Sex offenders who do not complete treatment have been shown to have a higher rate of reoffending compared to those who do complete treatment. A previously conducted meta-analysis concluded that only anti-social personality disorder is a reliable and consistent predictor of non-completion. Clinician expertise is a vehicle through which to expand current knowledge of what might influence being selected for and completing treatment. This study is a qualitative study utilizing a focus group of 4 clinicians with 78 years of combined expertise in sex offender treatment. Grounded theory was used to analyze the results and a 90% inter-rater reliability level was achieved. Eight themes emerged that influenced the clinicians’ selection process that addressed individual, logistical, and contextual factors including the number of infractions incurred over the previous year, logistical factors affecting admission, such as release dates, outside support from other individuals, and overt signs of interest. Several factors identified by the clinicians were not included in the list used in the meta-analysis, including group cohesion or outside support, indicating that there may be unexplored factors that have not been included to date in the current literature. Additional implications for research and practice are discussed.

INTRODUCTION

Sexual violence is a serious public health problem (Bonnar-Kidd, 2010). The World Health Organization (WHO) has identified the rapidly escalating
rates of sexual violence as a global health crisis, noting that nearly 20% of all women and 5–10% of men were sexually abused as children (Krug, Dahlberg, Mercy, Zwi, & Lorenzo, 2002). WHO also reports that at least 33% of physically violent acts are accompanied by sexual violence. Creating effective treatment programs to prevent sexual reoffending by convicted offenders is an essential step towards the goal of decreasing the incidence of sexual violence and there is a growing body of research that indicates that sexual offender–specific treatment programs do reduce recidivism rates (Duwe & Goldman, 2009; Hanson et al., 2002; Lösel & Schmucker, 2005).

Although these outcome studies report encouraging results, participants only benefit from them if they complete the treatment. Unfortunately, there is a high treatment drop-out rate among this population (Larochelle, Diguer, Laverdière, & Greenman, 2011) and research has shown that those sexual offenders who do not complete treatment are more likely to offend than those who do (Hanson et al., 2002; Lösel & Schmucker, 2005). As such, it is essential to not only provide effective treatments, but also to provide treatment that will encourage individuals to remain in treatment and complete it.

This study’s aim is to contribute to the research on retention rates in sex offender treatment programs by adding to the knowledge regarding screening factors or protocols that may ensure a higher completion rate. Using the expertise of four experienced clinicians, this study will present the findings of a qualitative study that is based on a focus group where they discuss the screening protocols used to predict successful retention in a prison-based sex offender treatment program.

LITERATURE REVIEW

As mentioned previously, sex offenders have a high treatment non-completion rate and these individuals are more likely to offend when compared to those who complete treatment (Hanson et al., 2002; Lösel & Schmucker, 2005). In an effort to understand this issue further, a number of studies have been conducted to identify reliable and valid predictors for non-completion. In a meta-analysis of these 18 studies, Larochelle and colleagues (2011) found that the number of non-completers ranged from 15% to 86% among the different studies. The authors state that “discontinuation of treatment among sex offenders constitutes a major problem” and that “it is essential to identify the characteristics that affect TNC (treatment non-completers) among sex offenders” (p. 559). Yet, in their meta-analysis, the only characteristic that consistently predicted non-completion was a diagnosis of antisocial personality disorder (APD).

In the report of the meta-analysis, the potential predictors of treatment of non-completers among sexual offenders were separated into four broad
categories (Larochelle et al., 2011). These included: demographic and contextual variables (included age, education, employment status, income, marital status, amount of pressure to participate in treatment, previous treatment, and sexual victimization); criminality (included legal status, sexual offender type, sexual offense characteristics, sexual criminal history, and general criminal history); symptomatology (comorbid alcohol or drug disorder); and personality characteristics and disorders (included denial, minimization, and rationalization, motivation to treatment, schizotypal personality traits, passive/aggressive personality traits, narcissistic personality disorder, antisocial personality disorder, social desirability, social skills, self-esteem, ego strength, primitive defense mechanisms, identity pathology, disturbance in mental representations, impulsivity, inclination to lie, aggression behaviors in sessions; p. 555).

Although APD was the only significant predictor found among all of the proposed factors identified to be predictive of not completing treatment, it is not clear whether this predictor emerged as a result of the high rate of the diagnosis among all of the offenders included in the studies. It is not surprising that a high number of sex offenders are diagnosed with APD, especially in prison settings (Hare, 2003). It is possible that APD may be the most consistent characteristic among sex offenders, which may be due to the fact that the diagnosis of pedophilia does not fit for many offenders who do not offend against children (American Psychiatric Association, 2001).

