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Sex Offender Policy Board

# Review of the Special Sex Offender Sentencing Alternative (SSOSA)

## December 2013

# Executive Summary

## Purpose

In October 2012, the Senate Human Services & Corrections Committee asked the Sex Offender Policy Board (SOPB) to review the Special Sex Offender Sentencing Alternative (SSOSA). The committee's request directed review of SSOSA issuance related to four core areas:

- Victim's input and granting of a SSOSA over victim's objections
- Consistencies or inconsistencies between jurisdictions in determining offender amenability to treatment
- Results of SSOSA
- Recommendations for improvements to the SSOSA process

This report offers an historical background and current context to highlight SSOSA evolution, processes, issuance outcomes and makes recommendations for changes to the SSOSA option.

## Historical Context

Washington's mental health response to sex offenders has changed over time. The state's mental health response began in 1949 with the creation of sexual psychopath laws and inpatient treatment. Western State Hospital was originally exclusively responsible for the housing and treatment of sex offenders, with the addition of a treatment program at Eastern State Hospital in the 1970s. Over time, Western State Hospital developed specific inpatient treatment programing for deviant sexual behavior. While the sex offender program at Western was developing as an inpatient modality, other sex offender treatment providers in Washington and nationwide were developing community-based treatment methods and techniques.

Over time a notable change in public opinion and legislative focus resulted in a shift from rehabilitative models of response to sex offenders to enhanced punishment approaches. With this shift in approach to addressing sex offenses, the program at Western State Hospital closed and the Department of Corrections took over responsibility for convicted sex offenders. This was a significant event in sex offender management in Washington state.

Another historically significant event in the early 1980s was the state's change to using a determinate sentence model. This shift in sentencing resulted in significant concern from sexual assault victim advocates regarding the chilling impact this would have on child victims who know or who are related to the offender. This concern, coupled with the promising community-based treatment modalities, led to the creation of the SSOSA in1984. The number of offenders granted a SSOSA has been limited by the issuance practice of requiring that the offender and victim be related to each other, rather than simply known to each other as the statute stipulates.

## Observations

The science of sex offender risk assessment and treatment and the provision of services for victims of sexual assault have grown enormously over the twenty-plus years since SSOSA was created. Sex offenders granted a SSOSA continue to have very low recidivism rates and have demonstrated to be at the lowest risk for reoffense among sex offenders. The SOPB urges the legislature to consider the advances made over the past twenty years and to adopt a risk management approach in considering SSOSA for offenders.

The SOPB compared the costs of incarceration to the costs of SSOSA. The review took into account the 15 percent of SSOSA offenders who revoke (the vast majority are for offenses other than sex crimes). It is noteworthy that the sex offenders with the highest rate for sexual recidivism are those who have a prison-only sentence.

## Recommendations

The SOPB makes the following recommendations regarding the SSOSA option:

- **Reinstate Department of Corrections supervision to the length of the suspended sentence (pre 2001), thus eliminating lifetime supervision for non-revoked recipients.**
- **Reinstate and fund the Sex Offender Treatment Advisory Committee.**
- **Clarify the SSOSA statute language and/or emphasize adherence to the existing statutory language regarding known offenders.**

## Additional Considerations

Two additional concepts are presented for further consideration and study:

- The SOPB recognizes a group of sex offenders who are low-risk to reoffend and may be eligible for SSOSA, but who are not ready to fully engage or able to complete an initial SSOSA. The SOPB identified another group of sex offenders: those who may be eligible, but for whom an initial SSOSA is deemed to be too lenient for the crime or the circumstances. The SOPB members discussed an option similar to the Drug Offender Sentencing Alternative model wherein sex offenders serve an initial two-to-three-year prison sentence, but also have access to sex offender treatment and can participate in other DOC programs.
- In surveys of SSOSA-related professionals and discussions in the SOPB, there was a clear interest in examining non-contact sex crimes (such as viewing of child sexual abuse images and pornography involving children) in relationship to SSOSA. Data clearly demonstrate these offenders are low-risk to sexually reoffend. Perhaps these offenders could be successful SSOSA recipients, and both they and the community would benefit.

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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 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?

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

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, responsive to legislative inquiry, and inclusive of recommendations for legislative consideration.

To best answer questions and place 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. To that end, the report provides a historical overview prior to presentation of recommendations.

