

Draft 5: SSOSA Review

October 28, 2013

[Insert Executive Summary](#)

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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 (SSOSA) to assist policy makers in making informed judgments

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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?

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Additionally, the letter directs the SOPB to make any recommendations for improvements to the SSOSA process as identified in its review.

~~The SOPB convened a subcommittee who~~ Over the last year, a subcommittee convened by the SOPB 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 ~~place~~ contextualize recommendations in context, 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~~ provides a historical overview prior to presentation of recommendations.

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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..."¹ Dr. Giulio di Furia observed that, despite the focus placed on treatment in

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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 ~~weekly~~ ~~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 ~~were~~ 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, ~~with the addition of~~ ~~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, 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 ~~this~~ time period, there was significant sharing of information among ~~st~~ 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’s 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

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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 and legislators began to shift their support from treatment to punishment as a response to sex offenders, to one of punishment. This paradigm shift, known ~~to~~ as the "law justice movement," rests on the attitude that offenders could not be rehabilitated, thus prison was the only recourse.

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 wholeheartedly 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~~developing rapidly~~. 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

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(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 sentencing structure to one of determinate sentences. While there were still maximums-maximum sentences for each crime classification, ~~there was much more consistency imposed through the development of standard ranges and an offender scoring (based on criminal history) system (based on criminal history) imposed much more consistency.~~ 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 the individual 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 the Department of Social and Health Services to the 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

Sexual assault victim advocates were highly concerned about the chilling impacts a determinate model would have on victims seeking support and pursuing justice. The concerns were rooted in the knowledge that the majority of victims are children sexually assaulted by someone they know or to whom they are related ~~to~~. Children were placed in a position of reporting and potentially testifying against a caregiver or other known individual and this also placed the family stability (income and structure) in jeopardy; the rigid sentencing structure provided no consideration of these dynamics.

-Community treatment providers expressed concern and the desire to preserve an emerging and promising treatment model. Together, advocates and treatment providers formed an alliance to influence the legislation. Responsive to these concerns and desiring an effective approach, the legislature crafted the SSOSA model.

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 reporting of 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 improved considerably ~~getten 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, ~~ore~~ relatively unchanging and historical in nature) identified in the literature as

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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.

- Clinically adjusted actuarial approach: The evaluator uses an 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 have advanced. 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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<http://books.google.com/books?id=tKx434S9hDYC&pg=PA104&ipq=PA104&dq=Hanson+%EF%82%A7%09Research-guided+clinical+judgment&source=bl&ots=cBxWd-IT9p&sig=xv897J0ZOLBNIWA74oV4SOjtiFM&hl=en&sa=X&ei=dZFyJouyBYKeiAKQ24DgAQ&ved=0CCkQ6AEwAA#v=onepage&q=Hanson%20EF%82%A7%09Research-guided%20clinical%20judgment&f=false>

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A Rreview of SSOSA Elements - RCW 9.94A.670

Since its introduction in 1984, SSOSA has undergone significant modifications throughout the years.

. Key changes include:

- Consideration of w 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

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- Treatment periods expanded from 2 years to 3 years to the current up to 5 years
- ~~Inclusion of v~~Victim input included and later given great weight

The narrative below provides an overview of the changes to SSOSA legislation including the significant influence of the Community Protection Act of 1990.

The Beginning: Original Statute

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

- A 9A.44 (except 9A.44.040 or .050) sex offense conviction, other than Rape 1 or Rape 2 or other serious violent sex offense
- No prior convictions for a 9A.44 9A.64.020 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 six years.

There were two different approaches to how an offender could participate in a SSOSA:-

1) 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. After the report, the court shall then determine whether the offender and the community will benefit from use of the SSOSA.

- If yes, then the court shall impose a sentence within the sentence range and if the sentence is less than 6 years, the court may suspend the sentence and place the offender on community supervision for up to 2 years.

As condition of the suspended sentence, the court may impose other sentence conditions including up to 6 months of confinement, crime-related prohibitions and requirements that the offender perform any one or more of the following:

- Devote time to a specific employment or occupation;
- Undergo available outpatient sex offender treatment for up to two years, or inpatient sex offender treatment not to exceed the standard range of confinement for that offense
- Remain within prescribed geographical boundaries and notify the court or the Community Corrections Office (CCO) of any change in the offender's address or employment
- Report as directed to the court and a CCO
- Pay a fine, make restitution, accomplish some community service work, or any combination thereof; or
- Make recoupment to the victim for the cost of any counseling required as a result of the offender's crime

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If the offender violates these sentence conditions the court may revoke the suspension and order execution of the sentence.

