

Draft 3: SSOSA Review

October 14, 2013

Introduction

On October 16, 2012 Senators Hargrove, Stevens, and Regala, through Governor Gregoire's Office of Financial Management, requested the Sex Offender Policy Board (SOPB) convene. The request directed the SOPB to review the Special Sex Offender Sentencing Alternative to assist policy makers in making informed judgments about issues related to sex offender management, as authorized under the provisions of RCW 9.94A.8673. Specifically, the SOPB was asked to review the following:

- 1) RCW 9.94A.670 requires the court to give great weight to the victim's opinion and must enter written findings for its reasons for imposing the treatment disposition if the sentence is contrary to the victim's opinion. How often is a SSOSA imposed over the victim's objections and what are the reasons noted by the court in doing so?
- 2) Explore consistencies or inconsistencies between jurisdictions in determining that an offender is amenable to treatment and how this finding contributes to the decision to order a SSOSA. What happens if the Department of Corrections does not believe treatment can be successful? Should there be more consistent standards for determining when an offender is amenable to treatment and is therefore eligible for a SSOSA?
- 3) What are the results after a SSOSA has been imposed? How often does the offender successfully complete treatment? When the offender does not comply with the requirements of sentence, are consequences swift and certain and appropriate to the violation or noncompliance?

The SOPB convened a subcommittee who over the last year worked diligently to fulfill the legislative request. This report is reflective of the committee's work, is responsive to legislative inquiry and inclusive of recommendations for legislative consideration.

To best answer questions and contextualize recommendations, it is helpful for the reader to have a foundational understanding of the evolution of treatment services in Washington State and the origin of the Special Sex Offense Sentencing Alternative (SSOSA). To that end, the report is designed to provide a historical overview prior to presentation of recommendations.

Historical Sex Offender Treatment in Washington State

Inpatient Treatment

Washington's mental health response to sex offenders began in 1949. At that time the legislature passed "the first sexual psychopath laws in the state of

Washington...Chapter 198, an act relating to the care and treatment of mentally ill patients (including section 25 through 40) provided for the commitment, custody, detention, treatment, parole, and discharge of the sexual psychopath. By this legislative act, the state hospitals were given a dual responsibility of custody and treatment of offenders..."ⁱ Dr. di Furia observed that, despite the focus placed on treatment in the governing legislation, what really occurred was that sex offenders were housed in security wards or buildings of mental hospitals, but very little treatment was provided.

Two other Western State Hospital historians (MacDonald and Williams) described the conditions of those early years, from 1951-1958, as: "sex offenders were committed in increasing numbers to hospitals already overcrowded with psychotic patients, badly under staffed, and not prepared to offer any special treatment to this new type of patient. These offenders/patients were, therefore, segregated on maximum security wards or distributed throughout the hospital among psychotic patients on locked wards. With no treatment available and no hope of regaining their freedom, the offenders grew discontented and restless. This resulted in manipulative and disruptive behavior, frequently unauthorized leaves, and much staff anxiety and resentment which were often expressed in an increased and even punitive over control. The situation became steadily worse until a legislative investigation of hospital conditions in general, in 1957-1958, resulted in major reforms throughout the hospital."ⁱⁱ

MacDonald and Williams also described some of the major changes that resulted from the hospital reform. For the first time, sex offenders met together once a week for staff-directed group therapy. Over the course of the next decade, these once a week sessions evolved to become a specific sex offender treatment program. Initially, therapy was non-specific and not predicated on any stated hypothesis about the nature or course of sexually deviant behavior. Rather, therapy was directed toward somehow developing "insight," which was presumed to lead to a change in behavior. No defined criteria was consistently employed to evaluate change, and no program evaluation was undertaken, (MacDonald and Williams, 1984).

The decade of the 60's brought significant changes when the first program director, Dr. di Furia shaped the program based on his own clinical perspectives. More significant changes to the program occurred when Dr. di Furia became superintendent of Western State and he appointed Dr. George J. MacDonald as program director. This decade was marked by positive recognition and support in the media, the criminal justice system, and the legislature. It was also a period of growth, adding more professional staff, an assistant director, and the program's psychologist.

While great strides were occurring in the area of treatment programs and evaluation, trouble was just ahead. Rapid population growth in the mid-1970's contributed to overcrowding and inconsistent supervision. There were a number of highly visible escapes, some of which were followed by the offender committing rape or murder. As expected, media attention was intense, and the hospital responded by crafting institutional remedies. However, it is also important to note that during time period there was significant sharing of information amongst treatment providers and consistently effective treatment principles and models were developed.

By 1980, the sex offender population at Western State had grown back to the previous high of 212 (capacity 168) – the same level that precipitated Eastern State Hospital taking responsibility for offenders in eastern Washington. In an attempt to accommodate the growing numbers of patients, a waiting list was created. In the first year, there were 59 people waiting for a bed at Western Washington State Hospital. Two years later the number waiting was 95 and by the third year the number had risen to 145. Offenders on the waiting lists were being held in county jails, which caused overcrowding and much consternation from county officials. To avoid major lawsuits, the program expanded twice in the early 1980's.

In addition to conditions of overcrowding, rapid expansion, and budget crisis, there was another important factor beginning to take hold in the community. The public was beginning to shift its support from treatment as a response to sex offenders, to one of punishment. This shift was consistent with a general shift in attitudes of the public and legislators during this time period to what is recognized as the “law and justice movement.” Many states were eliminating their sexual psychopath statutes, and developing nothing in their place. Thus, jurisdiction for many sex offender programs shifted from mental health administrations to the Department of Corrections.

