May 26, 1995

Representative Doyle Mortimer
Utah House of Representatives
318 State Capitol Bldg
Salt Lake City UT 84114

Subject: Corrections Therapy Programs (Report #95-03)

Dear Representative Mortimer:

We have completed our review of five issues related to treatment of offenders within the state's correctional system. This study responded to the following questions:

- Are inmates who have committed sex offenses being denied treatment because they will not confess to crimes beyond the crime of conviction?
- Are offenders required to duplicate therapy received in prison after they are paroled to halfway houses?
- Are offenders in halfway houses being sent back to prison without being given adequate chances to change their behavior? Specifically, are some offenders sent back to prison merely for "being in denial" (not admitting to their crime of conviction) without being given a fair chance to progress in therapy?
- Is prison treatment or therapy effective in changing criminal behavior and reducing the number of inmates who return to prison (recidivism)?
- Should inmates be allowed to receive treatment given by therapists of their own choice while in prison, provided the inmates pay for this treatment?

In the rest of this paragraph we summarize our findings regarding the above issues. First, we did not find evidence that treatment was withheld from sex offenders because the offenders

refused to admit to committing crimes other than the crimes of their conviction. Second, we found some duplication of therapy between the prison and the halfway house, but in our opinion the duplication is justified. Third, we found that corrections' officials were giving halfway house parole violators adequate chances to change their behavior before they were sent back to prison. Fourth, we found that studies of prison treatment programs show promising results in reducing recidivism, but these studies are not conclusive. Fifth, we found that prison management has discretion in whether they allow inmates to hire their own therapist while incarcerated.

These issues are significant because they affect incarceration time and treatment costs. Most inmates are not incarcerated for a fixed amount of time. Rather, the Utah State Board of Pardons determines the inmate's length of prison stay depending on the board's analysis of the crime and the inmate's behavior. The Department of Corrections houses and supervises inmates but the Board of Pardons determines how long inmates remain in prison. Inmates who progress in treatment, develop job skills, and do not create problems in prison generally receive earlier parole dates than those with similar crimes who have not taken these positive steps. The issues you raised are important because if inmates are inappropriately denied therapy or are sent back to prison for trivial offenses they may be incarcerated longer than necessary, thus increasing costs. Also, it may not make sense to spend taxpayers' funds for ineffective treatment.

To address these issues, we conducted an extensive review of the literature, compared Utah's corrections programs with programs in other states, and reviewed three different samples of inmate files. Our conclusions are based on the documented evidence in the case file records and discussions with treatment staff both within Utah's correctional system and outside the system.

No Evidence That Treatment was Withheld Without Justification

We did not find evidence indicating that treatment was withheld from inmates until they admitted to additional crimes for which they were not convicted. Our review indicates that most inmates either admitted to the additional crimes prior to incarceration, or there was never any evidence to indicate additional crimes were committed. These inmates are eligible to receive treatment—if they request it—while in prison. A small percentage of inmates never confessed to the crime of conviction much less any additional crimes; these inmates are not eligible to receive treatment while in prison. Finally, another small percentage of inmates who confessed to the crime of conviction but denied additional crimes for which there is evidence, are also eligible to receive treatment.

To address the issue of whether treatment is withheld until offenders admit to crimes beyond their crimes of conviction, we selected a random sample of 30 sex offenders and reviewed the information in their case files maintained by the Board of Pardons. We used the Board of

Pardons' file because we believe it is potentially more complete than the inmate's prison file. The Board of Pardons' case files contain all the information in the prison files but, in addition, an inmate can challenge the Board of Pardons' files for accuracy. The inmate receives a copy of the complete file used in board hearings. The inmate reviews the case file before the board hearing and if he or she desires, can challenge the accuracy of documents in the file as well as add documents which make him or her appear more favorable before the board. As a result, we believe we are getting the most complete information by using the Board of Pardons as opposed to just using the inmate's prison file. From the inmate's case file we reviewed sentencing reports, psychological evaluations, and other key information.

As noted above, there was no evidence from our case file review that treatment was withheld from inmates for denying nonconvicted crimes. The following figure summarizes our results.

Figure I

Results of Case File Review Concerning Inmates Admitting Additional Crimes

Category Definition	Number of Inmates
Inmate admits committing the nonconvicted crimes prior to incarceration, or there is no evidence of additional crimes	24
Inmate denies both crime of conviction and additional crimes	3
Inmate admits to crimes of conviction but denies committing additional crimes	3
Total Sample	**30**

As shown above, 24 (80 percent) inmates either: (a) admitted prior to incarceration to committing crimes for which they were not convicted, or (b) there was no record they committed crimes for which they were not convicted. The remaining six (20 percent) inmates either denied their crime of conviction or denied committing additional crimes. It appears that the only people not getting treatment are those denying their crime of conviction. Below we describe more fully these categories.

