

SOCCPN

Annual Survey of Sex Offender
Civil commitment Programs

Rebecca Jackson, Ph.D.

Jennifer Schneider, Ph.D.

Tara Travia, Ph.D.

Changes and Additions from 2008

- Questions were added after 2008 SOCCPN Conference
- Surveys of conference attendees found state reps wanted more open-ended questions about a number of issues, specifically procedural mechanisms
- Surveys were split into three “waves” regarding (1) Census, Treatment, and Training, (2) Procedural, and (3) Discharge and Conditional Release
- Reminders were sent out via email and phone calls
- High response rate

Census, Treatment, and Training

Variables

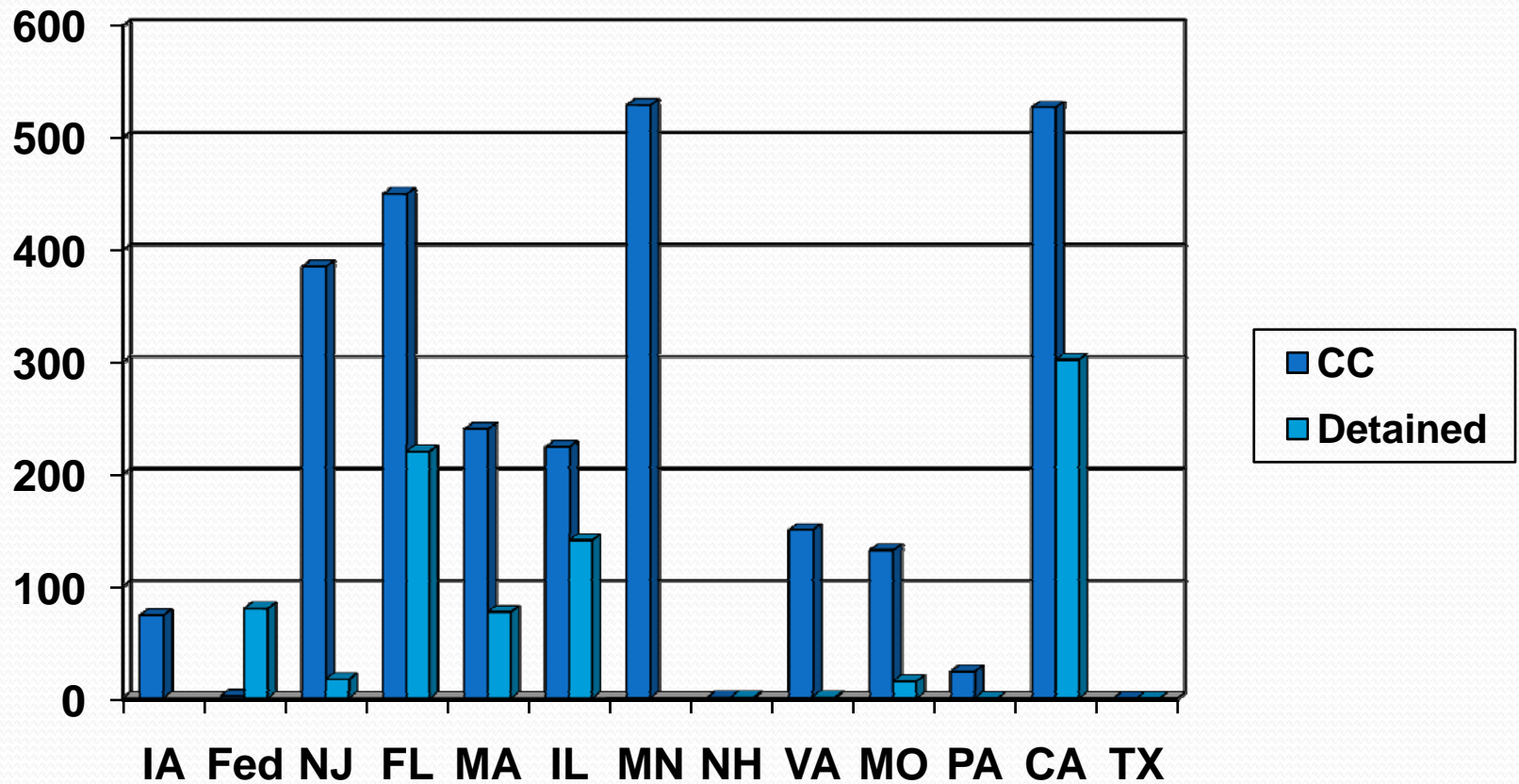
- Census
- Participation in treatment and treatment refusers
- Staffing ratios
- Sex offender specific treatment
- Vocational, Educational, and Recreational programming
- Assault rates
- Training/Professional education opportunities
- Staff turnover



