

## SPECIAL COMMITMENT CENTER FOR SEXUALLY VIOLENT PREDATORS: POTENTIAL PATHS TOWARD LESS RESTRICTIVE ALTERNATIVES, REVISED

In 1990, Washington State became the first state to pass a law authorizing indefinite civil commitment for persons found by the court to be Sexually Violent Predators (SVPs).<sup>1</sup>

Individuals found to meet criteria are housed at the Special Commitment Center (SCC) on McNeil Island for “control, care, and treatment”<sup>2</sup> until such time as:

- The person’s condition has so changed that the person no longer meets the definition of a sexually violent predator; or
- Conditional release to a less restrictive alternative is in the best interest of the person and conditions can be imposed that would adequately protect the community.

The 2011 Legislature directed the Washington State Institute for Public Policy (Institute) to examine the procedures and experiences associated with residents’ release from the facility and forecast the SCC population. An earlier publication addressed the population forecast.<sup>3</sup>

This report is organized in seven sections:

- I. Overview & Study Design
- II. SVP Treatment Approach & Participation
- III. Senior Clinical Team
- IV. Annual Reviews
- V. Discharges/Less Restrictive Alternatives
- VI. Comparisons with other Periodic Review Boards
- VII. Appendices (includes response from SCC)

<sup>1</sup> At present, there are 20 other states with similar laws. Lave, T. R., & McCrary, J. (2011). *Assessing the crime impact of sexually violent predator laws*. Retrieved from <http://dx.doi.org/10.2139/ssrn.1884772>

<sup>2</sup> RCW 71.09.060 (1)

<sup>3</sup> Murray, C. (2012). *DSHS Special Commitment Center: Population forecast, revised* (Document No. 12-11-1102). Olympia: Washington State Institute for Public Policy. **Note:** slight differences in the population numbers in this report and the population forecast are caused by differences between fiscal and calendar year reporting, the time period covered (this report is later), and the dynamic movement of residents from placement types. Also, 12 persons with SVP petitions are incarcerated for criminal convictions; depending on how they are counted, the number of commitments changes.

### Summary

Washington State law provides for indefinite civil commitment of persons found to meet criteria as sexually violent predators (SVPs). The Special Commitment Center (SCC) on McNeil Island houses persons who are detained and/or committed as SVPs.

The Institute was directed to study several aspects of SCC, including treatment participation, annual reviews, the role of the Senior Clinical Team, and Less Restrictive Alternatives. Major findings include:

**Releases:** As of CY 2012, 86 residents have been released from SCC. Of these, 54 were discharged from detainee status (i.e., never formally civilly committed) and 32 were unconditionally released after having been civilly committed.

**Treatment:** 37% of residents actively participate in sex offense treatment. The 2012 independent Inspection of Care Team rated the treatment program with high marks, but expressed concerns about the quantity of treatment hours, particularly for special needs residents, and lack of treatment for the severely mentally ill population.

**Annual Reviews:** A survey of legal practitioners revealed concerns about the timeliness of reviews, with mixed reports regarding the quality.

**Senior Clinical Team (SCT):** SCC’s group of senior clinicians and managers plays a key role in residents’ treatment progression and decision-making regarding readiness for a less restrictive alternative. Some practitioners in the legal community expressed confusion and/or concern about the SCT role.

**Less Restrictive Alternatives (LRAs):** Confinement at the state’s Secure Community Transition facilities costs significantly more than confinement at the main facility.

In SCC’s response to this report (Appendix A), they indicate that treatment hours have increased for the special needs population as of January 2013, and they have added programming for the severely mentally ill and aging populations.

Suggested citation: Lieb, R., Royster, A., & Lemon, M. (2013). *Special Commitment Center for Sexually Violent Predators: Potential Paths toward Less Restrictive Alternatives* (Document No. 13-01-1101r). Olympia: Washington State Institute for Public Policy.

## I. OVERVIEW & STUDY DESIGN

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When the 1990 Legislature established the civil commitment law for sexually violent predators, the intent language described a “small but extremely dangerous group of sexually violent predators” who do not meet criteria under the involuntary treatment act for short-term civil commitment. The Legislature declared that sexually violent predators had characteristics requiring an alternative law because:<sup>4</sup>

- These persons have “personality and/or mental abnormalities” which are “unamenable to existing mental illness treatment modalities and those conditions render them likely to engage in sexually violent behavior.”
- Additionally, the “prognosis for curing sexually violent offenders is poor, the treatment needs of this population are very long term” and the treatment modalities for this population are “very different” from those committed under the involuntary treatment act.

In order to identify sex offenders who may meet criteria as an SVP, a multidisciplinary committee within the Department of Corrections reviews persons who potentially meet the criteria for commitment as an SVP. If the committee determines that someone meets the definition, the case is referred to the Attorney General’s office or to the King County Prosecuting Attorney for offenders under its jurisdiction. The Attorney General or King County Prosecuting Attorney then decides whether to file a petition.

After a petition is filed, the person is detained at the Special Commitment Center; these individuals are known as “detainees.” These individuals are provided with a number of procedural protections, including access to counsel, expert witnesses, and trial by jury. If the jury or court finds, beyond a reasonable doubt, that the individual is a sexually violent predator, then the individual is civilly committed to the state for the purpose of treating the mental condition that produced the predatory acts of sexual violence. The commitment continues until the committing court or jury determines that the individual is safe to be released to a conditional discharge (a less restrictive alternative in a residential facility operated or contracted by DSHS or in the person’s own home in the community) or unconditionally discharged.

Initially, persons committed under the law were housed in a wing of the Twin Rivers Correctional Center in Monroe, Washington. In 1998, the Special

Commitment Center (SCC) was moved to a portion of a state prison, the McNeil Island Correctional center.

In 2004, a separate total confinement facility was opened on McNeil Island for the residents, with later construction of a 24-bed Secure Community Transition Facility on the island (Pierce County SCTF) and in Seattle, a 6-bed facility (King County SCTF).<sup>5</sup>

In 2011, the McNeil Island Correctional Center was closed, leaving the SCC and the Pierce County Secure Transition Facility (SCTF) as the only facilities operating on the island.

As of January 1, 2013, the SCC population included the following:

- 228 are committed;
- 21 are committed and on a less restrictive alternative (LRA):
  - 12 of the LRA residents are housed at the SCTFs in King and Pierce counties;
  - the remainder (9) are on LRA status either in a private residence or a group home; and
- 44 residents are detained and awaiting assessment.

The Institute’s recent population forecast for SCC observed that in FY 2012, releases from the SCC exceeded admissions for the first time in the history of the state’s SVP law.<sup>6</sup> As discussed in the forecast report, this is caused by “a general decline in admissions over the last 12 years and a more recent sharp increase in releases.”<sup>7</sup> This change in admission and release rates is largely attributable to the latest research on sex offender recidivism which revealed a general decline in the base rates for sexual violence and identified that sexual recidivism declines with advanced age. Furthermore, if this trend continues, “the number of people under the jurisdiction of the SCC is expected to remain at or about its current level for a few years and then gradually decline.”<sup>8</sup>

Given this trend toward discharge, there is increased interest by state policymakers in reviewing data and policies associated with release. The 2011

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<sup>5</sup> The Pierce County SCTF began operating in temporary quarters in late 2001 and moved its permanent location in February 2003. The King County SCTF opened in 2005.

<sup>6</sup> Murray, 2012

<sup>7</sup> Ibid, p. 1

<sup>8</sup> Ibid

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<sup>4</sup> RCW 71.09.010

Legislature directed that the Institute conduct such a review, in addition to the population forecast (see box, next page).<sup>9</sup>

## DATA SOURCES

In addition to interviews with SCC staff, this report relied on the following data sources.

### ***Inspection of Care Team Observations on Treatment Program***

In 2011 and 2012, the independent body that oversees SCC's compliance with its standards, the Inspection of Care team (IOC) visited the SCC and assessed the facility's compliance with its standards (as it has done for several years). The IOC provides an annual on-site inspection of care, providing "objective measures of service delivery, for internal program use and quality management."<sup>10</sup>

Members of the three-person IOC include individuals with expertise in SVP program administration, sex offender treatment, and health care. The team's inspection focuses on the SCC's 33 standards of care; these standards are divided into the following categories:

- Admissions;
- Sex offender specific treatment program;
- Health care services;
- Environment of care;
- Behavior expectations;
- Program administration; and
- Security.

The team's visits include meetings with key staff, inspection of files and documents, interviews with residents, and observations of treatment sessions. The SCC allowed one of the report authors to participate in the team's 2011 and 2012 inspection. Several findings from those inspections are incorporated into this report.

### ***Legal Practitioner Survey***

To learn about legal practitioner views toward the annual review process, we surveyed the judiciary, prosecutors, and defense bar in October and November 2012. The survey was sent to:

- Presiding judges in all counties' superior courts;<sup>11</sup>
- Attorney General and King County Prosecutor's units for distribution to the 15 prosecutors working on SVP cases; and
- Office of Public Defense for distribution to 23 defense lawyers with contracts for SVP cases.

We received 47 responses to the survey: 23 from the judiciary, 10 from prosecutors, and 14 from the defense bar. The vast majority of respondents (87%) were involved with an SVP case in the last two years.

### ***Additional Data Sources***

Interviews were conducted with individuals who either previously worked at SCC or were contractors. We also collected information about other states' practices for annual reviews of committed persons.

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<sup>9</sup> Supplemental Operating Budget, 2012 Wash. Sess. Laws 2225

<sup>10</sup> SVP programs that are incorporated into state mental health hospitals rely on hospital accreditation bodies for oversight and inspection. Programs outside the hospital system, like the SCC, need alternative oversight structures.

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<sup>11</sup> The initial email to presiding court judges was sent on October 1, 2012. We requested that the presiding judge forward the survey to judges on that bench with SVP experience. On October 30, 2012, we sent a follow-up email to two courts where no judges had responded (Pierce and King County). King County judges subsequently completed surveys.

### Study Authorization Language

In 2011, the Washington State Legislature directed and allocated general funds for the Institute to “conduct a detailed study of the commitment of sexually violent predators to the special commitment center pursuant to chapter 71.09 RCW and the subsequent release of those persons to less-restrictive alternatives.”

Specifically, the Institute shall examine:

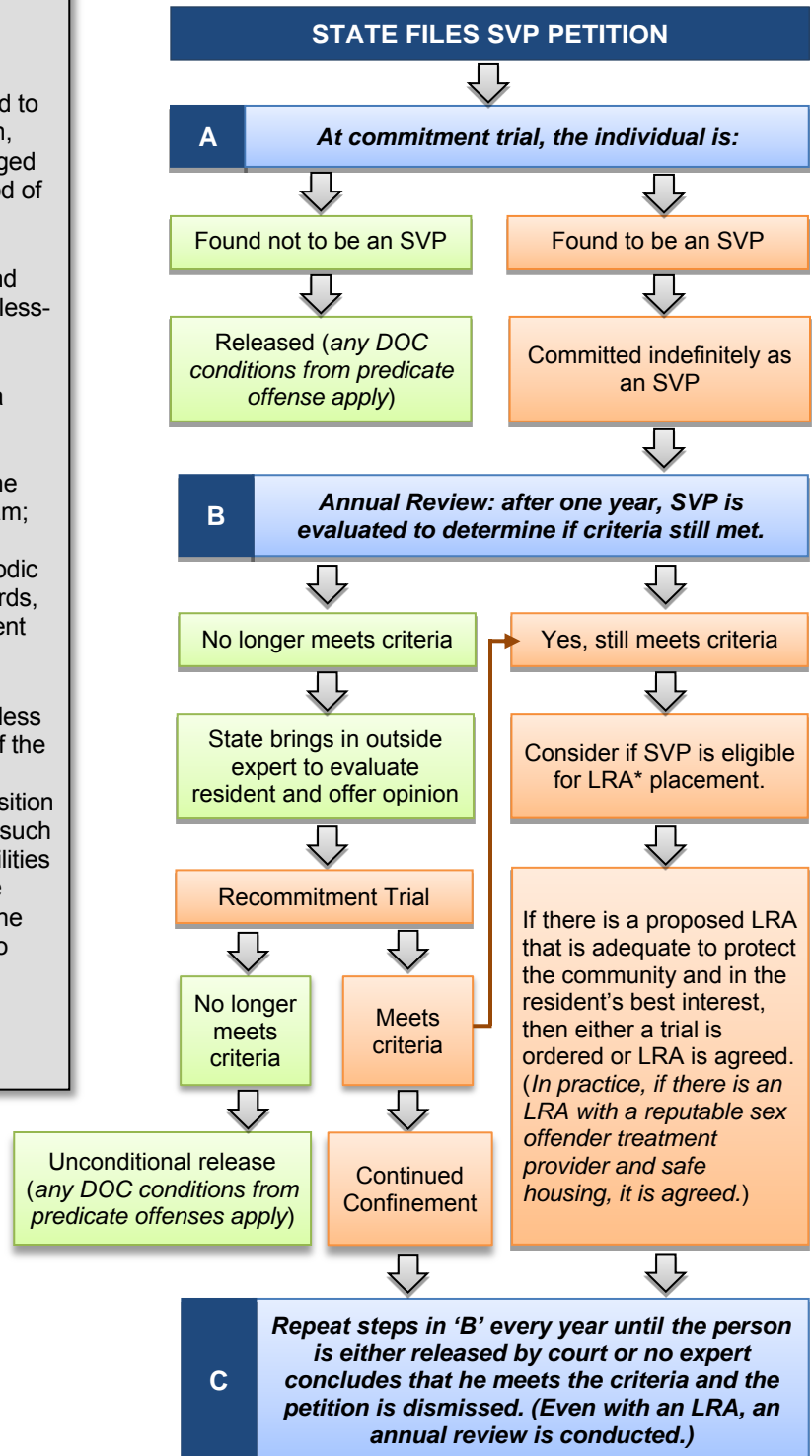
1. The projected future demand for the special commitment center, including profiles and characteristics of persons referred and committed to the special commitment center since its inception, whether the profiles of those persons have changed over time, and, given current trends, the likelihood of the continuing rate of referral;
2. Residents' participation in treatment over time and the impact of treatment on eventual release to a less-restrictive alternative;
3. The annual review process and the process for a committed person to petition for conditional or unconditional release, specifically: (A) The time frames for conducting mandatory reviews; (B) The role of the special commitment center clinical team; (C) Options and standards utilized by other jurisdictions or similar processes to conduct periodic reviews, including specialized courts, parole boards, independent review boards, and other commitment proceedings;
4. The capacity and future demand for appropriate less restrictive alternatives for moving residents out of the special commitment center, including: (A) The capacity and demand for secure community transition facilities; (B) Options for specialized populations such as the elderly or those with developmental disabilities and whether more cost-efficient options might be used to house those populations while keeping the public safe; (C) Prospects for moving residents to noninstitutionalized settings beyond a secure community transition facility.

2011-2013 Operating Budget, 2011 Wash. Sess. Laws 3931

### FLOW OF SVP CASES

The flow of SVP cases includes roles for the state (prosecutor), court, Department of Corrections (DOC) and the SCC. Readers may find it helpful to conceptualize this case flow (depicted in Exhibit 1) before reading the individual report sections.

Exhibit 1: SVP Case Flow



\*LRA is Less Restrictive Alternative

## II. SVP TREATMENT APPROACH & PARTICIPATION

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### FEDERAL COURT INVOLVEMENT IN TREATMENT PROGRAM

RCW 71.09.080 directs that persons committed as SVPs have the right to “adequate care and individualized treatment.” The statute requires that DSHS keep individualized records detailing all “medical, expert, and professional care and treatment” received by the person, as well as copies of all reports and periodic examination.

Over the course of SCC’s existence, the treatment program has changed significantly.

In August 1991, a civil rights lawsuit was filed in federal court alleging violations of the constitutional rights of SCC residents. In 1994, the Federal District Court for Western Washington entered an order and injunction requiring SCC to provide residents with “constitutionally adequate mental health treatment.” Beginning in 1995, the court held regular hearings on the state’s progress toward meeting the court’s requirements. Following a November 1999 hearing, the court found that SCC was making inadequate progress and ordered the accrual of a contempt penalty of \$50 per day per resident. The looming penalties were designed to motivate the state to make progress improving the treatment program.

The court also concentrated attention on the opportunities for SVPs to move from the facility into LRAs. The court found that the lack of less restrictive alternative (LRA) housing options limited the residents’ opportunity to demonstrate their reduced risk and ordered the state to arrange for the community transition of qualified residents, under supervision.<sup>12</sup>

Following the hearings in 2001 and 2002, the court recognized the state’s progress in creating LRA opportunities. Legislation had established the McNeil Island Secure Community Transition Facility (SCTF), and created a process to site additional facilities on the mainland. (An SCTF is defined as a secure community transition facility with supervision and security in addition to sex offender treatment services.)

After the December 2002 hearing, the court continued the accrual of the contempt sanctions until the state established an LRA facility off McNeil Island and otherwise complied with the injunction requirements.

In October 2003, DSHS entered into a long-term lease for a Seattle area building with the goal of creating a SCTF. That property was remodeled and ready for occupancy in September 2005. The first resident was placed there on a court-ordered LRA in February 2006.

In 2004, the federal district court found that Washington State was no longer in contempt of court and that the accrued sanctions did not need to be paid. In March 2007, the federal district court dismissed the injunction and closed the case.<sup>13</sup>

### CURRENT TREATMENT PROGRAM: RATIONALE/PHILOSOPHY

SCC’s treatment goal is to “provide evidence-based, best practice treatment that assists our residents in leading respectable lives, free of antisocial cognition and behavior and reduced risk for sexual recidivism.”<sup>14</sup>

The program approach is defined as follows:

- Primarily uses cognitive behavioral therapy and self-regulation principles;
- Supports an engagement model for residents unwilling to participate in sex offender specific treatment; and
- Relies on treatment phases that represent a sequential progression from orientation through community transition.

The “Risk Need Responsivity” model (RNR) has been selected as the SCC’s principle clinical orientation. This model was first formalized in 1990 by Canadian psychologists and is arguably the most effective model for assessment and treatment of offenders.<sup>15</sup>

As suggested by its name, RNR is based on three principles:

- 1) The *risk principle* asserts that criminal behavior can be reliably predicted and that treatment should focus on the higher risk offender. This principle guides the selection of which offenders

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<sup>13</sup> For a history of the federal courts’ deliberations related to SCC through 2003, see: Lieb, R. (2003). *After Hendricks: Defining Constitutional Treatment for Washington State’s Civil Commitment Program*. Olympia: Washington State Institute for Public Policy.

<sup>14</sup> “SCCs Treatment Program: Risk Need Responsivity” June 20, 2012. Document received from Holly Coryell, SCC Clinical Director.

<sup>15</sup> E. K. Drake & S. Aos (2012). *Confinement for Technical Violations of Community Supervision: Is There an Effect of Felony Recidivism?* (Document No. 12-07-1201). Olympia: Washington State Institute for Public Policy.

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<sup>12</sup> See Turay v. Richards (Order Granting Motion to Dissolve Injunction), Case No. C91-0664RSM.

will benefit most from treatment and supervision interventions, and directs that higher risk offenders should receive more intensive treatment and supervision and for a longer duration than low risk offenders.

- 2) The *need principle* focuses on criminogenic needs in treatment design and delivery. (Criminogenic needs are attributes of offenders that are directly linked to criminal behavior.) Treatment should take account of “dynamic risk factors”—that is, factors about the offender’s personality and/or lifestyle that are associated with an increased risk to sexually offend.
- 3) The *responsivity principle* is concerned with how treatment should be delivered. Treatment can be enhanced by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, abilities, strengths, and other individual characteristics of the resident.

An RNR approach is considered “state of the art” for sex offender treatment. The most recent meta-analysis of sex offender treatment reviewed 23 recidivism outcome studies that met basic criteria for inclusion. The authors concluded that sex offender programs that followed the RNR principles showed the largest reductions in sexual and general recidivism.<sup>16</sup>

The SCC treatment program includes sex offense treatment, as well as other activities such as employment, recreation and hobbies, and education. When residents first arrive, they are asked which, if any, groups they wish to participate in and are asked to sign a consent form for a self-management program. The consent form (see Appendix B) advises the individual that anything they say in the course of treatment is not confidential and can be used in decision-making about their treatment as well as their potential release.

Individuals who elect not to participate in treatment are assigned to a case manager who meets with the individual once a month (unless the person declines the meeting in writing). Those who have elected not to participate receive invitations to join the treatment program every six months. If a resident changes his or her decision and elects to participate in treatment, that person can do so without a waiting period.

All newly admitted residents who select treatment, or existing residents who request treatment, participate in a standard testing protocol that includes assessment of cognitive functioning, achievement, and personality

<sup>16</sup> Hanson, R. K., Bourgon, G., Helmus, L., & Hodgson, S. (2009). *A meta-analysis of the effectiveness of treatment for sexual offenders: Risk, need, and responsivity*. Retrieved from [http://www.publicsafety.gc.ca/res/cor/rep/\\_fl/2009-01-trt-so-eng.pdf](http://www.publicsafety.gc.ca/res/cor/rep/_fl/2009-01-trt-so-eng.pdf)

functions. (This battery of tests is a relatively new requirement for SCC and resulted from a recommendation from the IOC.)<sup>17</sup> Physiological testing such as the polygraph and plethysmograph<sup>18</sup> are integrated into the assessment process.

An initial treatment plan for each resident is completed within 45 days of the resident’s arrival at the facility.<sup>19</sup> This plan is based, at a minimum, upon the following information about each resident:

- Offense history;
- Psycho-social history;
- Person’s most recent evaluation; and
- Statement of high risk factors for potential re-offense.

The treatment plan describes the person’s needs in the following domains:

- Psychosexual;
- Psychological;
- Medical conditions that may influence treatment participation;
- Substance abuse;
- Responsivity issues;
- Vocational and educational;
- Recreation;
- Living skills; and
- Discharge planning.

The plan provides individual treatment goals and recommended interventions. For individuals with special needs, the treatment goals are adapted as necessary. Plans are also developed with input from the individuals and/or groups that manage discrete components of residents’ treatment, including vocational, education, and the Senior Clinical Team (defined later), as relevant to individual needs.

The treatment teams include a front-line staff member and manager from the person’s living unit, and if the person is in sex offender treatment, two involved clinical staff members. For residents not in treatment, a SCC case manager is included on the team. The SCC psychiatrist and medical staff (RN) participate in the Special Needs Treatment Team meetings (special

<sup>17</sup> Special Commitment Center. (2011). *Sex offender treatment program standards manual: October 2011 edition* (p. 57). Olympia: Washington State Department of Social & Health Services.

<sup>18</sup> A plethysmograph measures male sexual arousal to various types of visual and audio stimuli.

<sup>19</sup> WAC 388-880-040

needs cohorts are described later), and other team meetings on an as needed basis.

Additions to the treatment plan (termed “current conditions”) occur when there are significant changes in a resident’s conditions or behavior that necessitate clinical and/or residential intervention. Residents are informed of the results of evaluations and potential modifications they could make to change the results. Each resident’s treatment goals are periodically modified. When relevant, a physician or other health care provider participates either in person or by written report in the treatment team’s review and update of the resident’s current conditions. These plans are reviewed by the treatment team every six months, with a new treatment plan issued every twelve months or more often if needed.

## **TREATMENT PROGRAM ORGANIZATION**

The treatment program offered to SCC residents is divided into two tracks: conventional and special needs.

### ***Conventional Track***

For the conventional group, the first phase is intake and orientation where the resident learns about treatment approaches and expectations for treatment phases. Typically, this phase lasts for 45 days. The primary focus of each subsequent phase in treatment is as follows:

- Phase 2: self-exploration;
- Phase 3: skill acquisition;
- Phase 4: skill application; and
- Phase 5: skill generalization (typically occurs in a LRA setting)

For an overview of treatment phases and more detailed descriptions of what is expected of residents in each phase, please see Appendix C: SCC Treatment Phases & Expectations.

### ***Special Needs Track***

Residents who have cognitive, intellectual or learning deficits, psychiatric conditions or limitations that interfere with their ability to benefit from conventional treatment programming are placed in what is called a “Special Needs Track.” These residents are enrolled in a small group that jointly participates in treatment and supports each other in achieving individual and group goals. There are four levels (termed “Stages of Change”) for these cohorts.

