Department of Corrections
WASHINGTON STATE

Assessment of the Washington State Department of Corrections Sex Offender Treatment and Assessment Programs

FINAL REPORT

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- Cathi Harris, M. A., Sex Offender Treatment Director
  Sex Offender Treatment and Assessment Program
- Corey McNally M. S., LMHC, Clinical Quality Assurance and Training Manager
  Sex Offender Treatment and Assessment Program

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EXECUTIVE SUMMARY

In an effort to integrate and build on recent efforts to improve sex offender management in the State of Washington, the Washington State Department of Corrections (hereafter, "the WDOC") contracted with the consultants to evaluate the assessment and treatment practices of its Sex Offender Treatment and Assessment Program's (hereafter "SOTAP") continuum of care in adult prison facilities and the community.

To support the present review and develop recommendations to improve the SOTAP, the consultants reviewed relevant program documents, conducted site visits at the Airway Heights Correctional Center and the Monroe Correctional Complex SOTAPs, visited community SOTAP sites, and met with SOTAP and WDOC program administrators and stakeholders. Three site visits and interviews with SOTAP staff, clients, and stakeholders were conducted over ten days between January 11, 2017 and June 16, 2017.

This report is the culmination of this review process. The report is organized around 14 best practice areas that are linked with effective sex offender treatment programs. In this report, we define each key area, synthesize relevant research, assess the program's functioning in each area, and make recommendations for continued development.

Several notable program strengths were identified, many of which provide evidence of a sound foundation for sex offender management efforts. These include, but are not limited to, the following:

- The WDOC has a strong commitment and track record of establishing policy-driven, evidence-based approaches to sex offender management.
- Under the WDOC, the State of Washington is one of the few states in the United States that has an integrated network of prison and community sex offender treatment programs.
- The SOTAP has a strong clinical leadership team.
- The SOTAP uses a cognitive-behavioral treatment approach, which is consistent with evidence-based practices and is the dominant sex offender treatment model in the field.
- The SOTAP uses validated measures to assess client risk and treatment needs.
- The SOTAP has made considerable progress in matching the intensity of services to client risk level.
- The SOTAP provides community aftercare services to ensure that the progress that clients make in the institution is reinforced and strengthened by treatment and supervision in the community.
- The SOTAP continuity of client care from the prison to community is typically quite seamless.
- The SOTAP meets the needs of and has the support of several internal and external stakeholders.
- The SOTAP has mechanisms in place to monitor its operation to ensure that services are delivered as intended, the quality of services are improved, and the effects of services are evaluated.

At the same time, several potential areas for program improvement were identified. These include, but are not limited to, the following:

- The SOTAP should provide sex offender treatment, commensurate with the risk principle, to individuals who deny committing a sex offense but are otherwise eligible to enter the SOTAP.
- The SOTAP should consider adopting the new five-level Static-99R risk category system and revise its treatment prioritization policy accordingly.
- The SOTAP should place greater emphasis on skill teaching and practice focused on client problems that are directly linked to sexual offending.
- The SOTAP should strive to hire staff who meet the "preferred" employment qualifications compared to the minimum "required" qualifications.
- The SOTAP should finalize and implement its new treatment manual over the next several months.
- The SOTAP quality assurance plan should be closely linked to the new treatment manual and continue to focus on the broad areas of access, quality, and cost.
- The SOTAP prison programs should develop a formal referral process to psychiatry in order to make psychopharmacologic interventions available for those who need additional help with obsessive sexual thinking or deviant sexual arousal.
- The SOTAP should consider establishing a therapeutic milieu model of treatment at the Airway Heights facility similar to what is established at the Monroe facility.
- The WDOC should consider using Static-99R, Stable-2007, and Acute-2007 risk assessments to inform ongoing supervision standards beyond the initial assessment and provide training to community corrections officers about these assessments.

Without question, the WDOC has demonstrated a strong commitment to promoting public safety through efforts directed toward improving the management of sex offenders. It is hoped that the current review will contribute to these ongoing efforts.

BACKGROUND AND INTRODUCTION

REQUEST FOR ASSISTANCE

The State of Washington Department of Corrections (WDOC) contracted with the consultants to evaluate the current assessment and treatment practices of its Sex Offender Treatment and Assessment Program (SOTAP) in its adult prison facilities and the community. The consultation was a component of the SOTAP's quality improvement program.

CONSULTATION APPPROACH

The consultants evaluated the program against best practice standards and guidelines in the field. These included the Association for the Treatment of Sexual Abusers (ATSA) 2014 Practice Guidelines for the Evaluation, Treatment, and Management of Adult Male Sexual Abusers, national program accreditation criteria used in the United Kingdom, Canada, and Hong Kong, and the sexual offender and general criminology "What Works" research literature. Concerning issues where relevant guidelines and standards do not exist, the program was evaluated against common practices in the field, such as those described in Current Practices and Emerging Trends in Sexual Abuser Management: The Safer Society 2009 North American Survey. The consultants presented and discussed their findings with SOTAP leadership before preparing this report in order to help identify realistic strategies to make program improvements.

CONSULTANTS

Robert J. McGrath and Bradley R. Johnson served as the consultant advisors under this contract.

Robert J. McGrath, M.A. is President of McGrath Psychological Services, an international consulting practice. He is a licensed psychologist-master. For over 30 years he has specialized in preventing sexual abuse through his work, assessing, treating, and conducting research on individuals who have committed sexual offenses. He served as Clinical Director of the Vermont Department of Corrections network of prison and community sex offender treatment programs from 1996 to 2015. Among his over 50 publications, he is co-author of the books Supervision of the Sex Offender and Current Practices and Trends in Sexual Abuser Management. He is co-developer of several risk assessment instruments, including the Sex Offender Treatment Intervention and Progress Scale (SOTIPS) and the Risk of Sexual Abuse of Children (ROSAC). He has provided training, consultation, and program evaluation services in over 40 states and has served on numerous sex offender treatment advisory boards and accreditation panels including those for the national sex offender treatment programs in Canada, England, and Hong Kong. He is a former president of the Safer Society Foundation Board of Directors and was co-chair of the Association for the Treatment of Sexual Abusers (ATSA) Professional Standards Committee that wrote the organization's 2014 Practice Guidelines for the Assessment, Treatment, and Management of Male Adult Sexual Abusers. In 2015, he received the ATSA Significant Lifetime Achievement Award.

Bradley R. Johnson, M.D. is a psychiatrist who studied at Cornell University and the University of Arizona, having completed his medical degree in 1990, and his residency in psychiatry and subspecialty fellowship in child and adolescent psychiatry in 1995. He is board certified in psychiatry and forensic psychiatry. Although Dr. Johnson keeps a near full-time psychiatric private practice in his hometown of Tucson, he also works in a number of other settings simultaneously. Initially, he was a psychiatrist for the Arizona Department of Corrections (ADC), treating inmates in the highest security units, including Condemned Row, and helped design the ADC sex offender programing used. In 1999, he became Chief of Psychiatry at the Arizona Community Protection and Treatment Center, Arizona's sex offender civil commitment treatment program. Additionally, he is an Assistant Clinical Professor at the University of Arizona Department of Psychiatry. He has been actively involved with the American Psychiatric Association (APA), having served as the national Chair of the Assembly Committee of Area Members-in-Training Representatives, the Arizona Deputy Representative to the APA Assembly, the Public Affairs Representative for the Western United States and Canada, a member of the Task Force on the Psychiatric Aspects of Violence, and a member on the national APA Steering Committee on Practice Guidelines. He is a past President of the Arizona Psychiatric Society. He has served in many other professional organizations, including for a second time on the Executive Board of the Association for the Treatment of Sexual Abusers (ATSA) where he is currently the Membership Chair. Dr. Johnson has published and presented on psychiatric and forensic topics including violence, sexual offense, sexual abuse, clinician safety, and testifying in court. He consults with a number of sex offender treatment programs nationally.

PROCEDURES

To support the present review and develop recommendations to improve the functioning and effectiveness of the SOTAP, the consultants reviewed relevant program documents, conducted site visits at the Airway Heights Correctional Center SOTAP on January 11, 12, and 13, 2017 and the Monroe Correctional Complex SOTAP on February 28 and March 1, 2017. The consultants met with Washington State DOC central office staff in Tumwater, WA on March 2 and 3, 2017, and conducted interviews and observed treatment services related to SOTAP community programs in Tumwater, WA and the greater Seattle, WA areas on June 14, 15, and 16, 2017.

Documents Reviewed

Below is a list of the documents provided to the consultants for review:

- Data regarding admitting clients into the program at target date; Excel file dated 12/19/16
- Classification Policy 300.380 revised 4/14/14
- Distribution of clients based on risk level for year to date, dated 12/2/16
- Department Fact Card: Facts about Offenders in Confinement, dated 9/30/16
- Executive Summary of program model, dated 9/12/16
- Indeterminate Sentence Review Policy 320.100, revised 3/29/16
- Sample sex offender law enforcement bulletins (4)
- SOTAP Brochure, undated

- Quality Assurance and Training Vision, dated 12/19/16
- Washington State Law governing the SOTAP: RCW 9.94A.810, Transition and relapse prevention strategies, and RCW 9.94A.820, Sex offender treatment in the community
- SOTAP Organizational Chart, dated 11/7/16
- SOTAP Fact Sheet, dated 11/15
- SOTAP Manual, draft 12/15/16
- Sex Offender Treatment and Assessment policy 570.000, revised 5/19/16
- SOTP manual and assignments used in earlier versions of the program
- Numerous individual therapist's treatment documents and assignments
- SOTP Prioritization Matrix, revised 10/15, DOC 570.000 Reference
- SOTAP Initial Treatment Plan (ITP) based on STABLE 2007, undated
- Sample Stable-2007 pre- and post-treatment scores
- Policy letter to staff regarding staff searches and allowable items, dated 11/4/16
- SOTP Client Intake Process; Future State Map, dated 6/17/15
- WA DOC Group Facilitator Observation Form, dated 9/28/15

Airway Heights Correctional Center (AHCC) Site Visit

During the Airway Heights Correctional Center (AHCC) site visit on January 11, 12, and 13, 2017 we engaged in the following activities:

- Met in individual and group meetings with senior program managers, including:
    - Cathi Harris, Director
    - Corey McNally, Clinical Quality Assurance and Training Manager
    - Renee Schuiteman, Sex Offender Treatment Program Manager, AHCC
    - Shelly Hanson, Program Specialist, AHCC
- Toured the facility
- Met with the following staff without their supervisors' present:
    - Treatment Supervisors (3 individual meetings)
    - Treatment Specialists (12 individual meetings)
    - Psychologists (2 individual meetings)
    - Correctional Program Manager, Michael Klemke
    - Security Specialist, Juline Martin
    - Captain Barbara Arnett
- Attended the following staff meetings:
    - Daily Huddle meeting
    - Clinical Team meeting
    - Hope Café special facility event
- Observed 4 treatment groups
- Observed a Community Transition meeting
- Met with 10 randomly selected offenders in individual meetings
- Met with facility psychiatrist, Dr. Mira Narkiewicz
- Reviewed 10 SOTAP offender records

- Presented a verbal report out of our initial findings to Cathi Harris, Corey McNally, Renee Schuiteman, and Shelly Hanson.