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- When convicted of a sex offense and sentenced to more than one year but less than six years, the sentencing court may commit the offender for up to thirty days at Eastern State Hospital or Western State Hospital for an examination of the offender's amenability to treatment.
- Once the report is complete, the court shall review and may order the term of confinement imposed be served at Western State Hospital or Eastern State Hospital. If the offender does not comply with conditions of the treatment program, the offender shall be transferred to the Department of Corrections to serve the balance of the term of confinement.
- If the offender successfully completes the treatment program before the expiration of his term of confinement, the court may convert the balance of confinement to community supervision and may place conditions on the offender including crime-related prohibitions and requirements that the offender perform any one or more of the following:
 - Devote time to a specific employment or occupation;
 - Remain within prescribed geographical boundaries and notify the court or the ~~see~~ CCO of any change in the offender's address or employment;
 - Report as directed to the court and a ~~see~~ CCO
 - Undergo available outpatient treatment.

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If the offender violates any of the terms of his community supervision, the court may order the offender to serve the balance of the community supervision in confinement at the Department of Corrections.

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A Significant influence: Community Protection Act of 1990

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Two incidents in the late 1980's 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 events brought media coverage and captivated the public's attention, resulting in a frenzy of public outcry. Governor Booth Gardner created the Public Safety Task Force and appointed King County Prosecutor Norm Maleng the Chair. The task force conducted public forums and meetings throughout the state, gathering information for approximately a year. These efforts culminated in the release of the Washington State Public Safety Task Force Report. The recommendations contained in the Report were translated to a groundbreaking legislative proposal (later modeled across the US) which, when passed in February, 1990, became known as the Community Protection Act of 1990.

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,
- creation of sex offender registration,
- creation of community notification,
- implementation of civil commitment of offenders,
- establishment of the special commitment center,
- creation of the office of crime victims advocacy,
- significantly increased of 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 certification of treatment providers. The legislation directed the Advisory Committee to develop standards for certification by the Department of Health. (Note: 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 have 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.

Specific Impacts on SSOA:

- Lengthened treatment to 3 years
- Maximum sentence allowed extended from 6 years to 8 years
- Requires certification of sex offender treatment providers after July 1991

Significant Impact: Revision to Sentencing in Washington 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 who have a prior conviction 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}

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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; and
- 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}

SSOSA in Current Law

Eligibility for a SSOSA:

- Convicted of sex offense other than Rape 2 or a sex offense that is also a serious violent offense
- If part of a guilty plea, the offender must voluntarily and affirmatively admit he or she committed all of the elements of the crime to which the offender is pleading guilty
- Not available to offenders pleading guilty under an Alford plea
- No prior sex offense convictions or any other felony sex offenses in this or any other state
- No prior adult convictions for a violent offense committed within five years of the date of the current offense
- Offense did not result in substantial bodily harm to the victim
- Offender had an established relationship with, or connection to, the victim such that the sole connection with the victim was not the commission of the crime
- Offender's standard range for the offense includes the possibility of confinement for less than 11 years

Amenability to Treatment

If the court finds the offender is eligible for the alternative, the court, on its own motion or the motion of the state or the offender, may order an examination to determine

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required recommendation of affirmative conditions and crime-related prohibitions to include identification of any known precursors to offender's offense cycle.

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whether the offender is amenable to treatment. The report from the examination shall include the following:

- The offender's version of the facts and the official version of the facts;
- The offender's offense history;
- An assessment of problems in addition to alleged deviant behaviors;
- The offender's social and employment situation; and
- Other evaluation measures used.

The examiner shall assess and report regarding the offender's amenability to treatment and relevant risk to the community. A proposed treatment plan shall be provided and shall include, at a minimum:

- 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; and
- recommended crime-related prohibitions and affirmative conditions, which must include, to the extent known, an identification of specific activities or behaviors that are precursors to the offender's offense cycle, including, but not limited to, activities or behaviors such as viewing or listening to pornography or use of alcohol or controlled substances.