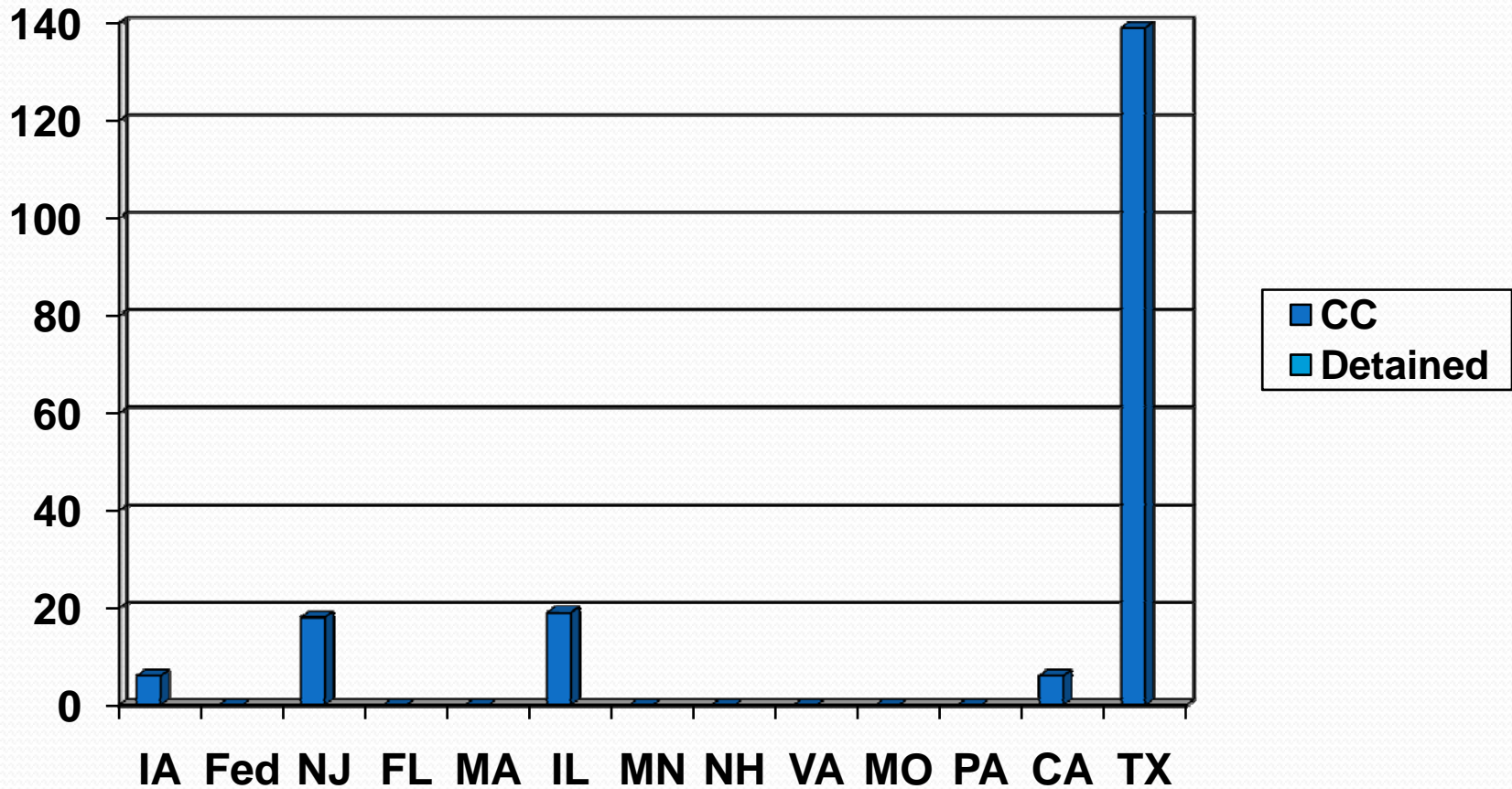
Respondents

- Iowa
- New Jersey
- Florida
- Massachusetts
- Illinois
- Minnesota
- New Hampshire
- Virginia
- Missouri
- Pennsylvania
- California
- Texas
- Federal

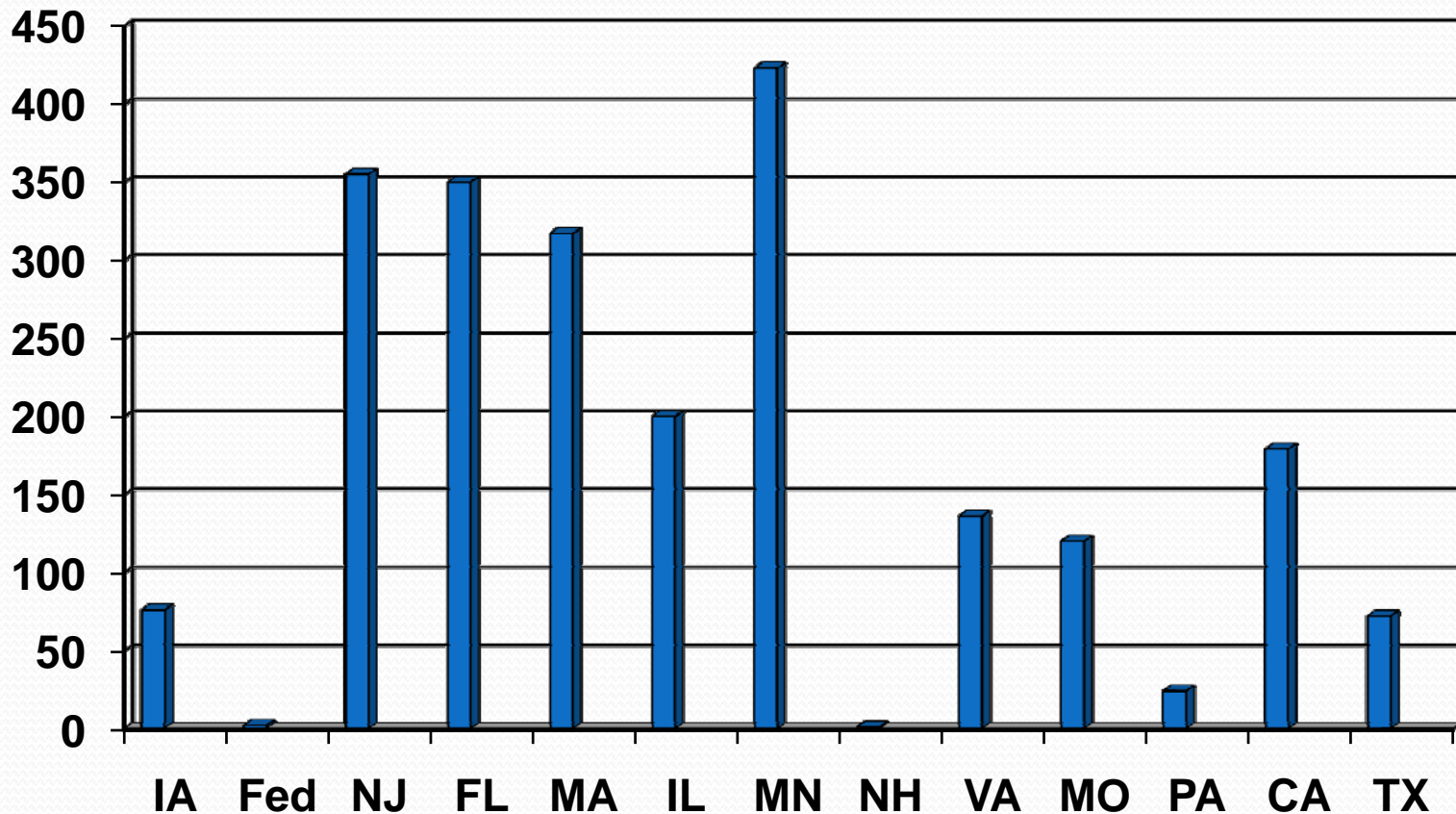
Current Census: Inpatient



Current Census: Outpatient



Participation in Treatment: Civily Committed Residents





Treatment Refusers

- Treatment refusers represent between 5 and 25% of all residents
- Majority of programs report less than 20% of their population is considered to be treatment refusers



Staff Ratios: Master's Level Therapists

- The number of Master's level therapists ranges from 0-55
- The ratio of Master's level therapists to residents varies from 2:1 to 33:1
- The average ratio of Master's level therapists is 16:1



Staff Ratios: Doctoral Level Psychologists

- The number of Doctoral level therapists ranges from 0-55
- The ratio of Doctoral level therapists varies from 8:1 to 79:1
- The average ratio of Doctoral level therapists to residents is 44:1



