California Sex Offender Management Board

Sexually Violent Predator Project: Sex Offender Treatment Program Participation Rate

May 2026

California Sex Offender Management Board (CASOMB)

SVP Committee

SOTP Participation Rate

I Purpose

"SVP" refers to the Sexually Violent Predator Law (CA Welfare & Institution Code, § 6600, et seq.) and represents the state's effort to treat and manage its highest risk sex offenders. In 2019, CASOMB prioritized understanding and making recommendations regarding four features of the state's implementation of the Sexually Violent Predator Law. These are: Duration of Detainee Status, Conditional Release Program Housing and Community Placement Issues, Sex Offense Specific Treatment Program Participation Rate, and Community Reintegration Resources for those Unconditionally Discharged. In 2022, CASOMB removed the Community Reintegration paper from its list of objectives, because CASOMB expanded the scope of the topic to apply to all PC290 registrants discharging from secure settings. A separate committee, the Reintegration Committee, was assigned to draft a paper on the topic.

This paper addresses:

The SVP Sex Offense Specific Treatment Program Participation Rate

The **Introduction Paper** should be read prior to reading this paper.

II Description

Considering the underlying purpose of the SVP law is to provide treatment to those that perpetrated sex crimes with a serious risk of re-offense and the immense state resources spent by California to implement the SVP program, it is surprising and concerning that most individuals at the Department of State Hospitals (DSH) pursuant to the Sexually Violent Predator law do not participate in the Sexual Offense Treatment Program (SOTP). This paper examines the SOTP enrollment rate and provides areas of concern and recommendations. CASOMB has reported on SVP matters in prior papers and End of Year Reports (Appendix A). CA SVP has also been described in other reports (e.g. CCOSO, 2009; California State Auditor, October 2024).

In 1996 the CA SVP Act was created to detain and treat persons convicted of one or more sex crimes who are legally determined likely to perpetrate future predatory sexual offending due to the presence of a mental condition. By statute, persons undergo an evaluation for SVP within six months prior to being paroled from the California Department of Corrections and Rehabilitation (CDCR, e.g., CA prisons). Notably, the law has two application gaps: 1. It does not provide a provision for evaluating individuals serving jail time. This gap was created by contemporary realignment legislation diverting offenders, particularly those that violate conditions of parole, from prison to jail. 2. The SVP Act does not screen those serving indeterminate sentences that achieve the possibility of parole.

The majority of individuals undergoing SVP evaluation–are approaching completion of lengthy prison sentences, and with small exception, no access to sexual offense specific treatment in prison. In 2016 CDCR implemented a pilot Sex Offense Treatment Program, Cognitive Behavioral Interventions for Sex Offenders (CBI-SO) program, at the Substance Abuse Facility in Corcoran. This sole CA prison based SOTP has an eight month curriculum. As of December 1, 2022, 266 adult males adjudicated of sex crimes have completed the program, which has 80 participant slots with ten participants assigned to each treatment group. As of January 10, 2025, the CBI-SO program has 39 participants (CASOMB Board Meeting, CDCR agency update, 1/10/2025). The prison SOTP does not track recidivism outcomes. It is not known what number of its participants went on to be evaluated for SVP nor the outcome of such evaluations.

Per the SVP law, if the person is found not to meet SVP criteria at the end of their prison term, they are released on parole. High Risk Sexual Offender (HRSO) designated parolees receive state funded mandatory sexual offense specific treatment in CASOMB certified outpatient clinics, along with parole supervision conditions. Those end of term prisoners found to meet SVP criteria are initially detained pursuant to Probable Cause (i.e. WIC6602), and if legal criteria are met Beyond a Reasonable Doubt, they are indefinitely committed (i.e. WIC6604) to the state hospital until no longer dangerous, no longer mentally ill, or their risk can be managed in the DSH SVP Conditional Release Program (CONREP). As detailed in other CASOMB papers, the duration of Detainee Status is unduly long, and SVP CONREP is an under-utilized, but highly successful, program that provides intensive sex offense specific treatment, conditions of release, supervision, and monitoring of the SVP individual in the community (See SVP CONREP Housing and Community Placement Issues paper and Duration of Detainee Status paper).