## Historical Sex Offender Treatment in Washington State

### Inpatient Treatment

Washington's mental health response to sex offenders began in 1949. At that time the legislature passed "the first sexual psychopath laws in the state of Washington…Chapter 198, an act relating to the care and treatment of mentally ill

patients (including section 25 through 40) provided for the commitment, custody, detention, treatment, parole, and discharge of the sexual psychopath. By this legislative act, the state hospitals were given a dual responsibility of custody and treatment of offenders…" (di Furia, 1966). Hospital Program Director Dr. Giulio di Furia observed that, despite the focus placed on treatment in the governing legislation, what really occurred was that sex offenders were housed in security wards or buildings of mental hospitals, but very little treatment was provided.

Other Western State Hospital historians (MacDonald, Williams, & Nichols, 1968) described the conditions of those early years, from 1951-1958:

> 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.

MacDonald and colleagues 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 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 et al., 1968).

The decade of the Sixties 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 Hospital 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 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-1970s 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 treatment providers and consistently effective treatment principles and models were developed.

By 1980, the sex offender population at Western State Hospital 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 the 1970s. 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 Hospital. Two years later the number waiting was 95 and by the third year the number had risen to 145. Offenders on the waiting lists were held in county jails, which caused overcrowding and much consternation from county officials. To avoid major lawsuits, the program expanded twice in the early 1980s.

In addition to conditions of overcrowding, rapid expansion, and budget crises, 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. This paradigm shift, commonly known in the advocacy community 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 the maintenance of the program. Subsequent legislation eliminated the sex offender treatment program at Western State Hospital.

In 1986, a revision to the Sentencing Reform Act 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 inpatient 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.

## 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 developing rapidly, especially in Washington. The evolving field of treatment for sex offenders organized around a few major principles (O'Connell, 2013).

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.

## Sentence Reform

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

The SRA radically changed the sentencing structure to one of determinate sentences. While there were still maximum sentences for each crime classification, the development of standard ranges and an offender scoring 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 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 (Indeterminate Sentence Review Board, or 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 (Washington State Department of Corrections, 2013).

As the work commenced in the area of sex offenses, the sexual assault victim advocate community was vocal with concern about implications for victims. They recognized that the majority of sex offenses are committed against children and that most often the offender and victim have a relationship, typically a familial one. There was concern from advocates that such a rigid sex offense sentencing structure would have a chilling 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 and undermine community safety.

## Creation of SSOSA – SHB 1247 in 1984

As mentioned previously, sexual assault victim advocates were highly concerned about the deterring 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. 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 also expressed concern and their 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 creation of SSOSA met both the need to support reporting of familial sexual assault incidents and the preservation of community-based treatment for offenders.*

The Special Sex Offender Sentencing Alternative 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 the 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 and the preservation of community-based treatment for offenders. This was especially important with the elimination, through SRA, of the inpatient 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 assessing risk. The science of treatment has likewise improved considerably. Following is a short description of the evolution of the methods assessing sex offender risk, as described by R. Karl Hanson (1998):

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

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

Despite the common misperception that nothing can be done to effectively treat sex offenders, recent research indicates that specialized treatment, as one aspect of an overall approach to managing sex offenders, can be effective. Ongoing research is helping to determine the exact degree of effectiveness and to identify the specific therapeutic components that contribute to reduced recidivism.

For roughly the past 30 years the most common approach used in sex offender treatment programs was a cognitive-behavioral practice with a focus on the relapse prevention model. The goal of such treatment was to help offenders understand their offense behavior, take responsibility for that behavior, increase their motivation to change harmful behavior, and learn the skills necessary to control their deviance. Training in relapse prevention techniques helped offenders identify the chain of thoughts and behaviors that, if uninterrupted, could culminate in the commission of a new sex offense. In addition to learning to identify this progression, the offender was

expected to master alternative non-harmful techniques to intervene and stop the process. In recent years, increased recognition of individual differences has spurred a more individualistic approach. Providers have come to recognize that "one size does not fit all." A careful intake evaluation can reveal areas of strengths and deficits, including interpersonal relationships, social skills, emotional dysregulation, etc. A focus on assisting offenders to use their strengths and improve their areas of weakness known as the "Good Lives Model" has been growing in utility. Since this is a more recent development in the field, there have not yet been significant controlled studies that indicate success, but it is a promising new development.