Washington soon followed suit. The demise of the state hospital treatment program began with the 1985 escape of a multiple rapist. An investigation was conducted, this time by a legislative committee. While the final report was not unfavorable, neither did it endorse, wholeheartedly, the maintenance of the program. Subsequent legislation eliminated the sex offender treatment program at Western State Hospital.

Emergence of Community-Based Treatment

Similar to the strides in treatment that were happening at institutions like Western State Hospital, community-based treatment was also in rapid development. The evolving field of treatment for sex offenders organized around a few major principles.

1. Sex offenses are the result of offenders experiencing sexual arousal to the offending behavior. Treatment should use behavioral methods to reduce deviant sexual arousal.
2. Sex offenders commit many more offenses against many more victims than are known to authorities.
3. Treatment should involve offenders coming to admit the attraction they experienced to the offending behavior and the many times they acted out this behavior. This would help them to engage in the difficult work of avoiding opportunities and temptations to experience and act on deviant sexual arousal and to build a lifestyle around reducing and maintaining a reduction in deviant sexual arousal.
4. Challenging and overcoming the denial and minimization that many offenders held onto about their sexual interests and offense history were essential to meaningful treatment interventions.ⁱⁱⁱ

Sentence Reform

Following a similar trend nationally, Washington made a significant change in its sentencing policy when the legislature passed the Sentencing Reform Act of 1981 (SRA). Implementation of this shift from an indeterminate to a determinate sentence system was effective in July 1984. The passage of the SRA eliminated the old sexual psychopath law. While treatment providers welcomed the elimination of this outdated law, the legislation did not include anything specific to sex offender treatment.

The Sentence Reform Act radically changed the structure to one of determinate sentences. While there were still maximums per crime classification, there was much more consistency imposed through the development of standard ranges and an offender scoring (based on criminal history) system. The Sentencing Guidelines Commission had the responsibility to develop the standard sentencing grid, and other statutory elements such as mitigating or aggravating factors. This brought a seemingly less disparate and seemingly more uniform approach to sentencing than was previously experienced.

The work needed to pass the SRA legislation included the painstaking effort to create sentence range minimums and maximums, as well as impacts of offender scores and additional factors for judges to use in determining the appropriate sentence for each offender. Offenders sentenced under the indeterminate system (having committed a crime prior to July 1, 1984) were given a maximum sentence by the Court at the time of sentencing. However, indeterminate sentencing law specifies that after the court sentenced the offender to the maximum and sent to prison, the Parole Board (ISRB) would set a minimum sentence: the minimum amount of time an offender would serve before being considered for parole. Indeterminate law allowed all offenders, except those sentenced to Life Without Parole, to be considered for parole before their maximum sentence was over. However, the ISRB has to find the offender "paroleable," e.g., "rehabilitated and a fit subject for release" (RCW 9.95.100) before parole can be authorized. Under this indeterminate system, offenders have a right to parole review, but they do not have a right to parole itself.^{iv}

As the work commenced in the area of sex offenses, a concern emerged from the victim advocate community. They recognized that the majority of sex offenses are committed against children and that nearly all the time the offender and victim have a relationship--often a familial relationship. There was concern that such a rigid sex offense sentencing structure would have a dampening effect on family member willingness to report and participate in the criminal justice process. At the same time, sex offender treatment providers were concerned that automatic prison sentences for sex offenders would render the promising community-based treatment option irrelevant.

In 1986, a revision to the SRA statute moved jurisdiction of the sex offender treatment program from Department of Social and Health Services to Department of Corrections. The revision provided a transition period wherein Western State Hospital had until 1993 to ultimately close the in-patient program. During this period, the Department of Corrections was to develop its own program and have jurisdiction of offenders whose crimes occurred after July 1, 1987.

Creation of SSOSA – SHB 1247 in 1984

Community treatment providers, wanting to preserve an emerging treatment model that showed great promise – and sexual assault victim advocates who were concerned about the chilling effect determinate sentences would have on families where the offender was within the family – formed an alliance to influence the legislation.

In response to this practical and real life concern, the Special Sex Offender Sentencing Alternative (SSOSA) became part of the SRA legislation. The original purpose of SSOSA was to support and encourage family member victims to engage in the criminal justice system, knowing there was opportunity for their offender to receive treatment rather than exclusively a prison term. The creation of SSOSA met both the need to support familial sexual assault incidents reported and the preservation of community based treatment for offenders. This was especially important with the elimination, through SRA, of the in-patient programs at Western State Hospital.

Development of Assessment and Treatment

Over the last three decades, the science of sex offender treatment and management has grown enormously. There is now a solid and growing empirical base for understanding risk. The science of treatment has likewise gotten much better. Following is a short description of the evolution of assessing sex offender risk, as described by R. Karl Hanson (1998).^v

- Unguided (or unstructured) clinical judgment: The evaluator reviews case materials and applies personal experience to arrive at a risk estimate, without regard to any specific list or theory being relied upon to prioritize or give specific weights to the information used.
- Guided (or structured) clinical judgment: The evaluator begins with a finite list of factors thought to be related to risk, drawn from personal experience and/or theory rather than from relevant literature.
- Research guided clinical judgment: The evaluator begins with a finite list of factors identified in the professional literature as being related to risk. While these factors are given priority weight in the risk assessment, they are combined with other factors and considerations using the clinician's judgment, rather than any specific, consistent means of combining the factors.
- Pure actuarial approach: The evaluator employs an existing instrument comprised of a finite, weighted set of factors (generally static, or relatively unchanging and historical in nature) identified in the literature as being associated with risk. The presence or absence of each risk factor is indicated, and an estimate of risk is arrived at through a standard, mechanistic means of combining the factors. This approach is the only risk

assessment method that can be scored using a computerized algorithm or by minimally-trained non-clinicians.