There are different perspectives proposed in the literature regarding how such predictors, were they to be valid, should be used clinically. One perspective is to use these predictors as a way to identify the specific risk factors for each individual offender and then tailor the treatment to meet the individual needs of each of these offenders. This model is known as the risk, need, and responsivity model or RNR (Andrews & Bonta, 2006). The RNR model proposes that treatments are most likely to be effective when they treat offenders who are likely to reoffend [moderate or higher risk], target characteristics that are related to reoffending [criminogenic needs], and match treatment to the offenders’ learning styles and abilities [responsivity; cognitive-behavioral interventions work best]. (Hanson, Bourgon, Helmus, & Hodgson, 2009, p. 867)

As such, the RNR model applied to retention rates would suggest that treatment programs should identify the unique risk factors for non-completion and in response, tailor the treatment program to meet those offender’s needs in an effort to keep the offender engaged in the program. It has been reported that programs that using RNR principles in treatment have higher effect sizes regarding reducing recidivism when compared to those that do not (Andrews et al., 1990; Hanson et al., 2009).
Another proposed way to use the predictors of non-completion is to identify those who will not be successful in treatment and only treat those who are seen as being most likely to benefit from or complete the treatment program (Beyko & Wong, 2005). Critics of this approach state that such programs have used the predictors to “expel these [inappropriate] offenders, thus adding to the attrition statistics rather than attempting to manage their behaviors” (Beyko & Wong, 2005, p. 384). Yet, Beyko and Wong argue that “maintaining these offenders in treatment is crucial as offenders who drop out are the ones who need treatment the most because treatment dropouts recidivate at a rate three times that of treatment completers” (Miner & Dwyer, 1995, as cited by Beyko & Wong, 2005, p. 384). As such, there are compelling arguments to design programs that will keep participants in treatment longer in the hopes that by creating a treatment program where the participants are more likely to remain in treatment, the risk of recidivism is reduced.

In addition to the individual characteristics that might predict whether someone will complete treatment, Lacrochelle and colleagues (2011) reviewed contextual factors as well. They included in their meta-analysis whether volunteering or being mandated to participate in programs, as well as the settings of the programs were predictive of non-completion. They reported that when treatment is voluntary, the average discontinuation rate is 60% compared to an average discontinuation rate of 38% for treatments imposed by the criminal justice system. They hypothesized the lower rate for those imposed by the criminal justice system is driven by the fear of additional sanctions that could be imposed if they do not complete the program. In addition, programs based in prison settings had a higher rate of non-completion (50%) when compared to outpatient settings (43%). The authors proposed that this finding may be due to the fact that prison populations have higher rates of individuals with APD compared to the general population, which is consistent with their finding that a diagnosis of APD is predictive of non-completion. However, they also noted that this explanation regarding the setting is inconsistent with Hanson and colleagues’ (2002) meta-analysis that “revealed no effect of setting on treatment outcome” (Larochelle et al., 2011, p. 560).

The above literature indicates that there is still much that needs to be learned about those individuals who have non-completion rates and what other contextual factors might also influence the rate of non-completion. As stated by Lacrochelle and colleagues (2011), the non-completion rate is a significant problem in sex offender treatment and is especially significant especially given that those who leave treatment have the highest risk of recidivism (Hanson et al., 2002; Lösel & Schmucker, 2005). Research that provides information on how to keep offenders in treatment must be conducted simultaneously with research that also identifies effective treatments and seeks to improve current treatments. As such, it is equally important
to understand how to create programs where sex offenders will remain in
treatment so that they may benefit from effective treatment programs.

This study was designed to utilize knowledge of seasoned sex offender
treatment providers who have designed a program with a very low attri-
tion rate (18%, Director [de-identified], personal communication, January 20,
2012). This program’s rate is significantly lower than the average reported
by Larochelle and colleagues (2011), especially for prison populations that
is approximately 50%. It is the intent of this study to discover what they
have learned in their years of providing treatment, and what characteristics
and other factors they have identified to influence a participant’s successful
completion of treatment. While there is a good body of literature on what
predicts non-completion, this study’s research question was aimed at under-
standing what created factors success in treatment, in addition to what might
contribute to non-completion.

METHOD

Because the clinicians who participated in this study are from one program,
specific information about the program and the individuals has not been
included to protect their identities. As such, some of the references have
been de-identified.

