Program, which provided group counseling and which was separate from, but under the supervision of, the psychiatric services. The Peer Counselors reported that, although some staff referred inmates to them, their program received little attention or support from the psychiatric services.

Conclusions

Over half of the sexual aggressives at CMF and approximately one fifth of the sexual aggressives at CMC were actively involved in therapy. Neither institution emphasized the recruitment of more therapy candidates, although the Peer Counselors at CMC recruited members for their groups.

Therapy for most inmates consisted of weekly two-hour group sessions, a treatment schedule more typically found in outpatient clinics than in intensive or inpatient treatment programs. Most groups at CMF were conducted by professionals, while at CMC most were led by inmates in the Peer Counseling Program.

Recommendations

In order to improve the extent to which treatment for sexual aggressives is provided at CMF and CMC, added staff are needed to improve inmate recruitment procedures and to intensify treatment schedules. Recruitment should involve: (1) inmate orientation, through providing detailed information about the availability, function, and objectives of the various types of treatment offered; and (2) inmate screening, in order to identify and contact those inmates who are most likely to benefit from the specific treatment components which are available.

Both programs should be expanded to provide more intensive treatment schedules and to expose each inmate to all treatment components which are relevant to his specific problem areas. Data regarding the effectiveness of the various types of treatment offered (including the Peer Counseling Program classes at CMC) should be used to determine which parts of the program are to be increased.

2. Adequacy of Treatment

Findings

a. Value of treatment. The majority of inmates at both CMF and CMC reported that the discussions in their therapy sessions were generally more helpful than not. Individual therapy contacts were typically rated as more helpful than group sessions. Although most inmates were in general agreement with the goals and direction of treatment, their descriptions of therapeutic goals were often vague, and many reported entering treatment without a clear idea of what they wanted from it. A few harbored the hope that their participation in therapy might earn them an earlier release date.

When asked how they would change the treatment program at their institution, inmates most frequently requested: 1) more structure and less "just talk"; 2) more frequent sessions; 3) more opportunities for individual therapy; and 4) more qualified therapists. A sample of inmate responses follows:

1. "The counselors shouldn't let us just talk about anything. We wander all over the place. They ought to lead. I never know where the counselor is coming from."

2. "Make counseling so I could understand what it is I am supposed to do. I came to counseling because I had a problem. It looks like no problems are going to get worked on except how to get by in here."

3. "I am seeing a student intern. She is nice. But what does she know? I know more than she does. I would like to see someone who knew what they were doing."

The issue of therapists' qualifications was most often raised by CMC inmates who had seen student interns. Several of these inmates questioned whether the interns were there to help or to learn about prison life.

The staff members interviewed for this study were divided on the issue of how valuable their treatment procedures were for sexual aggressives. Although some believed their efforts were successful, more were unsure about this, particularly those who received no systematic feedback regarding therapy outcomes. Many therapists expressed reservations about the effectiveness of traditional counseling methods, and frustration about the lack of time or resources available for improving their skills and learning new treatment approaches.

b. Relevance of treatment. Inmates were asked to rate the relevance of their treatment goals to their committing offenses, using a scale of one (relevant) to five (irrelevant). The composite score was 2.5, with approximately one fourth of the inmates indicating that therapy was irrelevant to their offenses. A sample of inmate comments follows:

1. "Talk was about everything and nothing, so I quit."
2. "It was explained to me you could bring up your problem and what got you in here. But then the meeting kind of fell apart. We got into stuff that did't seem to have anything to do with anything."
3. "The group was like a class on how to apply concepts. I'd say it was kind of helpful."
4. "For awhile I was getting a lot out of it then it turned into a lot of bullshit."
5. "We didn't deal with sex too much, but I think I was helped a lot by learning to control anger and I'll probably be a better parent because of counseling."
6. "I got to really talk about myself. It was mostly about my future after leaving here. I felt I really got something out of it."
7. "Rape was never discussed."

Although inmates frequently described their goals in terms of avoiding future sexual offenses, they rarely described the focus of therapy as being on ways to reduce their propensity toward rape. At CMF, most inmates found it relatively easy to discuss their offenses in therapy sessions, while over 75% of the CMC inmates indicated it would be "very difficult" to do so, primarily due to concerns about confidentiality and the reactions of other (nonsexual offender) inmates.

Neither institution had a treatment project, assessment procedure, or therapy group specifically designed for the sexually agressive offender. Although a number of therapists were experienced or had attempted to improve their skills by reading or attending therapy workshops, none had specialized in the treatment of sexual aggressives or had obtained any intensive training in this area. A few therapists reported focusing on the inmates' perceptions of rape and attitudes toward women, and others reported using some techniques which are considered by experts in the area to be important components of a comprehensive treatment program for rapists

(e.g., decision-making strategies and anger management/self-control skills).[1] In general, however, most therapies followed a generalist model rather than tailoring specific techniques to specific inmate needs or to the problem of reducing the individual's thoughts and fantasies about rape. Most of the treatment staff stated that rapists were merely members of their groups, and that the techniques used with them were the same as those used with all inmates, regardless of offense. For many therapists, this was due to their belief that treatment issues are similar across all types of offenders; for others, it was due to a lack of interest or expertise regarding the treatment of sexual offenders. Some therapists also feared that differential treatment of these offenders might result in their being identified and victimized by other inmates.

c. Organization and Focus of the Program. Neither of the designated treatment facilities presented a conceptual framework within which the treatment of sexual aggressives was planned, conducted or evaluated. Although various treatment components were offered, these were not organized into a program which identified goals, objectives, and appropriate treatment plans for this type of offender. Sexual offenders were not distinguished from other inmates in the treatment system, and were not assigned to specific therapists or treatment activities as a result of their offenses.

Although CMF interviewed all inmates to evaluate their amenability to treatment, neither facility had systematic procedures for: 1) matching inmates with particular counselors; 2) defining which individuals are seen on an individual and/or group basis; 3) prescribing specific treatment components based on the inmates' specific needs; 4) assessing the inmates' progress in therapy; or 5) defining the criteria for successful termination of treatment. The treatment staff reported that their program operated on a private practice model (each therapist having his/her own clients and preferred techniques), rather than on a comprehensive or structured treatment model which prescribed services based on the assessment of inmate needs.