Staff Ratios: Psychiatrists

- The number of Psychiatrists ranges from 0-2*
- The average is .9 Psychiatrists per program
- A number of programs do not employ Psychiatrists full time or at all

*Note: One large (> 800 residents) program reported 11 psychiatrists. Not included in calculations



Sex Offender Specific Treatment

- Residents participate in between 1.5 hours to 12 hours of sex offender specific treatment per week
- Groups meet between 1 and 12 times per week
- Group length ranges from 60-120 minutes per session
- The average length is 90 minutes per session



Group Treatment

- Group size ranges between 4 and 14 residents
- Residents spend between 1-19 hours per week face to face with therapists
- Groups are co-lead in majority of programs
 - 6 programs reported groups are co-lead
 - 4 programs reported groups are not co-lead



Individual Treatment

- Eighty-nine percent of programs provide individual treatment as necessary
- The percentage of the population that receives individual treatment ranges from 1.5% to 100%



Vocational, Educational, and Recreational Programming

- Of the six programs that offer vocational programming, participation varies from 10-100%
- Of the programs that offer educational programming, participation varies from 5-100%
- Of the programs that offer recreational programming, participation varies from 10-100%



Assault Rates

- Rates of resident assault on staff are relatively low, ranging from none to less than 2% per year
- Rates of resident assault on other residents range from none to 40 per year.



Training

- Clinical staff receive between 2 and 6 hours of training per month
- Direct care staff (non-therapists) receive between 2 and 6 hours of training per month



Professional Education Opportunities

- Internal training departments
- Ongoing clinical skill training through inservice sessions
- Training outlined in statute
- Reimbursement for attendance at local and national conferences
- Support for continuing education opportunities



Internal Training Opportunities

- Orientation and annual updated training
- Speakers on variety of topics
- Annual agency sponsored conferences and in-service training
- Weekly clinical supervision, monthly grand rounds
- Joint continuing education with colleagues from related agencies
- State based electronic learning system



External Training Opportunities

- Local ATSA and other professional association meetings with guest speakers
- Attendance at ATSA, SOCCPN
- Other conferences and workshops
- State/Agency organized and sponsored training conferences
- Full day workshops
- Webcasts and computer based instruction
- Support to apply for external training



Staff turnover

- Understaffing 57.1%
- Salary 71.4%
- Physical conditions of facility 28.6%
- Burnout 85.7%
- Injuries/safety 28.6%

Procedure

Treatment Process, Measurement of Progress, Mail, Advocacy, Contraband, Security, Media, Room Restrictions, Grievance, Computer/Cell Phone Use

Introduction

- 21 programs representing 20 states responded (CA inpatient and outpatient program responded separately)
- 50% (10) responded they are under an accrediting agency such as JCAHO or CARF.
 - One respondent noted they are seeking such accreditation

Procedural Issues

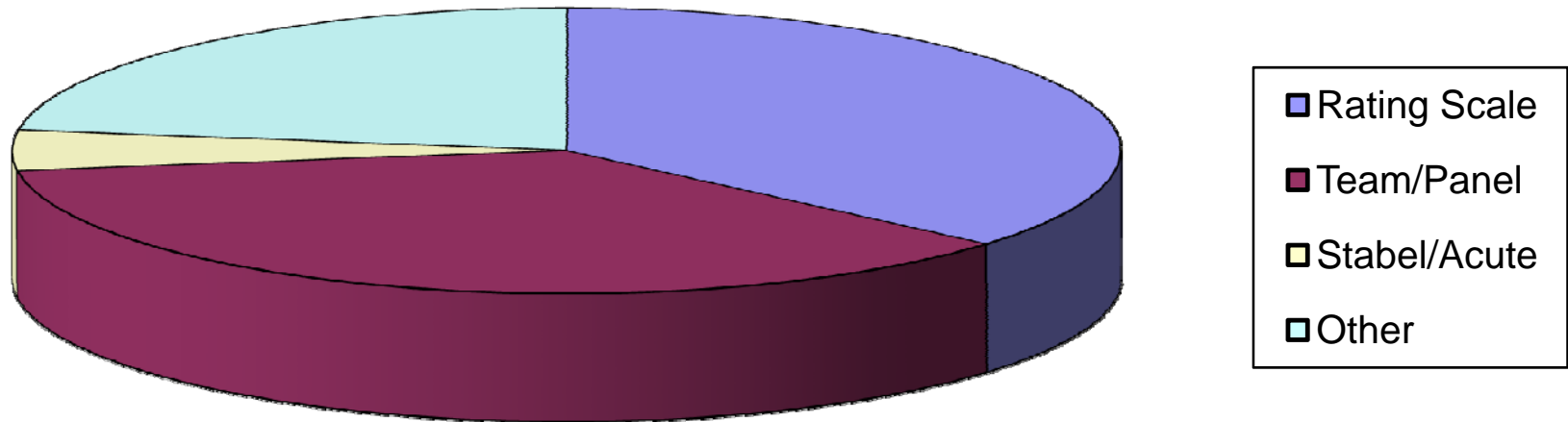
- 76.2% (16) have a standardized procedure/protocol for administering therapeutic treatment to clients
 - Of these 16, 5 “go beyond state ethical guidelines”
 - Explanations that were cited were the programs going for JCAHO accreditation , providing empirically-based treatments, and being more detailed. Of those not cited were equaling those guidelines or there being no specific guidelines for the treatment of sexual offenders
- **100% (21) reported using a “level system” of treatment**

Procedural Issues: How is Treatment Done

- 20/21 respondents reported using phase or level system with clear markers for success:
 - Move through assignments/learning objectives
 - Consent, honesty, understanding risk/cycle, empathy, observable behavioral changes (concern for others, reduce risk, change cognitive distortions, reduce criminal impulses)
 - Arousal management
 - Recommendations by a body of individuals
 - Community integration model (1/21) also measures progress by behavioral change

Procedural Issues: How is Treatment Done

How Treatment Is Measured



N=21 some overlap

Other = PPG, testing, Intuition

Procedural Issues: How is Treatment Done

- 57.1% reported there are consequences if a client fails or refuses treatment.
- 42.9% (9) reported there were programmatic sanctions for refusal/treatment failure
 - Fewer or no hours to work (one state pays their clients for being in treatment)
 - Less likely to gain release
 - Fewer privileges (such as number of packages into the facility)
 - One state reported failure leads to new charges (3rd degree which can be increased to a 1st degree)
- Two states reported they are either not allowed or choose not to impose sanctions on those who do not participate, but remarked that not being in treatment has natural consequences such as higher scores on risk measures or not getting healthier

Procedural Issues: Mail

- 100% have a mail policy
 - 77.8% (14) have clients open mail in front of staff to search for contraband
 - 61.1% (11) require a client to be present if/when mail is searched
 - In cases the client does not need to be present the following were given as explanations:
 - The facility does not allow any package in until it is searched (e.g. DOC)
 - There is obvious contraband that is suspected to be a danger to the facility (8)
 - Resident can sign a waiver (3)

Procedural Issues: Advocacy

- Of 21 respondents, 47.6% (10) have an external patient advocate, 20% (2) of which attend treatment team reviews and 50% (5) address patient concerns.