Setting/Program

The setting where the 4 clinicians work is in a state prison program in the
southeast. The program is administered by the Department of Public Safety
(DPS) in that state, formally called the Department of Correction (DOC). DPS
also oversees all of the other prison-based programs, such as vocational, edu-
cational and other therapeutic programs throughout the state system, in ad-
dition to post-release services, including probation and parole. The clinicians
work in a sex offender-specific treatment program that treats only incarcer-
ated sex offenders within the state prison system. Inmates from around the
state who have been convicted of a sex crime can apply for participation in
the program, which is based in a medium security prison administered by
the DPS. Participation is completely voluntary and those who are interested
are told that their participation will have no impact on their sentence or
post-release conditions.

Once the inmates enter the program, they are in the program for
20 weeks, 5 days a week, for 6 hr a day. There are two sessions of the
program each year, with approximately 30–40 inmate participants in each
session. It is a closed group, meaning that all participants enter the program
and graduate as a unit. The program uses an intensive group therapy format,
combining cognitive-behavioral therapy and relapse prevention intervention strategies. All of the program participants are housed together in the same residential unit or dormitory, which means that they eat, sleep and spend their leisure time in the same dormitory as their other program group members. There are three full-time master’s level psychologists on staff and one half-time master’s level psychologist who work at the program.

The inmates must meet the following criteria to be accepted into the program:

1. They must have a felony conviction
2. They must be age 21 or older;
3. They must be in medium or minimum secure custody;
4. They must volunteer for the program;
5. They must admit to committing a sexual offense;
6. They must not have a severe mental illness;
7. They must have a 6th grade reading level;
8. They must indicate willingness to participate in highly confrontational groups as a part of treatment (de-identified to protect identity of participants, 1997).

The time between a participant’s program completion and his release from prison can vary greatly because the probable release date is not a criterion for the program. Therefore, some inmates complete the program just prior to their release, while others remain incarcerated for months or years after completing it and still others are never released. In addition, after completing the program some participants have maintained involvement with the program by serving as peer counselors. There are 12 program graduates who serve as peer counselors for each group session.

The referral process is conducted internally through the prison system. Inmates can apply to the program individually, or a referral can come through one of the other staff members from one of the prisons, such as a mental health provider. These referrals are sent to the director of the program who screens them for general eligibility issues, such as level of security or IQ levels. The remaining individuals' referral information is then distributed to the clinicians, including the director, and reviewed using a screening form that the team recently developed (Appendix B). This form is completed by two of the clinicians so the decisions are not made by one person alone. If there are significant differences between the ratings, then an additional clinician reviews the file for a third review. Using this screening process, the team decides who will be admitted to the program.

For each group, the program has more volunteers than available slots. For example, in January of 2012, the program had 619 applicants for the 28 available openings they are funded to treat (Director, personal communication, May 9, 2012). Of these 619, 180 were deemed ineligible due to factors
such as non-English speaking or in closed-custody, leaving 439 eligible participants. Due to the limited number of spaces available, the clinicians must decide which of the inmates will be admitted to the program. They have shown through their internal process that they are able to select participants who have high completion rates. As of January of 2012, the program reported that 1,377 inmates have participated in the program, with 1,129 inmates completing it. In total, 248 did not complete the program, which is 18% non-completion rate, which is a significantly lower rate than other prison-based programs (Larochelle et al., 2011). The aim of this study is to share the process and the criteria they use, along with their rationale for these choices to add to the literature on identifying successful completers of sex offender programs.

Sample

The sample was comprised of the four masters’ level psychologists who are the clinicians at the program. Of the four clinicians, three of them are full-time employees of the program and the other is half time, however, this clinician is one of the founders of the program and has been involved in the program since its inception in 1991. Of the four clinicians, three are women and one is a man, and combined they have 78 years in working with sex offenders, in both prison and outpatient settings. One of the clinicians is a founding member of the local Association for the Treatment of Sex Offenders state chapter and all are actively involved in the design and implementation of the treatment program.