Monroe Correctional Complex (MCC) Site Visit

During the Monroe Correctional Complex (MCC) site visit on February 28 and March 1, 2017, we engaged in the following activities:

- Met in individual and group meetings with senior program managers, including:
    - Corey McNally, Clinical Quality Assurance and Training Manager
    - Lisa Dandescu, Sex Offender Treatment Program Manager, MCC
    - Dr. Christine Gomes, SOTAP Psychologist
- Toured the facility
- Met with the following staff without their supervisors' present:
    - Treatment Supervisors (3 individual meetings)
    - Treatment Specialists (14 individual meetings)
    - Psychologist (2 individual meetings)
- Observed 3 treatment groups
- Met with 10 randomly selected offenders in individual meeting
- Reviewed 10 SOTAP offender records
- Presented a verbal report out of our initial findings to Corey McNally, Lisa Dandescu, and Christine Gomes

Central Office Site Visit

During the visit to the Washington DOC central office in Tumwater, WA on March 2 and 3, 2017, we met in individual meetings with the following individuals:

- Jacob Bezanson, Program Manager, Law Enforcement Notification and Chair of the End of Sentence Review Committee
- John Campbell, Classification Administrator
- Tim Chase, Risk Assessment Specialist
- Rob Colley, SOTAP Risk Assessment Unit Supervisor
- Angel Davis, Community Corrections Specialist, Risk Assessment Specialist
- Leah Fisher, Washington State's Sex Offender Policy Board Coordinator; Office of Financial Management
- Victoria Frimpong, Risk Assessment Specialist
- Bruce Gage, M.D., Chief of Psychiatry
- Jessi Herrin, Correctional Records Technician
- Jeff Landon, Senior Administrator of Programs, Offender Change Division,
- Brian McElfresh, Cognitive Behavioral Intervention Fidelity Manager

- Justin Perry, Quality Assurance Supervisor
- Kecia Rongen, Indeterminate Sentence Review Board Chair and Jeff Patnode, Indeterminate Sentence Review Board member
- Keri Rainer Ph.D., Director Mental Health
- Diane Rowles, Risk Assessment Specialist
- Keri Waterland Ph.D., Assistant Secretary, Offender Change Division
- Dawn Williams, Program Administrator, Substance Abuse Recovery Unit
- Hilary Williams, Community Corrections Specialist, Risk Assessment Specialist
- Minna Swartz, SOTAP Community Program Manager

Community Programs Site Visit

During the visit to review SOTAP community programs we visited the community corrections offices in Tacoma, Chehalis, and Seattle, WA on June 14, 15, and 16, 2017 respectively and engaged in the following activities:

- Met in individual and group meetings with senior program managers, including:
    - Cathi Harris, Director
    - Corey McNally, Clinical Quality Assurance and Training Manager
    - Minna Swartz, Community Program Manager
    - Dr. Christine Gomes, SOTAP Psychologist
- Met with the following staff without their supervisors present:
    - Community Treatment providers (11 individual meetings in person and via Skype)
    - Community Corrections Officers and Field Administrators (6 individual meetings)
    - Philip Gibson, Ph.D., WDOC Staff Psychologist (1 individual meeting via phone)
- Reviewed sample treatment assignments
- Observed 4 treatment groups
- Met with 30 offenders in 4 treatment groups without their therapist present
- Presented a verbal report out of our initial findings to Cathi Harris, Corey McNally, and Minna Swartz

FINDINGS AND RECOMMENDATIONS

The following sections of the report are organized around 14 best practice areas that are linked with effective sex offender treatment programs. We briefly define each key area, assess the program's functioning in that area, and make recommendations for continued development.

1. MODEL OF CHANGE

The program has an explicit and empirically-based model of change that describes who the program is for and how it is intended to work.

FINDINGS

Program Admission Criteria

The SOTAP has clear and reasonable eligibility criteria for the prison program, which is set out in DOC Policy 570.000, revised 5/19/16. Clients who complete a prison SOTAP are eligible to enter a community SOTAP.

To be considered eligible for the prison SOTAP intensive long-term treatment, offenders must meet eligibility criteria as follows:

1. Convicted of a sex offense(s) for the current or a previous term of confinement.
2. Eligible for release from Prison at some point in the future.
3. Acknowledge/recall having committed a sex offense(s).
4. Agree to attend SOTAP and follow treatment rules and expectations.

Further, offenders who cannot read or speak English, who otherwise meet the criteria, may be eligible for treatment based on available resources.

Clients who are found eligible for the prison SOTAP are triaged for admission into the program based on the program's "Prioritization Matrix" that takes into account each client's risk level and sentence structure. The Prioritization Matrix is reviewed in more detail in the next section of this report (see Section 2. Risk and Intensity of Services). Individuals who complete a prison-based SOTAP are eligible for the community-based SOTAP upon release from prison.

SOTAP program administrators are reexamining eligibility criteria #3, "Acknowledge/recall having committed a sex offense(s)." Traditionally, one of the first steps in sexual offender treatment has involved asking clients to describe and accept full responsibility for their sexually abusive behavior. However, in multiple studies, client denial and minimization of sexual offending is not closely linked to increased rates of sexual reoffending (Hanson & Bussière, 1998; Hanson, & Morton-Bourgon,

2004, 2005; Mann, Hanson, & Thornton, 2010). Therefore, some sex offender treatment programs do not require offense admission and responsibility as a requirement for admission into or completion of their program (McGrath et al, 2010; Yates, 2009). Proponents of this approach argue that treatment of sex offenders in categorical denial can be effective (Thornton, Fernandez Marshall, Marshall, & Mann, 2001; Yates, 2009).

In recognition that offense denial, overall, is not likely a significant risk factor for sexual reoffending, the SOTAP expanded its programming and has developed and piloted a program called Moving Forward at the Airway Heights facility. It is a 14-week treatment program for men who categorically deny sexual offending behavior but otherwise meet program admission criteria. The program is designed to help these clients reduce their risk to sexual reoffend by teaching them skills in areas such as emotion management, impulsivity, problem solving, and cognitive restructuring.
Clients who at the conclusion of this program admit to sexual offending behavior may enroll in the standard prison SOTAP.

Program Model

The SOTAP's primary model of change is broadly cognitive-behavioral in nature, which it strives to deliver in accordance to the risk, need, and responsivity (RNR) principles (Andrews & Bonta, 2010).

The cognitive-behavioral model is the most empirically-supported model for treating sexual offenders and the dominant approach in the field (Association for the Treatment of Sexual Abusers, 2014; McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010). Overall, programs that follow a cognitive-behavioral model are more effective in reducing sexual and other reoffending rates than those that do not use this model (Aos, Miller, & Drake, 2006; Drake, 2013; Hanson, Bourgon, Helmus, & Hodgson, 2009; Schmucker & Losel, 2015).

The cognitive-behavioral model blends two approaches. Cognitive therapy is based on the premise that how individuals think largely determines how they act and that changes in behavior can be accomplished by changing individuals' patterns of thinking. Behavior therapy is founded on the premise that behavior is learned and that it can be changed by a variety of conditioning methods. Consistent with this approach, the SOTAP targets multiple problems causally linked to sexual offending and employs skill teaching and practice. However, as discussed later in this report (see Section #4: Effective Methods), the SOTAP should increase the amount of time devoted to skill teaching and practice in the program.

With respect to the RNR principles, simply stated, correctional programs found to be most effective in reducing reoffending are those that target offenders who are at moderate or higher risk to reoffend (risk), modify offender characteristics that are closely linked to reoffending (criminogenic needs), and use treatment methods that engage offenders and are matched to their learning styles and abilities (responsivity) (Hanson et al., 2009; Lovens, Lowenkamp, & Latessa, 2009; Schmucker & Losel, 2015). Application of RNR principles in the SOTAP are detailed in sections that follow (See Sections #2: Risk Principle; #3: Need Principle; and #5: Responsivity Principle).

The SOTAP integrates some additional treatment models into the program. With respect to the physical setting in which clients live and receive sex offender treatment in the two prison programs, the SOTAP uses two models. The Monroe program uses elements of a "therapeutic community" (TC) model, and the Airway Heights program uses an "outpatient" model.

In the Monroe TC model, clients all live on the same living unit and are expected to be active participants in their own and each other's treatment and in the healthy functioning of the unit. For example, clients are assigned or elected to a small number of leadership roles on the units, and the program holds unit meetings. Inconsistent with typical TC models, for example, treatment staff appear to spend little time with clients on the units, hold unit meetings rather infrequently (i.e., once a month), and do not involve security staff in unit meetings or other elements of the TC.

In contrast, in the Airway Heights "outpatient" model, clients are spread out in living units throughout the institution. Men living on these units are mixed in terms of whether or not they have committed sexual offenses or are enrolled in or have participated in sex offender treatment in the institution. Clients in the Airway Heights program go to the sex offender program's treatment building to attend treatment meetings. Although the majority of inmates at Airway Heights have been convicted of a sexual offense, it is typically more challenging to develop a therapeutic culture for sex offenders on units that house a "general population" (Schwaebe, 2005). Of note, the Airway Heights Correctional Center does use a unit-based TC model for clients enrolled in the Thinking for a Change program.

Finally, over the last few years, the SOTAP has increased emphasis on approach goals, which are concerned with helping residents develop interests, activities, and goals that are positively focused and incompatible with offending, rather than just avoiding the negative.

SOTAP leadership has written a draft program treatment manual that details the overall rationale, theory, structure, and empirical basis of the program. The draft manual focuses primarily on the prison programs and will expand to include community programs. The program work plan for the manual involves a several-month process of soliciting staff input and field testing the manual.

RECOMMENDATIONS

1.1. The SOTAP should provide sex offender treatment, commensurate with the risk principle, to individuals who deny committing a sex offense but are otherwise eligible to enter the SOTAP. This could include expanding the Moving Forward program that has been piloted at the Airway Heights site for men in categorical denial.

1.2. The SOTAP at Airway Heights should consider developing a therapeutic community (TC) model similar to the one at the Monroe site.

1.3. The SOTAP should complete the program treatment manual and should continue to seek staff input and feedback in its development.

2. RISK PRINCIPLE: RISK LEVEL AND INTENSITY OF SERVICES

The program assesses each client's risk to reoffend and matches the intensity of services to the client's risk level. Higher risk individuals are provided more intensive services and lower risk individuals are provided minimal or no services.

FINDINGS

Risk Assessment

The first step in applying the risk principle is to assess each client's risk to reoffend using a validated risk assessment approach. The SOTAP's implementation of a risk-based assessment and treatment approach is a notable program strength.