The SCC’s 2012 program standards call for a minimum of five hours per week of sex offense specific treatment

for regular track residents and four hours per week for the special needs track. Additional social skills, specialty groups and individual therapy are provided for participants of both tracks.

### ***Specialty Groups for Conventional Track:***

- Power to Change
- Counselor Assisted Self Health (addresses substance abuse/dependence)
- TruThought Group: addresses responsivity needs and several dynamic risk factors
- Dialectical Behavior Therapy Skills Training Group

### ***Specialty Groups for Special Needs Track:***

- Reasons for Change
- Arts and Crafts Group
- Life Skills Groups

An additional group (2D Group) has been recently created for residents who are highly motivated to participate in treatment but have not fared well in either conventional track or special needs programming for a variety of reasons. The residents have unique learning styles, cognitive and/or psychiatric impairments, interpersonal skills deficits, and require additional structure and assistance learning core sex offense treatment concepts, and completing assignments. The residents live in Program Area 2.<sup>20</sup> The group is co-facilitated by a regular track and special needs therapist and follows the regular track treatment program at a slower pace.

### ***Treatment Incentives***

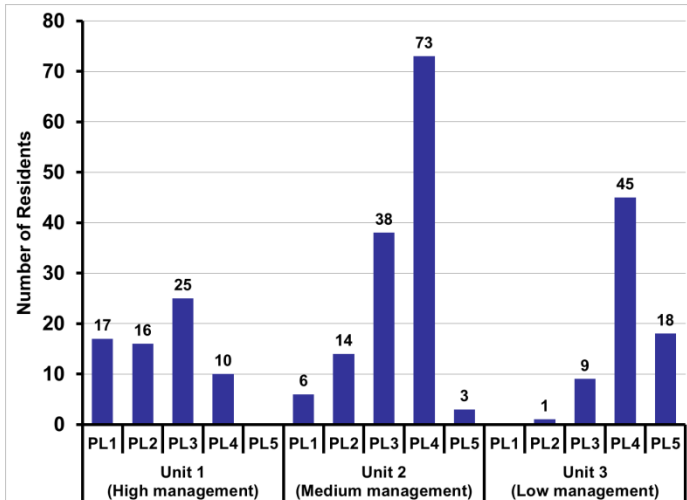
Several aspects of life for SCC residents are designed to encourage participation in treatment. Increased freedom and responsibility to move about the facility, higher wages for specific work assignments, and placement in more desirable residential units are all geared to encourage residents to engage in the treatment program. The primary incentive is that treatment participants are eligible for placement in a SCTF when they reach Phase 5.

Privilege levels in the living units are determined by a variety of behavioral factors as well as treatment participation. Exhibit 2 (next page) displays the privilege levels by the three program living units. More residents in the low management unit have reached the highest privilege level (PL5).

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<sup>20</sup> Program Area 2 is the mid-management living unit.

**Exhibit 2**  
**Privilege Levels (PL) by Program Living Units (Unit)**



Source: SCC

SCC residents have opportunities to engage in work at the facility. Those residents who work receive higher rates of pay depending on their privilege level and treatment participation (Exhibit 3).

**Exhibit 3**  
**SCC Pay Rates Related to Phase and Treatment Level**

PRIVILEGE LEVEL	TREATMENT LEVEL	RATE PER HOUR
5	5	\$3.00
5	4	\$2.90
5	3	\$2.80
4	5	\$2.80
4	4	\$2.75
4	3	\$2.70
3	5	\$2.70
3	4	\$2.65
3	3	\$2.60
2	5	\$2.60
2	4	\$2.55
2	3	\$2.50
NP*	4	\$2.50
NP*	3	\$2.00
ANY	2	\$1.00
1 / INTAKE	All	\$1.00

Source: SCC

\*NP is not participating in treatment

## SENIOR CLINICAL TEAM

The SCC has a Senior Clinical Team (SCT) that plays a key role in treatment phase advancement. The role and structure of the SCT has evolved over the course of SCC's history. In the mid-1990s, treatment teams had a direct role in recommending when residents should be considered for discharge. Because treatment staff members are interested in residents' achievement of treatment gains, SCC

management wanted a structure with more external review of recommendations. Thus, an SCT was formed.<sup>21</sup> Initially, residential and security staff were involved.

In 2002/03, the then CEO requested the formation of an SCT that did not include residential and security staff. Beginning in 2006, a voting representative from residential/security was added; this individual had a strong clinical background.

In June of 2010, new administrative rules concerning the SCT went into effect.<sup>22</sup> The SCT's role and purpose is currently divided into two categories:

### 1) Guidance and outreach:

- Provide general consultation regarding resident treatment and behavioral management issues;
- Conduct outreach to program areas of SCC including staffing and consultation of residents in sex offender treatment; and
- As requested, provide guidance and advice to the clinical director, the CEO and the treatment team.

### 2) Decision-making

The administrative code grants them specific decision-making authority:

- Make decisions about implementation of the sex offender treatment program;
- Approve/deny treatment team recommendations for phase promotions or demotions;<sup>23</sup>
- Make clinical recommendations about residents in LRA settings; and
- Consider residents for unconditional discharges, and identify clinical concerns, if any, to the CEO.

Members of the SCT are "directed to take into account all available relevant information, including contextual and situational factors, to make optimal, clinically supportable decisions."<sup>24</sup>

<sup>21</sup> D. Yanisch, personal communication, October 2012

<sup>22</sup> WAC 388-880-010

<sup>23</sup> H. Coryell, personal communication, October 2012. The clinical director indicated that the SCT does not review phase promotions from Phase 1 (Intake) to Phase 2. That responsibility is left to the original treatment team.

<sup>24</sup> WAC 388-880-010



The team members are defined as “professionally qualified persons “employed by DSHS and designated as members by the [CEO].”<sup>25</sup> There is no set number of members. The team may include a SCC contracted community based psychologist or psychiatrist with advanced forensic assessment and treatment expertise.

According to the SCC’s interim CEO, the membership of the SCT is designed to include the facility’s most experienced staff.<sup>26</sup> Because the last two CEOs have not been psychologists, the SCT plays a key role in advising the CEO on clinical matters. During legal proceedings related to the SVP’s potential release, questioning sometimes focuses on the CEO’s professional credentials and authority to make risk prediction decisions. The CEO has referenced the value of the SCT’s clinical expertise in responding to these questions.<sup>27</sup>

In 2012, the SCT members were:

- Clinical Director;
- Community Programs Administrator;
- Forensic Services Manager;
- Residential and Security Operations Chief;
- Medical Director;
- Forensic evaluator;<sup>28</sup> and
- Consulting psychiatrist.

Periodically, the managers from one of the three program living areas attend; they do not vote. SCT meets for three and a half hours every week, excluding holidays. The meetings are structured as follows:

- Announcements;
- Court preparations;
- Forensic services;
- Community programs;
- Action Items;
- Special Topics;
- Presentation (resident treatment progress); and
- Annual review(s).

<sup>25</sup> Those excluded from participating are: the resident’s attorneys; the prosecuting attorney; any representative of DOC; potential sex offender treatment providers or community providers who may treat the resident; and, any other party who may financially gain from the resident’s release.

<sup>26</sup> Don Gauntz is the interim CEO for the SCC.

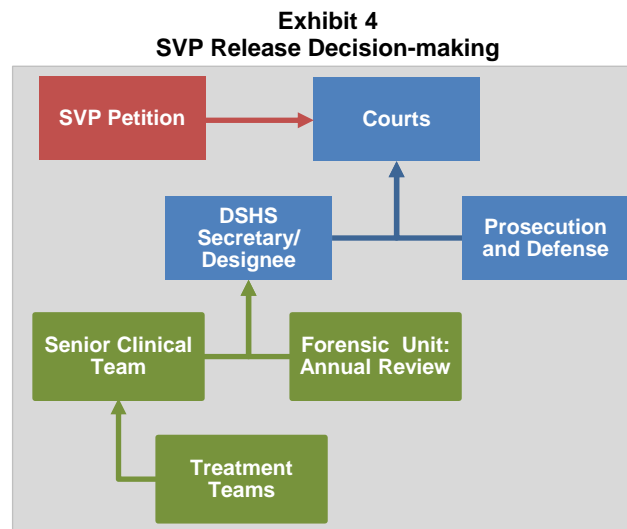
<sup>27</sup> D. Gauntz, personal communication, November 2012

<sup>28</sup> Initially, this was not a voting position but became so over time. Also, while contracted sex offender treatment providers are not members of the SCT, they are invited to participate in SCT staffings before a resident they have accepted into treatment is conditionally released to a LRA. D. Yanisch, personal communication, January 2013.

As mentioned, the SCT plays a key role in a resident’s advancement through treatment phases. The resident handbook specifies the role of the SCT and describes its significant role in phase promotions and conditional release recommendations.<sup>29</sup>

The SCT has additional functions associated with release decisions; these responsibilities will be covered later in this report.

Exhibit 4 displays the roles of the treatment teams and SCT in decision-making related to the release paths for SVPs.



The role of each entity in the exhibit is described below. We first explain the SVP petition, then provide explanations beginning with the treatment teams.

**SVP Petition:** Each resident can petition the court for conditional release to a LRA or unconditional release on an annual basis, and an attorney represents the person at a show cause hearing. The state can rely exclusively on the annual review during this show cause hearing.

**Treatment Teams:** For residents participating in treatment, these teams deliver cognitive-behavioral treatment. The teams recommend residents for phase advancement beyond phase 2; these decisions are made by the SCT.

**Senior Clinical Team:** In addition to determining treatment phase advancements, the SCT may participate in annual reviews for residents who are treatment participants. In cases where a resident is considered for conditional or unconditional discharge,

<sup>29</sup> Special Commitment Center. (2012). *Resident handbook, May 2012 edition*, (pp. 7-8). Olympia: Washington State Department of Social & Health Services.

the SCT offers an opinion to the CEO related to clinical considerations.

**Forensic Unit: Annual Review:** Forensic psychologists determine whether residents continue to meet statutory definitions of SVP.

**DSHS Secretary/Designee:** When the annual review indicates that a resident no longer meets the legal criteria for civil commitment, DSHS decides whether to support the person’s petition to the court for unconditional or conditional release. If DSHS authorizes the petition, a trial must be set within 45 days.

**Prosecution and Defense:** Both parties can elect to hire another expert to evaluate the person.

**Courts:** The court determines whether to set a hearing on whether the person continues to meet criteria or is safe to be released to a LRA or for unconditional release.

**TREATMENT PARTICIPATION RATES**

Calculating the percentage of treatment participants at the SCC would appear initially to be a relatively simple endeavor. However, some complexities regarding the definition of “participation” complicate the task.

The SCC Clinical Director must decide whether participation includes individuals attending non-sex offender treatment (e.g. substance abuse, cognitive behavioral therapy), as well as those who have serious mental illnesses and require significant clinical management by the facility psychiatrist.

Depending on how treatment is defined, treatment participation rates vary significantly.

Over the course of SCC’s five clinical directors, various calculation methods have been used. For the last three years, SCC’s current clinical director has used a consistent methodology. This definition counts participants in all types of treatment and then separately reports those participating in sex offense specific treatment.

**Exhibit 5  
SCC Treatment Participation Rates by Year:  
Percent of Residents**

Treatment Participants	2009	2010	2011	2012
All types	53%	55%	50%	48%
Sex offense only	40%	38%	35%	37%

Source: SCC

The 2012 IOC described SCC’s current definition of treatment participation as “very conservative” as many other states count a “much broader definition” of sex offense specific treatment activities, “ranging from self-management issues all the way to general structured activities.”

In discussions with SCC staff, the IOC was told that the facility’s budgetary allocations for treatment are principally determined by the number of residents in sex offense specific treatment, thus auxiliary treatment does not count in determining resource allocations. The team recommended that if the SCC’s definition of treatment does influence resource allocations, that SCC “may wish to assess whether its conservative approach” is having an adverse impact on its budget.”<sup>30</sup> In the IOC’s view, “a fairly wide array of activities which are not considered as sex offense-specific treatment are in fact a key part of an institution’s comprehensive sex offender treatment program.”

Another metric associated with SCC’s treatment program is the proportion of residents who advance in the phase system. Phase advancements in 2012 are summarized in Exhibit 6.

**Exhibit 6  
Treatment Phase Advances: 2012**

Phase Advances	Number of residents
NP to Phase 1	6
1 to 2	17
2 to 3	9
3 to 4	6
4 to 5	13

Source: SCC

Notes: (1) NP is not participating  
(2) In addition, there have been 5 residents supported by SCC to move from the SCTFs to a step-down LRA

**REASONS FOR TREATMENT REFUSAL**

Individuals who are civilly committed as an SVP choose not to participate in treatment for many reasons. A 2009 study of California’s SVP statute reported the following reasons that residents at their state facility refused treatment:

- Deny the offense or believe that their conduct was not harmful to their victims;
- Believe that sex offense treatment is not necessary for them not to reoffend;

<sup>30</sup> Special Commitment Center. (2012). *Sex offender treatment program standards manual: 2012 Inspection of care report* (p. 60). Olympia: Washington State Department of Social & Health Services.

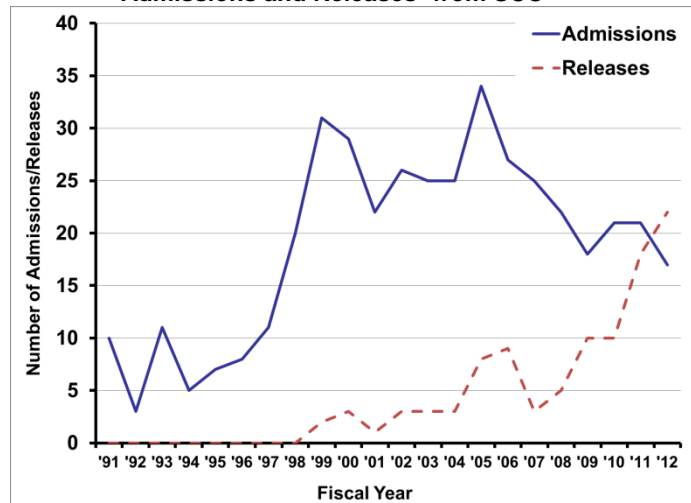
- Report that their attorney advised them not to participate;
- Judge the likelihood of release as greater for non-participants;
- State that their written assignments in treatment and progress notes from group sessions will be used to demonstrate that they continue to be at significant risk to reoffend; and
- View the treatment program as a hoax, believing that the real goal of the statute is to lock them up forever.<sup>31</sup>

The 2011 IOC report observed that resident frustration and anger are inevitable in a sex offender civil commitment program. The IOC observed that a variety of factors contribute toward many SCC residents' frustration and anger: "the legal uncertainties about their future, the difficult nature of progressing in sex offender treatment, distrust of the state and state-employed clinicians, the belief that their legal status entitles them to special treatment, the obvious hostility toward sex offenders throughout society, etc."

### RELEASE THROUGH TREATMENT: A NEW REALITY AT SCC

From the program's beginning in 1990 until FY 2004, no residents were unconditionally discharged after commitment. The first unconditional release took place in FY 2005, followed by a second in FY 2008. As Exhibits 7 and 8 demonstrate, since that time, discharges have occurred more frequently. In FY 2012, discharges and releases from SCC exceeded admissions for the first time in the history of Washington's SVP statute.

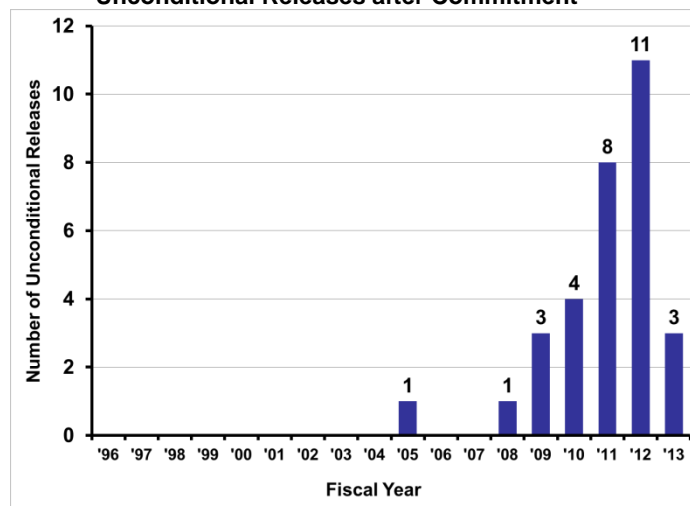
**Exhibit 7**  
Admissions and Releases\* from SCC



Source: WSIPP (Murray, 2012)

\*Discharges plus unconditional releases after commitment

**Exhibit 8**  
Unconditional Releases after Commitment



Source: WSIPP, 2013

\*Note: FY2013 only has 6 months of data.

The IOC observed that during their 2010 visit, a number of residents commented that they decided to enroll in treatment after observing a slight increase in the number of residents moved into less restrictive settings.

The IOC recommended that the treatment program maintain its current form, as stability is important for residents in maintaining their confidence that treatment offers a path toward release. The team observed that for residents, a stable clinical program provided reassurance to residents that the treatment "goal posts" remain predictable. As the team observed,

<sup>31</sup> D'Orazio, D., Arkowitz, S., Adams, J., & Maram, W. (2009, January). *The California sexually violent predator statute: History, description & areas for improvement* (p. 27). Los Angeles: California Coalition on Sexual Offending.

*“Now that the clinical program has become more stable, we assume that there will not be any more major restructuring for some considerable period of time. One of the most common complaints among residents is based on the changes that occurred in the program in previous years, and the perception that these changes were nothing more than a ruse to keep moving the goal line further away from the residents participating in treatment. This does not mean that the program should not make enhancements to its treatment efforts, but only that we urge the facility to be cognizant of the need to emphasize continuity and stability whenever possible.”<sup>32</sup>*

## **2011 AND 2012 IOC REPORTS: QUALITY OF TREATMENT PROGRAM**

The IOC in both 2011 and 2012 concentrated significant attention on the SCC’s treatment program.

Key findings in 2011:

- The treatment program “continues to maintain the improvements made over the last several years, and in some areas, it has improved.”<sup>33</sup>
- The IOC found that all treatment plans are up-to-date and well-documented. Furthermore, they reported that plans have “increased in sophistication and now routinely not only include treatment goals but also risk reduction.”<sup>34</sup>

In its 2012 report, the IOC’s conclusions about the quality of the treatment program were even more positive:

- They described the treatment program overall as a “well-functioning, cohesive effort that has continued to improve with a notable qualitative improvement over the last several years.”
- The treatment program’s leadership, as well as a “largely energetic, skilled and dedicated staff,” was judged as responsible for moving “a fairly dysfunctional program of six years ago to its current status as a solid sex offender treatment program.”<sup>35</sup>

<sup>32</sup> Special Commitment Center. (2010). *Sex offender treatment program: 2010 inspection of care survey final report* (p. 69). Olympia: Washington State Department of Social & Health Services.

<sup>33</sup> Special Commitment Center. (2011). *Sex offender treatment program standards manual: October 2011 edition* (p. 54). Olympia: Washington State Department of Social & Health Services.

<sup>34</sup> Ibid, p. 57

<sup>35</sup> Special Commitment Center. (2012). *Sex offender treatment program standards manual: 2012 Inspection of care report* (p. 60). Olympia: Washington State Department of Social & Health Services.

- The qualifications of the treatment providers at SCC were assessed to “meet or exceed the qualifications for similar sex offender treatment staff in the community or other institutional settings.”
- The energy and dedication of the clinical director and the treatment staff were rated as a “significant asset for the institution”<sup>36</sup> with effective supervision of staff provided by the director.<sup>37</sup>

## **2011 AND 2012 IOC REPORTS: CONCERN ABOUT TREATMENT HOURS (QUANTITY)**

While the IOC has been positive about treatment quality, in 2011 and 2012 they expressed significant concern about the limited number of treatment hours for special needs residents. They found during these last two inspections that the facility had not met its standard for treatment contact hours. “The 2011 standards called for a minimum of six hours of sex offense specific treatment per week, and social skills, specialty groups and individual therapy as needed.”<sup>38</sup>

In its 2011 report, the IOC rated this standard as “not met,” noting that because of SCC’s staffing restrictions, the conventional track residents were receiving five hours of treatment per week, and special needs’ residents receiving only two hours per week.<sup>39</sup>

The IOC identified the five hours of treatment for conventional track participants as the “lower end of an acceptable range,” and the two hours per week for special needs residents “falls short of what a civil program should be offering.”

The IOC recommended that the SCC consider increasing the number of treatment hours, acknowledging that resource constraints may make this difficult. The IOC advised that increasing hours while sacrificing quality is not preferable and connected treatment quantity with the residents’ ability to move toward release. The IOC commented that a “lower quantity of weekly treatment inevitably will result in longer secure institution placements for individuals who want to earn their release through treatment progress (thereby resulting in increased long-term costs).”<sup>40</sup>

<sup>36</sup> Ibid, p. 63

<sup>37</sup> Ibid, p. 65

<sup>38</sup> Special Commitment Center. (2011). *Sex offender treatment program standards manual: October 2011 edition* (p. 12). Olympia: Washington State Department of Social & Health Services.

<sup>39</sup> Ibid, p. 58

<sup>40</sup> Ibid

The IOC urged SCC management to consider its treatment hours in light of their long term goals, asking leaders to consider, “does the institution want to strive to become a leader in the SVP world, or does it want to establish goals that would be more consistent with an institution at the lower end of acceptable?”<sup>41</sup>

In 2012, the SCC reduced its standards for treatment contact from six hours for all residents to five hours of week of sex offense specific treatment for regular track residents,<sup>42,43</sup> and four hours per week for special need group.

As the IOC commented in their 2012 report, they found the treatment quantity for the special needs population (one to three hours per week) as “not at a level commensurate with the standard of performance for a civil commitment program”, and not meeting the SCC’s own standard. The team acknowledged SCC’s resource constraints, but indicated again that they did not believe this “substandard level of performance is any more acceptable now than when it was highlighted in last year’s report.” Looking to the future, the IOC noted that “the longer the current level of performance is maintained the more ‘acceptable’ it will become within SCC and the State,” and strongly recommended that SCC address this deficiency as “soon as possible.”<sup>44</sup>

## **2012 IOC REPORT: LIMITED PROGRAMMING FOR SERIOUSLY MENTALLY ILL RESIDENTS**

The IOC’s 2012 report also expressed concerns about the facility’s residents who are seriously mentally ill. The IOC observed that although ongoing psychiatric treatment is routinely available to this population, they do not have the “opportunity to receive other forms of programming that will be helpful in their progress in the overall treatment of their sex offending behavior.”<sup>45</sup> The IOC indicated that increasing this treatment/ programming has the potential to reduce long-term institutional violence associated with this population.<sup>46</sup>

## **SUMMARY OF SVP TREATMENT APPROACH**

At present, 37% of SCC residents participate in sex offense-specific treatment. An additional 11% participate in other treatment programming.

An independent body that oversees SCC’s compliance with its operating standards rated the content of the facility’s treatment program with high marks in terms of quality. For the second year in a row, however, the IOC found that the facility was not meeting its standards for number of treatment hours, in particular for residents with special needs. In addition, the IOC expressed concern about limited programming for residents with serious mental illnesses.

The next section will discuss the annual reviews that are submitted to the court regarding each SVP.

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<sup>41</sup> Ibid

<sup>42</sup> Ibid, p. 12

<sup>43</sup> Special Commitment Center. (2012). *Sex offender treatment program standards manual: 2012 Inspection of care report* (p. 12). Olympia: Washington State Department of Social & Health Services.

<sup>44</sup> Ibid, p. 87

<sup>45</sup> Ibid, p. 87

<sup>46</sup> Ibid, p. 60

### III. ANNUAL REVIEWS

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This section covers the SCC's process for annually reviewing residents for consideration for potential release.

We first describe the legal context for the annual review and a SVP's potential path toward release. Following that summary, we describe the steps taken by SCC forensic evaluators to produce annual reviews. Finally, we review the survey responses from practitioners regarding the perceived quality and timeliness of SCC's annual reviews.