• **Appropriateness of SSOSA**

Once the report is received, the court shall consider whether:

- the offender and the community will benefit from use of this alternative,
- the alternative is too lenient in light of the offense,
- the offender is amendable to treatment,
- the offender presents risk to the community, to the victim, or to persons of similar age and circumstances as the victim
- the victim's opinion opposes or supports the alternative. The court shall give great weight to the victim's opinion. If the sentence is in opposition to the victim's opinion, the court shall enter written findings stating its reasons for imposing the treatment disposition.

• **Sentencing**

Once the court determines this alternative is appropriate, the court imposes a sentence, a minimum term of sentence within the standard sentence range. If the sentence imposed is less than 11 years of confinement, the court may suspend the sentence, with the following:

- A term of confinement up to twelve months or the maximum term within the standard range, whichever is less

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- A term of custody equal to the length of the suspended sentence, the length of the maximum term, or three years, whichever is greater, and require the offender to comply with any conditions imposed by the Department of Corrections
- Treatment for up to five years (either inpatient or outpatient)
- Specific prohibitions and affirmative conditions relating to known precursor activities or behaviors identified in the treatment plan

Conditions

As a condition of the suspended sentence, the court may impose one or more of the following:

- Crime-related prohibitions
- Require the offender to devote time to a specific employment or occupation
- Require the offender to remain within prescribed geographical boundaries and provide notice of any change to address or employment
- Report to a community corrections officer
- Pay all court-ordered legal financial obligations
- Perform community restitution or
- Require reimbursement to the victim for the cost of any counseling required as a result of the crime

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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. ~~Although the original data is 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.

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Trends in SSOSA Sex Offenders^{ix}

- 75% of all sex offender cases involve child victims.
- 95% of offenders granted a SSOSA involve a child victim.
- 63% of convicted sex offenders in jail or community supervision involve a child victim.
- 73% of sex offenders in prison involve a child victim.

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Comment [JL10]: This wording is awkward, because offenders don't "involve" a child victim. Would it be appropriate to say "had" or "perpetrated against"? Or would it be better to say "95% of cases of offenders granted a SSOSA involve..." etc.?

- Proportionally fewer minorities receive SSOSA sentences than prison sentences.^v

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.

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SSOSA and Recidivism - 1986--1998^{xii}

- Felony sex offense recidivism rates for sex offenders released from prison, both those 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 and, 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 prison have the highest rates.^{xiii}
- Sex offenders sentenced to jail or community supervision have rates similar to, but slightly below, the recidivism rates of those sentenced to prison.

Comment [JL11]: I question the use of the present tense in this section because hte data are old.

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SSOSA Sex Offender Revocation

Revocation is the court's cancellation of the SSOSA agreement, resulting in the offender's return to prison. A revocation does not indicate that an offender sexually recidivated. A SSOSA can revoke for any violation of rules imposed as part of a SSOSA agreement, such as substance abuse or failure to register.

SSOSA Sex Offender Revocation Data^{xiv}

- 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.
- Of the SSOSA recipients (those 15% revoked within a ten-year follow-up period), 85% revoked within three years of being in the community.
- It is 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.

Comment [JL13]: This is a repeat of the heading above. Is this suggested heading appropriate?

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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.

~~The Sex Offender Policy Board considers questions brought to it~~ ~~it is~~ through the lenses of ~~both~~ legislative framework, with its original intent, as well as through the lens of 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.”² 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,³ 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,

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Comment [JL14]: I suggest: "One of the criteria on which the SOPB reviewed SSOSA is the cost of SSOSA in comparison to the cost of incarceration." More concise and accurate. I would remove the word "lens" in the rest of the paragraph: Substitute "cost is not the only basis or even the most important basis on which to determine value." For the portion of the sentence that says "cost is certainly not the only lens..." (Too many "lenses"!)

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 total projected cost savings for all offenders (95) ~~that who~~ were sentenced to SSOSA in State Fiscal Year (SFY) 2012 is \$16,149,600.

The Washington State Institute for Public Policy completed the last cost analysis for SSOSA in 1993. 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 lost savings to the state for offenders sentenced to the programs ~~and~~ who are subsequently revoked and sent to prison. When these costs are included in the calculations, the cost savings per offender is \$166,424.