The SOTAP began using the Static-99R, Stable-2007, and Acute-2007 as its primary sex offender specific risk instruments in 2014. All three of these instruments have been validated and are the most commonly used instruments of their kind in sex offender assessment and treatment programs in the United States (e.g., McGrath et al., 2010).

Static-99R. The SOTAP administers the Static-99R to all inmates who have been convicted of a sexual offense within 30 to 90 days of being incarcerated. Static-99R scores are used as a primary factor for prioritizing individuals for available prison treatment slots. The Static-99R is composed of 10 static (i.e., unchangeable) risk factor items that pertain to sexual and nonsexual offense history, victim characteristics, and offender demographics (Helmus, Thornton, Hanson, & Babchishin, K., 2012).

Stable-2007. The SOTAP administers the Stable-2007 to clients upon admission into the prison SOTAP programs, at the end of prison treatment, at the beginning of community treatment, if recent scores are not available, and at the end of community treatment. Stable-2007 scores are used for treatment planning and measuring client progress. The Stable 2007 is composed of 13 dynamic (i.e., potentially changeable) risk factor items that pertain to social influences, intimacy deficits, general self-regulation, and sexual self-regulation (Fernandez, Harris, Hanson, & Sparks, 2012).

Acute-2007. The SOTAP administers the Acute-2007 to clients enrolled in the community SOTAP programs once a month. Acute-2007 is composed of seven transient environmental and intrapersonal stresses factors that can change over a period of several hours or days and signal the timing of new offenses (Hanson, Harris, Scott, & Helmus, 2007).

Combined Static-99R, Stable-2007, and Acute-2007 scores predict sexual reoffending slightly better than any instrument alone, so the program uses combined scores to further inform resource prioritization in the prison and community programs.

Six program staff are presently certified Static-99R, Stable-2007, and Acute-2007 trainers. SOTAP staff must be certified to use these tools soon after they are hired. The SOTAP has instituted several quality assurance mechanisms to ensure that staff score and use these tools as intended.

Treatment Prioritization and Treatment Dose

The second step in applying the risk principle is to match the amount and intensity of services to each client's risk level. The amount and intensity of services is called treatment dose.

Treatment Prioritization. The SOTAP uses its Prioritization Matrix to make decisions about who to accept into available treatment beds (see Table 1).

The Prioritization Matrix takes into account a client's risk level and sentence structure. In terms of risk to sexually reoffend, clients are classified according to four Static-99R risk categories; low, moderate-low, moderate-high, and high. In terms of sentence structure classifications, "Court Ordered Treatment" means that the court sentenced a client to a minimum and maximum prison release date with a requirement that the client complete sex offender treatment while under the jurisdiction of WADOC. Treatment may occur in prison or while the client is under community supervision. The SOTAP is voluntary and the client may choose to participate in this programming while in prison with a mandatory follow up community based treatment, or the client may opt to pay for treatment on their own once released into the community.

The sentence structure designation "Community Custody Board (CCB)/Indeterminate Sentence Review Board (ISRB)", which is based on crime of conviction, means that a client has a minimum and maximum prison release date, and that the CCB/ISRB reviews his case approximately 120 days before his minimum release date. The CCB/ISRB may condition a client's release on or near his minimum release date based on several factors, including whether he has completed the prison SOTAP. The CCB/ISRB may hold a client in prison up to his maximum prison release date, which is often life, depending on the person's individual characteristics, which includes but is not limited to the completion of treatment.

As noted above, offenders are sentenced under the CCB/ISRB statutes based on crime of conviction, not risk to reoffend. Previous statute directed WDOC to prioritize these offenders for treatment, thereby taking away the programs ability to prioritize treatment based primarily on risk. At WADOC's request, over the past 2 years, legislation has been revised and proposed to modify these practices. In the 2017 legislative session, the WADOC requested House Bill 1754 passed modifying statute to allow the prioritization of clients for treatment commensurate with risk.

Treatment Dosage. Research has examined recommended treatment dosage in correctional programs, including those that serve individuals who have committed sex offenses. In this report, we base our recommendations on a review of the general correctional treatment literature (Andrews & Bonta, 2010; Bourgon & Armstrong, 2005; Hanson & Yates, 2013; Sperber, Latessa & Makarios, 2013), the sexual offender treatment literature (Beech, Fisher & Beckett, 1998; Hanson &

Yates, 2013; McGrath et al., 2010; McGrath, Cumming, & Williams, 2015), and common practices in programs. Following this research, a reasonable approach is that incarcerated SOTAP clients classified as high risk receive about 300 or more treatment hours, those at moderate risk receive about 200 treatment hours, and those at low risk receive no or minimal treatment hours. Upon release from prison, clients should receive aftercare treatment in the community commensurate with their risk.

For the most part, the prison SOTAPs are following these broad guidelines. The prison SOTAPs are designed to be 12 months in duration for high risk clients. During this time clients typically attend 6 hours of core group treatment per week and about 1 hour of individual treatment per month. Assuming treatment groups are delivered 48 weeks per year and clients receive 12 one-hour individual treatment sessions per year, the treatment dose is 300 hours. This treatment dose is slightly higher for clients who are referred to attend one or more time-limited topic-specific treatment groups that the program offers periodically (e.g., victim empathy, healthy relationships, dialectical behavior therapy, community transition, and sexual education). Program Managers and Program Supervisors have input into each client's treatment plan and generally recommend that moderate and low risk clients complete less intense versions of the program. However, these recommendations are not structured in a formal manner. Many moderate risk clients complete about 8 to 10 months of treatment, which is about 200 to 250 hours. Many low risk clients complete treatment in about 6 months, which is about 150 hours.

Although the prison SOTAPs make some efforts to aggregate lower risk clients in the same treatment groups, there is no formal process for how these decisions are made. Regardless, treatment of low risk sex offenders is unlikely to have an impact on reducing their reoffense rates (e.g., Schmucker & Losel, 2015). In fact, providing high intensity treatment to lower risk sex offenders may actually increase their risk to reoffend (Lovens et al, 2009). Research in the general correctional treatment literature has also found that treatment interventions for low risk offenders can have harmful effects (e.g., Andrews & Bonta, 2010). Low risk sex offenders who are over treated may develop anti-social attitudes and beliefs from associating with higher-risk offenders, adopt deviant self-labels, and see themselves as more criminal than they really are. For these reasons, the limited resources available in SOTAP should be directed to moderate and high risk clients for whom treatment is likely to have the greatest positive impact.

As the SOTAP Prioritization Matrix in Table 1 shows, the program is broadly applying the risk principle. Clients who score in the high range (1A-C) are given the highest priority for treatment, those in moderate-high group (2A-C) the next highest priority, and so on. As Table 1 also shows, consistent with the risk principle, the majority of clients (64%) receiving services in the prison SOTAPs in January 2017 were designated either high or moderate-high risk. Twelve percent of clients in the program in January 2017 were classified as low risk. Table 1 indicates that low risk clients are more likely to be accepted into the SOTAP if the court or ISRB requires them to complete sex offender treatment as a condition of early release. Overrides to place low risk clients into the prison SOTAP is often done at the request of the ISRB, which considers referral factors in addition to risk level, such as offense severity, victim input and perceived criminogenic needs not accounted for

by the Static 99R. Discretionary overrides in the SOTAP should typically account for about five percent of placement decisions and should be equally balanced between increases and decreases in custody levels.

Table 2 shows the total number and percentage of clients that the SOTAP Risk Assessment Unit evaluated in calendar year 2016 by Static-99R risk level. Comparisons between the data in Tables 1 and 2 indicate further evidence that the SOTAP is applying the risk principle. This assumes that the percentage of incarcerated sex offenders in recent years is similar in terms of the risk level distribution shown in Table 2. The SOTAP appears, for example, to be accepting a higher percentage of high and moderate-high risk clients into the program than are contained in the total prison population (64% versus 45%) and a lower percentage of low risk individuals than are contained in the total prison population (12% versus 23%).

In terms of the SOTAP applying the risk principle in the future, the program should consider whether it is using an overly broad definition of low risk for classifying clients. Based on the original four Static-99R risk categories, the SOTAP now classifies scores of -3 to 1 as low risk in the Prioritization Matrix (see Table 1). In practice, the SOTAP prioritizes higher risk clients based on Static 99R score within the original risk categories, for example for low risk clients, the SOTAP will prioritize a client who scores a 1, over a client who scores -3. However, the Static-99R developers have recently recommended a five-level system in which a score of 1 is considered to represent an "average" level of reoffense risk as opposed to a low level of risk (see Figure 1). Individuals who score 1 on the Static-99R have predicted 5-year sexual re-offense rate of about 4% and could reasonably be expected to benefit from treatment and reduce their risk to reoffend. The two lowest risk categories in the new five-level system (i.e., scores from -3 to 0) are arguably a better way to classify sexual offenders who need minimal or no intervention (Hanson, et al., 2016). The recent changes in Static-99R risk levels are part of a broader movement in corrections to develop an empirically-based common language for risk communications (Hanson, Bourgon, McGrath, Kroner, D'Amora, Thomas, & Tavarez, 2017).

To further assist the SOTAP in reviewing cut-off scores for allocating treatment services, we have included in this report two figures that show updated Static-99R data and risk score data for incarcerated sex offenders in Washington State. Figure 1 shows Static-99R predicted 5-year sexual recidivism rates for use with routine samples of sex offenders as well as the new risk categories. Figure 2 shows the percent of clients evaluated by the SOTAP Evaluation Unit in 2016 by the new Static-99R risk categories, score ranges, and predicted 5-year sexual recidivism rate ranges.

The consultants note that the Static-99R developers released the new five-level risk system a few months before the present evaluation commenced and did not offer recertification training on the new system until this year. The SOTAP has stated a commitment to adopt the new five-level system, but this is not a critical priority at this time given the other program changes the SOTAP is undertaking. Changing agency policies and procedures and IT systems will take some time.