#### LEGAL CONTEXT FOR REVIEWS

RCW 71.09.070 directs that each person committed under this chapter shall have a current examination of his or her mental condition by DSHS at least once every year. This document shall "include consideration of whether the committed person currently meets the definition of an SVP and whether conditional release to a LRA is in the best interest of the person and conditions can be imposed that would adequately protect the community."<sup>47</sup> The annual review is filed with the court and copies are provided to the prosecutor and defense counsel.

If the DSHS Secretary determines that the resident no longer meets commitment criteria, or an LRA can adequately protect the community, he or she is directed to authorize the person to petition the court for conditional release to a LRA or unconditional discharge. The Secretary must also provide the committed person with an annual written notice of the person's right to petition the court for conditional release to a LRA or unconditional discharge over the Secretary's objection.<sup>48</sup>

If the person petitions for conditional release or unconditional discharge, the court must set a show cause hearing to determine whether probable cause exists to warrant a hearing. If the court finds probable cause, the court sets a hearing. If the court determines that the person no longer meets the definition of an SVP, the person must be released. The SVP or the state may propose a conditional release plan to a LRA.

A DSHS-endorsed release plan first involves placement in a Secure Community Transition Facility (SCTF). In this setting, the person lives in a facility

with 24-hour security. At the SCTF, the person is allowed greater freedom and gradual transition to the community, while continuing treatment.

If an SVP submits his or her own LRA proposal, the plan must meet specific statutory criteria.

Individuals found no longer to meet criteria can also be unconditionally discharged by the court.

#### ANNUAL REVIEWS: ROLES OF FORENSIC AND CLINICAL STAFF

Annual reviews are the responsibility of the Forensic Services Unit in the SCC.<sup>49</sup> This team of six psychologists and one manager produces the majority of annual reviews; periodically, contracted psychologists complete reviews.

The unit uses actuarial risk assessment instruments to assess the person's risk in relation to other populations of sex offenders. In addition, the unit relies on clinical information that is gathered through document review, interviews, and interpretation of psychological testing. This role is distinguished from clinical staff that lead treatment groups and are expected to create a therapeutic alliance with the individual and assist them in addressing their problem behaviors and mental states.

This section describes the four principal ways that states with SVP laws produce periodic reviews/progress notes to the court for persons committed under an SVP statute:

1. The annual review or treatment progress report is produced by clinical staff members who either work at the SVP facility or for the state mental hospital.
2. Evaluators are employed by the state but are separate from the clinical program. In some cases, these evaluators conduct multiple types of forensic evaluations, including competency to stand trial assessment.
3. The review is produced by independent evaluators.
4. A board appointed by a state official produces the review.

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<sup>47</sup> RCW 71.09 identifies this report as an "annual report". It is typically called an "annual review" among practitioners; this document uses annual review, unless specifically referencing the law.

<sup>48</sup> RCW 71.09.090 (2)(a)

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<sup>49</sup> The term "forensic" is generally associated with court-related matters.

In reviewing the variations, one author, Shan Jumper, observed that independent evaluators typically have the advantage of “apparent objectivity” in their recommendations. Also, he commented that this expert is less likely to be influenced by emotional entanglements that can occur for therapists who are treating an individual (a condition known as countertransference). Treatment committees, Jumper observes, have the advantage of multiple perspectives that potentially control for “inherent biases stemming from dual roles or multiple professional relationships.”<sup>50</sup>

SCC generally follows the second of the four variations, separating clinical and forensic staff. Forensic psychologists report to a Forensic Services Manager and the clinical staff report to the Clinical Director. This separation is not precise, however, in that some forensic staff lead treatment groups and also participate on the SCT.

Before describing the specific steps taken in producing an annual review, it is useful to consider the context for the forensic evaluator’s assignment in Washington State. Because the law is reserved for sex offenders found to be highly likely to “engage in predatory acts of sexual violence if not confined in a sexual facility,”<sup>51</sup> the residents typically have extensive histories of sexual offending. Once committed under the statute, residents are placed in a secure environment on an island where their in-person interactions are limited to other residents, SCC staff, and periodic visits from family and friends. (Residents have relatively unrestricted access to the telephone and mail for other types of interactions with the external community.) For residents who participate in treatment, clinical staff lead them through a series of activities and group discussions intended to help them understand how their actions hurt their victims, and how they can choose to live crime-free if and when they are released.

As described earlier, residents who do not participate in treatment are assigned a case manager. In many situations, however, little concrete information exists on which to judge the person’s psychological condition and risk potential. In the case of both treatment participants and non-participants, the evaluator can review documentation regarding staff observations concerning residential behavior. In reviewing this documentation, however, the 2012 IOC judged the quality and quantity of this documentation as “generally deficient.”<sup>52</sup>

<sup>50</sup> Jumper, S. (2010). Conditional release of civilly committed sexual offenders. In A. Schlank (Ed.), *The sexual predator* (pp. 21-1-21-18). Kingston, NJ: Civic Research Institute, Inc.

<sup>51</sup> RCW 71.09.060

<sup>52</sup> Special Commitment Center. (2012). *Sex offender treatment program standards manual: 2012 Inspection of care report* (p. 70).

The annual review investigates whether the person’s condition has “so changed” that either they no longer meet the commitment definition of an SVP or conditional release to an LRA is in the “best interest of the person and conditions can be imposed that adequately protect the community.”<sup>53</sup>

In a review of SVP laws across the country, one researcher commented on the political stakes associated with releases of SVP. Andrew Harris observed the following: “From a political standpoint, the prospect of releasing a previously convicted sex offender into the community represents a high risk proposition,” particularly when that person has been designated as a sexually violent person. For these decisions, Harris observed, “the potential stakes of release are ratcheted even higher.”<sup>54</sup>

## STEPS IN PRODUCING ANNUAL REVIEWS

To produce the annual review, the evaluator investigates the person’s conduct in the facility, rescores the actuarial instruments, and contacts the primary clinician or case manager. The steps for this review are as follows:

- The evaluator calls or sends a written invitation to the resident requesting an interview. The resident has the right to decline the interview if he/she so chooses. In 2012, approximately 50% of residents met with the evaluator.<sup>55</sup>
- The evaluator contacts the clinical staff if the resident is in treatment or the assigned case manager if he/she is a non-participant.
- In addition, the evaluator contacts/interviews various staff members who have interacted with the resident over the course of the year, including medical staff, Pierce College staff associated with educational programming, and recreational and residential staff as appropriate.
- For newly committed residents, the evaluator first reviews discovery material from the prosecution and defense regarding the initial commitment decision. This material comes to the SCC from the Department of Corrections’ unit that prepares material for the Joint Forensic Unit evaluations.<sup>56</sup>

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Olympia: Washington State Department of Social & Health Services.

<sup>53</sup> RCW 71.09.090

<sup>54</sup> Harris, A. J. (2009). The civil commitment of sexual predators: A policy review. In R. G. Wright (Ed.), *Sex offender laws: Failed policies, new directions* (pp. 339-372). New York: Springer Publishing Company, LLC.

<sup>55</sup> B. Duthie, personal communication, November 1, 2012

<sup>56</sup> The Joint Forensic Unit (JFU) is comprised of a pre-selected group of nationwide expert forensic psychologists who have particular qualifications related to sexually violent predator and/or sex offense risk evaluations.

This documentation includes all available juvenile and adult criminal and legal records, psychological/psychiatric evaluations, institutional records, medical records, etc. An average initial evaluation involves approximately 3,000 to 4,000 pages of documentation.

- For residents with prior annual reviews, the evaluator reviews previous annual reviews, residential living reports, and psychological testing. For residents who are participating in treatment, additional material includes clinical progress notes, and any polygraph and plethysmograph tests. The range of pages to review is between 400 and 1,000. The amount of attention required to review these pages varies considerably; some, for example, are property inventory documents and others concern treatment progress. For non-participants, there are approximately 400 pages of information.<sup>57</sup> If the non-treatment participant has significant medical and/or legal issues, and is actively pursuing a LRA or unconditional release, additional interviews with medical or other staff are necessary.
- If the individual is housed at the SCTF, the evaluator also must review and take account of monthly reports from the treatment provider and treatment team notes

The administrative code spells out a specific procedure for SCC evaluators to follow when the SVP refuses to participate in examinations, interviews or testing associated with post-commitment proceedings. If the person refuses to participate, the evaluator “must notify the SCC forensic services manager...The SCC will notify the prosecuting agency for potential court enforcement.”<sup>58</sup> This provision is important to prosecutors in cases where evaluators have determined that they cannot find that persons continue to meet criteria because of insufficient information. According to the Attorney General’s lead prosecutor, to date the SCC has only requested court intervention one time on her caseload and that occurred after a specific discussion with the evaluator.<sup>59</sup>

## ANNUAL REVIEW PRODUCTIVITY

As of November 2012, SCC’s Forensic Services Manager indicated that the unit is responsible for producing 245 annual reviews each year. As mentioned earlier, there are six evaluators and three vacant positions. SCC has a performance measure to produce 25% of the annual reviews per quarter. The production in the last three quarters has been as follows:<sup>60</sup>

**Exhibit 9  
Annual Review Productivity**

Quarter	% per Quarter
FY 12 Quarter 3	19.6%
FY 12 Quarter 4	14%
FY 13 Quarter 1	20.7%

Source: SCC Data

Data from SCC indicate that on average, forensic evaluators produce two annual reviews per month.<sup>61</sup>

SCC relies on a point system to monitor productivity for evaluators. Each evaluator is expected to earn four points a month (thus one point is the equivalent of 40 hours of work). The points are calculated as follows:

**Exhibit 10  
Forensic Evaluator Productivity Point System**

Activity	Points
Annual review on a new resident	2
Annual review for other residents	1
Supervision of interns, post-doctoral fellows	1
Leading a treatment group of residents	1

Source: SCC

This point system is adjusted based on sick and vacation time, as well as exceptional circumstances. For example, one new resident had multiple boxes of case material that needed to be reviewed, so the points for this review were higher.

In FY 2012, SCC sent two evaluators to Western State Hospital to assist with their evaluation backlog between February and May.<sup>62</sup>

With a group of six evaluators producing an average two reports per month, the forensic unit can produce 144 reports per year. Thus, the SCC could have

<sup>57</sup> D. Yanisch, personal communication, December, 2012

<sup>58</sup> WAC 388-880-035

<sup>59</sup> B. Burbank, personal communication, January 2013. The Attorney General represents cases from all counties except King.

<sup>60</sup> M. Davis, SCC performance measures, 2012. There were two vacant evaluator positions for all three quarters.

<sup>61</sup> B. Duthie, personal communication, November, 2012

<sup>62</sup> M. Davis, SCC performance measures, 2012.



expected a backlog with its reports, even before it loaned its evaluators to WSH.

When asked about the backlog, SCC described it as “growing.” To address this situation, they indicated that they “are in the process of recalibrating the method of determining work load” and “hiring additional forensic evaluators.”<sup>63</sup>

## STATES WITH SVP LAWS

Earlier, we discussed the various ways that other states with SVP laws produce periodic reviews for the courts. As described, there are four principal variations in these approaches, with some states assigning this role to treatment staff, others to independent forensic evaluators, and others to a board or providing a combination of both clinical and forensic reports.

Although most states rely on common statutory language regarding the periodic review, in practice, there is significant variation in the detail and nuance of the review. In some states, the review is a relatively modest description of treatment activity, whereas in others, the document re-examines the person’s actuarial risk while also supplying individualized consideration of the person’s treatment progress and related risk concerns. (This latter approach is followed in Washington.)

In three states, the statute requires something other than an annual review. In New Hampshire, the person is committed for five years; at that point, he or she is evaluated for recommitment or release. Under Virginia’s law, an annual review is produced for the first five years of commitment, followed by a review every two years. In Texas, the SVP is not confined but supervised in the community; and in that state, the review is every two years (the SVP can still petition for release once per year).

The amount of court testimony associated with the periodic reviews also varies extensively by state. In some states, testimony is described by state officials as occurring very frequently, in others, very rarely. In recent years, the SCC forensic evaluators have been infrequently required to testify regarding their annual reviews.<sup>64</sup>

We interviewed state officials in 20 states with SVP laws, inquiring about their annual reviews and the expectations for their production. Eight states were similar to Washington in terms of their statutory direction, annual review components, and staffing arrangements. The monthly expectations for review

production in these states varied from 1.4 to 8.1 per evaluator. North Dakota and Washington had the lowest expectations, at 1.4 and 2 per month per evaluator. Exhibits 11 and 12 (next page) display this information.

### ***Western and Eastern State Hospital***

Forensic evaluators are employed at both Western and Eastern State Hospital. These psychologists evaluate an individual’s competency to stand trial. A competency evaluation has some similarities to a SVP annual review, but also significant differences:

- The question of competency to stand trial is a much narrower question than an SVP’s commitment criteria and readiness for an LRA.
- A competency evaluation constructs a picture of the defendant’s current functioning, whereas the SVP evaluation covers psychological functioning in the past year.
- The amount of documentation that needs to be reviewed in a competency case is significantly less.
- A competency evaluation requires an interview with the defendant; about half the SVPs choose not to be interviewed.
- The liberty interests in the two types of cases are significantly different; a competency assessment is for a time-limited period, whereas a SVP commitment is indefinite.
- Finally, SVP cases are highly adversarial and almost always have conflicting expert testimony. Generally, this is not the case with competency cases.

These differences need to be taken into account when comparing the work production expectations for psychologists working at SCC in the forensic unit and other forensic psychologists in state employment. The state hospital production figures, however, are the most closely aligned in Washington State government for comparison with SCC.

At Eastern State Hospital, forensic psychologists are expected to produce nine competency evaluations each month. Because the hospital has a large catchment area, some evaluators need to travel to distant counties. Evaluators also must coordinate schedules with defense attorneys, jail space availability, interpreters when needed, and patient transport for those on personal recognizance.<sup>65</sup> From May to July of 2012, forensic psychologists at Eastern produced an average of 8 evaluations per month.<sup>66</sup>

<sup>65</sup> S. Mailke, personal communication, November 2012

<sup>66</sup> Joint Legislative Audit and Review Committee. (2012) *Competency to stand trial, Phase I: Staff productivity standards, data reliability, and other parties’ actions may impact DSHS’s ability to meet timelines.* p. 12.

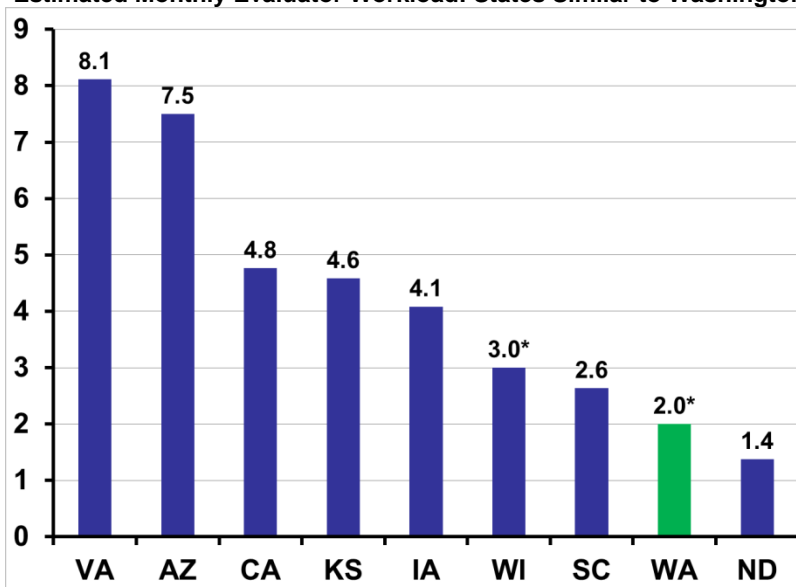
<sup>63</sup> D. Yanisch, personal communication, December 2012

<sup>64</sup> H. Coryell, personal communication, November 2012

**Exhibit 11  
Comparison of SVP States: Evaluator Workload**

State	SVP Census	Review	Evaluator Specifics
Arizona <sup>67</sup>	90	Annual	1 full-time psychologist
California <sup>68</sup>	400	Annual	7 full-time evaluators
Iowa <sup>69</sup>	98	Annual	2 evaluators
Kansas <sup>70</sup>	220	Annual	4 psychologists
North Dakota <sup>71</sup>	66	Annual	4 forensic psychologists
South Carolina <sup>72</sup>	158	Annual	3 psychologists in Forensic Division, 2 psychologists in SVP Program; Oct-Nov 2012: 21 evaluations.
Virginia <sup>73</sup>	292	Annual: for 5 years, then every 2 years thereafter	3 psychologists from an Independent Forensic Division; caseload is not divided equally.
Washington <sup>74</sup>	250	Annual	6 psychologists and 1 manager in Forensic Evaluation Unit; 1 contractor on standby; average 2 per evaluator, per month.
Wisconsin <sup>75</sup>	385	Annual	12 forensic reviewers who conduct the examination for the initial commitment, and 3 treatment progress evaluators, with an average of 3 evaluations per evaluator per month.

**Exhibit 12  
Estimated Monthly Evaluator Workload: States Similar to Washington**



Source: WSIPP 2013

\*Indicates actual number provided by state official. For other states, workload calculations were estimated using census, number of evaluators, and frequency of evaluations.

<sup>67</sup> B. Johnson, M.D., P.L.L.C., Tucson, AZ, personal communication, November 12, 2012

<sup>68</sup> J. Hicks, Psychology Department Office Technician, Contract Manager, Department of State Hospitals, personal communication, December 5 & 18, 2012

<sup>69</sup> J. Smith, Psy.D., Administrator, Cherokee Mental Health Institute, Civil Commitment Unit for Sexual Offenders, personal communication, December 4 & 13, 2012

<sup>70</sup> A. DesLauriers, Ph.D., L.P., Clinical Program Director, Kansas Sexual Predator Treatment Program, personal communication, November 15, 2012

<sup>71</sup> K. Wicks, Program Director, North Dakota State Hospital, personal communication, December 11, 2012

<sup>72</sup> M. Gehle, Ph.D., Sexually Violent Predator Program, South Carolina Department of Mental Health, personal communication, December 12, 2012

<sup>73</sup> A. Schlank, Ph.D., ABPP, Clinical Director, Virginia Center for Behavioral Rehabilitation, personal communication, December 10 & 18, 2012

<sup>74</sup> M. Davis, Administration Services Chief Special Commitment Center, WA Department of Social and Health Services, personal communication, December 11, 2012

<sup>75</sup> L. Sinclair, LCSW, Court Assessment and Community Programs Director, Sand Ridge Secure Treatment Center, personal communication, January 4, 2013; additional information from S. Watters, January 2013.

At Western State Hospital, seasoned forensic psychologists are expected to produce 12 competency evaluations per month; for evaluators with less than a year's experience, the expectation is at least 10 per month.<sup>76</sup> From May to July of 2012, Western's forensic psychologists produced an average of 9 evaluations per month.<sup>77</sup> Some of the hospital's most experienced psychologists produce 20 evaluations each month.<sup>78</sup>

### **Strategies to Streamline Reports**

In some states, a common format for the annual review has been produced. In Wisconsin, for example, a template for the annual review guides the evaluator through the key questions that need to be answered. As a result, lawyers working on SVP cases can anticipate where topics will be covered.<sup>79</sup> In Kansas, the annual review is termed a progress report; it follows a standard format covering the person's criminal history and background. The most dynamic sections of the document concentrate on the resident's behavior and treatment participation in the past year. A brief section outlines the plans for the upcoming year and key issues that the resident will address to move forward in treatment phases.<sup>80</sup>

WSH created a pilot initiative to standardize the competency evaluation process for psychologists in the forensic inpatient program. The hospital administrators have predicted this standardization will lead to increased efficiency of the evaluation process. This process will be implemented at ESH as well.<sup>81</sup>

The SCC is in the process of implementing new procedures for annual reviews. According to the SCC's interim CEO, the facility will be undertaking a "lean management" approach that has been the focus on the executive branch in Washington,<sup>82</sup> specifically using annual reviews as an area of attention. In addition to streamlining the process of collecting relevant records, the annual reviews will have "less focus on documenting specific incidents in the resident's file, and more emphasis placed on summarizing and synthesizing the information." The forensic team will be "seeking a balance between documenting enough information to satisfy judges and attorneys for a show cause hearing, without

doing an exhaustive reiteration of what is already in the record."<sup>83</sup>

### **SURVEY: LEGAL PRACTITIONERS' VIEWS CONCERNING SCC ANNUAL REVIEWS**

As indicated earlier, we conducted a survey of court personnel on issues related to this legislative assignment. The topic of annual reviews was included in the survey.

#### **Questions**

The relevant survey questions asked respondents to assess the following criteria, based on 5-point scale:

- Provision of quality information that assists the court decision-making;
- Clarity of reports in the following areas:
  - ✓ Rationale for conclusions
  - ✓ Individual meeting statutory criteria
  - ✓ Individual risk factors
  - ✓ Readiness for LRA
  - ✓ Treatment participation/progress
  - ✓ Forensic conclusions
- Length of reports; and
- Timeliness.

#### **Results**

The full results of the survey are included in Appendix D. This section summarizes the responses.

The judgments about the overall quality of the reviews revealed an interesting split, with 60% of judges finding that the annual reports provide quality information to the court, while majorities of both prosecutors and defense attorneys reporting mixed or negative perceptions.

Judges reported finding the content areas of the reports "clear and understandable" in most of the six content areas. Prosecutors expressed the most satisfaction with the sections addressing whether the person meets statutory criteria, and readiness for less restrictive placements and treatment participation. However, prosecutors expressed more mixed results concerning rationale for conclusions, individual risk factors and forensic conclusions. For defense attorneys, a greater percentage reported mixed views (some agreement, some disagreement) in all but one content area, while a majority was dissatisfied with the sections addressing readiness for less restrictive placements.

<sup>76</sup> B. Waiblinger, personal communication, November 2012

<sup>77</sup> Joint Legislative Audit and Review Committee, 2012, p. 12

<sup>78</sup> WSH psychologists, personal communication, October 2012

<sup>79</sup> S. Sachsenmaier, personal communication, March 2012

<sup>80</sup> A. DesLauriers, personal communication, December 2012

<sup>81</sup> Washington State Government Management Accountability and Performance (GMAP), Final GMAP Reports. (2012). *Are we reducing the number of adults waiting in jail more than 7 days for inpatient competency evaluations?* Retrieved from <http://performance.wa.gov/VCA/VCA081512/Mental%20Health/EvaluationsInpatient/Pages/Default.aspx>

<sup>82</sup> D. Gauntz, personal communication, November 2012; also see [http://www.accountability.wa.gov/leadership/lean/documents/2012\\_Lean\\_Report.pdf](http://www.accountability.wa.gov/leadership/lean/documents/2012_Lean_Report.pdf)

<sup>83</sup> D. Yanisch, personal communication, November 2012

This split pattern was also present in perceptions of timeliness, where the vast majority of judges rated the reports as completed in a timely manner and the other respondents revealing substantially more dissatisfaction. Only 8% of defense attorneys expressed agreement that the reports are completed in a timely manner; for prosecutors, that percentage was 33%.

In the comments section of the survey, attorneys reported that there have been times in the past when the reports were largely completed in a timely manner; more concerns were expressed about recent delays.

While a majority of judges and prosecutors endorsed the view that the reports were about the right length, only a third of defense attorneys agreed with this statement. Several prosecutors and defense attorneys judged the reports as overly repetitive from year to year, relying on a “cut and paste” approach that repeated historical information. Several practitioners reported that the reports concentrated too much on historical facts with insufficient attention to relevant analysis in the diagnostic and risk sections.

When asked how the reports could be improved, many prosecutors and defense attorneys recommended that the reports concentrate greater attention on the two essential questions: whether the person still meets the definition of a SVP and whether the person is ready for an LRA. Additionally, several recommended that the reports focus on an in-depth analysis of changes in the resident over the prior year. It was noted by one person that “dynamic risk factors are listed but there is no connection to why that makes the individual risky.”

Some prosecutors and defense attorneys commented that the reports vary in quality among the evaluators. One person recommended that each evaluation be subject to peer review.

Additional comments from respondents are summarized below, separated by those from prosecutors and defense.

#### *Prosecutors*

##### Treatment description:

The description of residents’ treatment participation was of concern to some because of imprecision. One respondent recommended the inclusion of “a more systematic articulation of the extent and degree of treatment participation.”