[1] See Appendix B for a description of a comprehensive approach to the treatment of rapists, or Brecher (1978) for a review of current programs for sex offenders.

With the exception of the internship programs at these facilities, which provided supervision of students' therapy activities, there was no evidence of ongoing, systematic clinical supervision of treatment staff. Some therapists reported discussing cases with colleagues, but most operated in relative isolation and lacked a clear picture of how their individual efforts related to the overall goals of the program or the institution. The staff at both facilities reported that little time and/or resources were provided for upgrading their professional knowledge and skills. Although weekly clinical seminars were held at CMF, there was no reported inservice training specifically on the treatment of sex offenders. Most therapists were at both facilities were unfamiliar with recent developments in this field.

At CMC, therapists received no systematic follow-up data on inmates they had treated. At CMF, however, one staff member had developed an inmate tracking system for this purpose, and was providing recidivism data for therapists on a regular basis.

Conclusions

Most inmates interviewed at the two designated treatment facilities found their therapy sessions to be generally helpful to them, but had difficulty specifying their treatment goals. A range of treatment interventions was found, most of which were generalist approaches and did not specifically address the problem of sexual agression which caused the inmates' incarceration.

Both treatment programs operated on a private practice model, rather than on a structured, prescriptive treatment model. Neither had a clear conceptual framework, a procedure for assessing the inmate's specific needs and therapeutic progress, or a system for coordinating the various treatment components offered. Most staff who treated sexual aggressives were operating without the benefit of specialized training or ongoing clinical supervision. At CMC, since outcome (e.g., recidivism) data were not available to therapists, the staff were also not given an opportunity to test the accuracy of their clinical predictions or to assess the effectiveness of their interventions.

Recommendations

Both facilities need to organize their overall treatment programs, and to offer therapies specifically designed for sexual aggressives as well as therapies which follow a generalist model. Developing an adequate treatment program for rapists will require the allocation of considerable resources to : 1) define the goals of the program and of each component offered; (2) train staff in the use of interventions specifically designed for this type of offender; (3) provide

systematic pre-and post-treatment assessment of the individual inmate's problem areas to guide assignment to appropriate treatment components and to facilitate program evaluation; and (4) provide explicit criteria for inmates regarding how they can successfully complete the program. A specialist in the treatment of sexual aggressives should be employed to guide the development, implementation, and evaluation of the program.

Provisions must be made to allow the sexually aggressive offender to work on the problems which caused his incarceration, both in individual and group therapy settings. Groups specifically for these offenders, in which confidentiality is strictly maintained, would facilitate this. More attention should also be given to including interventions which have been developed to modify the inappropriate cognitive and behavioral patterns of rapists (e.g. covert sensitization, social skills training, anger management). This is not to suggest that only behavioral therapies should be employed, but that behavioral components should be included in a comprehensive treatment program for these offenders (see Appendix B).

In addition to program development, both CMF and CMC need to focus on staff development. They should draw upon the considerable resources available in the state by developing ongoing liaisons with each other, Atascadero State Hospital, and other programs treating the sexual offender. Inservice training and structured clinical supervision are needed to improve the staff's knowledge of existing treatment modalities. In-house specialists in the treatment of sexual aggressives should also be developed. At CMC, supervision of interns and Peer Counselors must be intensified to insure that they are providing quality services as well as learning clinical skills. Internal and external reviews should be periodically scheduled at both institutions not only to maintain standards but to promote staff communication and the development of an integrated program in which each member sees the importance of his/her contribution.

If programs are to improve, they must have current data on what types of inmates, receiving what kinds of treatments, are likely to succeed (i.e., not re-offend) after their release. The CMF staff involved in developing a data monitoring system should be supported, and CMC should also begin to compile inmate and treatment statistics in order to assess the effectiveness of their various treatments in reducing recidivism. It is recommended that the State make every effort to provide such a follow-up system for these programs as well as others which are treating sexual aggressives.

Finally, collaborative projects among the Departments of Corrections, Mental Health, and the California Youth Authority should be implemented to facilitate clinical training and outcome research designed to improve the effectiveness of treatment programs for these offenders.

IV. Other Correctional Facilities: California State Prison, San Quentin
California State Prison, Folsom
Correctional Training Facility (CTF)
Deuel Vocational Institution (DVI)

A. Introduction

Although the heaviest concentration of sexual aggressives was found in the designated treatment facilities at the time of this study, significant numbers of these offenders were housed in four other correctional facilities: the California State Prisons at San Quentin and Folsom, the Correctional Training Facility (CTF) at Soledad, and the Deuel Vocational Institution (DVI) at Tracy. Of these four, only San Quentin offers intensive psychiatric treatment. According to the Department of Corrections' Classification Manual, inmates who are in need of psychiatric observation or can benefit from intensive outpatient care may be placed at San Quentin if otherwise suitable for the institution. In addition to psychiatric services, San Quentin offers specialized academic and vocational training, intensive medical and surgical care, and security housing for inmates unable to adjust to the general population.

Folsom Prison, described in the Classification Manual as the state's maximum security institution for older recidivists in need of intensive custodial supervision, offers educational and vocational programs but no ongoing psychiatric treatment. Although the hospital has a small psychiatric unit, services are limited to short-term interventions, and inmates in need of intensive therapy are transferred to one of the treatment facilities. The Manual describes similar policies on psychiatric transfers for CTF and DVI. CTF, a cluster of three facilities near Soledad, is designed for inmates suited to medium custody and to academic and vocational training or industrial assignments. It is not staffed to provide psychotherapy or to treat the psychotic. DVI is also designed for inmates in need of academic and vocational programming rather than those requiring psychiatric care. Young men who cannot be managed in juvenile institutions but who are too immature for adult prisons are typically placed in this facility.

Since these four facilities had significant numbers of sexual aggressives but few in treatment, the site visits were briefer than those at CMF and CMC, and included interviews with inmates who were not in therapy. The three-member clinical review panel collected data for two days at San Quentin, and one day at each of the other three institutions. Interviews were conducted with eight of the San Quentin psychiatric staff and 15 inmates, 11 of whom were in treatment at the time of the study. At Folsom, six correctional counselors, one psychiatrist, and 10 inmates who were not in treatment were interviewed. Four correctional counselors and 15 inmates, one of whom was in treatment, were included in the sample at CTF. At DVI, interviews were conducted with both of the mental health professionals at that facility and with eight sexual aggressives, none of whom was in treatment. The panel's findings, conclusions, and recommendations regarding the treatment provided (or needed) at these four facilities are presented in the following section.