Table 1. Distribution of Clients in SOTAP Prison Programs by Prioritization Matrix Categories in January 2017

Sentence Structure	Static-99R Risk Level and Score			
	High 6+	**Moderate-High 4 to 5**	**Moderate-Low 2 to 3**	**Low 1 to -3**
Community Custody Board (CCB)/Indeterminate Sentence Review Board (ISRB) with Court Ordered Treatment	1A n =29	2A n=52	3A n=45	4A n=21
Non-CCB/ISRB with Court Ordered Treatment	1B n=29	2B n=50	3B n=18	4B n=9
Non-CCB/ISRB with No Court Ordered Treatment	1C n=13	2C n=14	3C n=8	4C n=4
TOTALS N=292	n=71 24%	n=116 40%	n=71 24%	n=34 12%
	n=187 64%			

Table 2. Clients Evaluated by the SOTAP Risk Assessment Unit in 2016 by Four Static-99R Risk Levels

Sentence	Static-99R Risk Level and Score			
	High 6+	**Moderate-High 4 to 5**	**Moderate-Low 2 to 3**	**Low 1 to -3**
TOTALS Evaluated by Evaluation Unit 2016 N=785	n =140 18%	n=217 28%	n=245 31%	n=183 23%
	n=357 45%			

Figure 1. Static-99R Predicted 5-Year Sexual Reoffending Rates and Five Risk Categories (Hanson et al., 2016)

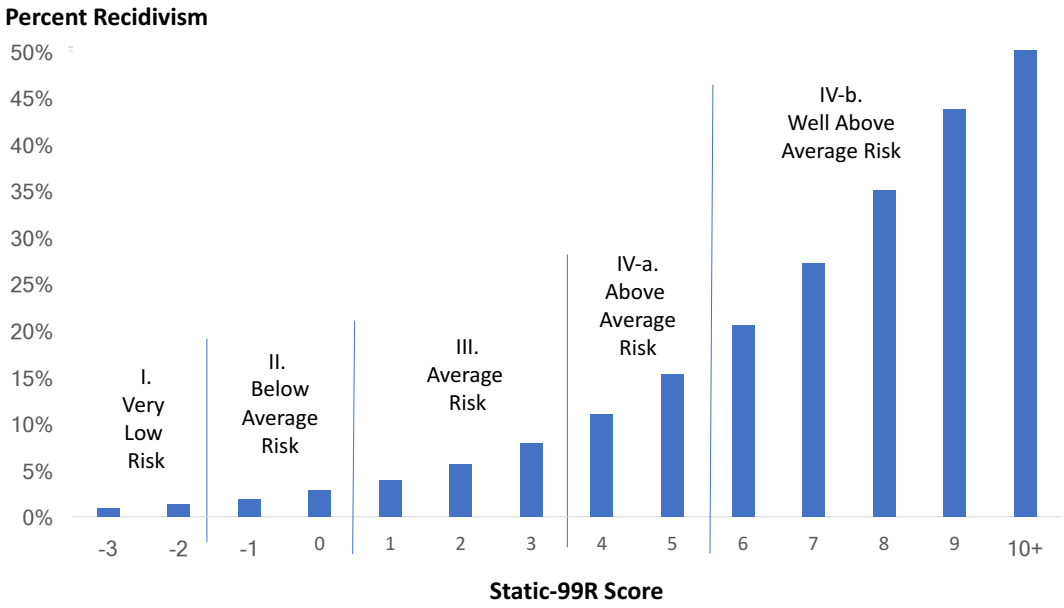
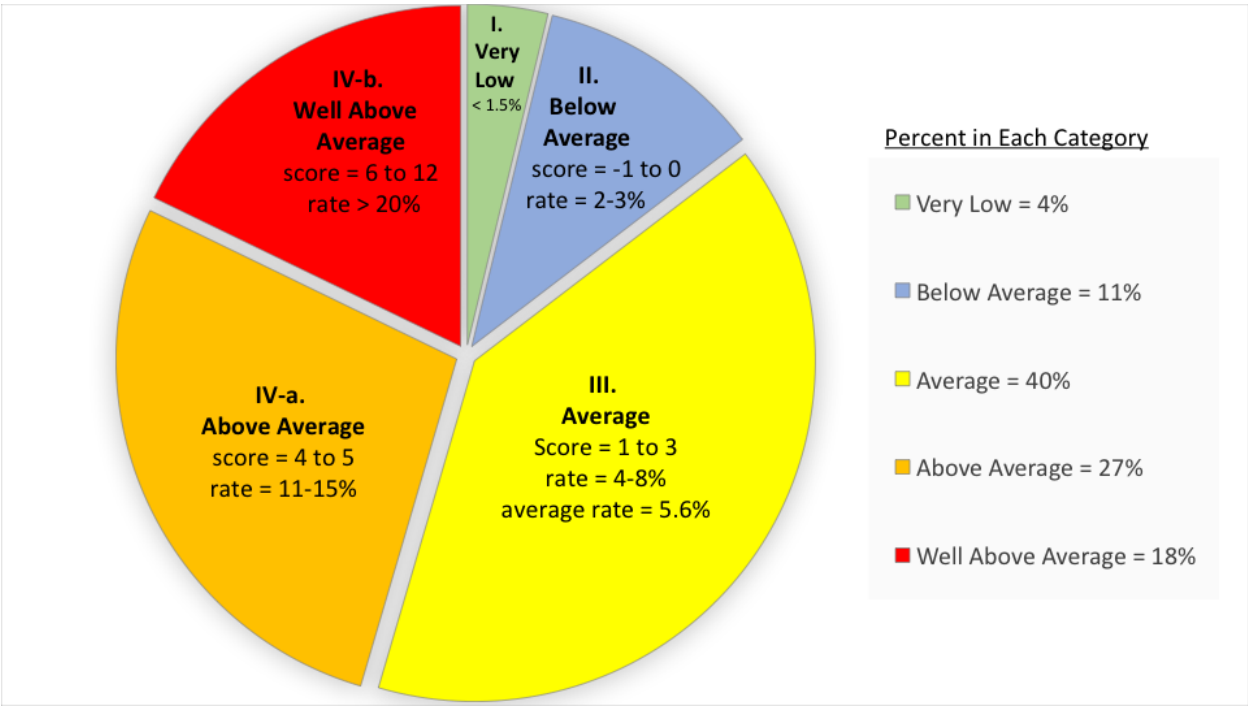


Figure 2. Percent of Clients Evaluated (N = 785) by the SOTAP Risk Assessment Unit in 2016 by Five Static-99R Risk Categories and Predicted 5-Year Sexual Reoffending Rate



With respect to treatment dosage in the community SOTAPs, the programs are designed to be up to about 12 months in duration. During this time, clients typically attend one 2-hour treatment group per week, which may reduce to bi-monthly after about six months depending on the client's risk level and treatment progress. In addition, depending on client treatment needs and local treatment provider practices, clients also typically receive between about three and 12 individual treatment sessions and possibly a few joint sessions with a spouse or partner. A few treatment providers meet with clients individually more frequently as needed. Thus, the treatment dosage in community programs typically ranges from about 50 to 100 hours.

The composition of community treatment groups is largely dependent on the characteristics of the relative small number of clients enrolled in treatment in a particular county at any given time. Low risk clients are typically mixed in treatment groups with higher risk clients.

RECOMMENDATIONS

2.1. The SOTAP should continue to prioritize treatment services based on client risk. This should involve continuing to provide education to and continuing to collaborate with the Indeterminate Sentence Review Board, the courts, and the legislature about the wise use of available resources.

2.2. The SOTAP should complete its plan over a moderate term time frame to adopt the new five-level Static-99R risk category system and revise the treatment "Prioritization Matrix" accordingly.

2.3. The SOTAP should continue to match treatment dose to client risk level. For example, using the Static-99R 5-level risk category system, it would be reasonable to categorize low risk sex offenders as individuals who score -3 to 0 (Static-99R Risk Level I and II) and provide them no or minimal treatment; moderate risk sex offenders as individuals who score 1 to 3 (Static-99R Risk Level III) and provide them about 200 hours of treatment; and high risk sex offenders as individuals who score 4 to 12 (Static-99R Risk Level IVa and IVb) and provide them with about 300 hours or more of treatment.

2.4 The SOTAP, if it provides prison sex offender treatment to low risk sex offenders, should not mix these offenders in the same group as higher risk sex offenders. If the SOTAP develops a separate prison program for low risk sex offenders, it should be low dosage and focus on release preparation. This could be a closed group that is offered a few times a year, or as otherwise needed. Similarly, community treatment for this population should be minimal, which could consist of individual SOTAP treatment sessions and/or referral to community services (e.g., family counseling, general mental health treatment) if needed.

3. NEED PRINCIPLE: TREATMENT TARGETS

The program assesses each client's changeable problems that are closely linked to sexual and other offending behavior and targets them in treatment. These are commonly called "criminogenic needs" or "dynamic risk factors."

FINDINGS

Treatment Needs Assessment

The first step in applying the need principle is to assess each client's treatment needs. The results of several meta-analyses have identified sexual offenders' major criminogenic needs that should be targets of treatment in sex offender treatment programs (Hanson & Morton-Bourgon, 2004, 2005; Mann, Hanson, & Thornton, 2010), and they are listed in Table 3.

Table 3. Criminogenic Treatment Needs of Sex Offenders

- Deviant sexual interests
- Sexual preoccupation
- Offense-supportive attitudes
- Emotional congruence with children
- Lack of adult love attachments
- Lifestyle impulsivity
- Poor problem solving
- General self-regulation problems
- Resistance to supervision and rules
- Grievance/hostility
- Employment instability
- Negative social influences

As previously noted, the SOTAP uses a validated risk assessment approach for assessing clients' treatment needs. The SOTAP began using the Stable-2007 and Acute-2007 as its primary sex offender specific dynamic risk instruments across the continuum of care in 2014 and has implemented use of these instruments with integrity. That is, the program uses certified internal staff trainers, certifies frontline staff to administer the instruments, provides booster training, and conducts interrater reliably checks. These tools provide a very good survey of need factors related to sex offender recidivism. Use of these instruments across the system of care provides a common language for communication between treatment providers, community corrections officers, and program stakeholders.

Treatment Needs Targeted

The second step in applying the need principle is to target each client's criminogenic needs in treatment. Ideally, about 75% of treatment time should focus on criminogenic needs, and multiple criminogenic needs should be targeted. Time in treatment not focused on criminogenic needs focuses on areas such as treatment engagement and motivation (see Section #4: Responsivity).

Overall, both prison SOTAPs evidence the same general strengths and areas for improvement with respect to targeting client's criminogenic needs. A particular program strength is the focus on

helping clients address problems related to offense supportive attitudes, problem solving, impulsivity, and developing healthy support systems.

With respect to areas of improvement, the prison SOTAPs focus an inordinate amount of treatment time on offense disclosures and offense responsibility, which are not factors closely linked with reducing sexual reoffending (e.g., Hanson & Bussiere, 1998; Mann et al., 2010; Yates, 2009). The program is aware this practice is not aligned with relevant research. In 2015, the program contracted with Liam Marshall, Ph. D. for a 2-day training to begin the discussion about making changes in these practices. Specifically, the SOTAP discontinued the use of the disclosure for non-therapeutic purposes and is limiting its focus on victim empathy.

Similarly, traditional victim empathy interventions do not appear to result in reduced sexual reoffending rates and time spent on this target could be reduced (Mann et al., 2010). A greater focus should be placed on addressing client "blocks" that have impaired victim empathy in the past (Barnett & Mann, 2013). These include attitudes that support sexual and other criminal offending as well as deviant sexual interests and sexual preoccupation. The prison and community SOTAPs do not have a clear structured approach for targeting deviant sexual interests and sexual preoccupation, either in terms of psychological or medication treatments.