- Adjusted actuarial instrument, and then employs a finite list of considerations which can then be used to raise or lower the risk assessment.

Accompanying the development of more methodical and accurate assessment of risk posed by sex offenders, has been the advancement of empirically derived tools and techniques that provide specific target treatment goals for individual clients. This affords us a systematic approach to enhance the response to sex offenders, using advances of treatment to enhance community safety.

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Elements of SSOSA - RCW 9.94A.670

The original statute specifies who is eligible for consideration of a SSOSA. The elements of eligibility are:

- A sex offense conviction, other than Rape 1 or Rape 2 or other serious violent sex offense
- No prior convictions for a felony sex offense in this or any other state
- Standard sentence range for the offense of conviction includes the possibility of confinement for less than eleven years (originally the max range was 6 years and as sentences lengthened so did this element to 8 and now less than 11 years).

The court on its own motion or motion of the state or offender, may order an examination to determine whether the offender is amenable to treatment. The statute is directive regarding the contents of the report, which must include:

- Offender's version of the facts and the official version of the facts
- Offender's offense history
- Assessment of problems in addition to alleged deviant behaviors
- Offender's social and employment situation
- Other evaluation measures used

Further, the examiner shall assess and report regarding the offender's amenability to treatment and relative risk to the community. A proposed treatment plan shall be included, with the plan including:

- Frequency and type of contact between offender and therapist
- Specific issues to be addressed in the treatment and description of planned treatment modalities
- Monitoring plans, including any requirements regarding living conditions, lifestyle requirements, and monitoring by family members and others
- Anticipated length of treatment
- Recommended crime-related prohibitions

The court then imposes a sentence. If the standard sentence range includes the possibility of confinement of less than 11 years, the court may suspend the sentence. There are statutory conditions related to the suspended sentence.

Over time, specific elements of SSOSA have changed, including the elements the court must consider - after reviewing the evaluative reports. Examples of those changes are listed here:

- Whether the offender and the community will benefit from use of the SSOSA
- As sex offense sentences lengthened over time, the sentence years for eligibility were also extended (from original sentences of 6 years, expanded to 8 years to the current of less than 11 years).
- Term of community custody is equal to the length of the suspended sentence, the length of the statutory maximum sentence, or three years, whichever is greater
- Treatment periods expanded from 2 years to 3 years to the current up to 5 years

Community Protection Act of 1990

• There were two incidents that occurred in the late 1980's that galvanized the public demand for an improved response to sex offenders. These were the murder of Diane Ballasiotes by a sex offender on work release and the sexual assault/mutilation of "the little Tacoma boy." These two events engaged the media and captivated the public's attention, resulting in a frenzy of public outcry. Governor Booth Gardner called for the creation of a Public Safety Task Force and appointed King County Prosecutor Norm Maleng as the chair. The task force met throughout the state and gathered information for approximately a year, culminating in the release of the Washington State Public Safety Task Force Report. The recommendations contained in the Report were translated to a legislative proposal which, when passed in February 1990 became known as the Community Protection Act of 1990.

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Most of the sex offender management elements that are common today emanate from that legislation. Those elements include:

- Leveling of sex offenders based on risk,
- Elimination of earned early release,
- Lengthened sentences,
- Created sex offender registration
- Created community notification,
- Enacted the concept of civil commitment
- Established the Special Commitment Center,
- Created the Office of Crime Victims Advocacy
- Significantly increased resources available for services to victims of sexual assault

The Community Protection Act included the creation of the Sex Offender Treatment Advisory Board and the requirement for licensing of treatment providers. The legislation directed the Advisory Committee to develop standards for licensing by the Department of Health. (Note that the Advisory Committee has since been unfunded and the authorizing statute repealed 2009).

It is clear that the Community Protection Act and the consequent systems that now frame Washington's sex offender management system has had a profound impact on how we view sex offenders and how we monitor them in communities. This legislation became a model for other states throughout the country to emulate and aspects of it are contained in most other states' sex offender laws.

Revision to Sentencing 2001

The legislature created Determinate Plus Sentencing, which applies to two groups of offenders.