Although SVP is a civil commitment with the express legal purpose of treatment and not punishment, many SVP individuals admitted to DSH experience commitment as an extension of punishment by the criminal justice system. Most have served lengthy criminal sentences followed by lengthy SVP commitment proceedings (i.e. a third of proceedings take more than 10 years to complete (see SVP Duration of SVP Detainee Status paper). By the time the individual is committed to DSH for treatment as an SVP, their most recent sexual crime typically occurred well over a decade ago.

Because the SVP law is a civil commitment, sex offense specific treatment participation must be voluntary (Kansas v Hendricks, 1997). Less than half of those committed (i.e., WIC6604) participate in the sexual offense treatment program. This treatment participation rate is much less than the average for SVP programs nationally which a survey of programs reported as 89.1% (Schneider et al., 2021). Further, CA does not legally require consideration of treatment participation to be released from SVP commitment. Statistically, many more persons committed as SVP get released from the commitment having *not* completed the treatment program than those who are released having completed the treatment program.

Significant research has found that sex offense specific treatment effectively reduces the likelihood of further sex offending (Gannon et al. 2021; Lussier et al., 2022; Hanson et al., 2009), even for higher risk offenders (Hanson et al, 2014). Merging the CA treatment participation rate data and the sex offense treatment efficacy data illuminates a large

population of higher risk sex offenders being released in CA without the benefit of Sex Offense Treatment programming.

Those who participate in the CA SVP treatment program vary in age, social and cultural background, criminal history, risk factors for re-offense, and mental disorder diagnoses. Since implementation of the SVP statute in 1996, the SOTP at that Department of State Hospitals (DSH) has evolved. In 2005 the SVP program was transferred from the state hospital in Atascadero to the state hospital in Coalinga. A significant number of the SVP individuals enrolled in the treatment program have been enrolled for more than a decade, although DSH does not report information on duration of treatment, which makes it challenging for stakeholders to understand the realities of SVP treatment participation. Lacking transparency from program administration is inconsistent with best practice standards and likely to impedes treatment engagement (Thornton & D'Orazio, 2013). Attorneys report their SVP clients often complain of program staffing issues, lengthy waits for assessments, and hopelessness about their ability to complete the SOTP.

The living space for SVP persons at DSH is comprised of units. There is no unit segregation for SOTP enrollment, -those that participate in SOTP are housed with the larger number who are resistant to SOTP participation. The intermixing of pro-treatment and treatment refuser populations is reported by some staff and treatment participants as creating tension. Since treatment participation is often perceived as akin to admitting to sex offending and/or sex offending related problems, it is not unreasonable for treatment participants to desire anonymity.

III Relevant Data

1. Since the 1996 SVP law was enacted through 2023, 1,068 persons were committed as SVP (CASOMB board Meeting, DSH Agency Report, 5/16/24)
2. There are currently 947 individuals at DSH pursuant to the SVP law. This includes 371detainees (WIC6602, Probable Cause) and 574 fully committed as SVP (WIC6604, SVP) (CASOMB board meeting, DSH Agency Report, 11/14/24)
3. The average length of stay at the DSH state hospital for discharged detainees is 12.3 years (WIC6602) and for the fully committed (WIC6604) it is 14.3 years (CASOMB board meeting, DSH Agency Report, 5/16/24)
4. The national sex offense specific treatment participation rate average among sex offender civil commitment programs is 89.1% (Schneider et al., 2021)
5. About 46 out of every 100 persons at DSH pursuant to the SVP law participate in sex offense treatment. There are 450 individuals at DSH who are engaged in the active modules of the Sex Offense Treatment Program. This includes 228 clients who are detainees (WIC6602) and 222 fully committed (WIC6604) clients (CASOMB board meeting, DSH Agency Report, 11/14/24)
6. Since the SVP law was enacted in 1996 through 2023, 498 detainees have been discharged; and 292 fully committed clients (WIC6604) have been discharged as having been found to not or no longer meet SVP criteria, including withdrawn petitions (CASOMB board meeting, DSH Agency Report, 5/16/24)
7. More than 90% of persons committed as SVP who get discharged did not complete the DSH Sex Offense Treatment Program for SVP persons.