The community SOTAP providers appear to place an appropriate emphasis on client's criminogenic needs. Community treatment providers and clients appeared to have a good understanding of Stable-2007 and Acute-2007 risk factors, which are the primary treatment targets in the community SOTAPs. As noted, improvements can be made in how the community treatment providers help clients address deviant sexual interests and sexual preoccupation.

RECOMMENDATIONS

3.1. The prison SOTAPs should continue to decrease the amount time spent on targeting non-criminogenic needs such as disclosure, life history, and victim empathy assignments. The SOTAP should increase the amount of time spent on targeting the criminogenic needs listed in Table 3 to about three-quarters of program time.

3.2. The SOTAP should develop a clear structured approach for targeting the treatment needs of clients who have deviant sexual interests and sexual preoccupation. In the prison SOTAPs, this should include developing closer working relationship with DOC psychiatry services to support the use of medication treatments for sexual arousal control and an adjunct treatment group focused on managing arousal control. In the community SOTAPs, this should include continuing to develop working relationships with psychiatrists and other physicians in the community.

4. RESPONSIVITY PRINCIPLE: CLIENT ABILITIES AND LEARNING STYLES

The program delivers services in a fashion that accounts for clients' abilities and learning styles. This section addresses specific responsivity, which concerns specific individual client characteristics such as those related to motivation, intelligence, mental health, and culture.

FINDINGS

Responsivity Characteristics Assessment

The first step in applying the responsivity principle is to assess each client's responsivity characteristics. Overall, these characteristics are assessed appropriately. Upon incarceration, all clients are sent to Washington DOC's reception and classification facility at the Washington Corrections Center, Shelton WA, for up to approximately 90 days. As part of the prison intake process, prison staff facilitate an orientation program and develop each client's initial case plan. Responsivity assessments examine each client's intellectual functioning, mental health status, substance abuse needs, and general program and security needs. In 2013, SOTAP staff began conducting in-person screenings for SOTAP amenability on eligible offenders. SOTAP staff report that this practice has been instrumental in engaging higher risk clients in the treatment program and identifying client responsivity needs early in the treatment process. SOTAP staff have not received special funding to conduct these in-person classification screenings, which demand considerable staff time. However, using SOTAP staff to engage clients at orientation appears to be successful in recruiting higher risk clients into the program, which is consistent with the risk principle.

Once a client is accepted into one of the prison SOTAPs, he undergoes an initial program assessment that includes a review of the initial classification documentation and the completion of the Stable 2007. The SOTAP does not administer a standardized set of responsivity-related psychometric tests or interview schedules to those who are newly admitted to the program. However, SOTAP treatment providers can refer clients to program psychologists for consultation and testing related to client responsivity characteristics such as mental health, intellectual, and educational issues. Responsivity assessments conducted in the prison SOTAPs follow clients into the community.

Responsivity Characteristics Addressed

The second step in applying the responsivity principle is to address clients' individual responsivity characteristics. There are several markers for assessing how well a program addresses clients' responsivity characteristics.

Client Satisfaction. At each prison SOTAP, we conducted individual interviews with 10 clients for a total of 20 interviews. Eighty percent of clients interviewed were very positive about their experiences in the program. They reported that clinical staff treat them with respect, are competent, and are interested in helping them be successful in the program. Most clients interviewed reported that they have a clear understanding about how the program works and

understand what they need to accomplish to reduce their risk to reoffend and successfully move through the program. The few client complaints concerned personality conflicts with a therapist and inconsistency among therapists concerning instructions for completing treatment assignments. The SOTAP does not solicit formal client feedback about the program, such as using written client satisfaction surveys.

At the three community SOTAP sites visited, we conducted group interviews with a total of 30 clients across four treatment groups. Again, about eighty percent of clients interviewed were very positive about their experiences in the program. However, several clients discussed the challenges of taking time off from work to attend treatment sessions and supervision meetings. A few clients pointed out that they had to attend multiple treatment programs simultaneously (e.g., sex offender treatment, substance abuse treatment, and Thinking for a Change), and they said that this was very disruptive to maintaining employment and leading a balanced life.

The SOTAP in both prisons and the community does not solicit formal client feedback about the program, such as using written client satisfaction surveys.

Program Completion Rates. Program completion rates are a broad marker for how responsive a program is to clients' individual responsivity characteristics. Low completion rates may mean that the program is too difficult to complete, and very high completion rates may mean that the program is not challenging enough.

The completion rate in the SOTAP prison programs in FY 2015 was 81% of 272 total participants and in FY 2016 was 82% of 315 total participants. These rates fall well within the appropriate range for this metric. In a survey of North American residential sex offender programs, the average completion rate for 63 United States programs was 71% (McGrath et al., 2010).

The completion rate in the SOTAP community programs in FY 2016 was 68% of 264 participants that ended treatment in that year. This is slightly below the average completion rate in United States community programs, which was 76% across 312 programs in the McGrath et al. (2010) survey.

Specific Responsivity. The SOTAP addresses several client responsivity issues.

- SOTAP staff personally interview each individual who has been convicted of a sex crime shortly after admission to the reception and classification facility. The goal is to provide clients with an accurate description of the SOTAP and encourage them to participate in the program.

- The prison SOTAPs provide clients at least one hour of individual treatment per month and sometimes more. The community SOTAPs provide clients individual treatment, primarily on an as needed basis. Sex offender treatment programs that provide for some individualization of services are more effective than those that do not (Schmucker & Losel, 2015).

- SOTAP has a Spanish speaking group at the Airway Heights facility for individuals for whom English is a second language.

- SOTAP has a special "responsivity" group for individuals with learning and intellectual disabilities and individuals with serious mental illness at the Monroe Facility.

- SOTAP has piloted and established the Moving Forward program at the Airway Heights facility, which is a 14-week treatment program for men who categorically deny their sexual offending behavior.

- SOTAP has a special program for individuals with major mental illness in the Special Offender Unit at the Monroe facility. The program has a dedicated and very skilled full-time treatment provider. This position requires a master's degree in the social and behavioral sciences. The program is overseen by the SOTAP Psychologist at the Monroe facility.

- SOTAP has a support group at the Monroe facility to address the special needs of individuals in the program who identify as Lesbian, Gay, Bisexual, Transgender or Intersex, or who are allies of LGBTI individuals.

- The prison SOTAPs attempt, albeit informally, to match the strengths of treatment providers with the responsivity characteristics of clients in the program.

- The SOTAP has piloted a co-occurring group at the Monroe facility for clients with high needs in both substance abuse and sex offender treatment. These individuals score moderate to high on the Static 99R and high in substance abuse treatment needs. The group is co-facilitated by a SOTAP therapist and a Chemical Dependency Counselor.

- Both the Airway Heights and Monroe programs have "tutors" and a "study hall" where clients who are farther along or have completed the program help newer clients with assignments, such as providing assistance with reading, writing, and comprehension.

- Both the Airway Heights and the Monroe programs have adapted the curriculum and increase therapist and client contact in 1:1 sessions when needed to help clients respond to treatment in a positive manner.

- The prison SOTAPs have purchased hearing assistance devices outside of the medical division in order to help clients with hearing disabilities respond to the program.

- The community SOTAPs refer clients to ancillary services (e.g., mental health treatment) when needed.

- SOTAP has developed a draft Group Facilitator Evaluation Form that is a quality assurance/improvement intervention designed to assure that treatment providers facilitate groups as intended and in a manner that is responsive to clients' learning styles.

There are also areas for improvement.

- SOTAP and health services within the institutions are not well coordinated. The correctional facilities in which the two SOTAP programs are located each have medical and mental health departments. However, these health departments and the SOTAP are under different administrative departments within the DOC. As a result, SOTAP staff cannot directly refer a client to health services, except in an emergency, and cannot talk with medical or mental health staff about a client without a formal signed release of information authorization. Psychiatric and psychology administrators at the Monroe and Airway Heights facilities and at DOC central office were open to working out solutions to better integrate care among departments.

- Clients in the SOTAP who have been assessed as low risk are sometimes placed in treatment groups with moderate and high risk clients. As previously noted, this is counter to best practice in general offender treatment as well as sex offender treatment programs (Andrews & Bonta, 2010; Lovens et al, 2009).

- Prison SOTAP treatment groups visited during the evaluation typically had between 10 and 12 members, which is in line with a therapy group size of 8 to 10 members recommended by Yalom (2005). Similarly, Bush, Glick, and Taymans (2011), authors of the Thinking for a Change correctional program, recommend a group size of 8 to 12 members. Community SOTAP treatment groups visited during the evaluation had no more than 9 members and treatment specialists told us that group size has generally been about 8 members. During brief periods of understaffing, some community groups have been as large as 12 to 15 members in some areas of the state.

- Clients receive a facility disciplinary infraction for dropping out of the SOTAP. A few external partners reported that clients who receive medical, psychiatric, and psychology services have the right to discontinue services without incurring facility disciplinary infractions. Common practice in medical and psychological treatment settings, including those in correctional settings, is that clients can voluntarily withdraw from treatment services without suffering disciplinary consequences.

- The composition of community treatment groups, as previously noted, is largely dependent on the characteristics of the relative small number of clients enrolled in treatment in a particular county at any given time. Consequently, there can be considerable heterogeneity among clients in a treatment group in terms of risk level, treatment needs, intellectual and developmental disabilities, reading ability, and other responsivity characteristics. In a small number of cases, clients with special responsivity needs may be more appropriately placed

in individual SOTAP treatment or referred to outside specialists (e.g., mental health practitioners) rather than be treated in a SOTAP sex offender group.

RECOMMENDATIONS

4.1. SOTAP staff should continue to engage clients soon after they are admitted to the reception and classification facility in order to recruit higher risk clients into the program, which is consistent with the risk principle.

4.2 SOTAP treatment group size should ideally be 8 to 12 clients. Group size for some psychoeducation groups could be larger depending on the nature of the group and whether the group is co-facilitated.

4.3. The SOTAP should examine with DOC leadership the DOC policy regarding issuing clients a facility disciplinary infraction for dropping out of treatment. An alternative policy would be that clients who drop out of treatment would simply be allowed to suffer the logical consequences of their actions such as movement to another facility or a lengthier sentence for failure to complete court ordered or ISRB treatment expectations.

4.4. The SOTAP should develop a closer working relationship with DOC psychology and psychiatry services to improve coordination of mental health services for SOTAP clients. Such intervention could be for the purpose of providing adjunctive medication interventions for arousal control and for ongoing better coordination of general psychiatric conditions. For example, this could include a monthly joint SOTAP and mental health staff meeting to coordinate client care.

4.5. The community SOTAPs should continue to identify the few clients whose special responsivity needs (e.g., very low risk level, mental illness, intellectual and developmental disabilities) contraindicate placement in available treatment groups and provide individual SOTAP treatment or refer to outside specialists (e.g., mental health practitioners) rather than providing treatment in a SOTAP sex offender group.