*A key component of managing sex offenders in the community is the provision of specialized treatment services for them.*

A key component of managing sex offenders in the community is the provision of specialized treatment services for them. This includes the initial assessment once they are arrested or identified, as well as the treatment interventions they are expected to learn to reduce the likelihood of reoffense. As noted in the report by the Center for Sex Offender Management, *The Comprehensive Assessment Protocol: A Systemwide Review of Adult and Juvenile Sex Offender Management Strategies* (2008)*:*

> Because current research reveals that adult and juvenile sex offenders who receive treatment recidivate at lower rates than those who do not (see, e.g., Hanson, et al., 2002; Lösel & Schmucker, 2005; Reitzel & Carbonell, 2006), treatment plays an important role in promoting the success of these individuals and enhancing public safety. To be most effective, the nature, intensity, and targets of treatment should be assessment–driven, developmentally appropriate, and guided by the research about "what works" for adults and juveniles. Further, treatment cannot occur in isolation; providers must collaborate with other stakeholders to make sure that interventions are informed by a more complete "picture" of the individuals who are involved in the treatment process (see, e.g., Carter et al., 2004; Cumming & McGrath, 2005; English et al., 1996; NAPN, 1993).

What has evolved from the research is a more focused approach of identifying and targeting risk factors (known as 'dynamic risk factors' or 'long-term vulnerabilities'). Specialized assessment measures can be used by evaluators or community custody agents to better determine when and how an offender may be at increased risk. Instruments (such as the Static-99R, STABLE-2007, SRA-FV, and RSVP) have been developed in the past 5-15 years. These aid in first pinpointing the specific factors that contribute to a particular offender's risk and then measuring how active a risk factor may be in the present.

Essentially these risk assessment instruments are designed to help decision-making and monitoring of those who have already committed sexual offenses. By sharpening the focus of what contributes to offending, evaluators do a better job of identifying who is at higher risk. Treatment providers are better equipped to target particular areas of vulnerability for each client. Interventions can be better crafted to improve a client's responsiveness to treatment, which increases the effectiveness of treatment over all.

It should be noted that recidivism rates *are* lower for those individuals who complete sex offender treatment than for those who do not receive or complete treatment (Gallagher, Wilson, Hirschfield, Coggeshall, & MacKenzie, 1999; Hanson et al., 2002; Losel & Schmucker, 2005).

## A Review of SSOSA Elements - RCW 9.94A.670

Since its introduction in 1984, SSOSA has undergone significant modifications over the years. Key changes include:

- Consideration of whether the offender and the community will benefit from use of the SSOSA.
- As sex offense sentences lengthened over time, the eligible sentence length was also extended (from original sentences of 6 years, expanded to 8 years, to the current limit of less than 11 years).
- Term of community custody is equal to the length of the suspended sentence, the length of the statutory maximum sentence, or three years, whichever is greater.
- Treatment periods expanded from 2 years to 3 years to the current up to 5 years.
- 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 specified who was eligible for consideration of a SSOSA. The elements of eligibility included:

- Any violation of chapter 9A.44 RCW or RCW 9A.64.020 except RCW 9A.44.040 or RCW 9A.44.050;
- and has no prior convictions of chapter 9A.44 RCW, RCW 9A.64.020; or
- any other felony sexual offenses 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 pathways that could result in the issuance of a SSOSA:

1. In the first pathway, 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 the determination is that there is benefit, 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 two years.

   As a condition of the suspended sentence, the court may impose other sentence conditions including up to six 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.

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

2. The second path included:

   - 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 amenability 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 CCO of any change in the offender's address or employment;
  - Report as directed to the court and a CCO.
  - Undergo available outpatient treatment.

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.

## A Significant Influence: Community Protection Act of 1990

Two incidents in the late 1980s galvanized the public demand for an improved response to sex offenders. These were the murder of a young Seattle woman 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 (CPA).

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
- reduction 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
- significant increase of resources available for services to victims of sexual assault

The CPA also included the creation of the Sexual Offender Treatment Providers Advisory Committee and the requirement for certification of treatment providers. The legislation directed the Advisory Committee to develop standards for certification by the Department of Health (the Advisory Committee has since been unfunded and the authorizing statute was repealed in 2009).

It is clear that the CPA 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 and aspects of it are contained in most other states' sex offender laws.