Procedure

This study used a focus group format and was conducted by the lead author of this article who is a university-based researcher and has no affiliation with the program. The focus group session took place in the spring of 2011 at the prison program and was audio-recorded and then transcribed by a master’s level research assistant. The session lasted approximately 1 hr with each clinician present throughout the entirety of the focus group. A pre-approved interview guide was used to guide the focus group (see Appendix A). However, the participants were also encouraged to elaborate on any themes or information that they deemed relevant to share. They were informed that the study’s aim was to understand how they identified potential candidates from their volunteer pool and how they determined who should be included in the program as participants. They were encouraged to identify their reasons for these choices to further provide a rationale for their clinical decisions. The study was approved by the institutional review board (IRB) at the principal investigator’s university and by the DPS’s own IRB.
Data Analysis

After the transcription process, grounded theory methodology was used to develop the codes used for the analysis (Strauss & Corbin, 1998). This process is defined as moving from one inductive inference to another by selectively collecting data, comparing and contrasting this material in the quest of patterns or regularities, seeking out more data to support or qualify these emerging clusters, and then gradually drawing inferences from the links between other new data segments and the cumulative set of conceptualizations. (Miles & Huberman, 1994, p. 14)

In this grounded theory process, “the researcher begins with an area of study and allows the theory to emerge from the data” (Strauss & Corbin, 1998, p. 12).

Following this grounded theory method and in consultation with the principal investigator (PI), two graduate level research assistants (RAs) reviewed the coding procedures, data analysis processes and ATLAS.ti, which was used to manage the data. Initially, each of the RAs independently reviewed the interview transcripts and separately identified themes that emerged from the data. The research assistants met and compared their codes with oversight and input from the PI, resulting in a list of themes present throughout the focus group.

During the second review, the research assistants identified a discrepancy in how one of the codes, referred to as “Logistical Factors Affecting Admission” was being considered. After discussing this issue, the RAs agreed to split Code 5 into two parts, “Logistical Factors Delaying Admission” and “Logistical Factors Increasing Admission.” The RAs conferred after independently reviewing the transcript with this amendment and decided to make further changes to the codes in order to have more unity regarding the scope of information covered by each code and ensuring that there were no gaps in the information collected and revised the codes accordingly.

In a third review the RAs independently coded the transcript with the new codes, and agreed to alter the codes again in an attempt to better capture the subthemes that emerged. Following the identification of the subthemes, the RAs reviewed and coded the transcript a fourth time and upon conferring with the PI, discovered discrepancies in the way the coding was conducted. Some themes were used inconsistently between the way the RAs coded the units of inquiry, resulting in a 66% inter-rater reliability, which was considered insufficient for the standard set for the study.

In consultation with the PI, the RAs met and discussed their process, clarifying the use of codes and agreed to code individual sentences. The fifth independent review brought the inter-rater reliability to 76%. The RAs again met and discussed the possible causes of discrepancy and decided to simplify
the codes they were using and eliminate codes that did not directly relate to
the research question. In addition, the team determined that the subthemes
did not enhance the themes that emerged, so they were eliminated from the
final coding process.

In utilizing these codes on the sixth and final review, a comparison
of the researchers’ independent coding yielded a 90% inter-rater reliability,
which met the standard set by the research team. The researchers therefore
read through and recoded the transcripts a total of six times each, meeting
after each time to clarify the coding process and definitions of the codes
until they reached a 90% inter-rater reliability level.

RESULTS

The results of the findings using the final eight themes that emerged from the
coding process are presented in this section. The total number of times each
code was noted during the focus group is listed in Table 1, with behaviors
over time being the most frequently noted factor in the decision to admit
to the program. However, this count should be considered an estimate due
to the nature of the focus group format. Many of the participants built on
comments from another, so that the ideas and themes often flowed into each
other. The final list of codes and their frequencies are listed in Table 1.

A brief description of each theme is provided and quotes from the
participants (set in italics) are given to illustrate the discussion. If one of the
clinicians referred to the name of the treatment program, the name has been
replaced with [THE PROGRAM].

Theme 1: Whole Picture

The clinicians discussed that no single factor affected admission to enter the
program. Throughout the conversation, the clinicians repeatedly stated that

<table>
<thead>
<tr>
<th>Code Title</th>
<th>Number of Times Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Whole Picture</td>
<td>17</td>
</tr>
<tr>
<td>2. Logistical Factors Affecting Admission</td>
<td>40</td>
</tr>
<tr>
<td>3. Post-Acceptance Factors</td>
<td>35</td>
</tr>
<tr>
<td>4. Behavior Patterns Over Time</td>
<td>85</td>
</tr>
<tr>
<td>5. Outside Support</td>
<td>28</td>
</tr>
<tr>
<td>6. Quality of Referral</td>
<td>29</td>
</tr>
<tr>
<td>7. Overt Signs of Interest</td>
<td>16</td>
</tr>
<tr>
<td>8. Overt Negative Signs</td>
<td>29</td>
</tr>
</tbody>
</table>
in selecting program participants they had to “look at the whole picture” and “not one element” before making a final decision. One clinician noted, “If that’s the only write up he’s had and he’s been in there for 20 years, I’m going to overlook maybe that one thing and say maybe we might look at the whole picture on this guy.”