4.6 The community SOTAP should stagger and sequence programming for clients that need to complete multiple treatment programs because taking these programs simultaneously can be overly disruptive to obtaining and maintaining employment and living a balanced life.

4.7. The SOTAP should develop a formal method of soliciting client feedback about the program in order to inform quality improvement activities. Examples are a client suggestion box and client satisfaction surveys.

5. EFFECTIVE METHODS

The program employs methods that have been consistently demonstrated to be effective with clients. Overall, programs for offenders that are manualized are more effective than those that are not. Programs should be structured and skill oriented, and utilize techniques such as cognitive restructuring, training in self-monitoring, modeling, role-play, and graduated practice with feedback. In general, more effective correctional programs allocate about half of treatment time to skill building interventions focused primarily on clients' criminogenic needs.

FINDINGS

Treatment Manual

Overall, correctional programs for offenders that are manualized are more effective than those that are not (Mann, 2009; Marshall, 2009). The prison SOTAPs have used various versions of SOTAP treatment manuals that have been replaced and revised over the years. These manuals contain treatment assignments that clients complete and present sequentially in group over the course of treatment (e.g., goal setting, autobiography, disclosure, behavior chain, risk factors, relapse prevention plan). However, there are now several different versions of the same assignments in use across the two prison programs and the community programs. As well, some treatment providers have introduced new assignments that are not covered in the treatment manuals. Treatment providers, especially new providers, reported that it is confusing to know which assignments or versions of assignments to use. Some clients had similar complaints.

As previously noted, the SOTAP leadership has written a draft program treatment manual that details the overall rationale, theory, structure, and empirical basis of the program, as well as detailed treatment assignments. The program work plan for the manual involves a several-month process of soliciting staff input and field testing in the prison programs, and this process should follow for community programs. Goals are to provide consistency in how treatment is delivered between treatment specialists and treatment sites.

Skill Building

The prison SOTAPs place considerable emphasis on helping clients acquire new insights and information, but comparatively less emphasis on helping clients learn and practice new skills to avoid reoffending. Overall, the community SOTAPs emphasize helping clients use skills in the community that they learned in the prison treatment, although little explicit skill practice, such as role play, appears to occur.

Correctional programs that emphasize skill development and practice are clearly more effective than those that do not (Andrews & Bonta, 2010; Latessa & Lowenkamp, 2006).

Recommended steps for teaching new skills are similar across a variety of correctional programs (McGrath, Cumming, & Williams, 2015), which commonly include the following steps:

a. Identify the skill to teach.
b. Help the client identify the usefulness of the skill.
c. Model the skill, as in a demonstration role play.
d. Have the client practice the skill in the treatment session.
e. Provide corrective feedback.
f. Assign skill practice outside of treatment sessions.
g. Provide opportunities and encouragement to enhance the skill.

RECOMMENDATIONS

5.1. The SOTAP should increase the program time spent on skill building and practice, including role plays. Overall, about half or more of clinical program intervention time should focus on skill building and practice that targets clients' criminogenic needs.

5.2 The SOTAP should ensure that treatment specialists deliver treatment using the new treatment manual as intended. Recommendations that treatment specialists and other staff make to improve the manual should be approved by SOTAP clinical leadership prior to being implemented.

6. PROGRAM SEQUENCE, DESIGN, AND STRUCTURE

The sequence, spacing, and structure of services is logical and responsive to clients' treatment needs and learning styles.

FINDINGS

Program Start Date

The SOTAP strives to start clients in SOTAP prison programs near the end of their minimum release date, but early enough so that clients can finish treatment and be released by their "earned release date" (ERD). This is important since clients who enter treatment late may have to stay in prison beyond their ERD. This is a liberty issue for clients and a cost issue for the state when valuable prison beds are used for clients whose sentences are unnecessarily lengthened by failure to complete treatment in a timely manner.

The SOTAP has made considerable improvements in ensuring that clients enter treatment in a timely manner. Based on a recent analysis of 167 prison SOTAP admissions, 77% (128) of clients entered the program early enough to be considered for release to the community by their ERD upon successful completion of treatment. Of those who were not, most started treatment "late" by only a

few months and none exceeded 12 months. Twelve months prior to this analysis, the program only had 23% of clients entering the program early enough to be considered for release to the community before their ERD upon successful completion of treatment.

Similar to the WDOC SOTAP, almost all prison treatment programs in the United States admit clients into sex offender treatment near the end of their minimum release dates. This practice has not been well studied, but the idea is that clients learn and practice skills to prevent reoffending as close as possible to when they will need these skills most, namely, as close as possible to the date that they return to the community.

Treatment Sequence

The sequence of services should be logical and responsive to clients' treatment needs and learning styles. Broadly, effective treatment programs generally focus on a sequence of four broad treatment phases:

a. motivation and engagement
b. strengths and treatment needs identification
c. skill building to enhance strengths and overcome deficits
d. transition planning

The SOTAP follows this program sequence. As has been previously noted, however, the current prison SOTAPs place too much emphasis on problem identification (i.e., treatment needs) and not enough on skill building. The community SOTAPs appear to allocate treatment time appropriately in terms of these four treatment phases, although as previously noted the programs focus on skill building would benefit from including more explicit skill practice.

Program Structure

As is common in other sex offender treatment programs, most treatment in the SOTAP is delivered in group therapy (McGrath et al., 2010). Groups can be closed, open, or mixed. The prison SOTAPs deliver 6 hours a week of core groups that are open groups in which clients begin and complete the group at different times and work on assignments at their own pace. The prison SOTAPs offer a small number of closed groups in which clients begin a treatment group together and progress through various treatment phases as a group. In closed groups that are facilitated using a treatment manual, the sequencing of interventions is set in the manual. Open groups provide more flexibility, and sequencing can be more individualized. With increased flexibility though, a risk is that providers may drift away from delivering the program as designed. Closed groups pose challenges for programs as well. These include client wait time for entry into the group and the need to begin with a larger-than-ideal group size to account for attrition.

Whereas some treatment specialists at the two prison programs deliver the six hours of CORE group treatment to their clients in three 2-hour groups, others do so in two 3-hour groups. In general,

"spaced" learning is more effective than "massed" learning (Dunlosky, Rawson, Marsh, Nathan & Willingham, 2013). That is, learning is enhanced when sessions are briefer, more frequent, and spaced apart rather than packed into a short span of time. Group schedules ensure that there is a day or more between residents' CORE group sessions, which allows for assimilation and skill practice between sessions. The three 2-hour group schedule is more consistent with good adult learning principles than the two 3-hour group schedules.

The prison SOTAPs are re-evaluating program structure. An option under discussion is a plan to break the 12-month program for high risk offenders into four 12-week quarters separated by a 1-week break during which time staff would do planning for the next quarter. Also under consideration is a plan to reduce the number of core open group hours and replace those hours with several 12-week closed specialty groups that would target some specific client treatment needs that are not presently targeted in detail in core groups. Examples of potential specialty groups include cognitive restructuring, anger management, relationship skills, release planning, and arousal management. The WDOC already delivers the Thinking for a Change (T4C) and Alternatives to Aggression (A2A) programs in its facilities and components of these programs could be valuable additions to the SOTAP. The program offers separate groups through the Substance Abuse Recovery Unit to address both sex offending and substance abuse needs.

Client assignment to specialty groups would be based on client's particular treatment needs. High risk clients, would be expected to have high number of treatment needs, would take a large number of specialty groups and have a treatment dose of around 300 hours. This allows for better individualization of treatment needs and better targeting of specific criminogenic needs. Moderate risk clients, would be expected to have a fewer number of treatment needs, would take a fewer number of specialty groups and have a treatment dose of around 200 hours.

The community SOTAPs, as previously detailed, typically deliver 2 hours of core group a week or every other week. Because there are a limited number of clients in treatment in each county at any given time, groups are open. That is, clients begin and complete the group at different times and work on assignments at their own pace.

RECOMMENDATIONS

6.1. The SOTAP should continue its positive efforts to ensure, as much as is reasonably feasible, that clients are admitted into the SOTAP early enough to complete treatment before their earned release date.

6.2. The SOTAP should, as is reasonably feasible, deliver the six hours of core group in a three 2-hour group schedule, which is more consistent with good adult learning principles than a two 3-hour group schedule.

6.3. The SOTAP should continue to examine treatment models that will provide services to meet clients' individual treatment needs, such as increasing the number of specialty groups that address specific treatment needs.

6.4. SOTAP specialty group facilitators and CORE group facilitators should communicate on a regular basis to ensure coordination of care.

7. CONTINUITY OF CARE

Progress that clients make in the institution is reinforced and strengthened by treatment and supervision in the community.

FINDINGS

Continuity of client care from the prison to community is typically quite seamless. Washington State is one of the few states in the United States that has an integrated network of prison and community sex offender treatment programs. The prison and community programs all are under the leadership of the SOTAP Director. SOTAP prison and community treatment providers are employed by the DOC. The SOTAP risk assessment approach (e.g., Static-99R, Stable-2007, Acute-2007) and general treatment approach (e.g., cognitive-behavioral model) are designed to be consistent across prison and community programs and share a common language.

Prison SOTAP treatment providers prepare clients for release to the community in a variety of ways. Release planning includes treatment groups in which clients prepare relapse prevention plans and meet with community treatment providers, community correctional officers, and housing specialists. As well, law enforcement officers visit prison groups and provide clients with information about community registration and notification requirements. With treatment providers, clients review their court orders and supervision expectations, and they review and sign informed consent documents regarding community treatment expectations prior to release. Therapists encourage clients to develop community support networks and include community support people in a client's treatment process as is indicated. These services primarily occur within the Community Transition classes where the community treatment providers come into the prison and provide these services before the client transitions to the community.

SOTAP community treatment providers and community corrections officers (CCOs) reported that they receive timely information about clients' pending releases from prison. They then access information about clients located on the WDOC computer system. Treatment staff and CCOs reported that this information includes treatment summaries, treatment notes, presentence investigations, and court documents. Community staff typically reported that this information is relevant and useful for developing case management and treatment plans, although most community treatment providers do not make written treatment plans. Most staff reported that the timeliness and quality of the information received has improved over the past few years. Several

staff reported that it would be helpful also to receive copies of clients' major treatment assignments that they complete in the prison SOTAP, such as offense disclosures, relapse prevention plans, and risk factors and interventions assignments. We, the evaluators, opine that treatment summaries or some other easily accessible document should include a summary of each client's sexual offending history to include a summary of the index as well as prior sex offenses and criminal history. The present document only emphasizes the index sex offense/s.

It is the practice of a few SOTAP community treatment providers to talk directly with their clients' prison treatment providers when the client transfers to the community. The goal is to learn as much about the client as possible to ensure a smooth transition to the community and develop an informed and individualized treatment plan.