Admission to Additional Crimes Prior to

Incarceration or There is no Evidence of Additional Crimes

Most offenders admitted before being incarcerated to committing crimes beyond their crime of conviction or there was no evidence in the case file that they committed crimes other than their crime of conviction. For these reasons, the cases do not apply to the legislative concern.

There were 17 offenders who reduced the severity of their offense by accepting a plea bargain agreement. These offenders admitted in psychological evaluations to committing crimes beyond their crime of conviction. Most inmates were originally charged with a first-degree felony sex offense. To eliminate the potential risk of increased prison time associated with losing a trial, these inmates pled guilty to a lesser, second-degree felony in exchange for having the prosecution drop the higher charges. The state also gets a conviction without the expense of a trial. The plea bargain, the psychological reports, criminal histories and other information (including evidence of crimes committed for which the inmate was not convicted and other information relating to the individual's sexual deviancy) remained in the case file. This information is updated and reviewed by treatment staff and the Board of Pardons throughout an individual's incarceration. Before their incarceration, inmates in this category admitted to psychologists or others that they committed crimes for which they were not convicted. Because the inmate confessed to additional crimes from the very beginning, the legislative concern that treatment was withheld until the inmate admitted to additional crimes does not apply. Rather, the case file evidence indicates that the inmate admitted to committing additional, nonconvicted crimes even before incarceration.

Seven inmate case files we reviewed did not contain documents indicating the inmate committed additional crimes other than the crime of conviction. This supports the conclusion that there were no additional crimes committed by the inmate. As with the previous category, legislative concern that treatment is being withheld from inmates who deny committing additional crimes likewise does not relate to individuals in this category.

Denial of Both Crime of Conviction and Additional Crimes

In three instances, the case file indicates the inmate denied both the crime of conviction and additional crimes. None of these individuals received treatment while incarcerated. In all three instances, the inmate denied that he committed the crime for which he was convicted, claiming the sex act was consensual or that he was a victim of circumstances. These inmates could not get treatment because they would not admit to their crime of conviction. Unless an individual takes responsibility for his actions and desires change, therapists believe treatment will not be effective.

For instance, in one case an inmate was convicted of "Forcible Sexual Abuse," the result of a plea bargained reduction from "Rape." The inmate stated his crime was nothing more than

consensual sex; he maintained he had done nothing wrong. The case file notes that he showed no empathy for the victims. Another inmate denied his crime, arguing that he did not commit sexual misconduct. Psychological reports indicate that because this inmate believed he did nothing wrong, he did not get treatment. In the final case, the inmate was convicted of "Sexual Abuse of a Child" which was reduced from "Rape of a Child" through a plea bargain. This inmate denied any sexual crime claiming that he had done nothing that could be considered sexual abuse. Prison staff reports indicated that the inmate had not sought sex offender treatment. In fact, the inmate told one psychologist that he did not have a sex abuse problem and that he did not need treatment.

The director of Utah's prison sex offender program as well as directors of sex offender programs in other states indicate that inmates must admit they committed the crime of conviction or at least admit to sexual deviancy before they can be treated because unless an individual takes responsibility for his actions and desires change, treatment will not be effective. We contacted prison sex offender program staff in prison programs in four other states. These individuals said that an inmate must admit that he has committed a sex crime or at least admit that he is a sexual deviant. He must then accept responsibility for his actions before he can be treated. Utah's prison sex offender program has similar requirements. However, sex offender program staff in other states and in Utah also said that an inmate does not have to confess to any additional, nonconvicted crimes in order to receive treatment.

Admission to Crime of Conviction but Denial of Additional Crimes

In three instances, inmates admitted committing their crimes of conviction but denied committing additional crimes for which there is evidence in the case file. They all received treatment, but because they were uncooperative in therapy or had other problems, two of the three did not complete therapy.