Procedural Issues: Contraband

- 94.4% (17) reported they have a policy governing contraband
 - 3 did not reply and one state reported that they do not provide supervision on this matter to residents who live in a half-way house (or in own homes)
 - 56% (9) stated it is difficult to deal with due to media and tobacco being difficult to detect and due to the time consuming nature. 44% (7) stated it was not difficult due to consistency or just not a lot getting in
- How is contraband dealt with:
 - Confiscate, destroy, limit mail privileges, DOC investigation
 - Stored or mailed back home or destroyed per resident
 - If illegal, sent to law enforcement

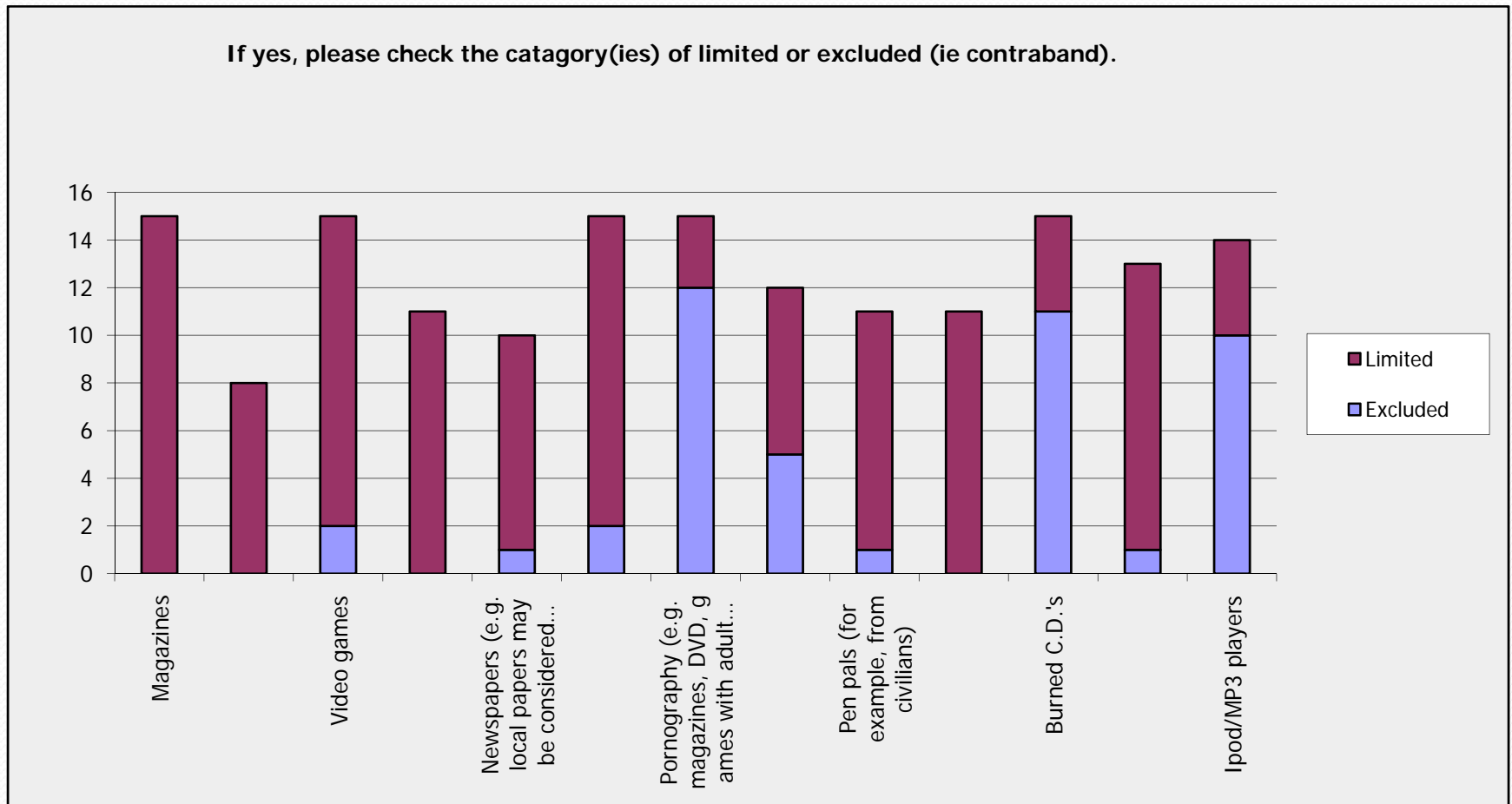
Procedural Issues: Contraband

- Tobacco, lighters
- Pornography, violent depictions
- Cash
- Cell phones, pagers, etc
- Metal, glass
- Contra-indicated material
- Medication
- Weapons/Sharps/dental floss/paperclips...
- Gum
- Keys
- Matches
- Dried flowers
- Sport affiliated clothing jerseys, bandanas, wallets
- Markers, pens, postage stamps
- Fruit in excess
- Hygiene products not purchased through facility
- Recording devices
- Food
- Hair (synthetic or real or animal), jewelry, cosmetics
- Id cards
- Travel tickets
- Glue, molds, petroleum

Procedural Issues: Media

- 12 states reported a written media policy
- 15 responded and stated they limit what types of media come into the facility
 - Staff, DOC, case managers, therapists, room searches and a number reported these are searched at the time the material arrives
 - 47⁰% (7) limit by treatment level, 50⁰% do not, 1 state replied this was not applicable
 - Some reported gaming systems/DVD players are only allowed at certain levels, other reported the whole system works this way, others that having trouble might limit as a special circumstance

Media Limitations: N=15



Communication Limitations

- 100% of 16 respondents stated they do, at times, limit who a client talks to
- 3/16 said it requires a medical order, 2/16 not applicable, while 11/16 responded it did not
- 10 specifically stated they limit contact with victims, other states noted probation, legal issues, or therapeutic reasons
- 7 /16 reported this approval had a time limit and 12/14 reported there is an outline provided to the client about how this is determined
 - Some states reported this is individually based (per victim, per treatment team) while one reported it was reviewed monthly. Predominately, this is approached individually.
 - 10/16 have this issue within the care plan

Procedural Issues: Security

- 100% place clients in shackles when transporting at least some of the time
 - 43.8% (7) reported this is by law
 - 11 stated only a medical order (and in one case and/or a court order for the courtroom) would lead to taking the resident out of shackles; 3 reported that a change to a higher level would also lead to this (i.e. lesser restrictive environment)
 - 9/11 reported they could take clients out without these measures under certain circumstances:
Policy, Stage/Level, Medical Issue and/or Court Order determined this.