Specific Impacts on SSOSA**:**

- lengthened treatment to 3 years
- maximum sentence allowed extended from 6 years to 8 years
- required 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:

1. Offenders convicted of their first two-strike offense
2. Offenders convicted of a non-two-strike sex offense (except failure to register) 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 as determined by the Indeterminate Sentence Review Board after a certain period of time, but will remain on community supervision for the remainder of their maximum sentence, or life (even where a SSOSA is granted) (Morishima, 2007).

## Revisions to SSOSA 2004

A significant SSOSA statutory revision occurred in 2004. The revision added eligibility elements. Those additions are (Barnoski, 2006, 06-01-1205):

- No prior adult conviction for a violent offense within the past five 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.

There was also an additional requirement of a recommendation of affirmative conditions and crime-related prohibitions to include identification of any known precursors to offender's offense cycle.

The court must consider additional factors as well. Those additions are:

- An examination report provided by a treatment provider
- Whether the offender and the community will benefit from the SSOSA
- Whether the offender had multiple victims

- 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 is amenable to treatment
- The risk the offender poses
- Whether the SSOSA is too lenient in light of the circumstances of the offense

An annual review by the court was also considered as a factor.

## 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 (Rape 1).
- 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
- Standard range for the offense includes the possibility of confinement of 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 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;
- 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.

## 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 (Barnoski, 2005, Doc No. 05-08-1203). The authorization 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 and the findings are summarized below (Barnoski, 2005, Doc No. 05-08-1203; Barnoski, 2005, Doc No. 05-09-1202; Barnoski, 2006, Doc No. 06-01-1206; Barnoski, 2006, Doc No. 06-01-1205).

When the SOPB sought more recent data on these topics, we were unable to find any system to which we had access that captured relevant data. We understand that when WSIPP conducted their studies, they were able to access extensive criminal justice data. Thus, when looking at trends, information in this report 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 nearly a decade old, the SOPB determined it to be important and still relevant to this current study of SSOSA.

### Trends in SSOSA Sex Offenders (Barnoski, 2005, Doc No. 05-08-1203)

- 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 had a child victim.
- 73% of sex offenders in prison involve a child victim.
- Proportionally fewer minorities receive SSOSA sentences than prison sentences.

### Trends in SSOSA Eligibility (Barnoski, 2006, Doc No. 06-01-1205)

- 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 (Barnoski, 2006, Doc No. 06-01-1205)

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

## SSOSA and Recidivism – 1986-1998 (Barnoski, 2005, Doc No. 05-08-1203)

- Felony sex offense recidivism rates for sex offenders released from prison have generally been decreasing, for both those eligible for SSOSA and those not eligible. Both felony sex and violent felony recidivism rates for those granted SSOSA remain consistently low.
- Recidivism rates 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 (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 of recidivism in all categories.
- Sex offenders sentenced to jail or community supervision have rates similar to, but slightly below, the recidivism rates of those sentenced to prison.

## 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 be revoked for any violation of rules imposed as part of a SSOSA agreement, such as substance use or failure to register.

### SSOSA Sex Offender Revocation Data (Barnoski, 2006, Doc No. 06-01-1206)

- SSOSA revocations increased from an initial rate of 15% in 1986 to a high of 25% in 1994, and then fell 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 rates 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 be revoked. 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. (This average is based on SSOSA offenders who were revoked and then released from prison between 2000 and 2005).
- 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.

## SSOSA/Treatment Cost vs. Incarceration Cost

One criterion on which the SOPB reviewed SSOSA was the cost of SSOSA in comparison to the cost of incarceration. Without the SSOSA option, these sex offenders would be in our state prison system. As with many complex policy positions, cost is certainly not the only criterion or even the most important lens through which to determine value. However, the cost comparison has merit and was part of our work in reviewing SSOSA. It should be noted that offenders granted a SSOSA sentence 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 (n=95) who were sentenced to SSOSA in state fiscal year 2012 is $16,149,600.

WSIPP 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 WSIPP or another 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. For additional detail regarding the assumptions, see Appendix A.