8. SVP CONREP, the final SOTP step for those committed as SVP, has had 58 participants since the SVP law was enacted in 1996 (CASOMB board meeting, DSH Agency Report, 11/14/24)
9. 43% of all SVP CONREP participants have achieved full discharge (e.g., “unconditional release”), with an average length of stay 6.1 years (CASOMB board meeting, DSH Agency Report, 11/14/24)
10. As of November 2024, 18 SVP individuals in SVP CONREP, plus 19 additionally ordered to SVP CONREP pending placement (CASOMB board meeting, DSH Agency Report, 11/14/24)

IV SOTP Participation Rate Best Practice Analysis: Are the RNR Principles met?

The Risk, Needs, Responsivity Principles are the research supported guidelines for effective interventions with offenders (Andrews & Bonta, 2016). Any program or policy involving offenders should strive to maximize its adherence to each of the three principles. The current examination of the SVP program focuses on the impact of the Treatment Participation Rate on the program’s ability to adhere to these best practice standards. Since CASOMB is comprised of various agency stakeholders, often with competing interests (e.g. district attorneys strive to commit and defense attorneys strive to release offenders), CASOMB member expressly set aside their roles in completing this analysis. The analysis is conducted through the lens of what research supported treatment methods and principles, are most effective in reducing sex offense recidivism. The following section describes each RNR principle followed by an enumerated list of specific ways the principle applies to CA SVP.

Risk Principle

The level of intervention assigned (i.e., the frequency and duration of supervision and treatment services) should match the person’s risk for recidivism, with higher risk offenders receiving the highest levels of treatment. Low risk offenders should receive little or no treatment. Risk levels are typically provided by statistical measures that incorporate static Risk Factors and dynamic/changeable Risk Factors (aka Criminogenic Needs). The Risk Principle applied to the SVP population means there should be intensive treatment and supervision that gradually attenuates in response to treatment progress and risk reduction. The number and frequency of interventions should be reduced when there is sustained management of the person’s criminogenic needs, and increased interventions when their risk increases. The individual’s treatment plan and external supervision services should be regularly modified in response to fluctuations in risk. Risk Principle analysis for CA SVP treatment rate:

1. Low treatment enrollment rates in a program whose core purpose is to provide sexual offense specific treatment is a serious flaw. Considering the fiscal resources allocated to the state program, this flaw is a foremost concern.
2. Those that fully meet legal commitment criteria are, by definition, greater risk than those that do not. Thus, SVP commitment of those meeting legal criteria

should proceed swiftly and those not meeting criteria should be swiftly processed out of the SVP facility. CA SVP does not occur this way.

3. Treatment should be offered as close in time to the sexual offense as possible. The lack of access to sexual offense specific treatment in CDCR prior to SVP commitment is a serious flaw.
4. Restriction of freedom should be determined by risk. When an SVP individual shows sufficient reduction in risk through treatment engagement, they should be placed in a less restrictive alternative to full confinement. Step-down options from full commitment should exist. In the CA program there is just one, CONREP; it is not frequently utilized, and has access problems (see CONREP Housing and Community Placement Issues paper). Notably, CONREP requires the patient to petition for CONREP and many complete the inpatient program only to be delayed years to enter CONREP.
5. Risk is reduced by appropriate engagement in sex offense specific treatment. The SVP program should increase efforts to motivate individuals to meaningfully participate in the SOTP. Meaningful participation means active and personal application of treatment concepts, not simply sitting in a group therapy session.
6. In the interests of procedural justice and therapeutic jurisprudence, access to inpatient SOTP modules and transition to the outpatient step, CONREP, should be examined by attorneys', judges, law makers, and DSH so that treatment is available and transfer to CONREP swiftly occurs for those suitable.
7. The DSH SOTP should assure that frequency and duration of treatment is determined by the individual person's risk and treatment needs; lower risk/needs person's generally need less treatment than those with higher risk/needs, as determined by peer reviewed assessment tools such as those supported by SARATSO.
8. Detainees (WIC6602) are not eligible to complete the DSH SOTP. Lengthy detainee status impedes treatment access. Detainees that are released from DSH do not have the protective factor of treatment completion, and do not have access to CONREP (the community-based support, treatment, and monitoring program).