Theme 2: Logistical Factors Affecting Admission

Many factors arose in the discussion among clinicians that affect decisions on who to accept into the program based on practical issues rather than attributes or merit of the referred inmates. The clinicians noted that release date and possibility of parole, where the applicant was being held, medical conditions, IQ, and the inmate’s security level all played a part in deciding if and when to admit an applicant to the program.

The clinicians stated that release date was the first factor considered when deciding who to accept into the program. If an applicant was closer to his release date, this inmate would be more likely to be accepted for treatment. Regarding this decision, clinicians discussed research on recidivism rates and the preference of the parole board that inmates complete the program. In the words of one clinician, “Yeah if they’ve only got a year left we want to really take a real hard serious look at him because this might be their last chance.” They also considered inmates with life sentences because “they could be considered for parole…[and] we want to give them the best shot.”

The clinicians discussed that inmate location may impact admission into the program. The clinicians noted that they would often put on the alternate list people from the camp where the program was located because, “You know, the week before the program starts and one guy says I’m not getting on that bus, I’m not going to this program…the male [THE PROGRAM] therapist can pull in a guy right from this camp…and it’s easier.”

Due to the importance of inmate participation in every session, inmate admission could be delayed due to medical problems if the issue would decrease ability to attend sessions. According to one clinician, “if they are in and out of here constantly [for physical therapy and other medical appointments]…it’s really hard for them to stay caught up, to not get overwhelmed, to not feel left out.” The camp where the program is located is equipped to manage “a certain level of medical disability,” so those with serious medical conditions may not be able to attend the program.

Inmates who have a very low IQ score or who are unable to read at all may also be denied admission. The clinicians stated that participants had “to be able to understand the material” and that they wanted “to look at reading level and things like that because…we do ask a lot of writing, a lot of reading.” The clinicians indicated that if the applicant was an otherwise
good candidate with a somewhat low IQ they would sometimes include him in a group with inmates with higher reading comprehension and IQ scores if the other participants “could help them along.”

Finally, the facility that the program is run out of is a medium custody prison and therefore the clinicians can only accept inmates who are being held at “medium or honor grade” (minimum security) facilities. The clinicians noted that “we check up on them, or at least we are now, to make sure that they are still in closed custody or if they’re now in medium.”

Theme 3: Post-Acceptance Factors

The clinicians indicated a variety of factors they worked towards in creating treatment groups to promote group cohesion, feelings of inclusion, and high participation and completion rates. As stated earlier, it was important to the clinicians that participants not miss sessions for medical or other reasons. Additionally, the clinicians worked to create groups where participants could support one another and help each other understand the material. The clinicians discussed that they make it clear to participants that they want them to succeed and ensure that every participant is present at the start of each session. One clinician stated,

And we tell them that from the very beginning... that we hand-picked you and I count them, you know like when you go on a field trip in preschool, you count kids? Every day when I come in I count my guys to make sure they’re all there and I say that to them—’Are we all here?’

The same clinician later expanded:

I think that when we tell them that we picked them and they’re here and we want to keep them and we want them to stay here, I think that maybe for some of them that’s one of the first times someone in their life has maybe said... ‘We want you.’

Ensuring that participants were able to complete the program was also important to the clinicians. The clinicians weeded out applicants whose records included behavior patterns indicating that the individual would have difficulties following the rules or staying motivated. In the words of one clinician, “You want the whole group that you pick to finish. You hate to see anybody for whatever reason not finish.”

Theme 4: Behavior Patterns Over Time

To determine if an applicant would be a good candidate for the program, the clinicians looked at behavior patterns over time including criminal history, prison infractions, sexual acts in prison, and history of program completion.
The clinicians looked to see if the applicant was ready to face his problems and commit to treatment. As one clinician stated,

Maybe when they were young, you know they came in the prison maybe in their early twenties and they had a whole bunch of infractions then and then suddenly they hit like 35 and you hardly see any at all during this period of time and you see him doing more constructive stuff and you think, ‘Oh, maybe this guy’s finally reached a point where maybe he’s ready,’ and that tells you something.

The clinicians noted that they took into account the criminal records of applicants and more diverse criminal histories led them to believe that the applicant had larger issues that would not necessarily be treatable through the program. The clinicians discussed that they looked at:

- the extent and variety of different kinds of criminal behavior…[Its] The antisocial behavior that we’re looking at…If they are an equal opportunity criminal…They’re going to be willing to…Commit anything, its widespread, just do anything. Sex offense is just one piece of it and you’re not going to have as much treatment success.