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. Fiscal year 2012 data was used for developing the assumptions, with the exception of the revocation rate which is an average of three fiscal years. For offenders who were sentenced to SSOSA in fiscal year 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 that are subsequently revoked and then sent to prison. When these lost savings 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 fiscal year 2012 is $16,149,600.**

**SSOSA Sentence vs. Prison Sentence**
**Cost Savings per Offender**

| | Prison | SSOSA Completers | SSOSA With Revocations |
|---|---|---|---|
| **Program Costs** | $247,116 | $45, 246 | **$22,263 additional |
| **Savings to the State** | $0 | $201,870 | $166,424 |

**includes the additional cost of offenders with a revoked sentence and the state paying for both the period of time on SSOSA and the original sentence.

**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 fiscal year 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 fiscal year 2012 that will complete the program.**

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

## 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 (2006).

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 percent of women who had experienced a sexual assault in their lifetime, 80 percent 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 over those decades 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 and questioned 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 by examining the legislative framework, with its original intent, as well as through the lens of decades of experience, research, science, and multidisciplinary expertise. It is with this combination of perspectives that the SOPB examined the questions related to the Special Sex Offender Sentencing Alternative brought before it currently.

An element of eligibility includes that the defendant "voluntarily and affirmatively admit he or she committed all of the elements of the crime to which the offender is pleading guilty." Notably, research on factors related to sex offense recidivism has failed to find a correlation between denial and sexual reoffense. Meta-analytic studies, combining many smaller research studies, have found that deviant sexual arousal and psychopathy are the two factors that most predict sexual recidivism. These other factors have been incorporated into actuarial tools that have been tested in field studies

and found to have moderate predictive value. But, denial has not been found to predict sexual reoffense.

While the statute only requires there to be a relationship between the offender and the victim, some jurisdictions in practice go further than the law to require that the offender and victim be family members. This practice narrows the eligibility pool by restricting those that may benefit.

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

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

## Questions from the Senate and Responses

The SOPB's 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 specifically to review and respond to questions related to the role and influence of victim input in SSOSA issuance, offender amenability, and SSOSA 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 obtained through surveys of professionals statewide who are involved in the SSOSA 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 surveys across the professions included one identical open-ended question asking what changes they would make to SSOSA. Given lack of systematic collected data, the surveys yielded valuable insight and practice information. Survey questions can be found in Appendix A.

### Victim Input

#### Question Posed to SOPB

***How often is a SSOSA imposed over the victim's objections and what are the reasons noted by the court in doing so?***

RCW 9.94A.670 requires the court to give great weight to the victim's opinion; the court must enter written findings for its reasons for imposing the treatment disposition if the sentence is contrary to the victim's opinion.

#### Findings

Of those surveyed, each profession had varied experiences of SSOSA being issued when contrary to a victim's opinion. It is noteworthy that the survey results indicate 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 SSOSAs have been granted in opposition to victims' 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 the victim, the defendant's background, the 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

To increase the consistent application of practices associated with the requirement for obtaining victim input, we recommend adding a section to the Pre-Sentence Investigation Report form that indicates if the victim was consulted and if they approved of a SSOSA option.

## Offender Amenability

### Questions posed to SOPB

***Explore consistencies or inconsistencies between jurisdictions in determining that an offender is amenable to treatment and how this finding contributes to the decision to order a SSOSA. What happens if the Department of Corrections does not believe treatment can be successful? Should there be more consistent standards for***

***determining when an offender is amenable to treatment and is therefore eligible for a SSOSA?***

## Findings

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.***

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 differences across jurisdictions.

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

- Treatment providers were asked: **"*In your experience, SSOSA evaluators have a common definition of 'amenable to treatment'.*"**
    - 53% responded Yes
    - 29% responded No
    - 18% responded 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% responded Yes
    - 22% responded No
    - 39% responded Don't Know

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

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

There is no verifiable data to respond to this question. 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 upon 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 his or her 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?***
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

### 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

***Completion of Treatment and Recidivism***
Data provided by the Department of Corrections collected from 2009-2011 shows revocation rates of SSOSA at an average of 16 percent. A revocation of SSOSA does not indicate that an offender sexually recidivated. Rather, a SSOSA can be revoked for any violation of rules imposed, such as substance use or failure to register. In fact, data show that only 3.8 percent revoke for felony sex crime recidivism.

Sex offenders who complete SSOSA have the lowest recidivism rate of sex offenders across sex offense categories (felony and misdemeanor). Additionally, offenders who complete a SSOSA have lower recidivism rates than otherwise SSOSA eligible incarcerated offenders. This reduced recidivism rate is demonstrated across felony, felony sex, violent felony and felony sex crime charges (Barnoski, 2006, Doc No. 06-01-1205). The efficacy of the SSOSA program is demonstrated in reduced recidivism rates, low revocation frequency, and significant cost savings to the state.