##### Individual assessment:

One prosecutor observed that the reports often reiterate the individual’s history, risk assessment and diagnoses, and often conclude he still meets criteria.

The person noted that the purpose of the review is to make an individual assessment, not “just report the statistics.”

#### *Defense*

##### Scientific findings:

One defense attorney commented that sometimes the reviews do not incorporate the latest in scientific findings about sex offender risk.

##### Variable quality:

According to one respondent, the quality and bias among evaluators varies greatly.

##### Focus on past:

In one person’s views, the annual reviews are “written by the same people who incarcerate our clients. There is no objectivity or scientific rigor. If the powers that be determine a resident deserves a scathing annual review, the resident receives a scathing annual review. The annual review is nothing more than a forum for prosecutors and jailers to rehash and regurgitate old crimes, facts, and allegations.”

## **PERSPECTIVES FROM RESEARCH LITERATURE**

Concerns about the quality of forensic mental health evaluations in general have led to specific recommendations from experts. Although this body of research does not specifically focus on SVP forensic reports, there are strong parallels between SCC’s reports and other forensic reports concerning mental health treatment.

Robert Wettstein (2005) reviewed empirical studies related to forensic evaluation and concluded that the most commonly reported quality concerns addressed issues related to timeliness, effectiveness, and efficiency, among others. These limitations, Wettstein argued, result in evaluations that are “less useful and cogent to the attorney or court.” The author noted that there are numerous barriers to quality improvement in this field, including what he termed “motivational or psychological factors.”<sup>84</sup>

In discussing these motivational/psychological factors, Wettstein observed that forensic evaluators are “likely to be satisfied with the quality of their evaluations, believe that little improvement is needed, and fail to undertake self-assessment or quality improvement unless externally mandated.” The imposition of a quality agenda, he observed, has the

<sup>84</sup> Wettstein, R. (2005). Quality and quality improvement in forensic mental health evaluations. *Journal of the American Academy of Psychiatry and the Law*, 33(2), pp. 158-175.

potential to be perceived by practitioners as a “threat to the evaluator’s autonomy.”<sup>85</sup>

As a remedy to these barriers, Wettstein recommended that forensic evaluators solicit “repeated input” from stakeholders. His recommended “client satisfaction form” relies on many of the questions that were asked for this paper’s court practitioner survey.<sup>86</sup>

## **IMPROVING COMMUNICATION BETWEEN SCC AND THE LEGAL COMMUNITY: EXAMPLES FROM WISCONSIN**

The survey results overall indicate that for prosecutors and defense attorneys involved with SVP cases, there are significant concerns with the annual reviews produced by SCC. Although one can anticipate that some tension will exist between the facility that houses SVPs and the attorneys who represent the residents and the state, the survey revealed degrees of animosity and confusion/uncertainty that deserve attention.

In Wisconsin, managers at the Sand Ridge facility were proactive in addressing the communication barriers that can emerge between an SVP facility and legal practitioners. Their efforts included the following.<sup>87</sup>

- Every two to three years, they sponsored a major training in the latest research on actuarial risk assessment that was offered free of charge for defense attorneys, prosecutors, and other clinical staff (including defense experts). These efforts were important in bolstering Sand Ridge’s credibility as impartial parties in these proceedings.
- With about the same frequency, Sand Ridge offered training regarding the facility’s treatment program for the same audience. Through this effort, the legal community learned about the treatment program in a comprehensive way.
- Each year, they gave presentations at the state’s judicial conference, with 90 minutes to explain risk assessment, the sex offender treatment program, and the facility’s processes. Also, the institution participated in an annual program where judges were able to tour the institution and hear presentations about its programming.
- On several occasions, the director gave presentations at the annual Public Defender conference and discussed Sand Ridge programs and policies.

- Sand Ridge had a Community Relations board which included a public defender, a prosecutor and a judge.

Proactive efforts similar to those used in Wisconsin could be beneficial in improving the relationships among court personnel and the SCC.

## **SUMMARY OF ANNUAL REVIEWS**

Annual reviews play a significant role in the potential release of an SCC resident. At present, there is a backlog in review production. The unit has a goal of producing 25% of SCC residents’ reviews each quarter. Averaging the last three quarters, they have produced 18% of these reviews.

For persons confined as SVPs, the annual review represents a significant opportunity for potential release; the chief architect of the SVP law, David Boerner, explained that the law was drafted with “procedures to protect the public from dangerous persons and protect those committed from the long-term warehousing characteristic of Washington’s civil commitment system prior to the 1973 reforms.” He referenced the annual reviews after commitment as a key aspect of this protection from warehousing.<sup>88</sup>

In this context, a backlog in the production of annual reviews represents a real impact on the liberty interests of the residents. According to the SCC, they have recently initiated efforts to address the backlog; it will be important for the legislature and executive branch to monitor the results. In addition to the backlog, quality issues revealed in the survey deserve attention. The survey used for this report could, for example, be administered on a regular basis. It would allow the SCC to efficiently monitor perceptions regarding quality and timeliness of annual reviews.

The next section discusses the Senior Clinical Team, in particular its role in annual reviews.

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<sup>85</sup> Ibid, p. 172

<sup>86</sup> Ibid, p. 169

<sup>87</sup> S. Watters, personal communication, December 2012

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<sup>88</sup> Boerner, D. (1992). Confronting violence: In the act and in the word. *University of Puget Sound Law Review*, 15 (3), p. 571.

## IV. SENIOR CLINICAL TEAM (SCT)

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### SCT ROLE IN ANNUAL REVIEWS

Section II of this report outlined the role and purpose of the SCT, as well as its membership. As we reported, the SCT oversees a resident's progress through treatment phases and offers clinical input to the CEO regarding residents' potential releases.

This section provides further detail on the SCT's procedures. We also summarize the survey results from legal practitioners regarding the SCT's role and include comments from other observers/participants.

When annual reviews do not recommend a change in a resident's legal status, the report is sent directly to the court. However, when an evaluator has submitted a draft annual report that recommends an LRA placement or unconditional release, the document is first distributed to SCT members. The clinical director schedules the case for discussion at an upcoming SCT meeting, to which the resident is invited. During the meeting, clinical staff members summarize their treatment activities with the resident and discuss potential additional therapeutic avenues. SCT members may ask questions or make suggestions about how the therapist should proceed with the next phases of treatment.

The resident is then brought before the team and asked to sit at the head of the table. The clinical director usually starts the questioning with open-ended questions such as: "What are you working on in treatment? How do you see your treatment progressing?" (The same process is used in SCT when phase advancement is recommended. However, the SCT's discussion of the annual review only occurs when the resident potentially will receive a conditional or unconditional release.)<sup>89</sup>

The conversations with the residents can take many different directions, including discussion about treatment goals and risk factors. On some occasions, SCT members make efforts to "break through resistances" and can push back and provide strong confrontation. On rare occasions, a resident will walk out of the session.<sup>90</sup>

Following the interview, the resident leaves the room. Team members agree on the primary issues to be addressed in the SCT's recommendations. One team member summarizes the comments from the meeting and these notes become part of the resident's clinical record.

Administrative rules direct the SCT to take account of the following factors concerning a SVP when making a recommendation to the CEO:<sup>91</sup>

- Behavior;
- Medication compliance;
- Manifestation and management of dynamic risk factors;
- Evidence or absence of paraphilia and personality disorder;
- Responsivity to treatment; and
- Psychological testing, polygraph results, plethysmograph assessment results, etc.

The SCC clinical director, Dr. Holly Coryell, explained that over time, the focus of the SCT's analysis has broadened. As she observed, "the original intention was to provide the superintendent (now CEO) with information regarding the residents' treatment participation, and progress." The team concentrated on "both level of phase and evidence of change in dynamic risk."<sup>92</sup>

Dr. Coryell explained that "one of the psycho-legal questions that the forensic evaluator is asked to answer is whether the person continues to meet criteria as an SVP." This orientation, she noted, does not specifically address "in what situations or circumstances might this person be more likely than not to reoffend, and in what context or under what external controls might the person's risk be mitigated?" Dr. Coryell observed that these "questions are often addressed by the SCT as part of their discussion and review of a draft annual review that recommends some kind of release (unconditional or conditional). Thus, the SCT formulates a recommendation to the CEO based on a blending of the risk analysis and treatment progress."<sup>93</sup>

Ultimately, the CEO (as the DSHS Secretary's designee) decides whether the resident is authorized to petition the court for conditional or unconditional release.

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<sup>89</sup> H. Coryell, personal communication, January 2013

<sup>90</sup> D. Yanisch, personal communication, October 2012

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<sup>91</sup> WAC 388-880-010

<sup>92</sup> H. Coryell, personal communication, January 2013

<sup>93</sup> Ibid

## SCT LETTERS TO THE CEO

As described earlier, the SCT offers its opinion to the CEO when an annual review determines that a resident no longer meets criteria or is ready for an LRA.

Until the recent past, the SCT letters to the CEO were not distributed routinely to the prosecutor and defense. These parties typically have received the SCT letters, but they were not distributed as part of a package with the forensic review and DSHS's letter to the court, if any. The SCC recently changed this practice, and will be distributing the forensic opinion and the SCT and CEO letter, if any, in one mailing.<sup>94</sup>

To learn more about the SCT's decision-making, we examined 60 letters on these subjects that were sent from this group to the CEO from 2010 to 2012. Of these:

- 9 were sent in 2010
- 29 were sent in 2011
- 22 were sent in 2012

The letters during these years involved 46 separate individuals; some individuals were the subject of multiple letters.

In 17 out of the 60 separate reviews, the SCT and the annual review reached different conclusions regarding the resident's readiness for release. In two additional cases, the SCT was either divided or unable to come to a decision.

Out of the 19 reviews in which the SCT disagreed or reached a divided decision, 16 were disagreements concerning the opinion in the annual review that the person no longer met criteria or should be unconditionally released, and three times, the disagreement focused on a recommendation for a step-down LRA.

In examining the attributes associated with the SCT's recommendation that a resident be released, not surprisingly, the key variable was the resident's progress in treatment. Another important variable was the resident's willingness to undergo a polygraph or plethysmograph. These exams can be useful to the SCT when an annual review indicates that there is insufficient information to conclude that the resident continues to meet criteria and SCT members are interested to learn about potential risk areas.<sup>95</sup>

According to the SCC, the SCT conducted interviews with residents in 25 cases and did not conduct

interviews in 33 cases (in one case, it was unclear and one resident declined an interview).

## SCT ROLE IN CONDITIONAL RELEASE VIOLATIONS

The SCT also plays a role when a resident on conditional release is alleged to have committed a violation of his or her court-ordered conditions and is pending a hearing on revocation or modification. The CEO may direct the SCT to review the matter and make a clinical recommendation. The team is directed to consider a range of information, including:

- The resident's transition activity;
- The factors surrounding the situation(s)/behavior(s) causing the revocation review;
- The ability of SCC and DOC to adequately assure the public's safety and the resident's compliance with LRA conditions if the resident remains in the community or is allowed community access;
- The ability of SCC and DOC to adequately manage the resident in the community given existing resources; and
- Any other relevant information (e.g., medication compliance, manifestation and management of dynamic risk factors, evidence or absence of paraphilia and personality disorder, responsivity, psychological testing, polygraph results, plethysmograph assessment results, etc.).

The SCT provides the CEO with a clinical recommendation regarding the revocation and any potential modifications to conditions.

## SURVEY AND OBSERVER COMMENTS ABOUT SCT

To learn about the views and perspectives regarding the SCT, our legal practitioner survey included questions related to this decision-making body.

We also conducted interviews with individuals who have been SCT members or observers both recently and in the past. The interviews focused on open-ended questions such as "I am interested in your opinion about how the SCT functions," with follow-up questions as warranted. Commentary from the IOC regarding the SCT is also included.

We will first discuss the survey findings then cover the responses from people who have been SCT participants/observers, followed by IOC recommendations.

<sup>94</sup> B. Duthie, personal communication, November 2012

<sup>95</sup> H. Coryell, personal communication, December 2012

## Responses

Of the judicial respondents, 40% described the SCT's role as beneficial, with 40% neutral and 20% endorsing the "other" category. Some judges who marked "other" commented that they did not know about SCT's role.

Prosecutors and the defense bar were knowledgeable about the SCT's role and expressed several opinions about its operations. The comments from these two groups are summarized below.

### Prosecutors

#### Role:

Close to 90% of prosecutors endorsed the view that the SCT should have a role in the annual review process. A third of this group viewed the SCT's role in annual reviews as beneficial; however, a significant portion reported concerns about the current functioning of the SCT.

#### Confusion of two voices:

Several prosecutors noted that having SCC say "two different things" is puzzling to the courts and parties. Instead, these individuals observed that the SCT's strength lies in providing a "diagnostic appraisal" that should be "considered and weighed by the evaluator who authors the annual review." A frequent recommendation was that the SCT staff the case with the assigned reviewer prior to the report's finalization in an effort to "reach consensus" and "minimize the situations in which there are conflicting opinions."

#### Protocol:

Some respondents observed that it would be beneficial to improve SCT's process. One respondent noted that there is no "discernible protocol" for the interview or for the SCT's letter. In this person's view, the SCT should review the resident's written work, comment on his or her demeanor, attitude, and ability to provide information, and ask about the person's mental preparations for a LRA.

#### Documentation:

Another respondent commented that the SCT meetings are poorly documented, in that the meetings are "written up as if they are daily progress notes and do not stand out from other progress notes as an important Senior Clinical evaluation."

## Defense

Overall, the defense bar expressed strong reservations about SCT's role, with almost two-thirds rating it as disruptive or confusing. The reasons for these ratings can be summarized as follows:

#### Legitimacy:

Several respondents expressed the view that the SCT does not have a legitimate role in the annual review process. For example, one respondent observed that the "annual review evaluators should be presumed to be competent professionals looking at the totality of a resident's progress in treatment and current risk of reoffense" and that the evaluator's "reports and recommendations should not be subject to revision by the SCT." Similarly, another respondent commented that the SCT should be involved in "reviewing disciplinary issues and in monitoring progress in treatment levels", but should "not be involved in the annual review process."

#### Transparency:

Other respondents expressed the view that the SCT's role in the annual review process be more transparent and integrated with the evaluator's report. One respondent noted that the process is "mysterious to me, and it should not be, it causes a lack of trust." This respondent argued that the team's role and expectations of residents should be "defined for residents in their manual because as of now, they have no idea what these people are supposed to be doing there...which builds paranoia and deters treatment participation." Another respondent wrote that the SCT's role "should be an informed and iterative process with the evaluator" in order to ensure that "evaluators understand the forensic question they are answering."

#### Inconsistency:

In the view of some respondents, the SCT's decision-making process is inconsistent, with one respondent noting that there were "too many hands" in decisions.

#### Focus:

Some respondents expressed the view that the SCT's decision-making process is not properly focused. For example, one respondent argued the SCT makes "semi-judicial and forensic decisions" rather than "clinical" decisions. The respondent stated that if the SCT makes these types of decisions, it should "publish the detailed reasons for its conclusions." Another respondent noted that the "SCT seems to only be focused on a person's phase in treatment, past crimes, and BMRs [Behavior Management Reports], not whether a person still meets criteria," judging the group's focus primarily on punishment rather than "therapeutic interventions."



### Treatment staff role:

Other respondents recommended that the SCT should more fully include the opinions and observations of treatment staff in their process. One respondent observed that the SCT has “little direct contact with the person, knows little about the person, but make the final decision on the case,” which “often confuses the client.” Another respondent noted the SCT’s membership “includes staff from both the forensic as well as clinical operations,” and argued that “Treatment staff who know the residents the best have only a modest voice in decisions.”

### **Comments from SCT Observers / Participants**

As mentioned earlier, we conducted interviews with individuals who have observed and participated in SCT both recently and in the past.

The comments are summarized below, grouped into the following categories:

### Role of SCT:

One person who was interviewed commented that SCT tries to do too much. Decision-making would be more objective if a separate body made the most important decisions involving movement to less restrictive treatment setting or release. SCT is better for routine day to day decisions involving emergent clinical issues and authorizing level changes within the inpatient treatment program.

In the view of one observer, the SCT’s responsibilities overlap significantly with the role of a clinical director. The SCT has authority to second guess the clinical director’s judgment regarding the treatment program. Since the skill and judgment of a clinical director is so significant to a well-functioning SVP program, it seems important to establish a system that gives sufficient authority to someone who has this important role.

If SCT and the SCC CEO disagree with an annual review opinion, one respondent believes they should be required to back this up in writing with an opinion signed by a licensed senior clinical psychologist. With the current system, there is a danger that SCT and the CEO’s decision can devolve into a political process where no resident can petition under RCW 71.09.090(1) despite the annual review. Disclosing the SCT opinion and requiring it in writing with professional endorsement prevents this problem by making an official record with transparent rationale.

One person noted that SCT supposedly provides clinical expertise for the CEO’s decisions, but the group is a mixture of clinical and forensic (evaluator) staff.

### Clinical staff interaction:

One observer noted that about two years ago, SCT started to shift their attention to legal issues. The clinical staff used to receive notice about which residents were going to be the focus of annual review, thus they could prepare thoughtful summaries of treatment progress. When there was time for clinical staff to prepare and present cases, the feedback from the team was often judged as valuable by the clinical staff. Lately, cases are scheduled with little notice, and there is very limited time for staff preparation and presentation. These time constraints limit the amount of direction that SCT can provide to clinical staff.

### Decision-making by team members:

For several of those interviewed, SCT’s decision-making does not appear to be systematic. They commented that it is not possible to follow the variables that influence the group’s decisions because they change from case to case. Sometimes, the team is heavily influenced by the underlying offenses, and for other residents with similar backgrounds, the resident’s treatment activity appears to have significantly more weight. Sometimes major conduct infractions are considered important, and in other instances, they receive little weight in decision-making. The SCT could benefit from using a standard check-list so they review the same key pieces of information in every case and strive for more consistency.

One person who participated extensively in the meetings observed that the group tends to overrate their ability to make accurate predictions about how residents will perform in less restrictive settings. In this person’s view, they are not attentive toward their own prejudices.

### Resident interviews:

For residents to believe in treatment as a way “off the island,” one person noted that they need to see the SCT as fair and have confidence in the process. The interviews with residents should follow a consistent protocol, with the same SCT members leading the discussion. The tone should also be consistent from resident to resident and not swing from encouraging to confrontational.

According to one respondent, many residents are very anxious to go before the SCT as they understand the power of this group in determining their release. This person noted that when the team treats a resident in an aggressive way, that story is repeated throughout the SCC and it does lots of damage regarding residents’ views about potential paths to release through treatment.

### ***Inspection of Care (IOC) Recommendations***

In its 2011 report, the IOC stated that it “may be appropriate” for the SCC to review the role played by the SCT in treatment advancement and potential LRA placements. The IOC observed that the SCT “represents a major investment of top-level clinical management time and energy.” Noting that the SCC may find that the SCT plays a “valuable role in guiding treatment decisions and making recommendations to the CEO concerning potential LRA placements,” and if so, the IOC expressed its understanding of that decision.

Given the facility’s resource constraints, however, the IOC suggested that the facility review the SCT’s structure and functions, with the potential goal of “freeing up resources that could be used to increase treatment quantity and/or quality.”<sup>96</sup>

### **SUMMARY OF SCT**

The direction for this study required that we focus on the role of the SCT in release decisions. In conducting surveys with court practitioners as well as interviews with observers and participants, significant controversy about the role and function of SCT emerged. The SCT makes its recommendations on conditional and unconditional releases to the CEO. The interim CEO places a high value on the SCT’s recommendations.

Given the important role of the SCT in SCC’s operation, as well as resident’s path to release, one might expect that facility management would collect data on its decisions, as well as solicit ongoing feedback from facility staff and the legal community. Instead, we observed little effort to view decision-making in a systematic way. This result was undoubtedly influenced by the workload of SCC managers, in addition to the facility’s extremely limited technical support for data collection. External views about the SCT, including those expressed by the IOC, did not appear to cause much questioning about alternative approaches.

As the SCC moves forward, the observations and concerns about the SCT’s role may be of value in considering potential modifications. Section VI covers periodic review boards that are similar to the SCT for other organizations and identifies potential areas for modification.

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<sup>96</sup>Special Commitment Center. (2011). *Sex offender treatment program standards manual: October 2011 edition* (p. 59). Olympia: Washington State Department of Social & Health Services.

## V. DISCHARGES / LESS RESTRICTIVE ALTERNATIVES

As reported earlier, the number of individuals discharged from SCC has increased significantly in recent years. These releases include discharges, unconditional releases, and conditional releases.

**Exhibit 13**  
**SCC Discharges by Category, 1996–Present**

Detainees	Civilly Committed	
<i>Discharged</i>	<i>– To SCTF/LRA – Then Unconditionally Released</i>	<i>Unconditionally Released from Total Confinement</i>
54 individuals	14 individuals	17 individuals

Source: SCC

As the table indicates, some SVPs have been unconditionally released from total confinement without going to an SCTF. As discussed earlier in the paper, individuals can petition directly to the court for release. In some instances, the court has approved an agreement reached by the prosecutors and defense that does not include an SCTF and the person lives in a private residence or group home. These releases are sometimes referred to as “attorney generated releases.”

The next section reviews the history of community transition for SVPs, the statutory requirements for SCTFs and LRAs, and the typical court requirements related to residences, supervision, and treatment. In addition, we detail the costs for SCTFs and LRAs.

### LEGISLATIVE HISTORY

In Washington’s original SVP legislation, there were no provisions for a community transition facility. As part of the federal injunction in 2000, Judge Dwyer issued a court order requiring that the state develop a step-down facility. “Mental health treatment,” Dwyer observed, “if it is to be anything other than a sham, must give the confined person the hope that if he gets well enough to be safely released, then he will be transferred to some less restrictive alternative.” Dwyer stated that the political opposition to these facilities, although “real and understandable”, cannot justify a deprivation of SCC’s residents constitutional right to treatment.<sup>97</sup>

The legislature responded to the court order by directing all counties and cities to amend their comprehensive plans and development regulations to

<sup>97</sup> Lieb, R. (2003). *After Hendricks: Defining Constitutional Treatment for Washington State’s Civil Commitment Program* (p. 485). Olympia: Washington State Institute for Public Policy.

account for a Secure Community Transition Facility (SCTF). When this direction was not followed, the 2002 Legislature passed additional legislation, preempting and superseding local laws and regulations and granting authority for the state to situate the facility if counties did not plan for their location.<sup>98</sup>

The legislation incorporated what was termed a “fair share” concept, requiring counties that have committed the largest number of SCC residents to “take back a fair share of those who are conditionally released.” The initial search for a facility was concentrated in King County, given that more than 50% of the SCC residents had been committed from that county.<sup>99</sup>

The political controversy associated with locating the two SCTFs was extensive. The King County facility was described in the press as “one of the most-despised public projects in recent local memory.”<sup>100</sup> Ultimately, the state remodeled a warehouse in the South End of Seattle; it opened in 2005. By 2006, the facility had its first residents; it has a capacity of six residents.

In siting the SCTF on McNeil Island, concerns about the safety of island residents made this siting politically difficult as well. At that time, McNeil Island Corrections Center was operating on the island, with approximately 50 homes for prison staff and their families scattered across the island. In late 2001, the state opened temporary quarters for an island SCTF; in February 2003, a permanent location was opened. This SCTF is known as the Pierce County SCTF and has a maximum capacity of 24 residents. This SCTF is physically separate from the main facility.

### SECURITY REQUIREMENTS FOR SCTFS

Statutory direction guides many aspects of the SCTF operations. Because of the controversies associated with placing persons designated as sexually violent predators in the community, these placements received attention in the legislature and resulted in statutory requirements about the levels of security.

<sup>98</sup> Secure Community Transition Facilities, 2002 Wash. Sess. Laws 214

<sup>99</sup> Department of Social & Health Services, Health and Rehabilitative Services Administration, Special Commitment Center. (2002). *Status report on the development of Secure Community Transition Facilities*. Olympia, WA: Department of Social & Health Services.