SOTAP community treatment is very accessible to clients. Community SOTAP treatment providers (N = 11) are geographically dispersed throughout the state and each provide treatment services in one or more local community corrections offices in a region. Therefore, clients can attend treatment sessions that are typically within a reasonable geographic distance from their residence. CCOs and other WDOC partners were uniform in their praise that clients do not have to pay for SOTAP community treatment, which makes treatment much more accessible than for sex offenders who have not completed a SOTAP prison program. Similarly, CCO's reported high satisfaction that there is typically no wait time for clients to enter SOTAP community treatment following release from prison. As previously noted, improvements could be made in helping clients receive ancillary mental health and psychiatric services when needed, including medical interventions to help with arousal control.

The SOTAP Assessment Unit uses the Static-99R to identify clients whose risk to sexually reoffend is not adequately accounted for by the WADOC's generic risk assessment tool. The Static-99R, Stable-2007, and Acute-2007 are not used in a structured manner to assess clients after they complete community SOTAP.

Although the SOTAP prison and community staff are trained in use of the Static-99R, Stable-2007, and Acute-2007 to assess risk, treatment and supervision needs, and measure client progress, almost all CCOs interviewed reported little familiarity with these instruments. These instruments form the basis for delivering evidenced-based sex offender treatment, supervision, and management services and are clearly underutilized among CCOs. Most CCOs reported that they would welcome receiving training in how to use the results of these instruments to inform the services they provide.

RECOMMENDATIONS

7.1. The SOTAP treatment summaries or some other easily accessible document should include a summary of each client's sexual offending history to include a summary of the index as well as prior sex offenses and criminal history. The present document emphasizes only the index sex offense/s.

7.2 The SOTAP should require, as much as is reasonably feasible, community and prison treatment providers to talk directly with each other about their mutual clients to facilitate the continuity of care.

7.3. The SOTAP prison programs should place clients' major treatment assignments in the clinical record and make these available to community providers to facilitate the continuity of care.

7.4 The SOTAP should provide training to CCOs about the Static-99R, Stable-2007, and Acute-2007 risk instruments and how to use these tools to assess risk, treatment and supervision needs, measure client progress, and modify case plans and supervision levels.

7.4. The WDOC should consider using Static-99R, Stable-2007, and Acute-2007 risk assessment to inform ongoing supervision standards beyond the initial assessment, which is informed by the Static-99R.

8. STAFF SELECTION, TRAINING, SUPERVISION, SUPPORT, AND WORKLOAD

Staffing levels are adequate. Staff are appropriately selected, trained, supervised, and supported, and have a reasonable workload.

FINDINGS

Staffing Structure

The SOTAP Director supervises two prison Program Managers. One Program Manager oversees the Monroe SOTAP and the other oversees the Airway Heights SOTAP. Each of the two prison Program Managers supervise three Treatment Supervisors who in turn each supervise about 5 Treatment Specialists who provide group and individual therapy services to clients. The SOTAP Director also supervises one Program Manager who oversees the SOTAP community program services which are delivered by about 11 Treatment Specialists. In addition, the SOTAP Director supervises two psychologists and one psychology associate, one Clinical Quality Assurance and Training Manager, and the supervisor of the Risk Assessment Unit, who in turn supervises a staff of seven.

Staff Selection and Experience

The SOTAP Director and Program Managers are very well qualified for their positions. Each has an advanced degree in a mental health field and several years of relevant experience, primarily in the areas of sex offender assessment, treatment, and program management. The two Psychologists, the Community Programs Manager, and the Clinical Quality Assurance and Training Manager are licensed practitioners. The Psychologist at the Monroe facility, SOTAP Director, and Clinical Quality Assurance and Training Manager have experience working with civilly committed Sexually Violent Predators.

Overall, the SOTAP Treatment Supervisors have considerable experience in the sex offender treatment field. Most Treatment Supervisors have an advanced degree in a mental health field, and the others hold baccalaureate degrees. Similarly, many Treatment Specialists have advanced degrees in a mental health field but many others' highest degree is a baccalaureate degree. Some Treatment Specialists have master's degrees that are not geared toward providing therapy, but in a related field. Treatment Specialist turnover rates in the two prison programs have been rather high in the last few years. Slightly over half of Treatment Specialists in the prison programs have been in their present positions in the SOTAP for one year or less. Some of the high turnover appears to be related to staff discontent with higher job expectation demands over the last few years. Treatment Specialists in the community programs have typically been in their current positions for at least two or more years.

During our interviews with SOTAP staff and non-SOTAP professionals at DOC Central Office, several individuals opined that SOTAP Supervisors and Treatment Specialists should have an advanced degree in a mental health profession and be a licensed, certified, or registered mental health professional who is certified to examine and treat sex offenders pursuant to the Washington State's Special Sexual Offender Sentencing Alternative Act. The job descriptions for SOTAP Supervisors and Treatment Specialists indicate advanced degrees are "preferred" but not "required." It is common practice in corrections programs throughout the United States and elsewhere to hire staff without advanced degrees to deliver structured correctional psychoeducational programs (e.g., Thinking for a Change and Aggression Replacement Training). However, it is more common to have staff with Master's degrees in counseling or social work to provide sex offender specific treatments, especially in regular sex offender treatment groups that require processing and more cognitive-behavioral treatments. Currently at Airway Heights, the vast majority of staff have advanced degrees in the social and/or behavioral sciences, as do treatment staff who facilitate SOTAP community programs.

Staff Training

New SOTAP prison staff, including all new DOC staff in prisons, must complete the same generic CORE DOC 6-week training program soon after they are hired. In terms of sex offender specific training, all SOTAP prison treatment staff receive training and must attain certification on how to administer the Static-99R, Stable-2007, and Acute-2007 risk instruments soon after they are hired. SOTAP prison Treatment Specialists receive closely supervised on-the-job training on how to facilitate treatment groups. They are required to observe multiple Treatment Specialists lead groups, typically over the course of 4 to 6 weeks, and co-lead groups with their Treatment Supervisor or other experienced clinicians before they lead groups themselves. Treatment Supervisors provide ongoing training and feedback by sitting in on their supervisee's groups on a regular basis, typically once or more a month. Almost all prison and community treatment staff said they supported the program's current project to write a new SOTAP treatment manual and that this manual should be a basis for staff training on how to deliver the program in a clear and consistent manner. Without a currently agreed upon SOTAP treatment manual, staff report that there is some confusion and an inconsistency among treatment providers in assignments used and how treatment is delivered.

SOTAP community treatment staff also receive training and must attain certification on how to administer the Static-99R, Stable-2007, and Acute-2007 risk instruments soon after they are hired. Community treatment staff also support the program's current project to write a new SOTAP treatment manual, which would be a basis for staff training on how to deliver the program in a clear and consistent manner across prison and community programs. Community treatment staff reported that under past leadership they did not receive much training about the program model or how to deliver treatment.

Staff Supervision

Staff supervision in the prison SOTAP is a program strength. Treatment Supervisors reported that they meet with their Program Managers on a regular basis, who also were readily available for unscheduled consultation when needed. Treatment Supervisors consistently reported that they valued this supervision. Almost all Treatment Specialists said that they have weekly individual supervision meeting with their Treatment Supervisors and almost all value this supervision. Treatment Supervisors typically hold at least monthly group supervision meetings with their team, and the two prison programs hold all-staff meetings for training and case consultation at least a few times a month. The SOTAP at the Airway Heights site holds a "daily briefing" each morning.

In the community SOTAPs, the supervision model for treatment providers is less well developed. A major challenge is that community treatment providers are spread across the entire state, which covers a large geographical area. Currently, community treatment providers have a quarterly one-day in-person staff meeting, one-hour Skype meetings during the other months, and individual supervision meetings as supervisor time is requested or available. Treatment providers said that their supervisor was very responsive to emails and phone calls when they had clinical or administrative supervisory requests. Community treatment providers should have regularly scheduled individual supervision on at least a monthly basis for experienced staff and on a more frequent basis for newer staff. This recommendation will likely require an increased supervisor staffing level.

Staff Support

Prison Program Managers and Treatment Supervisors typically reported feeling well supported by their direct supervisors and administration. Prison SOTAP staff at Airway Heights and newer staff at Monroe reported general job satisfaction and support from their supervisors. A small group of Treatment Specialists at the Monroe site expressed somewhat negative views about the program. These centered primarily on grievances against prior program supervisors and administrators, some of which dated back several years. As previously noted, other direct line staff grievances against the program concerned hiring staff that they believed were not appropriately credentialed (e.g., bachelors versus master's degree). Two staff complained about the systems used to call security staff in an emergency. This security issue is detailed in section #10: Facility and Treatment Environment.

The community Treatment Specialists reported general job satisfaction and, as noted, good support from their supervisor and other administrators.

Staff Workload

Overall, Treatment Specialists in the prison SOTAP programs have a relatively low workload. They each have a caseload of about 12 clients. The expectation is that they provide these clients with six hours of core group treatment per week and about one hour of individual treatment per month. Consequently, during a 40-hour work week, they provide about nine hours of face-to-face client treatment services per week. Other responsibilities include attending clinical supervision, team, and staff meetings as well as completing assessments, treatment plans, and progress notes. Some treatment specialists volunteer for and facilitate an additional approximately 1 to 3-hour specialty group each week and staff often cover for each other's groups when one of them is away from the program. Some treatment specialists told us that they did not have enough work.

In programs similar to the prison SOTAP, a common and reasonable workload is that treatment providers spend up to about 50% of their time providing face-to-face treatment services to clients. This assumes that providers do not have additional duties, such as staff supervision. Some programs have higher work expectations.

In SOTAP community programs, treatment providers have caseloads that average about 25 clients. This appears to be a reasonable caseload size given current job expectations for providing group and individual services. Treatment providers who serve in just one community corrections office appear to have slightly higher caseloads, and treatment providers who spend a considerable time traveling to and from multiple community corrections offices to deliver treatment appear to have slightly lower caseloads. Spending about 50% of "in-office" time delivering face-to-face services to clients is a reasonable workload for the community treatment providers as well.

A final workload issue is that most treatment groups, whether in prison or the community, are facilitated by one treatment provider, although clinical supervisors and trainees often sit in on groups with primary facilitators. There are clear advantages for groups to be co-facilitated, but evidence to support the relative efficacy of single versus co-facilitated treatment groups has not been closely studied. Nonetheless, co-facilitation does allow for more than one clinician to assess clients' treatment progress in a group, conduct role-play and practice exercises, share notetaking responsibilities, and cover for each other when one facilitator is absent, which ensures that groups are less frequently cancelled. Of course, new staff should not be expected to facilitate groups on their own until they obtain a reasonable amount of experience in the program.

RECOMMENDATIONS

8.1. The SOTAP should continue efforts to reduce staff turnover. For example, implementing a new treatment manual should provide staff with clear direction about how to implement the program and may thus improve staff satisfaction.

8.2. The SOTAP should strive to hire staff who meet the "preferred" employment qualifications compared to the minimum "required" qualifications. In particular, we encourage the program to fill new Treatment Supervisor positions with staff that hold an advanced degree in the mental/behavioral health/counseling field from an accredited university. As well, the program should continue to assign staff with higher levels of qualifications to assess and provide CORE group and individual treatment to higher risk and need clients.