One inmate was uncooperative and low functioning. He was considered to be a management problem and would frequently fake seizures when confronted about his crimes. Although he admitted his crime, he minimized his responsibility, stating that he was under the influence of alcohol at the time the crime was committed. The inmate did eventually begin the first phase of the sex offender program, but caseworker reports show that he did not pass the written examinations. On occasion, this inmate would also retreat into defensive behavior concerning his sexual deviancy. This inmate was later assigned to a different therapist to be given another chance to pass "Phase I." According to the director of the sex offender program, this inmate still did poorly in the second attempt. Because of his poor reading skills, he was given the opportunity to take the Phase I examinations verbally, but still did poorly. In addition, he was diagnosed by prison evaluators as mildly retarded. For instance, his level of reading comprehension and other intellectual functions were below a third-grade level. The treatment staff eventually determined

that he was not suitable for advancement to the next phase of sex offender programming because of his limited intellectual functioning, poor reading skills, and inability to pass even the verbal exams. An outside psychologist concurred by stating that the inmate would be incapable of adequately participating in the current program.

Subsequently, the director of the sex offender program recommended that the inmate enroll in the Cedar City Jail Sex Offender Program, which is tailored specifically for low mentally-functioning individuals. This recommendation was given after the therapists gave the inmate numerous opportunities to progress. We discussed this recommendation with the inmate's caseworker, who said that he had been given the opportunity to move to the Cedar City jail program, but was not interested in participating. We were concerned that low functioning inmates may not want to leave the local area where they receive support and help from friends and family. The director of the prison's sex offender program agreed with our concern and said that he wants to bring this program back to the Draper prison site. Currently, the prison contracts with the Cedar City Jail to provide services to these low functioning inmates. However, he believes it would be better to provide the program in the Draper prison site where the majority of the inmates are located. He plans to make this proposal to Department of Correction's management.

Another inmate was likewise uncooperative and low functioning. He too was diagnosed as mildly retarded. Prison mental health therapists assigned him to a mental health program upon incarceration. He was an immediate management problem, showing aggressive behavior toward other inmates in the program, receiving numerous disciplinary actions, and lying to therapists. He complained that he was the real victim in his sex crimes and minimized the impact of his crimes against his victims.

Therapists attempted to treat the offender, but he did not make progress in treatment. He attended sex offender group sessions for three months, but he would not write in his journal, which is a program requirement. Because he had trouble writing he was given the option of using inmate volunteers to help him, but he did not seek such help. He was removed from the sex offender program for failure to progress. The most recent interview with a psychologist showed that the inmate was not interested in reapplying for this program.

The third inmate was uncooperative at first, but later changed his attitude. He admitted to the sexual crimes for which he was convicted, but denied committing additional crimes listed in his case file. A few months after his incarceration, he was considered for acceptance into the sex offender program. Prison staff reports show that he was denied entrance for "lack of victim empathy, minimization of crime, and lack of motivation to change." We discussed this inmate with the prison's sex offender treatment staff who said that at the time this inmate initially applied and was denied treatment (1991), the sex offender treatment program had fewer therapists and treatment resources than it presently does. At that time, inmates were not being

admitted to the program for the above reasons because there were not enough resources to treat them. Now, however, there are enough resources to treat those who may still not possess victim empathy, who minimize their crime, or who lack motivation to change, but who still admit to their crime of conviction. However, this inmate was later accepted into the sex offender program.

In addition to the case file review, we followed-up on those inmates graduating or nearly completing the sex offender program in recent months to see if they were denied treatment. We reviewed the files of four of the five inmates who graduated from the program since November of 1994. We also reviewed cases of three inmates who are within 60 days of graduating. All seven (four graduates and three near-graduates) inmates had additional crimes listed in their Pre-sentence Investigation Report (PSI) and all but one admitted to these additional crimes. The inmate who denies committing additional crimes told us he has been accused of having six victims but he maintains that he has had only two victims. He has told both his therapists and the Board of Pardons that he has not committed these additional crimes. He also said he has never been denied treatment because he will not admit to having other victims. In fact, he is currently in Phase III (the final phase) of the sex offender program and is scheduled to graduate from the program in 60 days. Further, in the four years this inmate has been in the program he is not aware of any instances where treatment has been withheld because an offender will not admit to additional crimes.

In our opinion, this analysis shows that treatment is not being withheld because an inmate does not admit to crimes for which he was not convicted. First, our review shows that there are very few inmates who do not admit to committing additional crimes prior to incarceration if there is evidence that such crimes occurred. Second, the few inmates who denied committing additional crimes did receive sex offender treatment. Third, there are inmates who remain in denial of additional crimes who have completed the entire sex offender program. In the next section of this report we review the second legislative concern, ‘Is treatment received by offenders in prison being duplicated in the halfway houses?