- Offenders convicted of their first, two-strike offense
- Offenders convicted of a non-two-strike sex offense (except failure to register) and have a prior convicted for a two-strike offense

The statute requires the court to sentence a determinate-plus offender to a maximum and a minimum term. For those convicted of a Class A felony, the maximum term is life. Thus, an offender who is under a determinate-plus sentence (those convicted after 2001) may release from prison after a certain period of time, but will remain on community supervision for the remainder of their maximum sentence, or life (even where a SOSSA is granted).^{vi}

Revisions to SSOSA 2004

A significant statutory revision occurred to SSOSA in 2004. The revision added eligibility elements. Those additions are:

- No prior adult conviction for a violent offense within the past 5 years of the current offense and
- The current offense did not cause substantial bodily harm to the victim; and
- The offender has an established relationship or connection to the victim
- Addition of affirmative conditions and known precursors to offender's offense cycle

The court must consider additional factors. Those additions are:

- An examination report provided by a treatment provider

- Increased emphasis to victim input : The court shall give “great weight to the opinion of the victim. If the court grants a SSOSA in contrast to the victim’s wishes, the court shall enter the written findings of the reasons for doing so
- Whether the offender and the community will benefit from the SSOSA
- Whether the offender had multiple victims
- Whether the offender is amenable to treatment
- The risk the offender poses
- Annual review by the court
- Whether the SSOSA is too lenient in light of the circumstances of the offense^{vii}

Trends in and Observations of SSOSA

In 2004, the Legislature directed the Washington State Institute for Public Policy (WSIPP) to analyze the “impact and effectiveness” of current sex offender sentencing policies.^{viii} The authorizing of this study is contained in ESHB 2400, Chapter 176, Laws of 2004. WSIPP developed a series of reports, many of which are specific or relevant to SSOSA. Those specific reports were released between August 2005 and January 2006.

When the SOPB sought more recent data on these topics, we were not able to find any system that captured relevant data and to which we had access. We understand that when WSIPP conducted their studies, they were able to access actual case records and files. Thus, when looking at trends, information here comes from those studies. We acknowledge that more recent data would be helpful to determine if trends we saw nearly a decade ago have continued. While still being nearly a decade old, the SOPB determined the original data to be important and still relevant -to this current study of SSOSA.

Trends in SSOSA Sex Offenders^{ix}

- 95% of offenders granted a SSOSA involve a child victim;
- Sex offenders in jail or community supervision, 63% involve a child victim;
- Sex offenders sentenced to prison, 73% involve a child victim;
- 75% of all sex offender cases involve child victims
- Proportionally fewer minorities receive SSOSA sentences than prison sentences

Trends in SSOSA Eligibility^x

- Until 2000, 80% of all sex offenders met the statutory criteria for eligibility.
- By 2005, only 63% of all sex offenders met the statutory criteria for eligibility.

Trends in SSOSA Granted^{xi}

In 1986, 59% of sex offenders meeting the statutory criteria received a SSOSA.

By 1997, that percentage dropped to approximately 40%.

In 2005, 35% of sex offenders meeting the statutory criteria received a SSOSA.

Between 1986 and 2004, as a portion of all sex offenders sentenced, SSOSA had declined from approximately 40% to 15%.

This decline is a combination of fewer sex offenders meeting the statutory eligibility criteria (as criteria have narrowed over time) and a decrease in eligible offenders receiving a SSOSA.

SSOSA and Recidivism – 1986 – 1998^{xii}

Felony sex offense recidivism rates for sex offenders released from prison, both eligible for SSOSA and those not, have generally been decreasing.

Both felony sex and violent felony recidivism rates for those granted SSOSA remain consistently low.

Recidivism of those statutorily eligible for a SSOSA, but sentenced to prison, are higher than rates for those receiving SSOSA.

Decreases in recidivism rates for sex offenders sentenced to jail and community supervision and those sentenced to prison may be attributable to other changes such as registration and notification, longer sentences, demographics, and other societal influences.

Sex offenders who offended against a child, who received a SSOSA have the lowest sexual offense recidivism rate of 2.3%, compared to all sex offenders.

Sex offenders who complete SSOSA have the lowest recidivism rates in all categories.

Sex offenders sentenced to jail or community supervision have rates similar to, but slightly below, the recidivism rates of those sentenced to prison.

Sex offenders sentenced to prison have the highest rates.^{xiii}

SSOSA Sex Offender Revocation^{xiv}

Of the SSOSA recipients, those revoked within a ten-year follow up period, 85% were revoked within three years of being placed in the community

SSOSA revocations increased from an initial rate of 15% in 1986 to a high of 25% in 1994, and then back to 13% in 2002.

Unclear if the changes in revocation are a result of changes in policy and practice or offender characteristics.

Based on demographic and criminal history factors, it is not possible to predict with any degree of accuracy which SSOSA offenders will revoke. This implies that changes in revocation, then, are more likely attributable to changes in policy and practice.

Those revoked go to prison for an average of 4.4 years^{xv}

Felony recidivism is 15.2% for those revoked, compared to 3.1% for those not revoked

Violent felony recidivism is 7.5% for those revoked, compared to 1.9 for those not revoked

Felony sex recidivism is 3.8% for those revoked, compared to 1.3% for those not revoked

Observations Regarding SSOSA

Sometimes legislation is created in response to one or more extreme incidents that capture the attention of the media and the concern of the public. This is true of the Community Protection Act, and can also be said of the more recent federal response through the Adam Walsh Act.

The incidents that precipitated these pieces of legislation were heinous and reprehensible. The criminal justice system, victim services, prevention professionals, the courts, law enforcement, sex offender treatment providers, and public policy makers are all committed to doing everything possible to ensure such acts do not occur in the future. In so doing, however, we must also be aware of and attentive to the majority of sexual assaults – not just the extreme ones. We must always keep in mind, as we develop policy, law, and response systems, that the vast majority of sexual offenders assault people they know. More than half of the time, the victim and offender are related to each other. In the Office of Crime Victims Advocacy's Washington State Sexual Assault Incidence and Prevalence Study (2001), it was reported that of the 38% of women who had experienced a sexual assault in their lifetime, 80% of those women were assaulted before they reached the age of 18.