Procedural Issues: Security

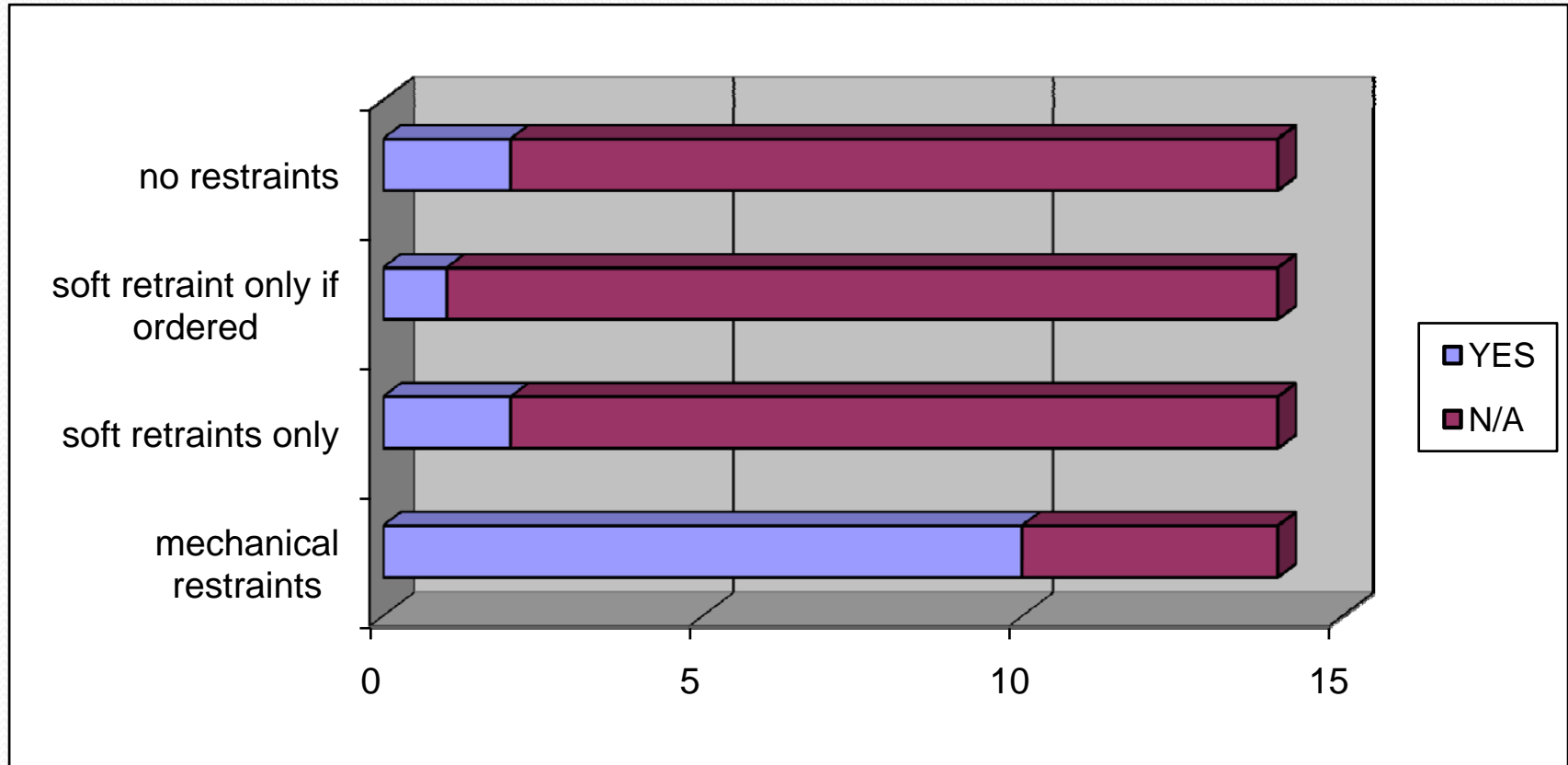
- Who transports:
 - Facility Staff/Security Staff were mentioned predominately
 - Mental Health Professional (only one)
 - Corrections Staff (at least two facilities)
 - Sheriff (only for court)
- 14/16 replied they required 2 or more staff to transport
 - One replied it is individually assessed and the other that only one was required
- 10/16 replied the number was based on client dangerousness (more for more dangerous or more restrictive measures may be used such as leg and wrist restraints).
- 14/16 remarked that a specific manner of client placement in the transport vehicle was utilized. 13/16 reported this was policy driven.

Procedural Issues: Security

- 14/16 use radios/cell phoned to report emergencies.
- 14/16 reported this was determined by policy
- 14/15 reported they have first aid equipment in vehicles for transports and 15/16 reported this is also determined by policy.
- 14/16 provide cell phones/radios for transport and 15/16 reported this is determined by policy.
- 15 responded to the question regarding medication procedures on transport (11/16 policy-driven)
 - 4/15 have a nurse accompany resident if will need meds
 - 1/15 has staff certified as “med passers”
 - 2 have staff administer or client has possession
 - 5 reported it is not done on trips

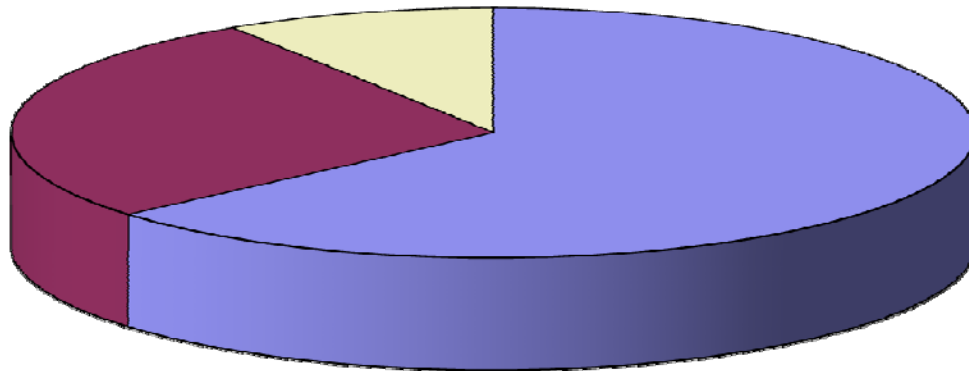
Procedural Issues: Restraint

- 3/13 reported this was their “own” creation while 10/12 reported they were either mandated by the state or followed corrections or another intuitions model



Procedural Issues: Restraint

Are Restraints Documented or Tracked?