Duplication of Therapy Appears Justified

Our case file review showed that: (a) duplication of treatment between prison and the halfway house does exist, and (b) this duplication is justified. Although there appears to be some duplication, caseworkers and therapists argue that treatment received while in a halfway house builds on what the inmate received while incarcerated. Further, they believe that some duplication of therapy (reinforcement of basic concepts) is necessary because situations outside the prison are much different than inside.

We found that therapy is adjusted according to what the offender needs. Offenders often receive therapy for a particular problem, such as substance abuse, both in prison and in the halfway house. However, before therapy is given in a halfway house, providers screen the offender to determine what treatment they received in prison. Though the therapy provided in the halfway house duplicates prison therapy in that it addresses similar problems, this duplication appears justified because the therapist takes into account what treatment the inmate already received.

To conduct this review we randomly selected 25 offenders at the Ogden Community Corrections Center (called the "halfway house"). We reviewed inmate files at both the halfway house and the prison. We chose the Ogden halfway house because it houses offenders of all types including sex offenders, substance abusers, and offenders needing other types of therapy. We reviewed the parole/probation agreements of the offenders to determine if there was any therapy required as a condition of parole. We also reviewed offender files at the halfway house and at the prison to determine what therapy, if any, the inmate received. Finally, we interviewed experts and treatment staff in Utah and in other states to compare therapy offered.

Many sampled inmates received treatment addressing similar problems in both the prison and the halfway house. Others received therapy addressing different problems; some received no therapy at all. There are therapy programs in prison and halfway houses designed to help inmates overcome criminal behaviors. Offenders can receive group and individual counseling to help them overcome substance abuse or sexual deviancy problems. Offenders may also attend classes and receive counseling to help them adjust to life's problems. For instance, offenders can attend courses on anger and stress management. Our sample showed that some offenders received therapy for substance abuse both in the prison and the halfway house. Some received treatment for sex offenses in both places. Others received treatment for life skills deficiencies such as an inability to control anger both in the prison and the halfway house. Finally, others received no treatment in prison or treatment for different problems than in the prison. The following figure summarizes the results of our review.

Figure II
Summary of Therapy Duplication

Where Therapy Received	Number of Inmates
Both halfway house and prison	16
Prison only	3
Halfway house only	4
Neither halfway house nor prison	2
Total Sample	**25**

As shown in Figure II, there were nine cases where no potential duplication exists because therapy was not received at either the prison, the halfway house, or both. The figure also shows there were 16 cases where offenders received therapy while incarcerated and when paroled to a halfway house. These cases were the only ones where the potential for duplication exists. Many of these 16 offenders had parole agreements that required therapy for multiple problems. An inmate may receive therapy for one problem in the prison and another problem in a halfway house. For example, some offenders required therapy for substance abuse and life skills deficiencies. Other offenders required therapy for sex offenses and also for substance abuse.

Therapists said that continuing therapy beyond the prison and duplicating some therapy is both common and beneficial. For example, the therapist we interviewed concerning one case said that covering similar topics in both the prison's substance abuse program and in the halfway house program benefitted the offender. This offender participated in group therapy and some self-help classes while incarcerated. Prison therapy sessions helped the inmate understand addiction problems and how to resolve those problems. Group therapy also provided help in developing life skills such as anger control and "healing" one's life. While in the halfway house this inmate participated in group therapy covering similar subjects. However, before the inmate received treatment, the therapist conducted a screening interview to determine what therapy had been received in prison. The therapist felt that additional therapy, covering some of the same topics covered in prison, would be helpful. Some of these topics included "learning values", "controlling behavior", and "learning responsibility in life." The group therapy provided in the halfway house was similar to that given in prison because it included peer group discussions of problems and issues. The therapist believed that

the therapy received in the halfway house was effective because it added additional skills to those received in prison, thus helping reinforce coping skills needed outside the prison.

Another offender received group therapy for substance abuse in both the prison and while on parole. Prison therapy included group discussion of problems with addictions and also some instruction on coping skills and anger management. The group therapy given while the offender was on parole also covered the same topics. The prison substance abuse therapists explained that although the topics sound the same, each group brings different persons with different experiences and problems to the discussion, thus differentiating each session. This variety of experience is helpful because it shows the offender that his peers have similar problems; it gives him a support group with which to identify.