<sup>100</sup> Ko, Michael. (2003, April 6). State official runs gauntlet of anger, threats: His job is to take heat over sex-offender home. *Seattle Times*. Retrieved from <http://archives.seattle-times.nwsources.com/web/>

The SCTF requirements are as follows:

- King County SCTF: Direct care staffing shall be at least two qualified, trained staff.
- Pierce County SCTF: Direct care staffing shall be at least three, qualified, trained staff.<sup>101</sup>

Requirements for residents and escorts:

- Wear electronic monitoring devices at all time.
- At least one staff or authorized escort must accompany each resident for appointments, employment, or other approved activities.
- The escort must supervise the resident closely and maintain close proximity.
- The escort must immediately notify law enforcement of any law violations.
- The escort may not be a relative, or someone with whom the person has/had a dating relationship.
- The escort must carry a cell phone at all times.

The law has established requirements intended to reduce the public safety risk. When a property is considered for a SCTF, DSHS must consider the following:<sup>102</sup>

- The facility cannot be sited “adjacent to, immediately across a street or parking lot from, or within the line of sight of a risk potential activity or facility in existence at the time the site is considered.”
- Risk potential activities and facilities are: public and private schools, school bus stops, licensed day care and preschools, public parks, publicly dedicated trails, sports fields, playgrounds, recreational and community centers, churches, synagogues, temples, mosques, and public libraries.
- Within line of sight means that it is “reasonably possible to visually distinguish and recognize individuals.” DSHS uses 600 feet for purposes of this measure.<sup>103</sup>
- Additional considerations include whether there are natural and man-made visual screens between the SCTF and adjacent properties, if electronic monitoring services are available to the area, and if there is reasonable access to community services such as treatment, employment, vocational training, etc.

<sup>101</sup> The original staffing ratio requirement was higher; it was amended in 2011 (See: Secure Community Transition Facilities—Staffing, 2011 Wash. Sess. Laws 440).

<sup>102</sup> RCW 18.92.020

<sup>103</sup> See <http://www.dshs.wa.gov/scc/Safety.shtml>

## LRA STATUTORY REQUIREMENTS

As described earlier, SVPs can also be released directly to a community LRA, either a group home or private residence (see box, next page, for statutory language).

The court must find the following before ordering a community LRA:

- A qualified treatment provider has agreed to treat the person,<sup>104</sup>
- The treatment provider has outlined a specific treatment plan and rules that the person is expected to follow; progress is regularly reported to the court; and any violations immediately reported to the court, prosecutor, supervising Community Corrections Officer (DOC), and the SCC;
- The person will comply with the treatment provider and all requirements imposed by the treatment provider and the court;
- The person will live in housing that is sufficiently secure to protect the community, and the housing provider has: agreed in writing to allow the person to reside there; will provide the security required by the court; and will immediately report to the court, the prosecutor, the supervising CCO, and the SCC if the person leaves the housing without authorization; and
- The person will comply with DOC supervision requirements.<sup>105</sup>

Residents can only leave their residence for specific purposes as authorized by a court order and only with approval of the resident’s Transition Team (members include a Community Corrections Officer (CCO), a sex offender treatment manager, and an SCTF manager).

Unless otherwise directed by a court order, each resident must have one-to-one supervision by a trained SCTF staff, or court-authorized escort (CCO, sex offender treatment provider).

<sup>104</sup> The treatment provider must be certified by the Department of Health, see <http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionalsNewReneworUpdate/SexOffenderTreatmentProvider.aspx>

<sup>105</sup> RCW 71.09.092

**RCW 71.09.096:**

**Conditional release to less restrictive alternative**

Prior to authorizing any release to a less restrictive alternative, the court shall impose such conditions upon the person as are necessary to ensure the safety of the community. The court shall order the department of corrections to investigate the less restrictive alternative and recommend any additional conditions to the court. These conditions shall include, but are not limited to the following:

- specification of residence,
- prohibition of contact with potential or past victims,
- prohibition of alcohol and other drug use,
- participation in a specific course of inpatient or outpatient treatment that may include monitoring by the use of polygraph and plethysmograph,
- monitoring through the use of global positioning satellite technology,
- supervision by a department of corrections community corrections officer,
- a requirement that the person remain within the state unless the person receives prior authorization by the court, and
- any other conditions that the court determines are in the best interest of the person or others.

A copy of the conditions of release shall be given to the person and to any designated service providers.

**LRA PROCESS AND CONDITIONS**

When a community LRA is under consideration by the court, DOC completes an investigation to determine the suitability of the placement and potential public safety risks. These investigations include interviews with the resident, other persons who will be living at the structure and the suitability of the location in terms of potential risk to children, etc. CCOs spend an average of 200 hours conducting each investigation for a community LRA.<sup>106</sup>

In recent years, several residents have been placed in community LRAs. In each case, a court order has established conditions to protect public safety. These conditions can be grouped into three primary categories:

- Standard/supervision conditions;
- Residential conditions; and
- Treatment conditions.

To better understand the typical conditions imposed by the court for a community LRA, we reviewed 28 LRA court orders that were issued between September 1998 and June 2012. The following are summaries of the categories of conditions imposed by the court. Exhibit 14 (next page) details some of the specific conditions in each category.

***Standard/Supervision Conditions***

The standard conditions cover a broad range of conduct and behavior, focusing primarily on restricting movement, prohibiting contact with persons of particular ages, limiting the types of establishments and businesses that may be visited, prohibiting substance use and the types of materials possessed. The conditions often overlap with supervision conditions required by DOC.

***Residential Conditions***

Residential conditions cover the person's living situation, including residents under LRAs. All persons who live with the SVP must complete the requirements to become "approved monitoring adults" and testify under oath to abide by the court's requirements and to report any violations. In all instances, the SVP cannot change residency without further court order.

***Treatment Conditions***

These conditions include the requirement to participate in sex offender treatment with a designated provider, compliance with verbal and written rules as determined by the treatment provider, participation in other treatment as deemed necessary by the Transition Team, and monthly progress and compliance reports from the treatment provider to the county prosecuting attorney, defense attorney, and each member of the Transition Team.

<sup>106</sup> A. Hanskins, personal communication, November 2012

**Exhibit 14**  
**Examples of Imposed Conditions for SVPs on LRAs, by Category**

<b>Standard/Supervision Conditions</b>	
<ul style="list-style-type: none"> <li>• Shall not have intentional direct or indirect contact with prior victims or families; questions regarding whether or not an individual is a “victim” constitutes no contact with that individual;</li> <li>• Shall not have intentional direct or indirect contact with minor children under the age of 18 without express written consent of the court, and then only in the presence of an approved adult monitor;</li> <li>• Shall not frequent establishments that cater primarily to minor children without express written approval from Transition Team, including but not limited to parks, playgrounds, schools, public pools, and arcades;</li> <li>• Prohibited from unapproved contact with known convicted felons, except those in treatment group or those with whom offender has participated in treatment;</li> </ul>	<ul style="list-style-type: none"> <li>• Shall not own, possess, receive, ship, or transport any firearms, ammunition, incendiary device, or explosive, nor possess any parts thereof;</li> <li>• Shall not purchase, possess, or view any pornographic materials, including but not limited to materials depicting sex with violence or force, sex with non-consenting adults or sexual activities with children; and</li> <li>• Shall not use or have access to Internet (including via cellular telephones) or any other computer modem or communications software without direct supervision by an approved monitoring adult, and with written permission of the Transition Team.</li> </ul>
<b>Residential Conditions</b>	
<ul style="list-style-type: none"> <li>• Shall not be at large alone in the community;</li> <li>• Shall not leave the confines of residence except for activities pre-approved by the Transition Team; the SVP must be accompanied at all times and under the supervision of an “approved monitoring adult” who must supervise closely and maintain close proximity;</li> <li>• Must register as a sex offender with the county’s Sheriff’s Office;</li> </ul>	<ul style="list-style-type: none"> <li>• DNA test results must be on file with Washington State Patrol; and</li> <li>• For those released to a non-facility residence, DOC shall establish a clearly marked perimeter surrounding the house and outbuildings which the SVP cannot proceed beyond unless accompanied by an approved adult monitor.</li> </ul>
<b>Treatment Conditions</b>	
<ul style="list-style-type: none"> <li>• Periodic assessment of deviant arousal and requirements to use techniques designed to modify that arousal;</li> <li>• Address chronic anger, hostility and defensiveness;</li> <li>• Abstain from alcohol and drugs;</li> <li>• Review of offense cycle with regard to “triggers” and errors of judgment;</li> <li>• Complete homework assignments such as daily treatment journal, monitoring fantasies, developing strategies for dealing with community situations, confronting thinking errors;</li> </ul>	<ul style="list-style-type: none"> <li>• Follow all guidelines from the therapist related to contact with family members;</li> <li>• Obey restrictions on viewing sexually explicit materials, including videos, movies, magazines, and TV programs;</li> <li>• Complete periodic polygraph exams; and</li> <li>• Abstain from any sexual relationship except those expressly approved in advance by treatment provider.</li> </ul>

## **LRA PLACEMENTS, SUSPENSIONS, AND REVOCATIONS**

The statute provides that any service provider, CCO, prosecuting attorney or the SCC CEO can petition the court for an immediate court hearing to revoke or modify the terms of a SVP's conditional release. During the hearing, the state has the burden to prove by a preponderance of the evidence that the person has violated the court's conditional release order, or is in need of additional care, monitoring, supervision, or treatment.<sup>107</sup> Examples of the types of incidents that may prompt a hearing include: violations of specific conditions outlined in the court order, being terminated from treatment by the SOTP, or for mental health stabilization if the person has decompensated mentally, emotionally, or behaviorally.

While awaiting a hearing the resident may be held in the county jail, at a secure community transition facility, or at the total confinement facility, at the discretion of the secretary's designee. Following the hearing, the court can choose to modify the conditions of release by adding new or additional conditions, or to revoke it and have the person returned to the main facility. In some instances, an individual placed on an LRA will have multiple suspensions and court hearings during their time on conditional release.

Exhibits 15 and 16 on the next page provide detailed information on the types of releases that have occurred at SCC.

Exhibit 15 displays the placement changes associated with various categories of LRAs.

In the category titled "type of placement," the chart identifies unconditional releases, in addition to five types of LRA releases:

- LRA private home;
- SCTF;
- SCTF (Accommodated Transition for special needs' residents);
- Relationships through Self Discovery Group Home; and
- Adult family home.

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<sup>107</sup> RCW 71.09.098

The third column shows the number of releases that are the result of agreements between the prosecutor and defense (called “attorney generated”).

**Exhibit 15**  
**Frequency of Releases by Placement Type, and Suspensions: through January 1, 2013**

Type of Placement	Number Supported by SCC	Number Attorney Generated	Total	Percentage of Total Placements	Suspensions	Percentage of Total Suspensions	Ratio of Suspensions to s/ Placements
Unconditional Release	14	0	14	15%	0	0%	0%
LRA Private Home	16	7	23	24%	7	20.5%	30%
SCTF	40	0	40	42%	18	53%	45%
SCTF Accommodated Transition (special needs)	11	1	12	13%	7	20.5%	58%
Relationships Through Self-Discovery Group Home	3	1	4	4%	2	6%	50%
Adult Family Home	2	0	2	2%	0	0%	0%
<b>Total</b>	86	9	95	100%	34	100%	-

Source: SCC

Exhibit 16 provides detail on the individuals whose LRA was suspended and they were returned to total confinement for various reasons (e.g. violations of court order, SVP dropped by treatment provider, resident needed mental health stabilization). As indicated, 54% have had no suspensions.

**Exhibit 16**  
**Frequency of LRA Suspensions by Individual: through January 2013**

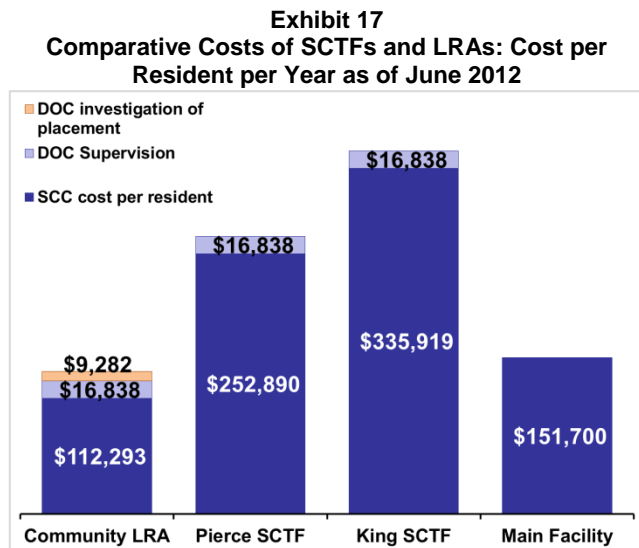
	Number of Individuals	Percentage of LRA Population	Number of Total Suspensions	Percentage of Total Suspensions
No Suspension	29	54%	0	0%
One Suspension	17	31%	17	50%
Two Suspensions	7	13%	14	41%
Three Suspensions	1	2%	3	9%
<b>Total</b>	54	100%	34	100%

Source: SCC



## COSTS FOR SCTF AND LRA

In terms of the SCC budget, the costs as of June 2102 for those residents in community LRAs, the two SCTFs and the main facility, are summarized in Exhibit 17 (see Appendix E for a detailed description of SCC costs). The exhibit includes estimates associated with DOC supervision and placement investigation.<sup>108</sup>



Source: SCC

Because of the high staffing ratios required by state law for the SCTF, costs for placement in these facilities are significantly higher than a LRA community placement.

In terms of the costs for the main facility, the island location contributes significantly to the costs. For FY 2012, the total costs of services due to the island location were estimated at \$6.6 million.<sup>109</sup>

## OTHER POTENTIAL LRAS

The legislature directed the Institute to investigate options for specialized populations such as the elderly or those with developmental disabilities and whether more cost-efficient options might be used to house those populations while keeping the public safe. Additionally, we were to investigate prospects for moving residents to non-institutionalized settings beyond a SCTF.

To that end, we examined two existing programs run by the DOC and DSHS that involve community placement for high-risk sex offenders. At present,

SCC residents are not eligible for either program. The experiences of these programs, however, offer insight concerning the costs associated with placement options and the approaches used to create placement options. These two programs are:

- DOC's Extraordinary Medical Placement program; and
- DSHS's Community Protection Program

The next sections will summarize key aspects of these programs that are relevant to SCC's population.

### DOC's Extraordinary Medical Placement

A 2009 change in state law allows DOC to move qualified offenders out of prison before their planned release and into community settings that provide personal care. Individuals who are out of prison on an "Extraordinary Medical Placement" (EMP) are under the guidance and supervision of DOC and can be moved back to prison if their qualification changes.

The law's goal is to save the state money while ensuring public protection.<sup>110</sup> Most individuals on EMP status qualify for the federal Medicaid program, and DSHS receives a federal match for medical or personal care services provided to these individuals while they are in the community.

DOC policy requires that all the following conditions are met:

- The offender has a serious medical condition requiring costly care or treatment;
- The EMP will result in cost savings to the state;
- The offender poses a low risk to the community because of physical incapacitation due to age or medical condition.<sup>111</sup>

DOC policy established an extensive procedure to consider such placements, including involvement of DOC's Chief Medical Officer, CCO placement investigation, and careful review of the offender's criminal history and institutional behavior.

State law requires that DOC and DSHS jointly report expenditures and savings related to the law. In 2010, the agencies reported that 58 individuals were considered for this program, however only 16 met sufficient criteria for detailed review. Of these 16, ultimately 8 were selected for an EMP placement.<sup>112</sup>

<sup>108</sup> A. Haskins, personal communication, November 2011

<sup>109</sup> Criminal Justice Planning Services. 2011. *Evaluation of cost-effective provision of services for the Special Commitment Center McNeil Island* (p. i.). Olympia: Author.

<sup>110</sup> RCW 9.94A.728

<sup>111</sup> DOC Policy 350.270

<sup>112</sup> The circumstances associated with the remaining individuals included death, later denial by DOC, release before the placement,

The 2010 report concluded that the total state savings associated with the program were approximately \$102,000.

The report concluded that there were several factors related to the small number of offenders on EMP status. These included:

- Because offenders are referred when they are likely to fit the criteria, they are typically close to their earned release date, thus reducing the saved costs.
- Some offenders considered for the program have been at the end stage of a terminal illness and have died before the placement, or soon afterwards.

In 2012, the majority of individuals with EMPs have been sex offenders. According to DOC staff, locating a placement for these individuals is very challenging. Because of concerns about their vulnerable populations, nursing homes are extremely reluctant to accept sex offenders.<sup>113</sup> DOC managers have found the most realistic option is to place sex offenders in facilities with other sex offenders. To identify potential resources, DOC staff contact adult group home owners and inquire about whether there may be housing options for persons on EMP status. In some instances, these inquiries have resulted in placement options.

### ***DDD Community Protection Program***

In 1996, the state created a program offering voluntary 24-hour supervision and support for people over age 18 with developmental disabilities who committed crimes and were released after a sentence, or were not charged or found incompetent to stand trial.<sup>114</sup> The program serves individuals who are assessed as high risk to re-offend, either sexually or violently. Individuals accepted into the program receive housing, therapy, employment, and close supervision.

In 2011, there were 456 individuals in this program; the vast majority are sexual offenders.

The voluntary program offers two key elements:

- 24-hour on-site awake staff;
- Individuals live in the community while they learn skills to assist them not to reoffend.

The state received a waiver from the Centers for Medicare and Medicaid Services for this program.

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and private pay. See Report to the Legislature, "Extraordinary Medical Expenditures and Savings."

<sup>113</sup> B. Goupillion, personal communication, October 2012

<sup>114</sup> RCW 71A.12.200

For the period of 2007 through 2012, the state's Health Care Authority determined that the program cost approximately \$115,000 per person.<sup>115</sup> By state law, this program is not open to SCC residents. In the definition of LRAs for SVPs, the statute explicitly denies placement in the community protection program.<sup>116</sup>

Although both the DOC and DDD programs are not open to SCC residents, they are useful in understanding the type of LRAs that are politically viable for persons with histories of sex offending.

### **2012 IOC RECOMMENDATIONS: REVISE SCTF LAW**

The 2012 IOC examined the use of the SCTFs. Since a greater number of SCC residents have been placed in this setting in recent years, there is greater experience on which to judge this aspect of the law's operation.

As noted by the IOC, the overarching goal of an SVP law is to reduce the longer term rate of reoffending for high risk sex offenders. For persons committed as SVPs, the stakes are very high. As observed by the IOC, "Those individuals who are unable and/or unwilling to engage in activities that reduce their risk may ultimately end up spending the rest of their life (or a major portion of it) in the state's total confinement facility."

In contrast, the law provides a "path to release" for individuals whose risk has been reduced to an appropriate level and they are returned to the community. To this end, the state has adopted the SCTF and LRA options as the means for this transition to occur.

The SCTF and LRAs are the final phase of an SVP commitment. At this stage, the goal is to prepare the individual for unconditional release to the community. The IOC observed that the program's ability however, to exercise this responsibility is significantly hampered by the statute; specifically, the requirements for one-to-one staffing ratio whenever an SCTF resident is outside the physical structure. This restriction severely limits flexibility in preparing an SCTF resident for life after unconditional release. "To the extent that an individual is always in close proximity to a staff member (or approved chaperone)," the IOC commented, "there is little

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<sup>115</sup> U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Region 10. (2012). *Final report: Home and community-based services (HCBS) waiver review, Washington state community protection waiver* (Control #0411). Seattle, WA: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Region 10.

<sup>116</sup> RCW 71.09.020(6)

testing of the individual in terms of how he will handle future situations that may arise in the community in the future.”

The IOC observed that,

*“This is a natural tension that exists in any community transition program. Obviously, short-term risk for re-offense is reduced by having a state staff person always in the presence of an SCTF resident in the community. However, this requirement may have little positive effect in terms of long-term risk reduction, and many sex offender management experts would argue that it likely increases the individual’s long-term risk for re-offense (i.e., once the individual is granted unconditional release, he will not be prepared to face community living challenges on his own).”*

The team commented on the distinctions between the levels of control for SCTF residents and those placed in another type of LRA. They noted the increased level of control for SCTF residents, even though their risk was reduced through treatment, and other SVPs living in LRAs who may not have participated in any treatment during their confinement.

Another difference between the two placements is that while SCTF residents must always be escorted in the community, individuals placed at other LRA’s do not necessarily have this requirement. As noted by the IOC, this situation creates a policy inconsistency—i.e., individuals who have reduced their risk through treatment have a higher level of mandated security mandated.

The IOC referenced the “long, difficult political and community process” that was involved in establishing the SCTF laws, and expressed skepticism about the prospects for statutory revision. “Nevertheless, we believe that this sort of conceptual discussion may encourage SCC to assess programmatic changes which could be made in the context of current laws that would extend higher privileges/greater freedoms to SCTF residents who are making progress towards unconditional release.”

The team recommended statutory changes concerning the specifics of the Pierce County SCTF. In this SCTF, the SCC faces challenges in identifying sufficient activity and work opportunities for the residents. In the case of the Pierce County facility, numerous employment activities on the island (outside of the perimeter of the SCTF) are possible, such as noxious weed control. The statutory mandate for one-to-one staffing ratios applies even in the case of McNeil Island, which makes it cost-prohibitive to have SCTF residents work on island projects.

The IOC observed that “the complete isolation of the island setting,” combined with the fact that all residences have now been removed from McNeil Island, offer opportunities for the state to discuss revisions to the staffing ratios.

## **SUMMARY OF DISCHARGES/LRAS**

In the vast majority of cases where LRAs are an alternative to institutional placement, for both SVPs and other individuals with mental health issues, LRAs are less costly than institutional confinement. In the case of SCC, the community-based LRAs follow this pattern; however, the SCTFs are significantly more expensive than confinement at the main facility. When the SCTF legislation was passed, concerns about community placement of persons found to be sexually violent predators led to extensive protections, notably in terms of required staffing levels. As a consequence, the SCTFs are structured like mini-institutions, and the small populations make the per-person costs extremely high. The Pierce County facility costs \$100,000 more per resident per year compared to the main facility; the King County facility costs slightly more than twice as much.

For each resident conditionally released to a community LRA or an SCTF, the courts also impose extensive requirements for treatment and supervision conditions. For potential community LRAs, DOC conducts extensive investigations to determine the suitability of the proposed residence, persons living with the SVP, and the location of the home in relation to schools, bus stops, etc.

When the legislature directed this study, the state had limited experience transitioning SVPs to community LRAs. Since that time, however, the courts have agreed to several community LRAs and a common set of conditions related to public safety have been established. This pattern of releasing SCC residents to community LRAs is likely to continue.

In terms of elderly SVPs and those with serious medical issues, placement in traditional nursing homes is unrealistic because of concerns about the vulnerability of other residents. If the state is interested in pursuing opportunities associated with nursing homes, the most practical solution is to establish specialized homes exclusively for this population. These homes could potentially be operated under contract by a private nursing home operator, be limited to male residents, and operate under restrictions appropriate to the population. By placing the homes on the mainland, specialized medical care would no longer require a ferry trip with escorts.

On the other hand, locating a facility for persons found to be sexually violent offenders, even if they are elderly, would be a significant challenge. In addition, the state would be assuming financial responsibility for individuals who potentially otherwise could be eligible for discharge and thus not under DSHS care.

As the SCC considers options for its elderly population and those with serious medical issues, the agency may find it beneficial to consult with DOC about its Extraordinary Medical Placement program. Since the majority of individuals in the DOC program are sex offenders, there may be opportunities for coordination.

## VI. COMPARISONS WITH OTHER PERIODIC REVIEW BOARDS

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The Legislature directed that this study examine options and standards utilized by other jurisdictions or similar processes to conduct periodic reviews, including specialized courts, parole boards, independent review boards, and other commitment proceedings.

Section III discussed the annual review process used in other states with SVP laws. This section describes additional entities that have similarities to SVP populations with periodic review functions.

### OTHER PERIODIC REVIEW BOARDS

The organizations identified in the legislative assignment have similar supervision and release roles for persons confined under a criminal statutory scheme or civil commitment statute, or they make recommendations to the court that has that responsibility.

For those entities operating in a criminal statutory scheme, the individual typically receives a maximum sentence for the offense and then the specialized court or parole board determines when they will be discharged.