Need Principle

The Need Principle means that treatment and supervision efforts should focus on the psychological and social factors that predispose further offending. These factors are referred to as "criminogenic needs" because they need to be targeted for risk to reduce. Research shows that criminogenic needs are associated with increased recidivism rates, meaning that those with a higher number of criminogenic needs present are more likely to sexually reoffend than those with a lower number of criminogenic needs present. The DSH SVP Sex Offense Specific Treatment Program is designed to address participants' individual criminogenic needs in the context of a structured treatment program delivered

by trained professional staff, and includes ongoing assessments, and behavioral monitoring.

1. The majority of those committed pursuant to the SVP law do not participate in the SOTP, which means that most of the state's higher risk offenders with mental conditions are not accessing the specialized program to treat the underlying causes of their sexual offending. Some may find non SOTP activities, like self-help books, peer support groups, and religious services helpful. However, such activities are not delivered or monitored by sex offense specific treatment professionals; they are generally not designed to target the causal risk factors for sex offending; they do not include quality control mechanisms, nor do they provide objective assessments of the person's level of engagement, content understanding and change. The level of sex offense specific problems for the SVP population is serious and well founded. Such individuals should engage in the formal DSH SOTP.
2. There is no publicly available detailed description of the SOTP. Thus, there is no way to determine the degree that the SOTP adheres to best practice standards including addressing criminogenic needs.
3. The DSH inpatient facility is tasked with monitoring and assessing for risk related changes in functioning in patients' daily living. They document these observations and consider assessment results when making progress and discharge decisions. Attendance in the SOTP results in increased observation and assessment opportunities for patient progress, including when the patient expresses or shows successful replacement behavior for their identified criminogenic need(s). For the more than half of SVP individuals that do not participate in SOTP, there is less risk relevant and reliable chart notes to inform evaluations and release decision-making than there is for SOTP participants.
4. CONREP is the final stage of the DSH SOTP. It has been shown to effectively reduce reoffending. CONREP provides a community-based opportunity for the participant to safely transfer inpatient skills to a community setting. However, less than 5% of SVPs (WIC6604) achieve CONREP, which means a known effective treatment component is being severely under-utilized.
5. Participants successfully achieve the objectives of the Need Principle when they learn to identify when their criminogenic needs are activated on a daily basis and successfully use coping strategies to manage them. This includes the willingness to consider suggestions and feedback from mental health professionals and peers in the structured group treatment setting. Ambivalence and discomfort during the process of changing maladaptive behavior patterns is common, and can show up as treatment resistance, denial, and even relapse. Lapses and mistakes are expected and should not be considered "failures" but rather signals for increased treatment engagement and opportunities for change. -
6. Research shows that persisting in risk-related functioning late in treatment (or after treatment completion) is associated with elevated recidivism rates. For example,
   (1) Beginning treatment but failing to complete it (Hanson et al, 2002; Losel and

Schmucker, 2005); (2) Failing to demonstrate treatment gains (Marques et al, 2005; McGrath et al, 2012); and (3) Continuing to show behavioral evidence of criminogenic needs at the end of treatment (Olver and Wong, 2007; Beggs and Grace, 2010). Thus, participation in treatment only implies reduced risk when there is sustained management of the underlying factors being targeted in treatment.

7. There are four categories of criminogenic needs relevant to sexual offending: attitudes supportive of sexual offending, sexual interests, self-regulation, and relational style. The SOTP should address each of these when present in participants and the variety of ways they are manifested. For example, those that have a positive attitude to sexual offending, shown by statements that women who dress a certain way are asking for sex, or children benefit from sex with adults, typically have an "approach pathway" to offending rather than poor inhibition. The program should assess for and treat failure to attempt to use self-management skills not just poor self-management skills for those with offense supportive attitudes.

Responsivity Principle

Interventions are most effective when they fit the learning style and abilities of participants. This means that treatment should ultimately be experienced as help to participants. Treatment and supervision providers should use methods that have been shown to work with offenders and that are a good fit with the individual client. Methods should be adapted to maximize participants' positive response, motivation, individual learning style, abilities, and culture.