As we continue to create and refine legislation that governs Washington's sex offender management system, we must also bear in mind that the framing structure of this system was written more than twenty years ago. We have learned much in those twenty years about services to victims and certainly about treatment and management of sex offenders. Since the passage of the Adam Walsh Act we have gained significant experience in the efficiency, effectiveness, and cost of many of the mechanisms put in place by that legislation. Research has emerged that has examined many of these mechanisms, such as community notification and sex offender registration. Assessment tools have continued to be improved and validated through strong scientific testing. Standards of practice in both the sexual assault victim service community and the sex offender treatment profession have been developed and implemented.

It is through the lenses of both legislative framework, with its original intent, as well as the accumulation of decades of experience, research, science, and multi-disciplinary expertise that the Sex Offender Policy Board considers questions brought to it. It is with this combination of perspectives that the Board examined the questions related to the Special Sex Offender Sentencing Alternative brought before it currently.

An element of eligibility includes the defendant "voluntarily and affirmatively admit he or she committed all of the elements of the crime to which the offender is pleading guilty". Notably, research on factors related to sex offense recidivism has failed to find a correlation between denial and sexual re-offense. Meta-analytic studies, combining many smaller research studies have found that deviant sexual arousal and psychopathy are the two factors that most predict sexual recidivism. These other factors have been incorporated into actuarial tools that have been tested in field studies and found to have moderate predictive value. But, denial has not been found to predict sexual re-offense.^{xvi}

While the statute only requires there to be a relationship between the offender and the victim, many in practice go further than the law to require that the offender and victim be family members.

Eligibility for and granting of SSOSAs has steadily decreased since it was created by statute.

It is our stance that community-based treatment of sex offenders is effective and does not jeopardize community safety, per se.

Tools and methods aimed at assessing risk and managing sex offenders have improved significantly over the past two decades.

SSOSA/Treatment Cost vs Incarceration Cost

One of the lenses through which the SOPB reviewed SSOSA is on the cost of SSOSA in comparison to the cost of incarceration. Without the SSOSA option, these sex offenders would be in our state prison system. As with many complex policy positions, cost is certainly not the only lens or even the most important lens through which to determine value. However, the cost comparison has value and was part of our work in

reviewing SSOSA. It should be noted that offenders granted a SSOSA disposition are expected to pay for their own treatment. This usually includes group and / or individual therapy sessions, plethysmography assessments, and polygraph testing on a regular basis.

Cost Analysis

The last cost analysis for SSOSA, that was available for this report, was completed in 1993 by the Washington State Institute for Public Policy. A similar, but less complete, methodology was used for providing the following cost information. For a more complete cost analysis, it is recommended that the WSIPP or other similarly situated agency be directed to complete such an analysis. The assumptions that were used for determining the savings to the State for this program are listed below in Chart #1. For additional detail regarding the assumptions, see addendum #1.

This analysis, consistent with the results of the WSIPP study, shows significant cost saving to the state per offender who completes the SSOSA program - when compared to the costs if they had received a prison sentence. State Fiscal Year 2012 data was used for developing the assumptions with the exception of the revocation rate which is an average of three SFYs. For offenders who were sentenced to SSOSA in SFY 2012 and completed the program, there is an anticipated cost savings to the State of \$201,870 for each offender. There are increased costs to the state for offenders sentenced to the programs and who are subsequently revoked and sent to prison. When these additional costs are included in the calculations, the cost savings per offender is \$166,424.

The total projected cost savings for all offenders that were sentenced to SSOSA in SFY 2012 is \$16,149,600.

Chart # 1

ASSUMPTIONS

1. 81.6 months is the average length of time on the program for an offender who completes the SSOSA program.
2. \$45,246 is the average cost to the State for an offender sentenced to SSOSA in SFY 2012.
3. 16% is the average annual revocation rate and there is 22,623 associated increased cost over a prison sentence per offender.
4. \$201,870 per offender is the avoided costs (or savings) to the State for an offender that completes SSOSA. That decreases to \$166,424 per offender when including revocations.
5. \$16,149,600 is the projected State dollars saved for offenders sentenced to SSOSA in SFY 2012 that will complete the program.

*Cost savings may be higher for CCB offenders, which is not captured in this analysis.

Questions from the Senate and Responses

The SOPB SSOSA review process was initiated at the request of Senators James Hargrove, Debbie Regala and Val Stevens. In their review request letter, the Senators asked the SOPB to specifically review and respond to questions related to the role and influence of victim input in SOSSA issuance, offender amenability, and SOSSA efficacy.

Given the absence of systematically collected data and lack of access and resources to conduct research on source data, information specific to questions posed were obtained through surveys of professionals statewide who are involved in the SOSSA issuance process. Groups surveyed were: Prosecuting Attorneys, Victim/Witness Staff in Prosecutor Offices, Defense Attorneys, Sex Offender Treatment Providers, and Judges. Each group received a survey tailored to their profession; however, each survey across the professions included one identical open-ended question asking what changes they would make to SSOSA.

While not validated scientific research, the surveys yielded valuable insight and practice information. Survey questions can be found as an appendix.