B. Findings, Conclusions, and Recommendations

1. Extent of Treatment

Findings

a. Number of inmates in program. Slightly under 10% (13/143) of the sexual aggressives at San Quentin were in active treatment at the time of the study. Only two of the 325 sexual aggressives confined at the other three facilities were in treatment: 1/102 at Folsom, 1/161 at the Correctional Training Facility (CTF), and 0/62 at the Deuel Vocational Institution (DVI).

At San Quentin, potential therapy clients were recruited and screened by a correctional counselor who: (1) reviewed records of incoming inmates to find those with current psychiatric referrals, histories of psychiatric disorders, or particularly violent crimes; and (2) interviewed these inmates to determine their amenability to treatment.

Administrators at both CTF and DVI stated that if more treatment were offered at their facilities, it would not focus on the sexual offender, but on inmates presenting management problems within the institution. None of the staff at Folsom, CTF or DVI reported any plans to intensify the treatment offered to inmates or to provide any specific programs for sexual aggressives. Reasons given for not treating these offenders included: (1) the institutions lack the necessary professional staff and treatment facilities; (2) the milieu is not therapeutic (e.g. not conducive to open discussions of offenses and problems); (3) sexual offenders might be victimized by other inmates if identified in therapy groups; (4) these facilities are not designated as treatment institutions by the Department of Corrections; and (5) sexual offenders do not typically present management problems, and thus would not be the most important group to treat.

b. Frequency and types of sessions. At San Quentin, group therapy was the most common type of service provided for sexual aggressives, but nearly half of those interviewed were in individual therapy, and one inmate had both group and individual sessions. The typical treatment schedule was weekly sessions of 1-2 hours, with individual sessions usually lasting 1 hour and groups 1½-2 hours. The two sexual aggressives in therapy at Folsom and CTF were also in groups which meet weekly for 1½-2 hours.

c. Treatment resources. Offices suitable for individual therapy were provided at San Quentin, but the staff shared a single group therapy room in the psychiatric services area. The other three institutions also provided individual offices for professional staff, but groups were typically held in classrooms or other areas not specifically designated as therapy rooms.

The treatment staff at San Quentin consisted of 5 full-time psychiatrists, 2 psychologists, and 4 correctional counselors. At CTF, there were no full-time mental health professionals on staff, and evaluations were performed by a consulting psychiatrist. Folsom and DVI each had two professionals, whose primary duties were to write diagnostic and evaluative reports, monitor psychotropic medications, facilitate transfers for inmates in need of treatment, and intervene in psychiatric emergencies. Although these professionals maintained a small caseload of selected individual therapy clients, none was seeing any sexual aggressives at the time of the study. Most inmates who were identified by the professional staff as needing treatment at these two facilities were referred for transfer to CMF or CMC. The staff at Folsom, however, reported that inmates with long sentences were rarely transferred for treatment until near the end of their terms.

Each of the institutions had a Counseling Center, or staff of correctional counselors, in addition to the psychiatric personnel. With the exception of the 4 correctional counselors at San Quentin who were on the psychiatric services staff, and one counselor at CTF who led the "behavior modification" group, these individuals provided counseling which was not psychiatric but institutional in nature. Each counselor was assigned 150-200 inmates, and handled most of the administrative casework and custody tasks related to these men (e.g., attending Classification and Adult Authority meetings, planning vocational and educational programs, investigating disciplinary actions and appeals, advising inmates regarding institutional procedures). Although the correctional counselors did not define themselves as therapists, some inmates were unclear about the counselors' roles, and expected them to provide psychological or psychiatric services.

d. Needs assessment. A random sample of sexual aggressives who were not in therapy participated in interviews at each of the four institutions. When asked whether they would be interested in entering a therapy program at their facility, 25% said they would be "very interested", and another 25% said they would be "not at all interested". The remaining 50% were between these extremes, describing themselves as unsure, or more typically, as interested in therapy if it were provided under certain conditions (e.g. if therapists were professionals, or the content of sessions was confidential). A sample of inmate comments follows:

1. "If I could have one-to-one sessions, I'd get into counseling here."
2. "I would be interested in a group of sex offenders, if it wasn't too boring."
3. "I'd be interested in it if the counselors were professionals. They shouldn't have too much police in them".
4. "Yes, if the group wasn't superficial and if they would keep what we say out of the mainline."
5. "No, I don't have a sexual problem."

More inmates at Folsom were interested in therapy than were those at the other two institutions.

Conclusions

Of the four facilities covered in this section, San Quentin had the largest and most active treatment program. The San Quentin psychiatric services staff were treating nearly 10% of the sexual aggressives at that institution, with most of those inmates receiving 1-2 hours of therapy per week. Recruitment efforts focused on selecting violent offenders, as well as those with psychiatric referrals.

Less than 1% of the sexual aggressives confined at the other three facilities (Folsom, CTF and DVI) were in treatment, and none was being seen by the professional staff at the time of the study. The role of the mental health professional at these institutions was primarily that of evaluator, not therapist. The correctional counselors also did not typically do therapy, but functioned as administrative caseworkers; however, inmates were often unclear about their counselors' roles, and expected them to help with psychological problems. Administrators at these three institutions indicated that they had no plans to intensify their treatment programs, and intended to continue the policy of transferring those in need of therapy to the designated treatment facilities. The needs assessment interviews, however, found that approximately one-fourth of the sexual aggressives would be "very interested" in therapy if it were offered at Folsom, CTF and DVI.

Recommendations

The San Quentin program should expand its recruitment procedures and improve its accessibility in order to offer more sexual aggressives an opportunity for treatment. Inmates with sexually aggressive offenses should routinely be included among those who are selected for interviews upon their arrival at San Quentin, and should be given instructions regarding how to contact a therapist if they decide later to pursue treatment.

If possible, treatment schedules for sexual aggressives in the San Quentin program should also be intensified in order to maximize their exposure to relevant treatment components.