Inmates who had repeatedly committed sexual acts in prison were seen by the clinicians to have impulse control issues and would therefore have difficulties completing the program. One clinician noted a higher risk inmate would be,

- a guy whose sexual behaviors are still getting him in all kinds of trouble even though he’s been caught and had all kinds of consequences, he’s still choosing to do it…[like] a sexual act or where he’s targeting female staff, but his sexual behavior is still getting him in trouble.

The clinician continued,

- [It’s] the rule breaking. He’s in a dorm with a lot of other guys that have maybe sexual addiction problems. I think it maybe increases the chance that we could lose that slot to somebody that’s not having…that issue.

Inmates who had committed several infractions, even minor infractions such as smoking, were seen as less likely to be successful in the program as rule breaking seemed to correlate with issues respecting authority. It was preferred by the clinicians that applicants have no infractions for at least a year prior to acceptance to the program. One clinician stated,

If you can’t follow the rules in here, and we put him in a treatment program where not only do they have to follow DOP [Department of
Prisons] rules, but our contract rules, they are not going to be very likely to make it through the program.

Another clinician noted,

Their infraction history is real telling because you can look at a guy's infraction history and see he has multiple infractions, every year for the last 10 years he has two or three, right up until the present. That guy's not going to make it. I mean, he can't even make it in a regular population and you put him in a stressful environment and think that he's going to make it.

The clinicians also indicated that having completed other programs while in prison was a factor linked to success in the program. One clinician stated that prior program completion led to a “better indication we have that they're going to stick with us too….Somebody called that 'stick to it-iveness'?….We're looking for stick-to-it-iveness.”

Theme 5: Outside Support

Outside support from family members, past program graduates, and other professionals such as a case manager or chaplain was another factor that clinicians believed made good candidates for the program. Inmates whose family members are supportive, make calls, or write letters are more successful candidates. In the words of one clinician, “We're big on mothers and grandmothers calling.” The clinicians also indicated that discussing family could motivate inmates to participate more fully by making statements such as “Your mom wanted you here, you got here, now you better straighten up.” In addition, one clinician stated, “And I think….research [shows] that the more family support a guy has, the more likely he is to succeed in the community too, right?”

The clinicians indicated that when other professionals showed support for an inmate’s acceptance to the program through calling or writing letters, the candidate was more likely to be accepted. Such professionals would make statements such as “I've been working with this guy, he'd really be a good candidate. Would you please take a look at him?” Recommendations from past program graduates were also important to the clinicians as the graduates have a better understanding of what makes a successful participant and closer relationships with the applicants. One clinician stated,

The other nice thing is if it's a graduate, they might have known the guy for a long time…a guy that knows him might come back and say 'look, this guy's been talking to me all the time about the program, he wants more information, who do I send him to?' They usually have a better
picture of the guy than a clinician that’s only seen him once, maybe twice, so they’re a good referral that way.

Theme 6: Quality of Referral
While outside support was a strong factor in admission, the clinicians noted some issues in the quality of the referral and how much trust they would put into recommendations. According to the clinicians, “There are some people whose word we trust. . . . And they have a good track record with us and there’re other people that don’t have a clue.” One clinician noted, “We like our [THE PROGRAM] connections.” The program connections the clinician referred to includes individuals with knowledge of the program and what is expected of participants, such as past program graduates, aftercare clinicians, and DPS personnel. The clinicians referred to the treatment providers in the community as “a mixed bag” and emphasized the need to double check information and analyze the source.

Another issue with recommendations was the completeness of information received by the clinicians. The clinicians noted that some referrals are received with incomplete or conflicting information, which presents a problem in the referral process. In one example, “somebody put they recommended the guy for the program but the motivation was checked low. . . . she said . . . he wasn’t quite ready to face his issues.” In another example, a clinician stated,

we got a guy that the group this time that had an IQ of 62 and the first time we met with him we said, ‘This guy's much smarter than this,’ and we went back and the clinician had put the wrong IQ on it. It was an IQ of 116 or something.

According to the clinicians, the recommendations “give us the names and they give us a starting point . . . but we don’t take everything they say.”

Theme 7: Overt Signs of Interest
The clinicians also noted many ways applicants could show their interest in the program and make themselves better candidates. The clinicians indicated a positive regard for inmates who took initiative and respectfully and meaningfully inquired about the program by stopping by a clinician’s office or writing a letter. One clinician stated that “if he’s writing letter after letter or he’s having multiple people refer him,” it showed high motivation. Another clinician noted,
We look at the letter that they write because again that shows motivation for treatment... if they were saying “Look, I really need help, I don’t want to do this again,” then that speaks to how motivated they are and how willing they are to take responsibility.