- Not Tracked
- Documented in Plan or Other
- N/A

Procedural Issues: Room Restriction

- 4/14 reported using therapeutic room restrictions
- Only 7 responded (likely because wording was confusing). 2 reported this equaled seclusion and therefore was disallowed, while three suggested they could seclude a resident into a room for safety and security purposes or restrict what they could do/have in their room
- JCAHO, state standards and legal council were cited

Procedural Issues: Keys

- 9/14 reported who has keys depends on need and usually an administrator who determines the level of need.
- 1/14 reported that no one has personal keys due to being located at a DOC facility. 3/14 cited specific policies
- 13/14 reported that keys are secured by an internal system (sally port, security, etc.).
- 3/14 reported staff keep personal keys on them, 2/14 reported they do not manage personal car keys, 8/14 reported a method of securing them (e.g. exchanging them for work keys, placing in lock box or locker)
- A number of policies were cited.
- Lost keys could result in facility lockdowns, changing locks, and/or facility-wide searches
- Lost Keys were reported mainly through incident reports or to an administrator

Procedural Issues: Due Process

- 16/17 allowed clients to contact their attorney whenever they wish while ONE facility restricted this to weekly.
- 16/17 reported staff DO NOT monitor calls with ONE reporting they do so on their full confinement unit
- 16/17 replied someone other than the client paid for the attorney if the resident could not do so. Two replied this would be the county, while the other 14 reported this was the state.
 - ONE state replied that it was the client's responsibility alone.
 - 10/17 reported the percentage of clients with a private attorney was less than 5% or "tiny,"
 - 4/17 reported they did not know and did not give an estimate
 - 3/17 gave estimates of <10%, <25% and <50%

Procedural Issues: Grievance

- 100% (17) have grievance procedures
- Responses varied with regards to who monitors and answers grievances from identified “grievance specialists”, to resident advisors, executive or “appointed” staff,, or an advocate.
- Some identified very “formal” procedures with levels in which various people were involved in examining and/or responding to the grievances while some appeared to have informal procedures
- Staff, food/living conditions, property (allowances) were most commonly cited grievances

Procedural Issues: Grievance

1. Genuine issues that cannot be addressed in any other manner
2. Residents are not allowed to grieve treatment team decisions other than a reduction in level. They are advised to utilize informal resolution procedures prior to resorting to the grievance procedure. They are not allowed to grieve issues over which staff have no control (e.g., those governed by statute). Typical issues include denial of requests or changes in policies, and application of policies. Most issues are resolved at informal levels and few reach the grievance level.
3. Actions by persons that violate the facility's policies, lack of policy or procedure when there is a disagreement between resident and staff, the method a policy or procedure is applied.
4. Any
5. The grievance process is utilized for any requests.
6. Rights and program procedural issues
7. Anything not covered by due process, i.e., anything for which there is not a negative consequence to the resident, systems issues, violation of rights.
8. Those not involving human rights, such as food issues, medication/medical treatment.

Procedural Issues: Grievance

9. concerns about staff conduct, physical plant conditions, access to services, etc.
10. State law establishes an array of "patient rights" that cover all mental health patients. Any time that a patient believes that his rights have been violated, he is directed to the grievance process.
11. Statute listed rights
12. Requests or issues unresolved by the treatment team or
13. Anything that the client deems grievable.
14. Food service, staff abuse allegations, complaints about surveillance/lack of privileges, are examples

Procedural Issues: Computer and Communication

- Only 2/17 allow cell phones
 - 9/13 reported this is covered by policy
 - 9/15 reported specifically that they would confiscate the phone and 9/15 specifically stated the resident would suffer consequences.
- 4/17 allow personal computers while 16/17 provide access to computers
 - 15/17 do not provide internet access
 - 1/17 uses visual observation while 1/17 uses a monitoring program
 - Staff observation, IT checking hard drives, and sign in sheets are used for monitoring computer use

Procedural Issues: Property

- 9/15 reported clients ask the treatment team to obtain items.
 - Others reported that policy determined what they were allowed, security/officers checked and allowed packages in, some limited packages to a few times a year, others allowed clients to order from approved vendors.
 - A paper trail of requests and permissions, room searches, and team involvement were noted as the means of monitoring this process.

Discharge & Conditional Release



Overview

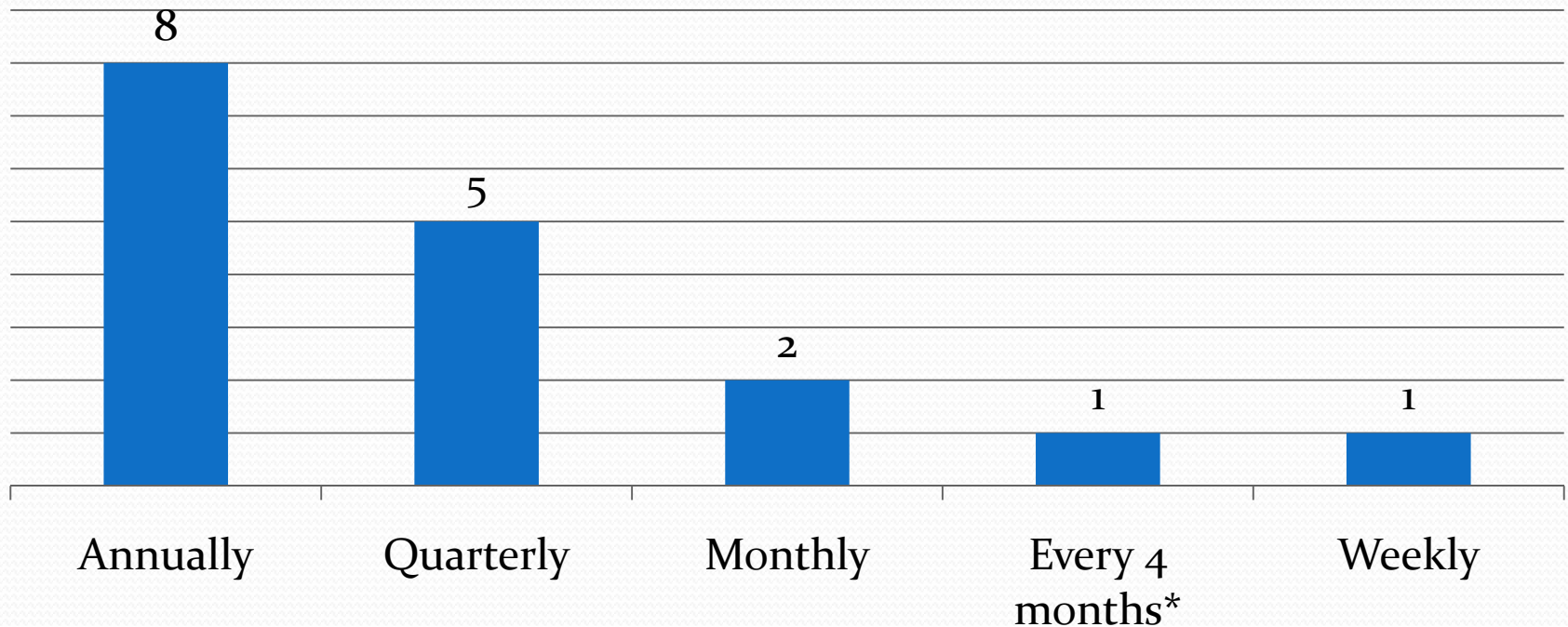
- Review process
- Conditional vs. Unconditional Release
- Frequency & Avenue of Discharges
- Recidivism