Victim Input

Question Posed to SOPB: RCW 9.94A.670 requires the court to give great weight to the victim's opinion and must enter written findings for its reasons for imposing the treatment disposition if the sentence is contrary to the victim's opinion. How often is a SSOSA imposed over the victim's objections and what are the reasons noted by the court in doing so?

Findings:

Of the professionals surveyed, each profession had varied experiences of SOSSA issuance when contrary to a victim’s opinion. It is noteworthy, that the data indicates that more often than not a victim’s opinion and choice is regularly considered and upheld.

Q: In your experience, a SSOSA is granted over a victim’s objections-

Profession	Never	Rarely	Sometimes	Most of the Time
Defense	28%	38%	32%	0%
Judges	30%	30%	67%	4%
Prosecutors	11%	44%	33%	11%
Victim Witness	17%	44%	39%	0%

Table reflects the percentage of professional respondents who selected each option category.

Each survey group emphasized the importance of victim input and highlighted that it holds great weight in decision making.

When asked about their experiences as to why SOSSA’s have been granted despite victim’s wishes, professionals shared that a victim’s opinion may change over time as their healing process progresses. Given this, professionals indicated the importance of balancing victim input with professional opinion based on case factors. Factors that professionals identified as influencing issuance were whether the victim was an adult or child, vulnerability of victim, the defendant’s background, defendant’s timely admission of responsibility, seriousness of allegation, number of victims involved, support networks for the defendant and political will.

Judges:

“Our office usually attempts to ascertain the victim’s opinion before agreeing to recommend a SSOSA. Regardless of our recommendation, the victim or victim’s family participates by speaking at the sentencing hearing if they choose. At all steps of the case, our office attempts to be victim centered and ask the opinion of the victim in regard to the proceedings, with ultimately decision left to the DPA handling the matter” – survey respondent

In efforts to further consistency of victim input practices and to gather data on victim input, we suggest adding to the Pre-Sentence Investigation form a line indicating victim consultation was conducted and SOSSA preference noted.

Offender Amenability

Questions posed to SOPB: Explore consistencies or inconsistencies between jurisdictions in determining that an offender is amenable to treatment and how this

finding contributes to the decision to order a SSOSA. What happens if the Department of Corrections does not believe treatment can be successful? Should there be more consistent standards for determining when an offender is amenable to treatment and is therefore eligible for a SSOSA?

Findings:

Determining amenability to treatment is nuanced. Amenability to treatment indicates that a person is willing to engage in treatment and believes it would be beneficial. While these are important factors to consider, they do not directly translate to whether treatment will produce change. option, and while an important factor in gauging ability to impact behavioral change, it does not directly translate to whether treatment will be effective. Assessing for amenability is guided by a common definition of amenability. _____ (insert that definition); however determination of amenability is somewhat subjective as it warrants consideration of the entirety of an offenders known behavior. Given this variation, treatment providers themselves have differing opinions about whether amenability can truly be defined. This was reflected in survey findings where treatment providers were asked:

In your experience, SSSA evaluators have a common definition of amenable to treatment.

Of practitioner respondents 53% responded Yes, 29% No, and 18% selected that they don't know. Further, of the 53% of treatment providers who responded yes indicated the definition was applied:

Most of the time	Sometimes	Always used
65%	19%	15%

A similar question was posed to prosecutors, **Do you think SSOSA evaluators in your community have a common standard or definition of "amenability to treatment"** 39% of prosecutors report thinking treatment providers have a common definition; 39% of prosecutors were unsure; and 22% of prosecutors thought there was not a common definition.

The subjective nature of the definition of amenability to treatment in combination with additional considerations, together account for observed jurisdictional differences.

Determination of amenability by the SSSA evaluator is relied upon heavily. There is no concrete data source to assess what occurs in instances where DOC feels treatment would not be beneficial. However, anecdotal and survey information indicates that DOC staff base their determination to not recommend treatment on information contained in the Pre -Sentence Investigation (PSI). However, it is notable that the PSI is a presentation of information, highlighting risk and protective conditions, often with no particular conclusion. Thus, it can't be consistently relied upon for forming a recommendation. In other instances, opinions have been collected from community correction officers. Despite the opinion/recommendation of DOC, all the collected information is brought to a judge for review and it is the judge who makes a

Comment [DJY1]: And believes it would be beneficial. While these are important factors to consider, they do not directly translate to whether treatment will produce change.

Comment [DJY2]: responsive to suggestion and likely to cooperate.

determination based on information presented, as well as their own analysis, perspective, and opinion.

Data collected through the survey process as well as scientific research highlights the complex nature of sex offender treatment, of which amenability to treatment is only one facet. In fact, there is an emerging body of research indicating that amenability assessment may be less valuable to determining efficacy and a review of all risk factors is warranted. [\(add citation\)](#)

The emphasis on amenability, alone, to treatment has been shown to be a misplaced emphasis. Amenability to treatment must be considered in the context of all risk factors.

SOSSA Efficacy-

Questions posed to SOPB: What are the results after a SSOSA has been imposed? How often does the offender successfully complete treatment? When the offender does not comply with the requirements of sentence are consequences swift and certain and appropriate to the violation or noncompliance?

Data provided by the Department of Corrections collected from 2009-2011, shows revocation rates of SSOSA at 16% per year. A revocation of SSOSA does not indicate that an offender sexually recidivated. Rather, a SOSSA can be revoked for any violation of rules imposed, such as substance abuse or failure to register.