The total projected cost savings for all 95 offenders sentenced to SSOSA in SFY 2012 is \$16,149,600.

SSOSA vs. Prison Term:

	Prison	SSOSA	Revocation
Costs	\$247,116	\$45,246	\$166,424
Savings	\$0	\$201,870	\$35,446 (accounts for average bed nights not used while in community)

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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 ~~who~~ 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.

Comment [JL15]: CCB is not previously defined.

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 to review and respond to questions related to the role and influence of victim input in SOSSA issuance, offender amenability, and SOSSA efficacy.

Obtaining data to respond to legislative inquiry proved challenging. For many of the questions there is neither data collected nor a statewide system to support collection. Information ~~was~~ obtained through surveys of professionals statewide who are involved in the SOSSA issuance process proved useful. 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, ~~all~~ each surveys 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.

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Victim Input

Question Posed to SOPB

RCW 9.94A.670 requires the court to give great weight to the victim's opinion; the court ~~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	0%	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 in opposition to 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.

“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” – prosecutor 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**.

Comment [JL16]: change to "and noting SOSSA preference."? If preference is noted on the form, it should read this way. If it is noted elsewhere, the way it reads is fine.

Offender Amenability

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Questions posed to SOPB:

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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:

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This is a multi-pronged question, which will be answered by the individual elements of the question.

Q. 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.

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Determining amenability to treatment is nuanced. Amenability to treatment should include an assessment of an offender's willingness to engage in treatment and if they believe it would be beneficial. Additionally, it should consider risk and protective factors. Some common factors include employment, support systems, transportation, stable housing, substance abuse, medication and general mental health.

There is variation in how professionals in the sex offender management field define amenability. Some narrowly define it to indicate one's willingness to engage in treatment only, while others use a more expansive definition that includes a variety of elements and conditions that indicate potential for successful intervention. Subjectivity in determination of amenability may contribute to difference across jurisdictions.

This was reflected in survey findings of prosecutors and treatment providers.

- Treatment providers were asked: ***"In your experience, SOSSA evaluators have a common definition of amenable to treatment."***
 - 53% responded Yes, 29% No, and 18% selected that they don't know.
- 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.

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Comment [JL17]: I think this is much easier to follow in bulleted format.

Survey results further yield that the determination of amenability by the SOSSA evaluator is relied upon heavily for granting a SSOSA.

Q. What happens if the Department of Corrections does not believe treatment can be successful?

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There is no verifiable data. However, anecdotal and survey information indicates that DOC staff typically base their determination to not recommend treatment on information contained in the Pre-Sentence Investigation (PSI). The PSI is a presentation of information, highlighting risk and protective conditions, sometimes with community correction officers' opinions, often with no particular conclusion. Thus, the PSI cannot be consistently relied on for a recommendation. Regardless of the opinion/recommendation of DOC, all the collected information is brought to a judge for review and it is the judge who makes a determination based on information presented, as well as their own analysis, perspective, and opinion.

Q. Should there be more consistent standards for determining when an offender is amenable to treatment and is therefore eligible for a SSOSA?

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A common definition and understanding of amenability to treatment would improve consistency of recommendations. A way to achieve this could be through reinstatement of the sex offender treatment advisory committee, discussed later in this report.

SSOSA Efficacy-

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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?

Findings

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Completion of Treatment and Recidivism

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. In fact data shows that only 3.8% revoke for felony sex crime recidivism.

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 felony sex crime (WSIPP, 2006) charges (WSIPP, 2006). The efficacy of the SOSSA program is demonstrated in reduced recidivism rates, low revocation frequency, and significant cost savings to the state.

Response to Violations

While SOSSA offenders do not technically meet the conditions for the specific DOC “swift and certain” program, the SOPB reviewed practice to assess if the spirit or intent of recent “swift and certain” principles applies to SSOSA offenders. Based on the experience of members and discussions with DOC staff, the SOPB understands that SSOSA offenders are supervised closely and with great attention. We found no evidence that indicates less than an appropriately timely and responsive action by DOC in response to violations.

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SOPB Recommendations

The SOPB has developed recommendations for consideration that are science- and data-driven to the extent possible, with the goal of enhancing public safety and cost-effective resource allocation. The following recommendations are also informed by a survey to professionals involved in SSOSA, previous studies of SSOSA, recent research, and the expertise of the multi-disciplinary composition of the SOPB.