***Response to Violations***
While SSOSA 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 is employed by DOC in response to violations. However, action after arrest is influenced by the availability of the court.

## SOPB Findings and Recommendations for Improvements to the SSOSA Process

The SOPB has developed findings and 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 findings and recommendations are also informed by a survey given to professionals involved in SSOSA, previous studies of SSOSA, recent research, and the expertise of the multidisciplinary composition of the SOPB.

### SSOSA Issuance

#### Findings

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

By 2005, only 63 percent 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 percent to 15 percent, demonstrating a decrease of sex offenders who are statutorily eligible and an increase 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 (see Appendix B) indicates inconsistent application by judges and prosecutors of the victim/offender relationship standard outlined in the statute.

The operating practice of many respondents requires the offender and victim to be family members, rather than "known" as illustrated below:

***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 as outlined by the statute plus 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 consideration to family members have narrowed the intent of the statute and impacted the number of otherwise SSOSA

eligible offenders. This constricting 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 instances where the offender is known but not a family member and thereby directs resources toward incarceration, a more costly and less effective response

**Recommendation:**

**Clarify the statute language and/or emphasize adherence to the existing statutory language.**

## Length of Supervision

### Findings

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

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

Approximately 15 percent of SSOSA sex offenders are revoked. [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.]

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

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

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

### 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, 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 develop 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 a 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 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 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.

**Recommendation:**

**The state should strengthen oversight of the certification requirements of sex offender treatment providers. The Sex Offender Treatment Provider Advisory Committee should be reinstated and funded to carry out this responsibility.**

## 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 recognized a group of sex offenders who are at low risk to reoffend and may be eligible for SSOSA, but yet 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. These offenders are likely candidates to revoke within the first three years, when the vast majority of revocations occur. 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 prison-based SSOSA concept whereby these sex offenders would serve a two- to three-year prison sentence, with the remainder of the sentence suspended. During their incarceration, 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 both 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 exploring this concept further.

## Data Collection and Analysis 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 seven 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 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.

## Community-Based Treatment for 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 questions posed on the survey by the SSOSA review committee in May 2013 specifically addresses the issue of pornography cases. 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; 85 percent of respondents proposed changes to SSOSA eligibility in order to include these cases.

A recent study by Seto et al. (2005) provided important information on this topic. He found that nine studies of online (mostly child pornography) offenders who were followed for an average of three-and-a-half years, showed 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 three percent of child pornography offenders were arrested, charged or convicted for a new child pornography offense. Further, only about two percent were arrested, charged or convicted for a new contact (hands-on) sexual offense.

While such offenders may not have a relationship with the victim, they are at low risk and likely could benefit from community-based treatment rather than a prison term – whether under SSOSA or another mechanism.

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# Appendices

## Appendix A - 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 sentences completed in the community results in additional supervision cost of $22,623 (50% of supervision time) per offender who is revoked.

   Revocation = 16% (average of SFY 2009-2011) rate (x) 95 offenders in fiscal year 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 fiscal year 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 fiscal year 2012 is 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 fiscal year 2012 who 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.

(*All data provided by the Department of Corrections, August and September 2013)

## Appendix B –SSOSA Survey Questions

Final SSOSA Survey

**General demographic questions:**

Geographically, your office is best described as being in North Puget Sound Puget Sound Peninsula Southwest WA North Central WA South Central WA North East WA South East WA

In an average year, the number of sex offense cases managed by your office 1-5 6-15 16-25 26-35 36+

The number of staff who work in your office 1-5 6-10 11-15 16-20 21+

**Victim/Witness Survey Questions**

In your office, victim witness staff are involved in the SSOSA process Never Rarely Sometimes Most of the Time Always

In the past year, the number of SSOSA cases in which your office was involved 1-5 6-15 16-25 26-35 36+

Typically, the SSOSA option is explained to the victim by: V/W Deputy PA Pros Att No One Other:

In your experience, SSOSA is granted over the victims stated objections Never Rarely Sometimes Most of the Time Always

In cases where the defendant and victim are family members, the defendant's requirement to pay for treatment had a negative impact on the victim and/or the rest of the family Never Rarely Sometimes Most of the Time Always