Sex offenders who complete SOSSA have the lowest recidivism rate of sex offenders across sex offense categories (felony and misdemeanor). Additionally, offenders who complete a SOSSA have lower recidivism rates than incarcerated offenders. This reduced recidivism rate is demonstrated across felony, felony sex, violent felony and misdemeanor crimes (WSIPP, 2005) charges. The efficacy of the SOSSA program is demonstrated in reduced recidivism rates, low revocation frequency, and significant cost savings to the state.

SOSSA offenders do not technically meet the conditions for “swift and certain”, however, practice data indicates timely and responsive action by DOC in response to violations.

SOPB Recommendations

The recommendations below are derived from the survey results of the specific questions posed to the SOPB, a review of previous studies of SSOSA, recent research, and the expertise of the multi-disciplinary composition of the SOPB.

Reinstate the Department of Corrections supervision to the length of the suspended sentence (pre 2001); thus eliminating lifetime supervision to non-revoked SSOSA recipients. This applies to Class A felony offenses.

Background and Rationale:

Both felony sex and violent felony recidivism rates for those granted SSOSA remain consistently low.

Recidivism of those statutorily eligible for a SSOSA, but sentenced to prison, are higher than rates for those receiving SSOSA.

Of those revoked within a ten-year follow up period, 85% were revoked within three years of being placed in the community

Revocations increased from an initial rate of 15% in 1986 to a high of 25% in 1994, and then back to 13% in 2002.

While data doesn't "exist" the impressions of clinicians are that revocations generally are not for re-offense behavior but other violations of court order restrictions such as substance abuse

Also, even when there is a revocation, that doesn't mean higher risk in terms of sex offense behavior, but it's rule breaking (breaking deal with the court)

If this is a data point of interest, it would require file review. We think the data likely exists.

This data, in combination with the experience and expertise of SOPB members resulted in the conclusion that lifetime supervision for this group of sex offenders is a public policy resulting in an unwarranted and high cost being directed at a population whose risk to public safety is minimal. In other words, we are expending more resources on offenders who are already categorically at lower risk and who have demonstrated compliance to supervision and treatment.

Eligibility for SSOSA should be based on risk and amenability to treatment. The legislature should re-evaluate the risk factors listed in the current statute governing SSOSA. (RCW 9.94A.670)

Background and Rationale:

Until 2000, 80% of all sex offenders met the statutory criteria for eligibility.

By 2005, only 63% of all sex offenders met the statutory criteria for eligibility.

Between 1986 and 2004, as a portion of all sex offenders sentenced, SSOSA has declined from approximately 40% to 15%.

Some risk factors are more politically than research driven, such as amenability to treatment; type of crime committed.

Comment [AP3]: Above we need to highlight that here's an area we have been doing a good job and we see value in amenability

Separate political from the research. Climate continues (political) they are grounded in research, but are of importance in policy considerations to that end we have identified insert nexus where there is one and or highlight the differences.

Development of statistically relevant risk factors into actuarial risk assessment instruments has mushroomed in the past 10-20 years and can be incorporated into the evaluation.

The explosion of technology has contributed to a dramatic increase in child sex abuse images being distributed through the Internet. While such offenders may not have a relationship with the victim, they are at low risk and likely could benefit from SSOSA type treatment.

Since the creation of SSOSA, additional criteria for eligibility and shifts in application of the statute have continued to result in the reduction of sex offenders who are both eligible and if eligible, considered for a SSOSA. The review process indicates to the SOPB that these shifts and declines are not soundly based on data, research, and the development of risk assessment tools and sex offender treatment advances over time. Science has demonstrated that empirical assessment of risk, rather than crime of conviction, is by definition a much more accurate measure of the likelihood of sexual re-offense.

The State should have oversight of the licensing requirements of sex offender treatment providers. The sex offender treatment advisory committee should be re-instated and funded to carry out this responsibility.

Background and Rationale:

The original statute creating SSOSA included the concept of state oversight of the requirements for sex offender treatment providers, through licensure. As part of the Community Protection Act, the Department of Health was charged with the licensing process, as with most other professional licenses in Washington. In addition, however, a statutory advisory committee was established and charged with the task of establishing the education and experience requirements for the license. The advisory committee established the original requirements in 1991 and periodically reviewed and updated the requirements as advancements were achieved in the field of sex offender treatment. The advisory committee was disbanded during the economic crisis and budget reductions that marked the past few years.

A concept for consideration

The following is offered as a concept for consideration and potential further development, but not as an SOPB recommendation at this time.

In the course of conducting this review of SSOSA, the members began to recognize a group of sex offenders who are low risk to re-offend and may be eligible for SSOSA, but are not really ready to fully engage and be able to complete an initial SSOSA. This lack of readiness may be due to a number of factors, such as lack of support or lack of stability in housing or employment, for instance. These offenders are likely candidates

Comment [AP4]: Something about modeling other prison model may be worth entertaining, appears to be support for and highlight the importance and recognition of value of treatment and potential cost savings, ability to enhance community safety through treatment, incentive for treatment to be completed with a like model- which is a win. Statute seems to allow already, not employed or fleshed out process wise to rely on. Note that this is not a formal rec, but an item for consideration with demonstrated interest by majority of stakeholders.

to be revoked within the first three years, when the vast majority of those who are revoked are revoked. There is another group of sex offenders who may be eligible, but a SSOSA is deemed to be too lenient for the crime or circumstances.