While it is not feasible to suggest that the other three institutions develop major treatment programs, two areas of psychiatric service should be intensified. First, the process by which an inmate without a psychiatric referral from the reception center can later be considered for therapy or transfer to a treatment facility should be streamlined, and should be explained to inmates during orientation. The role of correctional counselors should also be clarified at that time. At present levels of professional staff, all inmates cannot be evaluated on a regular basis; however, the correctional counselors should be given clear criteria to use in selecting which inmates to refer for a professional assessment of their treatment needs. Also, sexual aggressives with lengthy sentences should not be excluded from treatment early in their terms if they are motivated for therapy. Second, since it is unlikely that all inmates who are amenable to treatment can be transferred to the treatment facilities, more in-house therapy must be offered. If possible, professional staff should be increased to offer some direct service as well as supervision of paraprofessionals who serve as group leaders or crisis counselors.

2. Adequacy of Treatment

Findings

a. Value of treatment. Nearly all of the inmates in treatment at San Quentin described their therapy sessions as more helpful than not, and over half agreed with the goals which had been set in their treatment programs. The one inmate in treatment at CTF who was interviewed also reported that his group sessions were helpful to him. When asked how they would change the treatment program, San Quentin inmates most often suggested increased contact with the therapists, either through making the psychiatric service area more accessible, or through developing a longer and more structured program with more frequent meetings.

The therapists interviewed for this study varied greatly in both their theoretical orientations and opinions regarding the effectiveness of their interventions. Since they received no systematic feedback regarding therapy outcomes, the staff reported that they relied on informal or intuitive data sources in evaluating the therapeutic impact of their interventions.

b. Relevance of treatment. Since a majority of the San Quentin interviewees denied their committing offenses, many did not answer the question of whether their treatment goals were relevant to their offenses. Most of those responding to this question rated their therapy as relevant, although the goals they described more often concerned broad personality changes than sexual aggression. A

majority of the San Quentin inmates reported they found it relatively easy to discuss their offenses in therapy. Again, however, many of these discussions were not about the inmate's commission of rape, but about the circumstances under which the inmate was erroneously accused, arrested, or convicted of a sexual assault. The inmate in treatment at CTF also maintained he was innocent, but described his therapy as relevant to a "temper control" problem which had contributed to his arrest.

None of the four institutions had a treatment component specifically for sexual aggressives, although in previous years San Quentin's staff had included a therapist who specialized in treating these offenders. This staff member, who worked at the institution for nearly 30 years, had developed a long-term structured group program for sexual aggressives which focused on the inmate's offense and on the development of controls and alternatives to sexual aggression. This therapist's program was highly regarded by both inmates and staff, but ended with his retirement in 1978. Since that time, none of the therapists at San Quentin has specialized in treating sexual aggressives, although most have worked with these offenders. Those who were interviewed generally focused on the attitudes and feelings underlying sexual aggression or criminality rather than on the sexually aggressive behavior itself. Most therapists did report, however, that they include impulse control as a therapeutic goal. At Folsom, CTF and DVI, most of the therapists interviewed were not treating any rapists at the time of this study, and those who had worked with sexual aggressives did not report using any techniques specifically designed for these offenders. The correctional counselor at CTF who led the "behavior modification" group focused on teaching anger management skills to aggressive offenders of all types. Another correctional counselor at CTF had proposed a group program specifically for rapists, but was not allowed to start the program because of administrative concerns about the lack of professional supervision available at the institution.

The samples of inmates at Folsom, CTF and DVI who were not in treatment were asked if they believed therapy could help them avoid re-offending. Responses of inmates at CTF and DVI were equally divided on this question, with half of the interviewees answering "yes". At Folsom, however, where most of the interviewees were repetitive offenders with lengthy sentences, over 2/3 believed that therapy could help them avoid future offenses.

c. Organization and focus of the program. According to the San Quentin staff who were interviewed, their program has focused on identifying and treating the most dangerous and most disturbed inmates in the institution. Inmates selected in the screening process (those with psychiatric referrals, histories of psychiatric disorder, or extremely violent crimes), and inmates in crisis situations, were systematically referred to the therapist assigned to their living area. This therapist then determined the type of therapy which was provided, conducted the treatment, and evaluated the inmate's progress. The therapists at San Quentin had a number of required duties (e.g. testing, medication monitoring, crisis management, board reports), but reported having from 25-50% of their time available for therapy sessions. None reported any ongoing clinical supervision of his/her work, although all written reports were reviewed by the Chief Psychiatrist. A consultant from Langley-Porter met with the staff for a bi-weekly case conference (at which the treatment of sexual aggressives had been discussed), but no formal inservice training on this topic was reported by the San Quentin staff. The Chief Psychiatrist stated that the $1000 training budget covered only the continuing education required for professionals to maintain their licenses. Although some of the staff had used their own resources to pursue outside training, none reported completing any specific training on the treatment of sexual offenders. Most therapists were not familiar with recent developments in this area, or with treatment approaches currently in use at other state facilities and programs in the country.

According to the staff at Folsom, CTF and DVI, their programs focused on evaluation and referral rather than on treatment. The professionals who were interviewed reported that most inmates who came to their attention and who were in need of ongoing psychiatric treatment were transferred to CMF or CMC. Although the professionals were required to evaluate some inmates (e.g., "lifers" and convicted child abusers) during their terms in prison, most inmates were not seen unless they were referred by other staff members. The staff reported that most of these referrals were from correctional counselors, who handled requests for therapy from inmates and investigated incident reports. Many of the staff viewed inmate requests for therapy as more often manipulative than sincere; that is, the inmates were seen as wanting to get into another institution (CMF or CMC) rather than into treatment. According to one adminsitrator at CTF, the fact that many transfers began with inmate requests, often resulted in the most verbal and assertive inmates getting treatment.

Conclusions

At San Quentin, a majority of the sexual aggressives in treatment regarded their therapy sessions as generally helpful, and their treatment goals as relevant to their offenses. Most therapists and inmates, however, described therapy sessions which focused on attitudes and feelings presumed to underlie sexual aggression or criminality, rather than on the inmate's specific thoughts and fantasies about rape. Numerous therapeutic orientations were represented, but none of the San Quentin therapists had specialized in the treatment of sexual aggressives.