Covering similar topics in life skills management in both the prison and the halfway house appear to benefit offenders. For instance, one inmate attended a course in anger management at the prison. When paroled to a halfway house he completed another course in anger management. The treatment providers for this parolee said he was interviewed by a therapist prior to treatment in order to discover what the problems were and what previous therapy was received. It was determined that the offender continued to have trouble controlling his anger. Consequently, a course of treatment included topics similar to those covered in prison and also group discussions on how to cope with stressful situations outside of prison. Therapists believe some duplication is beneficial because it builds on what has already been covered, which in turn gives the offender stronger coping skills. Also, because situations outside the prison are much different than inside the prison, the offender needs help in applying the basic concepts. In addition, therapists argue that treatment for addicting behavior is needed throughout the life of the offender. In the cases we reviewed treatment was continued beyond the prison.

We contacted several independent treatment providers in Utah and in other states. Their comments were very similar to what we heard from treatment staff providing therapy for inmates in our sample. They said that well-designed treatment programs take into consideration what therapy the inmate received in prison and then build on this basic foundation. They believe some duplication is beneficial because offenders face different situations, problems, and temptations outside the prison. Once outside the prison, the offenders have many opportunities to revert to their old behavior. Illicit drugs, alcohol, and sex are readily available and the temptation is much stronger to participate in these activities once outside the prison. It takes continued therapy and support to avoid relapse.

For instance, according to a sex offender program director in Colorado, duplication is an important part of therapy. Because sex offenders have difficulty admitting their crime, their natural tendency is to deny guilt and to not discuss their deviancy. If they are allowed to block out their crimes without acknowledging the consequences of their actions, they will likely re-offend. However, when they write down their offenses and discuss them with the group on

repeated occasions, both within the prison and outside on parole, they are more likely to take responsibility for their actions. This process is very important and may be repeated often until treatment staff feel the offender has accepted responsibility for his or her actions. Each time a phase of therapy is repeated it can help the offender feel more remorse and help him or her to control their behavior.

As another example, a clinical psychologist treating parolees in New Mexico said that all offenders are evaluated to determine what type of therapy they have received and what they need. Therapy is often repeated depending on how well the offender has internalized previous treatment both in the prison and elsewhere. Repeating therapy can be helpful to provide a continuous reminder and link of support to the offender. In fact, the psychologist said that some offenders feel the therapy is even more beneficial the second time they participate in it.

In our opinion, these examples show that some duplication of treatment is reasonable. Therapists in halfway houses appear to build on therapy that inmates receive in prison. Circumstances are different outside the prison and it seems reasonable to reinforce concepts covered in prison. In the next section we address the issue of why offenders are being sent back to prison from halfway houses. The issue related to whether some offenders may be sent back to prison without being given adequate chances to change their behavior.

Offenders' Return to Prison Appears Justified

The halfway house staff members appeared justified in sending back to prison those who violated parole conditions. Most parolees were sent back to prison for committing new crimes, violating halfway house rules, and/or failing to live by special parole conditions. Of the 636 instances of parole violations coming before the Board of Pardons hearings in the first half of fiscal year 1994, we found that 81 percent of parolees had violated at least one or more provisions of their general parole agreement, primarily displaying new criminal behaviors. Another 19 percent violated special parole conditions.[1] We focused on 14 cases, or 2 percent, of the parolees who were sent back to prison for failure to complete the sex therapy program in the halfway house. Parolees in this category related most directly to the legislative concern

[1] Special parole conditions are extra requirements which a particular offender must complete beyond the normal parole conditions by which all offenders must abide. For example, one general parole agreement states that all offenders will not possess any firearms or dangerous weapons. A special parole condition might be that a particular offender can not possess or consume alcohol.

that offenders were being sent back to prison merely for denying their crime of conviction; consequently, we analyzed these cases in more detail.

We conducted a detailed review of 14 cases, or less than one percent of the 636 total cases, because these 14 cases were the only cases that directly related to your concern. The Board of Pardons held a hearing on 636 offenders sent back to prison in the first six months of fiscal year 1994. If an inmate is sent back to the prison, he or she has a hearing with the Board of Pardons. At this hearing, the inmate is represented by an attorney and the inmate has the right to challenge the actions of the Department of Corrections in sending the offender back to prison or any other issue the inmate deems significant. As noted previously, of the 636 offenders, 517 were sent back to prison because they violated a general provision of their parole agreement, primarily displaying criminal behaviors. Because these 517 offenders generally committed more serious offenses, we did not analyze these cases further. Of the 119 offenders remaining, 105 had more than one violation of their parole conditions. For example, they may have tested positive for drugs and violated their curfew. Of the remaining cases, we identified 14 parolees whose only offense was failure to complete a sex therapy program. As noted above, these 14 offenders related most directly to the legislative concern that inmates were being sent back merely for denying their crime of conviction. The following figure summarizes the results of our analysis of these cases.