1. The low treatment enrollment rate is an example of a lack of adherence to the Responsivity Principle, -the program is not successfully engaging individuals' motivation to participate.
2. Most persons committed pursuant to SVP are not treatment participants. The treatment resistant majority likely undermines the motivation and ability of SVP persons to engage in treatment. Commonly, the majority influence the minority. For example, if 60% of a living unit are comprised of treatment resistant patients, it is likely challenging for the other 40% to show high treatment engagement. Treatment participants should be clustered together in their living units and treatment participation incentives should be implemented.
3. Delays in advancing participants through the SOTP modules and placement in CONREP unfairly deprives persons of liberty. Participants that complete the inpatient modules should be swiftly transferred to CONREP and then off of CONREP to full community reintegration when they no longer meet criteria. Delays likely discourage patients from participating in treatment.
4. Low treatment enrollment and completion rates likely undermine patient and staff morale, which in turn effects not only the efficacy of the SVP law, but also the credibility of the SVP SOTP
5. The program should offer a variety of methods to enhance protective factors not simply reduce risk factors. These encourage patients to change by developing

prosocial identities and lifestyles and affiliate with networks of support persons with similar "prosocial" goals and lifestyles. The program should create therapeutic communities, incentives for treatment, units comprised solely of treatment participants, an advanced treatment unit that simulates features of community living where those in higher modules can prepare for community discharge, a transitional living facility, and supervised community outings for those in the highest inpatient module.

6. SVP patients are the consumers of the SOTP and should be surveyed for their reasons for declining to engage in SOTP, and this information should be utilized by the SOTP to overcome barriers to treatment engagement. Some patients have reported concern that their disclosures in SOTP will undermine their goals for release from the inpatient facility.
7. Institutional living can trigger traumas and mental health symptoms. A trauma responsive institutional milieu should be created that mitigates the institutional capacity to create trauma and institutionalization.

Another research finding is when the three RNR principles are met, when greater care is taken to implement a program as intended, there are better outcomes (this is referred to as program fidelity) (Bonta & Andrews, 2007). Similarly, cutting out components in actual practice and a drift away from the therapeutic design are associated with worse outcomes (Thorton & D'Orazio, 2013).

1. The features of the SVP treatment program (e.g., what it addresses, its methods, what is required to advance, etc.) are not made available to interested parties and as such it is not known the degree that drift/fidelity occurs.
2. The SVP treatment program does not include ongoing program evaluation or external review.

V Recommendations

The CA SVP program has a low treatment participation rate. Less than one out of two persons committed pursuant to the SVP law actively participate in the SOTP. The fact that many more SVP individuals are released without completing the SOTP than treatment completers mean the underlying purpose of the SVP law is not being fulfilled. Low treatment enrollment also means significant wasted fiscal resources. The low SVP treatment participation rate is caused by lack of adherence to the RNR principles and best practice standards for sex offender treatment. These are serious flaws that undermine California's ability to effectuate the purpose of the SVP law to provide treatment to higher risk sex offenders that have diagnosed mental conditions.

Immediate actions involving the full spectrum of stakeholders involved in SVP commitment and treatment are warranted. Improving the California SVP program has significant potential to reduce the prevalence of sexual offending and enhance community safety and the lives of the many people admitted to the state hospital pursuant to the SVP law. We make the following recommendations to improve the SOTP low treatment

enrollment rate.

1. The California SVP system should be part of an integrated response to sexual offending that includes a continuum of services. SVP commitment should only be applied when other less extreme and less costly interventions have failed. While the law's intent is to protect the community by attending to the risk related mental health treatment needs of SVP individuals, the timing of SVP commitment and lack of access to sex offense specific treatment in prison to mitigate the need for SVP commitment is a gross inefficiency of resources and a significant obstacle to SVP treatment engagement. These deficiencies set the stage for the low treatment participation numbers observed in the CA SVP treatment program.

California needs a viable prison-based sex offender treatment program that allows all prisoners, that might be evaluated for SVP, the opportunity for treatment while serving their prison sentence. Collaboration between the existing CDCR treatment program and the SVP program should occur and ensure that all prisoners facing potential SVP commitment have access to sex offense specific treatment.

2. The numerous judicial steps involved in SVP commitment and Conditional Release (CONREP) do not occur efficiently. The delays cause lengthy detainee status and lengthy duration from CONREP readiness to CONREP placement. These lengthy wait times also undermine treatment motivation. Stakeholders should collaborate and implement strategies to prevent, monitor, and reduce delays. Reducing delays will increase treatment enrollment and treatment completion, which has been proven effective at reducing recidivism. Reduced procedural delays will reduce fiscal costs by lowering the total time at the DSH facility and from CONREP order to placement. Commitment proceedings and CONREP placements must occur more speedily.