This section briefly reviews the periodic review function of specialized courts and parole boards, followed by more detailed discussion of forensic review boards.

### SPECIALIZED COURTS

Specialized courts differ from traditional courts in that they focus on one type of offense or offender. Usually the judge plays an intensive supervisory role and functions as the entity providing periodic review for offenders. Other criminal justice components (e.g., probation) and social services agencies (e.g., drug treatment) are involved and collaborate closely in case processing. Examples of specialized courts include drug courts, mental health courts, domestic violence courts and reentry courts.

### PAROLE BOARDS

A parole board is a panel of individuals with authority granted by the state's governor to determine whether or not a prisoner can be granted parole. After serving at least a minimum portion of the sentence as prescribed by the sentencing judge, an inmate may be released on parole if the parole board so determines. In Washington State, the Indeterminate Sentence

Review Board serves in this role for two types of offenders:

- ✓ Felony offenders who committed crimes before July 1, 1984 and went to prison; and
- ✓ A select group of sex offenders who have committed offenses after August 31, 2001.

### FORENSIC REVIEW BOARDS

Forensic review boards function within the context of civil commitment laws for persons found Not Guilty By Reason of Insanity (NGRI). They have strong similarities to the SVP law, which make them more relevant for comparison purposes.

The SVP statute was originally borrowed from the NGRI law.<sup>117</sup> As noted by David Hackett, a former SVP prosecutor, the same substantive due process law surrounds civil commitment in both systems. To varying degrees, he observed, both systems deal with individuals who have been found to have both Axis I and II diagnoses, with frequent psychopathy issues as well.<sup>118</sup> Finally, both systems involve the same set of parties: DSHS, DOC, prosecutors, defense attorneys, and the courts.<sup>119</sup>

In Washington State, we have two types of internal review boards with responsibility for NGRI patients; both Western and Eastern State Hospital have Risk Review Boards. When a NGRI patient requests partial or full conditional release, or final discharge, these boards make recommendations to the DSHS Secretary and the court.

A separate entity, the Public Safety Review Panel (PSRP), advises the DSHS Secretary and the court regarding changes in commitment status, furloughs or temporary leaves, and patient movement in the treatment facility. The panel was created in 2010,<sup>120</sup> following the escape of a patient from Eastern State

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<sup>117</sup> Boerner, D. (1992). Confronting violence: In the act and in the word. In N. Watkins Anderson et al. (Eds.), *University of Puget Sound Law Review* (Vol. 15, No. 3) (pp. 535-577). Tacoma, WA: University of Puget Sound School of Law.

<sup>118</sup> **Common Axis I disorders** include depression, anxiety disorders, bipolar disorder, ADHD, autism spectrum disorders, anorexia nervosa, bulimia nervosa, and schizophrenia; **Common Axis II disorders** include personality disorders: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder; and intellectual disabilities.

<sup>119</sup> D. Hackett, personal communication, November 2012

<sup>120</sup> RCW 10.77.270

Hospital and a subsequent 2009 review by an appointed body.<sup>121</sup>

Before describing how forensic reviews boards operate in Washington State, we discuss the historical development and purposes of these entities.

## INTERNAL REVIEW BOARDS

The first internal forensic review board was established in 1975 in Washington DC. The board was created to help mitigate conflict and intimidation that hospital ward treatment teams experienced from staff, patients and others concerning changes in privileges and discharge recommendations. The review board considered recommendations from the treatment team, examined written documentation, listened to discussion, and then after asking the treatment team to leave the room, voted. The decision and an explanation were delivered to the team, with opportunity for immediate clarification. The board's recommendation became the basis of the report to the court.<sup>122</sup>

As is clear from their names, internal forensic review boards function as an in-hospital entity. These boards review treatment team recommendations for changes in patient security levels, and for conditional or unconditional release to the community.

Members of internal boards frequently include the hospital's clinical director, with clinical, security and administrative department leaders. The group's meetings are often structured so a treatment team representative delivers a written report following a prescribed format, that includes the patient's clinical and legal history, treatment response, and the team's rational for status change in security level or release. The board's decision is documented and becomes a key document in the hospital's report to the court.

The literature concerning internal review boards references the following advantages offered by these entities to the hospital's decision-making and court recommendations:

- The board can review the treatment team's thinking regarding an individual patient's progress, offering advice and new perspectives.
- It offers additional continuity as the patient moves through ward and security levels'
- The process is relatively inexpensive and can be easily integrated into the hospital's clinical and administrative structure.

- Membership includes individuals with primary responsibility for clinical management, as well as those responsible for effective and responsive administrative support. By including individuals with expertise on community resources, the board can realistically assess the team's recommendations and provide a continuing link between the treatment team and community providers. By including legal and security consultants, the body is aware of relevant statutory factors, as well as perspectives related to community safety.
- By requiring the treatment team to provide a written report in a standardized format, the board encourages treatment teams to present their requests "clearly and thoughtfully; this discourages reliance on staff memory of events that might affect their recommendations, such as patient assault, seclusion and use of restraint".<sup>123</sup>

The authors make specific recommendations regarding patient participation in internal review boards. In their view, direct participation by patients and others "may appear useful but could have undesirable consequences, such as splitting the patient and the team or introducing an adversarial tone into should be a cooperative effort."<sup>124</sup> A researcher in administrative law, Ian Freckelton (2010), observed that review panels in civil commitment matters can be "therapeutic, but can also be harmful if they leave a patient feeling stigmatized, hopeless and demoralized."<sup>125</sup>

Patterson and Wise warn that the boards can be expanded in ways that can undermine their effectiveness. These include utilization review, review of transfers between wards, and clinical review purposes such as medication review that can be better handled in clinical case conferences. In addition, they note that some states report a continuing debate regarding the desirability of participation by patients, advocates, victims, attorneys and others. The authors urge that the review board process "not become so cumbersome and complex that it loses its effectiveness to fulfill its primary function: to offer the courts a timely and expert review of the patient's readiness for a less restrictive environment, consistent with public safety."<sup>126</sup>

<sup>121</sup> Washington State Psychiatric Hospital Safety Review Panel. (2009). *Final report: State psychiatric hospital safety review panel*. Retrieved from <http://www.dshs.wa.gov/pdf/EA/121509SafetyReview.pdf>

<sup>122</sup> Patterson & Wise, p. 661-662

<sup>123</sup> Ibid, p. 663

<sup>124</sup> Ibid, p. 604

<sup>125</sup> Freckelton, I. (2010). Extra-legislative factors in involuntary status decision-making. *Rethinking Rights-Based Mental Health Laws*, p. 205.

<sup>126</sup> Patterson & Wise, p. 664

## EXTERNAL REVIEW BOARDS

These boards are usually situated outside the hospital operation, and are staffed, funded and operated under separate authority. Given this function, these boards usually follow a legal process, with participation by patients, advocates, prosecution, defense, family members and others. The composition of these boards is broader than hospital representatives, often including representatives of the legal community as well as citizens.

Two examples of external review boards are the Oregon and Connecticut Psychiatric Review Boards. Oregon's board was started in 1978 and Connecticut in 1985. Both boards have five members appointed by the governor and have executive staff. Key features of these entities are as follows:

**Oregon:** The board controls patient movement within the mental health system by making decisions about hospitalization, conditional release, revocation of conditional release, or discretionary discharge during the insanity sentence. When someone commits a crime and is found by the Courts to be "guilty except for insanity," he or she is placed under the jurisdiction of the Oregon Psychiatric Security Review Board (PSRB). Individuals found guilty except for insanity are placed under the jurisdiction of the PSRB for the maximum sentence length provided by statute for the crime. Depending on the offense, jurisdiction can be for decades, or life.

While under PSRB jurisdiction, an individual can be housed in the Oregon State Hospital or in a variety of residential treatment settings, ranging from secure residential treatment facilities to independent living. The PSRB determines what kind of facility is appropriate based on the level of treatment, care and supervision required.

Oregon state law is explicit about the primary focus of public safety in the board's decision-making—"In determining whether a person should be committed to a state hospital or to a secure intensive community inpatient facility, conditionally released or discharged, the board shall have as its primary concern the protection of society."<sup>127</sup>

**Connecticut:** The Psychiatric Security Review Board (PSRB) is a state agency to which the Superior Court commits persons who are found not guilty of a crime by reason of mental disease or mental defect. These individuals are called "acquittees." The PSRB's responsibility is to review the status of acquittees through an administrative hearing process and order

the level of supervision and treatment for the acquittee necessary to protect the public.

This PSRB, at the time of commitment, takes jurisdiction over the acquittee and decides which hospital an acquittee is to be confined and when and under what circumstances an acquittee can be released into the community. The board reviews individuals on a six-month and a two-year basis at a minimum.

## WASHINGTON'S SYSTEM: HOSPITAL INTERNAL REVIEW BOARDS AND A PUBLIC SAFETY REVIEW PANEL

In Washington, both Western and Eastern State Hospital have internal risk review boards. Washington has also created a body that is a hybrid between an internal and external review board—the Public Safety Review Panel (PSRP). The PSRP and the two state hospital's Risk Review Boards have independent, as well as coordinated, roles in making recommendations to the court regarding conditional release and final discharge for NGRI patients. Appendix F summarizes the membership and operating rules for these boards.

Both Western and Eastern State Hospitals' Risk Review Boards have detailed policies concerning their membership, procedures, as well as their meetings and presentations.<sup>128</sup> In discussions with hospital staff regarding the format for the meeting, one key difference with SCC's SCT procedures emerged; this concerned the protocol for patient interviews. In the hospitals' meeting, patient interviews are conducted by the medical director and there are no interruptions from other members or staff.

The flow of decisions between the hospital boards and the PSRP is complex. The sequencing of events and decisions can be described as follows:

- Any request for Conditional Release or Final Discharge from an NGRI patient that is reviewed and supported by the hospitals Risk Review Board (RRB) comes to the PSRP for review. The hospitals submit a standardized cover sheet and checklist to the Panel.
- Both hospitals have a designated PSRP liaison person. When the RRB meets and supports a release, the liaison puts together packets of information for the PSRP Executive Director. The Director reviews and summarizes the

<sup>128</sup> Eastern State Hospital Policy 2.2; Western State Hospital Appendix A Policy ("Steps Western State Hospital Takes Before Recommending a Client Found NGRI For Conditional Release or Final Discharge").

<sup>127</sup> ORS 161.336(10)

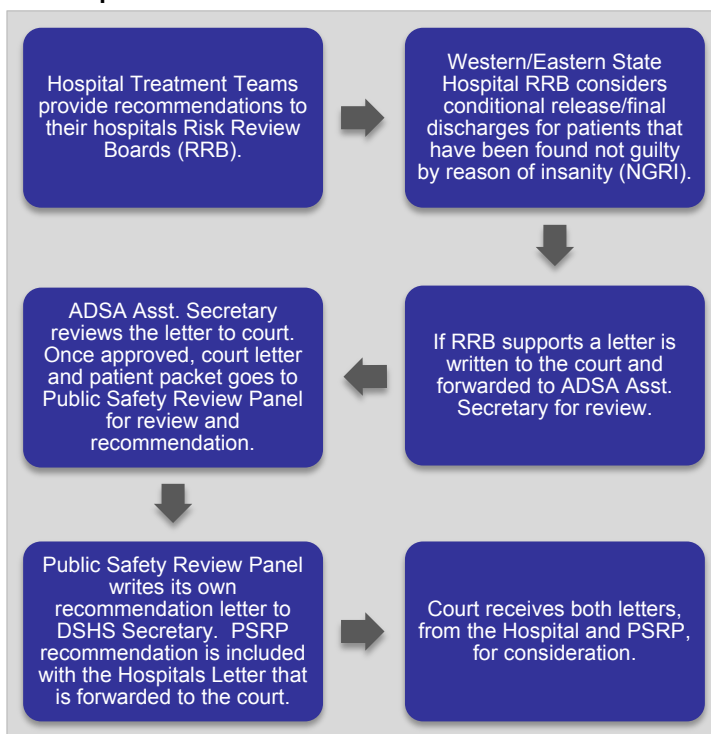
information and distributed to panel members prior to the group convening.

- The PSRP meets monthly and more often if necessary in order to review cases within the statutory timelines of 30 days for conditional and 45 days for final discharge.
- The PSRP provides an independent assessment to the DSHS Secretary and the court of the hospitals' recommendation, with specific attention to potential public safety risks. The hospitals get a copy of the PSRP recommendation and in some instances, incorporate PSRP suggestions into their letter to the court. Either way, the DSHS Secretary and the court receive both the hospital and PSRP recommendations.

Exhibit 17 displays this decision-making process.

**Exhibit 17**

**Hospital Review Boards and PSRP: Flow of Decisions**



Source: PSRP

Since its inception in December 2010, the Public Safety Review Panel (PSRP) has reviewed 26 individual cases for potential public safety risks associated with a patient's conditional release or final discharge from one of the state's psychiatric hospitals. Of the 26 cases, the Panel recommended that the Secretary not forward seven of these to court for consideration. Of these seven, four were identified as not having updated or adequate information. When additional information was obtained, these cases were eventually forwarded to

the court. Three cases were assessed by the PSRP to present too high of a public safety risk.

Recently, the process has been changed so all considerations for conditional and/or final discharge are reviewed by the Risk Review Board (RRB) at each state psychiatric hospital. The cases supported by the RRB are forwarded to the relevant DSHS Assistant Secretary's office where the letter to the superior court is reviewed and approved. The information is then forwarded to the PSRP for review and recommendation.

**SUMMARY OF PERIODIC REVIEW BOARDS**

Periodic review boards exist in many forensic settings. In Washington State, both Eastern and Western State Hospital have Risk Review Boards that make recommendations to the court, along with a newly created Public Safety Review Board.

In SCC, the SCT functions as a periodic review board that gives clinical advice to the CEO. Legal practitioners who were surveyed for this paper reported clear dissatisfactions and confusion about the operation of this board.

If SCT was restructured to include a smaller membership with a well-defined process that operates consistently it would improve its predictability for residents, SCC staff, and legal practitioners. In addition, the credibility of the body may be improved by adopting a defined set of criteria guiding its exercise of structured clinical judgment.



## SUMMARY

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Washington State law provides for indefinite civil commitment of persons found to meet criteria as sexually violent predators (SVPs). The Special Commitment Center (SCC) on McNeil Island houses persons who are detained and/or committed as SVPs.

The Institute was directed to study several aspects of SCC, including treatment participation, annual reviews, the role of the Senior Clinical Team, and Less Restrictive Alternatives. Major findings include:

**Releases:** At the end of CY 2012, 87 residents have been released from SCC. Of these, 54 were discharged from detainee status (i.e., never formally civilly committed) and 31 were unconditionally released after having been civilly committed.

**Treatment:** 37% of residents are actively participating in sex offense treatment. The 2012 independent Inspection of Care Team rated the treatment program with high marks, but expressed concerns about the quantity of treatment hours, particularly for special needs residents, and lack of treatment for the severely mentally ill population.

**Annual Reviews:** A survey of legal practitioners revealed concerns about the timeliness of reviews, with mixed reports regarding the quality.

**Senior Clinical Team (SCT):** SCC's group of senior clinicians and managers plays a key role in residents' treatment progression and decision-making regarding readiness for a less restrictive alternative. Some practitioners in the legal community expressed confusion and/or concern about the SCT role.

**Less Restrictive Alternatives (LRAs):** Confinement at the state's Secure Community Transition facilities costs significantly more than confinement at the main facility.

In SCC's response to this report (Appendix A), they indicate that treatment hours have increased for the special needs population as of January 2013, and they have added programming for the severely mentally ill and aging populations.

## ACKNOWLEDGEMENTS

The authors wish to thank SCC for their extensive assistance in preparing this report; in particular Holly Coryell, Dan Yanisch, and Mark Davis. Brooke Burbank and Shani Bauer generously contributed their time and expertise related to legal proceedings and construction of the survey questions. Annie Pennucci and Tabitha Hollenbeck provided valuable research assistance. Finally, we wish to thank the members of the IOC for sharing their insights about SCC and similar SVP programs in other states.

## **VII. APPENDICES**

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**APPENDIX A: SCC RESPONSE TO REPORT**

**APPENDIX B: SCC CONSENT FORM FOR THE SELF-MANAGEMENT PROGRAM**

**APPENDIX C: SCC TREATMENT PHASES & EXPECTATIONS**

**APPENDIX D: LRA AND SCTF EXPENDITURES THROUGH JUNE 2012**

**APPENDIX E: STATE HOSPITAL RISK REVIEW BOARDS / PUBLIC SAFETY PANEL: STRUCTURE AND FUNCTION**



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
SPECIAL COMMITMENT CENTER

P.O. Box 88450 • Steilacoom, Washington 98388  
January 22, 2013

TO: Roxanne Lieb, Associate Director  
WSIPP

FROM: Don Gauntz, Interim CEO   
DSHS/SCC

SUBJECT: **SCC Response to Special Commitment Center for Sexually Violent Predators:  
Potential Paths Toward Less Restrictive Alternatives Report**

The Special Commitment Center Administration and Staff have appreciated the opportunity to work with the Washington State Institute for Public Policy during the information gathering necessary for this document. We provide the following information in hopes to clarify or further elucidate issues brought forth by the *Potential Paths Toward Less Restrictive Alternatives* report:

(Page 7) **Special Needs Track** – It should be emphasized that the SCC Special Needs Program operates under the assumption that these residents will require significant external structure throughout the remainder of their lives. Any reintegration into the community would likely be in the form of some sort of group home or congregate facility that works with low functioning, or persistently mentally ill individuals.

(Page 10) **The SCC CEO is the DSHS Designee**-- When the annual review indicates that a resident's condition has so changed that he no longer meets criteria for civil commitment, or that conditional release to a less restrict alternative is in his best interest and that conditions can be imposed that adequately protect the community, the CEO must decide whether to support the person's conditional or unconditional release. If the CEO supports the release, he, as the Secretary's designee, so informs the court. If the CEO does not support the person's release, he informs the person of that fact and notifies him of his right to petition for release under the provisions of RCW 71.09.090(2). There have not been any instances where the Secretary has overruled the CEO's decision on a waiver.

(Page 13) **Summary addressing Limited Programming** -- As of January, 2013 core special needs treatment groups have increased to 3.75 hours per week. An additional 45-60 minutes of computer lab time for an assigned treatment assignment (i.e. review of high risks and "red flags") and assistance with assignments are offered weekly as well. This number does not include other specialty groups geared towards improving interpersonal skills, cooperation, group participation, more adaptive coping and self management. Also, SCC recently initiated programming for the severely mentally ill and the aging on the living units. An additional Clinical Team Lead has been appointed to head the development and implementation of this program in collaboration with the Program Area 1 Manager and clinical/residential staff.




(Page 17 – 18) **Comparison with Western and Eastern State Hospital Forensic Evaluations –** Probably a more accurate comparison standard (than number of evaluations) would be the typical number of hours it takes to complete an evaluation. An initial SVP evaluation requires in excess of 50 hours to complete, and the average follow up evaluation requires from 30 to 40 hours, depending on the complexity of the case. One area that was not examined in this study was that WSH has a critical problem keeping their competency evaluators, in part due to workload expectations.

(Page 19) **Survey Results regarding Annual Reviews --** It should be noted that for the past 3-4 years extensive historical information has been included in the form of an appendix to the annual review report, for ease of reference for the reader. The description of a resident's progress in treatment over the previous year is the focus of the report, and is much more prominent than the appendix. However, in a move to make the annual review reports more concise and consolidated, the Forensic Services Unit has decided to no longer attach the extensive history sections.

(Page 24) **Concerning documentation of the Senior Clinical Team meetings --** It is not the purpose of the SCT to conduct an evaluation. That is the purview of the Forensic Evaluator. SCT provides a clinical perspective for the CEO intended to augment the findings of the annual review report, so the CEO can determine whether or not to support LRA or unconditional placement. The clinical perspective can provide information directly relevant to the type of supervision conditions that might / should be placed on a person to maximize the success of their transition into the community.

While the format of the SCT progress note is similar to that of the standard facility progress note, it is clearly marked as the record of that meeting. They stand out from other progress notes in that they are often 2-4 pages in length, detail the discussion of the case being reviewed, what was said during an interview with the resident, and articulate recommendations for the resident and treatment teams to implement.

**APPENDIX B:  
SCC CONSENT FORM FOR THE SELF-MANAGEMENT PROGRAM**

	<b>SPECIAL COMMITMENT CENTER</b>  <b>Consent Form for the Self-Management Program</b>	Resident:
		SCC #:
		Date:

**Participation Consent for Review Period:** \_\_\_\_\_ (enter date)

\_\_\_\_\_, a clinician on Program Area \_\_\_\_\_, has discussed with me the group opportunities that are available to me through the Self-Management Program at the Special Commitment Center. By initialing a box beside a group title at the bottom of the page, I am agreeing to voluntarily participate in the group. I understand that I may withdraw my participation at any time.

I UNDERSTAND THAT GROUPS IN THE SOCIAL SKILLS TRACK AND SPECIALTY TRACK DO NOT REQUIRE OFFENSE RELATED DISCLOSURES OR TREAT OFFENSE SPECIFIC ISSUES. I FURTHER UNDERSTAND THAT BY NOT PARTICIPATING IN GROUP ACTIVITIES THAT ADDRESS SEXUAL RE-OFFENSE FACTORS THE SCC WILL NOT RECOMMEND ME FOR A CONDITIONAL RELEASE. I understand that for the SCC to consider me for a conditional release to a Secure Community Transition Facility, I must participate in groups that address re-offense factors.

I understand that if I choose to participate in groups that require I disclose offense related material I should discuss this with my treatment team and select groups based on my particular needs. If I choose to participate in groups that address my re-offense related factors, I will be expected to reveal information about my past sexual behavior and victims, but will not be required to provide specific information that would incriminate me.

For all groups, I understand that a progress note will be written regarding quality and content of my participation. These progress notes will become part of my clinical chart, already containing information about me. I understand that these documents will, upon request, be turned over to a legally approved party (i.e., prosecuting and defense attorneys, forensic evaluators, independent evaluators assigned by the court).

I understand that while participating in any activity at the Special Commitment Center, if I identify any specific child, adult dependent person or vulnerable adult as a victim of any abuse, the treatment professionals are mandated to report that information to the proper authorities.