Figure III
Why Selected Inmates Were Returned to Prison

Reason For Return To Prison	Number of Parolees
Lack of Progress in Treatment	9
Failure to Begin Treatment Because of Denial or Minimization	2
Failure to Change Behavior	3
Total Sample	**14**

As the above figure shows, there were 14 parolees who were returned to prison for failing to complete a sex offender program. In the paragraphs below, we describe in more detail why these offenders were sent back to the prison.

Lack of Progress in Treatment

Nine parolees returned to prison because they did not make satisfactory progress in sex offender therapy. According to the Department of Corrections (DOC) Sex Offender Level System Time Line, parolees must complete four levels (the first level is also divided into phase A and B) before a specified deadline. In each level, the treatment team will "pass" the parolees if they complete all the requirements as outlined by DOC. For instance, DOC guidelines indicate that an offender should complete the beginning level (1A) within one month following an initial halfway house adjustment period. Within another month the offender is supposed to complete level 1B. Our analysis shows that the parolees were given sufficient time extensions to complete their requirements but their progress was not within DOC guidelines. Three parolees did not even pass the first phase of level one. Two were in the halfway house for over five months and the other was in the halfway house for over seven months. These parolees started therapy but did not fulfill requirements to pass the first level such as completing their journals and participating meaningfully in therapy. These offenders were finally removed from the halfway house. The remaining six offenders completed at least the first level of treatment but failed to make significant progress as shown below.

Figure IV
Offender Progress Compared To DOC Time Guideline

Number of Parolees	Level Reached	Actual Length of Treatment	DOC Time Guideline to Finish the Level
1	1A	6 months	1 month
2	1B	8 months (average)	2 months
2	II	11 months (average)	6 months
1	N/A	13 months	N/A

As illustrated above, these six parolees were given sufficient time to complete their requirements to progress in treatment. One parolee did not advance beyond level 1A after six months when the guidelines indicate this level should be completed in one month. Two parolees did not advance beyond level 1B even though one was in treatment for ten months and the other for seven months. Two parolees did not progress beyond level II despite treatment for an average of eleven months. Among the two parolees, one spent ten months in therapy and the other spent twelve months. The last parolee was in therapy for thirteen months before the DOC guidelines were established. Therefore, he did not pass any levels. However, he was given sufficient time

(thirteen months) to complete therapy. Sending these offenders back to prison when they will not cooperate helps protect society because without treatment an offender is considered to be a greater risk to reoffend.

Therapists have discretion on how long the parolee can stay in therapy beyond the DOC guidelines. Because each individual is different, the duration of therapy beyond DOC guidelines can also be different. Nonetheless, each individual is given sufficient time and opportunity to complete the therapy requirements. According to case files these inmates were sent back generally after being given several written and verbal warnings to complete their requirements. In addition, parolees received hearings in which they were allowed to challenge the evidence presented against them and argue for being allowed to continue in the halfway house.

For example, one parolee was transferred from a Salt Lake to an Ogden halfway house after working with a therapist for over thirteen months. The therapist was frustrated at the offender's lack of progress. The inmate would not complete assignments, would not take responsibility for his crime and continued to minimize the impact of his crime on his victims. He was transferred to the Ogden halfway house in hopes that he would improve his attitude. However, after observing him for two months, Ogden halfway house treatment staff recommended that he be returned to the prison because his attitude remained the same. Because this offender and the other offenders in this category made very little progress, despite being given extensive time to complete their program, we believe the halfway house was justified in sending these offenders back to prison.

Failure to Begin Treatment Because of Denial and Minimization

Two parolees did not start the therapy as prescribed by the Board of Pardons because they either denied or minimized their crimes; therefore, therapists could not work with them. Halfway house practice indicates that an offender must admit to committing his crime of conviction as a requisite to receiving treatment. Therapists believe that an offender can not be treated if he or she will not take responsibility for his or her crime.

One parolee was referred to a halfway house after failing an out-patient treatment, he missed scheduled appointments and denied committing the convicted offenses. At an administrative hearing, he was given another chance to complete therapy in a residential setting. His parole agent felt his denial was supported by his family and environment, and it would help to remove him from his surroundings. When he arrived at the halfway house, during a screening interview, he denied committing any sex offenses and insisted that he did not need treatment. For the next five group sessions and two educational classes, he attempted

to assure the treatment team that he did not have any problems. Consequently, the treatment team removed him from the program.