The SSOSA review committee developed a concept whereby these sex offenders would be given a two – three year prison sentence, with the remainder of the sentence suspended. While being incarcerated, though, they would receive treatment.

This concept may prove to be more effect and less costly than never having a SSOSA or receiving a SSOSA and then experiencing early revocation.

(May already have authority to do this under RCW 9.94A.670 – subsection on jail time)

ⁱ Dr. di Furia, M.D., "On the Treatment and Disposition of Sex Offenders," Northwest Medicine 1966.

ⁱⁱ MacDonald, George J., Williams, Robinson, M.S.W., and Nichols, H.R., M.A., "Treatment of the Sex Offender, A Report on the First Ten Years of a Hospital Program." Western State Hospital, Fort Steilacoom, Washington November 1, 1968.

ⁱⁱⁱ Michael O'Connel summary for SOPB, September 2013.

^{iv} From Kecia per ISRB website. **Fix notation.**

^v Hanson, R. K. (1998). What do we know about sex offender risk assessment? Psychology, Public Policy and the Law, 4, 50-72.

^{vi} Sex Offender Sentencing in Washington, prepared by Jim Morishima, Office of Program Research, Washington House of Representatives, 2007.

^{vii} WSIPP Study, Sex Offender Sentencing in WA State: Special Sex Offender Sentencing Alternative Trends, January 2006. Covers pre and post 2004 eligibility and judge considerations.

Add, the Rise and Fall of a Sex Offender Program, Western State Hospital by Maureen Saylor, R.N., M.A., Program Coordinator – presented to The Seventh Annual Research and Data Conference on Evaluation and Treatment of Sex Abusers, Atlanta, Georgia, September 1988.

^{viii} WSIPP Study, Sex Offender Sentencing in WA State: Recidivism Rates, August 2005

^{ix} WSIPP Study, Sex Offender Sentencing in WA State: Initial Sentencing Decision, Sept 2005

^x WSIPP Study, Sex Offender Sentencing in WA State: SSOSA Trends, January 2006

^{xi} Same as above

^{xii} WSIPP Study, Sex Offender Sentencing in WA State: Recidivism Rates, August 2005

^{xiii} WSIPP Study, Sex Offender Sentencing in WA State: Recidivism Rates, August 2005

^{xiv} WSIPP Study, Sex Offender Sentencing in WA State: SSOSA Revocations, Jan 2006

^{xv} Based on SSOSA offenders revoked and then released from prison between 2000 and 2005.

Addendum #1

Add Blank Surveys

SSOSA Cost Savings Analysis, RCW 9.94A.670 (Methodology)

- 1. What is the average length of time on the program for an offender who completes the SSOSA program? 81.6 months**

The average time sentenced to SSOSA for all offenders in SFY 2012, 81.6 months

- 2. What is the Cost to the State for an offender sentenced to SSOSA? \$45,246**

The average estimated cost to the State for a SSOSA offender in SFY 2012 = \$45,246

(calculated by Average monthly Supervision Rate \$554.49 (x) 81.6 months on SSOSA = \$45,246)

- 3. What is the average revocation rate and associated increased cost over a prison sentence per offender? 16% revocation rate and \$22,623 in additional cost per offender revoked**

Average revocation rate is 16% (average of rate for SFY 2009-2011)

Assumed revocation rate at 50% of SSOSA sentence completed in the community, results in additional supervision cost of \$22,623 (50% of supervision time) per offender that is revoked

Revocation = 16% (average of SFY 2009-2011) rate (x) 95 offenders in SFY 2012 = 15 offenders at an increased cost of \$22,623 per offender = \$339,345 in increased costs for revocations

- 4. What are the avoided costs to the State for an offender that completes SSOSA (savings in avoided DOC bed costs plus community supervision costs minus the cost per offender on SSOSA)? \$201,870 per offender savings, including revocations \$166,424 per offender**

The average cost per day per offender in a DOC institution in SFY 2012 was \$90.18 per day.

The average suspended DOC sentence range for offenders in SSOSA is 81.6 months or 2,482 days. The average suspended sentence at 2,482 days multiplied by the average daily bed rate of \$90.18 = \$223,827 in avoided bed costs of per offender.

Average supervision time for Offenders released from a prison term in SFY 2012 42 months

42 months of supervision (x) monthly supervision rate \$554.49 = \$23,289 supervision costs + \$223,827 in avoided prison costs = \$247,116 in avoided costs minus the cost per offender on SSOSA (\$45,246) = \$201,870 per offender completing SSOSA.

Per offender projected savings including revocation rate = Total cost saving minus revocation additional costs (\$16,149,600 in savings - \$339,345 in increased costs for revocation = \$15,810,255) / total offenders (95) = \$166,424 savings per offender including revocations

- 5. Projected State dollars saved for offenders sentenced to SSOSA in SFY 2012 that complete the program? \$16,149,600**

\$247,116 = the average avoided DOC prison and supervision costs per offender minus the average cost per offender on SSOSA, \$45,246 = \$201,870 savings (x) 80 offenders = \$16,149,600 estimated cost savings for offenders sentenced in SFY 2012 that complete the program.

^{xvi} Yates, P.M. (2009) Is sexual offender denial related to sex offense risk and recidivism? A review and treatment implications. *Psychology, Crime, and Law*, Vol. 15, Nos. 2 & 3, February-March 2009, 183-199.