Although San Quentin's program included a systematic intake process and regular case conferences, it was not a structured or prescriptive program. Its organization basically followed a private practice model, with therapists managing their own cases and using their preferred techniques. No formal inservice training on the treatment of sexual aggressives had been provided, nor were therapists given systematic feedback regarding therapy outcomes.

Since only one of the inmates interviewed at Folsom, CTF and DVI was in therapy, no conclusions about the adequacy of treatment at these facilities could be drawn. Psychiatric services generally focused on assessment and referral, and inmates who appeared in need of ongoing treatment were transferred to CMF or CMC. At CTF, one correctional counselor was conducting a group for aggressive inmates, but other specialized therapy groups were not offered at these three facilities. Slightly over half of the inmates who were interviewed believed that therapy could help them avoid reoffending.

Recommendations

Recommendations for the San Quentin program are essentially the same as those for the designated treatment facilities (see Section III B). Providing adequate treatment for sexual aggressives will require the development of a systematic program with evaluation and treatment components specifically designed for these offenders. Treatment plans should be based on an assessment of the individual's problem areas and should include all relevant treatment components, particularly those which focus on the problems which caused the inmate's incarceration. A specialist in the treatment of sexual aggressives should be developed or added to the staff in order to offer components specifically for these inmates and to provide inservice training and supervision for other therapists working with sexual aggressives. The San Quentin program should also join with CMF and CMC in the development of a follow-up data system to assess the effectiveness of the various treatment approaches in reducing recidivism among sexual aggressives.

As was recommended under the "Extent of Treatment" section, Folsom, CTF and DVI should streamline and improve their evaluation and referral procedures, as well as offer more direct services for inmates who are not transferred to treatment facilities. Criteria for the systematic identification and referral of inmates who are in need of long-term treatment (which is offered at CMF or CMC), and inmates who could benefit from

short-term, problem-specific therapies (which could be offered at Folsom, CTF and DVI) must be developed. Given existing staffing patterns, little or no ongoing individual therapy can be provided at these three facilities. Professional time could be used, however, to develop and supervise group treatment programs which are both relevant and cost effective. For example, a number of groups could be formed which address specific deficit areas (e.g., assertiveness, heterosocial skills, self-control, anger management), and which follow a time-limited format. "Booster" sessions could then be scheduled near the release dates of inmates who finished a program earlier in their terms.

Optimally, professional staff at Folsom, CTF and DVI should be increased in order to effectively develop and direct programs such as those described above. If therapy resources remain limited, efforts should be made to: (1) focus on treating high priority problems (those closely related to the inmates's offense); (2) provide sufficient training and supervision to allow correctional counselors to function as group leaders and co-therapists; and (3) encourage the development of inmate self-help groups by providing staff support and supervision.

APPENDIX A

Text of Senate Bill No. 1716

CHAPTER 1311

An act relating to a study of convicted sexual offenders.

(Approved by Governor September 28, 1978. Filed with Secretary of State September 28, 1978.)

LEGISLATIVE COUNSEL'S DIGEST

SB 1716, Robbins. Study of convicted sexual offenders: psychiatric counseling.

Under existing law, there is no provision requiring the State Department of Mental Health to conduct a study to determine the number of convicted sexual offenders in state prisons who are receiving psychiatric counseling and to evaluate the adequacy and value of such counseling.

This bill would require the Department to conduct such a study. It would require the Department to transmit a copy of the study to the Legislature no later than July 1, 1980.

This bill would specify that the study shall be made by utilizing existing resources of the Department.

The people of the State of California do enact as follows:

SECTION 1. The State Department of Mental Health shall conduct a study to determine the number of convicted sexual offenders in state prisons who are receiving psychiatric counseling and shall evaluate the adequacy and value of such counseling.

For the purposes of this section, a sexual offender is a person who has been convicted of a violation of Section 261, 286, or 288a of the Penal Code.

The State Department of Mental Health shall transmit a copy of the study to the Legislature no later than July 1, 1980.

The study shall be made by utilizing existing resources of the department, provided that to the extent federal funds are available, such funds shall be used in lieu of state budgeted funds.

The following pages (25-36) contain material protected by the Copyright Act of 1976. (17 U.S.C.): Common Elements of Current Treatment Programs for Rapists, Appendix B, An Evaluation of Psychiatric Counselling for Sexual Offenders in State Prisons; Final Report to the Legislature in Response to SB1716.

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APPENDIX B

COMMON ELEMENTS OF CURRENT TREATMENT PROGRAMS FOR RAPISTS

Gene Abel, M.D.

Before an adequate review of treatment programs for sexual aggressives in California correctional facilities could be undertaken, it was first necessary to determine what standard treatment(s) existed for sex offenders throughout the United States. This was not an easy task because although treatment programs are available, few have been described in sufficient detail to enable one to understand what is actually being done for the rapist. Furthermore, minimal attempts have been made to examine the common elements of treatment offered by these various programs.

Most treatment programs attempt to include seven major elements.[1] The first is the establishment of an empathetic relationship between the patient and therapist. Whether the treatment is psychodynamically oriented,[2-3] pastoral counseling,[4] milieu therapy,[5] or a group therapy strategy,[6-9] the importance of a warm, accepting relationship between the rapist and therapist is seen as a necessary prerequisite for treatment effectiveness.

A second component involves confrontation regarding the rapist's responsibility for his rape behavior. The manner in which the offender is confronted ranges from marathon group therapy in which offenders are given videotape feedback of their disclosures,[6] to very direct verbal feedback from staff and others.[7] Boozer reports that isolating the offender with other rapists also confronts the rapist's denial of being responsible for his own rape behavior.[5]

Psychodynamically-oriented psychotherapists use a less direct means of confronting the patient.[2-3] The therapist explores with the patient his unconscious motivations that lead to rape behavior. Through insight regarding antecedent conflicts the rapist realizes that the unconscious motives are his own motives, and, therefore, he is ultimately responsible for his rapes.

Pastoral counselors who treat offenders are frequently faced with individuals who deny responsibility for their actions by claiming that a mystical, religious understanding occurs during their deviant behavior.[4] They may also feign a religious conversion as evidence that they have changed their rape behavior. The pastoral counselor confronts the patient with his denial system and magical thinking, and uses the patient's religious beliefs in a more constructive manner to identify what he is actually going to do to prevent himself from raping in the future.[4]

Behavior therapy programs require a very active participation in treatment by the patient. The patient is confronted with, and made responsible for his behavior as a prerequisite for this type of treatment, since it is his behavior that must change.