In your office, describe the ways the victim is involved in the sentencing/SSOSA determination process

**Deputy Prosectutor/Prosecutor Survey Questions**

In your office, victim witness staff are involved in SSOSA Never Rarely Sometimes Most of the Time Always

In the past year, the number of SSOSA cases in which your office was involved 1-5 6-15 16-25 26-35 36+

The SSOSA option is typically explained to the victim by: V/W Deputy PA Pros Att No One Other:

SSOSA is granted over the victims stated objections Never Rarely Sometimes Most of the Time Always

Please describe how, in your office, the victim is involved in the sentencing/SSOSA determination process

Judges ask the victim about SSOSA in court Never Rarely Sometimes Most of the Time Always

How and where do judges record the reasons they are granting a SSOSA over the victim's wishes?

Judges rulings are consistent with the psychosexual amenability to treatment assessment Never Rarely Sometimes Most of the Time Always

Do you think SSOSA Evaluators in your community have a common standard or definition of "amenability to treatment"? No Yes Don't know

Judges grant SSOSA if an offender is assessed as **not** amenable to treatment? Never Rarely Sometimes Most of the Time Always

In assessing eligibility, it is a requirement that SSOSA defendants' crime(s) were against a family member Never Rarely Sometimes Most of the Time Always

Assuming the appearance of eligibility, your office considers a SSOSA Never Rarely Sometimes Most of the Time Always

In cases you have prosecuted, the defendant's (otherwise eligible) ability to pay for treatment has been an obstacle to being granted a SSOSA Never Rarely Sometimes Most of the Time Always

Do you have SSOSA related data? Is it easy to acquire?

If you could make changes to SSOSA, what would those changes be?

**Judges Survey Questions**

In the past year, the number of cases that came before you with a request for SSOSA 1-5 6-15 16-25 26-35 36+

In cases where SSOSA was requested, it was granted Never Rarely Sometimes Most of the Time Always

You ask the victim's opinion regarding the defendant's request for a SSOSA Never Rarely Sometimes Most of the Time Always

I will grant a SSOSA even if the victim has stated they do not want it granted Never Rarely Sometimes Most of the Time Always

How/where do you document the reasons for granting the SSOSA?

In assessing eligibility, it is a requirement that SSOSA defendants' crime(s) were against a family member Never Rarely Sometimes Most of the Time Always

SSOSA is granted if the assessment shows the defendant is amenable to treatment Never Rarely Sometimes Most of the Time Always

Do you think SSOSA Evaluators in your community have a common standard or definition of "amenability to treatment"? Yes No Don't Know

List examples of reasons you have not granted a SSOSA when the assessment showed the defendant was amenable to treatment

**WATSA Survey Questions**

Do you serve multiple jurisdictions? Yes No How many? 2-3 4-7 8+

Do multiple judges preside over sex offense cases in these jurisdictions? Y N How many? 2-3 4-7 8+

In your experience, SSOSA evaluators have a common definition of "amenable to treatment" Yes No Don't Know

If so, you think evaluators apply the definition Never Rarely Sometimes Most of the Time Always

In assessing SSOSA eligibility, you require that the defendant's crimes were against a family member Never Rarely Sometimes Most of the Time Always

I know if a SSOSA was granted or not on evaluations I made Never Rarely Sometimes Most of the Time Always

If yes, how do you learn the SSOSA granted or not on evaluations you made?

If you could make changes to SSOSA, what would those changes be?

**Defense Attorney Survey Questions**

In the past year, the number of your SSOSA cases in which your office was involved 1-5 6-15 16-25 26-35 36+

In your experience, a SSOSA is granted over a victim's objections Never Rarely Sometimes Most of the Time Always

Judges rulings are consistent with the amenability to treatment recommendation Never Rarely Sometimes Most of the Time Always

Other factors you know judges use to determine whether to grant a SSOSA are:

Your office represented SSOSA cases where the defendant was accused of assaulting someone other than a family member Never Rarely Sometimes Often Always
Assuming the appearance of eligibility, a SSOSA is considered Never Rarely Sometimes Most of the Time Always

What factors do you consider when requesting a SSOSA on behalf of a client?

The ability to pay for treatment is an obstacle for defendants your office has represented Never Rarely Sometimes Most of the Time Always

If you could make changes to SSOSA, what would those changes be?