**SPECIAL COMMITMENT CENTER**

**Consent Form for the  
Self-Management Program**

Resident:

SCC #:

Date:

**Offense Risk Reduction Groups:**

<input type="checkbox"/> Accommodated Transition	<input type="checkbox"/> Awareness and Preparation	<input type="checkbox"/> Sex Offender Cohort
<input type="checkbox"/> Transition		<input type="checkbox"/> Other:

**Social Skills Groups:**

<input type="checkbox"/> Assertiveness	<input type="checkbox"/> Communication	<input type="checkbox"/> Coping and Emotional Regulation
<input type="checkbox"/> Healthy Relationships		<input type="checkbox"/> Other:

**Specialty Groups:**

<input type="checkbox"/> Barriers to Discharge	<input type="checkbox"/> Counselor Assisted Self Help (CASH)	<input type="checkbox"/> Dialectical Behavioral Therapy (DBT)
<input type="checkbox"/> Journal Group	<input type="checkbox"/> Life Skills	<input type="checkbox"/> Mindfulness
<input type="checkbox"/> Substance Treatment Group – Beginning	<input type="checkbox"/> Substance Treatment Group – Intermediate	<input type="checkbox"/> Substance Treatment Group - Advanced
<input type="checkbox"/> TruThought		<input type="checkbox"/> Other:

**CONSENT: I have read, understand, and have had the opportunity to ask questions about the above information, and I wish to consent.**

\_\_\_\_\_  
**Resident**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**

**REFUSE: I have read, understand, and have had the opportunity to ask questions about the above information, but I do not wish to consent.**

---

**Resident**

---

**Date**

---

**Witness**

---

**Date**

## APPENDIX C: SCC TREATMENT PHASES & EXPECTATIONS

### SCC TREATMENT PHASES

#### **Phase Advancement 2 – 3: Contemplation**

##### **Activities**

Attends Group:

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Awareness &amp; Preparation</li> <li>• Cohort/Offense Specific</li> <li>• Assigned Social Skills/Specialty Groups</li> </ul> | <ul style="list-style-type: none"> <li>• Evidence of challenge to distortion</li> <li>• Acknowledges problem with sex offending</li> <li>• Accepts treatment</li> </ul> |
|---|---|

##### **Behavioral Evidence**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Cooperation</li> <li>• Awareness of obstructing attitudes/behaviors:                             <ul style="list-style-type: none"> <li>✓ Secretive</li> <li>✓ Narcissistic</li> <li>✓ Antisocial</li> <li>✓ Suspicious/complaining</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li>• Transparency</li> <li>• Management of sexual issues within the institution</li> </ul> |
|---|--|

##### **Accomplishments**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>• Good Life Plan</li> <li>• Basic Autobiography (Approved by Treatment Team Psychologist)</li> </ul> | <ul style="list-style-type: none"> <li>• Reviews Assessment</li> </ul> |
|---|--|

#### **Phase Advancement 3 – 4: Preparation-Action**

##### **Activities**

Attends Group:

- Cohort/Offense Specific
- Assigned Social Skills/Specialty Groups
- Identifies common distortions
- Evidence of challenge to distortion

Behavioral Evidence:

- Cooperation
- Transparency
- Management of obstructing attitudes/behaviors
- Management of sexual issues within the institution
- Group skills
- Consistent group attendance
- Addressing substance abuse (if an issue) through classes or Counselor Assisted Self-Help group (CASH)

##### **Accomplishments**

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Offense cycle</li> <li>• Treatment needs and interventions</li> <li>• Start journaling</li> <li>• Physiologic testing (polygraph, plethysmograph)</li> </ul> | <ul style="list-style-type: none"> <li>• Cognitive distortion assignments</li> <li>• Attends annual review interview</li> </ul> |
|---|---|

##### **Evaluative Understanding**

- Open, as opposed to resistant/defensive dialogue with evaluators about significant dynamic risk factors
- Non-defensive disclosure of sexual history

#### **Phase Advancement 4 – 5: Pre-Maintenance (Phase 5 constitutes a LRA)**

##### **Activities**

Attends Group:

- Cohort/offense Specific
- Assigned social skills/specialty groups
- CASH, as required

Behavioral Evidence:

- Cooperation
- Transparency skill application evidence
- Skill application evidence
- Management of obstructing attitudes/behaviors
- Management of sexual issues within the institution

##### **Accomplishments**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Refined Relapse Prevention Plan</li> <li>• Refined/defined good life plan</li> <li>• Refined transition plan</li> <li>• Journals</li> </ul> | <ul style="list-style-type: none"> <li>• Regular polygraphs</li> <li>• Regular UA's (urinalysis testing)</li> </ul> |
|--|---|

##### **Evaluative Understanding**

- All details adequately clarified
- New testing
- New annual review



## **SCC TREATMENT EXPECTATIONS BY PHASE**

### **PHASE 1**

The first phase of treatment consists of a series of assessments, which will help define the problems and the sequence in which you work on your problems.

### **PHASE 2**

During the Phase 2, or Contemplation, you will be asked to participate in Awareness and Preparation. You will begin work on an autobiography, and begin work on a Good Life Plan. You and your team will identify attitudes that lie in the way of your making progress. We will keep track of how you do in managing your general behavior at the SCC, as well as paying specific attention to how you manage sexual issues. When you have completed Awareness & Preparation, you will be assigned to a Cohort Group. The Cohort Group will be the primary area of treatment, and you'll be asked to complete assignments from the "Blue Book." These assignments shouldn't be thought of as "hoops" or as a checklist. Instead, they are intended to help you progress along your journey to change. It's the change we're interested in as opposed to a mere volume of written work.

Additional tasks during Phase 2 may include participating in groups to address specific problems and to develop interpersonal skills. Good group skills will be essential to success in the Treatment Program. Each phase promotion beyond Phase 2 will be accompanied by an interview with the Senior Clinical Team. It's essential that you participate in these interviews, because the developmental process leading to the transition to the community will be monitored by Senior Clinical. Each time you're staffed by Senior Clinical, there will be specific recommendations for you and your Treatment Team to work on.

### **PHASE 3**

This represents a stage of more preparation. You will be asked to learn about the steps that were involved leading to your offending behavior. The point here is not to get stuck in all the shame and regret over your offending. Rather, we believe that you have specific vulnerabilities and patterns of response to the world around you that led, in a predictable fashion, to the crime. Parts of those vulnerabilities are the cognitive distortions that you used to give yourself permission to act. It's important to learn about your thinking errors, as well as to find ways to challenge them and come up with more effective solutions. By the time you're a Phase 3 resident, you will have had the chance to meet with a Forensic Evaluator. Because your Annual Review is part of the conversation about your risk, we expect a Phase 3 and above resident to meet with the evaluator as opposed to a "records only" Annual Review.

This is a time that we'll ask you to participate in a sexual history polygraph as well as a plethysmograph. This physiologic testing will be incorporated into your treatment planning, and may be repeated to determine how you're doing in applying treatment skills. Journaling represents an important task, as it provides the opportunity to identify the challenges of everyday living, and to try out various interventions. You'll be expected to Journal actively for many years to come, as a tool to communicate with your treatment provider as well as for your own personal review. By the time you're ready to leave Phase 3, you should be able to have an open conversation with your Treatment Team as well as with Senior Clinical Team about your work and about your issues and problems.

### **PHASE 4**

This is where you'll be expected to start demonstrating meaningful changes in your behavior. You'll continue to have the opportunities to participate in specialty groups that address social skills, personal victimization, and emotional regulation. We want to see how well you monitor your own thoughts, feelings, and behaviors. We expect complete transparency around sexual arousal, fantasy, and masturbation practice. Looking ahead, you will work on a relapse prevention plan. Relapse prevention is a lifelong activity, and we expect your plan to be realistic, concise enough to use, and to accommodate any new learning you have as you navigate the issues that life lays in front of you. Phase 4 is also the time to begin to develop a transition plan. The plan should reflect a realistic choice of where you live, community supports, and treatment. By this stage, your evaluators will expect to see meaningful change in the attitudes and behaviors that have proven to be troublesome to you.

## **PHASE 5**

This is the last treatment phase prior to transition to the community. The expectation during Phase 5 is that you will be able to take your new skills and apply them more generally in the context of your life. You'll be doing some "practice" for your life transition. Part of this practice has to do with ongoing monitoring of your transparency through the use of the polygraph. You'll also have more frequent monitoring for substance abuse through the UA program. Prior to transition, you'll have another psychological assessment, as well as another annual review. At this point, the Senior Clinical Team will review all of the data and make a recommendation to the Chief Executive Officer regarding your readiness for transition. A person ready for transition monitors and manages her/himself. S/he's open to input from the Treatment Team and Transition Team. This person goes the "extra mile" to make sure that the team knows everything that's going on with her/him.

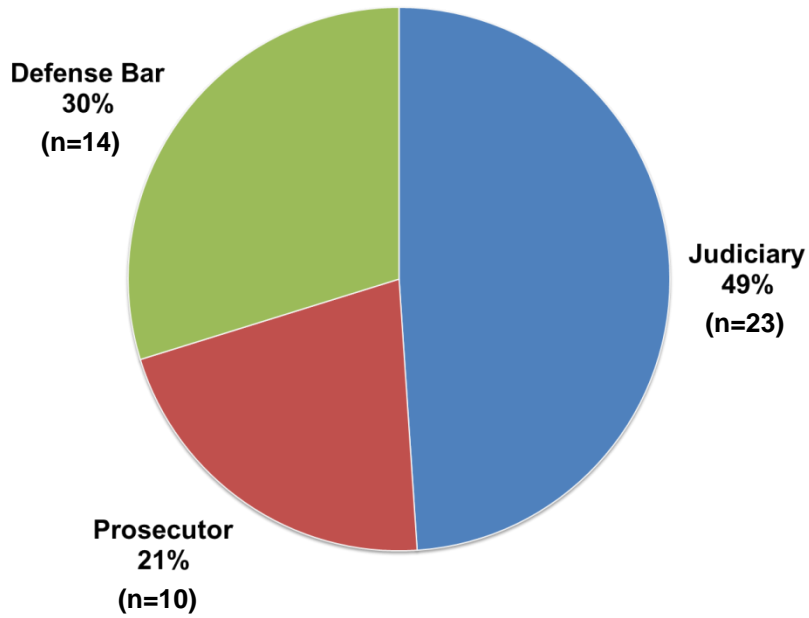
## **CLOSING**

Overall, we'd like to know you well. We'd like you to know yourself well, and to have the concern that you need to manage the risk that you present. Change of this magnitude does not come easily or painlessly. Nonetheless, this degree of change is what the community expects of you.

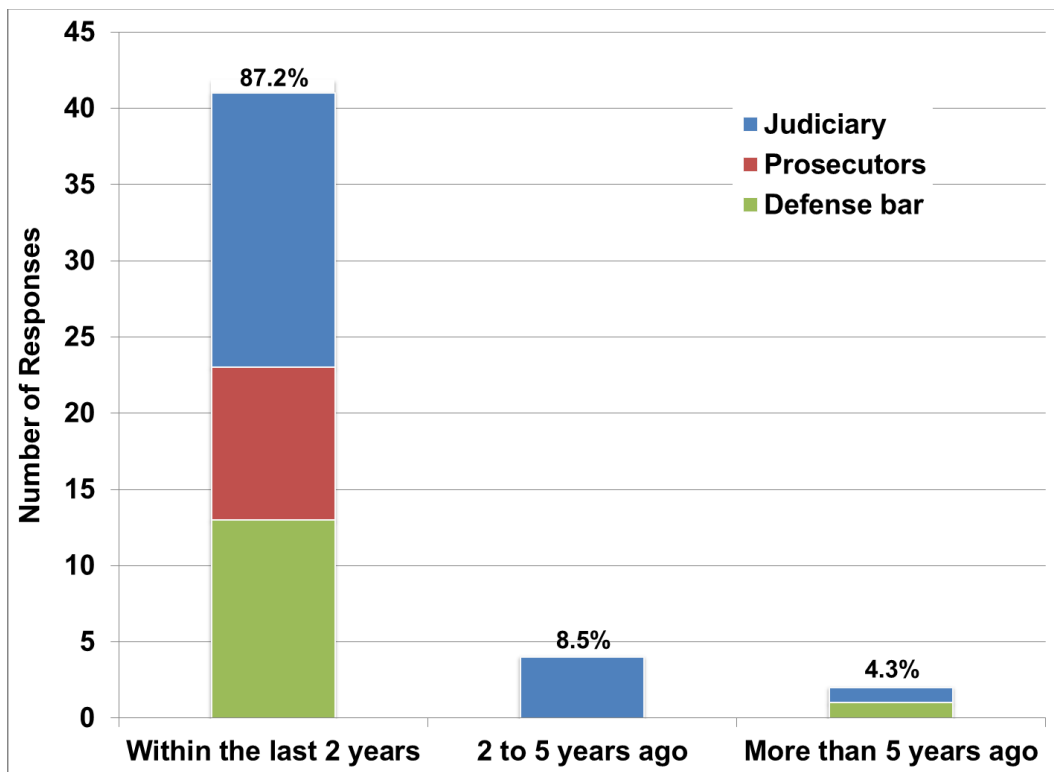
*Special Commitment Center. (2012). Resident Handbook, May 2012 Edition. Olympia: Washington State Department of Social & Health Services.*

**APPENDIX D:  
SCC SURVEY RESULTS (N=47)**

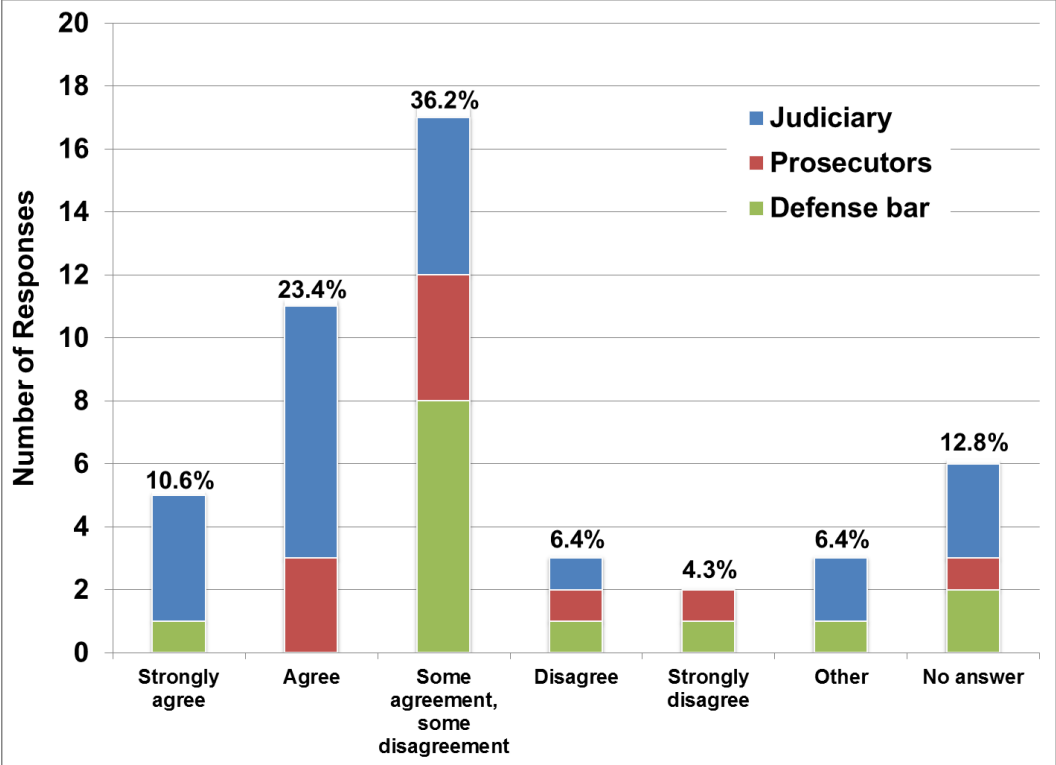
*Please identify your role in SVP cases.*



*When was the most recent SVP case you participated in?*

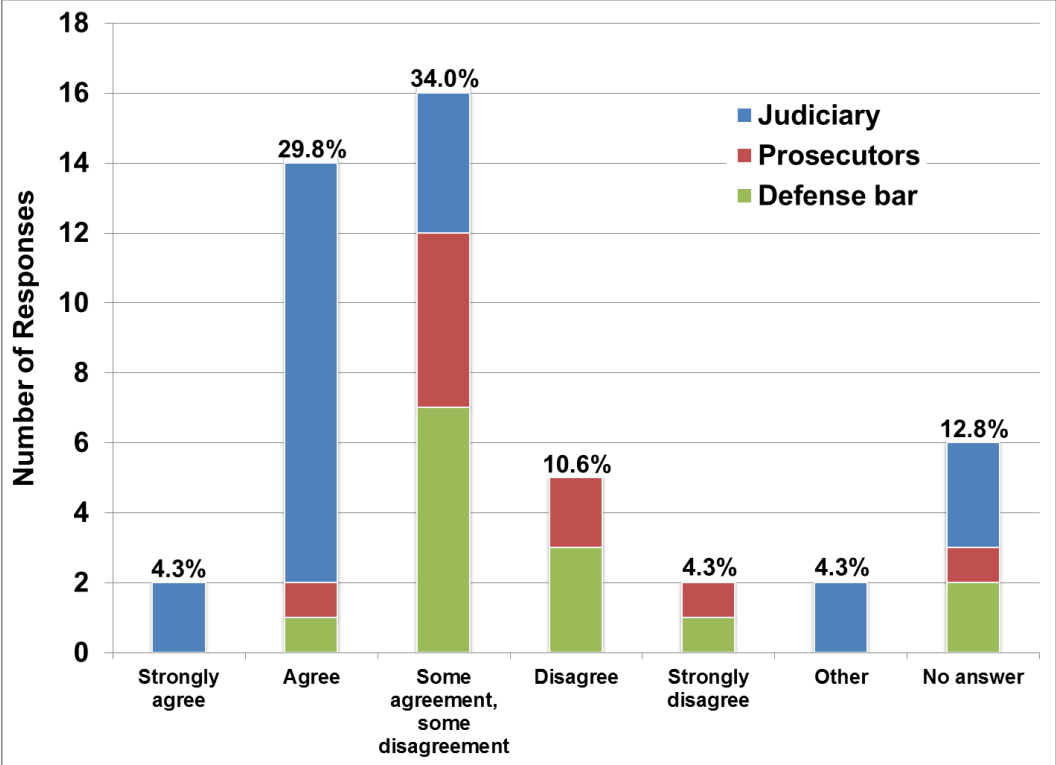


Overall, the annual reports provide quality information that assists the court's decision-making.



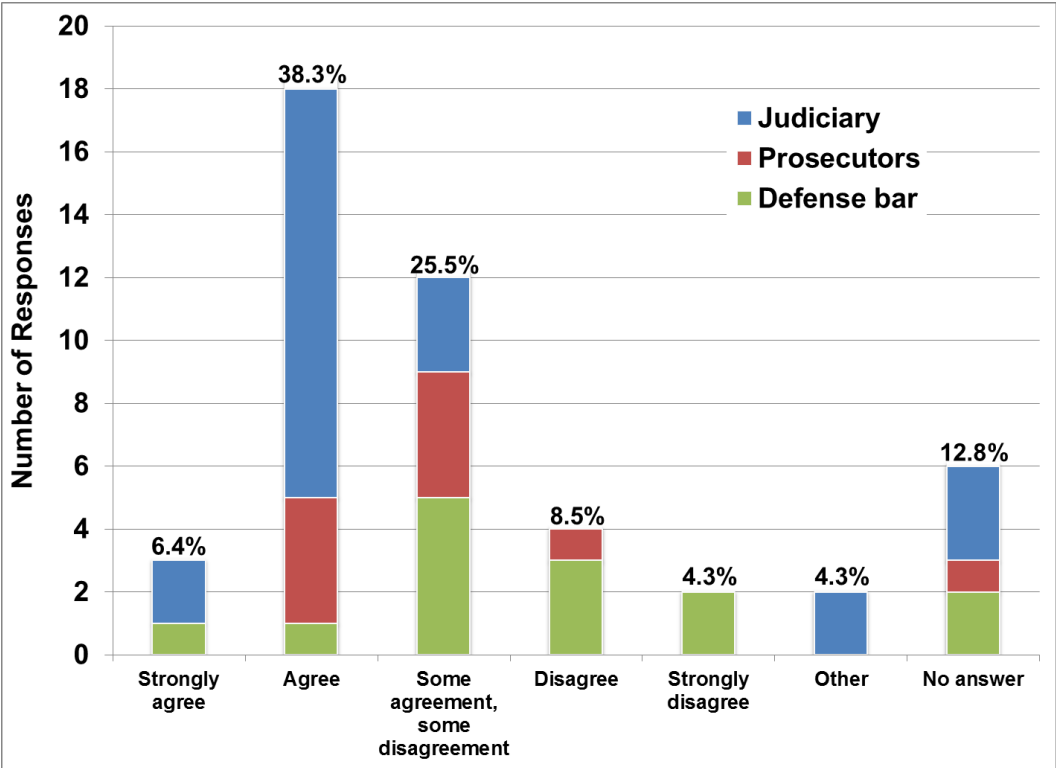
Overall, the annual reports are clear and understandable in the following areas:

(1) Rationale for conclusions

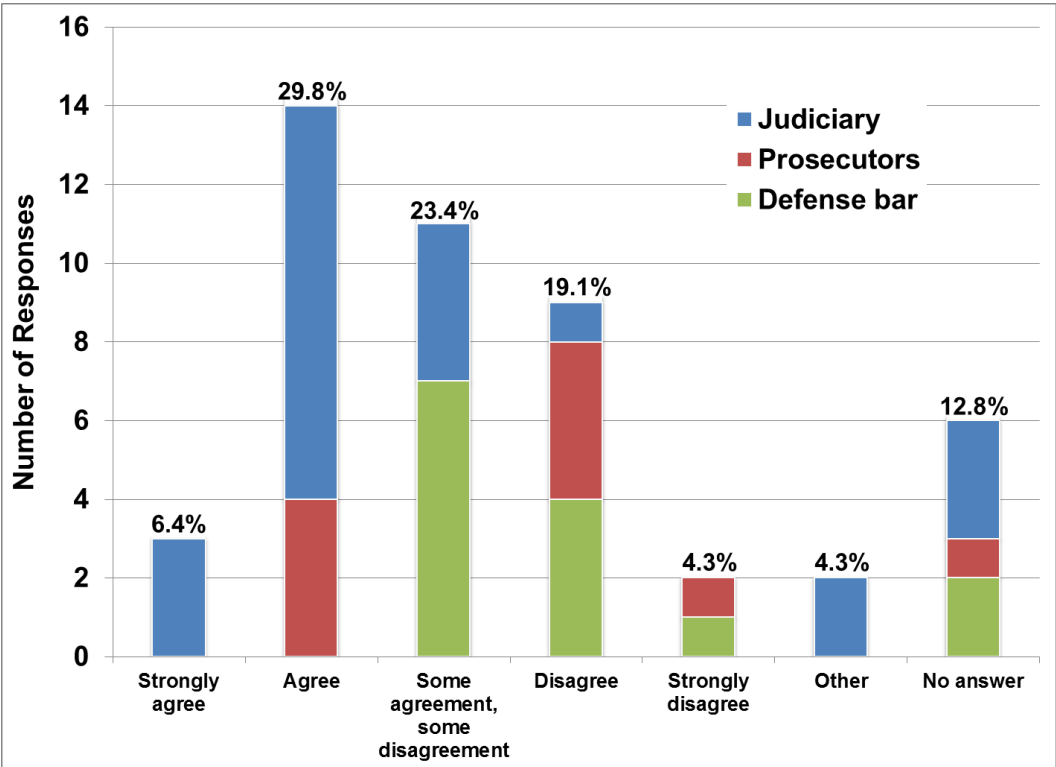


Overall, the annual reports are clear and understandable in the following areas (continued):