SSOSA Issuance

Findings:

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%, demonstrating a decrease of sex offenders who are statutorily eligible and of those who are eligible but for whom SSOSA is not granted.

One of the statutory requirements for SSOSA eligibility pertains to the relationship between victim and offender. RCW 9.94A.670 states “*The offender had an established relationship with, or connection to, the victim such that the sole connection with the victim was not the commission of the crime.*”

Practice data collected through the SOPB survey (2013) indicates inconsistent application by judges and prosecutors of the victim/offender relationship standard outlined in the statute.

An operating practice of many requires the offender and victim to be family members, rather than “known” as illustrated below:

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Q: Do you require that the victim and offender are related to each other to grant or request a SSOSA?

	Always	Most of the time
Judges	12%	16%
Prosecutors	0%	33%

Conclusion

Since the creation of SSOSA, additional criteria for eligibility of the statute and shifts in practice have continued to result in the reduction of sex offenders who are eligible and if eligible, considered for a SSOSA.

Prosecutor and judge practices of limiting SSOSA eligibility to family members has narrowed the intent of the statute and impacted the number of otherwise eligible SSOSAs. This narrowing practice of requiring the victim and offender to be family members:

- excludes low-risk offenders who are otherwise eligible
- may discourage victims from reporting in instance where the offender is known but not family
- directs resources toward incarceration, a more costly and less effective response-

While not a legislative recommendation, adherence to the statutory language regarding relationship of victim and offender is warranted.

Length of Supervision

Findings:

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.

Approximately 15% of SSOSA sex offenders are revoked^{xvii}.

Of the 15% who are revoked, 85% violate supervision within the first three years of being placed in the community.

-Of the 15% who are revoked, only 3.8% of these SSOSA offenders commit another sex crime

As aforementioned, revocation means a term of sentencing has been violated. Thus, a revocation cannot be assumed to indicate a higher risk in terms of sex offense behavior.

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Conclusion:

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 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.

Recommendation: 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.

Oversight of Treatment Provider Certification

Findings:

The original statute creating SSOSA included the concept of state oversight of the requirements for sex offender treatment providers, through certification. As part of the Community Protection Act, the Department of Health was charged with the certification process. In addition, however, a statutory advisory committee was established and charged with the task of establishing the education and experience requirements for the certification. 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.

Conclusion:

Continual oversight of certification requirements, involving the establishment of best practices and infusing requirements with recent advances and research, is an invaluable tool to the sex offender management system. The field of sex offender treatment continues to be a rapidly developing and evolve rapidly, and the certification must keep pace.

Prior to the official disbanding of the committee (repeal of statute), the role of the committee had been significantly diminished when, for example, the Department of Health changed the certification exam to be an open-book test with questions limited to what was contained in the relevant statutes and agency rules.

As supported by this recommendation, the advisory committee should be a vehicle that provides up-to-date technical expertise to the Department of Health administrative staff. This advice should be incorporated into updated certification requirements and the

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certification examination. Empirical research that has accrued in the past decade has included:

- validated actuarial risk assessment instruments
- a growing body of outcome research that demonstrates the efficacy of particular treatment approaches
- evidence of the importance of adhering to the Risk-Need-Responsivity principle-Model in delivering treatment services to correctional populations

The advisory committee should help integrate these research-based practice improvements into the standards and practices overseen by the Department of Health. It could also act as experts in the field to review and make recommendations in cases where providers are under investigation for unethical practices.

The State should have oversight of the certification requirements of sex offender treatment providers. The Sex Offender Treatment Advisory Committee should be re-instated and funded to carry out this responsibility.

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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 SOPB 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 ready to fully engage or able to complete an initial SSOSA. This lack of readiness may be due to a number of factors, such as lack of community support or lack of stability in housing or employment, for instance. These offenders are likely candidates to revoke within the first three years, when the vast majority of those who are revoked do revoke. There is another group of sex offenders who may be eligible, but for whom a SSOSA is deemed to be too lenient for the crime or circumstances.

Based on the concepts above, the SOPB developed a concept whereby these sex offenders would serve a two- to -three- year prison sentence, with the remainder of the sentence suspended. While being incarcerated, though, they would receive treatment and be able to take advantage of other DOC programs that will better prepare them to be successful once in the community.