Although confrontation regarding one's responsibility for the rape is seen in all therapies, as with the first treatment component, no studies have been reported with rapists to evaluate how important this component is for effective treatment.

Heterosocial Skills training is a third component found in a majority of treatment programs. Skills training involves the teaching of social interaction skills to sexual offenders as a means of facilitating appropriate interaction with adult females (or males). Although rapists may have adequate sexual arousal to females, unless they are versed in conversation, "flirting", and other dating behaviors that are prerequisite to explicit sexual activity, they will be unsuccessful at establishing a sustained relationship with a woman.

Group therapy programs allow the offender the opportunity to learn to relate to other people in a safe, supportive atmosphere where he can view and practice basic skills of interacting with males or females.[5,9-10] Boozer has emphasized the importance of the rapist developing social skills specifically with women and consequently hires only female attendants as part of the treatment staff.[5]

Pacht has also attempted to teach rapists heterosocial skills by enlisting female staff as confederates and requiring the patients to "ask out" and "date" (within the confines of the prison) female staff members.[11-12] Both Pacht[12] and MacDonald[8], however, have addressed the problem that is inherent in implementing such social skills training in a prison system. Incarceration in most treatment facilities inherently provides minimal opportunity for such social encounters, since there are typically only a few female staff members in most forensic units. Nonetheless, most treatment programs for rapists see heterosocial skills training as a valuable component of a total treatment program.

In some cases, rapists are very unskilled in how to proceed during sexual intercourse with a woman. They may be aroused to adult females and know how to talk to women, but due to a lack of sexual knowledge, or in a few cases, because of specific sexual dysfunctions (impotence), they are unable to perform. Most treatment programs have a fourth component, sex education or sexual dysfunction treatment. This component is similar to sex education/sexual dysfunction treatment for any type of client, except that it is conducted with rapists in a prison setting. The standard sex education or Masters and Johnson treatment programs are implemented.

A fifth component involves assertive training. Some rapists have marked difficulties asserting themselves with others. For example, the rapist may become angry with his wife, but rather than express that anger directly to her, he leaves the house, seeks out an unknown woman and rapes her, as an expression of anger originally meant for his wife.

One treatment to correct this inappropriate expression of anger is called assertive training. The rapist practices with a therapist in a controlled setting, role playing and modeling appropriate expressions of emotion, feelings or requests for others to change their behavior. As the rapist learns successful methods of interacting with others, he no longer needs to inappropriately express his anger by raping innocent victims. Other treatments, including anger management and self-control programs, have also been developed to help sexual aggressives avoid expressing anger in inappropriate or violent ways.

A number of rapists fail to have adequate heterosexual arousal to adult females. Therefore, a sixth component of treatment includes generating or increasing heterosexual arousal to adult females. Some rapists indicate that mutually enjoyable or consensual intercourse is not erotic to them and that the elements of force or coercion are a prerequisite to their sexual arousal.[17]

Psychoanalytically oriented therapists view heterosexual fears as the basis for sexual aggression.[2-3,18-19] Treatment thus involves exploring with the patient the genesis of his fear of women. It is assumed that once the patient understands the counterphobic nature of his rape behavior he will be able to establish a nonaggressive, sexual union with an adult female and a reduction of his rape behavior will naturally follow.

Behavior therapy has developed a number of specific techniques to help patients generate sexual arousal to activities that were formerly non-erotic to them. Some of the more effective types of treatment include masturbatory conditioning, exposure, fading and systematic desensitization. Each of these particular methods has been validated by controlled studies as highly effective at helping the patient develop a new arousal pattern when needed.

Decreasing sexual arousal to rape is the seventh and final component and should be a major objective of all treatment programs dealing with rapists. Some programs are more direct in accomplishing this goal than others.

Group therapy programs rely on a variety of self-control methods, confrontation, catharsis, and testimonials to decrease deviant sexual arousal. Chemical and surgical castration have been employed to reduce sexual drive as a deterrent to rape.[20] Chemical agents such as cyproterone acetate or medroxyprogesterone, which functionally cause a depletion of testosterone and a declining sexual drive, have also been used to decrease urges to rape.[21-23]

A variety of specific methods have been developed to decrease the rapist's urges to rape women. Each is designed to help the rapist gain control over his aggressive impulses by thoughts of rape taking on a negative valance. These methods include:

(1) Electrical Aversion. Although numerous case reports show that patients who block their deviant fantasies improve, McGuire, Carlisle and Young[24] were the first to suggest direct intervention at the fantasy level to block the use of deviant fantasy during genital arousal. McGuire et al, systematically investigated the histories of a large group of sexual deviates, identifying the content of fantasy during genital arousal. Of their group of 52 sexual deviates, 79 percent reported the use of deviant fantasies during genital arousal. McGuire suggested that, since deviant arousal is maintained by the constant pairing of deviant fantasies with orgasm, treatment may only need to involve these deviant fantasies, utilizing a technique such as aversion to extinquish the deviant fantasy's arousing qualities.

In a report of 14 cases of various sexual deviations, McGuire and Vallance report the results of electrical aversion applied to the subjects' deviant fantasies.[25] Relying on the subjects' report at the time of one-month follow-up, the authors reported good improvement or actual elimination of the deviant behavior in 71 percent of the cases.

Only five other case studies have been sufficiently controlled to allow some interpretation of the effects of blocking deviant fantasies. Marks and Gelder[26] and Marks[27] describe the results of aversing subjects' deviant fantasies and deviant acts in the treatment of a series of transvestites and fetishists. All the subjects who were treated successfully stopped using deviant fantasies during genital arousal; the one clear failure continued to use deviant fantasy throughout treatment.

Gelder and Marks[28] and Marks, Gelder, and Bancroft[29] report a two-year follow-up of 24 sexual deviates who were treated with electrical aversion. Transvestites, fetishists, and sadomasochists all significantly improved as measured by a reduction in their use of deviant fantasies and behaviors, whereas seven transexuals failed in all measures. Although occasional transient relapses of deviant behavior occurred with the successfully treated cases, this relapse was quickly controlled without further treatment.