Frequency of Progress Reviews

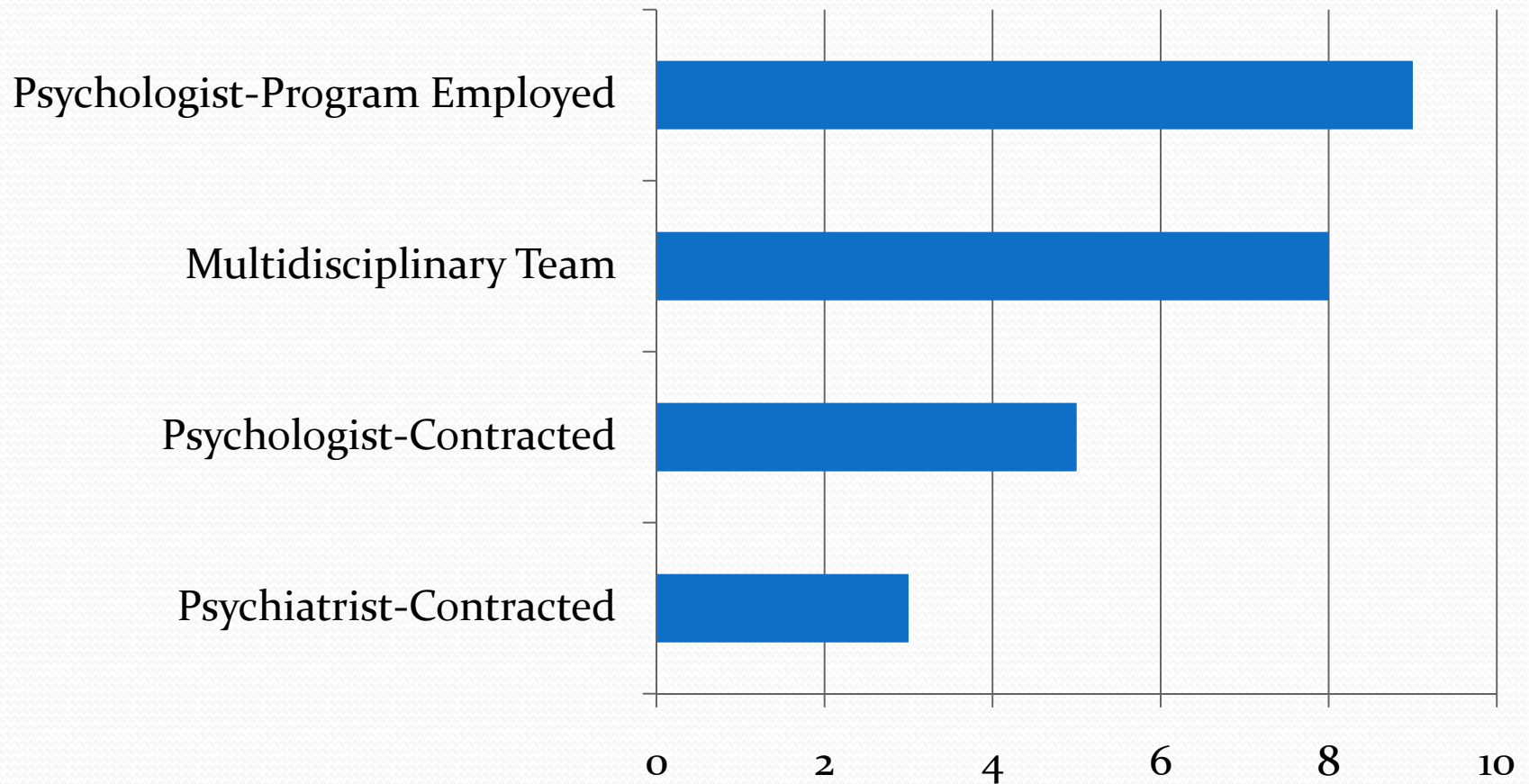
n = 17


Frequency



* Note: Review every 4 months for residents in SO treatment; every 6 months for non-treatment

Who conducts progress reviews





Discharges from Total Confinement ($n = 16$)

- 6 programs = Zero discharges ^a
- 8 programs = Range 1-39; Total = 179^b
- 1 program outpatient only
- 1 program > 600 total discharges ^c

^a Includes AZ

^b For programs housing detained and committed individuals, figures may represent both