Treatment is more cost effective and prevents future victimization better than a prison- only sentence or unsuccessful SSOSA. Thus, SOPB asserts that supporting a modified approach to SSOSA makes public policy and public safety sense. The Washington Association of Prosecuting Attorneys, sex offender treatment providers, and other members of the SOPB express interest in developing this concept further.

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

Data Issues

The SOPB wishes to draw attention to the profound lack of data regarding SSOSA. While the 2005-2006 series of studies conducted by the Washington State Institute for Public Policy were immensely helpful, this was a significant endeavor requiring financial resources and time to gather and analyze the data. The SOPB had to rely on WSIPP findings from data that is at least 7 years old.

The SOPB asserts it is extremely important to continue to review, evaluate, study, and improve the sex offender management system in Washington. Looking into the future, there will be no SSOSA data readily collected and readily accessible to determine if policy changes made now will have the desired impact. If the legislature wishes to continue creating and revising SSOSA public policy based on sound research and data, it is imperative that requirements for standard data collection and the mechanism to do so be in place.

Related Crimes

In addition to the concept of a prison-based SSOSA and the need for data, the SOPB wishes to draw attention to the issue of Internet-assisted child sexual pornography crimes. The explosion of technology has contributed to a dramatic increase in child sex abuse images being distributed through the Internet. We agree that the public and professionals alike find these crimes repugnant. At the same time, the SOPB turns to the research and allied professionals to guide public policy in this arena.

One of the survey questions posed specifically addresses the issue of pornography situations. Responses were made by Defense attorneys, prosecutors, and treatment providers responded on this topic. It is important to note that none of the comments were negative about including these cases as SSOSA eligible; and 85% of respondents proposed changes to SSOSA eligibility in order to include these cases.^{xviii}

A recent (2011) study by Seto provided important information on this topic. He found that nine studies of online (mostly child pornography) offenders, followed for an average of three- and a-half years, found recidivism rates for child pornography offenders to be much lower than for those who had committed hands-on sexual offenses. Within the four-year study period, about 3% of child pornography offenders were arrested, charged or convicted for a new child pornography offense. Further, only about 2% were arrested, charged or convicted for a new contact (hands-on) sexual offense.^{xix}

While such offenders may not have a relationship with the victim, they are at low risk and likely could benefit from SSOSA-type treatment.

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Comment [JL20]: substitute "cases"?

THE END.

When looking at hybrid model, especially if going towards payment for offender treatment (to prevent future or repeat victimization) also add money for SA Prevention work.

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Comment [JL21]: Is this the actual heading? If you use "Conclusion," you may want to modify it to prevent confusion with previous subheadings, for example, "REPORT CONCLUSION."

Comment [JL22]: Needs to be written out.

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.

^{xvii} [Revocation means that the SSOSA suspended sentence is voided and the offender must return to prison for the remainder of the sentence. Revocations are based on violations of community supervision rules or requirements. This often includes behaviors such as alcohol or drug use or failure to register.](#)

^{xviii} [Survey conducted by SSOSA review committee, May 2013.](#)

^{xix} [Seto reviewed several studies to inform his conclusions. The original studies are: Endrass, J., Urbaniok, F., & Hammermeister, L.C., Elbert, T., Laubcher, A., & Rossegger, A. \(2009\). The consumption of internet child pornography and violent and sex offending. *BMC Psychiatry*, 43, 9-16.](#)

[Faust, E., Renaud, C., & Bickart, W. \(October, 2009\). Predictors of re-offense among a sample of federally convicted child pornography offenders. Paper presented at the 28th Annual Conference of the Association of sexual Abusers, Dallas, TX.](#)

[Seto, M.C. & Eke, A.W. \(2005\). The criminal histories and later offending of child pornography offenders. *Sexual Abuse: A Journal of Research and Treatment*, 17 \(2\), 201-210.](#)

[Andrea and Bev Parking Lot](#)

Some risk factors are more politically than research driven, such as amenability to treatment or type of crime committed. Development of statistically relevant risk factors into actuarial risk assessment instruments have expanded in the past 10-20 years and are incorporated into the evaluation.

. The review process demonstrated to the SOPB that these shifts and declines are not soundly based on data- or research. Nor does the change in policy and practice seem to consider, 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