8.3. The SOTAP should consider increasing the percentage of time that prison Treatment Specialists provide face-to-face services to clients. A common and reasonable expectation of treatment staff is to spend up to about 50% of work time providing face-to-face assessment and treatment services to clients (e.g., individual, group, specialty group facilitation and unit meetings). Community treatment providers should spend up to about 50% of in-office work time providing face-to-face assessment and treatment services to clients as well. In-office work time does not include travel time to and from multiple community corrections offices to deliver treatment.

8.4. The SOTAP should increase the level of individual supervision provided to community Treatment Specialists to at least monthly for experienced staff and on a more frequent basis for newer staff. This recommendation will likely require an increased supervisor staffing level.

8.5. The SOTAP should continue to use co-facilitated groups to train new treatment staff and elsewhere where possible.

9. PROGRAM CAPACITY

The program has the staffing, financial, and other resources to provide the intended services to the intended population.

FINDINGS

SOTAP administrators reported that the prison program has the resources to provide treatment services to clients who request treatment and are designated on the Prioritization Matrix (see Table 1) as moderate-low, moderate-high, and high risk. Low risk clients who have been accepted into the program have not taken away treatment slots from any moderate and high risk clients who have requested treatment. However, the SOTAP has not collected data to determine the number and percentage of incarcerated sex offenders by risk group who refuse treatment and why they refuse.

This data could be used to determine whether there is a need to increase efforts to recruit clients into treatment, especially those at high risk to reoffend who if successfully treated might be diverted from costly civil confinement.

The community SOTAPs appears to have the capacity to deliver needed treatment services. There is generally no wait time for a client to enter community treatment following release from prison. The referral system from prison to community is quite seamless.

RECOMMENDATIONS

9.1. The SOTAP should collect data to determine the number and percentage of incarcerated sex offenders by risk group who refuse treatment and determine why they refuse. Based on the results of this data, the SOTAP should consider implementing further treatment engagement strategies, especially among high risk sex offenders, that might further reduce sexual reoffending rates among released sex offenders.

10. SERVICE DOCUMENTATION

Staff document services in an appropriate, thorough, and timely manner.

FINDINGS

The SOTAP is transitioning to a computer-based clinical record. Based on a review of 20 prison program files and brief review of the requirements for community program files, documentation appeared to be appropriate and thorough. Staff who audit clinical records reported that treatment provider compliance rates for meeting documentation expectations is overall excellent. Overall, treatment plans in the prison SOTAPs are appropriately tied to treatment goals, which are primarily based on clients' Stable-2007 scores. Community SOTAPs service documentation requirements do not include a written treatment plan. Some staff reported that the community SOTAP DAP (description, assessment, and plan) treatment note format is not useful and the SOTAP has a committee that is reviewing the treatment note format for both prison and community programs.

RECOMMENDATIONS

10.1. SOTAP community programs should develop written treatment plans for all clients and update them throughout treatment as is determined to be appropriate.

11. FACILITY AND TREATMENT ENVIRONMENT

The facility and treatment environment is safe, secure, and therapeutic.

FINDINGS

Prison SOTAP and security staff report that they have reasonably good communication and working relationships. However, it was challenging for the SOTAP at the Airway Heights site to develop good working relationships with security staff when the program started about seven years ago. At the Monroe site, unit security staff have not been invited to participate in therapeutic community unit meetings.

The treatment buildings and group rooms at both prison programs display therapeutic materials on the walls (e.g., group rules, model offense cycles, Stable-2007 treatment needs). On the one hand, these materials generally support and promote positive treatment concepts. On the other hand, many of the wall hangings represent individual Treatment Specialist's approaches. For example, there were multiple variations of lists of thinking patterns, offense cycles, and group rules. There was not a consistent set of treatment concepts displayed across group rooms at the two prison program sites.

As previously noted, two staff complained about the security systems at the Monroe facility, Twin Rivers Unit. When staff press "panic buttons" to alert security officers assigned to the building, a buzzer sounds at the officer's station. However, if the officer is away from the station, such as during a building walk-through, the officer may not hear the alarm, so cannot respond quickly. Program staff also have the option of signing out a "radio" that can be used to quickly alert security staff to an emergency. These radios transmit to everyone carrying a radio in the prison including the officer in the SOTP building regardless if they are at the desk or not. The radios also have panic buttons to alert everyone of an emergency. However, some staff reported that they believe that signing out a radio signals clients that the staff member is afraid of clients. Although staff did not report any incidents in which they had been injured by a client, policy driven security procedures should be in place to safeguard staff and clients.

In the community, SOTAP groups and individual meetings are held at WDOC community corrections offices. Group rooms and offices were adequate for delivering treatment services. Treatment related education materials (e.g., lists of dynamic risk factors) were posted in all groups rooms visited. The community treatment program is in the process of developing posters with approach oriented themes related to the dynamic risk factors focused on in treatment.

RECOMMENDATIONS

11.1. The SOTAP should consider integrating unit security staff in therapeutic community activities at the Monroe program, such as participating in unit meetings.

11.2. The SOTAP should continue to display therapeutic material in group rooms and other program areas. Display materials should promote a consistent set of treatment concepts that are linked to treatment manuals used across the program. Displays should focus on approach goals where appropriate (e.g., what to do, not just what not to do).

11.3. The SOTAP clinical leadership at the Monroe facility should facilitate discussions and training with staff about staffs' security concerns and available procedures (e.g., using radios) to address those concerns.

12. ADMINISTRATIVE STRUCTURE AND ORGANIZATION

The administrative structure and organization supports the healthy functioning of the program. Staff communicate effectively in order to ensure that clients' services are coordinated.

FINDINGS

The program continues to have a very strong administrative organization and structure with processes in place to ensure ongoing staff communication. Although a new SOTAP Clinical Director has been hired recently, there is overall stability in senior administrative and clinical leadership. Overall, clinical staff consistently reported that they feel supported by clinical management. The clinical management team has a clear work plan for continued program quality improvements, most notably the development of a new treatment manual, quality assurance program, clinical training, on-boarding and mentoring.

RECOMMENDATIONS

None

13. INTERNAL AND EXTERNAL STAKEHOLDER SUPPORT

The program meets the needs of and has the support of internal and external stakeholders.

FINDINGS

The Indeterminate Sentence Review Board (ISRB), those who prepare Law Enforcement Notification Bulletins, and classification staff report that they have good collaborative working relations with SOTAP staff and that it has improved in recent years. Multiple stakeholders reported improvements in the SOTAP prison treatment summaries in the past few years and that they are of good quality and very useful. One stakeholder said treatment summaries could be further improved by providing more detailed summary statements about client treatment progress in the program.

The ISRB continues to value the input of Treatment Specialists who typically attend board hearings to testify in person. The ISRB occasionally requests that the prison SOTAP override its treatment prioritization criteria and admit clients who have been determined by assessment tools to be low risk sex offenders into the program. Professional discretion, if used in a small number of cases, is considered good correctional practice. Overall, the SOTAP and ISRB appear to have a good working relationship and are able to resolve differences of opinion.

Psychiatry and Mental Health have typically not had close collaborative working relationships with the SOTAP. Structurally within the DOC, close collaboration between these departments presents some challenges. The SOTAP is under the Offender Change Division and Psychiatry and Mental Health are under a different division. However, senior leadership in both Psychiatry and Mental Health reported that they have better communication with the new SOTAP leadership during the past few years and are open to helping better coordinate services for clients in the SOTAP who need or are currently receiving psychiatric and other mental health services.

As previously noted, community corrections officers (CCOs) and administrators appear overall to be very supportive of the SOTAP. They reported that they receive timely information about clients' pending releases from prison. Useful information about clients is readily available on the WDOC computer system. Overall, treatment staff and CCOs reported good collaborative working relationships.

RECOMMENDATIONS

13.1. The SOTAP should continue to collaborate with internal and external stakeholders to maintain positive working relationships and promote the provision of quality services.

14. PROGRAM MONITORING AND EVALUATION

The program monitors its operation continuously to ensure that services are delivered as intended, the quality of services are improved, and the effects of services are evaluated.

FINDINGS

The program has designated a relatively new position to conduct and oversee quality assurance activities in the SOTAP, namely, the Clinical Quality Assurance and Training Manager position. The QA Manager has drafted an updated SOTAP QA plan with respect to training, program fidelity, coaching, data collection, and data analysis. The plan also includes an increase in staffing levels in this department.

Currently, the SOTAP has in place several processes for monitoring the ongoing functioning of the program. These include a structured schedule of individual and group staff supervision meetings. The SOTAP has conducted audits to ensure program compliance with clinical records

documentation, interrater reliability checks on risk assessment scoring, and review of various other data points such as client risk scores, program admission rates by prioritization matrix categories, and program completion rates. The program collects pre- and post-treatment Stable-2007 scores. The SOTAP has a Group Facilitator Evaluation Form that is a well-designed and an appropriate instrument to facilitate feedback and supervision activities with Treatment Specialists which should be implemented with the new treatment manual.

The major current SOTAP quality assurance project is to complete and implement a new program treatment manual, which will detail a program-wide evidence-based delivery model. Following development of this manual, the program plan is to further develop quality assurance procedures to ensure that the new model is being implemented with integrity.

RECOMMENDATIONS

14.1. The new SOTAP draft treatment manual is well designed and should continue to detail a program-wide evidence-based delivery model that continues to be consistent with the best practices detailed in this report. The program should periodically solicit feedback from treatment providers to identify what improvements need to be made to the treatment manual.

14.2. The SOTAP Group Facilitator Evaluation Form is a well-designed and an appropriate instrument to facilitate feedback and supervision activities with Treatment Specialists and should be implement in the near future.

14.3 The SOTAP quality assurance plan should be closely linked to the new treatment manual and continue to focus on the broad areas of accesses, quality, and costs. The SOTAP should hire staff to implement quality assurance activities, which should include the following:

- develop a data base to collect and track client variables of interest (e.g., demographic, offense type, and treatment completion)
- track program access to ensure that clients are admitted into the SOTAP early enough to complete treatment before their earned release date
- track admission rates by prioritization matrix categories and ensure that services are allocated by risk
- conduct interrater reliability checks on scoring risk assessments
- provide trainings in the areas of the static and dynamic risk assessment
- audit client files
- monitor delivery of treatment groups using the Group Facilitator Evaluation Form data to improve service delivery
- develop, administer, and collate client satisfaction surveys
- assess program completion rates and reasons for client terminations and drop outs
- assess intermediate program outcome, such as on pre- and post-test measures
- assess long term program outcomes, such as recidivism rates

- develop and implement an on-boarding program for new clinicians that includes teaching the program theory, how to deliver treatment according to the program manual, and coaching and mentoring for professional development in clinical skills and professional competencies.

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