The other parolee also denied his crime of conviction. During three months of group therapy, he denied any culpability. He insisted that he was not guilty of the offense, and that he did not have sexual problems; he did not want the treatment offered at the halfway house. The treatment team members felt they had no choice but to remove him.

The policy of returning sex offenders who deny or minimize their crimes is consistent with other states. Treatment staff in Arizona, Colorado, and New Mexico said that parolees are sent back to prison if they deny or minimize their offenses.

Failure to Change Behavior

Three parolees' actions indicate they failed to change their behavior despite technically progressing in treatment. One parolee met all the technical criteria of therapy by completing assignments but failed to internalize treatment. While his girlfriend was pregnant, he pursued another woman at his workplace and was accused of sexually harassing her by pushing her against a wall and grabbing her leg. Later, he pursued another woman and lied to the staff about the relationship. When confronted with these behaviors, he "maintain(ed) his position as the victim." Therefore, staff decided to remove him from the program because his progress in treatment was only superficial.

The second parolee was likewise accused of sexual harassment at work and was sent back to prison. According to the victim, the parolee touched her and made sexual innuendos on a daily basis. On several other occasions she reported that he tried to kiss her. Once he asked her to have sexual intercourse with him and he tried to expose himself. Staff felt this was a serious offense and removed him to the prison for 60 days, after which he was returned to the halfway house.

The third parolee sexually harassed another halfway house resident by touching her, asking her to rub lotion on her back, and making other sexual advances. During an administrative hearing, she was warned that repeated behavior of this kind would result in removal. Nonetheless, she continued and therefore staff removed her from the program.

In our opinion, the halfway house was justified in sending these inmates back to the prison. Offenders were generally given repeated chances to change their behavior, but they refused. Consequently, treatment staff returned them to prison. In addition to reviewing those reasons why offenders are sent back to the prison, we also addressed the larger question of whether treatment itself is effective.

Studies on Recidivism are Promising

but not Conclusive

Correction's literature indicates that certain types of treatment show promising results in reducing recidivism (the rate of inmates returning to prison), but the literature does not contain conclusive evidence to support that position. Further, given limitations of time and resources, it would be impractical for our office to conduct random, control group experiments as to the effectiveness of treatment programs. Some researchers believe that treatment that follows certain principles can reduce recidivism. They believe that, although individual studies may have weaknesses in research design, the sheer number of studies pointing to positive results of certain types of treatment indicate that treatment can reduce recidivism. However, because of the expense of treatment, other researchers are not fully convinced that these results are cost beneficial. In our opinion, the research is promising but not totally conclusive. Further, to conduct a definitive research study in Utah would require researchers to conduct a carefully controlled experiment spanning multiple years. This study would be very costly and may not apply to current treatment methods because the study would have to track recidivism of individuals receiving particular treatment in the past.

Studies are Encouraging

The studies reviewed are encouraging because they indicate treatment can reduce recidivism; however, they are not conclusive. Some researchers are convinced that programs that contain certain principles can be effective in reducing recidivism. This conclusion is based primarily on a "meta-analysis" (a statistical review of multiple studies conducted on recidivism). There are three kinds of recidivism studies:

1. **Control group studies.** Offenders are randomly assigned to either a group that receives treatment (experimental group) or a group that does not receive treatment (control group). The recidivism rate of those receiving treatment is compared to the recidivism rate of those not receiving treatment.

2. **Quasi-experimental studies.** Rather than being randomly assigned, offenders on a waiting list to receive treatment are assigned to a group that does not receive treatment. The recidivism rate of those receiving treatment is compared with those not receiving treatment.

3. **Correlational studies.** Offenders receiving treatment are compared to all inmates. In a correlation study there is no control group that does not receive treatment versus an experimental group that does receive treatment. In the correlation study, the recidivism

rate of those receiving treatment is compared with the recidivism rate of the entire prison population.

Some methodologies are stronger than others in determining whether recidivism is reduced through treatment. The strongest research design is a "control" group comparison. Because individuals are randomly assigned to either group, any difference in recidivism between the two groups can clearly be attributed to the treatment because all other variables are controlled. The "quasi-experimental" study is not as strong since the individuals are not randomly assigned to either group. Researchers may not be able to clearly distinguish between treatment effects which may have reduced recidivism and other characteristics which may have been inherent within the group which caused recidivism reduction. The "correlational" study is the weakest because it does not isolate the impact of treatment since other factors are allowed to have an impact because of the way the groups are structured.