The clinicians also looked at inmates’ attempts to make positive changes and noted the importance of participating and completing self-help programs while in prison. One clinician noted looking at,

Has he done anything else, like a pre-[THE PROGRAM] group or has he participated in other educational [programs]?... That’s part of the motivation though you see somebody who’s doing things to try to improve himself, you know, that they’re really motivated to try to change and that says something about [their past motivation] and they’ve acted on it, they’re trying to do some things.

Theme 8: Overt Negative Signs

In addition, the clinicians discussed negative signs or behaviors that inmates exhibited, such as “pestering” clinicians with what appeared to be “meaningless or disingenuous statements or requests,” which could prevent someone from being accepted to the program. One clinician stated,

part of our screening process is that we’re trying to weed those who have a less than genuine motivation. In other words, they’re only applying because they want secondary gain. They’re only in for self-promotion. They’re not really interested in treatment.

Another clinician noted, “if they’re just whining and complaining about their situation and not taking any responsibility and things like that then that would be a downside.”

CONCLUSION

Summary of Results

In determining whether someone should be accepted into the program, the clinicians identified a number of issues that influenced their decision. These issues included logistical issues as well as characteristics of the individual and other contextual factors. Some of the logistical factors that eliminated individuals from the applicant pool immediately were the inmates’ security level and if there were any significant medical conditions, as well as not meeting the eligibility criteria listed by the program. Some of the individual factors that were identified included at least 1 year of being infraction free, able to understand the material (have a high enough IQ level), wrote their
own letters and showed genuine interest in the program, had a history of completing other prison programs, and their perceived readiness to confront their problems and make positive changes in their lives. Regarding the contextual factors, applicants were more likely to be selected if they were going to soon be eligible for parole or release, had outside support from family members, therapists, clergy, and/or past program graduates.

Applicants were less likely to be selected for participation in the program if they had committed a wide variety of crimes or had continued to commit sex acts in prison, with both scenarios indicating a larger impulse control problem that may not be treatable through the program. The clinicians, however, highlighted that they took the “whole picture” into consideration and no singular factor would qualify or disqualify an applicant. In addition, the clinicians looked to create treatment groups that would be able to work well together and support one another with the goal of a 100% completion rate. The clinicians also noted that they did not always trust the formal referrals that came to them and the completeness of information they provided; therefore, the clinicians often needed to check facts and conduct further evaluations.

Implications

Many of the factors that were identified by these clinicians were different from those listed in the meta-analysis by Larochelle and colleagues (2011). For example, the infractions in prison and the level of outside support were not identified in the meta-analysis as possible factors that might influence non-completion. These examples may indicate that there are factors that have not yet been considered by some studies focused on treatment non-completion, and also indicate that more research needs to be done to expand the list of potential predictors. Additional studies that include the perspectives of those individuals who treat the offenders, such as this one, might be a way to continue to identify additional factors that can then be tested in empirically based studies. Materials such as the screening protocol used by this group of clinicians (Appendix B) that could be shared with other researchers and clinicians might further the knowledge and continue to add to the possible areas that should be explored further.

Another factor that was not identified in the meta-analysis by Larochelle and colleagues (2011) was the importance of group cohesion. Future research should include this factor in exploring attrition rates. Do groups with less group cohesion have higher rates of non-completion? It is plausible that if one or several group members feel targeted or singled-out in a negative way, they may be more likely to withdraw from the treatment. If there does appear to be a correlation between attrition rates and group cohesion, more research should be conducted and disseminated to identify the ingredients that help support a cohesive group.
This issue of group cohesion is related to the debate about how to use factors to make treatment decisions that was discussed in the literature review section. Here the clinicians do not appear to personalize the treatment as suggested by the RNR approach (Andrews & Bonta, 2006), yet use the information to create a balanced group as a whole. Although each individual is evaluated, how those individuals fit within the context of the larger group appears to be a critical factor in their decision-making process. This use of the factors is a different way of thinking about the utility of predictors. One could argue that they are not being used to exclude individuals necessarily solely on the basis that they are at higher risk, but used to build a successful treatment unit. Their approach does not appear to attempt to create a perfectly homogeneous group based on any one characteristic, but on creating a group where everyone stays engaged. As this approach appears to be different than what has appeared in the literature, more research should be done to determine whether this approach leads to lower attrition and ultimately lower recidivism rates.