(2) Individual meeting statutory criteria

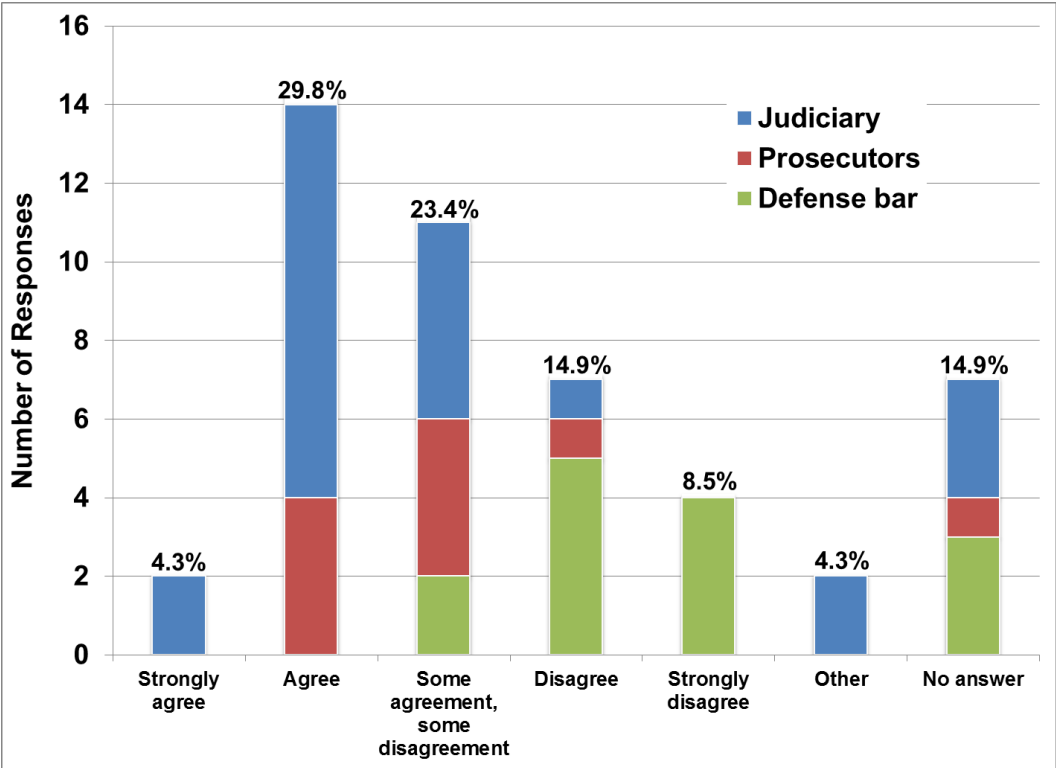


(3) Individual risk factors

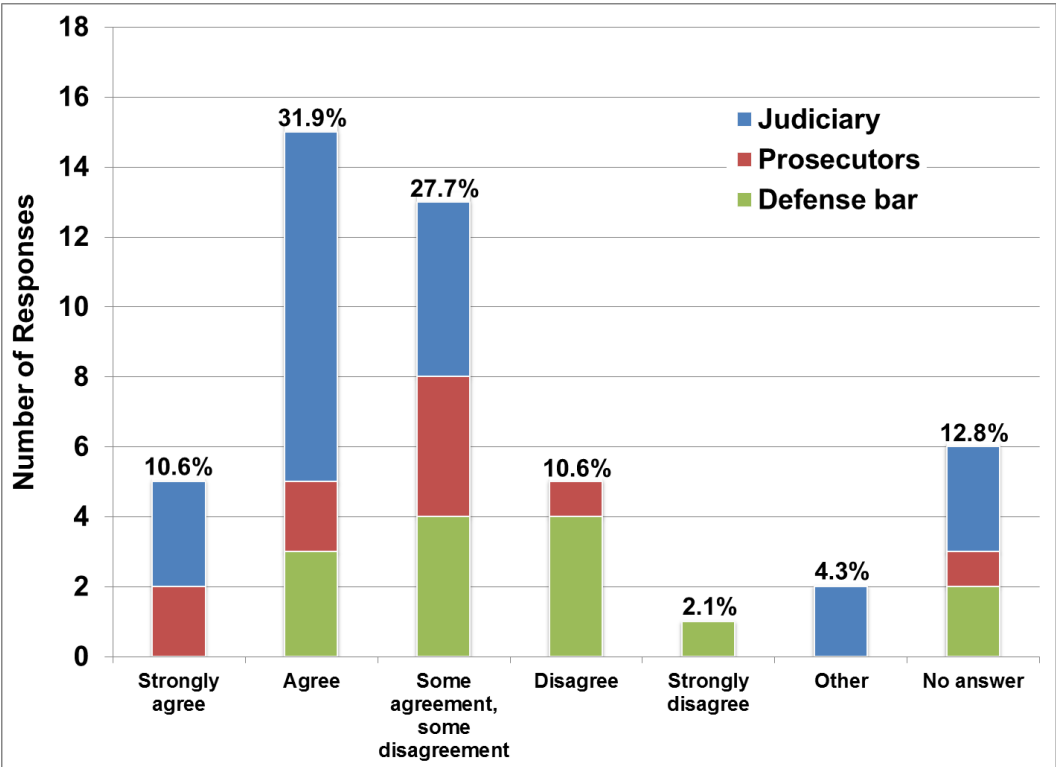


Overall, the annual reports are clear and understandable in the following areas (continued):

(4) Readiness for less restrictive placement

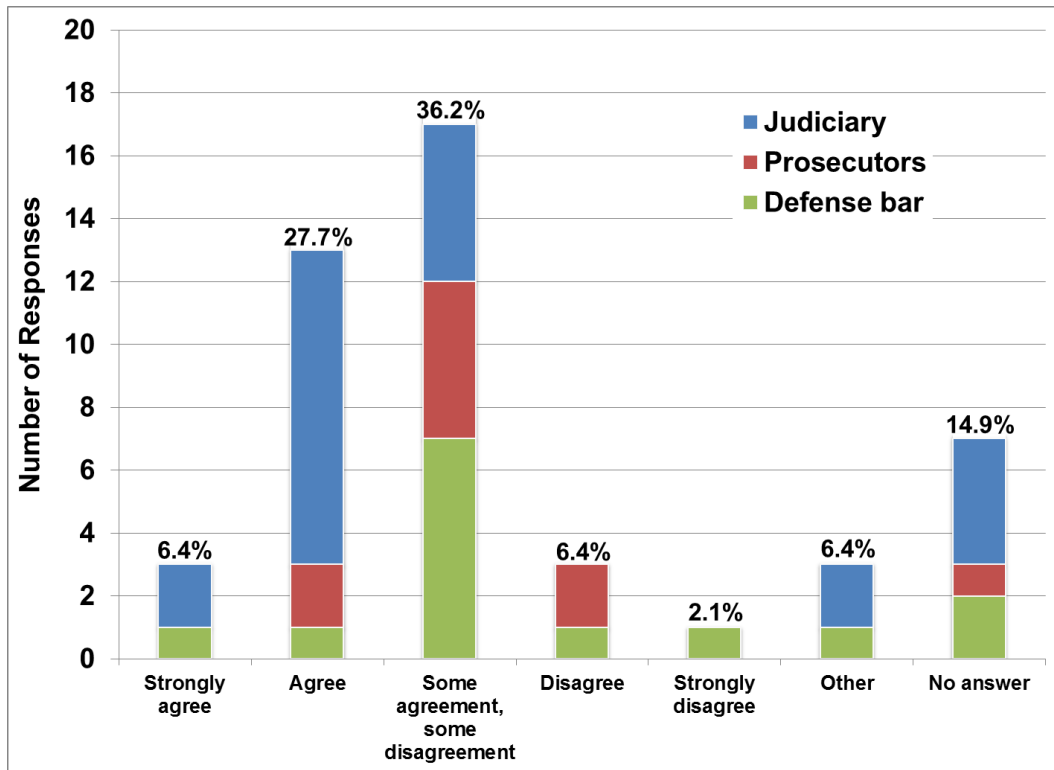


(5) Treatment participation/progress

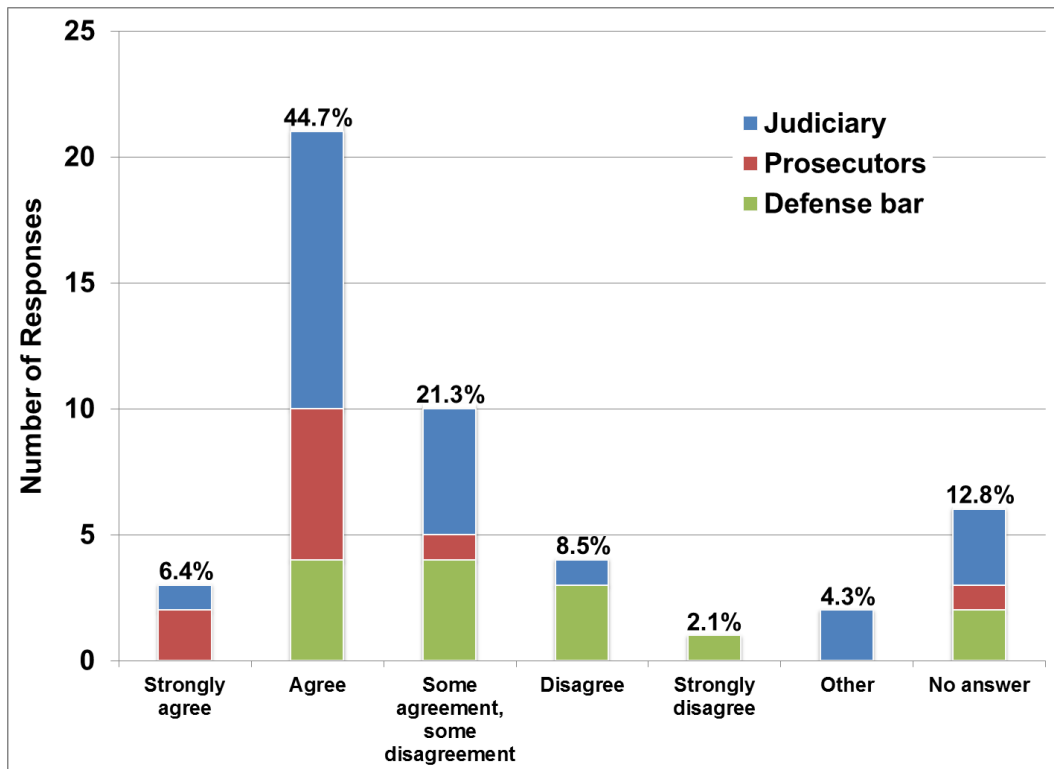


Overall, the annual reports are clear and understandable in the following areas (continued):

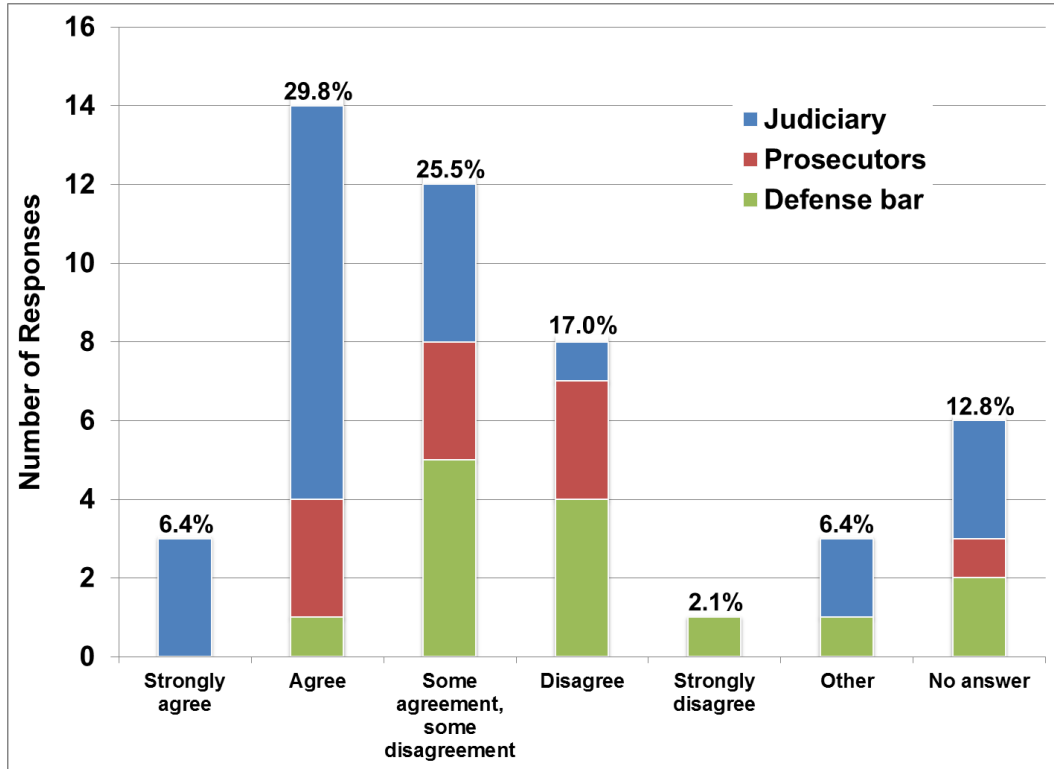
(6) Forensic conclusions



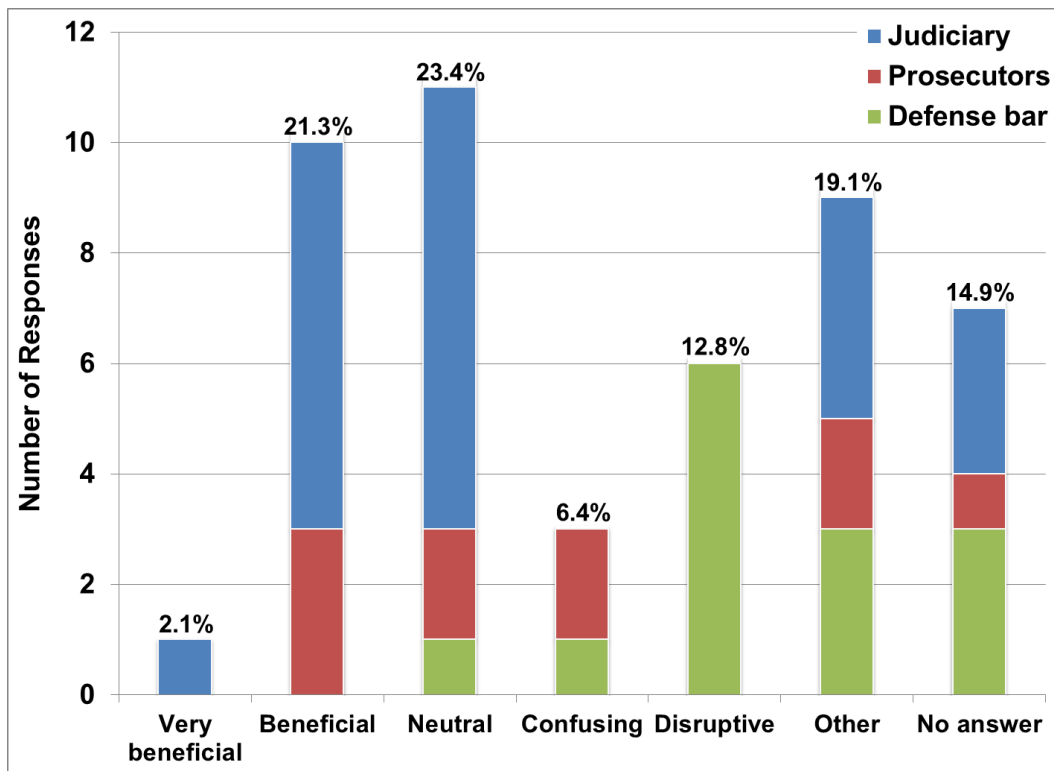
Overall, the annual reports are about the right length.



Overall, the annual reports are completed in a timely manner.

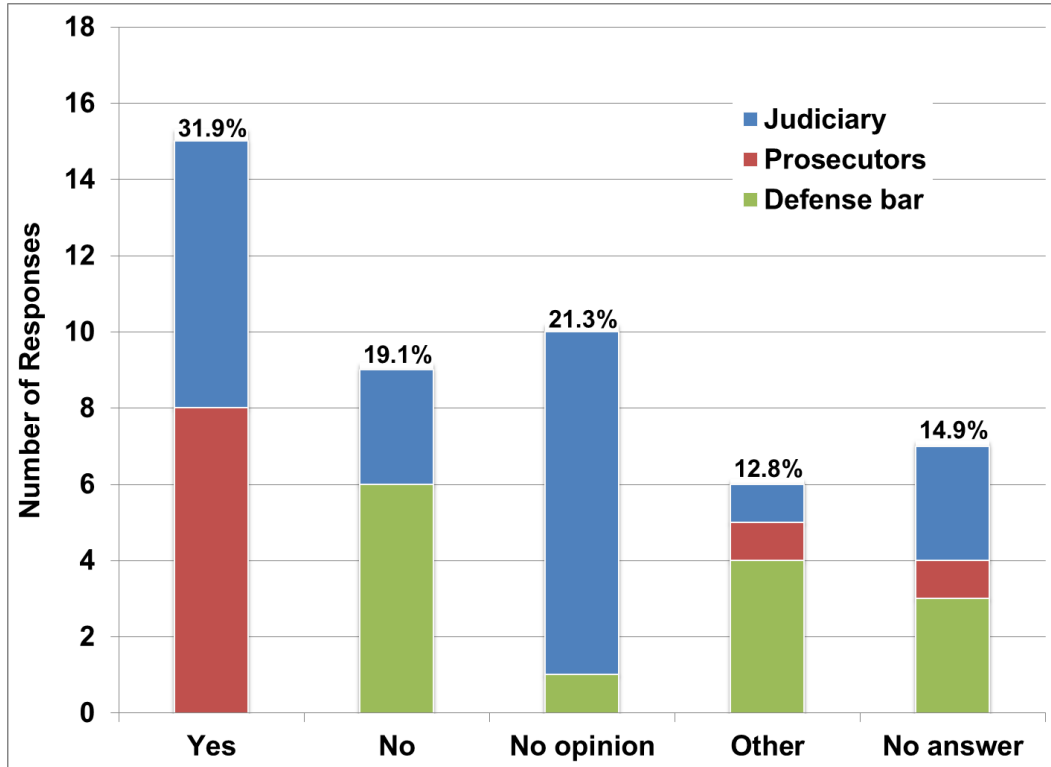


Overall, what is your view of the Senior Clinical Team's designated role as it pertains to the SCC's recommendations for conditional or unconditional release?

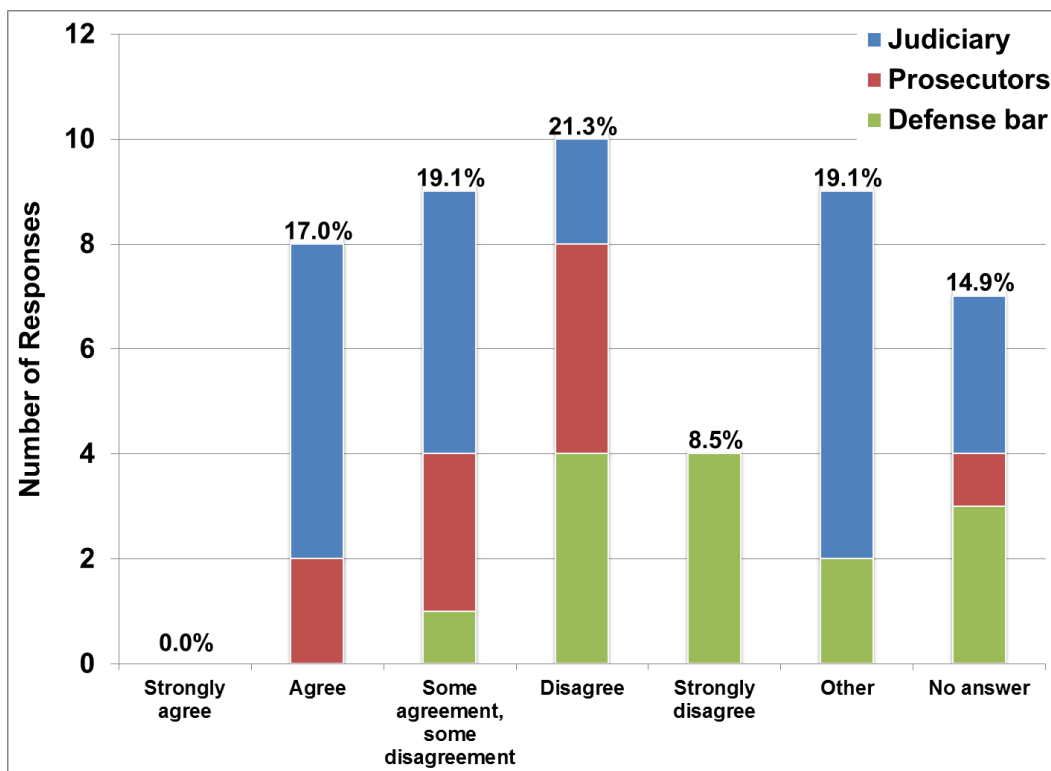




Do you think that the Senior Clinical Team should have a role in the annual report process?



Overall, the Team's decision-making provides quality contributions to the annual reports / release process.



**APPENDIX E:  
LRA AND SCTF EXPENDITURES THROUGH JUNE 2012**

	Community	Pierce SCTF	King SCTF	Main Facility
FTEs	1.8	27.8	15.3	351.5
Salary	95,093	1,175,479	687,412	17,679,237
Benefits	37,828	515,776	283,139	7,182,566
Personal Service Contracts	-	-	-	968,011
Goods & Services	26,775	62,944	276,360	4,824,540
Travel	-	1,176	71	6,120
Chaplain Services	-	-	-	1,050
Equipment	-	-	536	212,424
Group Homes	255,517	-	-	-
Psychological Consultants	141,120	182,618	71,195	8,973
Residential Placement	22,376	33,223	15,674	-
Sign Language Interpreters	-	-	-	60,088
Training	-	-	-	94,047
University of Washington	-	-	-	16,393
Direct Payments to Providers	64,830	129,340	68,150	2,812,144
* Aggression Replacement Training	-	-	-	48,375
* Day Health Care	-	-	-	1,400
* Dental Services	8,674	1,108	3,531	206,299
* Laboratory & Radiology Services	-	103	6	28,657
* Laboratory Fees	660	1,292	104	25,404
* Medical - Inpatient	23,436	2,241	-	203,038
* Medical - Outpatient	9,504	26,179	54,747	464,821
* Medical - Prescription Drug	1,000	-	-	384
* Misc - Contractors	-	-	8,000	37,548
* Miscellaneous	-	-	-	71,171
* Optometry Eyewear Services	413	0	-	12,473
* Other	-	-	-	14,513
* Other Practitioners	-	-	-	208,540
* Other Professional Services	-	-	-	156,081
* Patient Transportation	22,682	1,482	-	5,024
* Physician Services	6,893	1,203	4,365	81,502
* Prescription Drugs	241	96,943	933	750,059
* Professional Evaluation	-	-	-	61,037
* Proshare HOSP	-	-	-	2,684
* Psychiatric Services	-	-	-	48,048
* Radiology Services	5,521	2,952	428	66,889
* Skilled Nursing	-	-	-	310,606
* Special Medical Equip/Supplies	-	-	-	7,591
Assessment	5,125	5,270	5,960	70,656
Legal	207,411	144,918	123,339	8,421,807
Debt Services	-	-	-	117,015
Inter-Agency Reimbursements	-	-	-	1,038
Intra-Agency Reimbursements	-	-	3,815	530,423
	<b>870,272</b>	<b>2,254,933</b>	<b>1,539,630</b>	<b>43,006,883</b>
Residents	8	9	5	284
Cost Per Resident:	112,293	252,890	335,919	151,700

Source: SCC

**APPENDIX F:  
STATE HOSPITAL RISK REVIEW BOARDS / PUBLIC SAFETY PANEL:  
STRUCTURE AND FUNCTION**

Organization	Population Base	Membership	Meetings per month/year (Average duration of hearing)	Voting rules
Eastern State Hospital Risk Review Board	NGRI inpatient: 68 Conditional release: 25 <sup>1</sup> Total: 93	<ul style="list-style-type: none"> <li>• Forensic Services Unit (FSU) clinical director as chair and facilitator</li> <li>• Attending psychiatrists from relevant wards</li> <li>• FSU Nurse Manager</li> <li>• FSU Psychiatric Social Worker</li> <li>• Psychology Department representative</li> <li>• Forensic therapist/social worker presenting case</li> <li>• Public safety Review Panel liaison</li> <li>• Administrative staff</li> </ul>	Average 12 per year (3 hours)	Consensus
Western State Hospital Risk Review Board	138 NGRI patients in-residence <sup>2</sup> For community program, 14 on ward and 67 in the community <sup>3</sup> Total: 219	<ul style="list-style-type: none"> <li>• WSH Medical Director</li> <li>• WSH Clinical Operations Director</li> <li>• Forensic Psychology Services Supervisor</li> <li>• Forensic Social Work Supervisor</li> <li>• Forensic Community Program Director</li> <li>• Forensic Treatment and Recovery Center Director</li> <li>• Forensic Nursing Representative</li> </ul>	4 per month (1.5 hours)	The RRB must unanimously support the NGRI patient for Conditional Release for this recommendation to be forwarded on to the CEO and Clinical Operations Director. If the RRB does not support a Conditional Release, the client waits another 6 months before petitioning the RRB again.
Public Safety Review Panel	318 (ESH and WSH combined)	<p>The members are appointed by the Governor and include:</p> <ul style="list-style-type: none"> <li>• A psychiatrist;</li> <li>• A licensed clinical psychologist;</li> <li>• A representative of department of corrections;</li> <li>• A prosecutor or representative of a prosecutor's association;</li> <li>• A representative of law enforcement or a law enforcement association;</li> <li>• A consumer and family advocate representative; and</li> <li>• A public defender or a representative of a defender's association.</li> </ul>	At least once per month (2 hours)	At least 4 members must concur to issue recommendation

<sup>1</sup> R. Kenney, personal communication, October 2012

<sup>2</sup> B. Hawkins, personal communication, October 2012

<sup>3</sup> N. Fredrickson, personal communication, October 2012

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