Marshall, in studies conducted in Canada, has reported on the treatment of 12 patients with various sexual deviations including rapist.[30] All patients were treated simultaneously with electrical aversion to fantasies of deviant behavior chains assisted by audiotape descriptions and slides, and orgasmic reconditioning. The results, presented as grouped data, show a significant decrease in deviant arousal and a significant increase in arousal to heterosexual fantasies.

Marshall and Williams[31] have reported further data from a combination behavioral treatment program for rapists in prison. Groups of sexual aggressives, primarily rapists and pedophiles, were treated with either a combination of behavioral techniques including electrical aversion, masturbatory conditioning, systematic desensitization and social skills training, or standard psychodynamically-oriented group psychotherapy. Sexual arousal to deviant and nondeviant cues was assessed prior to and after tratment. As a group, those receiving the combination behavior treatment showed significant decreases in deviant arousal and significant increases in nondeviant arousal as measured objectively. The group receiving psychotherapy showed no change in arousal patterns. When this group was subsequently given the combination of behavior treatments, they showed improvements equal to the first group.

(2) Covert Sensitization. The second principal means of reducing urges to rape has involved using aversive imagery as a noxious stimulus. Covert sensitization involves the exclusive use of imagined stimuli, pairing the patient's fantasy of his usual deviant behavior with scenes considered to be aversive to the subject, e.g., images of pools of fecal material, vomitus, or bleeding lacerations.

Barlow, Leitenberg, and Agras measured the effects of pairing of aversive fantasied scenes with two patients' sexually deviant fantasies.[32] Their results indicated that the subjects' report of deviant fantasies and their subjective arousal to deviant cues were significantly reduced by covert sensitization.

Callahan and Leitenberg compared electrical aversion with covert sensitization in six patients,[33] and found both treatments to be equally effective.

(3) Chemical and Olfactory Aversion. In two other forms of aversion therapy the noxious stimulus has been either the feelings of nausea caused from injections of apomorphine or emetine, or the unpleasant odors from certain substances. Work in both areas has been rather limited with only a few case reports of successful application having appeared.

(4) Masturbatory Satiation. A final method used to control the patient's urges to rape is called masturbatory extinction. The method is based upon the theory that rapist's maintain their urges to rape by frequently recalling their prior rapes during genital excitement. In this manner, images of rape are frequently associated with genital arousal and orgasm. Thoughts of rape thereby maintain their arousal properties over time, since a single rape experience provides the fantasies for numerous associations between fantasies of rape and orgasm.

Masturbatory extinction disrupts this association. During the treatment the rapist recalls his numerous rape fantasies after he has ejaculated, and thereby associates them with masturbation that cannot lead to orgasm. The rape fantasies thus become exceedingly boring to the rapist, he no longer finds himself attracted to urges to rape and thus, gains control over his rape behavior.

The importance of treatments to help the rapist control his urges to rape is that of all the potential elements of treatment, control of the urges to rape is most closely associated with rape behavior. Without this particular element of treatment, the likelihood of the rapist recommitting his crime remains high. Fortunately, many varieties of treatments to reduce these urges have been demonstrated in controlled studies to be

highly effective. Furthermore, some of them (covert sensitization and masturbatory satiation) have a very low possibility of ethical abuse, which permits their use in prisons where the possibility of ethical abuse is high.

Conclusion. Table 1 outlines the seven potential treatments for rapists. Any one rapist may need one, two, three or even all seven treatments to be effectively treated. It is the responsibility of any institution treating rapists to evaluate each individual rapist and determine which of these potential treatments is needed, to then offer that treatment and finally, evaluate if the treatment has been effective. It is only through such an integrated treatment program that the rapist can be effectively treated and return to the community as a productive citizen.

Table 1

Treatment for Rapists

		Excess or Deficit	Treatment Methods
	1.	Deficient empathetic relationships	Establish patient/therapist rapport
	2.	Rapist does not feel responsibility for his rapes	Confrontation
Social Skills Deficits	3.	Heterosocial skills	Heterosocial skills training
Social Skills Deficits	4.	Sexual performance	Sexual dysfunction treatments
Social Skills Deficits	5.	Assertive skills	Assertive training/anger management
	6.	Deficient arousal to nonrape, sexual stimuli	Generation of arousal to nonrape cues 1. masturbatory conditioning 2. exposure 3. fading 4. systematic desensitization
	7.	Excessive arousal to rape stimuli	Aversion-suppression methods 1. covert sensitization 2. electrical aversion 3. odor aversion 4. chemical aversion 5. masturbatory satiation

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APPENDIX C

INFORMED CONSENT - INMATES

A. Description of the Project

The California Department of Mental Health is conducting an evaluation of psychiatric counseling that is provided to persons who are now in state correctional facilities. We are especially interested in the reaction of persons convicted under Section ________________ of the Penal Code. We understand that you were convicted under this statute.

The purpose of this study is to give the State Legislature basic information concerning the amount and quality of the counseling being given in CDC institutions. The legislature may want to change the way in which counseling is provided but we have no way of predicting how or even if they will change it at all.

B. Procedures to be Followed

We will ask for two things. First, we will want you to agree to be interviewed by a person who will be writing the report to the Legislature. This person will be asking you about your experiences with counseling in CDC. We want to know what you think about counseling programs in CDC as you see them. Second, we will want your permission to examine your file. We are interested in your history as it is written there and in any record of counseling that may exist. All information we obtain in the interview and from records will be strictly confidential. No information which could identify you will be reported to anyone in the Department of Corrections. The people who will be doing the interviewing and records review are not employees of Corrections; they have been hired from outside the state system to do this evaluation. Any notes or other materials having identifiers will be destroyed.

C. Potential Discomforts or Risks

(1) Discomforts
The interviewer may ask questions which may make you uneasy. These questions may involve your committing offense or other items concerning your history. You may decline to answer any question about which you feel uneasy.

(2) Risks
There is some risk that if the final report is critical of CDC, persons who volunteered could be held responsible by CDC staff. Also, if the report is negative, it is possible that counseling programs in CDC might be reduced or eliminated.