^c Short term admissions (72 hour holds, etc.) included in total figure

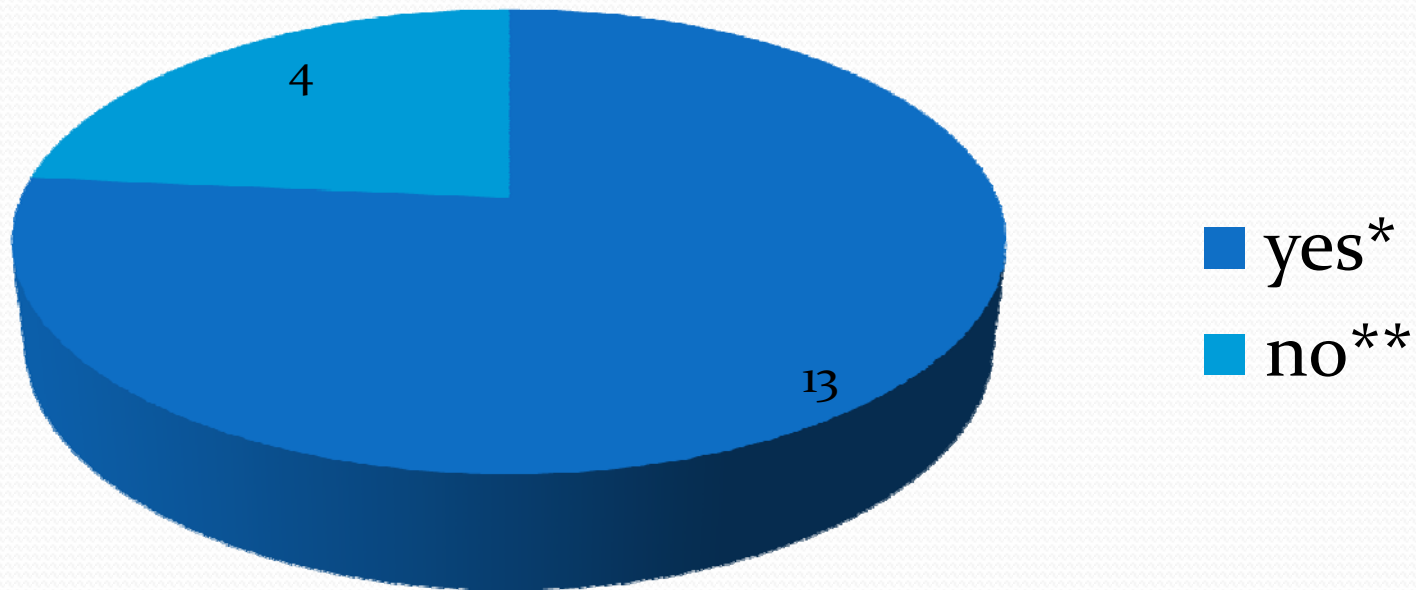
Of the programs with discharges ($n = 12$)

- Roughly:
 - 47 completed treatment/achieved maximum benefit
 - 90 without recommendation from treatment team or facility* (plus 575 from outlier state)
 - 99 died
 - Other avenues of discharge from total confinement included successful appeals in court and returning to DOC following new or additional charges (n unknown)

Note: Numbers are approximate due to missing or estimated entries (e.g., several, limited to one year, I think, etc.) or missing data/no access to the data

*2 programs indicated they do not make recommendations regarding release

Conditional Release Programs (n = 17)



*Includes outpatient only program

** One program currently working toward release procedures



Discharges from CR/LRA

- 45 Discharges from CR
 - 21 Completed treatment/maximum benefit
 - Only 4 were discharged without or against the recommendation of program*
 - 16 have died while on CR/LRA
 - 5 programs have zero discharges
- 110 AZ LRA Discharges
 - 5 without support from the program
 - Zero deaths

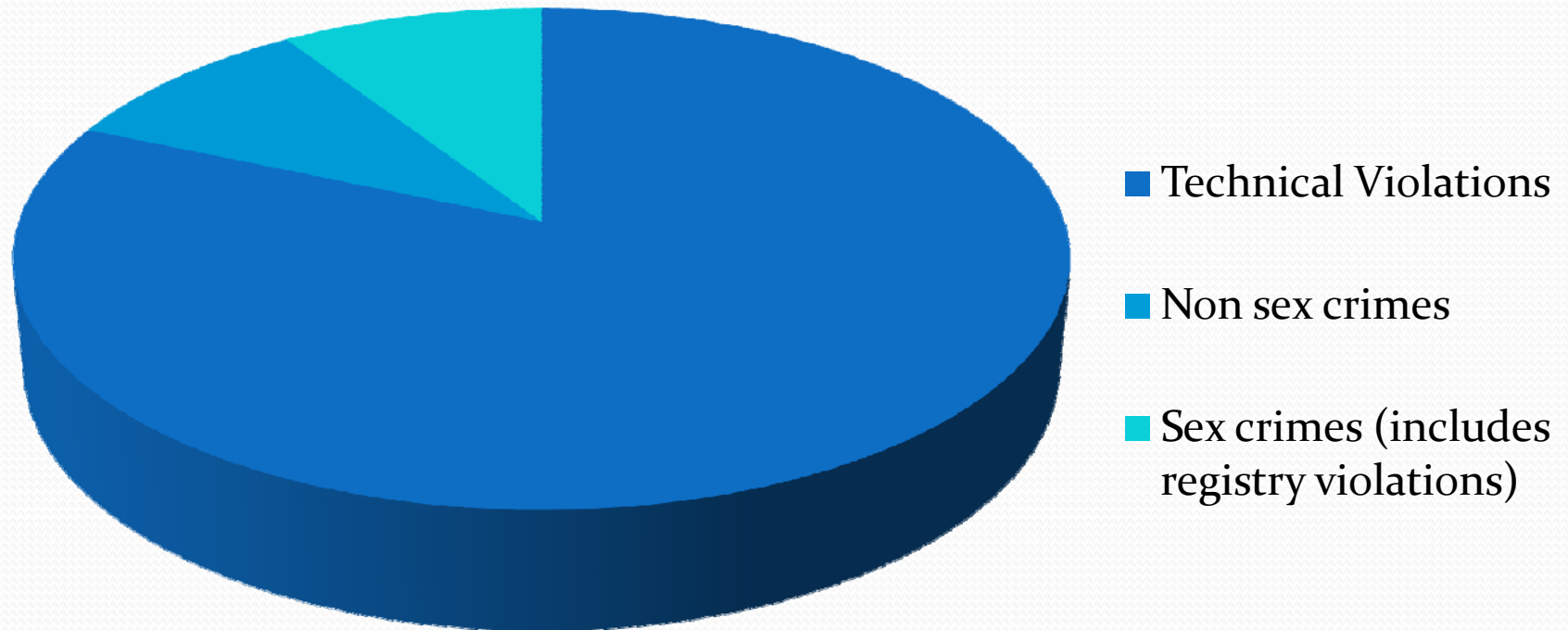
*Two programs do not provide discharge recommendations

Supervision After Discharge

n = 13

- None (n = 4)
- Unspecified supervision (n = 3)
- Only if unfinished probation or parole or subject to lifetime probation or parole (n = 2)
- Court has option at time of discharge (n = 1)
- Probation or parole, unspecified (n = 1)
- Probation/parole-mandated tx, GPS, polygraph (n = 1)
- Lifetime GPS (n = 1)

Violations & Recidivism



$n = 164$ reported events; 7 programs



Returned to Secure Facility*

- Returned to total confinement facility following violation (n = 49)
- Returned to jail or prison (n= 46)
- Outpatient only –approximately half returned to prison for new charges or failure to comply with civil commitment

*Based on 9 reporting programs

Thank you!

- For information about the survey or recommendations for next year, please contact Tara Travia (c-ttravia@state.pa.us), Jennifer Schneider (Jennifer.Schneider@dhs.state.nj.us) or Rebecca Jackson (bjackson@pgsp.edu)

SOC CCPN