3. DSH should implement an internal treatment review team to assure that participants are appropriately advancing through the SOTP without preventable delays. Safeguards should be put in place to identify cases where module treatment duration is excessive and identify and strive to overcome treatment progress barriers (e.g. any duration over a specified threshold should go to the review team).

4. When DSH determines a patient is suitable for CONREP, DSH should immediately notify the court that the person is CONREP suitable and request judicial review for CONREP (WIC 6605 (c)) Currently, the patient must affirmatively petition for CONREP, without any legal guidance provided or assistance by DSH, which is a broken policy that results in extraordinary delays and failure to initiate review.

5. State government and DSH should improve the housing and placement crisis for those ordered to CONREP. Waiting more than two years to access CONREP after completing inpatient SOTP and being judicially ordered to CONREP is a serious flaw in the SVP program. It creates a bottleneck where persons complete inpatient modules, are deemed suitable for a lesser restrictive setting, but cannot access to the outpatient stage of DSH treatment, CONREP. This bottleneck makes it easier for persons to get fully released from SVP commitment then placed in CONREP.

6. DSH, attorneys, judges and law makers must collaborate to fix the low CONREP rate. Low treatment enrollment together with CONREP housing and placement delays undermine SVP program efficacy, efficiency, and patient and staff morale. DSH and a committee of external stakeholders should collaborate to 1. identify and overcome the barriers to speedy CONREP placement for inpatient program completers. 2. identify the reasons that more SVP individuals get released without treatment than with treatment 3. Collaborate to implement systemwide strategies to improve the treatment enrollment rate.

7. Information about the SVP treatment program is not currently available to the public. The SVP program's lack of transparency regarding SOTP likely exacerbates the problem of low treatment enrollment. Transparency is an important procedural safeguard. DSH should implement a tracking system to identify the average duration of each module, and CONREP, and duration from intake to discharge for treatment participants and treatment refusers, and place statistical summaries on their website.

8. The fact that the chance of achieving release is much higher when one chooses not to participate in the SOTP places SVP persons in an untenable position where choosing treatment equates to delays in freedom. When SVPs get released without completing treatment, it means the purpose of the SVP law is not being fulfilled. Improved adherence to RNR will increase the number of SVPs enrolled in treatment. This has three aspects: meaningfully engage SVP individuals in treatment (Responsivity principle); provide treatment that effectively addresses the factors that underlie offending (Need principle); and provide sufficient treatment to reduce risk within a reasonable timeframe (Risk principle). Achieving this depends on the quality of available treatment and assessment services, the resources allocated to the treatment program, the knowledge of those who design the SOTP, and the skills of SVP treatment providers. DSH should implement a treatment enhancement team comprised of experts in the field of sexual offender treatment, representatives from the inpatient facility, and external stakeholders to routinely provide feedback, monitoring, and development of the DSH SVP sex offender treatment program. These efforts should include participant feedback.

9. Currently there is only one less restrictive alternative to full inpatient confinement for SVPs, - CONREP. CONRREP is significantly under-utilized. The DSH and external stakeholders should collaboratively engage in active steps to increase the number that achieve and complete CONREP. Additional less restrictive residential alternatives to full confinement at the state hospital and preparatory steps for CONREP that involve small steps toward community placement should be implemented. These should include a transitional living skills unit at the hospital or on hospital grounds and one or more transitional facilities. Transitional living facilities are intermediary residential options between full hospitalization and CONREP for those treatment participants that have completed the inpatient treatment program and will next go to CONREP.

10. Most individual committed pursuant to SVP are older than 50-yrs-old. There is a growing population of physically disabled SVP individuals (i.e. by way of physical infirmity, terminal illness, advanced age, cognitive decline, etc.) that do not need the security of the inpatient state hospital but do need a medically supportive setting. This

vulnerable SVP sub-population is lacking advocacy. Housing alternatives for SVP persons that are physically disabled should be implemented.