The different approaches regarding how to use the predictors discussed in the literature review do not necessarily address the issue of creating a program that encourages completion. The RNR approach is focused on individualizing the program around the risks of the offender (Hanson et al., 2009) and the second approach is to use the predictors as a way to eliminate offenders who may be more difficult from the treatment process (Beyko & Wong, 2005). Both of these look at the issue of a match between the program and the offender in two different ways. Another way to think about the match is what is happening programmatically. In other words, it will also be important to evaluate how program factors might influence the likelihood of non-completion. In addition to group cohesion, other factors that might correlate with non-completion rates might be related to the skills of or the relationship with the clinician(s), the materials used within the group, or logistical issues, like the cost of treatment. While some of these factors have been considered previously, such as the relationship with the clinician, the current findings are inconclusive as to how this factor and other factors external to the offender might influence the non-completion rate among sex offenders (Larochelle et al., 2011).

Limitations
This study had several limitations that limit the conclusions that can be drawn from its findings. The first is that the factors that have been identified by these clinicians have not been empirically linked to recidivism rates. So while the factors identified expand the current knowledge base of what factors might influence non-completion, the factors listed here need to be explored further to determine whether these newly identified factors might be empirically be associated with recidivism, non-completion rates or both.
Another limitation was the limited sample included in the study. Only four clinicians were used from one program. Although several of the clinicians had worked at other programs in addition to their current place of employment, their responses cannot be generalized to other clinicians who work with sex offenders. Their setting and the broader DPS system in which they work may have influenced their perspective that is not consistent with other clinicians who work in different practice settings.

In spite of these limitations, this study contributes to the knowledge regarding the significant problem of treatment non-completion among sex offenders. Finding reliable and valid predictors of what influences non-completion remains elusive. Using the perspectives of clinicians who treat this population, such as the ones included in this study, is a potential approach to identify other predictors that have not yet been identified and studied in the current literature.

Future Research

More research needs to be done to determine how sex offenders can remain in treatments that have been shown to be effective in reducing their recidivism rates. Future research might include analysis of the factors in the program’s group itself and the techniques used that might add insight to what in their program may be unique, other than the elimination of people who are more likely to be non-completers. Another research project might analyze whether attrition rates change after clinicians adopt this program’s criteria. It would be important to determine how generalizable these criteria are to other prison-based programs as well as how they may translate to other community-based prison programs. Through such projects and similar ones, it may be possible to create more programs that increase completion rates that will in theory translate to lower recidivism rates and fewer victims.

REFERENCES


**APPENDIX A**

**Study Questionnaire**

Focus group agenda and procedure:

- Welcome and invite people to take light refreshments. Give them consent forms to read while the group is gathering.
- PI will describe the study.
- The PI will stress the important of maintaining confidentiality of what is said in the group, but that each participant must also decide what they are comfortable sharing.
- The PI will invite the members of the group to suggest other ground rules. These will be discussed and agreed on by conference.
- PI will review the consent form and elicit and respond to any questions. As part of this review process, the PI will note that each member must be willing to be audio taped as part of the consent for participation.
• Each volunteer will be asked to sign one copy and keep one copy for their records, and those who have chosen not to participate will be invited to now leave and will be thanked for their time.
• Begin focus group questions listed below.

Questions for focus group:

1. Please describe the screening process that is used at the X program.
2. How did this process develop?
3. What are your criteria for a success story in X?
4. What criteria are used to determine which volunteers are invited to participate?
5. What criteria do you use to reject some applications for participation?
6. How did you develop the above criteria?
7. What patterns have you seen regarding what type of individual is successful in the X program?
8. What patterns have you seen regarding what type of individual is NOT successful in the X program?
9. How well do you believe your current screening process is able to identify successful participants or exclude those that will not be successful?
10. What changes do you think would be helpful to include in your current screening process?
11. Are there other any other comments or questions you have regarding your screening process?
APPENDIX B

Name: _________________________________________ ID#: _______________ Race: _____
(Last, First)
PRD*: __________ PED*: __________ Crime: _______________ Victim(s): _______________

*PRD = Projected Release Date. PED = Parole Eligibility Date.

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<td>Few or no other arrests</td>
<td>Extensive criminal history</td>
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<tr>
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<td>Prior sex offense(s)</td>
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<td>Ed/Voc completion</td>
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<td>Few or no infractions</td>
<td>Many infractions and/or within one year</td>
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<td></td>
<td>Sex acts in prison</td>
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<td>Special issues (med, alerts, etc.)</td>
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Reviewed by:      Date:

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