The "meta-analyses" statistically analyzes large groups of these studies. Researchers argue that: individual studies have weaknesses in research design, but, taken as a whole, multiple research studies indicate that treatment can reduce recidivism. They base this belief on their review and statistical analyses of several hundred, generally quasi-experimental, studies.

We reviewed meta-analyses conducted by researchers that are promising but not totally convincing. For instance, one prominent researcher conducted a meta analysis of 80 research studies, primarily quasi-experimental, of the effectiveness of various treatment programs. He believes that these studies showed that, overall, treatment reduced recidivism. He believes that 54 of the 80 studies identified effective treatment principles that reduced recidivism by an average of 50 percent. Some of these "principles of effective treatment" are: treatment should be matched to the needs of the offender, treatment needs to be continued beyond the prison, and treatment needs to change offender's thinking patterns. Other researchers have conducted meta-analyses that they likewise believe indicate that certain types of treatment can be effective. However, there are other researchers who believe that the meta-analyses do not conclusively show that treatment reduces recidivism. These researchers question the conclusions. For instance, reviewing the same studies, other researchers argue that the studies do not fully support the principles mentioned above. They believe the studies support greater emphasis on sanctions, such as more prison time, to reduce criminal behavior.

In addition to the meta-analyses, we reviewed over 30 quasi-experimental studies claiming recidivism reductions. These studies likewise indicate that treatment reduced recidivism, but they do not conclusively prove treatment reduced recidivism. For instance, one study had 82 offenders in the control group and 70 offenders in the experimental group (inmates receiving treatment). The control group had a recidivism (re-incarceration) rate of 55 percent and the experimental group had a recidivism rate of 37 percent. However, this study also has weaknesses: (a) there are not an adequate number of inmates in either group, and (b) because inmates volunteered for

treatment, there is some screening bias. This bias prevents a conclusion that the findings are applicable to any but those inmates who volunteer to be treated. We reviewed numerous other studies with similar kinds of methodological problems.

As explained above, reviewing the literature is encouraging in that many studies indicate that treatment can reduce recidivism; however, these studies are not conclusive. We explored the possibility of conducting our own experiment, but chose against it for the reasons listed below.

Tests to Measure Recidivism in Utah Would Likely be Impractical and Inconclusive

For the reasons explained below, we believe we cannot develop a strong, control group study. Further, we believe that the quasi-experimental design studies would not conclusively show that programs reduce recidivism.

Conducting a Control/Experimental Group Study Would Be Impractical. Though the strongest study is a control group/experimental group study, we believe that our office is not in a position to conduct this type of study because there is insufficient time. Assuming our office was able to get approval for some kind of random assignment of inmates to programs, it would take at least four to five years to start seeing defensible results. We would need to track those who didn't get treatment versus those who did get treatment throughout their stay at the prison. (Correction's data indicates that average length of stay for all offenders at the prison is 26 months.) We would then need to track them in halfway houses and on parole for at least another 24 months. Since our office typically spends about twelve months on a major project, a study lasting four to five years is outside the scope of what our office normally does. This study would be very costly and may not apply to current treatment methods because the study would have to track recidivism of individuals receiving particular treatment in the past. In our opinion, this type of study is more of a research study than a typical audit.

Conducting Quasi-experimental/Other Studies Would Likely Be Inconclusive. Quasi-experimental and other studies are not as strong as control group studies. As explained above, the quasi-experimental study cannot conclusively show whether the treatment led to a reduction in recidivism. Further, waiting lists may not be accurate, nor may case file information on individual inmates be adequate. For these reasons, we decided against trying to conduct our own quasi-experimental study.

Prison Management has Discretion in Hiring Therapists

It also appears that prison management has discretion in choosing an inmate's treatment providers. Prison management can either refuse or allow an inmate to hire his or her own therapist during incarceration. An attorney from the Office of Legislative Research and General Counsel and an attorney from the Attorney General's Office both feel that the courts have traditionally allowed prison management wide discretion in how the inmates are managed. Based on this view, these attorneys believe the courts would uphold prison management's prerogative to either prohibit or allow inmates to hire their own therapists. They also said that allowing inmates to be treated by their own therapist could lead to potential security problems; it could also be perceived by some inmates as being unfair. In addition to our discussions with these attorneys, the six states we contacted do not allow inmates to use outside therapists, citing similar problems.

We hope this letter adequately responds to your concerns in these areas. Letters of response from the Department of Corrections and the Board of Pardons are attached. Please call if we can further assist you.

Sincerely,

Wayne L.Welsh
Legislative Auditor General

WLW:CLM/lm