11. The SVP program has been in existence for more than 25 years, but there is no system of research to assess its efficacy. The SVP program should include an active research program to develop knowledge on the degree to which it adheres to the Risk, Needs, Responsivity principles, and the recidivism rate of those discharged. This research should be used to recommend program changes. It should assess whether SVP individuals recidivate at higher or lower rates than other groups of CA sexual offenders.

12. The SVP program will increase enrollment by better addressing the responsivity needs of those committed. This should include consumer satisfaction surveys (including a discharge survey), routine methods to survey and integrate feedback from program delivery staff, interaction between program leaders and consumers, increased transparency about the program, the effects of long-term institutionalization, peer support features (e.g., allowing increased prosocial interaction between advanced participants), an inpatient residential unit for treatment participants, furlough/day trip activities, program incentives, less restrictive alternatives, and motivational strategies. Residential separation between the treatment and non-treatment individuals in the SVP state hospital should occur.

13. The high level of sensationalized media attention undermines motivation for treatment by causing shame, fear, and hopelessness for SVP individuals and their supports, and has resulted in violent acts against patients, staff, judges, and homeowners. Media involvement in SVP Conditional Release judicial proceedings should be restricted. The public already has access to SVP information through criminal trial court records, Megan's Law website, and community notification features of the SVP law.

14. CA is but one of 21 US states/jurisdictions with sex offense civil commitment. Although it has been in existence longer than most, and is heavily resourced, it has a much lower SOTP participation rate. CA should learn what other states with SVP laws are doing to maintain higher SOTP participation rates and develop its program. CA should do a features and cost comparison to other SVP programs nationally.

15. CA DSH serves the state's highest risk sexual offenders but does not require its providers to obtain the highest level of certification required to treat sexual offenders. This is a paradox that likely effects the quality of treatment and credibility of the program. DSH should minimally require the staff that provide modules 3, and 4 of the SOTP to obtain CASOMB certification.

16. CASOMB, DSH, and law makers should collaborate to modify the label: Sexually Violent Predator because the intensely negative title is not factually accurate, and its use undermines the ability of program completers to safely reintegrate into the community. The new label should acknowledge the person's human dignity first, e.g. Sexually Violent Person, Sexually Dangerous Individual.

17. CASOMB will survey the range of stakeholders involved in the SVP law for reasons and remedies for the topics addressed in its SVP papers: treatment enrollment rate, duration

of detainee status, and CONREP housing and placement issues. The results of this survey will be disseminated to the stakeholder groups.

VI Conclusions

This CASOMB review finds a Low Treatment Enrollment Rate in the Sex Offense Treatment Program for SVP persons in California. The low treatment rate seriously undermines the efficacy and efficiency of the SVP law. In order to fix this, CASOMB recommends completion of the enumerated list above. First steps toward achieving the recommendations above are for CASOMB to complete the survey described above; disseminate these papers and the survey results to stakeholder groups, and request that DSH provide a written response to this paper. CASOMB will also ask DSH to facilitate a roundtable meeting comprised of representatives from each stakeholder group involved in the implementation of the SVP law: DSH executive staff and clinical leadership, CONREP leadership~~,~~ judiciary, district attorney and public defender groups, law enforcement, victim advocacy, patient advocacy, sexual offender treatment experts and CASOMB representatives. The objective of this meeting is to discuss the topics addressed above and develop plan of action with ongoing collaboration until recommendations are satisfactorily completed. DSH is an essential collaborator in the SVP law implementation, representing a difficult task with a challenging population within an adversarial socio-political context. Finally, the topics of these CASOMB papers should remain on CASOMB agenda until the board finds them appropriately addressed.

References

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Appendix A

CASOMB Year-End Reports

2023 CASOMB Year-End Report

2022 CASOMB Year-End Report

2021 CASOMB Year-End Report

2020 CASOMB Year-End Report

2019 CASOMB Year-End Report

2018 CASOMB Year-End Report

2017 CASOMB Year-End Report

2016 CASOMB Year-End Report

2015 CASOMB Year-End Report

2014 CASOMB Year-End Report

CASOMB SVP Papers

CASOMB SVP Intro and Detainee Status

CONREP Housing and Community Placement Issues

Conditional Release Program Housing and Community Placement Barriers Addendum