Members of the evaluation project will take every precaution to reduce or eliminate these risks and discomforts. All persons on this project are required to sign an Oath of Confidentiality. Violation of this confidentiality is a violation of this State's Welfare and Institutions Code and is punishable by a heavy fine for each offense.

Please do not give information to me concerning any past actions for which you could be prosecuted. Information obtained in these interviews would not be protected from subpoena under existing law.

D. Benefits

A possible outcome of this project is that the State Legislature will increase or improve the counseling being provided in CDC.

You will, by consenting to be interviewed, have your attitudes and feelings about psychiatric counseling in CDC included in a report to the State Legislature.

E. Alternative Procedures

If you wish to give your opinions about counseling in CDC but do not want to be interviewed, you may write your comments, place them in a sealed envelope and mail them to:

William J. DeRisi, Ph.D.
Department of Mental Health
Research and Evaluation Branch
P.O. Box 254829
2260 Park Towne Circle
Sacramento, California 95825

F. Questions Concerning Project

The project staff will answer any questions you might have concerning this project and your participation in it. If you have further questions, you may call Doctor DeRisi, collect, at (916) 920-7161.

G. Withdrawal of Consent

You may withdraw your consent to participate in this project at any time without prejudice. There will be no consequences to you if you choose to withdraw.

H. Refusal to Participate

If for any reason you do not wish to participate or if you feel that your safety or well-being may be jeopardized, you may refuse this request to participate.

I. Consent

I have read the above statements or they have been read and explained to me. I agree to participate in this survey.

Signed:________________________

PSYCHIATRIC COUNSELING EVALUATION

INTERVIEW OUTLINE - INMATES

The items below are topics to be covered by project interviewer with inmate subjects. Verbatim questions are not given since interviewers will want to use their own interview styles in posing the questions.

ITEM	RATING	COMMENTS
A. Descriptive Data		
(1) Length of time in this institution		______________________
(2) Length of incarceration for this episode		______________________
(3) Length of time in counseling		______________________
B. Recruiting for Counseling		
(1) How was inmate recruited for counseling (a) volunteered - no prompting by CDC staff (b) prompted by CDC staff (c) prompted by other inmates (d) prompted by other person		
(2) Did CDC staff ever recommend or suggest that you enter counseling? (a) No (b) Yes. If so, ____ Times Per Month		
(a) how was this done?		______________________
(b) how often and over what period of time?		______________________

ITEM | RATING | COMMENTS

C. Description of Counseling Process

(1) What is the schedule of counseling sessions?

(a) sessions per month ______

(b) minutes per session ______

(2) How are sessions staffed?
(a) do you know if that person conducting the counseling is a psychiatrist, psychologist, social worker, correctional officer, etc?

(b) what other staff (M.D., Ph.D., M.S.W., etc.) are also present?

(3) How many other inmates are typically in each session with the inmate?

D. Inmate's Evaluation of Counseling

(1) Are the discussions of problems and experiences of others in the group helpful to you?

1 2 3 4 5
Not At All — Very Helpful

(2) Is it difficult or easy to talk about your sex offense in these sessions?

1 2 3 4 5
Very Difficult — Very Easy

(3) Can the inmate identify his therapeutic goals and/or objectives?

1 2 3 4 5
Not At All — Completely

ITEM	RATING	COMMENTS
(4) Does the inmate know what he has to do to successfully terminate therapy?	1 2 3 4 5 Not At All ... Absolutely	
(5) Does he see his goals as being relevant to his committing offense?	1 2 3 4 5 Relevant ... Irrelevant	
(6) Does he agree with the goals and general direction of the treatment?	1 2 3 4 5 Not At All ... Completely	
(7) Would the inmate like the goals to be different? List These: ____________________ ____________________ ____________________		
(8) Who originally set the goals?	1 2 3 4 5 Change Agent ... Client	
(9) Does the inmate see this counseling as having potential value for him in controlling or changing his behavior: (a) inside the institution? (b) outside the institution?	(a) 1 2 3 4 5 (b) 1 2 3 4 5 Not Valuable ... Very Valuable	

ITEM	RATING	COMMENTS
(10) Are you hassled by inmates because you are in counseling?	1 2 3 4 5 Tremendous Pressure ... Not At All	
(11) Are you hassled by staff because you are in counseling?	1 2 3 4 5 Tremendous Pressure ... Not At All	
(12) What would the inmate change about counseling here?		

PSYCHIATRIC COUNSELING EVALUATION

INTERVIEW OUTLINE - INMATES NOT IN TREATMENT

The items below are topics to be covered by project interviewer with inmate subjects. Verbatim questions are not given since interviewers will want to use their own interview styles in posing the questions.

ITEM	RATING	COMMENTS
A. Descriptive Data		
(1) Length of time in this institution ____ months.		____
(2) Length of incarceration for this episode ____ months.		____
(3) Ever had psychiatric evaluation/counseling in CDC? ___No ___Yes (Describe)		____
B. Recruiting for Counseling		
(1) Did CDC staff recommend or suggest that you enter counseling ___ no ___ yes		____
If so, (a) how was this done ____		
(b) how often and over what period of time? ____		
C. Assessment of Inmates's Needs/Interest		
(1) Would you be interested in entering a counseling program here? 1 2 3 4 5 Not At All ... Very Interested		____

ITEM	COMMENTS
(2) If you entered counseling, what problems would you most like to work on?____	
(3) What would be your personal goals for counseling?	
(4) Do you think counseling would help you avoid reoffending? ___no ___yes If so, how?____	

PSYCHIATRIC COUNSELING EVALUATION

INTERVIEW OUTLINE - STAFF INTERVIEWING

WHAT TECHNIQUES DO YOU USE HERE WITH RAPISTS?	WHICH INTERVENTIONS HAVE BEEN FOUND TO BE EFFECTIVE IN TREATING RAPISTS?	WHICH TREATMENT TECHNIQUES MIGHT PROVE OF VALUE IF USED HERE?	WHAT ARE YOU DOING TO IMPROVE YOUR SKILLS IN THIS AREA?

IF ONE OF YOUR RELEASED INMATES SEES A WOMAN AND CONTEMPLATES RAPING HER, WHICH OF YOUR TREATMENT INTERVENTIONS WILL PREVENT HIM FROM RAPING HER? HOW?

END